GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 10, 2024

Erin Ottenbreit
Cedarbrook of Northville
15700 N. Haggerty Road
Plymouth, MI 48170

RE: License #: AH820389476
Cedarbrook of Northville
15700 N. Haggerty Road
Plymouth, MI 48170

Dear Licensee:

Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. 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 dates 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 home for the aged authorized representative and a date.

Upon receipt of an acceptable corrective action plan, a regular license will be issued. If you fail to submit an acceptable corrective action plan, disciplinary action will result.

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 feel free to contact the local office at 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AH820389476
Licensee Name:	BMSH I Cedarbrook Northville MI LLC
Licensee Address:	# 300 1450 West Long Lake Troy, MI 48098
Licensee Telephone #:	(248) 284-2765
Authorized Representative:	Erin Ottenbreit
Administrator/Licensee Designee:	Colleen Irvin
Name of Facility:	Cedarbrook of Northville
Facility Address:	15700 N. Haggerty Road Plymouth, MI 48170
Facility Telephone #:	(734) 743-3646
Original Issuance Date:	07/31/2017
Capacity:	96
Program Type:	ALZHEIMERS AGED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 01/08/2024

Date of Bureau of Fire Services Inspection if applicable: 10/3/2023, 11/14/2023

Inspection Type: ☐ Interview and Observation ☒ Worksheet ☐ Combination

Date of Exit Conference: 01/08/2024

No. of staff interviewed and/or observed 22
No. of residents interviewed and/or observed 18
No. of others interviewed 0 Role

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.

- Medication(s) and medication records(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☐ No ☒ If no, explain. No resident funds held.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.

- Fire drills reviewed? Yes ☐ No ☒ If no, explain.
  Bureau of Fire Services reviews fire drills. Disaster plan reviewed and staff interviewed regarding disaster plan.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.

- Incident report follow-up? Yes ☐ IR date/s: N/A ☒
- Corrective action plan compliance verified? Yes ☒ CAP date/s and rule/s: CAP dated 2/10/2022 to Renewal Licensing Study Report dated 1/26/2022: R 325.1931(2), R 325.1932(2), R 325.1932(3)
- Number of excluded employees followed up? Two N/A ☐

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following rules:

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 **Definitions.**

Rule 1. As used in these rules:

(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.

Interview with Ms. Irvin revealed there were three residents with bedside assist devices. Ms. Irvin stated the facility maintained a policy prohibiting bedside rails, but not a written policy for use of other devices. Ms. Irvin stated maintenance staff conducted an initial check on bedside assist devices after they were installed, but there were no checks on the devices after that time, except by staff.

Interview with the maintenance staff person revealed he was uncertain if he maintained the manufacturing guidelines for the devices.

Observation of Resident A's beside assist device revealed it was u-shaped grab bar, that was approximately two feet long and one foot wide. The device was not affixed directly to the bedframe and slid under the mattress. The device presented with a large enough gap for a limb to become entangled or in the event the occupant's body pushed the device away from the mattress, it would become an entrapment zone with risk of suffocation. Ms. Irvin stated the device was not approved to be placed on the bed and was installed without permission by the Resident A's daughter.

Observation of Residents H and I's bedside assist devices revealed they were commonly referred to as "Halo Rings." Observation of Resident H's bed revealed she had one Halo Ring secured to the left side of the bed frame. Observation of Resident I's bed revealed she had two Halo Rings secured to both sides of the bedframe. Both Residents H and I's Halo Rings lacked protective covers.

Review of Resident A's medical records revealed she lacked a written physician order for use of a bedside assist device.

Review of Residents H and I's medical records revealed both had written physician order for use of the beside assist devices.

Review of Residents A, H and I's service plans revealed they omitted or lacked information pertaining to specific use, care, and maintenance of the various devices including methods for on-going monitoring of the resident, methods of monitoring the equipment by trained staff for maintenance of the device and for monitoring measurements of gaps to protect the resident from the possibility of physical harm related to entrapment, entanglement, strangulation, etc.

Resident A's service plan read *"[Resident A] will maintain ability to ambulate and transfer independently with device*."

Resident H's service plan read "*Bed enabler (bed device) will encorage (sp) and allow resident to function with independence at highest practical level*." The plan read Cedarbrook staff will report increased difficulty with ambulation or transfers to the neighborhood nurse. Nursing will evaluate changes and notify [Resident A's] physician and responsible party as needed.

Resident I's service plan read "*Bed enabler (bed device) will encorage (sp) and allow [Resident I] to function with independence at highest practical level.*" The plan read staff were to monitor resident routinely while in bed for risk of entanglement and to evaluate that there are no gaps in bed.

Given the observations listed above and lack of an organized plan, the facility has not provided reasonable protective measures to ensure resident well-being and safety during the use of a bedside assistive device.

VIOLATION ESTABLISHED.

R 325.1932 Resident medications.

(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.

Observation and review of memory care narcotic count log with Employee #2 revealed it was incomplete in which staff did not always complete the log for their worked shift. For example, one or more shifts on the following dates were left blank: 12/21/2023, 12/22/2023, 12/23/2023, 12/28/2023, 12/29/2023, 12/30/2023, 1/1/2024, 1/4/2024, 1/5/2024,1/6/2024, and 1/7/2024.

Review of Resident B's November and December 2023 medication administration records (MARs) revealed she was prescribed both Haloperidol and Lorazepam as needed for restlessness, thus it was unknown how staff would determine which medication to administer as needed for restlessness.

Review of Resident C's November 2023 MARs revealed there were one or more medications left blank on 11/16/2023, therefore it could not be determined if she received the medications or not.

Review of Resident D's December 2023 MARs revealed she was prescribed Lorazepam 0.5 mg tablet, take one tablet by mouth two times a day in which one dose was left blank on 12/23/2023 at 1:00 PM, therefore it could not be determined if she received the medication or not.

Review of Resident E's November 2023 MARs revealed he was prescribed Triamcinolone cream, apply a thin layer to lower legs affected areas topically every day in which one dose was left blank on 11/20/2023, therefore it could not be determined if he received the medication or not.

Review of Resident I's November and December 2023 revealed she was prescribed duplicate medications. For example, the MARs read she was prescribed Morphine Sulfate, take 0.25 mL by mouth every three hours as needed and Morphine Sulfate, take 0.25 mL by mouth every four hours as needed. Additionally, Resident I's MARs read she was prescribed Lorazepam 0.5 mg, take one tablet by mouth every six hours as needed and Lorazepam 0.5 mg, take one tablet by mouth every four hours as need. Therefore, it was unknown how staff would determine which medication and timeframe to administer each as needed medication.

VIOLATION ESTABLISHED.

R 325.1932 Resident medications.

(6) For a resident who is identified as self-administered in his or her service plan, the home must have a policy to offer a secured method of storage for medications if desired by the resident and to notify the applicable health care professional or legal representative if there is a change in a resident's capacity to self-medicate.

Interview with Employee #1 revealed Resident J's family set-up her medications daily for her to self-administer them. Employee #1 stated Resident J's family maintained her medications in her apartment; but they were not in a secured method of storage.

VIOLATION ESTABLISHED.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, renewal of the license is recommended.

Jessica Rogers

01/10/2024

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Date

Licensing Consultant