GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 9, 2024

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

RE: License #: AH630236929
Investigation #: 2025A1027012
Brookdale Farmington Hills North II

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. 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.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.
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 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
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH630236929
Investigation #:	2025A1027012
Complaint Receipt Date:	11/20/2024
Investigation Initiation Date:	11/21/2024
Report Due Date:	01/19/2025
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:	09/25/1999
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	32
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents were reported to have inadequate care and visible bruises, and caregivers were allegedly under the influence of drugs.	No
Medications were administered late or missed. Resident B did not receive his medications as prescribed. There were also reports that no medication technicians were on-site.	Yes
Additional Findings	No

Allegations pertaining to a resident elopement were investigated under Special Investigation Report 2025A0585012.

III. METHODOLOGY

11/20/2024	Special Investigation Intake 2025A1027012
11/21/2024	Special Investigation Initiated - Letter Email sent to Mary North and Rebecca Eagle to request documentation pertaining to allegations
11/21/2024	Contact - Document Received Email received with requested documentation
11/25/2024	Inspection Completed On-site
12/02/2024	Contact - Document Sent Email sent to Employee #1 requesting additional information
12/02/2024	Contact - Document Received Email received with requested information
12/05/2024	Inspection Completed-BCAL Sub. Compliance
12/09/2024	Exit Conference Conducted by email with Mary North and Rebecca Eagle

ALLEGATION:

Residents were reported to have inadequate care and visible bruises, and caregivers were allegedly under the influence of drugs.

INVESTIGATION:

On 11/20/2024, the Department received allegations forwarded from Adult Protective Services (APS), which included claims that residents were sitting in feces, were not being washed or cleaned, and were developing wounds. The complaint also read that Resident A had bruises and that caregivers were under the influence of drugs.

On 11/25/2024, I conducted an on-site inspection at the facility and interviewed staff.

Administrator Rebecca Eagle reported that two female police officers visited the facility on 11/22/2024 to investigate the abuse allegations. They observed Resident A, spoke to her daughter, and were closing the case with no findings. The administrator also stated that APS investigated and was closing their case with no findings.

The administrator further explained that no reports or observations of staff being under the influence of drugs were made. If such an allegation arose, the administrator said they would inquire about specific signs observed, and the manager would take the employee to Concentra for a drug test. If the employee refused a drug test, then they were terminated.

Employee #1 stated that Resident A had returned from rehabilitation months ago with a black eye, but currently, there were no bruises. Employee #1 confirmed that Resident A's daughter had no concerns regarding her care. Additionally, Employee #1 noted that Resident A received services from Heart to Heart Hospice, which reported no concerns either.

Employee #1 explained that residents had designated shower days according to their individualized service plans but were often given showers more frequently if necessary. They also mentioned that no families or agencies had raised concerns about bathing or care, and that there were no residents with wounds in the facility.

During my visit, I reviewed the resident census, which showed 12 residents. I observed Resident A, who did not have visible bruises on her face or arms. I also observed six other residents who appeared well-groomed and dressed in clean clothing. The facility lacked any foul odor. Two caregivers were attending to residents and did not appear to be under the influence of drugs.

I reviewed Resident A's service plan, dated 6/30/2024, which indicated she required physical assistance with showering, bathing, and toileting, and wore disposable briefs.

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:	After reviewing staff statements, facility documentation, and conducting observations, I found no evidence to substantiate the allegations of abuse or neglect nor caregivers under the influence of drugs.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medications were administered late or missed. Resident B did not receive his medications as prescribed. There were also reports that no medication technicians were on-site.

INVESTIGATION:

On 11/20/2024, the Department received allegations forwarded from Adult Protective Services (APS), which stated that medications were missed and not given on time, and that Resident B did not receive his medications during the final stages of his life.

On 11/25/2024, I conducted an on-site inspection at the facility and interviewed staff.

Administrator Rebecca Eagle denied any concerns regarding the administration of medications to residents. She stated that one medication technician was on duty during each of the three shifts.

Employee #1 explained that medications were to be administered within one hour before or after the prescribed time. Occasionally, residents refused medications, in which case the staff member was to attempt administration three times before reporting it. Employee #1 also noted that sometimes medications were delayed

when a medication technician was assisting a resident. Additionally, there had been requests to change the administration times for certain medications, such as creams, to three times a day while the resident was awake to avoid disrupting their sleep.

Employee #1 confirmed that Resident B received Beaumont Hospice services prior to passing away and received medications as prescribed.

Employee #2, the assigned medication technician on duty, stated that most medications were on a 28-day cycle and were automatically sent to ensure residents did not run out. Medications were administered according to physician orders. If medications were given late, the reason was documented in the charting system, and the facility could generate a late medication administration report.

I reviewed the employee list, which indicated that staff members were designated as medication technicians.

I reviewed Resident A's October and November 2024 Medication Administration Records (MARs), where staff initialed the medications as administered or noted the reason for any missed doses.

On 12/2/2024, email correspondence with Employee #1 confirmed that Resident B passed away on 10/25/2024. I also reviewed Resident B's service plan, dated 10/22/2024, which was consistent with staff statements. His October 2024 MARs indicated he was prescribed Amoxicillin and Doxycycline from 10/16/2024 to 10/19/2024, and staff initialed that he received them. His MARs also showed Haloperidol, Lorazepam, and Morphine Sulfate were prescribed as needed, and staff initialed that these were administered at various times.

A review of the Medication Audit Reports for Residents A and B from October and November 2024 revealed that medications were sometimes administered more than half an hour past the prescribed timeframe, which violated facility policy. For example, Resident A's 8:00 AM medications were administered at 10:57 AM on 10/12/2024, at 10:47 AM on 10/17/2024, and at 9:32 AM on 10/28/2024. Additionally, her 8:00 PM medications were administered at 10:51 PM on 10/4/2024. Resident B's two antibiotics, scheduled for 9:00 AM on 10/17/2024, were administered at 10:56 AM.

On 12/2/2024, email correspondence with Employee #1 revealed that nurse notes provided reasons for the late medication administrations. Resident A's nurse notes included an entry from 11/25/2024, which read that she was reluctant to take medications and required redirection. It also noted that she was not always compliant with her medication schedule, and her power of attorney and hospice agency were aware. A medication review had been requested to accommodate her

condition. Resident B's records did not contain nurse notes explaining the late administration of his medications.

APPLICABLE RULE	
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.
ANALYSIS:	Staff statements, facility documentation, and observations did not substantiate the claims that medications were missed, that Resident B did not receive his medications, or that no medication technicians were on-site. However, it was confirmed that medications were administered late. While facility staff attested that nurse notes explained the reasons for late medication administration, Resident A's records contained only a general note regarding her reluctance to take medications, without providing specific reasons for the delays on various dates and Resident B's records lacked a nurse note for administration of his late medications. Therefore, a violation was substantiated for this part of the allegations pertaining to medications given the facility did not follow their own policies.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

12/05/2024

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Jessica Rogers Date
Licensing Staff

Approved By:

12/05/2024

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