GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 21, 2024

Mary North
Brookdale Farmington Hills North II
27900 Drake Road
Farmington Hills, MI 48331

RE: License #: AH630236929
Investigation #: 2025A0585012
Brookdale Farmington Hills North II

Dear Ms. 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 268-1788

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630236929
Investigation #:	2025A0585012
Complaint Receipt Date:	11/04/2024
Investigation Initiation Date:	11/06/2024
Report Due Date:	01/04/2024
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	105 Westwood Place Brentwood, TN 37027
Licensee Telephone #:	(615) 221-2250
Administrator:	Rebecca Eagle
Authorized Representative:	Mary North
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:	07/01/1999
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	28
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A went missing from the home.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/04/2024	Special Investigation Intake 2025A0585010
11/06/2024	Special Investigation Initiated - Telephone Contacted APS worker for additional information.
11/06/2024	APS Referral Allegations referred from Adult Protective Service (APS).
11/07/2024	Inspection Completed On-site Completed with observation, interview and record review.
11/07/2024	Inspection Completed – BCAL Sub. Compliance.
11/22/2024	Exit Conference. Conducted via email to authorized representative Mary North.

ALLEGATION:

Resident A went missing from the home.

INVESTIGATION:

On 11/04/2024, the department received this complaint from Adult Protective Service (APS) via BCAL online complaint system. The complaint alleged that on 11/2/2024, around 8:30 p.m., Resident A was reported missing by staff. The complaint alleged that Resident A was found two and a half miles away from the facility which he had fallen. The complaint alleged that Resident A had sustained a cut around his eye and a knot on his head.

On 11/6/2024, I received a call from the assigned APS worker Tina Edens regarding the allegations. Ms. Edens stated that Resident A is in the hospital.

On 11/7/2024, an onsite was completed. I interviewed administrator Rebecca Eagles who said that Resident A left out of the door. The administrator stated that on the night of the incident there were six staff members working during that shift. The administrator said that the latch on the door had been pushed and the screws had come out of the door. The administrator said that Resident A was able to push the door and get out. The administrator said that the last time staff saw Resident A was at 9:30 p.m. and when staff went back to check on him at 9:50 p.m. he was not there. The administrator said that it was the beginning of a new shift.

I interviewed Employee A who statements were consistent with the administrator. Employee A stated that Resident A was dropped off to the facility at 8:00 p.m. by his power of attorney (POA). She said that Resident A needed his brief changed but when staff attempted to change him, he was agitated and aggressive. Employee A stated that staff left Resident A and when they came back, he was not there. Employee A stated that she called the Resident's POA to report that they could not find Resident A. Employee A stated that Resident A's POA were able to air tag Resident A's location, and the police found him.

Resident A's service plan dated 9/24/2024 read in the section *Cognitive/Psychological* "Resident wanders and requires redirection". In the section *Behavior Management* "Resident attempts to exit building without needed supervision. Redirect resident away from exit using a gentle voice and offer preferred activities. Direct to an appropriate wandering space. Be alert to resident's pattern and reason for exit attempts (e.g. change of shift, end of a party as families leaves) and involve in meaningful activity prior to these points in time."

Resident A's service plan dated 10/23/2024 read in the section *Cognitive/Psychological* "Resident wanders and requires redirection.

Staffing documents showed employees on duty consistent to administrator's statement.

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.

R 325.1901	Definitions
	(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.
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the 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:	According to Resident A's service plan, he was a wanderer. Resident A was able to get out a secured door in a secured memory care unit by pushing the door that was broken. The staff did not know when he left. Resident was found with injuries to his head and a cut around his eye where he had fallen. Therefore, the facility failed to protect Resident A, and his care were not consistent to his service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

The administrator stated that the door was broken at the time of the incident, but they did not know it was broken. She said the door has since been repaired. The administrator stated that the alarm did not go off to alert staff that Resident A was going out of the door, and she did not know why it didn't work.

During the onsite, I inspected the door that Resident A left out of. The door and the alarm worked at that time.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	The building, equipment and furniture shall be kept clean and in good repair.
ANALYSIS:	The side door in the memory care was broken and the alarm system did not work to alert staff when residents exit the door. The resident was able to leave out the door and sustained injuries. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED.**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Brender L. Howard 11/21/2024

Brender Howard Date
Licensing Staff

Approved By:

Andrea L. Moore 11/21/2024

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