GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 15, 2021

Beth Mell
Brookdale Grand Blanc AL
5080 Baldwin Road
Holly, MI 48442

RE: License #: AH250236939
Investigation #: 2022A1027007
Brookdale Grand Blanc AL

Dear Ms. Mell:

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 the licensee authorized representative 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) 284-9727.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 241-1970
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250236939
Investigation #:	2022A1027007
Complaint Receipt Date:	10/27/2021
Investigation Initiation Date:	10/27/2021
Report Due Date:	12/26/2021
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	Suite 2300 6737 West Washington St. Milwaukee, WI 53214
Licensee Telephone #:	(414) 918-5000
Administrator:	Heather Lauwers
Authorized Representative:	Beth Mell
Name of Facility:	Brookdale Grand Blanc AL
Facility Address:	5080 Baldwin Road Holly, MI 48442
Facility Telephone #:	(810) 953-7111
Original Issuance Date:	10/01/1998
License Status:	REGULAR
Effective Date:	05/07/2021
Expiration Date:	05/06/2022
Capacity:	78
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had a fall.	No
Resident A did not receive his medications per physician order.	Yes
The facility's contracted nurses were not trained.	Yes
Additional Findings	No

III. METHODOLOGY

10/27/2021	Special Investigation Intake 2022A1027007
10/27/2021	Special Investigation Initiated - Letter Email sent to administrator Heather Lauwers requesting Resident A's facesheet, service plan and medication administration records for October 2021
10/28/2021	Contact – Document Received Email received from administrator Heather Lauwers with requested documentation
11/15/2021	Inspection Completed On-site
11/15/2021	Inspection Completed-BCAL Sub. Compliance
11/22/2021	Exit Conference Conducted with authorized representative Beth Mell

ALLEGATION:

Resident A had a fall.

INVESTIGATION:

On 10/27/21, the department received an anonymous complaint which read Resident A had a fall possibly due to his medications being given by staff incorrectly.

On 11/15/21, I conducted an on-site inspection at the facility. I interviewed Health and Wellness Director Scott Barnier who stated Resident had a fall in October. Mr. Barnier provided the facility's incident report for Resident A's fall. The report read Resident A had a fall on 10/15. The report read staff went to Resident A's room to answer the call pendant and observed Resident A laying on the floor in the doorway of the bathroom. The report read Resident A stated he was walking to the bathroom and "blacked out." The report read Resident A complained of left upper arm pain. The report read staff notified the facility nurse, as well as Resident A's primary care physician, hospice team and authorized representative. The report read an x-ray showed a fracture in the head of the humerus which did not require surgery and was placed in an immobilizer. Additionally, the report read it was submitted to licensing staff Aaron Clum on 11/16.

I reviewed Resident A's service plan which read he has a diagnosis of syncope and vasovagal syndrome. The plan read Resident A was to be instructed to rise slowly from a seated position to standing and if feels dizzy, to wait five minutes before ambulating alone. The report read Resident A has fallen in the last 12 months.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	Interview with the Health and Wellness director along with review of facility documentation revealed Resident A had fallen on 10/15/21. Facility staff sought treatment and reported the fall to the department as well as Resident A's authorized representative, physician, and hospice agency. It cannot be determined if the fall was related to medication error or due to the Resident's history of falls and diagnoses.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A did not receive his medications per physician order.

INVESTIGATION:

On 10/27/21, the department received an anonymous complaint which read Resident A did not receive his medications per physician orders on 10/11, 10/13 through 10/18 and 10/20 through 10/22.

On 11/15/21, while on-site, Ms. Lauwers and I reviewed Resident A's October medication administration records (MARs). The MAR read Metoprolol Tart Tab 50 mg 1 tablet by mouth two times a day (hold for systolic blood pressure less than 150 or heart rate less than 64) (Related diagnoses: Essential (primary) Hypertension). Ms. Lauwers stated Resident A should not be administered medication Metoprolol if Resident A's blood pressure is either less than 150 or his heart rate is less than 64. The MAR read Resident A was given Metoprolol on the follow dates:

10/2 for a blood pressure of 130/60
10/6 for a blood pressure of 147/79
10/8 for a blood pressure of 102/63
10/11 for a blood pressure of 136/79
10/13 for a heart rate of 63
10/14 for a blood pressure of 146/78
10/15 for a blood pressure of 138/78
10/16 for a blood pressure of 143/80
10/17 for a blood pressure of 140/81
10/18 for a blood pressure of 146/74
10/20 for a blood pressure of 145/79
10/21 for a blood pressure of 148/76
10/22 for a blood pressure of 146/80

The MAR read some staff did not administer Metoprolol when Resident A's blood pressure was less than 150 or heart rate of less than 64 in which they marked the reason as "vital sign outside of parameter." While on-site, I reviewed the MARs with Health and Wellness Director Scott Barnier whose statements were consistent with Ms. Lauwers. Mr. Barnier confirmed the physician order for Metoprolol was printed on the MAR correctly per facility documentation and staff did not administer the medication per the order.

I reviewed Resident A's service plan. The plan read

"Staff to check B/P two times day, see MAR for scheduled times. Normal rang of B/P for res is 145-155/under 95 per previous PCP, Dr. Larry Braver. Staff to hold B/P meds listed on MAR if Systolic Blood pressure is less than 150."

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.

ANALYSIS:	Staff interviews along with review of facility documentation revealed staff administered Resident A's medication Metoprolol when his blood pressure or heart rate were outside the parameters per the written physician order, thus the medication was not administered correctly.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility's contracted nurses were not trained.

INVESTIGATION:

On 10/27/21, the department received an anonymous complaint which read the contracted nurses were not trained properly.

On 11/15/21, Ms. Lauwers stated the Brookdale corporation has a contract with agency Snap Nurses. Ms. Lauwers stated the agency provides nurses to all Brookdale Facilities. Ms. Lauwers stated the facility is utilizing three contracted licensed practical nurses (LPN) from Snap Nurses to administer medications. Additionally, Ms. Lauwers stated the facility has some full-time staff employed who are trained to administer medications. Ms. Lauwers stated facility's staff training for medication administration requires staff to review a medication binder, complete quizzes, and train with another staff member on the floor. Ms. Lauwers stated the contracted LPNs review the facility's policy and procedures and train with another staff member to learn the residents for two or three days. Ms. Lauwers stated most Brookdale facilities have the same Point Click Care system in which medication administration is conducted. Mr. Barnier's statements were consistent with Ms. Lauwers. Mr. Barnier stated some of the contracted staff such as Dearnikke Jackson worked at other Brookdale facilities recently. While on-site, I reviewed three staff files, all who had administered Resident A's medications incorrectly at least once in October. Ms. Lauwers stated Samra Pierce was a full-time employee of Brookdale Grand Blanc Assisted Living and Dearnikke Jackson, as well as Jessica Connors were both contracted LPNs through Snap Nurses. Ms. Lauwers referenced her October staff schedule in which she stated Ms. Connors trained with staff on the floor on 10/13, 10/14 and 10/15 and Ms. Jackson trained with staff on the floor on 10/11, 10/12 and 10/13. Ms. Lauwers stated Ms. Jackson and Ms. Connors did not have documentation in their employee file verifying they received training on the facility policies and procedures nor the binder for medication administration. I reviewed Ms. Pierce's employee file which read she received Foundation training in 2008 upon hire with the facility, then completed skills check off training for medication administration in 2009. Ms. Lauwer's stated the Foundation Training consisted of

training regarding policies and procedures, personal care, resident rights and responsibilities, safety, and standard precautions. The medication practicum checklist from 2009 read Ms. Pierce received training on oral medications, rectal/vaginal mediations, eye drops/ointments, insulin injections, liquid medications, nasal drops and sprays, inhalation therapies, transdermal patch medications, ear drops, disposing of medications, handling a resident's refusal to take medications, sharps procedure, handwashing techniques, handling of medication for a resident who will be away from the residence, handling medication errors, and administering sublingual medication. Additionally, Ms. Pierce's employee file consisted of documentation which read she received yearly training since hire, some which included quarterly medication administration audits.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**
ANALYSIS:	Staff interviews along with review of employee files revealed the contracted LPNs did not have documentation of training upon hire with the facility unlike the full-time staff. Although it is presumed an LPN has received education and training regarding medication administration prior, it is assumed the facility did not assess the LPNs competency per their training program.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/22/2021, I shared the findings of this report with authorized representative Beth Mell. Ms. Mell verbalized understanding of the citations.

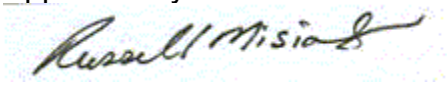
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

11/17/21

Jessica Rogers Date
Licensing Staff

Approved By:



11/19/21

Russell B. Misiak Date
Area Manager