GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 25, 2023

Mary North
Brookdale of Troy MC
4900 Northfield Parkway
Troy, MI 48098

RE: License #: AH630236937
Investigation #: 2023A1019074
Brookdale of Troy MC

Dear Licensee:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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. 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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630236937
Investigation #:	2023A1019074
Complaint Receipt Date:	09/12/2023
Investigation Initiation Date:	09/12/2023
Report Due Date:	11/12/2023
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	6737 West Washington St., Suite 2300 Milwaukee, WI 53214
Licensee Telephone #:	(414) 918-5000
Administrator:	Ralph Scarano
Authorized Representative:	Mary North
Name of Facility:	Brookdale of Troy MC
Facility Address:	4900 Northfield Parkway Troy, MI 48098
Facility Telephone #:	(248) 267-9500
Original Issuance Date:	06/01/1999
License Status:	REGULAR
Effective Date:	05/12/2023
Expiration Date:	05/11/2024
Capacity:	52
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was improperly supervised.	Yes
Additional Findings	No

III. METHODOLOGY

09/12/2023	Special Investigation Intake 2023A1019074
09/12/2023	Comment Complaint was forwarded to LARA from APS. APS denied the referral and is not investigating.
09/12/2023	Special Investigation Initiated - Telephone Called placed to Oakland County Community Mental Health worker for additional information. Left voicemail requesting return call.
09/13/2023	Contact - Document Sent Emailed records department at Troy PD requesting a copy of the police report.
09/13/2023	Contact - Document Received Police report received via email.
09/14/2023	Inspection Completed On-site
09/14/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A was improperly supervised.

INVESTIGATION:

On 9/12/23, the department received a complaint alleging that Resident A had eloped from the facility on 8/21/23. The complaint alleged that facility staff were unaware that Resident A was gone and was brought back to the facility by police.

On 9/13/23, I obtained a copy of the police report the Troy Police Department. The report outlined the following:

- A call was dispatched at 7:31pm on 8/21/23 reporting a confused elderly female wandering through a neighborhood.
- When officers approached the female, she was confused and reported that she was looking for her sister's house. The subject confirmed that she was [Resident A].
- Telephone contact was made with Relative A, who informed the officers that Resident A lived at the facility.
- Officers reported that Resident A was found over a mile away from the facility.
- Officers transported Resident A back to the facility, staff were unaware that she had left.

On 9/14/23, I conducted an onsite inspection. I interviewed administrator Ralph Scarano at the facility. Mr. Scarano stated that he was not working at the time of the incident, but report that on the evening on 8/21/23, he received a call from a caregiver informing him that Resident A had been brought back by police. Mr. Scarano stated that he immediately drove up to the facility to determine what had occurred. Mr. Scarano confirmed that Resident A resides in a secured memory care unit, which has locked doors that alarm when opened. Mr. Scarano stated that staff reported last seeing Resident A during the evening med pass at 7:20pm. Mr. Scarano stated that staff interviewed attested that they did hear the door alarm, but that they assumed someone had leaned on the cross bar and set the delayed egress alarm off inadvertently. He stated that staff did not physically go outside and see if anyone had left the building and did not complete a headcount after the alarm sounded. Mr. Scarano stated that Resident A was returned to the facility around 8:30pm.

While onsite, Mr. Scarano provided an incident report that read:

> *On Monday 8/21/23 it was reported to this nurse that the resident care associate, [Employee 1] who was the afternoon shift supervisor for the assisted living building received a call from the troy police department asking if [Resident A] was a resident and informed him that she was found walking on the sidewalk off the property. Around 8:30pm [Employee 1] contacted the med tech [Employee 2] in*

the memory care building to confirm [Resident A] was a resident of memory care, relaying that TPD was in route to bring her back to the community. [Employee 2] then reached out to inform the community nurse, who notified her physician and the executive director, who contacted the responsible party once he arrived to the community. Upon entry back to the community [Resident A] was assessed for injuries; vital signs WNL, no signs of pain or distress. When asked where the resident was going at the time, she responded, "I was going to my son's."

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.**
For Reference R 325.1901	**(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.** **(u) "Supervision" means guidance of a resident in the activities of daily living, and includes all of the following:** **(iv) Being aware of a resident's general whereabouts as indicated in the resident's service plan, even though the resident may travel independently about the community.**
ANALYSIS:	Facility staff failed to adequately supervise Resident A and follow proper protocol for when a door alarm sounds. As a result, Resident A was able to leave the secured memory care unit without staff knowledge. Resident A was at significant risk of harm while unattended outside the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

09/25/2023

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

09/25/2023

Andrea Moore Date
Area Manager