GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 5, 2024

Kattie LaRose
Brookdale Senior Living Communities, Inc.
Suite 2300
6737 West Washington St.
Milwaukee, WI 53214

RE: License #: AL230079864
Investigation #: 2024A0622001
Brookdale Delta AL

Dear Ms. LaRose:

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 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) 284-9727.

Sincerely,

Amanda Blasius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL230079864 |
| | |
| **Investigation #:** | 2024A0622001 |
| | |
| **Complaint Receipt Date:** | 11/27/2023 |
| | |
| **Investigation Initiation Date:** | 11/27/2023 |
| | |
| **Report Due Date:** | 01/26/2024 |
| | |
| **Licensee Name:** | Brookdale Senior Living Communities, Inc. |
| | |
| **Licensee Address:** | Suite 2300<br>6737 West Washington St.<br>Milwaukee, WI 53214 |
| | |
| **Licensee Telephone #:** | (414) 918-5000 |
| | |
| **Administrator:** | Kattie LaRose |
| | |
| **Licensee Designee:** | Kattie LaRose |
| | |
| **Name of Facility:** | Brookdale Delta AL |
| | |
| **Facility Address:** | 7323 Delta Commerce<br>Lansing, MI 48917 |
| | |
| **Facility Telephone #:** | (517) 327-5566 |
| | |
| **Original Issuance Date:** | 03/17/1998 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 07/03/2023 |
| | |
| **Expiration Date:** | 07/02/2025 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| It was reported that for 2-3 hours there was no staff coverage at this AFC home on December 23rd into the morning hours of December 24th. During that time, a resident did request help and rang their call light. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 11/27/2023 | Special Investigation Intake 2024A0622001 |
| 11/27/2023 | Special Investigation Initiated – Telephone Interview with Sarah Kate Van Aker. |
| 12/11/2023 | Inspection Completed On-site |
| 12/11/2023 | Contact - Telephone call made to DCW, Shantoria Brown. |
| 12/12/2023 | Contact - Voicemail left for DCW's, Benaiah Sams and Shaylana Boyce. |
| 12/12/2023 | Contact - Telephone call made to Resident A's nephew. |
| 12/12/2023 | APS Referral |
| 12/14/2023 | Contact - Telephone call made to Resident A. |
| 12/14/2023 | Contact - Telephone call made to DCW's Marie Nelson and Benaiah Sams. |
| 12/20/2023 | APS denial received. |
| 01/05/2023 | Exit Conference with Operations Specialist, Michael Kegley |

**ALLEGATION: It was reported that for 2-3 hours there was no staff coverage at this AFC home on November 23rd into the morning hours of November 24th. During that time, a resident did request help and rang their call light.**

**INVESTIGATION:**
On 11/27/23, I interviewed executive director Sarah Kate Van Auker via phone who stated there was a "mix up" in direct care staff schedules during the third shift on 11/23/23 into the early hours of 11/24/2023. Ms. Van Auker stated a direct care staff member was called over to help at the adjacent licensed property and that direct

care staff member was unaware that no additional direct care staff members were onsite at the AFC facility. Ms. Van Auker stated the direct care staff member left the AFC facility and was gone for approximately 2-3 hours. During this time a resident at the AFC facility needed assistance and pushed their call light to no avail.

On 12/11/2023, I conducted an unannounced investigation and interviewed Operations Specialist, Michael Kegley who is filling in for Sarah Kate Van Auker. Mr. Kegley stated he was aware of the incident that occurred on 11/23/2023 but was not directly involved. Mr. Kegley provided this worker requested documentation. When reviewing documentation, it was determined Resident A ended up calling 911, because she could not find any staff member in the building and was needing a medication. A police report was reviewed, and it confirmed Resident A called 911 at 1:26am and the police arrived at the facility at 1:34pm. According to the police report, they left the facility at 2:04 after completing a well check. Resident A's prescribed medications were reviewed, and this worker confirmed that she is prescribed five PRN/as needed medications. This worker attempted to interview Resident A, but she was offsite for an appointment.

On 12/11/2023, I interviewed DCW Shantoria Brown via phone. DCW Brown reported that she had the on-call phone on 11/23/23 and 11/24/2023. DCW Brown stated that she mainly works at the adjacent licensed facility and worked first shift on 11/23/2023. DCW Brown explained that there was a mix up in the schedule and another DCW Jaleesa Long was scheduled to work first, second and third shift for 11/23/2023. When DCW Long arrived, the schedule was discussed and DCW Brown reported that DCW Long agreed to leave her first shift early and leave her second shift early, so she could work the full third shift. DCW Brown stated that when she left her shift at 2pm, DCW Long was still working. At 7pm, DCW Brown reported that she received a call, on the on-call phone from DCW Long who stated that she was leaving work because she could not work over sixteen hours in one day. DCW Brown reported that she attempted to call another third shift direct care staff and also left a message for Resident Care Coordinator Amanda Spanke. DCW Brown reported that at 3am on 11/24/2023, she received a call from Executive Director Sarah Kate Van Auker stating that no direct care staff member was present at Brookdale Delta AL and she needed a direct care staff member to come in as soon as possible. DCW Brown reported that she called a few other staff members, but none of them answered their phone.

On 12/12/2023, I interviewed DCW Jaleesa Long via phone. DCW Long stated she mainly works at the adjacent licensed property and was scheduled to work first, second and third shift on 11/23/23 and 11/24/23. She explained that on 11/23/23, she received a text to come in for first and second shift. DCW Long stated she notified her manager Amanda Spanke that she could not stay for third shift. DCW Long reported DCW Benaiah Sams contacted another staff member to come into work at Brookdale Delta AL for third shift. DCW Long reported that she left her shift at 10pm on 11/23/23.

On 12/12/2023, I attempted to contact Resident A via phone. The phone number provided was for Relative A1. Relative A1 reported he was aware of the incident of no staff being present in Brookdale Delta AL on 11/23/23. He explained that it was his understanding that Resident A pushed her call light as she was needing cream to be put on her back for pain. He reported that Resident A was not harmed in the incident and was found to be safe.

On 12/12/2023, I interviewed Resident Care Coordinator Amanda Spanke via phone. Ms. Spanke reported that she creates the schedule for Brookdale Delta AL. She reported that there was a mistake in the schedule, as DCW Jaleesa Long was scheduled for three shifts in a row, but it was changed last minute for her to work second and third shift. Ms. Spanke stated that DCW Long ended up working first and second shift on 11/23/2023. DCW Long did call Ms. Spanke at 7:30pm on 11/23/23 to notify her that she could not work the third shift. Ms. Spanke reported that DCW Benaiah Sams contacted DCW Shaylana Boyce who stated she could come in and work the third shift at Brookdale Delta AL. Ms. Spanke explained that she was notified after 2am that no staff had been present in Brookdale Delta AL from 10:30pm-2am.

On 12/12/2023, I left a voicemail with DCW Shaylana Boyce. As of 12/21/2023, she has not returned this workers call.

On 12/13/2023, I interviewed DCW Rosetta Jones-Toms via phone. DCW Jones-Toms stated that she worked on 12/23/2023 at Brookdale Delta AL from 2pm-10pm. She explained that she remembered DCW Marie Nelson coming into the facility at 10pm.

On 12/14/2023, I interviewed DCW Marie Nelson via phone. DCW Nelson reported that DCW Jones-Toms transferred the medication keys for Brookdale Delta AL to her at 10pm. DCW Nelson reported that she had texted DCW Boyce to confirm she was in Brookdale Delta AL before going over to the memory care unit. She explained that she received a text back from DCW Boyce stating “yes.” DCW Nelson reported that around 2am a fire fighter showed up at the memory care facility and reported that a resident called from Brookdale Delta AL and was requesting help. DCW Nelson reported that when she entered Brookdale Delta AL, there were no direct care staff present. She then assisted Resident A with her PRN medication and stayed in the facility until additional staff arrived.

On 12/14/2023, I interviewed DCW Benaiah Sams via phone. DCW Sams reported that she worked at the memory care facility on 11/23/2023. She reported that she was initially scheduled to work in Brookdale Delta AL, but was transferred last minute over to another licensed building on the property. DCW Sams reported that she had confirmed with DCW Boyce via phone that she could work at Brookdale Delta AL on 11/23/2023 for third shift. DCW Sams also stated that she spoke with DCW Boyce on the phone, where she stated that she was in the facility. DCW Sams

explained DCW Shaylana Boyce was working in another AFC facility and was never present in Brookdale Delta AL on 11/23/2023.

On 12/14/2023, I interviewed Resident A via phone. Resident A stated that on 11/23/2023 around 11:30pm, she needed a prescribed cream that she uses on her back for pain. She explained that she started with pushing her call light and waited an hour. When no direct care staff came to assist her, she got in her wheelchair and went around the whole facility looking for a direct care staff member. Resident A reported that when she could not find a staff member, she decided to call executive director Sarah Kate Van Auker, but she did not answer the phone. She then called the main phone number for the facility and Sarah Kate Van Auker again. Resident A explained that no one answered the phone so she then called 911. Resident A reported that two or three police officers arrived, and they asked if she needed to go to the hospital but she reported “no”. Resident A stated DCW Nelson also arrived in Brookdale Delta AL and assisted Resident A with her prescribed pain cream.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15206** | **Staffing requirements.** |
| | **(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.** |
| **ANALYSIS:** | DCW Brown, Nelson and Sams all confirmed that no direct care staff member was present in Brookdale Delta AL from 10:30pm-2am. Executive Director, Sarah Kate Van Auker and Resident Care Coordinator, Amanda Spanke also confirmed that no direct care staff member was present in the facility on 11/23/2023 and 11/24/2023 for about two to three hours. Confirmation of no staff present was also verified with Resident A and the documentation of the police report that confirmed they arrived at the facility on 11/24/2023 at 1:26am and could not locate any direct care staff member. Consequently, the ratio of direct care staff members to residents was not adequate to meet resident needs during that time. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains the same.

12/20/2023

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Amanda Blasius Date
Licensing Consultant

Approved By:

01/05/2024

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Dawn N. Timm Date
Area Manager