GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 20, 2021

Catherine Reese
Vibrant Life Senior Living Sterns Lodge
667 W. Sterns Road
Temperance, MI 48182

RE: License #: AH580353904
Investigation #: 2021A1028039
Vibrant Life Senior Living Sterns Lodge

Dear Ms. Reese:

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 (616) 356-0100.

Sincerely,
Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH580353904
Investigation #:	2021A1028039
Complaint Receipt Date:	08/17/2021
Investigation Initiation Date:	08/18/2021
Report Due Date:	09/16/2021
Licensee Name:	Vibrant Life Senior Living OC Temperance, LLC
Licensee Address:	5720 Williams Lake Road Waterford, MI 48329
Licensee Telephone #:	(734) 847-3217
Administrator:	Catherine Reese
Authorized Representative:	Molly Bowman
Name of Facility:	Vibrant Life Senior Living Sterns Lodge
Facility Address:	667 W. Sterns Road Temperance, MI 48182
Facility Telephone #:	(734) 847-3217
Original Issuance Date:	02/20/2014
License Status:	REGULAR
Effective Date:	02/20/2021
Expiration Date:	02/19/2022
Capacity:	46
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility did not follow Resident A's and Resident B's service plans.	Yes
Resident A's medications were improperly administered by care staff.	Yes

III. METHODOLOGY

08/17/2021	Special Investigation Intake 2021A1028039
08/18/2021	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
08/18/2021	APS Referral APS referral emailed to Centralized Intake
09/16/2021	Contact - Telephone call made Interviewed the complainant A by telephone
09/16/2021	Contact - Telephone call made Interviewed Resident A by telephone
09/16/2021	Contact - Telephone call made Interviewed Administrator Molly Bowman by telephone
09/22/2021	Contact – Telephone call made Interviewed care staff person Tami Hardison by telephone
09/22/2021	Contact – Telephone call received Interviewed former care staff person Logan Minkler by telephone
09/22/2021	Contact – Telephone call made Interviewed care staff person Lasha Riccardi by telephone
09/23/2021	Contact – Telephone call received Interviewed care staff person Amy McKimm by telephone

On 9/23/2021	Contact – Telephone call made Interviewed Resident B's authorized representative by telephone
10/20/2021	Exit Interview

ALLEGATION:

The facility did not follow Resident A's service plan.

INVESTIGATION:

On 8/17/21, the Bureau received the allegations from the online complaint system.

On 8/18/21, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 9/16/21, I interviewed the complainant by telephone. The complainant reported Resident A "was neglected throughout [their] stay at the facility". The complainant reported Resident A had multiple falls, was not showered or bathed in accordance with the service plan and required assistance with toileting and often did not receive assistance in a timely manner, even after the call-light was pulled. The complainant reported Resident A had a bedside urinal that was used to prevent getting up out of bed during the night to deter falls, as Resident A had a lot of falls at the facility. Resident could use the bedside urinal with modified independence but needed care staff assistance to empty the urinal daily. The complainant reported staff did not assist Resident A with emptying the urinal daily resulting in cold urine being spilled on Resident A multiple times. The complainant reported Resident A had to ask to be showered and even fell through the shower chair seat in the community spa due to lack of staff assistance. The complainant reported Resident A would also require care staff assistance intermittently to don compression socks, but care staff would often not assist Resident A. The complainant reported "[Resident A] did not receive appropriate care or care consistent with the contract that was signed. With the exception of two aides, the rest of the staff were neglectful and often verbally abusive to Resident A and other residents there." The complainant also reported while visiting with Resident A, the complainant often witnessed Resident B being left outside in a chair for a prolonged periods of time with no staff supervision. The complainant reported Resident B required "pretty much total assist, as they were chair bound." The complainant reported Resident B would sometimes have urine soaked through [their] chair that would leak onto the concrete below the chair when sitting outside. The complainant reported it was very concerning to see "[Resident B] being left there for so long without any staff around. A few times I went to get staff to help [Resident B]."

On 9/16/21, I interviewed Resident A by telephone. Resident A reported having to ask for showers or “I might not get showered that week.” Resident A also reported using a bedside urinal to avoid getting out of bed in the middle of the night because “I was having a lot of falls.” Resident A reported the urinal was not emptied daily resulting in cold urine being spilled on [Resident A] and the bed multiple times. Resident A reported requiring assistance for toileting and the call light was pulled, but “no one would come after several minutes of being on the toilet. I would then yell and sometimes no one would still come. A neighbor tried to help a couple of times because she heard me yelling and she would get up and tell the aides to come help me.” Resident A reported being able to dress themselves “for the most part” but required assistance with compression socks due to the diagnosis of Parkinson’s disease. Resident A reported care staff often did not assist with the compression socks and at times Resident A went without wearing them or had to wait until family came in to assist. Resident A also confirmed to witnessing Resident B being left outside with no staff supervision and that Resident B was left to sit in urine while outside.

On 9/16/21, I interviewed the facility administrator Molly Bowman by telephone. Ms. Bowman reported no knowledge of Resident A having to request showers, of urine being spilled on Resident A and the bed, or care staff being neglectful in their duties Resident A, Resident B, or to any of the other residents at the facility. Ms. Bowman provided a copy of Resident A’s and Resident B’s admission contract, service plan, record notes, and medication administration record for my review.

On 9/22/21, I interviewed care staff person (CSP) Tami Hardison by telephone. Ms. Hardison reported Resident A was provided care per the service plan in place. Ms. Hardison reported Resident A could use a urinal with modified independence, but urine was not spilled on the bed or Resident A. Ms. Hardison reported Resident could use the call light and “would yell if help did not arrive right away” and that Resident A often attempted to do things for [themselves] instead of waiting for staff. Ms. Hardison reported no knowledge of Resident A falling through the seat of the shower chair. Regarding Resident B, Ms. Hardison reported Resident B is total assist and “does not go outside. Staff does not take [Resident B] outside”.

On 9/22/21, I interviewed former CSP Logan Minkler by telephone. Ms. Minkler reported Resident A could use the call light and would ask for help with emptying the urinal due to “other staff not helping with it or emptying it.” Ms. Minkler reported urine was spilled on Resident A and the bed on more than one occasion due to lack of staff help or inappropriate staff care. Ms. Minkler reported Resident A would not always receive a shower in timely manner or assist in a timely manner when the call light was pulled. Ms. Minkler reported Resident A could perform some care with modified independence and set-up, but mostly required care staff assist. Ms. Minkler reported “[Resident A] did not receive the best care while at the facility”. However, Ms. Minkler reported no knowledge of Resident A falling through the seat of the shower chair, but “that doesn’t mean it didn’t happen. I just might not have heard about it, or I wasn’t working there when it happened”. Regarding Resident B, Ms.

Minkler reported Resident B was total assist. Ms. Minkler reported Resident B did go outside sometimes with care staff assist or if family was there to take Resident B outside. Ms. Minkler reported “I believe there was something in [Resident B’s] care plan about going outside with supervision.”

On 9/22/21, I interviewed CSP Ms. Riccardi by telephone. Ms. Riccardi reported Resident A can “get some things started like putting on a shirt” for themselves but mostly requires assist from care staff to complete care. Ms. Riccardi reported Resident A would use the call light and would request assistance with use of the urinal or toileting. Ms. Riccardi reported Resident A’s urinal should have been emptied after every use by care staff. Ms. Riccardi reported she would empty the urinal but had found the urinal a few times with prior urine left in it upon coming onto the shift for the day. Ms. Riccardi reported to her knowledge urine was not spilled on Resident A or the bed and no knowledge of Resident A falling through the seat of the shower chair. Ms. Riccardi reported Resident A received showers and required assistance with showering. Regarding Resident B, Ms. Riccardi reported “[Resident B] is total assist and does not go outside ever”.

On 9/23/21, I interviewed CSP Amy McKimm by telephone. Ms. McKimm reported Resident A was a one person assist with most care. Ms. McKimm reported Resident A used a urinal and care staff were supposed to assist Resident A with it, but “[Resident A] often used it on [their] own”. Ms. McKimm also reported Resident A used the call light appropriately but would often not wait for care staff to arrive and assist. Regarding Resident B, Ms. McKimm reported Resident B goes outside if the family takes Resident B outside. Ms. McKimm reported Resident B is total assist with care and if staff were to take Resident B outside, Resident B would require supervision from care staff.

On 9/23/21, I interviewed Resident B’s authorized representative by telephone. Resident B’s authorized representative reported Resident B is dependent for care. The authorized representative reported it was requested by family that Resident B be allowed to sit outside on the patio with staff supervision in weather appropriate clothing on good weather days. The authorized representative had no knowledge if Resident B was outside unsupervised or if Resident B’s chair was urine-soaked while outside. However, the authorized representative reported [they] have had to “stay on top of staff” to ensure the service plan is followed at times “because it is important to us that [Resident B] enjoy the sunshine on nice days and that [Resident B] be taken care of with dignity because [they] cannot do things for [themselves] anymore”. The authorized representative reported speaking with the facility during a visit in late July 2021 about Resident B’s chair being fifthly, about Resident B’s nails being “very dirty” and needing trimming; and about Resident B’s bed and room “smelling of urine”.

On 9/23/21, I reviewed Resident A’s service plan. The service plan is signed by Resident A’s authorized representative and dated 6/3/21. Resident A requires assist

with toileting, showering, grooming, dressing, but can feed self with modified independence and set-up. The service plan also read:

- *Resident A requires supervision to one person assist for transfer and with use of wheelchair.*
- *Resident A required daily use of compression socks with staff assist.*

I could not determine through interviews or documentation if Resident A received compression sock care.

I also reviewed Resident B's service plan. The service plan is signed by Resident B's authorized representative and dated 2/21/21. The service plan identified that Resident B is dependent for all care and ambulation. It also read:

- *Resident B is to be with family or staff when outside of the facility.*
- *Family has requested [Resident B] is to sit outside on the patio for some time during the day when its nice out.*
- *[Resident B] isn't able to communicate [their] needs. Staff are to check on [Resident B] frequently throughout their shift to ensure [their] needs are met.*

I have been unsuccessful in making contact with care staff persons Cassaundra Doll, Jacqueline Hunter, and Latrice Crockett.

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:	Interviews with management, current and former care staff, Resident A's authorized representative, Resident B's authorized representative and Resident A reveal a lack of appropriate follow through and understanding of Resident A's and Resident B's service plans. • Resident A was not showered in accordance with the service plan. • Resident A did not receive appropriate assistance with the bedside urinal. • Resident A required daily use of compression socks with staff assist, but it cannot be determined through interviews or documentation if Resident A received compression sock care.

	• Resident B was not provided appropriate time outside with supervision as outlined in the service plan. • There is evidence care staff interviewed did not have good knowledge or understanding of Resident B's service plan requirements of being allowed outside with staff supervision. Therefore, facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's medications were improperly administered by care staff.

INVESTIGATION:

On 9/16/21, the complainant reported that on 7/21 Resident A was found with two Rivastigmine patches on self, with one dated 7/18 and the other dated 7/20. The complainant reported the patches are to be removed and replaced daily. The complainant reported "showing care manager Josh the patches right then at the facility. I removed the patches in front of staff and requested to review [Resident A's] medications right then." The complainant reported completing a medication audit of all Resident A's medications and finding multiple medication errors during their audit. The complainant provided me the medication audit [they] conducted and copies of communication with the facility.

On 9/22/21, Ms. Hardison reported that to her knowledge Resident A did not have any medication administration issues when she worked with Resident A.

Ms. Minkler reported she is "unsure if there were medication issues with [Resident A's] medications."

Ms. Ms. Riccardi reported to her knowledge there were no medication issues with Resident A's medications. However, during the interview Ms. Riccardi reported staff "cleaned and organized the med room and med carts because they were a mess today".

Ms. McKimm reported "there should not have been any issues with [Resident A's] medications because staff know they are supposed to remove and replace those patches daily. We also have to date and initial the patches."

On 9/23/21, I reviewed Resident A's medication administration record which read:

RIVASTIGMINE 13.3 MG / 24 HR {EXELON 13.3MG / 24 HR}

- *Use 1 Patch Topically Daily as Directed. REMOVE OLD PATCH BEFORE APPLYING NEW ONE*
- *8:00 AM*
- *Start date for Rivastigmine was 4/30/21.*

Further review of the MAR revealed Resident A received the Rivastigmine patch from 4/1 to 4/30, but the prescription start date was not until 4/30. Resident A also missed receiving the Rivastigmine patch on 6/19 and 7/21. There are no notes in the MAR to explain why Resident A did not receive this medication on these days.

A medication study on Rivastigmine patches was completed. The Mayo Clinic reports the following:

- *Rivastigmine patch is used to treat dementia (memory loss) associated with mild, moderate, or severe Alzheimer's disease, or mild to moderate dementia associated with Parkinson's disease. Rivastigmine will not cure these diseases and it will not stop these diseases from getting worse. However, rivastigmine can improve thinking ability in some patients with these diseases.*
- *Do not stop using this medicine without asking your doctor. If you have not used your medicine for several days in a row, do not start using it again without talking to your doctor first. You may need to start the medicine again using a lower dose.*
- *If you forget to wear or change a patch, put one on as soon as you can. If it is almost time to put on your next patch, wait until then to apply a new patch and skip the one you missed. Do not apply extra patches to make up for a missed dose. If you go 3 days in a row or longer without wearing a patch, do not apply a new one until you have talked to your doctor. You might need to go back to a lower dose.*

There is also inconsistency with the medication administration of Buspirone which is used to is used to treat certain anxiety disorders or to relieve the symptoms of anxiety according to the Mayo Clinic. Under scheduled medications Resident A medication administration record read:

BUSPIRONE 5MG TABLET (BUSPAR 5MG TAB)

- Take 1 Tablet by Mouth Twice Daily at 8:00AM and 2:00PM.

Dates 5/12 to 5/31 are blank on the MAR and it cannot be determined if Resident A received this medication. There are no notes on the MAR as to why Resident A did not receive this medication. The Mayo Clinic reports contraindications as:

- *Follow your doctor's orders or the directions on the label. If you miss a dose of this medicine, take it as soon as possible. However, if it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do not double doses.*

- *Do not suddenly stop taking this medicine without checking first with your doctor. Your doctor may want you to gradually reduce the amount you are taking before stopping it completely. This is to decrease the chance of having withdrawal symptoms such as increased anxiety; burning or tingling feelings; confusion; dizziness; headache; irritability; nausea; nervousness; muscle cramps; sweating; trouble with sleeping; or unusual tiredness or weakness.*

There is conflicting information for this medication listed under the scheduled medication section of the MAR as well.

- Line 5 reads: to *Take 1 Tablet by Mouth Twice Daily* but line 35 read to *Take 1 Tablet Three Times Daily*.

Upon further review of Resident A's MAR, there are further inconsistencies with medication administration and no notes in the MAR to explain why Resident A did not receive the following medications:

- Citalopram – 1 tablet (20MG) Taken by mouth once daily; One dose missed on 7/21.
- Clopidogrel – 1 tablet (75MG) Taken by mouth once daily (blood thinner); One dose missed on 7/21.
- Entacapone – 1 tablet (200MG) Taken by mouth four times daily (Parkinson's); two doses missed on 7/21; One dose missed on 7/22, 7/23, and 7/24.
- Famotidine – 1 tablet (20MG) (Pepcid 20MG TAB) Taken by mouth twice daily; One dose missed 7/21
- Finasteride – 1 tablet (5MG) Taken by mouth once daily; One dose missed 7/21
- Fludrocortisone – 1 tablet (0.1 MG) (Hypotension) Taken by mouth twice daily; Two does missed on 7/21.
- Fluticasone – 50MG Spray (Flonase Nasal Spray 0.05%) Spray 2 sprays in each nostril daily; One dose missed 7/21.
- Midodrine – 1 tablet (10MG) Taken by mouth four times daily; Two doses missed on 7/21.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Interviews with the complainant, Resident A's authorized representative, Resident A, and facility care staff along with

	review of Resident A's medication administration record (MAR) reveal several inconsistencies with the medication Rivastigmine to include: • Resident A received the Rivastigmine patch from 4/1 to 4/30, but the prescription start date on the MAR shows the prescription start date as 4/30. • The MAR is blank for 6/19 and 7/21. Resident A missed receiving the patch on 6/19 and 7/21. There are no notes in the MAR to explain why Resident A did not receive this medication. • On 7/21, Resident A was found to have two Rivastigmine patches on self, dated 7/18 and 7/20. The following inconsistencies were found for medication administration of Buspirone. • Dates 5/12 to 5/31 are blank on the MAR. It cannot be determined if Resident A received this medication. There are no notes on the MAR as to why Resident A did not receive this medication. There are also missed medication administration for the following of Resident A's medications during the month of July 2021: Citalopram, Clopidogrel, Entacapone, Famotidine, Finasteride, Fludrocortisone, Fluticasone, and Midodrine. There is significant risk established for medication contraindications and harm for Resident A because the facility did not appropriately follow Resident A's medication administration instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend this license remain unchanged.

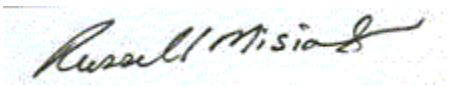
Julie Viviano

9/24/21

_____

Julie Viviano Date
Licensing Staff

Approved By:



10/20/21

Russell B. Misiak Date
Area Manager