GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 16, 2022

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

RE: License #: AH630392068
Investigation #: 2022A1021055
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 the 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 (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630392068
Investigation #:	2022A1021055
Complaint Receipt Date:	08/25/2022
Investigation Initiation Date:	08/26/2022
Report Due Date:	10/24/2022
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:	05/29/2022
Expiration Date:	05/28/2023
Capacity:	61
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Care staff not responsive to Resident A.	Yes
Resident A did not receive physical therapy.	No
Resident A had chest pains and family was not notified.	Yes
Additional Findings	No

III. METHODOLOGY

08/25/2022	Special Investigation Intake 2022A1021055
08/26/2022	Special Investigation Initiated - Letter referral sent to APS via centralized intake
09/01/2022	Inspection Completed On-site
09/01/2022	Contact-Telephone call made Advanced Medical House Calls Nurse Practitioner Thomas Schaffer by telephone
09/02/2022	Contact-Telephone call made Interviewed facility nurse Debra Huff
09/12/2022	Contact- Telephone call made Interviewed SP8
11/16/2022	Exit Conference Exit conference with authorized representative Hemant Shah

The care provided by staff person 1 (SP1) and staff person 2 (SP2) at the facility was investigated under special investigation 2022A1021054.

ALLEGATION:

Care staff not responsive to Resident A.

INVESTIGATION:

On 8/25/22, the licensing unit received a complaint with allegations that Resident A does not receive adequate care at the facility. The complainant alleged on 8/16, Resident A did not receive breakfast and was found soiled in his chair. The complainant alleged care staff refused to care for Resident A because how he treats the care staff. The complainant alleged on 8/20 and 8/21 care staff did not respond to Resident A's call pendent alert.

On 8/26/22, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 9/1/22, I interviewed marketing director Gloria Smith at the facility. Ms. Smith reported Resident A's family came into the facility on 8/16 and was very upset because of how they found Resident A. Ms. Smith reported the administrator and facility nurse were busy with other residents, so she spoke with the family. Ms. Smith reported on that day, staff person 1 (SP1) and SP2 reported to her that they were told they did not have to care for Resident A because Resident A calls them names. Ms. Smith reported Resident A's family came in sometime after 9:00am and Resident A had not eaten breakfast even though breakfast is served at 8:30am and other residents had been served. Ms. Smith reported she told the administrator and facility nurse about the behaviors of SP1 and SP2.

On 9/1/22, I interviewed administrator Gary Kosten at the facility. Mr. Kosten reported the expectation is for staff persons to respond to call pendants within 5-10 minutes. Mr. Kosten reported Resident A pushes his call pendent multiple times each day. Mr. Kosten reported it takes at least two people to transfer Resident A.

On 9/1/22, I interviewed Resident A at the facility. Resident A was in his chair and was not dressed. Resident A reported it can take up to one hour to receive assistance from caregivers. Resident A reported he has had one bathroom accident because of the delay in receiving care. Resident A reported he typically eats meals in the dining room and has received meals. Resident A reported he goes to bingo.

On 9/2/22, I interviewed facility nurse Debra Huff by telephone. Ms. Huff reported Resident A requires a sit-stand device to transfer. Ms. Huff reported there was a delay in receiving the device due to Resident A's family would not pay for the device. Ms. Huff reported the facility now has the device to use with Resident A. Ms. Huff reported prior to this, it would take two or three people to provide care to Resident A.

On 9/2/22, I interviewed SP9 at the facility. SP9 reported Resident A was a two-three person transfer and at times there was a delay in providing care because of the amount of people it took to provide care to him. SP9 reported Resident A now has a lift in the room which has decreased wait times for Resident A. SP9 reported Resident A can be very demanding on staff and often will press the call button multiple times.

On 9/1/22, I interviewed Advanced Medical House Calls Nurse Practitioner Thomas Schaffer by telephone. Mr. Schaffer reported on 6/8/22, a prescription was sent to Health Care Solutions for the sit-stand device. Mr. Schaffer reported on 6/23/22, the company reported to the facility they do not provide this type of device. Mr. Schaffer reported on 6/23/22, a prescription was sent to Hart Medical Equipment. Mr. Schaffer reported the facility reportedly attempted to contact Relative A1 for payment for the device. Mr. Schaffer reported on 8/10/22, the facility spoke with Relative A1, and the device was delivered on 8/11/22.

I reviewed shower log documentation for Resident A. The documentation revealed Resident A received was offered a shower on 8/7, 8/12, 8/19, 8/23, and 8/30.

I reviewed call log documentation for Resident A for 8/20 and 8/21. The document revealed Resident A pushed his call pendent 26 times. The average call response time was 13 minutes. There were eight occurrences where Resident A had to wait over 30 minutes for assistance.

I reviewed service plan for Resident A. The service plan read,

> *"(Resident A) has a wheelchair and two walkers. He primarily using his wheelchair at this time. Ensure it is within reach at all times."*

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:	Interviews with staff members revealed Resident A required two-three people to provide care and that there were delays in

	providing care to Resident A due to the lack of the sit-stand device. Call light response times revealed Resident A would at times have to wait up to 31 minutes for staff to respond. The facility was aware of the need for the sit-stand device but did not act swiftly to receive the device at the facility as evidenced by it took two months from the time the Rx was ordered to when the device was delivered to the facility. The facility did not appropriately and adequately ensure the protection of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**
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:	Review of Resident A's service plan revealed lack of detail on the transfer status of Resident A and the use of the sit-stand device.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A did not receive physical therapy.

INVESTIGATION:

The complainant alleged Resident A did not receive physical therapy as requested.

On 9/1/22, I interviewed intake at Optimal Home Care. The intake department reported Resident A was discharged from therapy services on 7/15/22.

On 9/1/22, I interviewed Amber Home Care occupational therapist Jessica Vanderpoel at the facility. Ms. Vanderpoel reported upon admission, Resident A received therapy services with a different company. Ms. Vanderpoel reported she was told by care staff at the facility that Resident A's family was requesting for Resident A to re-start therapy services. Ms. Vanderpoel reported she is uncertain how long Resident A's family had been requesting services and when the request was brought to her attention. Ms. Vanderpoel reported she reached out to Mr. Schaffer to obtain orders for therapy services. Ms. Vanderpoel reported there was a

little delay with beginning therapy due to orders were not received. Ms. Vanderpoel reported Resident A began therapy with her company on 8/18/22.

Mr. Schaffer reported on 6/8/22, physical therapy was ordered for Resident A with Optimal Home Care. Mr. Schaffer reported on 7/28/22, a new request for therapy was obtained. Mr. Schaffer reported he completed the face-to-face order on 8/2 and orders were then sent to Amber Home Care.

APPLICABLE RULE	
R 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference:	**2(e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services.**
ANALYSIS:	Interviews conducted revealed Resident A admitted to the facility with Optimal Home Care and was discharged from therapy services on 7/15/22. A new request for therapy services was sent to Resident A's physician on 7/28/22 and therapy services began on 8/18/22. There is lack of evidence to support the allegation Resident A did not receive physical therapy services as requested.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A had chest pains and family was not notified.

INVESTIGATION:

The complainant alleged on 8/13/22, Resident A was having chest pain and was sent to the hospital for an evaluation. The complainant alleged family was not notified.

Ms. Huff reported on 8/12/22, Resident A slide out of his chair and there were concerns Resident A had a stroke. Ms. Huff reported the facility sent Resident A to the hospital for an evaluation.

Mr. Schaffer reported he was not notified of any transfers to the hospital for Resident A.

On 9/12/22, I interviewed SP8 by telephone. SP8 reported on 8/12, Resident A was complaining that his arm was numb, and he could not feel his face. SP8 reported Resident A reported having a difficult time breathing. SP8 reported she attempted to contact Resident A's emergency contacts, but they did not answer. SP8 reported with the seriousness of Resident A's complaints, it was decided to send Resident A to the hospital. SP8 reported Relative A1 returned the facility's telephone call and spoke with her for 30 minutes. SP8 reported later in the evening, Relative A1 contacted the facility again and alleged she did not speak with the facility. SP8 reported she did not contact Relative A's physician because she believed the physician was automatically notified.

I reviewed the license file for the facility. There was no incident report completed and submitted to the department for the event with Resident A.

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:	Interviews conducted and document review revealed appropriate parties were not notified of Resident A's transfer to the emergency room.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/16/22, I conducted an exit conference with authorized representative Hemant Shah by telephone.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

9/12/22

Kimberly Horst Date
Licensing Staff

Approved By:

11/15/2022

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