GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Mary North
Brookdale Northville
40405 Six Mile Road
Northville, MI 48167

March 14, 2024

RE: License #: AH820236941
Investigation #: 2023A1022049
Brookdale Northville

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 #:	AH820236941
Investigation #:	2023A1022049
Complaint Receipt Date:	08/21/2023
Investigation Initiation Date:	08/22/2023
Report Due Date:	10/20/2023
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	Suite 2300 6737 West Washington St. Milwaukee, WI 53214
Licensee Telephone #:	(414) 918-5000
Administrator:	Leslie Aneed
Authorized Representative:	Mary North
Name of Facility:	Brookdale Northville
Facility Address:	40405 Six Mile Road Northville, MI 48167
Facility Telephone #:	(734) 420-6104
Original Issuance Date:	10/10/1996
License **Status:**	REGULAR
Effective Date:	10/29/2023
Expiration Date:	10/28/2024
Capacity:	72
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The Resident of Concern (ROC) did not receive the assistance and personal care that she needed.	Yes
The ROC was taunted by a caregiver.	No
Although the ROC was a full code, the facility claimed on several occasions that they had a “Do Not Resuscitate (DNR)” order for her.	No

The complainant identified concerns that are not related to or addressed in licensing rules and statutes for a home for the aged, including medical care and regular provision of leisure activities. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The items listed above were those that could be considered under the scope of licensing.

III. METHODOLOGY

08/21/2023	Special Investigation Intake 2023A1022049
08/22/2023	Special Investigation Initiated - Letter Complainant contacted by email.
08/22/2023	Contact - Telephone call made Interviewed complainant by phone.
08/25/2023	APS Referral
08/25/2023	Inspection Completed On-site
09/27/2023	Contact - Telephone call received Information exchanged with the facility via email.
10/26/2023	Contact - Telephone call received Information exchanged with the facility via email.
03/14/2024	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) did not receive the assistance and personal care that she needed.

INVESTIGATION:

On 08/17/2023, the Bureau of Community and Health Systems (BCHS) received a complaint that in part read, “(Facility caregivers) wheeled her (the Resident of Concern/ROC) into a room alone for hours, hours long call back time from when she presses her button for help that would often leave her without proper hygiene (bathroom etc.) that would leave her in tears… they (the facility) would consistently tell me they had a schedule and everything would get better and it never did. She (the ROC) would be sitting in pee-soaked adult diapers all day and rarely got an actual "bath". Once she went a full month without one…”

On 08/22/2023, I interviewed the complainant by phone. The complainant stated that she was a family member of the ROC, was a “main contact” but not the Power of Attorney (POA). She described the ROC as having intact cognition and able to reliably answer questions but needed the assistance of 2 people for transferring from bed to chair and most other activities of daily living (ADLs) because she had sustained a stroke. The complainant went on to say that the ROC did not receive timely incontinence care nor was she provided with regular showers. According to the complainant, she would have very long waits for her pendant calls for assistance.

On 08/25/2023, a referral was sent to Adult Protective Services.

On 08/25/2023, at the time of the onsite visit, I interviewed the administrator and the interim resident care coordinator (RCC). The administrator acknowledged that the ROC had recently moved out from the building, however, she did not have any knowledge of the concerns brought forth by the complainant.

According to documentation provided by the facility, the ROC was to receive a shower or a bath twice a week and required physical to use the toilet. The ROC’s service plan dated 04/17/2023 noted that the ROC was “experiencing increased urine output and incontinence episodes.” When the administrator and the authorized representative (AR) were asked if they could provide additional documentation or other evidence that the ROC received appropriate incontinence care and bathing assistance, in an email exchange dated 09/27/2023, the AR stated, “We do not keep daily ADL (activity of daily living) records. The documentation on all residents is by exception…”

At the time of the onsite visit, I asked to make observations of the provision of incontinence care. According to the RCC, all of the residents in the facility at the time of the visit were reliably able to answer questions, make their needs known and

were able to either ask for assistance to the toilet or to identify when they needed care. I visited with Resident A and Resident B. Neither resident needed incontinence care. Neither Resident A nor Resident B felt that they could not get assistance from a caregiver whenever they needed assistance. Resident A stated that she would like to get into the shower, but all she was getting was bed baths. According to the administrator, Resident A had a diagnosis of Multiple Sclerosis, and due to her mobility and balance limitations, was not safe in the shower, even when using a shower chair.

According to the administrator, when a pendant was activated, a signal was sent to the four pagers carried by the care giving staff and to the front desk as well. Caregivers were expected to answer the call within 3 to 5 minutes. The administrator explained that it was expected that the caregiver would provide whatever assistance requested by the resident, with the exception of the event that answering the pendant signal interrupted care being provided to the previous resident. In that case, the caregiver was expected to explain the situation to the resident who activated the pendant. The caregiver was to ensure that no resident was in an emergency situation without help.

Review of caregivers' response time to answer the ROC's pendant for the month of July 2023, revealed the following occasions when it took more than 15 minutes to answer the ROC's call for assistance:

7/3
0019 to 0134 (75 minutes)
1410 to 1440 (30 minutes)

7/5
0142 to 0232 (50 minutes)

7/10
2225 to 2309 (44 minutes)

7/12
0053 to 0120 (27 minutes)

7/13
0009 to 0048 (39 minutes)
2224 to 2310 (46 minutes)

7/16
1849 to 1914 (25 minutes)

7/19
0440 to 0504 (24 minutes)

7/18
1029 to 1101 (32 minutes)
2312 to 2236 (24 minutes)

7/21
1258 to 1342 (44 minutes)

7/23
1418 to 1440 (22 minutes)

7/25
1255 to 1329 (34 minutes)
1518 to 1551 (33 minutes)

7/27
2243 to 2308 (35 minutes)

On 10/26/2023, via an email exchange, when asked about the length of time that the ROC waited for assistance, the administrator said, “We do recognize the opportunity on our call light response times and since July and August there has been coaching and discussions on not only call light response times but also reminding the associates to turn the call light off upon entering the residents room. – there have been multiple occasions where associates have forgotten to reset the call light after assisting the resident.”

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.**
ANALYSIS:	The investigation could not substantiate if the ROC received appropriate assistance with either toilet use/incontinence care or bathing, as no documentation existed, and current residents received appropriate care. However, the length of time the ROC waited on multiple occasions was found to be excessive.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The ROC was taunted by a caregiver.

INVESTIGATION:

According to the written complaint, “I (complainant) have names of some caregivers who verbally threatened my grandmother…” and listed the first name of caregiver #1. When interviewed, the complainant clarified that a caregiver had told the ROC that if she (the ROC) continued to be “sassy” (that is, uncooperative), then caregiver #1 would not assist her out of bed.

When the administrator was asked how staff were expected to treat residents, the administrator answered that staff were to treat residents with dignity and respect. If a resident or a family member alleged that an employee mistreated a resident in any way, she or the director of health and wellness or the resident care coordinator would investigate the allegation. If the allegation was substantiated, the employee would be subject to a disciplinary action, beginning with counseling, but could ultimately result in employment termination.

According to the administrator, caregiver #1 was a trusted employee who had demonstrated valuable leadership skills. The administrator went on to say that the facility had received no previous complaints and that there were no personnel actions against caregiver #1. The administrator did not believe that caregiver #1 had intentionally “taunted” the ROC.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
For Reference: R325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking

	into account the preferences and competency of the resident.
ANALYSIS:	The investigation could not establish that caregiver #1 was verbally inappropriate with the ROC.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Although the ROC was a full code, the facility claimed on several occasions that they had a "Do Not Resuscitate (DNR)" order for her.

INVESTIGATION:

When interviewed, the complainant stated that she (the complainant) had attended several meetings where the facility representatives told her that the ROC had a DNR order. The complainant went on to say that was not true and that she did not know how the facility had determined that.

According to the administrator, the ROC had been a hospice patient, although hospice services had been discontinued well before the ROC left the facility. According to the ROC's progress notes, on 09/19/2022, family members agreed to the ROC entering into hospice care. The facility provided a Do-Not-Resuscitate order for the ROC dated 09/23/2023. The administrator went on to say that she could find no documentation that the DNR order had been rescinded when the ROC left hospice care. The administrator emphasized that the DNR order was entirely separate from the order for hospice care and that the two orders were not mutually exclusive.

APPLICABLE RULE	
R 325.1942	**Resident records.**
	(2) A home shall assure that a current resident record is maintained and that all entries are dated and signed.
ANALYSIS:	There was no evidence that the DNR had been rescinded.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 03/14/2024. 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.

03/14/2024

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

03/11/2024

_____

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