



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

February 17, 2023

Garry Young  
Lake (Bloomfield) TRS LLC  
Suite 1700  
2711 N Haskell Ave  
Dallas, TX 75204

RE: License #: AH630409730  
Investigation #: 2023A0585002  
The Avalon of Bloomfield Township

Dear Mr. Young:

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 responsible party 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,

A handwritten signature in cursive script that reads "Brender Howard".

Brender Howard, Licensing Staff  
Bureau of Community and Health Systems  
611 W. Ottawa Street, P.O. Box 30664  
Lansing, MI 48909  
(313) 268-1788

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

**I. IDENTIFYING INFORMATION**

|  |  |
|--|--|
| <b>License #:</b>                              | AH630409730  |
| <b>Investigation #:</b>                        | 2023A0585002   |
| <b>Complaint Receipt Date:</b>                 | 10/06/2022   |
| <b>Investigation Initiation Date:</b>          | 10/06/2022   |
| <b>Report Due Date:</b>                        | 12/05/2022   |
| <b>Licensee Name:</b>                          | Lake (Bloomfield) TRS LLC                            |
| <b>Licensee Address:</b>                       | Suite 1700<br>2711 N Haskell Ave<br>Dallas, TX 75204 |
| <b>Licensee Telephone #:</b>                   | (214) 754-8623                                       |
| <b>Authorized Representative/Administrator</b> | Garry Young  |
| <b>Name of Facility:</b>                       | The Avalon of Bloomfield Township                    |
| <b>Facility Address:</b>                       | 100 W Square Lake Rd<br>Bloomfield Twp, MI 48302     |
| <b>Facility Telephone #:</b>                   | (248) 480-7343                                       |
| <b>Original Issuance Date:</b>                 | 09/30/2022   |
| <b>License Status:</b>                         | TEMPORARY  |
| <b>Effective Date:</b>                         | 09/30/2022   |
| <b>Expiration Date:</b>                        | 03/30/2023   |
| <b>Capacity:</b>                               | 158  |
| <b>Program Type:</b>                           | ALZHEIMERS<br>AGED                                   |

**II. ALLEGATION(S)**

|   | <b>Violation<br/>Established?</b> |
|---|-----------------------------------|
| Resident A's call pendant is not being answered in a timely manner. | Yes                               |
| Additional Findings   | No                                |

**III. METHODOLOGY**

|            |  |
|------------|--|
| 10/06/2022 | Special Investigation Intake<br>2023A0585002   |
| 10/06/2022 | Special Investigation Initiated - Letter<br>Emailed referral to Adult Protective Services (APS). |
| 10/19/2022 | Inspection Completed On-site<br>Completed with observation, interview and record review.         |
| 02/17/2023 | Exit Conference<br>Conducted with authorized representative Garry Young by<br>telephone.         |
|            |  |

**ALLEGATION:**

**Resident A's call pendant is not being answered in a timely manner.**

**INVESTIGATION:**

On 10/6/2022, the department received the allegations from an anonymous complainant via the BCHS Online Complaint website. The complaint alleges that Resident A pages for caregiver and they respond only to disengage the pendant without assisting with care.

On 10/6/2022, a referral was made to Adult Protective Services (APS).

On 10/19/2022, an onsite was completed at the facility. I interviewed administrator Garry Young at the facility. Mr. Young stated that the census is 41. He stated that they are often overstaffed. He stated that the morning and evening shift consists of 3-4 care staff and 2 medication passers. He stated that the midnight shift has three caregivers and a medication passer.

On 10/19/2022, I interviewed health and wellness director Brandy Nagy at the facility. Ms. Nagy stated that if a pendant is not answered timely, she will get an alert to her phone. She stated that the expected respond time for caregiver to answer call pendant is 15 minutes or less. She stated that sometimes if a staff is busy assisting another resident, they will go and let the resident know that they will be with them ASAP. She stated that Resident A uses her call pendant a lot. She explained that staff goes in to check on Resident A every two hours unless requested otherwise. She stated that sometimes Resident A does not like to be bothered at night. Ms. Nagy statement was consistent with Mr. Young regarding staffing.

On 10/19/2022, I interviewed Employee A at the facility. Employee A stated that they are told to respond to call lights 15 minutes or less. Her statement was consistent with Mr. Young and Ms. Nagy regarding the staff on duty.

On 10/19/2022, I interviewed Employee B at the facility. Employee B stated that she works in the memory care unit. She stated that most of the residents in that unit don't use the call light. She stated that staff check on residents every hour. She stated that most memory care residents sit in the common area and eyes are on them all the time. She stated for the memory care unit, there are ten residents and two care staff. She stated that they have monthly staff meetings, and they do regular in service.

On 10/19/2022, I interviewed Employee C at the facility. Employee C's statement was consistent with Mr. Young, Ms. Nagy, Employee A and B regarding staffing and call light respond time.

On 10/19/2022, I interviewed Resident A at the facility. Resident A stated that she is okay, and she has no issues with the staff. She said sometimes it take a while, but they do come to see about her.

On 10/19/2022, I interviewed Resident B at the facility. Resident B stated that she doesn't have any issues with staff. She stated that staff see about her.

On 10/19/2022, I interviewed Resident C at the facility. Resident C stated that she uses the call light and most of the time the staff are prompt. She stated that she knows they have a lot of residents and must wait.

On 10/19/2022, I interviewed Resident D at the facility. Resident D stated that the staff care for her needs. She stated that she uses the call pendant and staff comes to see about her.

Resident A's service plan reads, "Check on resident three times during nighttime. Understand without difficulty. Totally incontinent on a regular".

Resident A's event report shows:

| <b>Occurred</b>  | <b>Responded</b> | <b>Response Time</b> |
|------------------|------------------|----------------------|
| 9/20/22 12:10 pm | 9/20/22 12:47 pm | 37 minutes           |
| 9/20/22 1:20 pm  | 9/20/22 8:38 pm  | 29 minutes           |
| 9/21/22 5:51 pm  | 9/21/22 6:29 pm  | 37 minutes           |
| 9/22/22 9:55 pm  | 9/22/22 10:28 pm | 32 minutes           |
| 9/22/22 10:46 pm | 9/22/22 11:49 pm | 62 minutes           |
| 9/23/22 7:24 pm  | 9/23/22 8:07 pm  | 43 minutes           |
|                  |                  |                      |

Resident D's service plan reads, "orient to person, place and time and remember information. Easily understood. The resident is able to complete task without reminders, prompting assistance from others.

Resident D's event report shows

| <b>Occurred</b>  | <b>Responded</b> | <b>Response Time</b> |
|------------------|------------------|----------------------|
| 9/20/22 1:25 am  | 9/20/22 2:15 am  | 49 minutes           |
| 9/20/22 10:38 pm | 9/20/22 11:09 pm | 31 minutes           |
| 9/23/22 7:41 pm  | 9/23/22 8:41 pm  | 59 minutes           |
|                  |                  |                      |

| <b>APPLICABLE RULE</b> |  |
|------------------------|--|
| <b>R 325.1921</b>      | <b>Governing bodies, administrators, and supervisors.</b>  |
|                        | <b>(1) The owner, operator, and governing body of a home shall do all of the following:</b><br><br><b>(a) Assume full legal responsibility for the overall conduct and operation of the home.</b>  |
| <b>ANALYSIS:</b>       | The complaint alleges that the staff are not answering call pendants in a timely manner. The Resident Event Report shows that on several occasions, staff did not respond to call pendant timely. Therefore, this claim was substantiated. |
| <b>CONCLUSION:</b>     | <b>VIOLATION ESTABLISHED</b>   |

On 2/17/2023, I conducted an exit conference with licensee authorized representative Garry Young by telephone.

**IV. RECOMMENDATION**

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



02/17/2023

---

Brender Howard  
Licensing Staff

Date

Approved By:



02/10/2023

---

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

Date