GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 2, 2023

Sunil Bhattad
Auburn Fields Assisted Living II, LLC
4710 Stephanie Ct
Auburn, MI 48611

RE: License #: AL090356074
Investigation #: 2023A0572034-**AMENDED**
Auburn Fields Assisted Living

Dear Mr. Bhattad:

Attached is the **AMENDED** Special Investigation Report for the above referenced facility. Amendments were made to page 5 to include additional information in the exit conference. 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) 643-7960.

Sincerely,

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL090356074
Investigation #:	2023A0572034
Complaint Receipt Date:	03/22/2023
Investigation Initiation Date:	04/07/2023
Report Due Date:	05/21/2023
Licensee Name:	Auburn Fields Assisted Living II, LLC
Licensee Address:	4710 Stephanie Ct Auburn, MI 48611
Licensee Telephone #:	(248) 765-5209
Administrator:	Sunil Bhattad
Licensee Designee:	Sunil Bhattad
Name of Facility:	Auburn Fields Assisted Living
Facility Address:	4710 Stephanie Court Auburn, MI 48611
Facility Telephone #:	(248) 765-5209
Original Issuance Date:	09/16/2014
License **Status:**	REGULAR
Effective Date:	03/16/2023
Expiration Date:	03/15/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 03/17/2023, Resident A was checked on at 7 a.m. and was fine, but at 8 a.m., her right foot was between the mattress and the heat radiator. She sustained two large bruises and burns.	Yes

III. METHODOLOGY

03/22/2023	Special Investigation Intake 2023A0572034
03/22/2023	APS Referral APS made referral.
04/07/2023	Special Investigation Initiated - Letter Complainant.
04/07/2023	Contact - Telephone call received Resident A's Family Member #1.
04/10/2023	Inspection Completed On-site Med Coordinator, Aly Jones
04/11/2023	Contact - Telephone call made APS, Julie Anderson
05/08/2023	Contact - Face to Face Staff, Morgan Gallaty; Sara Gillard; Home Manager, Desiree Biggs; Staff, Marsh Slates.
05/08/2023	Contact - Telephone call made Ralph Martin, Bureau of Fire Safety.
05/11/2023	Inspection Completed-BCAL Sub. Compliance
05/12/2023	Exit Conference Licensee Designee, Sunil Bhattad.

ALLEGATION:
On 03/17/2023, Resident A was checked on at 7 a.m. and was fine, but at 8 a.m., her right foot was between the mattress and the heat radiator. She sustained two large bruises and burns.

INVESTIGATION:
On 03/22/2023, the local licensing office received a complaint for investigation. Adult Protective Services (APS) were also conducting their own investigation.

On 04/07/2023, contact was made with Resident A's Family Member #1. I was informed that the allegation was true. Resident A's health deteriorated quickly after the incident and passed away. Family Member #1 will send an email with more information.

On 04/10/2023, I made an unannounced onsite at Auburn Fields Assisted Living, located in Bay County Michigan. I interviewed the Med Coordinator, Aly Jones.

On 04/10/2023, I interviewed Med Coordinator, Aly Jones regarding the allegation. Ms. Jones informed that Resident A had been moved to another facility where she had passed away. Resident A's bed was alongside a wall where the electric heater radiator was located. Staff went in to check on Resident A in the morning and removed the covers from her and saw that her legs were stuck in between the wall and the mattress. Her feet were resting on top of the radiator, causing severe burns. Resident A has full use of her limbs, but she was not strong enough to walk, so she would not have been able to get her legs unstuck on her own. Ms. Jones believes that Resident A may have been turning over to get comfortable when her legs got caught in between the wall and her mattress. Resident A only made a small whimper, which is surprising considering how bad the burns were.

On 04/10/2023, I contacted APS, Julie Anderson. She informed that Resident A was on hospice at the time of the incident. Family members are split on if it was accidental or something that could have been avoided.

On 05/08/2023, I interviewed Staff, Morgan Gallaty regarding the allegation. Ms. Gallaty was not working but heard about the incident. She observed the wound, and it was very bad and Resident A was in a lot of pain. She does not believe that there is a covering that can go over the electric radiator. The facility was aware that Resident A would try to get out of bed, which is why she had a bed alarm, but Resident A had never tried to get out of from that side of the bed before because there is no room to get out. Ms. Gallaty is not aware if anyone known beforehand that the radiator could get hot enough to scald someone. The room temperature was always normal in her room. Ms. Gallaty described Resident A as elderly and very frail at nearly 100 pounds. Resident A would swing her legs off the bed, but this time she did this on the other side of the bed, which caused her burns. After the incident,

they were instructed to move all the beds in the facility away from the wall which has the radiator.

On 05/08/2023, I interviewed Staff, Sara Gillard regarding the allegation. Ms. Gillard was not working but heard about the incident. The incident would have occurred somewhere in between 3rd and 1st shift as Resident A was found by a staff on 1st shift with her legs hanging off the bed, in between the wall and the mattress, which caused her to be severely burned due to the electric radiator on the wall. The facility has had a very hard time trying to keep Resident A from swinging her legs off the bed to keep her safe, while simultaneously not being restrictive. Ms. Gillard informed that the electric radiators could get hot to the touch during the wintertime. She does not believe that anyone knew that that the radiators could cause such a severe burn on someone. After the incident, they moved all the resident's beds away from the radiators in their rooms and now they only use the central heating system. Ms. Gillard is not aware of any covering that can go over top of the radiators.

On 05/08/2023, I interviewed Home Manager, Desiree Biggs regarding the allegation. Ms. Biggs informed that Resident A legs were found between the mattress and the wall where the electric radiator was located. She is not sure if she was trying to get out of bed or not. Resident A surprisingly never screamed out for help. Resident A had very high anxiety and would yell out a lot but did not do so when she received the severe burns on her feet. Ms. Biggs is unaware of any covering for the electric radiator and informed that they moved all the beds away from the electric radiators. Resident A's burn was bad, but it got noticeably worse with each passing day and began blistering. They have discussed removing all the electric radiators because it is a fire hazard if the sheet or blanket are too close to them. Ms. Biggs informed that the family set up the room and had turned on the radiator to their liking.

On 05/08/2023, I interviewed Staff, Marsha Slates regarding the allegation. Resident A never showed any signs of pain when she found her. Resident A was facing the wall with her legs in between the wall and the bed, as if she were trying to get up. Ms. Slates moved the bed over to get her feet from in between the wall and the bed and observed very noticeable burns, which had begun to blister and gotten worse each day. Ms. Slates had never turned on the electric radiators before, so she was unaware as to how hot they can get. All rooms were rearranged so that the beds are not near the radiators in the rooms. She does not believe that there is a cover that can go over the radiators.

On 05/08/2023, I contacted Bureau of Fire Safety, Ralph Martin and asked if he know of any coverings that can go over the radiators and he indicated that he is not aware of anything like that but will probably have to make another trip to the facility to see how they look. He informed that for the time being, to make sure that the beds and other objects are 3 feet away from the radiators.

On 05/08/2023, I reviewed the Incontinence Record for Resident A. On the date of the incident, Resident A was checked on by staff at 6am and again at 8:30am. In between that time is when Resident A moved her legs off the bed.

On 05/08/2023, I reviewed the Healthcare Appraisal, and it indicates that she utilizes a wheelchair and a walker and diagnosed with Dementia, Cardiomyopathy, Hypertension, Hyperlipidemia, GERD and Charcot-Marie-Toothe disease.

On 05/08/2023, I reviewed the incident report which indicates that on 03/17/2023, staff checked on Resident A and her legs were stuck beside her bed and up against the heat register. A major burn and blister were found on her foot. Staff yelled for Med Coordinator to come assist and got her on a chair to evaluate the wound. Med Coordinator took vitals, called Hospice and Management. Staff moved Resident A's furniture around so that nothing that she sits or lays on is neat the heater.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	During my investigation, Resident A was found with her legs stuck in between the wall and her bed. It was resting on top of a built-in electric radiator. Staff that were interviewed all informed that Resident A's legs were stuck, and she received severely bad burns on her feet.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/12/2023, an Exit Conference was held with Licensee Designee, Sunil Bhattad. He was informed of the results of the special investigation and that a corrective action plan will be required within 15 days of the receipt of this special investigation report. It should be noted that the facility and staff fully cooperated with the above investigation. The facility has proactively disconnected all radiant supplemental heat units to prevent any future incidents.

IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this large adult foster care group home, pending the receipt of an appropriate corrective action plan (Capacity 1-20).

06/02/2023

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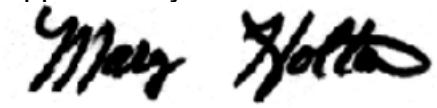
Anthony Humphrey Date
Licensing Consultant

Approved By:



06/02/2023

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Mary E. Holton Date
Area Manager