GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 20, 2024

Vera Gjolaj
Sunrise Assisted Living Of Bloomfield Hills
6790 Telegraph Rd.
Bloomfield Hills, MI 48301

RE: License #: AH630391696
Investigation #: 2024A1019041

Dear Licensee:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630391696
Investigation #:	2024A1019041
Complaint Receipt Date:	03/07/2024
Investigation Initiation Date:	03/07/2024
Report Due Date:	05/06/2024
Licensee Name:	Welltower OpCo Group LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(419) 247-2800
Administrator and Authorized Representative:	Vera Gjolaj
Name of Facility:	Sunrise Assisted Living Of Bloomfield Hills
Facility Address:	6790 Telegraph Rd. Bloomfield Hills, MI 48301
Facility Telephone #:	(248) 858-7200
Original Issuance Date:	12/23/2019
License Status:	REGULAR
Effective Date:	06/23/2023
Expiration Date:	06/22/2024
Capacity:	132
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Suspected poisoning of Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/07/2024	Special Investigation Intake 2024A1019041
03/07/2024	Special Investigation Initiated - Telephone Call received from AR reporting the incident, interview conducted.
03/07/2024	Contact - Document Sent Requested additional information and documentation from admin/AR- awaiting reply.
03/07/2024	APS Referral
03/13/2024	Contact - Document Received Progress note and service plan received, still awaiting additional information as requested on 3/7/24.
03/25/2024	Contact - Telephone call made Call placed to Relative A to conduct interview, left voicemail requesting return phone call.
03/25/2024	Contact - Telephone call received Call received from Relative A, interview conducted.
03/25/2024	Contact- Telephone call made Call placed to medical examiner's office
03/25/2024	Contact - Document Sent Medical records requested from Corewell Health William Beaumont University Hospital
03/25/2024	Contact - Document Sent Police report requested from Bloomfield Township PD
03/27/2024	Contact - Telephone call made

	Interview conducted with Bloomfield Hills Police Detective D. VanKerckhove
03/27/2024	Contact- Document Received Police report received
03/27/2024	Inspection Completed On-site
03/27/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Suspected poisoning of Resident A.

INVESTIGATION:

On 3/7/24, the department received a complaint alleging that Resident A passed away after drinking a dish detergent at the facility.

On 3/7/24, a phone interview was conducted with administrator and authorized representative Vera Gjolaj. Ms. Gjolaj reported that on the evening of 3/6/24, staff suspected that Resident A drank dish detergent after discovering him alone in the kitchen and observing the detergent on the counter. Ms. Gjolaj reported that no one observed Resident A ingest the detergent and staff asked Resident A multiple times if he drank the detergent and he denied doing so, but staff sought out the nurse to evaluate him onsite. Ms. Gjolaj reported that the nurse took Resident A's vitals, and his blood pressure was elevated, so 911 was called to have him taken to the hospital. Ms. Gjolaj reported that she was not made aware of the situation until the following day, and the resident had already passed away.

Ms. Gjolaj reported that the detergent should always be kept in a locked cabinet under the kitchen sink and that only shift leads have keys to the cabinet. Ms. Gjolaj reported that staff denied taking the detergent out and denied unlocking the cabinet so the detergent could be accessed. Ms. Gjolaj reported that the cabinet lock was intact and functioning properly at the time of the incident. However, as a precautionary measure, maintenance staff replaced the locks in both memory care kitchens. Ms. Gjolaj stated that only the maintenance coordinator and dining services coordinator have keys to the new locks on the sink cabinets in memory care.

On 3/7/24, I requested supporting documentation from the facility regarding the event. On 3/13/24, Ms. Gjolaj supplied the service plan and a progress note. The progress note dated 3/6/24 read "*Staff reported resident possibly drank Ecolab dish detergent. Resident coughing up pink tinged saliva. No facial grimacing, BP 186/110*

P 56 T 97.9% O2 88% room air. EMS called." Resident A's service plan dated 10/15/23 read in part "*Requires ongoing/constant individualized intervention due to Alzheimers*" and "*Hazardous materials will be kept secured to keep me safe through the next review date".*

On 3/25/24, I spoke with the Oakland County Medical Examiner's office. They confirmed that an autopsy was completed; however, the results are pending toxicology reports. The autopsy report was still pending as of the time of issuing this report.

On 3/25/24, I obtained Resident A's medical records from Corewell Health William Beaumont University Hospital. Some notable excerpts from the records are as follows:

> *Admission Diagnosis:*
> *Ingestion of toxic substance [T65.91XA]*
> *Patient has increased secretions, spitting into the bag. He is able to swallow and does not tolerate the secretions. No significant stridor or hoarseness noted. There are superficial burns and erosions present throughout the entire mouth including the tongue, soft palate, posterior pharynx, uvula. Visualization with the glide a scope shows similar on the epiglottis with swelling.*
>
> *Glidescope exam: enlarged tongue, white membranes over soft palate, uvula, pharynx, epiglottis (swelling noted), esophageal and with small superficial hemorrhages in many places, secretion clearance difficulty.*
>
> *Patient is a 91-year-old male who presents from his nursing home facility with suspected ingestion of liquid dishwasher detergent approximately 30 minutes prior to arrival. This was unwitnessed, could be greater than 30 minutes. Based on the chemicals found in this detergent, likely liquefactive necrosis to the intraoral cavity, esophagus and potentially the airway based on my exam. On arrival, patient's vitals reveal hypertension at 182/78, otherwise within normal limits. Given his history and physical exam the decision to intubate for airway protection was made. There was significant swelling in the airway, but first attempt of intubation was successful and without complication. I did contact poison control shortly after this who is in agreement with the current workup and plan. Supportive care measures at this time. Involve GI if worsening GI type symptoms.*
>
> *Hospital Course:*
> *91 M with PMH of dementia presented from Sunrise of Bloomfield hills for accidental ingestion of sodium hydroxide. Patient was intubated in the emergency department for airway protection due to significant swelling of the oropharynx. [Relative A] requested patient be made comfortable and patient was compassionately extubated. Patient expired on 3/7/2024 at 12:12am.*

Documentation from Bloomfield Township Fire Department was included in the hospital documentation. It was noted that dispatch received a call from the facility on 3/6/24 at 16:52:37, they were on scene at 16:55:53, were physically to the resident at 16:57:00 and were at the hospital at 17:20:04. The fire department documentation read in part:

> *BTFD station 3 dispatched to a nursing home from a 91 male cc swallowed dish detergent. ATF pt sitting in wheelchair with no signs of distress. Staff states they found pt with the bottle open next to him and they were unsure of how much he drank. Staff states pt has Alzheimer's and he doesn't remember if he swallowed any detergent. Assessment find pt AO baseline gcs15, vitals as shown, hx noted, pt has wet cough, pt has signs of irritation inside of mouth. Tongue swollen and throat red. Pt loaded onto stretcher and into rescue with no incident. Pt monitored while en route to show no changes. WBRO notified via phone. All documents signed by RN. Station 3 clear.*

On 3/27/24, I conducted an onsite inspection along with long term care state licensing section manager Andrea Moore. We interviewed Ms. Gjolaj at the facility. Ms. Gjolaj's account of the events was consistent with what she reported during the phone call with licensing staff on 3/7/24. When questioned about documentation of the event, Ms. Gjolaj reported that an incident report was completed, but she does not have a copy of it at the facility. Ms. Gjolaj reported that the incident report was not available for release per guidance of corporate legal counsel. Ms. Gjolaj did provide Resident A's medical record; however, it did not contain any documentation about this incident. At the time of this report, no additional supporting documentation pertaining to the incident has been provided.

While onsite, licensing staff interviewed Employee 1. Employee 1 reported that she was working at the time of the incident and was very familiar with Resident A. Employee 1 reported that she came on to work her shift at 2:00pm on 3/6/24. Employee 1 reported that she saw Resident A as soon as she came into the memory care unit, as he was sitting in his wheelchair near the elevator. Employee 1 reported that he was at his baseline level of functioning during their interaction, and no issues were reported from staff on the previous shift during their "crossover" meeting. Employee 1 reported that after "crossover", she began to make rounds on the unit and then once she had eyes on each resident, she went to provide brief checks and changes on those residents with incontinence issues. Employee 1 reported that shortly before dinner time, Employee 2 called out to her and asked for her to come to the "north" kitchen, also referred to as the "big" kitchen. Employee 1 reported that when she got to the kitchen, she observed Resident A in his wheelchair at the end of the island and noted that there was a bottle of dish detergent that was out of place on top of the counter. Employee 1 reported that Employee 2 didn't see Resident A drink it, but that she had concerns that he did. Employee 1 reported that she asked the resident if he drank the detergent and replied "no". Employee 1 reported that she offered the resident water, which he accepted. Employee 1 reported that took a sip of the water, swirled it around in his

mouth and then spit it out. Employee 1 reported that this happened twice, and she thought it was strange that he didn't swallow the water, which prompted her to look inside Resident A's mouth. Employee 1 reported that she put on a rubber glove, looked inside Resident A's mouth, and swept the inside of his mouth with her index finger to ensure there wasn't an obstruction. Employee 1 reported that she did not see anything abnormal inside of Resident A's mouth and reported that she smelled the inside of Resident A's mouth but didn't detect an odor. Despite this, Employee 1 reported that she went and got Employee 3 to evaluate him. Employee 1 reported that when she returned from getting Employee 3, Resident A was clearing his throat and coughing out a pink tinged mucous. Employee 1 reported that she witnessed Employee 3 ask Resident A twice if he drank the detergent, and he denied doing so. Employee 1 reported that Employee 3 took Resident A's vitals and noted that his blood pressure was elevated. Due to this, Employee 3 advised Employee 1 to call 911. Employe 1 reported that she immediately called 911 as instructed, then called Relative A (who did not answer) and notified Resident A's physician. Employee 1 reported that EMS was at the facility within a few minutes. Employee 1 reported that she heard EMS ask Resident A if he drank the detergent, and his reply was "No, if I drank that I would be in bad shape." Employee 1 reported that EMS agreed with Employee 3 that he should be taken to the hospital, and he was loaded onto the stretcher and left without incident. Employee 1 reported that prior to Employee 2 calling her into the kitchen, she had not observed the detergent on the counter and denied unlocking the cabinet under the sink that housed the detergent.

Employee 1 was interviewed by the Bloomfield Township Police Department on 3/7/24. The following is an excerpt of Employee 1's interview from the police report:

> *After [Resident A] left for the hospital, [Employee 1] stated she tried locking the two cabinet doors where the detergent was located (under the sink). [Employee 1] stated she could not get one of the doors to stay locked. [Employee 1] does not think the cabinet door was locked when the incident occurred, but she also stated she did not pull on the cabinet doors when she did her walk through (normally she does not). [Employee 1] also gave the key to [Employee 4] to try and lock the cabinet, but [Employee 4] was also unsuccessful. [Employee 1] also stated that [Resident A] seemed his normal self when she did her walk-through earlier. [Employee 1] saw [Resident A] in his wheelchair by the elevator where he usually liked to be so he could try to sneak on and get downstairs. This concluded our interview with [Employee 1].*

While onsite, licensing staff interviewed Employee 4. Employee 4 reported that she was working at the time of the incident and was very familiar with Resident A. Employee 4 reported that her shift was going normally on the afternoon of 3/6/24 when she began to get the dining room set up for dinner service. Employee 4 reported that she set the tables and then went downstairs to the commercial kitchen to fill up pitchers of juice to serve at dinner. Employee 4 reported that when she got the pitchers out of the north kitchen, Resident A was not in there and the detergent was not on the counter. Employee 4 that she returned to the memory care unit with

the juice roughly five minutes later. Employee 4 reported that she put the juice away in the north kitchen and then began tending to the resident in the common area. Employee 4 reported that shortly after she put the juice away, Employee 2 went into the north kitchen and observed Resident A in the room and saw that the detergent was out. Employee 4 reported that Employee 2 asked her if she took the detergent out and told her that she hadn't and did not access the cabinet that day. Employee 4 reported that she and Employee 2 thought it was best to notify Employee 1 of their observation. Employee 4 reported that Employee 1 checked the resident over and also asked him if drank the detergent, which he denied. Employee 4 reported that Employee 1 tried to get Resident A to drink water, but that he spit it out and then started gurgling. After spitting the water out, Employee 4 reported that Employee 1 went to get Employee 3 for further evaluation. Employee 4 reported that when Employee 3 arrived, Resident A was alert and responding at his baseline level. Employee 4 reported that Employee 3 took Resident A's vital signs and observed that his blood pressure was high and said to call 911. Employee 4 reported that when EMS arrived, they wanted to see the bottle of detergent and noted that the cabinet that the detergent is kept in could be opened without a key. Employee 4 reported that she has worked at the facility since June 2023, and the lock has been broken the entire time. Employee 4 reported that her previous supervisor knew about the lock issue and put in at least two work orders for the repair. Employee 4 reported that other staff were also aware that the cabinet could be opened without a key because it was previously discussed.

Additional staff who were on duty at the time the incident occurred were not present during licensing's onsite visit, however their statements were obtained from the police report. The police interview transcript with Employee 2 read as follows:

> *[Employee 2] advised that she was working "support shift" yesterday which ran from 2:00pm to 6:00pm. [Employee 2] went into the kitchen and noticed [Resident A] sitting in his wheelchair near the dining tables. [Employee 2] also stated that she noticed the bottle of dish detergent out of the "corner of her eye", which was sitting on top of the counter near the kitchen sink. The proximity from where [Employee 2] located [Resident A] near the tables, and where the bottle of detergent was seen by the sink is approximately 30 feet.*
>
> *[Employee 2] asked [Resident A] if he was OK and also asked him if he drank the detergent. According to [Employee 2], [Resident A] told her he did not drink the detergent. At that time [Employee 2] called the other care managers to assist. The other employees, [Employee 4], [Employee 5], and [Employee 1], arrived and also asked [Resident A] if he drank the detergent and he continued to say no. The employees provided [Resident A] with water, but he began to spit out the water upon drinking some. After spitting out the water, [Employee 2] stated [Resident A] began to making a choking noise.*
>
> *[Employee 2] stated that the Lead Care Manager, [Employee 1], put on a pair of medical gloves and started checking for any obstruction in [Resident A's] mouth.*

None was found. The nurse, [Employee 3], was called up to the memory care floor and did an assessment on [Resident A]. [Employee2] stated that she asked [Employee 4] about the bottle of detergent, but [Employee 4] did not know why the bottle was left out. [Employee 4] called [Relative A] and assisted him of the situation with his father. According to [Employee 2], [Relative A] wanted his dad observed by the staff before going to the hospital. However, EMS had already been called, and was on their way. This concluded our interview with [Employee 2].

The police interview transcript with Employee 3 read as follows:

I spoke with [Employee 3], and she stated that the dish detergent [Resident A] ingested was called Ecolab. [Employee 3] was not certain where the bottle of dish detergent was located when [Resident A] found it because [Resident A] was out of the kitchen when she arrived on the floor. [Employee 3] did see the detergent and said there was a pinkish color on the bottle, which she stated was the same color liquid that [Resident A] was spitting out. [Employee 3] stated she assessed [Resident A] in the common area just outside of the kitchen and noticed his blood pressure was elevated and his oxygen level was low. At that time 911 was called and EMS arrived.

The police interview transcript with Employee 5 read as follows:

[Employee 5] stated she was doing activities with the residents with fellow employee, [Employee 4]. While doing activities, [Employee 2] came to [Employee 4] and asked her if she left out cleaner. [Employee 5] stated she went into the kitchen with other employees to assist [Resident A]. [Resident A] was given water to drink, but he began to spit it up soon after taking a sip. [Employee 5] stated the on=duty nurse [Employee 3] was called to assess [Resident A's] vitals, which resulted [sic] [Employee 3] wanting EMS to be called.

When asked about the location of the detergent, [Employee 5] stated that is it located under the sink. There are tubes that go into the cleaner (which can be seen in the pictures) that pump the cleaner into the dishwasher. The detergent does not need to come out of the cabinet unless it is being replaced. There are two doors for the cabinets under the sink, and both doors have a lock. [Employee 5] stated that the lock on one of the cabinets was not worked properly since she started working there (approximately 8 months). [Employee 5] stated employees have reported the lock not working, but it was never fixed by maintenance. When asked who would be responsible for checking the reports to maintenance and completing the work, [Employee 5] state the maintenance worker is [Employee 6]. This concluded our interview with [Employee 5].

While onsite, licensing staff conducted an inspection of the memory care kitchens (north and south). When being escorted to the kitchens by Ms. Gjolaj, we walked through the reminiscence coordinator's office. As we passed through, we observed

scissors on the desk and three sets of keys. Ms. Gjolaj confirmed that the keys are to unlock resident rooms. The office had two doors that opened to common areas of the memory care facility; both doors were left wide open. Ms. Gjolaj then took us into the north kitchen (the kitchen was open and unlocked) and directed us to the cabinets where the dish detergent is kept. The cabinets underneath the north sink were locked securely, and Ms. Gjolaj had to obtain keys from another staff member to open them. When the cabinets were unlocked, we observed two large jugs of Ecolab solution, along with three bottles of Dial hand soap. The Ecolab jugs each had a tube inserted in the top, which fed directly into the adjacent dish machine. The two jugs were bound together by a metal cable, that was also padlocked, and the cable was screwed into the side of the cabinet for additional security. Ms. Gjolaj confirmed that the cable and padlock was implemented because of the incident with Resident A. Licensing staff also made the following observations while inspecting the north and south memory care kitchens:

- Broken mini fridge door with perishable food and beverage items inside
- One can of aerosol deodorant unsecured
- One jar of expired peanut butter (expired 10/2022)
- Two pair of scissors unsecured
- Two bottles of hand sanitizer unsecured
- Two large knives unsecured
- Two large jugs of syrup not labeled or dated
- Five bottles of hand soap unsecured

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 R 325.1901	**(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.**

ANALYSIS:	Resident A was not adequately protected from harm, as he was found in the north kitchen unsupervised with an open bottle of Ecolab dish detergent.
CONCLUSION:	**VIOLATION ESTABLISHED**

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.
ANALYSIS:	Resident A's service plan identified that hazardous material needed to be secured to ensure his safety. The service plan instruction was not followed as evidenced by the unsecured Ecolab jug, and the discovery of several harmful items during licensing's inspection in the memory care kitchens.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(3) Hazardous and toxic materials shall be stored in a safe manner.
ANALYSIS:	Some staff attested that the lock on the cabinet beneath the north kitchen sink was broken and did not require a key to gain access. While Ms. Gjolaj attests the lock was intact and functioning properly, she had them changed out by maintenance promptly following the event. Durling licensing staff's inspection of the kitchen, the cabinets were observed to be locked and secured. However, it is undisputed that on 3/6/24, a jug of Ecolab dish detergent was removed from beneath the sink and was found unsecured, atop of the kitchen counter.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

APPLICABLE RULE	
MCL 333.20175	**Maintaining record for each patient; wrongfully altering or destroying records;**
	(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:	Resident A's record did not contain sufficient documentation surrounding the alleged poisoning incident detailing the examinations performed, observations made, and treatments provided by the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(5) Records must be maintained that demonstrate incident reporting to the team, analyses, outcomes, corrective action taken, and evaluation to ensure that the expected outcome is achieved. These records must be maintained for 2 years.
For Reference R 325.1901	**(k) "Incident" means an intentional or unintentional event including, but not limited to, elopements and medication errors, where a resident suffers physical or emotional harm.**
ANALYSIS:	While Ms. Gjolaj stated an incident report was filled out, the licensee failed to produce evidence of its existence. Therefore, corrective measures pertaining to the incident could not be confirmed or evaluated.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1941	**Records; general.**
	A resident register, resident records, accident records and incident reports, and employee records and work schedules shall be kept in the home and shall be available to the director or the director's authorized representative.
ANALYSIS:	Per Ms. Gjolaj, the incident report was taken offsite and is not housed at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon approval of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

03/29/2024

_____

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

05/20/2024

_____

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