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

February 7, 2024

RE: License #: AH630236929
Investigation #: 2023A1022038
Brookdale Farmington Hills North II

Dear Mary North:

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 #:	AH630236929
Investigation #:	2023A1022038
Complaint Receipt Date:	07/11/2023
Investigation Initiation Date:	07/12/2023
Report Due Date:	09/10/2023
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	Suite 2300 6737 West Washington St. Milwaukee, WI 53214
Licensee Telephone #:	(414) 918-5000
Administrator:	Mary North
Authorized Representative:	Leslie Rowe
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 facility did not provide the Resident of Concern (ROC) with the protection, supervision, and assistance that she required.	Yes
Caregivers do not seem to know how to take care of residents.	No
Additional Findings	Yes

III. METHODOLOGY

07/11/2023	Special Investigation Intake 2023A1022038
07/12/2023	Special Investigation Initiated - Telephone Complainant contacted by phone.
07/18/2023	APS Referral
07/18/2023	Inspection Completed On-site
08/08/2023	Contact - Telephone call received Phone conversation with the authorized representative.
02/07/2024	Exit Conference

ALLEGATION:

The facility did not provide the Resident of Concern (ROC) with the protection, supervision, and assistance that she required.

INVESTIGATION:

On 07/11/2023, the complainant called the Bureau of Community and Health Systems complainant hotline with allegations regarding his mother, the Resident of Concern (ROC). According to the intake unit's interview, "…June 30th (2023) she had a laceration and didn't take her to the hospital they put her back in bed and then it kept bleeding so they took her to the hospital. She was dehydrated and they had to take her to the hospital and that's when they found out that she went the day before… They found their mom laying in the hallway unconscious in the hallway (of facility)."

On 07/12/2023, I interviewed the complainant by phone. The complainant stated that his mother, the Resident of Concern (ROC) had lived in the facility for the past year. While there had been some concerns about the services provided, these had generally been resolved by discussions with the facility staff. However, beginning in June 2023, the family began to see larger problems that only seemed to be getting worse. According to the complainant, at the beginning of June 2023, the ROC came down with a COVID-19 infection and was placed in isolation. The complainant stated that the ROC had very poor eyesight, very poor hearing, and needed assistance to eat and drink, especially locating the food or liquid, getting food onto utensils, and then getting it into her mouth. The complainant went on to say that once the ROC was placed into isolation, the family was told that staff were not to be in her room more than 5 minutes at a time and the ROC was no longer being provided assistance at meals. The complainant stated that at mealtime, staff would bring the ROC a food tray and leave it in her room. According to the complainant, the ROC was in isolation for at least a week, and he was concerned that she barely ate or drank anything during that time.

The complainant went on to say that the ROC sustained an injury on 06/30/2023, that the family was not informed by any facility staff member. Apparently, at 6 am on 06/30/2023, a caregiver found the ROC on the floor of her room, bleeding from the back of the crown of her head. The caregiver assisted the ROC from the floor and back into her bed, where she was found by another facility staff member, still bleeding with her pillow covered with blood. At that point the ROC was sent out to a local hospital emergency room (ER) for treatment for a laceration. The complainant reiterated that this had occurred without the family's knowledge. On 07/01/2023, facility staff members found the ROC to be lethargic, somewhat nonresponsive, and not her normal self. The facility sent her back to the ER, this time with the knowledge

of family. When family members arrived at the ER, the ER physician mentioned that he had seen the ROC just the day before. This was how the family was informed of the injury of the previous day.

According to the complainant, after the ROC had another brief ER visit on 07/02/2023 for a low oxygen level, the family arrived at the facility on 07/04/2023 to find the ROC lying on the floor of the hallway outside of her room, naked, except for an incontinence brief. They were not able to immediately locate any staff members. At this point, the family elected to place the ROC on hospice care. The complainant stated that the ROC was at the end of life and not expected to live more than a few days. The ROC passed away on 07/12/2023.

On 07/18/2023, a referral was made to Adult Protective Services.

On 07/18/2023, at the time of the onsite visit, I interviewed the interim administrator and the resident care coordinator. When asked about the ROC, the administrator acknowledged that the ROC had expired, after an overall decline in condition. When asked specifically about the ROC being sent to the local ER on 06/30/2023, the administrator stated she had no knowledge of that incident. At first, the administrator was unable to say who was in charge of the facility on that day, because they had just hired a new wellness director who was in the middle of orientation, and she, the administrator, was on leave. The administrator was finally able to identify the resident care coordinator as being the employee who was in charge of both the building where the ROC resided, as well as the sister facility that was next door. When the resident care coordinator was asked to explain what had happened to the ROC, the resident care coordinator stated that on 06/30/2023, at approximately 6 am, the ROC was provided care by the overnight caregiver. She was in bed at that time and not injured. At 6:30 am, the resident care coordinator was rounding on residents and when she entered the ROC's room, she found the ROC on the floor. When asked if the ROC was injured at that time, the resident care coordinator stated that the ROC appeared to be fine, not hurt at all, just on the floor. The resident care coordinator stated that she helped the ROC back into bed, and left the building for the sister facility, where she had an office. The resident care coordinator went on to say that a caregiver brought the ROC a breakfast tray at 8 am. At that time the ROC was "fine," but sometime after 9 am, when the caregiver came back to collect the breakfast tray, the ROC was bleeding. The resident care coordinator stated that was when she was called back to the ROC's room and found the ROC's pillow to be covered in blood. The resident care coordinator stated that she called 911 (emergency medical services/EMS) to come to the building. When the resident care coordinator was asked if she had notified the ROC's responsible family member to let them know the ROC was being sent to the ER, the resident care coordinator responded that she did not. The resident care coordinator stated that she assumed that the caregiver who completed the incident report (IR) would notify the ROC's family. Review of the IR dated 06/30/2023 revealed that while the caregiver left a message for the ROC's health care provider, the ROC's family had not been notified. The space on the IR to document when the authorized representative was notified

had been left blank. Review of the facility's policy titled, "Quality Review Program MI-19" revealed that "The QRP (Quality Review Program) leader will be responsible for the review of incident(s) in the following areas… b. Review and evaluation of incident(s) for … documentation in the resident record of notification to the resident's physician/healthcare provider and designated responsible person/family member within 48 hours after the incident.

When asked about the incident alleged by the complainant to have occurred on 07/04/2023, when the ROC was found naked on the floor of the hallway outside of her room, both the administrator and the resident care coordinator denied having any knowledge of this incident. No documentation could be found that noted this incident.

When asked about the complainant's allegation that the ROC did not receive assistance with meals, due to her impaired eyesight and impaired hearing, the resident care coordinator stated that she knew the ROC to be independent for eating and drinking. According to the resident care coordinator, while the ROC did not eat great quantities of food, maybe 50% of the meal, she usually drank all fluids offered to her. The resident care coordinator went on to say, that even when residents were "sequestered" due to COVID-19, caregivers had been supplied with personal protection equipment and instructed to assist all residents as necessary. The ROC's service plan did not indicate that she needed assistance for eating. The service plan noted the ROC's need for foods to be cut up in the kitchen prior to service. In a progress note dated 6/26/2023, the facility community nurse documented, "Appetite at meals is fair to good. Intake is encouraged during meals and snacks."

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: 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:	The facility did not inform the ROC's family that she was sent to a local ER for treatment of an injury on 06/30/2023. Because they were unaware of the need for medical intervention, the family was unable to provide the ROC support for her emotional well-being during this episode.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Caregivers do not seem to know how to take care of residents.

INVESTIGATION:

When interviewed, the complainant stated that it appeared as though there were many new employees in the facility that did not seem to know how to take care of residents. The complainant expressed concern that these new employees had not been properly trained.

Training records for 4 caregivers on duty at the time of the onsite visit were reviewed. Caregiver #1 was hired 01/09/2023; caregiver #2 was hired 01/232023; caregiver #3 was hired 01/31/2023; and caregiver #4 was hired 03/30/2023. Review of these records revealed that all 4 caregivers had received the required training and had been deemed able to carry out their respective duties by a supervisor.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.**

	(f) Containment of infectious disease and standard precautions. **(g) Medication administration, if applicable.**
ANALYSIS:	There was no evidence that newly employed caregivers were inadequately trained.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

At the time of the onsite visit, the interim administrator and the resident care coordinator were asked to provide all documentation notes for the ROC made by facility staff from 06/25/2023 until her death on 07/12/2023. The facility provided the incident report for 06/30/2023, when the ROC was found bleeding from the laceration on her head and a Progress Notes dated 06/27/2023. Other Progress Notes provided were dated 06/07/2023 and 06/08/2023.

During a phone conversation with the authorized representative (AR) on 08/08/23, the AR acknowledged that the ROC's visits to the local ER on 06/30/2023, 07/01/2023, and 07/02/2023 were not documented in the Progress Notes, nor was the episode that occurred on 07/04/2023, when the ROC's family found her on the floor in the hallway outside of her room.

APPLICABLE RULE	
MCL 333.20175	**Maintaining record for each patient; wrongfully altering or destroying records; noncompliance; fine; licensing and certification records as public records; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.**
	(1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization.

ANALYSIS:	The facility did not maintain a complete record of their observations of the ROC.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the AR on 02/07/2024. 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.

02/07/2024

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

01/17/2024

_____

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