GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 21, 2023

Jennifer Hescott
University Living
Suite 300, One Town Center Rd
Boca Raton, FL 33486

RE: License #: AH810401699
Investigation #: 2023A0585087
University Living

Dear Ms. Hescott:

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,

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 #:	AH810401699
Investigation #:	2023A0585087
Complaint Receipt Date:	08/24/2023
Investigation Initiation Date:	09/06/2023
Report Due Date:	11/23/2023
Licensee Name:	Ann Arbor Senior Housing OPCO, LLC
Licensee Address:	Ste 310 One Town Center Rd Boca Raton, FL 33486
Licensee Telephone #:	(734) 669-3030
Administrator:	Kelly Hardy
Authorized Representative:	Jennifer Hescott
Name of Facility:	University Living
Facility Address:	2865 S. Main Street Ann Arbor, MI 48103
Facility Telephone #:	(734) 669-3030
Original Issuance Date:	05/26/2021
License **Status:**	REGULAR
Effective Date:	11/26/2022
Expiration Date:	11/25/2023
Capacity:	90
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was given peanut butter that she was allergic to.	Yes
Staff did not give resident prescribed morphine.	No
Additional Findings	No

III. METHODOLOGY

08/24/2023	Special Investigation Intake 2023A0585087
09/06/2023	Special Investigation Initiated - Telephone Contacted complainant to discuss allegations.
09/06/2023	APS Referral Referral made to Adult Protective Services (APS).
09/12/2023	Inspection Completed On-site Completed with observation, interview and record review.

ALLEGATION:

Resident A was given peanut butter that she was allergic to.

INVESTIGATION:

On 9/5/2023, the department received the allegations via the BCHS Online Complaint website. The complaint alleged that staff gave peanut butter to a resident who was allergic to it.

On 9/6/2023, a referral was sent to Adult Protective Services (APS). This complaint was assigned to APS worker Precious Whitman.

On 9/8/2023, I interviewed the complainant by telephone. The complainant's stated that Employee #1 served Resident A a peanut butter and jelly sandwich. She stated that Employee #1 did not check to see what Resident A was allergic to. She stated

that Resident A was almost sent to the hospital and management did not give Employee #1 a write up or nothing. She stated that all staff is trained to look at the chart with the residents' allergies posted on the wall.

On 9/12/2023, an onsite was completed at the facility. I interviewed administrator Kelly Hardy at the facility. Ms. Hardy stated that Employee #1 gave Resident A peanut butter and jelly sandwich. She stated that she doesn't know what happened because it was posted that Resident A was allergic to peanuts. She stated that Employee #1 was taught to look at the service plan to learn about the residents. Ms. Hardy stated that Resident A's diet is written on the service plan, and it is posted on the wall. Ms. Hardy shared copies of Resident A's service plan and medication administration record (MAR), along with training documents for Employee #1.

On 9/12/2023, I interviewed Employee #1 at the facility. Employee #1 stated that she gave Resident A peanut butter, and she was allergic to it. Employee #1 stated that she did not realize that Resident A was allergic to peanuts. She stated that it was posted but it was in small print, and she didn't see it. Employee #1 stated that she was given a disciplinary for giving Resident A peanut butter.

On 9/12/2023, I interviewed Employee #2 at the facility. Employee #2 stated that Employee #1 gave Resident A peanut butter, and the resident was allergic to it. She stated that all allergies are posted in the residents' service plan and on a clip board.

Resident A's service plan read, "Resident is on a special diet (limited concentrated sweets, no added salt, renal diet, lactose intolerant, etc.). Report any changes, increased difficulty, or safety concerns. Diabetic diet. No peanuts.

I reviewed the training documents for Employee #1 and it showed that Employee #1 had training that consisted of service plan training.

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.**
	(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:	Employee #1 served Resident A peanut butter and jelly to eat. Resident A's service plan read that she is not to eat peanuts. Although Employee #1 was given disciplinary action and was trained on reading service plan, she still put Resident A at risk by providing her with peanuts that she was not supposed to have. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff did not give Resident prescribed morphine.

INVESTIGATION:

The complaint stated that she couldn't remember who the resident was that were not given the morphine. She stated the resident died.

There was no additional information given regarding what resident was not given morphine. I reviewed documents for other residents that was taking morphine who recently passed away.

Ms. Hardy stated that there are several residents who are prescribed morphine. She stated that they had several deaths who were on hospice and the residents were prescribed morphine. Ms. Hardy shared copies of MARs and service plans for several residents for review who had recently passed and were on hospice.

The MARs for residents reviewed showed that medication was given as prescribed.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.

ANALYSIS:	MARs reviewed showed that medication was given as prescribed. Therefore, the facility reasonably complied with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

09/22/2023

Brender Howard Date
Licensing Staff

Approved By:

09/21/2023

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