GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 8, 2024

Rick Goren
Brighton Gardens of Northville
7902 Westpark Dr
McLean, VA 22102

RE: License #: AH820408530
Investigation #: 2024A1022001
Brighton Gardens of Northville

Dear Rick Goren:

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.

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 #:	AH820408530
Investigation #:	2024A1022001
Complaint Receipt Date:	10/02/2023
Investigation Initiation Date:	10/02/2023
Report Due Date:	12/01/2023
Licensee Name:	SJV 2 Northville OpCo LLC
Licensee Address:	15th Floor 250 Vesey St New York, NY 10281
Licensee Telephone #:	(703) 273-7500
Administrator/Authorized Rep	Rick Goren
Name of Facility:	Brighton Gardens of Northville
Facility Address:	15870 N Haggerty Rd Plymouth, MI 48170
Facility Telephone #:	(734) 420-7917
Original Issuance Date:	06/18/2021
License **Status:**	REGULAR
Effective Date:	12/18/2022
Expiration Date:	12/17/2023
Capacity:	120
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was physically assaulted by Resident B.	No
Resident A was not administered medication according to the prescriber's orders.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/02/2023	Special Investigation Intake 2024A1022001
10/02/2023	Special Investigation Initiated - Telephone Complainant interviewed by phone.
10/13/2023	APS Referral
10/13/2023	Inspection Completed On-site
11/27/2023	Contact - Telephone call made. Phone conversation with the wellness director.
12/12/2023	Contact - Telephone call received. Information exchanged with the facility via email.
12/19/2023	Contact - Telephone call received. Information exchanged with the facility via email.
01/08/2024	Exit Conference

ALLEGATION:

Resident A was physically assaulted by Resident B.

INVESTIGATION:

On 10/02/2023, the Bureau of Community and Health Systems (BCHS) received a complaint that read, “After several reports and concerns about my mother (Resident A) safety and resident wandering in her room constantly. Writer was notified by the aide on Sunday morning October 1, 2023, approximately 6:30 a.m. that a resident (Resident B) had wandered in my mother room; in her bed on top of my mother hitting her. This incident of resident wandered in my mother room has been a constant issue to the point my mother room has been changed to provide close monitoring to no avail. this situation has become an unsafe situation and do to multiple compliant with the facility no resolution has been made. This unsafe situation has been constantly minimized by the management staff. As a result, my mother has been physically assaulted.”

On 10/02/2023, I interviewed the complainant by phone. The complainant reiterated her concerns as they appeared in her written complaint.

On 10/13/2023, a referral was sent to Adult Protective Services.

On 10/13/2023, at the time of the onsite visit, I interviewed both the resident care director and the director of wellness. When asked if Resident A had been involved in an altercation with another resident, both the resident care director and the wellness director identified Resident B as the other resident. Neither the resident care director nor the wellness director had direct knowledge of the altercation, but both had reviewed the incident report, and both had been involved in proposing interventions to prevent this type of incident from reoccurring.

According to the resident care director, both Resident A and Resident B resided on the facility’s memory care (MC) unit. Resident A was known to be awake during the overnight shift, but usually did not leave her room. During the overnight shift, she would stand in her doorway and watch staff and other residents, who might pass by her room. The resident care director stated that she thought Resident A had worked as a licensed nurse and was known to issue “directions” to other residents, as if they were her employees. However, at the time of the incident, early on the morning of 10/01/2023, Resident A was in her bed.

According to the resident care director, Resident B was a wanderer and was known to be verbally aggressive with both other residents and staff. Resident B had displayed physical aggression with staff, but never other residents. Resident B frequently responded to “yelling” and other loud noises by becoming agitated.

According to the incident report, a caregiver entered Resident A’s room after “hearing screaming,” and found Resident B “standing over her (Resident A) punching her yelling get out (of) my room.” According to the wellness director’s post-incident assessment of the incident. Resident B believed that Resident A was

“someone else” who had come into her home. Resident B had recently undergone some medication changes and her behavior had deteriorated.

According to her service plan, Resident A displayed deficits in judgment due to moderate dementia. She occasionally displayed inappropriate behavior and was easily redirected with verbal cues. According to her serviced plan, Resident B needed cues and prompts to maintain her level of orientation and had short-term memory issues. Resident B was also known to display significantly increased anxiety, especially when she experienced nerve pain. Staff were to attempt to manage her anxiety with activities and if unsuccessful, she could be administered an antianxiety medication. The service plan did not indicate that Resident B was aggressive with either staff or other residents.

When asked to describe the actions the facility would take to prevent any reoccurrence, the wellness director stated that the facility had decided to purchase a removable stop sign barrier, that could be placed at the doorway to Resident A’s room, to discourage Resident B, or any other wandering residents, from entering Resident A’s room. The resident care director went on to say that subsequent to that episode, the facility had added an additional caregiver for memory care unit on each shift, so that there would be another set of eyes to keep track of resident behaviors. The wellness director went on to say that the staff was using activities to divert Resident B whenever she started to display aggressiveness.

At the time of the onsite visit, I visited both Resident A and Resident B in their rooms. Although she was lying in bed, Resident A was awake and responsive to greeting; however, her speech was indistinct and difficult to understand. She indicated that she was in some discomfort, but neither the resident care director nor the wellness director was able to determine what was bothering her. Resident B was asleep in her bed.

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.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(l) A patient or resident is entitled to be free from mental and physical abuse**

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: R325.1901	**Definitions.**
	(16) "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.
ANALYSIS:	Although Resident B was the aggressor in the altercation with Resident A, there were no evidence that the facility had any prior warnings these two residents would be involved in an incident.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was not administered medication according to the prescriber's orders.

INVESTIGATION:

According to a supplemental complaint form, dated 10/01/2023, the complainant additionally alleged that "there has been other incident regarding my mother care, for example incident of fall and management failed to notify me, and several incidents related to medication management. Giving insulin when insulin should not have been given. Failure to monitor Blood Pressure, B/P medication given and my mother B/P already low."

On 11/27/2023, the wellness director was questioned about these further allegations. The wellness director acknowledged an incident that occurred at the end of September 2023, that was not documented in Resident A's record. The wellness director stated that she had come to the facility at about 2 am only to administer morphine to a hospice resident when she was notified that Resident A had slid out of bed. The wellness director stated that she went to Resident A's room and found her sitting on the floor, talking on her cell phone. The wellness director went on to say that she assessed Resident A and found her to be without injury. The wellness director stated that she did not notify Resident A's family at that time, due to the late hour and because she was scheduled to meet with Resident A's family member later in the day. The wellness director further acknowledged that after informing Resident A's daughter of the fall, the daughter expressed dissatisfaction with not being informed immediately of the fall and that the wellness director had agreed that in the future, the daughter would be immediately informed regardless of the time of day.

When the wellness director was asked about Resident A's blood pressure medications, the wellness director stated that Resident A had physician orders for two medications: hydralazine and carvedilol. For the hydralazine, the prescriber had indicated that the medication be held if Resident A's systolic blood pressure was less than 160. For the carvedilol, the prescriber had indicated that the medication be held if Resident A's systolic blood pressure was less than 100 or if her diastolic pressure was less than 60. Therefore, Resident A may have received the carvedilol on those days when her blood pressure was too low to administer the hydralazine.

Review of Resident A's September 2023 medication administration record (MAR) revealed the following orders and administration of medication:

Humalog insulin give 14 units in the morning (7 am); hold for a blood sugar reading less than 200. Resident A was not administered this medication on the following days: 09/01, when her blood sugar readying was 190; 09/05, when her blood sugar readying was 139; 09/06, when her blood sugar readying was 146; 09/07, when her blood sugar readying was 156; 09/08, when her blood sugar readying was 190; 09/10, when her blood sugar readying was 157; 09/12, when her blood sugar readying was 167; 09/13, when her blood sugar readying was 181; 09/14, when her blood sugar readying was 102; 09/15, when her blood sugar readying was 102; 09/24, when her blood sugar readying was 130; and on 09/29, when her blood sugar readying was 197. On all other days in September 2023, Resident A's blood sugar level was greater than 200 at 7 am.

Humalog insulin give 11 units in the evening (5 pm); hold for a blood sugar reading less than 200. Resident A was not administered this medication on the following days: 09/03, when her blood sugar readying was 195; 09/17, when her blood sugar readying was 183; 09/25, when her blood sugar readying was 198; 09/26, when her blood sugar readying was 195; and 09/27, when her blood sugar readying was 99. On all other days in September 2023, Resident A's blood sugar level was greater than 200 at 5 pm.

Carvedilol Tablet give 1 tablet in the morning (7:30 am) and 1 tablet in the evening (8 pm). Hold for blood pressure less than 100/60. Resident A was not administered this medication on the following occasions: 09/05 evening dose when her blood pressure was 110/57; 09/14 evening dose when her blood pressure was 115/51; 09/12 morning dose when her blood pressure was 105/77; and on 09/28 evening dose when her blood pressure was 94/53.

Hydralazine HCL give 3 times daily. Please do not give if (systolic) blood pressure below 160. According to the MAR, this medication was frequently not administered to Resident A. Resident A was only administered this medication on the following occasions: 09/14 morning dose when her blood pressure was 192/59; 09/15 morning dose when her blood pressure was 172/80; 09/18 morning dose when her blood pressure was 170/86; 09/20 morning dose when her blood pressure was 174/72 09/21 morning dose when her blood pressure was 189/86; 09/22 morning dose when her blood pressure was 183/82; 09/23 morning dose when her blood pressure was 211/120; 09/24 morning dose when her blood pressure was 182/75; 09/14 mid-day dose when her blood pressure was 185/72; 09/19 mid-day dose when her blood pressure was 176/74; 09/20 mid-day dose when her blood pressure was 184/61; 09/21 mid-day dose when her blood pressure was 126/77; 09/19 mid-day dose when her blood pressure was 176/74; 09/08 evening dose when her blood pressure was 131/66; 09/15 evening dose when her blood pressure was 162/83; and 09/16 evening dose when her blood pressure was 171/68.

On 12/12/2023, via an email exchange with the wellness director, the wellness director was asked to explain why Resident A was not administered her prescribed Carvedilol when she had a blood pressure reading that was greater than 100/60 (105/77). The wellness direction replied, “Carvedilol was held because the blood pressure of 105/77 was low already was told to the Nurse and reported to Doctor.” When asked why Resident A received Hydralazine HCL when her systolic blood pressure reading was lower than 160 (126/77 and 131/66), the wellness director replied, “I can't tell you why the med tech didn't hold the pill on these days. The former employee was given a write up and reeducated on when to hold medications and proper documentation.”

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.

ANALYSIS:	The allegation that medication technicians administered blood pressure medication to Resident A when unwarranted is substantiated. In September 2023, it was done twice. Medication technicians also did not administer blood pressure medication when it met the prescriber's parameters for administration.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

Review of Resident A's MAR for September 2023 revealed that medication technicians did not document anything for the medication administration for the following occasions:

For Namenda give 1 tablet by mouth at bedtime (8 pm) on 09/22/2023.

For Seroquel give 1 tablet by mouth at bedtime (8 pm) on 09/22/2023.

For carvedilol give 1 tablet by mouth at bedtime (8 pm) on 09/22/2023.

For hydralazine give 1 tablet by mouth 3 times daily, the 1:30 pm dose on 09/03/2023.

For hydralazine give 1 tablet by mouth 3 times daily, the 8 pm dose on 09/22/2023.

The spaces on the MAR for these medications were left blank.

When the wellness director was asked to explain via email why no documentation appeared on the MAR for these medications, the wellness director responded, "The document shows #5 and # 9 which means it was held and documented in the progress notes by other med tech only on 09/22 it was not documented, and that employee was terminated. The rest of the med techs was given in-services on the seven rights (of medication administration)."

At the time of review, it was noted that the facility's electronic MAR did not include any entries specifying what time the medication was administered. The AR and the wellness director were asked via an email exchange on 12/19/2023 to explain why the time of the medication administration was missing, the AR replied, "our current configuration in our computer program does not do a time stamp. We are working with our IT department to see if we can change this."

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The name of the prescribed medication.** **(ii) The prescribed required dosage and the dosage that was administered.** **(iii) Label instructions for use of the prescribed medication or any intervening order.** **(iv) The time when the prescribed medication is to be administered and when the medication was administered.** **(v) The initials of the individual who administered the prescribed medication.** **(vi) A record if the resident refuses to accept prescribed medication and notification as required in subdivision (c) of this subrule.** **(vii) A record of the reason for administration of a prescribed medication that is on an as-needed basis. medication or treatment. The home shall follow and record the instructions given.**
ANALYSIS:	The facility did not maintain their medication administration records as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 01/08/2024. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

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

01/08/2024

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

12/21/2023

_____

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