GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 18, 2021

Hemant Shah
Cranberry Park Of Milford
801 Whitlow Drive
Milford, MI 48381

RE: License #: AH630392068
Investigation #: 2022A1010006
Cranberry Park Of Milford

Dear Mr. Shah:

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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of authorized representative and a date.

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. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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 (616) 356-0183.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630392068
Investigation #:	2022A1010006
Complaint Receipt Date:	11/03/2021
Investigation Initiation Date:	11/04/2021
Report Due Date:	01/03/2021
Licensee Name:	CRANBERRY PARK MILFORD LLC
Licensee Address:	26900 FRANKLIN RD Southfield, MI 48033
Licensee Telephone #:	(248) 210-5981
Administrator:	Gary Kosten
Authorized Representative:	Hemant Shah
Name of Facility:	Cranberry Park Of Milford
Facility Address:	801 Whitlow Drive Milford, MI 48381
Facility Telephone #:	(248) 329-0750
Original Issuance Date:	11/29/2018
License Status:	REGULAR
Effective Date:	05/29/2021
Expiration Date:	05/28/2022
Capacity:	61
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents are not receiving care consistent with their service plans. Resident A fell and died after staff left her alone on the toilet.	Yes
Staff are not properly trained to administer resident medications.	No
The residents are not bathed.	No
Additional Findings	Yes

III. METHODOLOGY

11/03/2021	Special Investigation Intake 2022A1010006
11/04/2021	Special Investigation Initiated - Telephone Interviewed the complainant by telephone
12/01/2021	Inspection Completed On-site
12/01/2021	Contact - Document Received Received staff medication administration training documents, resident service plans, and resident incident report
12/03/2021	Contact - Document Received Received the same allegations from a new complainant regarding Resident A's fall
12/08/2021	Contact – Telephone call made Interviewed the second complainant by telephone
12/08/2021	Contact – Document Received Police report received via email from the second Complainant
12/13/2021	Contact – Telephone call made Interviewed shift supervisor Savannah Hayes by telephone
12/15/2021	Contact – Document sent Email sent to Mr. Kosten
01/18/2022	Exit Conference

	Completed with Mr. Kosten and licensee authorized representative Hemant Shah

ALLEGATION:

Residents are not receiving care consistent with their service plans. Resident A fell and died after staff left her alone on the toilet.

INVESTIGATION:

On 11/3/21, the Bureau received the allegations from Adult Protective Services (APS). The complaint was not assigned for APS investigation.

The complaint read, “The unknown staff have not been assisting the residents with eating. The residents have been feeding themselves.” The complaint also read, “The Unknown Staff are not caring for the residents appropriately. The residents are not being toileted every two hours. At least one of the residents was observed dripping with urine.”

On 11/4/21, I interviewed the APS complainant by telephone. The complainant reported residents were left soiled for long periods of time. The complainant stated she knew this because she observed residents with “dark urine” in their briefs. The complainant said it was the facility’s policy and procedure to toilet residents every two hours, however this was not being done. The complainant also said residents that required assistance with eating were not being helped by staff.

The complainant stated Resident B has Parkinson’s Disease and needed assistance from staff during meals. Resident B reported staff have not been assisting Resident B during mealtimes and she observed him soiled and “dripping with urine.” The complainant explained Resident B was so soiled that the urine “dripped off his wheelchair and onto the floor.”

The complainant explained Resident A was left on the toilet by staff for a long period of time approximately two weeks ago. The complainant reported Resident A tried to get up by herself and fell. The complainant stated Resident A hit her head and “bled out.” The complainant said Resident A died because of her fall and law enforcement were involved. The complainant did not know the name of the staff person who left Resident A unattended on the toilet. The complainant stated per Resident A’s service plan, staff were supposed to assist Resident A in the bathroom and not leave her unattended.

The complainant reported Resident C’s family moved her out of the facility because she did not receive care consistent with her service plan. The complainant was

unable to provide specific examples of this, however. The complainant said Resident D has hearing aids that staff do not charge or put on or off for her.

On 12/1/21, I interviewed administrator Gary Kosten at the facility. Mr. Kosten reported to his knowledge, residents received care consistent with their service plans. Mr. Kosten explained it was the facility's policy and procedure to toilet residents every two hours and as needed. Mr. Kosten stated he had not received complaints from staff, residents, or resident family members that this was not being done. Mr. Kosten reported residents were not intentionally left soiled for long periods of time.

Mr. Kosten stated there was one resident in the facility's secured memory care unit who required full assistance from staff at mealtimes. Mr. Kosten reported it was in Resident E's service plan that staff were to provide full assistance with eating during mealtimes. Mr. Kosten said to his knowledge, staff provided this assistance.

Mr. Kosten reported he submitted an incident report to the Bureau when Resident A fell. Mr. Kosten stated staff found Resident A on the floor and she was transported to the hospital after staff contacted emergency medical services (EMS). Mr. Kosten explained law enforcement also responded to the facility after the incident. Mr. Kosten said he provided a copy of Resident A's service plan and death certificate with the incident report he submitted to the Bureau.

Mr. Kosten provided me with a copy of Resident A's incident report for my review. The report was dated 10/26/21. The *Description of Incident* section of the report read, "Started morning medpass went to go check her blood sugar that's when I observed her laying on the floor on her left side unresponsive with a pool of blood around her head with multiple skin tears on her right fore arm." The *Action Taken By Staff/Treatment Given* section of the report read, "Immediately got another staff member for help. Went back outside her room as other staff member called 911. Then I called our wellness director. Another staff member came in immediately called family that's when EMS arrived." The *Corrective Measures Taken to Remedy and/or Prevent Recurrence* section of the plan read, "EMS on site Resident expired. Spoke with Police, called Dr. Wilkerson 9:50 am. Notified Kimberly Horst (left vm). Funeral home removed body."

Mr. Kosten provided me with a copy of Resident A's service plan that he submitted with Resident A's incident report for my review. The *TOILETING* section of the plan read, "Will be able to toilet safely with 1 person assistance. 1 person assistance required for toileting activities. [Resident A] is continent of bowel and bladder however she may required assistance with hygiene. Staff to assess hygiene is completed well after every BM."

On 12/1/21 I interviewed director of health and wellness Melissa Davey at the facility. Ms. Davey's statements were consistent with Mr. Kosten.

Ms. Davey reported Resident B did have Parkinson's Disease and was incontinent. Ms. Davey explained there were instances when Resident B was not compliant with care staff during the provision of his care. Ms. Davey stated Resident B was able to make his needs known to staff and did not require full assistance with eating from staff.

Ms. Davey stated the facility identified Resident C required greater care than what the facility could provide. Ms. Davey said this was discussed with Resident C's family and it was determined Resident C would be moved to a facility that could provide a greater level of care to meet Resident C's needs.

Ms. Davey reported Resident D had a cochlear implant and did not need hearing aids put in and out by staff. Ms. Davey stated staff assist Resident D in charging her cochlear implant device. Ms. Davey said there were charging instructions for the implant in Resident D's room. Ms. Davey reported Resident D's daughter was also proactive in showing staff how to charge the device.

Ms. Davey provided me with a copy of Resident B's service plan for my review. The *EATING/MEALS* section of the plan read, "Eats in dining room. [Resident B] likes most foods and can feed himself well. You will need to cut up tougher food such as meats, ect." The *TOILETING* section of the plan read, "[Resident B] wears briefs. He can tell you when he needs to go. Generally, if he is incontinent it is with bladder. An occasional accident with bowel. Family has been double briefing [Resident B] at night."

Ms. Davey provided me with a copy of Resident C's service plan for my review. The *EATING/MEALS* section of the plan read, "Eats in the Dining Room. [Resident C] likes most foods, can feed herself. She IS ON A MECHANICAL SOFT DIET. Encourage her to be as independent as possible but be prepared to assist as needed." The *TOILETING* section of the plan read, "Bathroom equipped with adaptive devices for toileting activities raised toilet seat. Care staff to utilize bed pan as needed for bowel and bladder when [Resident C] is in bed. [Resident C] wears briefs supplied by the family and at night she uses tabs provided by the facility. She is incontinent bladder. She can tell you she needs to relieve her bowel however with rarely an accident. [Resident C] will wipe herself after she urinates. When she has a bowel movement she will wipe but you should check to ensure proper hygiene. She may tell you that you will need to wipe her too." Needs regular or frequent assistance to/from bathroom." The plan also read that resident C "is NOT AMBUALTORY" and required assistance from two staff to transfer.

Ms. Davey provided me with a copy of Resident D's service plan for my review. The *HEARING* section of the plan read, "Has hearing loss, specify: right ear. Speak slowly and clearly. Wears hearing aids; Right cochlear implant. Staff may need to assist her to apply."

Ms. Davey provided me with a copy of Resident E's service plan for my review. The *EATING* section of the plan read, "Avoid dairy foods. May have ice cream occasionally. Diet: mechanical soft with thin liquids. Eats in the Dining Room. [Resident E] requires full feeding assistance from staff. Report changes in ability to eat or drink to the nurse." The *TOILETING* section of the plan read, "Needs 1 staff member assistance with toileting activities. Including brief changes, peri care transferring to and from the toilet. Needs assistance to change incontinence product, ie; adding peripad briefs. Report any changes in toileting ability to Nurse. Requires assistance with peri-care. Uses incontinence products (liner, brief). Supply managed by family. Dispose of used incontinence products every shift."

On 12/1/21 I interviewed medication technician (med tech) Sue Hilton at the facility. Ms. Hilton's statements were consistent with Mr. Kosten, Ms. Davey and the resident service plans.

On 12/1/21, I interviewed care staff person Colleen Macko at the facility. Ms. Macko's statements were consistent with Mr. Kosten, Ms. Davey, Ms. Hilton, and resident service plans.

On 12/1/21, I was unable to interview Resident A because she is deceased.

On 12/1/21, interviewed Resident B at the facility. Resident B reported staff changed him and help him get dressed every day. Resident B stated his care needs were met by staff.

On 12/1/21, I was unable to interview Resident C because she no longer resided at the facility.

On 12/1/21, interviewed Resident D at the facility. Resident D said all her care needs were met by staff. Resident D reported staff help her charge her hearing aid device. Resident D showed me where staff can look to see instructions regarding how to charge her hearing device. I observed Resident D's cochlear implant that was in place.

On 12/1/21, I attempted to interview Resident E at the facility. I was unable to engage Resident E in meaningful conversation. I observed Resident E was wearing clean clothing and was well groomed.

On 12/1/21, I observed several residents throughout the facility. The residents did not appear to be soiled and I did not detect any foul odors in the facility.

On 12/3/21, the Bureau received an additional complaint regarding Resident A's fall from a second complainant. The complaint read, "On 10/26/21 [Resident A] passed away in this ALF. We have obtained a copy of the police report related to her death. Per the police report, [Resident A] pressed her call button at 0657 to use the restroom, the facility was using temp agency for help, a temp staff person checked

on her at 0701 and she was in the bathroom on the toilet. The temp staff person reminded her to use her call button, left her room and closed the door. Her shift ended and she left the building at 0703. Per the report, the temp person, in passing the regular staff person, relayed "everything is good". When the regular staff person saw [Resident A's] door closed she knew that usually meant she was still in bed. There was no communication between shifts that she was in the bathroom and it was known that she needs assistance. She never used her call button and was found unresponsive on the floor around 0732. When asked by the police, none of the employees had any contact information for the temporary staff person. What is most concerning to us as [the complainants] is there was no relay of information between shifts and it was not communicated that she was in the bathroom."

On 12/8/21, I interviewed the second complainant by telephone. The second complainant reported The Milford Police Department responded after Resident A fell. The second complainant explained the Milford Police Department got the unknown agency staff person's name and interviewed her. The second complainant will provide the Milford Police Report by email.

On 12/8/21, I received the Milford Police Department's report regarding Resident A's fall via email from the second complainant. The *INTERVIEW WITH SAVANNAH HAYES* section of the police report read, "I made contact with Savannah Hayes. Hayes started her shift at 0700 hours. She came in and started getting medication ready for the residents. She told me when [Resident A's] door was closed, it usually means she is still in bed and it was closed. She advised she went into [Resident A's] room approximately 0732 hours. She saw [Resident A] on the floor of the bathroom and observed a large pool of blood. Hayes thought [Resident A] was deceased. Hayes advised she ran out of the room and down to Memory Care and yelled for Sue Hilton. Hayes then called Melissa (Wellness Director) at 0735 hours and explained the situation. Hilton called 911 at 0737 hours.

Hayes advised she did not know [Resident A] was using the restroom as she knows [Resident A] needs assistance. [Resident A] had returned from the hospital a week ago recovering from pneumonia. Prior to having pneumonia [Resident A] had been using a walker, but since her return was in a wheelchair. She gets out of breath quickly. Hayes advised [Resident A] needs assistance cleaning herself up and pulling her pants back up after using the toilet.

I asked if the night nurse was available to speak to. I was told she had left at 0700 hours. She works for a temp agency, Shift Med and her name is Siarra Grice. None of the employees had contact information for her. I asked if Grice had relayed any information about [Resident A]. Hayes advised Grice told her, 'everything was good' as they were passing each other and left the building."

The *INTERVIEW WITH SIARRA GRICE* section of the report read, "Grice contacted me via telephone. Grice was unaware of the situation. After I explained the situation, Grice advised she had responded to [Resident A's] call button. When she walked in,

[Resident A] was already in the bathroom and on the toilet. [Resident A] told Grice she was ok at the time, but will call her back when she needs assistance. Grice left the building before [Resident A] needed assistance. Grice advised [Resident A's] mental state seemed normal.

I asked Grice how Cranberry Park handles relaying of patient status (needing assistance) between shifts. Grice advised she has only been there for 2 weeks and they do not really relay information much between shifts."

On 12/13/21, I interviewed shift supervisor Savannah Hayes by telephone. Ms. Hayes' statements were consistent with the Milford Police report. Ms. Hayes reported Resident A should not have been left alone or told to use her pendant after she finished using the bathroom. Ms. Hayes explained Resident A was a one person assist while toileting, therefore Ms. Grice should not have left Resident A unattended on the toilet.

Ms. Hayes stated when agency staff are used by the facility they must review and sign a document that they read the resident service plans and know where to locate them. Ms. Hayes reported agency staff review resident service plans and sign the document in the nursing station. Ms. Hayes said if Ms. Grice read Resident A's service plan, she would have known she was a one person assist in the bathroom.

Ms. Hayes stated staff do complete a "report" during shift change. Ms. Hayes explained during the "report" any issues or concerns with a resident on the previous shift were discussed. Ms. Hayes reported the third shift supervisor on the morning of the incident did not report any concerns to her. Ms. Hayes said during the shift change report, it was not known Resident A had fallen in her bathroom. Ms. Hayes stated the third shift staff person on 10/26 that gave her the report was Alicia Black. Ms. Hayes reported Ms. Black was a facility employee, however she no longer works at the facility.

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.

ANALYSIS:	The interview with Ms. Hayes, along with review of the Milford Police Department report revealed agency staff person Siarra Grice responded to Resident A's pendant on 10/26. Ms. Grice left Resident A unattended on the toilet. This was not consistent with Resident A's plan that read she required assistance from one staff person in the bathroom. Resident A fell and was not located until Ms. Hayes arrived to administer her medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff are not properly trained to administer resident medications.

INVESTIGATION:

On 11/3/21, the complaint read, "The aides are passing meds out and they are not certified."

On 11/4/21, the complainant reported the medication administration training that med techs received was insufficient. The complainant stated staff received "a quick computer training" with "a test." The complainant explained the med tech must shadow experienced med techs on he floor "for a few days." The complainant reported the facility does not keep any documentation regarding the medication administration training staff received.

On 12/1/21, Mr. Kosten reported Ms. Davey was responsible for the medication administration training for med techs.

On 12/1/21, Ms. Davey stated med techs first complete a computer training and take a competency test. Ms. Davey explained the med techs then shadow experienced med techs on the floor. Ms. Davey reported the staff shadowing also included "reverse shadowing" in which the experienced med tech shadows the med tech in training. Ms. Davey said the shadowing portion of the training takes as long as needed for the staff in training to become "comfortable" administering resident medications. Ms. Davey said the medication administration training is sufficient and there have not been any medication errors.

Ms. Davey provided me with a copy of Ms. Hilton's medication administration training documents for my review. The *MEDICATION TRAINING MEETING Wednesday, 2/12/2019 @ 5:00 pm* document read, "I have attended medication training and the agenda attached was reviewed with me." This document was signed by Ms. Hilton and dated 2/12/20. The *6 RIGHTS TO MEDICATION ADMINISTATION QUIZ* was signed by Ms. Hilton on 2/12/20 and read she received

"100%." Ms. Hilton's *Certificate of Completion* document read she completed medication administration training on 1/24/20.

On 12/1/21, Ms. Hilton's statements regarding her medication administration training were consistent with Ms. Davey. Ms. Hilton reported the training she received was sufficient.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	The interview with Ms. Davey and Ms. Hilton, along with review of Ms. Hilton's medication administration training documents revealed staff received adequate training on the proper handling and administration of medication.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The residents are not bathed.

INVESTIGATION:

On 11/3/21, the complaint read, "Some residents have not been showered in 2-3 weeks."

On 11/4/21, the complainant reported Resident D had not been given a shower in three weeks. The complainant stated residents are supposed to be bathed at least twice a week. The complainant said Resident D was able to make her needs known.

On 12/1/21, Mr. Kosten stated it was the facility's policy and procedure to allow residents the opportunity to bathe at least twice a week and more as requested or needed. Mr. Kosten denied knowledge regarding residents not being bathed at least twice a week. Mr. Kosten said he had not received any complaints from residents regarding not being bathed.

On 12/1/21, Ms. Davey's statements were consistent with Mr. Kosten. Ms. Davey reported there were instances when Resident B refused to bathe for staff. Ms. Davey stated since Resident B's wife moved into the facility, he has been more compliant with his cares.

On 12/1/21, Ms. Hilton's statements were consistent with Mr. Kosten and Ms. Davey.

On 12/1/21, Ms. Macko's statements were consistent with Mr. Kosten, Ms. Davey, and Ms. Hilton.

On 12/1/21, Resident B stated he is bathed at least once a week. Resident B reported there are times he "doesn't want to shower" and therefore refuses.

Resident D reported she is bathed at least twice a week and denied concerns regarding staff.

On 12/1/21, I interviewed Resident F at the facility. Resident F's statements were consistent with Resident D.

On 12/1/21, I observed several residents in common areas and in the facility dining room. I observed the residents had clean clothing on and were well groomed. I did not detect any foul odors.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	The interviews with Mr. Kosten, Ms. Davey, Ms. Hilton, Ms. Macko, Resident B, Resident D, Resident F, along with my observation of several residents in the facility revealed residents are given the opportunity to bathe at least twice a week or mor often as needed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 12/1/21, Mr. Kosten reported the facility used agency staff to fill shift vacancies. Mr. Kosten stated the facility does not keep record or any documentation of trainings of the agency staff who worked in the facility.

On 12/15/21, I emailed Mr. Kosten. Mr. Kosten stated agency staff sign an acknowledgement form that they reviewed resident service plans. Mr. Kosten explained agency staff are also educated on the facility's elopement plan and policy, the location of the elopement procedures manual, and where the emergency equipment for elopements is located. However, the facility does not have formal documentation to acknowledge acceptance of elopement policies. Mr. Kosten reported the facility trains agency staff on elopement procedures, but there is no signed documentation.

APPLICABLE RULE	
R 325.1944	**Employee records and work schedules.**
	(1) A home shall maintain a record for each employee, which shall include all of the following: (a) Name, address, telephone number, and social security number. (b) License or registration number, if applicable. (c) Date of birth. (d) Summary of experience, education, and training. (e) Beginning date of employment and position for which employed. (f) References, if provided. (g) Results of initial TB screening as required by R 325.1923(2). (h) Date employment ceases and reason or reasons for leaving, if known. (i) Criminal background information, consistent with section 20173a, MCL 333.20173a, of the code.
ANALYSIS:	The interview with Mr. Kosten revealed employee records for agency staff used at the facility were not kept or maintained. Mr. Kosten reported agency staff received educated on the facility's elopement plan and policy, the location of the elopement procedures manual, and where the emergency equipment for elopements is located. However, the facility does not have formal documentation to acknowledge acceptance of elopement policies. The facility had no record of agency staff who worked at the facility or what trainings they received.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Hemant Shah and Mr. Kosten by telephone on 1/18.

IV. RECOMMENDATION

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

12/13/21

Lauren Wohlfert — Date
Licensing Staff

Approved By:

01/18/2022

Andrea L. Moore, Manager — Date
Long-Term-Care State Licensing Section