GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 11, 2024

Kimberly Wozniak
The Bradford Senior Living
2080 S. Telegraph Rd
Bloomfield Hills, MI 48302

RE: License #: AH630399613
Investigation #: 2024A1035081
The Bradford Senior Living

Dear Kimberly Wozniak:

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 responsible party 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 (517) 284-9730.

Sincerely,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 410-3226
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630399613
Investigation #:	2024A1035081
Complaint Receipt Date:	09/05/2024
Investigation Initiation Date:	09/06/2024
Report Due Date:	11/05/2024
Licensee Name:	Square Lake Care Operations, LLC
Licensee Address:	1435 Coit Ave. NE Grand Rapids, MI 49505
Licensee Telephone #:	Unknown
Administrator:	Lance Davis
Authorized Representative:	Kimberly Wozniak
Name of Facility:	The Bradford Senior Living
Facility Address:	2080 S. Telegraph Rd Bloomfield Hills, MI 48302
Facility Telephone #:	(248) 972-0800
Original Issuance Date:	01/08/2020
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	114
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Facility did not follow policy and procedure post Resident A being observed on the floor.	Yes
Additional Findings	No

III. METHODOLOGY

09/05/2024	Special Investigation Intake 2024A1035081
09/06/2024	Special Investigation Initiated - Letter
10/14/2024	Contact - Face to Face
12/10/2024	Inspection Complete. BCAL Sub Compliance.
12/11/2024	Exit Conference: Conducted by phone with Authorized Representative.

ALLEGATION:

Facility did not follow policy and procedure post Resident A being observed on the floor.

INVESTIGATION:

On September 5, 2024, the department received a complaint through the online complaint system which read:

> *"Resident A passed away at the facility on August 14th. Nurse called Family A before 6am in the morning. The facility found Resident A at the bathroom, laying on the floor. They took him back to bed and they asked him if he was okay. He said he was okay and went back to sleep. At 8:30 in the morning Family A missed a call from St Joseph hospital from the doctor. Resident A was being put in the ICU. Family A went to the hospital, and Resident A couldn't open his eyes and would not respond. He was unable to breathe on his own. His heart had stopped for at least 20 minutes. The facility did not contact EMS until over an hours after the incident. EMS arrived at the facility at 7:14 and Resident A heart was stopped already. They were giving him CPR for 10 minutes. No staff know what time his heart had stopped working. The staff never checked on him for over an hour after putting him back to bed. Her husband's call button to get assistance to use the*

bathroom does not work. Previously it took over an hour and a half for a nurse to attend to her husband. Her husband was not getting the necessary assistance to use the bathroom. The staff said they do not check the call lights for memory care. He fell often because he was not getting help fast enough and would take himself to the bathroom. He resided in the facility since April and Family A went to see him every day. He could not walk by himself, but the facility would let him. He would pass out when walking by himself because of his drop in blood pressure. His muscles were strong, but his blood pressure would drop suddenly. The facility staff did not assist him when walking."

On October 14, 2024, an onsite investigation was conducted. While onsite I interviewed Margaret "Maggie" Canny Administrator who states she was not employed with the company during the time of incident. Maggie provided progress notes, schedule, and incident report related to 8/1/2024, fall occurrence. Maggie stated her Wellness Director was employed during the time of the incident and will be able to provide more insight on the incident.

While onsite, I interviewed Staff Person (SP)1 who states she was notified by phone related to both fall occurrences. SP1 instructed staff to call 911 and have Resident A sent to the hospital for further evaluation. Resident A was found behind door 8/6/2024, 911 was contacted to assist entering room since Resident A was unresponsive and blocking door.

On October 17, 2024, a phone interview was conducted with complainant. Complainant states the facility called and informed her that Resident A had fallen in bathroom 8/1/2024 and had been sent to hospital. Complainant states she was not notified by the facility that Resident A was sent to the hospital on 8/6/2024 after being found nonresponsive. Complainant states she was notified by the hospital that Resident A was placed on a vent and was being transferred to ICU.

On October 22, 2024, a phone interview was conducted with SP2 who states she has been assigned to provide care to Resident A only a couple times. SP2 states Resident A had not fallen during the times she had been assigned care. Resident A was impulsive and had a bed alarm and a call light necklace. The facility provides phones that will notify staff members of call lights and bed alarms need to be answered. SP2 states in the event a Resident is observed on the floor an incident report is filled out, vital signs are taken, and a description of injury is noted on incident report and left for the nurse to review.

Maggie provided incident report completed for the August 1, 2024, related to Resident A being observed on bathroom floor; facility did not complete an incident report related to Resident A being found on floor in bathroom on 8/5/2024, nor 8/6/2024 incident related to Resident A being unresponsive on floor behind bedroom door.

Progress notes indicate Resident A was observed on floor in bathroom between wall and toilet on 8/1/2024 with left side flank pain. 911 was contacted and Resident A was

transported to the emergency room for further evaluation. On 8/5/2024 Resident A was observed on bathroom floor without injury. On 8/6/2024 Resident A was observed behind room door nonresponsive to verbal command, 911 was notified and assisted entry into room. Resident A was taken to local emergency room.

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: **(a) Assume full legal responsibility for the overall conduct and operation of the home.** **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.** **(c) Assure the availability of emergency medical care required by a resident.** **(d) Appoint a competent administrator who is responsible for operating the home in accordance with the established policies of the home.**
ANALYSIS:	Through record review facility policy states "all incidents or unusual occurrences at the community will be documented in a timely manner and appropriate action taken according to established procedures and state regulations. The Nurse or designee will complete an incident Report after taking the proper steps to see that the Resident or parties involved receive necessary intervention." Family A states she was not notified by facility of 8/6/2024, incident and Resident A transfer to the emergency room. Facility did not follow policy and procedure post fall occurrences. Based on information noted above this allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/29/2024

Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing Section

Approved By:

12/10/2024

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