GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 23, 2023

Amy Borzymowski
Brookdale Meridian AL
5346 Marsh Road
Haslett, MI 48840

RE: License #: AH330236940
Investigation #: 2023A1021055
Brookdale Meridian AL

Dear Ms. Borzymowski:

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 #:	AH330236940
Investigation #:	2023A1021055
Complaint Receipt Date:	04/19/2023
Investigation Initiation Date:	04/20/2023
Report Due Date:	06/19/2023
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	Suite 2300 6737 West Washington St. Milwaukee, WI 53214
Licensee Telephone #:	(414) 918-5000
Administrator:	Derick Redman
Authorized Representative:	Amy Borzymowski
Name of Facility:	Brookdale Meridian AL
Facility Address:	5346 Marsh Road Haslett, MI 48840
Facility Telephone #:	(517) 381-8700
Original Issuance Date:	02/03/2000
License Status:	REGULAR
Effective Date:	02/23/2023
Expiration Date:	02/22/2024
Capacity:	72
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Improper discharge issued to Resident A	No
Staff Person 1 rude to Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

04/19/2023	Special Investigation Intake 2023A1021055
04/20/2023	Special Investigation Initiated - On Site
04/21/2023	Contact-Telephone call made Interviewed The Care Team registered nurse
04/21/2023	Contact-Documents Received Received Resident A's chart documents
05/01/2023	Contact-Telephone call made Interviewed Staff Person 5 (SP5)
05/03/2023	Exit Conference
05/11/2023	Contact-Documents Received Received additional documents
05/23/2023	Exit Conference

ALLEGATION:

Improper discharge issued to Resident A

INVESTIGATION:

On 04/19/2023, the licensing department received a complaint with allegations Resident A was issued an improper discharge. The complainant alleged Resident A was issued discharge due to bedsores, but the bedsores have healed.

On 04/20/2023, I interviewed administrator Derrick Redman at the facility. Mr. Redman reported Resident A has been a resident at the facility since September 2022. Mr. Redman reported Resident A was issued 30-day discharge letter because

of her increased care needs. Mr. Redman reported Resident A has wounds on her buttocks due to incontinence and non-compliance with medical treatment. Mr. Redman reported Resident A can be upwards of a three person assist transfer and the facility cannot manage this level of care. Mr. Redman reported Resident A was active with The Care Team for home health care needs, skilled nursing, physical therapy, and occupational therapy, but the agency ended services because Resident A was not meeting goals and was not receptive to services. Mr. Redman reported Resident A was to have wound care but often would refuse said care. Mr. Redman reported the facility reached out to another home care agency for nursing care, but the agency refused to start services with Resident A. Mr. Redman reported Resident A was issued a discharge letter on March 23, 2023, with a discharge date of April 22, 2023.

On 04/20/2023, I interviewed staff person 2 (SP2) at the facility. SP2 reported at times Resident A will refuse to get out of bed. SP2 reported Resident A does have skin breakdown on her buttocks. SP2 reported Resident A is typically a 2 person assist and has required three people only a few times.

On 04/20/2023, I interviewed SP3 at the facility. SP3 reported Resident A is typically a two person assist transfer. SP3 reported caregivers are responsible for wound care for Resident A. SP3 reported caregivers are to clean Resident A, apply ointment, and apply A & D.

On 04/20/2023, I interviewed SP4 at the facility. SP4 reported Resident A is a two person assist transfer. SP4 reported Resident A had wounds on her buttocks but they have healed. SP4 reported caregivers were to clean Resident A and apply ointment to the wounds. SP4 reported at times Resident A would be reluctant for caregivers to provide care to her.

On 04/20/2023, I interviewed Resident A at the facility. Resident A reported she was issued a discharge due to care issues. Resident A reported it takes two people to transfer her. Resident A reported she does have wounds on her buttocks, but she believes they are healed. Resident A reported she will be moving to another HFA.

On 04/21/2023, I interviewed The Care Team registered nurse Patty Zea by telephone. Ms. Zea reported Resident A has been active with her agency for approximately two years. Ms. Zea reported her agency was providing once a week care and would evaluate the wound, measure the wound, and provide education to the staff and Resident A. Ms. Zea reported Resident A’s wounds are now closed but the wounds tend to get better and then get worse. Ms. Zea reported Resident A was discharged by her agency due to non-compliance. Ms. Zea reported Resident A was not following orders for the wound care. Ms. Zea reported Resident A does not relieve pressure from her buttocks to promote healing.

On 05/01/2023, I interviewed SP5 by telephone. SP5 reported at time of admission, Resident A was a Hoyer Lift with two people. SP5 reported with home therapy,

Resident A did progress to being able to ambulate to dining room. SP5 reported but then Resident A would not follow treatment plan and would regress. SP5 reported at time of admission Resident A did have wounds on her buttocks and her legs, which were weeping. SP5 reported Resident A's wounds would improve, Resident A would not follow treatment plan, and the wounds would get worse. SP5 reported the facility attempted to arrange Resident A to go to the wound clinic but transportation was a barrier. SP5 reported the PCP was still hopeful Resident A would go to the wound clinic. SP5 reported the facility is not equipped to deal with someone that wants to stay in bed and have their wounds get worse.

I reviewed the medication administration record (MAR) for Resident A for March 2023. The MAR revealed Resident A was prescribed Calmoseptine Ointment with instructions to apply to buttocks topically four times a day. There was multiple times in which Resident A refused this treatment.

I reviewed clinical notes for Resident A. The clinical notes read the following measurements of the wounds:

02/22/2023: Open right 1xm x 1.5cm
03/30/2023: Open Right 2cm x 2cm; Open left 1cm x 1cm
04/21/2023: Open Right 10cm x 4cm (5 open areas outside of larger area; Open left 9 cm x 4cm

I reviewed progress notes for Resident A. The progress notes read,

"3/3/2023: Resident has not been compliant with daily walking to lunch meal per therapy plan. Resident has not been walking to bathroom and has been staying in bed. PCP notified and will address at next visit/care conference.
3/14/2023: Care conference to discuss resident discharge from PT,OT and Skilled nursing related to wound care, and discuss placement options as community is unable to meet the level of care safely, and without third party provider to manage wound care. PT/OT and skilled nursing reiterated to resident that they were discharging resident due to continued non-compliance and refusals to follow treatment plan. Community ED discussed with Resident that her care needs were exceeding what could be safely met by Assisted Living and that we cannot provide 3 person assistance. Examples were given to resident of how she is able to get out of bed to use the bathroom with staff assistance, and can ambulate down the hall with 1 staff to dining room. (Resident A) chose not to comply with 3rd party therapy treatment plan causing further decline and requiring 2-3 staff to provide care to change her in bed. Community ED discussed 30 day notice being issued, ED stated he would provide a list of long term care facilities that had availability for (Resident A) to contact and seek placement. Recommendation was to go to a long term care community due to her continued decline and high level of care needs. ED explained that (Resident A) had the right to appeal the 30 day discharge. Primary care physician agreed and stated

he would continue to follow her while she was at the community until she was discharged."

I reviewed clinical documentation for Resident A. The docucementation read,

"At move in on 9/2/21, resident had venous stasis ulcers bilaterally on her lower legs which was discussed on her PSP in the skin comments section. She did not have wounds on her buttocks at that time. On 1/25/2023 her PSP does show a change in skin to account for wound(s) on her buttocks.

On 2/22/2023 Skilled RN back on services and notes Stage 1 with excoriation. Skilled RN educated Resident on using the call light to notify staff of need to urinate in the toilet, incontinence is partial cause of skin breakdown as well as lack of movement. Wound measurement RIGHT buttock 1cm X 1.5cm.

On 3/3/2023 Skilled RN visit for RIGHT buttock wound, Stage 1-2 with excoriation measurement 1cm x 1.5cm.

On 3/10/2023 Skilled RN visit for wound and new wounds. Skilled RN educated Resident on barrier cream order, incontinence adding to skin breakdown, and the need to ambulate to the bathroom to use the toilet instead of in brief. RIGHT buttock wound measurement 2cm x 2cm, LEFT buttock (A) wound 0.5cm x 0.2cm, LEFT buttock (B) wound 0.2cm x 0.2cm.

On 3/14/2023 at 1300 a care conference was held with Resident to discuss her care needs due to her decline with wounds and lack of mobility and the need for 3 staff members when providing care in bed.

On 3/17/2023 Skilled RN discharged Resident due to continued lack of compliance with treatment plan for wounds. RIGHT Buttock measurement 2cm x 2cm, LEFT buttock (now merged into one wound) 1cm x 1cm.

On 4/11/2023 PCP, Community HWD and HWC measured Resident's wounds. RIGHT buttock wound(s) 5 open areas inside wound total measurement of 10cm x 4cm. LEFT buttock wound measurement 9cm x 4 cm. PCP wrote orders for a Home health company Skilled RN to evaluate and treat for buttock wounds. Referral sent to Residential Home Health for review."

I reviewed the discharge letter for Resident A. The discharge letter read,

"We are sending you this letter as our official Discharge Notice for (Resident A) from Brookdale Meridian Assisted Living because the resident requires care and services that the Community is unable to provide in accordance terms and provisions of this Residency Agreement. The date of the discharge is thirty (30) days from the date of this notice. Accordingly, the effective date of discharge is

Saturday April 22, 2023. (Resident A) will need to vacate the facility and remove all belongings by that date."

I reviewed Resident A's service plan. The service plan read,

"(Resident A) is unable to use the bathroom and eliminates while in bed. She will need the assistance of 2 staff to help position her. (Resident A) requires assistance from staff to get to and from all meals and activities of her choosing. She requires two care staff with all transfers and uses a walker for short distances and a manual wheelchair for distance. (Resident A) does have a history of venous insufficiency that causes blisters to form and rupture. She has orders for home health skilled nursing to monitor and provide wound care treatment. She has barrier cream that must be applied with every toileting/brief change. Staff will report to nurse any observed signs of skin breakdown such as redness, rash, excessive dryness/flaking, soft mushy skin, or open areas."

I reviewed skin observation documentation for Resident A. The document read,

"(Skilled nursing) discharge on 3/17/2023 due to Resident's continued refusal of treatment plan and recommendations. PCP is aware. Community nurse taking over weekly measurements and monitoring due to being discharged from skilled nursing 3/17/2023."

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(3) The following additional requirements for the policy described in subsection (2) apply to licensees under parts 213 and 217: **(e) A home for the aged resident may be transferred or discharged only for medical reasons, for his or her welfare or that of other residents, or for nonpayment of his or her stay, expect as provided by title XVIII or XIX. A nursing home patient may be transferred or discharged only as provided in sections 21773 to 21777. A nursing home patient or home for the aged resident is entitled to be given reasonable advance notice to ensure orderly transfer or discharge. Those actions shall be documented in the medical record.**

ANALYSIS:	Review of documentation and interviews revealed Resident A had wounds that were not present at admission. Over the course of her time at the facility, Resident A developed wounds and the wounds progressed to the level that the facility could no longer manage the wounds of Resident A. Resident A was issued discharge letter due to increased medical needs that comports with statutory requirements.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff Person 1 (SP1) rude to Resident A.

INVESTIGATION:

The complainant alleged SP1 has been rude to Resident A.

Mr. Redman reported he has never received any concerns about SP1. Mr. Redman reported he has observed SP1 interactions with residents and the interactions are always respectful.

Resident A reported SP1 has always treated her rudely by not speaking nicely to her. Resident A reported SP1 was very rude to her when The Care Team discharged her from their services and reported to her that she would never find nursing care services.

On 04/20/2023, I interviewed Resident B at the facility. Resident B reported she feels safe at the facility and is treated respectfully. Resident B reported her quality of life has improved since residing at the facility. Resident B reported no concerns with caregivers at the facility.

On 04/20/2023, I interviewed Resident C at the facility. Resident C reported she is happy to be living at the facility. Resident C reported all the caregivers treat her well and she has no concerns with living at the facility.

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:	Interviews conducted revealed lack of evidence to support the allegation SP1 treats residents disrespectfully.

CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Mr. Redman and SP5 reported Resident A required at times three people to assist with care and transfers.

SP2, SP3, and SP4 reported Resident A only requires two people assist for transfers and cares.

I reviewed clinical docucementation for Resident A. The documentation read,

> *"Community ED discussed with Resident that her care needs were exceeding what could be safely met by Assisted Living, and that we cannot provide 3 person assistance. Examples were given to resident of how she is able to get out of bed to use the bathroom with staff assistance, and can ambulate down the hall with 1 staff to dining room. Sue chose to not comply with 3rd party therapy treatment plan causing further decline and requiring 2-3 staff to provide care to change her in bed."*

I reviewed Resident A's service plan. The service plan read,

> *"(Resident A) is unable to use the bathroom and eliminates while in bed. She will need the assistance of 2 staff to help position her. (Resident A) requires assistance from staff to get to and from all meals and activities of her choosing. She requires two care staff with all transfers and uses a walker for short distances and a manual wheelchair for distance."*

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Statements made by the management team and facility documentation revealed Resident A required three people for transfers and assistance. However, interviews conducted with floor staff and review of the service plan revealed Resident A only required two-person assistance. The service plan was not reflective of the care needs of Resident A.

CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Resident A's discharge letter read,

"Licensing Rules for Home for the Aged grants you the right to file a complaint with the Department of Human Services regarding this discharge."

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(13) A home shall provide a resident and his or her authorized representative, if any, and the agency responsible for the resident's placement, if any, with a 30-day written notice before discharge from the home. The written notice shall consist of all of the following: **(c) A statement notifying the resident of the right to file a complaint with the department. The provisions of this subrule do not preclude a home from providing other legal notice as required by law.**
ANALYSIS:	Review of Resident A's discharge letter did not have a statement in the letter on the right to file a complaint with Licensing and Regulatory Affairs.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Kimberly Horst 05/12/2023

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 05/19/2023

Andrea L. Moore, Manager Date

Long-Term-Care State Licensing Section