GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 4, 2022

Mark Bunk
Sunrise Assisted Living of Shelby Twp.
46471 Hayes Rd.
Shelby Twp., MI 48315

RE: License #: AH500281087
Investigation #: 2022A1027028
Sunrise Assisted Living of Shelby Twp.

Dear Mr. Bunk:

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 by the 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) 241-1970.

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 #:	AH500281087
Investigation #:	2022A1027028
Complaint Receipt Date:	01/14/2022
Investigation Initiation Date:	01/14/2022
Report Due Date:	03/13/2022
Licensee Name:	HCRI Sun III Tenant, Limited Partnership
Licensee Address:	Suite T-900 7900 Westpark Dr. McLean, VA 22102
Licensee Telephone #:	(703) 273-7500
Administrator/ Authorized Representative:	Mark Bunk
Name of Facility:	Sunrise Assisted Living of Shelby Twp.
Facility Address:	46471 Hayes Rd. Shelby Twp., MI 48315
Facility Telephone #:	(586) 532-9559
Original Issuance Date:	02/17/2006
License Status:	REGULAR
Effective Date:	09/08/2021
Expiration Date:	09/07/2022
Capacity:	106
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A received the COVID-19 booster vaccine without consent.	Yes
Resident A had not received showers for two weeks.	No
The resident rooms are dirty and unkept.	No
Additional Findings	Yes

III. METHODOLOGY

01/14/2022	Special Investigation Intake 2022A1027028
01/14/2022	Special Investigation Initiated - Letter Email sent to AR/Administrator Mark Bunk requesting resident roster
01/14/2022	Contact - Document Received Email received from Mr. Bunk with resident roster
02/01/2022	Inspection Completed On-site
02/04/2022	Inspection Completed-BCAL Sub. Compliance
02/08/2022	Exit Conference Conducted with authorized representative Mark Bunk

ALLEGATION:

Resident A received the COVID-19 booster vaccine without consent.

INVESTIGATION:

On 1/14/22, the department received a complaint which read Resident A received a COVID-19 booster vaccine without consent. The complaint read Resident A's family had taken Resident A out of the facility to have the COVID-19 booster injection on 12/6/21. The complaint read the facility's administrator Mark Bunk was notified by email on 1/5/22 that Resident A received the booster vaccine on 12/9/21. The complaint read facility staff notified Resident A's family that she had received the

booster vaccine at the facility on 1/11/22 and was having symptoms such as lethargy, not eating and being very tired.

On 2/1/22, I conducted an on-site inspection at the facility. I interviewed administrator and authorized representative Mark Bunk. Mr. Bunk stated the facility had utilized CVS pharmacy for all previous COVID-19 vaccines in which residents and/or their families would sign into the CVS pharmacy website to complete a COVID-19 vaccine consent form. Mr. Bunk stated the CVS pharmacy was not able to come to the facility to administer the COVID-19 booster vaccine, so the National Guard conducted the COVID-19 booster clinic at the facility. Mr. Bunk stated he sent an email to all resident's authorized representatives who had not received the COVID-19 booster vaccine to obtain consent from them by email. Additionally, Mr. Bunk stated he would obtain consent by telephone. Mr. Bunk stated he had received a response email from Resident A's authorized representative informing him she had received the COVID-19 booster vaccine. Mr. Bunk stated he had not received a copy of Resident A's updated vaccine card after she had received the booster injection. Mr. Bunk stated there was a "mix up of the paperwork" and Resident A had received the COVID-19 booster vaccine at the facility. Mr. Bunk stated there was a list of residents who had already received the COVID-19 booster as wells as residents who had not received it. While on-site, I observed the list which read Resident A was to receive the COVID-19 booster vaccine. Mr. Bunk stated he completed the COVID-19 vaccine consent forms from the National Guard on the day of the vaccine clinic. Mr. Bunk stated Resident A's physician was notified that she had received a second COVID-19 booster injection. Mr. Bunk stated Resident A's physician ordered for staff to monitor Resident A for five days and report any additional symptoms to him. Additionally, Mr. Bunk stated facility staff updated Resident A's authorized representative twice per day for those five days. Mr. Bunk stated there was not a facility policy regarding consent for residents receiving a vaccination from an outside company.

I reviewed Resident A's COVID-19 Vaccine Administration Record which read consistent with statements from Mr. Bunk and was dated 1/11/22.

I reviewed the facility's incident report for Resident A dated 1/13/22 which read consistent with statements from Mr. Bunk and was sent to the department on 1/14/22.

I reviewed the facility's documentation for Resident A in which facility staff monitored her temperature daily throughout January 2022.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following:

	(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.
For Reference: R 325.1901	**Definitions**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Interview with the facility's administrator/authorized representative, as well as review of facility documentation revealed Resident A received a COVID-19 booster vaccine without consent from her authorized representative. Although Resident A was not harmed, the facility lacked protection of Resident A as well as a process to ensure consents and vaccine paperwork were completed correctly.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A had not received showers for two weeks.

INVESTIGATION:

On 1/14/22, the department received a complaint which read Resident A did not receive a shower or have her hair washed for two weeks.

On 2/1/22, I conducted an on-site inspection at the facility. I interviewed administrator and authorized representative Mark Bunk. Mr. Bunk stated the facility was fully staffed and utilized both agency staff, as well as regular staff. Mr. Bunk stated it was brought to his attention that Resident A may not have had a shower. Mr. Bunk stated if a resident refuses a shower, the facility policy to ensure it was passed on to the next shift to offer a shower. I interviewed Resident A who stated she receives showers. I observed Resident A's clothing and hair which appeared

clean. I interviewed Resident B who stated he receives showers. I observed Resident B's clothing and hair which appeared clean.

I reviewed Resident A's service plan which read she requires one person assist with bathing and to encourage her to participate. The plan read when Resident A is unable to tolerate a full bath or shower, to offer a sponge bath. The plan read Resident A prefers to shower three times a week on the day shift per the shower schedule.

I reviewed the facility's documentation for Resident A's showers for December 2021 and January 2022. The documentation read Resident A was to receive bathing on Sundays, Wednesdays, and Fridays from 6:00 AM to 2:00 PM. The documentation read Resident A did not receive or refused bathing on 12/5/21, 12/8/21, 12/15/21, 12/26/21 and 1/4/22. The documentation read Resident A did not receive bathing on 12/12/21 on however she received bathing on 12/13/21. The documentation was left blank on 1/23/22.

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:	Staff and resident interviews along with review of documentation revealed although Resident A had not received showers three times per week, facility staff ensured bathing at least weekly.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The resident rooms are dirty and unkept.

INVESTIGATION:

On 1/14/22, the department received a complaint which read resident rooms are dirty and unkept.

On 2/1/22, I conducted an on-site inspection at the facility. I interviewed administrator and authorized representative Mark Bunk. Mr. Bunk stated the facility is maintained by three housekeepers. Mr. Bunk stated the housekeeping staff maintain the facility's cleanliness very well and they address any complaints immediately. Mr. Bunk stated Resident A's family had concerns regarding "crumbs" on her room floor, requiring vacuuming which was addressed by the housekeeping staff immediately. I interviewed housekeeping staff Anjie Decoster who has worked at the facility for 15 years. Ms. Decoster stated herself and two other housekeepers maintain the facility. Ms. Decoster stated there are two housekeepers on duty all days, except one, in which there are three. Ms. Decoster stated the common living areas as well as public bathrooms are cleaned daily. Ms. Decoster stated resident rooms are cleaned once weekly. Ms. Decoster stated cleaning resident rooms consists of wiping the counters down, dusting tables, cleaning the air filters, wiping the refrigerators out, vacuuming and spot cleaning the carpet, wiping down the bathroom including the mirror, sink, shower, toilet, and floor. I interviewed Resident A who stated her room was cleaned weekly. I interviewed Resident B who stated his room was cleaned weekly on Tuesdays. I observed six resident rooms, including Resident A and B's rooms, which appeared clean and well kept. I observed the resident's floors, tables, bathrooms, and kitchen spaces. I observed the common living areas on all three floors which appeared clean and well maintained.

I reviewed Resident A's service plan which read consistent with statements from Mr. Bunk.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Staff and resident interviews along with observations revealed resident rooms are cleaned per their service plans and common living spaces are kept clean as well.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's service plan read Resident A prefers to shower three times a week on the day shift per the shower schedule.

Review of the facility's documentation for Resident A's showers for December 2021 and January 2022 revealed Resident A did not receive showers three times weekly.

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:	Review of facility documentation for Resident A revealed facility staff lacked providing bathing consistent with her service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/8/22, I shared the findings of this report with authorized representative Mark Bunk. Mr. Bunk verbalized understanding of the findings.

IV. RECOMMENDATION

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

2/4/22

Jessica Rogers Date
Licensing Staff

Approved By:

02/07/2022

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