GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 19, 2024

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

RE: License #: AH630399613
Investigation #: 2025A1027018
The Bradford Senior Living

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed by the authorized representative and dated.

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.
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 #:	AH630399613
Investigation #:	2025A1027018
Complaint Receipt Date:	12/09/2024
Investigation Initiation Date:	12/09/2024
Report Due Date:	02/08/2025
Licensee Name:	Square Lake Care Operations, LLC
Licensee Address:	1435 Coit Ave. NE Grand Rapids, MI 49505
Licensee Telephone #:	(248) 972-0800
Administrator:	Maggie Canny
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?
Resident A was left in soiled briefs, and her wounds were left untreated.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/09/2024	Special Investigation Intake 2025A1027018
12/09/2024	Special Investigation Initiated - Letter Email sent to Maggie Canny and Kimberly Wozniak requesting documentation pertaining to Resident A
12/11/2024	Contact - Document Received Email received with requested documentation
12/16/2024	Contact - Document Sent Email sent to Maggie Canny requesting additional documentation
12/17/2024	Contact - Document Received Email received with requested documentation
12/18/2024	Inspection Completed-BCAL Sub. Compliance
12/19/2024	Exit Conference Conducted by email with Kimberly Wozniak and Maggie Canny

ALLEGATION:

Resident A was left in soiled briefs, and her wounds were left untreated.

INVESTIGATION:

On 12/9/2024, the Department received a complaint from Adult Protective Services (APS) regarding Resident A, who resided in memory care and moved to a new home on 12/5/2024. The complaint alleged that in October 2024, Resident A's hospice nurse observed bed sores and reported them to her durable power of attorney. The complaint read that staff were not treating the bed sores and were waiting for the hospice nurse's visits to provide treatment. It was further alleged that Resident A was left soiled, which led to the wound becoming infected. Hospice staff reportedly initiated antibiotics on 12/1/2024. APS did not open an investigation.

Resident A’s face sheet indicated she moved into the facility on 11/15/2020, with Relative A1 listed as her emergency contact and power of attorney. Resident A’s service plan, updated on 3/8/2024, noted that she was receiving residential hospice services. The plan included instructions to observe and report any changes to her skin, keep it clean and dry, and apply lotion after bathing.

Resident A’s chart notes from October to December 2024 documented the following:

- 10/17/2024 at 11:03 AM: The NP observed two unstageable pressure wounds on the left hip with eschar and a stage two pressure ulcer on the coccyx. Medi-honey was applied, and oral Bactrim was added to her medications. A wound care order was sent to hospice.
- 10/18/2024 at 10:10 AM: A message was left with Relative A2 notifying them about the pressure ulcers and the treatment plan.
- 11/14/2024 at 1:30 PM: Resident A began a course of antibiotics for an infected wound on the left hip. The NP notified the family.
- 11/14/2024 at 1:36 PM: Wounds on the coccyx and left hip were cleaned with soap and water, dried, and Medi-honey was applied, followed by an Opti-Foam dressing. A dressing was applied to the right hip to pad and protect the area.
- 11/15/2024 at 3:41 PM: The left hip wound showed a strong foul odor and purulent drainage, consistent with the previous note from 11/14/2024.
- 11/18/2024 at 3:09 PM: The wounds on the left hip, coccyx, and right hip were cleaned with a wound cleanser and dressed with Opti-Foam dressing; the coccyx wound was dressed with an ABD pad.
- 11/19/2024 at 2:15 PM and 11/21/2024 at 8:00 PM: Notes were consistent with the previous dressing change on 11/18/2024.
- 12/5/2024 at 12:02 PM: Resident A was discharged from the facility and transported by family.

Resident A’s Medication Administration Records (MARs) for October, November, and December 2024 show the following: On 10/17/2024, the licensed healthcare provider prescribed Medi-honey to be applied to the wounds on Resident A's left hip every other day. Staff initialed the MAR to indicate when it was administered or noted reasons why it was not. On 11/14/2024, a prescription for Bactrim DS (one tablet twice a day for 10 days) was written. Staff initialed the medication as administered or documented reasons for non-administration; however, staff noted the medication was awaiting arrival from the pharmacy on 11/15/2024. On 11/16/2024, the medication was unavailable for the morning dose, and a total of 15 doses were administered indicating the full course of antibiotics was not given. On 11/29/2024, the healthcare provider prescribed Clindamycin to be taken three times daily for 10 days. The first dose was initialed as administered on 11/30/2024 at 8:00 PM. However, on 12/2/2024, the MAR indicated that none of the prescribed doses had been administered.

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: **R 325.1901**	**Definitions.** **Rule 1. As used in these rules:**
	(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:	A review of Resident A's records revealed that she had wounds for which her healthcare provider prescribed wound care treatments, medications, and antibiotics. The MARs documented prescriptions for Medi-honey and antibiotics, but her service plan did not provide specific details about her wounds or prescribed treatments. It also did not indicate whether the hospice nurse had provided treatment instructions for the staff. The chart notes mentioned wound care as completed for five days in November 2024, but no further documentation confirmed its completion. Although it could not be definitively determined if the wound infection resulted from inadequate care, a violation was substantiated due to the lack of specific care instructions and wound management details in Resident A's service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Medications were not administered as prescribed by the licensed healthcare provider. For example, the November 2024 MAR indicated that Resident A was prescribed Bactrim DS, one tablet by mouth twice daily for 10 days. However, staff

initialed 15 doses as administered, meaning the full course of antibiotics was not completed. Additionally, the December 2024 MAR showed that Clindamycin, prescribed as one capsule by mouth three times daily for 10 days, had all three doses left blank on 12/2/2024. Staff circled their initials to indicate the medication was not administered due to "med not available" for two doses on 12/3/2024, then initialed all three doses as administered on 12/4/2024. Furthermore, the December 2024 MAR indicated that one or more doses of other prescribed medications were left blank on 12/3/2024 and 12/4/2024.

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:	Review of Resident A's medication administration records for October, November and December 2024 revealed she did not always receive her medications as prescribed by the licensed health care professional; therefore, a violation was substantiated for this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/18/2024

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Jessica Rogers Date
Licensing Staff

Approved By:

12/18/2024

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