GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 22, 2023

Amy Borzymowski
Brookdale Ann Arbor
2190 Ann Arbor-Saline Rd.
Ann Arbor, MI 48103

RE: License #: AH810305217
Brookdale Ann Arbor
2190 Ann Arbor-Saline Rd.
Ann Arbor, MI 48103

Dear Ms. Borzymowski:

Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. 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 dates 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 home for the aged authorized representative and a date.

Upon receipt of an acceptable corrective action plan, a regular license will be issued. If you fail to submit an acceptable corrective action plan, disciplinary action will result.

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 feel free to 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) 285-7433
enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AH810305217
Licensee Name:	Brookdale Place of Ann Arbor, LLC
Licensee Address:	Suite 2300 6737 W. Washington St. Milwaukee, WI 53214
Licensee Telephone #:	(414) 918-5000
Authorized Representative:	Amy Borzymowski
Administrator/Licensee Designee:	Jena Wisely
Name of Facility:	Brookdale Ann Arbor
Facility Address:	2190 Ann Arbor-Saline Rd. Ann Arbor, MI 48103
Facility Telephone #:	(734) 327-1350
Original Issuance Date:	10/19/2010
Capacity:	82
Program Type:	AGED ALZHEIMERS

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 03/22/2023

Date of Bureau of Fire Services Inspection if applicable: 02/8/2023, 4/10/2023

Inspection Type: ☐ Interview and Observation ☒ Worksheet ☐ Combination

Date of Exit Conference: 03/24/2023

No. of staff interviewed and/or observed 16
No. of residents interviewed and/or observed 31
No. of others interviewed One Role Hospice case manager

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.

- Medication(s) and medication records(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☐ No ☒ If no, explain. No resident funds held.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.

- Fire drills reviewed? Yes ☐ No ☒ If no, explain.
  Bureau of Fire Services reviews fire drills. Disaster plan reviewed and staff interviewed regarding disaster plan.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.

- Incident report follow-up? Yes ☐ IR date/s: N/A ☒
- Corrective action plan compliance verified? Yes ☒ CAP date/s and rule/s: Renewal LSR dated 5/21/2021 to CAP dated 5/25/2021: R 325.1923(2), R 325.1976(8)
- SIR 2022A1027009 dated 11/23/2021 to CAP dated 12/15/2021: R 325.1931(2)
- Number of excluded employees followed up? Two N/A ☐

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following rules:

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.**

(p) "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.

Inspection of Resident A's room revealed a u-shaped covered bedside assist device which was approximately 18 inches long and 12 inches above the mattress. It was not directly affixed to the bedframe but instead strapped to the bedframe with material mesh straps. Interview with administrator Jena Wisely revealed that device was not approved for use within the facility and her family placed it on the bed without the facility's approval.

Inspection of Resident B's room revealed two bedside assistive devices commonly referred to as "Halo Rings." The halo devices were attached securely to the bedframe; however, the mattress easily shifted away from the devices, creating a gap, putting the resident at risk of entanglement/entrapment. It was observed that the distance between the slats (horizontal or vertical supports between the perimeter of the Halo Rings) was large enough for a hand/foot to fit through and cause possible entanglement/entrapment.

Interview with Ms. Wisely revealed Resident B had a diagnosis in which caused her to have weakened muscles in which a therapy assessment was completed, and the devices were recommended. Ms. Wisely stated Resident B had a physician order for the devices. Ms. Wisely provided a copy of the halo devices' manufacturer guidelines which was maintained in Resident B's file. Ms. Wisely stated the facility did not conduct checks on the devices after installation however educated to staff to notify the supervisor if there were any concerns regarding the devices, such as if they became loose. Additionally, Ms. Wisely stated Resident B's cognition was assessed daily by care staff in which they were instructed to notify their supervisor of a change, as well as annually when her service plan was updated. Ms. Wisely stated the facility lacked manufacturer approved protective covers for the Halo Rings to close off the open spaces between the slats. Ms. Wisely stated the facility maintained a bedside assist policy.

I reviewed Resident B's service plan updated 2/17/2023 which read in part she had a diagnosis of Corticobasal Degeneration, a condition that slowly takes away her muscle strength. The plan read in part Resident B was unable to use her right arm to its fullest ability. The plan read in part Resident B was alert and orientated to person, place, and time in which she was able to communicate her needs and preferences. The plan read in part Resident B had a physician order which read she could self-administer her medications. The plan read in part Resident B could bare weight with one associate but required two associates for transfer. The plan read in part Resident B was a fall risk. The plan read in part Resident B utilized a "Halo Safety Ring" as a bedside mobility device.

I reviewed Resident B's physician order for the halo devices which read consistent with statements from Ms. Wisely.

I reviewed the halo devices' manufacturer guidelines which read in part to regularly check the Halo device to identify areas of possible entrapment. The guidelines read in part to regularly check to make sure that there was not a gap between the Halo

Safety Ring and the side of the mattress. The guidelines read a gap could allow the resident to become wedged between the bed rail and the mattress.

Resident B's service plan omitted or lacked sufficient information for specific use, care, and maintenance of the devices including a means for the resident to summon staff, methods for on-going monitoring of the resident, methods of monitoring the equipment by trained staff for maintenance of the device and for monitoring measurements of gaps to protect the resident from the possibility of physical harm related to entrapment, entanglement, strangulation, etc.

Given the observations listed above and the lack of an organized plan the facility has not provided reasonable protective measures to ensure resident well-being and safety during the use of a bedside assistive device.

VIOLATION ESTABLISHED

R 325.1931 Employees; general provisions.

(3) The home shall designate 1 person on each shift to be supervisor of resident care during that shift. The supervisor of resident care shall be fully dressed, awake, and on the premises when on duty.

Review of the daily staff schedule revealed the assigned shift supervisor was identified in bold print for each shift. Review of March 2023 daily schedules revealed there were two shift supervisors assigned on first and second shifts, and one shift supervisor on third shift. Interview with Ms. Wisely revealed the facility designated two shift supervisors on both first and second shifts in which one was assigned in assisted living, and one was assigned in memory care.

VIOLATION ESTABLISHED

R 325.1932 Resident medications.

(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.

Inspection of room 235 revealed Resident A maintained medications in blister packs which were located on her chair. Interview with Ms. Wisely revealed Resident A self-administered her medications in which she lacked a safe storage place for them.

VIOLATION ESTABLISHED

R 325.1964 Interiors.

(9) Ventilation shall be provided throughout the facility in the following manner:

(b) Bathing rooms, beauty shops, toilet rooms, soiled linen rooms, janitor closets, and trash holding rooms shall be provided with a minimum of 10 air changes per hour of continuously operated exhaust ventilation that provide discernable air flow into each of these rooms.

The residents' bathing/toileting facilities located in rooms 107, 123, 204, and 228 lacked adequate and discernable air flow.

VIOLATION ESTABLISHED

R 325.1970 Water supply systems.

(7) The temperature of hot water at plumbing fixtures used by residents shall be regulated to provide tempered water at a range of 105 to 120 degrees Fahrenheit.

Water temperatures in resident rooms read 125.4-degrees Fahrenheit in room 235, 121.8-degrees Fahrenheit in room 107, and 127.9-degrees Fahrenheit in memory care room 123.

VIOLATION ESTABLISHED

R 325.1974 Laundry and linen.

(1) A home that processes its own linen shall provide a well ventilated laundry of sufficient size which shall be equipped to meet the needs of the home.

Inspection of the first-floor laundry room revealed it lacked a vent to provide ventilation. Inspection of the second-floor laundry room revealed the vent was broken in which it also lacked adequate and discernable air flow.

VIOLATION ESTABLISHED

R 325.1976 Kitchen and dietary.

(8) A reliable thermometer shall be provided for each refrigerator and freezer.

Inspection of resident's refrigerators and freezers in rooms 107, 204, 214, 228, and 235 revealed they lacked reliable thermometers in either the refrigerator, freezer, or both.

VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, renewal of the license is recommended.

03/24/2023

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Date

Licensing Consultant