GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 4, 2021

Stephen Levy
The Sheridan at Birmingham
2400 E. Lincoln Street
Birmingham, MI 48009

RE: License #: AH630381578
Investigation #: 2021A0784048
The Sheridan at Birmingham

Dear Mr. Levy:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L. Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH630381578
Investigation #:	2021A0784048
Complaint Receipt Date:	08/23/2021
Investigation Initiation Date:	08/23/2021
Report Due Date:	10/22/2021
Licensee Name:	CA Senior Birmingham Operator, LLC
Licensee Address:	161 N. Clark Suite 4900 Chicago, IL 60601
Licensee Telephone #:	(312) 673-4387
Administrator:	Jordan Houston
Authorized Representative:	Stephen Levy
Name of Facility:	The Sheridan at Birmingham
Facility Address:	2400 E. Lincoln Street Birmingham, MI 48009
Facility Telephone #:	(248) 940-2050
Original Issuance Date:	03/29/2018
License Status:	REGULAR
Effective Date:	09/27/2019
Expiration Date:	09/26/2020
Capacity:	128
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A received inadequate supervision and assistance	Yes
Additional Findings	No

III. METHODOLOGY

08/23/2021	Special Investigation Intake 2021A0784048
08/23/2021	Special Investigation Initiated - Letter APS referral
08/23/2021	APS Referral
08/24/2021	Contact - Telephone call made Attempted with Complainant. Message left requesting a return call
08/25/2021	Contact - Telephone call made Interview conducted with Complainant
08/25/2021	Inspection Completed On-site
08/25/2021	Inspection Completed-BCAL Sub. Compliance
10/01/2021	Contact – Telephone call made Attempted contact with authorized representative Stephen Levy. Message left requesting a return call
10/04/2021	Contact – Telephone call made Attempted contact with Mr. Levy
10/04/2021	Exit Conference – Telephone Conducted with administrator Jordan Houston

ALLEGATION:

Resident A received inadequate supervision and assistance

INVESTIGATION:

On 8/23/21, the department received this complaint.

According to the complaint. Resident A is a 90-year-old a stroke victim and can't use the right side of her body. She needs and her care plan requires a two person assist to get in/out of bed, her chairs, the toilet and the shower. The facility only provides one person assist and staff often hurt [Resident A] when moving her. Staff frequently take an excessive amount of time to respond when Resident A uses her call pendent for assistance with activities of daily living (ADL's) such as using the restroom and getting out of bed and dressed in the morning.

On 8/25/21, I interviewed Complainant by telephone. Complainant stated Resident B, often has to assist Resident A when staff do not respond timely to her call pendent used to summons staff. Complainant stated that according to facility administration, staff are supposed to respond to resident activated call lights within 10 minutes "at least" and that Resident A often has to wait at least 30 minutes and sometimes in excess of an hour, for staff to arrive. Complainant stated the call pendent system also does not always work correctly which may be leading to some of the delays.

On 8/25/21, I interviewed Resident A and B together at the facility. Resident A stated she requires assistance with transfers to and from her bed to her wheelchair and into her reclining chair, which she was sitting in at the time of the interview. Resident A stated the facility usually has one person helping her to stand and transfer. Resident A stated she can sometimes stand on her own, but that she prefers staff assistance as she is not always certain she can do it. Resident A stated that usually a staff member will assist her on her right side as she is weak in that arm due to a previous stroke. Resident A stated that at times staff squeeze a little too tight on her arm and it can hurt. Resident A stated most staff do a good job of being gentle. Resident B stated Resident A is often uncomfortable and scared when she stands ups during her transfers as only one staff person will come to assist her, and she prefers two staff so one person can stand directly behind her. Resident A agreed with Resident B adding she often feels unsupported without someone behind her. Resident B stated he and Resident A have both requested two people for transfers and that they have been told only one person is required. Resident B stated Resident A also has a gait belt that can be used by staff. Resident B stated the use of the gait belt has been presented as an option for staff and that, "for some reason", it is never used. Resident B stated both he and Resident A have wristwatch pendants which, when pressed, alert staff that they are needed for assistance with ADL's. Resident B stated it is often the case that staff do not come to assist for more than 30 minutes and sometimes over an hour. Resident B stated that due to the lack of adequate response time, he will often help Resident A with assistance getting up and dressed in the morning and using the rest room. Resident A agreed with Resident B's statements regarding delayed responses from staff. Resident B stated that on some occasions staff do not respond at all and Resident A has to wait until a staff member

happens to check on them. During the interview I asked Resident B to press his wristwatch pendant to alert staff. I watched Resident B press the pendent and after approximately 25 minutes, staff had not arrived at the room to inquire about needed assistance.

On 8/25/21, I interviewed business operations manager Jordan Houston at the facility. Mr. Houston stated he is familiar with Resident A and B and has had a lot of discussions with them and their family regarding Resident A's care. Mr. Houston stated Resident A is service planned for a one person assist with transfers. Mr. Houston stated it was his understanding that Resident A felt comfortable with a one person assist. Mr. Houston stated he is aware that Resident A has a gait belt and that he was not aware of any requests to use or even aware that anyone felt it was necessary to be used. Mr. Houston stated Resident B has reported, on many occasions, that staff do not respond quickly enough to assist Resident A. Mr. Houston stated he is aware the Resident B will choose to help Resident A at times. Mr. Houston stated it seems that Resident B has an expectation that staff will respond immediately when summand's. Mr. Houston stated he would prefer staff to respond to call lights within five to seven minutes and that the general time of response for staff is "probably closer to 10 to 15 minutes". Mr. Houston stated he does not feel staff response times are excessive to Resident A. When asked about the functioning of the facilities pendent system, Mr. Houston stated he is not aware of any malfunctions in the system. Mr. Houston stated that when a resident presses the pendent, an alert is sent to phones which staff maintain during their shift. Mr. Houston stated that when staff respond to the alert, they have to place the phone in close to the pendent in order to turn the pendent alert off and show the call has been answered. Mr. Houston stated sometimes staff do not perform this action properly so it will appear as if no one responded. After informing Mr. Houston that I had Resident B press his pendent and no staff responded, he investigated and found that the battery on Resident B's pendent needed to be replaced. Mr. Houston stated that when a pendent battery is getting low, a notification is sent to supervision, in the same manner staff receive pendent notifications, and that someone should have changed the battery but apparently did not. Mr. Houston stated that residents also have a pull cord in their bathroom which notifies staff and does not require a battery change. Mr. Houston stated he has recently been granted a request he made with his corporate office for a new call pendent system but stated this was not due to any malfunctions in the current system.

On 8/25/21, I interviewed administrator Jane Goulette at the facility.
Ms. Goulette provided statements consistent with those of Mr. Houston.

On 8/25/21, I interviewed supervisor and care associate Bianca Johnson at the facility. Ms. Johnson stated she has worked with Resident A on many occasions. Ms. Johnson stated Resident A requires a one person "stand by" for assistance with transfers to "make sure she does not fall", but that Resident A "does not require physical support". Ms. Johnson stated Resident A has never expressed a fear of transferring or of falling during transfers. Ms. Johnson stated Resident A use to be

a two person transfer and that the facility discontinued this because “they”, Residents A and B, stated Resident A did not need two people for transfers. Ms. Johnson stated she could not recall how long ago this change was made. Ms. Johnson provided statements consistent with those of Mr. Houston as it pertains to call response time expectations of staff and of Resident B.

On 8/25/21, I interviewed associate Christian Garcia at the facility. Ms. Garcia stated she was helped Resident A with transferring on several occasions. Ms. Garcia stated Resident A can transfer “mostly on her own” and that she occasionally requires light support under one of her arms with a hand on her back. Ms. Garcia stated she is not aware of any requests by Resident A for additional staff for assistance or for the use of a gait belt.

On 8/25/21, I interviewed associate Canedra Polk at the facility. Ms. Polk provided statements consistent with those of Ms. Garcia.

I reviewed Resident A’s service plan provided by Mr. Houston. Under a section titled *Mobility/Ambulation*, the plan read, in part, “[Resident A] is dependent on staff members for all mobility/ambulation needs or requires hands on assistance on routine basis”. Under a section titled *Transferring*, the plan read, in part, “[Resident A requires routine hands on assistance with transfers and/or changes in position. [Resident A] is able to stand and pivot but does have poor weight bearing and becomes nervous with staff so staff will explain what they are doing prior to assisting. [Resident A] can be transferred with one assist but staff must explain to her step by step as [Resident A] becomes nervous easily during transfer and explaining the transfer process to her will decrease her anxiety”. Under a section titled *Bathing*, the plan read, in part, “1 person staff assist”. Under a section titled *Dressing*, the plan read, in part, “[Resident A] wears nightgowns daily and does not want to change her nightgown only on shower days and other days of her preference. [Resident A] is able to choose the night gowns and lift her arms to assist with taking the night gown on and off”. Under a section titled *Toileting*, the plan read, in part, “[Resident A requires physical assistance with all tasks related to toileting. [Resident A] is able to push her pendant to alert staff to take her to the toilet. [Resident A] wears pull ups and staff will need to assist her with changing these along with applying a pad inside the pull up per [Resident A’s] preference. [Resident A] is able to stand and pivot in the bathroom but requires staff to provide peri care as [Resident A is unable to wipe herself after toileting”.

I reviewed the facilities *CARECENTER ALERT RESPONSES SUMMARY* for Resident’s A and B between 8/21/21 and 8/24/21, provided by Mr. Houston. Of the 27 recorded calls, denoted as either “Emergency Call” or “Bathroom Pull Cord”, 14 of those calls are recorded as having a response time in excess of at least ten minutes of which, 11 of the calls indicate a response time in excess of 20 minutes.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
For Reference: R 325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	Interviews with staff, Residents A and B, as well as, review of Resident A's service plan, revealed contradictions regarding Resident A's transfer needs. For instance, Resident A stated she would prefer two staff persons to assist during her transfers to ease her fears of potentially falling while the plan outlined only one. The use of a gait belt for safety was not clearly defined despite Resident A knowing it was available as an added layer of protection for her. The plan also identified one methodology to follow as the verbalization of each step staff were to take when helping Resident A, however none of the staff verbalized this during their interview as something they do. The plan further outlines staff responsibility to assist her with multiple ADL's, including bathing, grooming, dressing and toileting. However, the timeliness of this assistance has not been at acceptable levels. While on the day of my inspection the reason for staff not responding was the failed battery, other instances have occurred with frequency that is not consistent with ensuring Residents A or even other residents' that are dependent on staff are treated in a dignified, including timely, manner when they summon for assistance. Resident A's plan was not developed to include her preferences and was not implemented in a manner consistent with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/4/21, I discussed the findings of the investigation with administrator Jordan Houston.

IV. RECOMMENDATION

Upon receipt of an acceptable correction action plan, it is recommended that the status of the license remain unchanged.

9/30/21

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Aaron Clum Date
Licensing Staff

Approved By:

10/1/21

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Russell B. Misiak Date
Area Manager