GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

Mary North
Brookdale Farmington Hills North II
27900 Drake Road
Farmington Hills, MI 48331

September 20, 2023

RE: License #: AH630236929
Investigation #: 2023A1022003
Brookdale Farmington Hills North II

Dear Mary North:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630236929
Investigation #:	2023A1022003
Complaint Receipt Date:	10/11/2022
Investigation Initiation Date:	10/11/2022
Report Due Date:	12/10/2022
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	Suite 2300 6737 West Washington St. Milwaukee, WI 53214
Licensee Telephone #:	(414) 918-5000
Administrator:	Alexis Clark
Authorized Representative:	Mary North
Name of Facility:	Brookdale Farmington Hills North II
Facility Address:	27900 Drake Road Farmington Hills, MI 48331
Facility Telephone #:	(248) 489-9362
Original Issuance Date:	09/25/1999
License **Status:**	REGULAR
Effective Date:	01/07/2023
Expiration Date:	01/06/2024
Capacity:	32
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The Resident of Concern (ROC) displayed problematic behaviors that were not addressed.	No
The facility was understaffed.	Yes

III. METHODOLOGY

10/11/2022	Special Investigation Intake 2023A1022003
10/11/2022	Special Investigation Initiated - Letter APS investigator contacted. She is willing to share her onsite notes.
11/15/2022	Inspection Completed On-site
03/02/2023	Contact - Document Received Email exchange with facility
09/20/2023	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) displayed problematic behaviors that were not addressed.

INVESTIGATION:

On 10/10/2022, the Bureau of Community and Health Systems received two anonymous referrals from Adult Protective Services (APS) that reported the same incident. APS opened an investigation and assigned a staff member to investigate. According to the first of the two referral sources, “An incident occurred at the facility on 10/06/2022. A resident, [name of the Resident of Concern (ROC)], was very aggressive and agitated on this day… [Name of the ROC] had choked one resident and kicked another resident. [Name of the ROC] also pushed a staff member and walked off. [Name of the ROC] then opened the door to the facility and left out…” According to the second APS referral source, “There are concerns for the female residents at the facility since resident [name of the ROC] moved in. He tends to attack the female residents, one in particular named [name of Resident A]. This occurred towards the end of September. He choked and hit [name of Resident A] in the head with a fake plant and was grabbing, hitting, and kicking other female residents. Law enforcement was not contacted and the incident was brushed off by management. The nurse that day said to just give [name of the ROC] his medications and that was it. It's unknown if anyone sustained any injuries. [Name of the ROC] also escaped and crossed over 12 Mile Rd. and almost got hit… The emergency door alarm is also not loud enough to hear, which is how it's so easy for residents to get out.”

According to the facility incident report that described the ROC’s elopement from the facility, “Nurse on call was alerted that resident (ROC) exited a court side door approx 5:30pm and was off the property before staff were able to direct him back to the community. [Name of caregiver #1] the Medication Technician on staff was able to get [name of the ROC] back to the community via a good samaritan helping her by transporting them back to the community in her vehicle. The remaining staff performed a head count and ground search during this incident… Investigation concluded 2 staff members failed to follow proper protocol when responding to door alarm. Staff focused on inside search for resident and did not immediately go outside to check the door that was alarming. When staff did go outside they exited the opposite door that alarmed allowing for more time that resident was able to exit the property onto the sidewalk.”

On 11/15/2022, at the time of the onsite visit, I interviewed the executive director and the director of wellness. According to the executive director, the ROC had moved into the facility on 9/16/2022, but he was a transfer from a corporate sister facility located in the state of Kansas. The ROC was known to have combative and

aggressive behaviors and had, in fact, demonstrated exit-seeking behaviors at his previous placement in Kansas, with a one-time successful elopement, that led to a geriatric psychiatric hospitalization in a Kansas facility.

Prior to 10/6/2022, the day that the ROC eloped from the facility, there was only one incident that the administrator and the wellness had knowledge of. Two days after he moved into the facility, 9/18/2022, according to an internal incident report, the ROC became “agitated and attacking another resident, no harm was done…” This other resident was identified by the facility as Resident A.

Review of Resident A’s charting notes revealed that the only entries made for 9/18/2022, indicated “no s/s (signs/symptoms) of distress, verbal, no c/o (complaints of) pain, family of concern aware of situation, documented in physician book…”

According to the executive director, through experience, they had come to recognize that certain events triggered problematic behaviors for the ROC. Some of the triggers identified by care staff members included when another resident “bothered” him, overstimulation by bright lights and loud noise. The staff further identified that the ROC could become anxious and aggressive during the dinner meal, which was the time frame that he successfully left the building in October. Subsequently, the staff was having the ROC dine in a smaller common room, where he could eat without having to be subjected to the stimulation of the other residents eating their dinners. The administrator also reported that staff could at times successfully redirect the ROC by talking to him about his interest in sports and gardening.

According to his service plan, the ROC was mainly independent for personal care with only minimal assistance of care staff. Regarding problematic behavior, the service plan documented that “[Name of the ROC] has a history of behaviors when upset, staff will redirect and provide a quiet place to calm down. [Name of the ROC] has a history of making inappropriate comments to female staff members, staff will redirect [name of the ROC] when he is talking inappropriately. [Name of the ROC] is noted to at times feel he is running the building and get frustrated when his is not listened to by other residents, staff will redirect him and remove the other residents from his personal space. [Name of the ROC] had a past behavioral stay at Sr. Anthony's Behavioral Health in Kansas July 2021, he returned successfully to his past community after the behavioral stay. 1:1 companion is needed for supervision for increase anxiety, agitation, and verbalizing of wanting to exit community… “

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.
ANALYSIS:	The ROC had just moved into the building and staff were still in the process of establishing a routine for him. With the establishment of a routine, the ROC's behaviors decreased.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility was understaffed.

INVESTIGATION:

According to the anonymous referral sources, "(On 10/6/2022) There was a lack of staff scheduled for the day at the facility… It was reported that the staff members were supposed to contact the director to notify them of the incident. However, the facility was understaffed and there was no time to do this..."

At the time of the onsite visit, the administrator was asked to describe optimal staffing. The administrator stated that the facility consisted of two separate houses to encourage a close sense of neighborhood. House #1 could accommodate 28 residents, but at the time of the incident the census was 14. House #2, where the ROC lived, could accommodate 32 residents, but the census was only 12. The administrator went on to say that care staff worked 8-hour shifts, the day shift, the afternoon shift, and the overnight shift. According to the administrator, there should be a minimum of 2 caregivers in each house for all three shifts. Additionally, for the day shift and the afternoon shift, there should be 1 medication technician in each house. For the overnight shift, there would be 1 medication technician who "floated" between the houses.

Review of the staffing assignments for the week of 10/2/2022 through 10/8/2022 indicated that despite the administrator's description of the staffing, only one medication technician was scheduled on any shift, who was shared between the two houses. When the administrator was asked about this discrepancy, she stated (by email sent on 3/23/2023) that when I had asked about "what was optimal—(the answer was) to have a med tech in each house is our optimal staffing and always what is our preference but sometimes based on staff availability, vacation requests, call offs we may have 1 med tech floating between both houses and at this time of lower occupancy that is appropriate… (staffing was) above even acuity guidelines for staffing with 12 and 14 in each house for a total of 26 residents --5 care staff plus leadership that was still on site."

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	The facility scheduled less than optimal staffing 10/2/2022 through 10/8/2022 because they believed that their staffing was "above even acuity guidelines."
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 09/20/2023. When asked if there were any comments or concerns with the investigation, the AR stated there were none.

IV. RECOMMENDATION

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

09/20/2023

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Barbara Zabitz Date
Licensing Staff

Approved By:

09/18/2023

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