

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

MARLON I. BROWN, DPA DIRECTOR

August 14, 2024

Catherine Reese Vibrant Life Senior Living, Superior Township, LLC 4488 Jackson Road Ste 2 Ann Arbor, MI 48103

> RE: License #: AL810390848 Investigation #: 2024A0122029

> > Vibrant Life Senior Living, Superior 1

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 (517) 284-9720.

Sincerely,

Vanita C. Bouldin, Licensing Consultant Bureau of Community and Health Systems

Vancon Beallin

22 Center Street Ypsilanti, MI 48198 (734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL810390848
	71201000000
Investigation #:	2024A0122029
Complaint Receipt Date:	07/16/2024
Investigation Initiation Date:	07/17/2024
Report Due Date:	09/14/2024
Licensee Name:	Vibrant Life Senior Living, Superior Township, LLC
Licensee Address:	4488 Jackson Road Ste 2
	Ann Arbor, MI 48103
Licensee Telephone #:	(734) 819-7790
Administrator:	Catherine Reese
Licensee Designee:	Catherine Reese
Name of Facility	Vibrant Life Conjurt Indian Congrism 1
Name of Facility:	Vibrant Life Senior Living, Superior 1
Facility Address:	1900 N. Prospect Road
acility Address.	Ypsilanti, MI 48198
	i pananti, ivii 40190
Facility Telephone #:	(734) 765-0505
r domey receptions in	(101)100 0000
Original Issuance Date:	10/18/2019
License Status:	REGULAR
Effective Date:	04/18/2024
Expiration Date:	04/17/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED
	ALZHEIMERS
	AGED

II. ALLEGATION(S)

Violation Established?

Residents enter into each other's bedrooms.	No
 Residents not cleaned/wiped after diaper change. Residents' briefs are not changed. Staff grab and yank residents when assisting them. 	No
Residents are given too much medication.	No
Residents are not given snacks between meals.	No
Residents are not showered.	No
 Residents are served molded food. Facility juice machine is not cleaned – residents served old juice. Meals are transported from the main kitchen in staff members personal vehicles. 	No
Meals are served cold.	No
Couches are placed in front of the building entrance.	Yes
Facility bathrooms and common areas are dirty.	No

III. METHODOLOGY

07/16/2024	Special Investigation Intake 2024A0122029
07/16/2024	APS Referral Adult Protective Services denied intake and referred to Bureau of Community Health Services.
07/17/2024	Special Investigation Initiated – On Site Inspected facility kitchen and laundry room. Reviewed Resident A, B, and C files. Reviewed Residents A, B, and C medication administration sheets and medications. Observed residents inside of the facility. Completed interview with Josh Reese, Manager.
07/22/2024	Contact – Telephone calls made. Completed interviews with Relatives A1 and C1. Left voice message for Relative B1.

07/24/2024	Contact – Documents received Resident A, B, and C's Huron Valley Pace Medical Notes.
07/26/2024	Contact – Email received Adult Protective Supervisor, Joy Clegg
07/26/2024	On site Inspection completed Inspected facility kitchen, common areas, and resident bedrooms and bathrooms.
08/06/2024	On site Inspection completed Inspected facility and completed interviews with staff 1, 2, and 3.
08/09/2024	Exit Conference Discussed findings with licensee designee, Catherine Reese.

ALLEGATION: Residents enter into each other's bedrooms.

INVESTIGATION: On 07/17/2024, I completed onsite inspections and interviewed manager, Josh Reese, of Vibrant Life Senior Living, Superior 1 adult foster care facility. I observed residents throughout the facility, some in their bedrooms and some in common areas. All residents were observed to be dressed appropriately, lounging comfortably, showing no signs of discomfort or distress.

Josh Reese confirmed that Vibrant Life Senior Living, Superior 1 is a facility that provides adult foster care services to adults diagnosed with dementia or Alzheimer's disease. He stated that due their diagnosis it is not uncommon for them to enter into the wrong bedroom. Per Mr. Reese, when this happens staff members give residents verbal redirection and guidance back into their assigned bedrooms. Mr. Reese stated there have been no problems and/or concerns with this issue.

On 08/06/2024, I completed interviews with staff 1, 2, and 3. All reported that due to residents' diagnosis of dementia/Alzheimer's they have observed residents entering into bedrooms that are not assigned to them as they are confused. All reported that they either give verbal redirection or offer activities to direct the residents out of the wrong bedrooms.

APPLICABLE RULE	
R 400.15304	Resident rights; licensee responsibilities.
	(1) Upon a resident's admission to the home, a licensee
	shall inform a resident or the resident's designated
	representative of, explain to the resident or the resident's

	designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: (o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with staff and Josh Reese, there is no evidence found to show that residents are not treated with consideration and respect with due recognition of personal dignity, individuality, and need for privacy. Residents of the Vibrant Life Senior Living, Superior 1 are diagnosed with dementia or Alzheimer's disease, therefore cognitive confusion is normal, and they may enter the wrong bedroom. Staff use appropriate redirection methods to address the issue.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- Residents not cleaned/wiped after brief change.
- · Residents' briefs are not changed.
- Staff grab and yank residents when assisting them.

INVESTIGATION: On 07/17/2024 and 07/30/2024, I completed onsite inspections and interviewed Josh Reese. Mr. Reese stated he had not received any reports that staff were not cleaning/wiping residents after brief changes. Nor had he received reports that staff were not changing resident's briefs or grabbing/yanking on them when assisting them.

On 07/22/2024, I conducted separate interviews with Relatives A1 and C1. Both stated they had no issues or concerns with the care staff provided to Residents A and C. Both stated that during visits with Residents A and C both have observed them to be clean and dressed appropriately. They have not witnessed incidents where Residents A and C were not cleaned/wiped after a brief change, both feel that Residents A and C's briefs are changed as needed. Neither had observed nor received reports that staff members grab or yank when aiding Residents A and C. As of 08/12/2024, I have received no contact from Relative B1.

On 07/25/2024, I reviewed Resident A, B, and C's Huron Valley Pace Medical Notes. Residents were medically assessed on 06/18/2024, 06/23/2024, and 07/11/2024. There was no bruising observed on any of the residents and no issues of concerns regarding care received by staff at Vibrant Life Senior Living, Superior 1 documented in the medical notes.

On 08/06/2024, I completed interviews with staff 1, 2, and 3. All reported they had not observed or received reports that residents are grabbed or yanked by staff when receiving assistance from them. Staff 1 and 3 reported that residents briefs are changed and cleaned as needed. Staff 2 stated she feels that resident's briefs are not changed on the midnight shift, as she has worked morning shift and observed residents with wet briefs.

APPLICABLE RULE	
R 400.15305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with staff, Josh Reese, relatives, and reviewed pertinent documentation relevant to this investigation there is no evidence to substantiate the allegations that residents are not cleaned/wiped after brief changes, residents' briefs are not changed, and staff grab or yank residents when assisting them. Therefore, the residents are treated with dignity and their personal needs, including protection and safety, are attended to at all times in accordance with the provisions of the act.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Residents are given too much medication.

INVESTIGATION: On 07/17/2024, I completed an onsite inspection and reviewed Resident A, B, and C's medication administration records and medications. All medications were present and accounted for. All medication administration records were completed correctly.

On 07/17/2024, I completed an interview with Josh Reese. Mr. Reese stated he had not received any reports that the residents of Vibrant Life Senior Living, Superior #1 was receiving too much medication.

APPLICABLE RULE	
R 400.15312	Resident medications.
	(1) Prescription medication, including dietary supplements,
	or individual special medical procedures shall be given,

	taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being \$333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based upon my investigation, which consisted of review of Residents, A, B, and C's medication administration records and medications, I find no evidence to support the allegation that residents are given too much medication. Therefore, residents are receiving prescription medication as prescribed by a licensed physician.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Residents are not given snacks between meals.

INVESTIGATION: On 07/17/2024, Josh Reese stated that breakfast is served at 7:30 a.m., lunch is served at 12:30 p.m., and dinner is served at 5:30 p.m. Mr. Reese stated in between meal snacks are made available to residents. The facility has a bistro, small kitchenette, that both residents and staff have access to. A resident can request a snack at any time.

On 07/17/2024, 07/30/2024, and 08/06/2024 I observed the facility bistro with fruit and juice visible to the residents sitting adjacent to the area. I observed snacks in the main facility kitchen as well, which residents can make requests to have access to them.

On 08/06/2024, I interviewed staff 1, 2, and 3. Staff 1 and 3 reported that residents are served snacks as requested. Staff 3 stated she supplies residents with snacks when she observes them to be agitated, she offers them a choice of snacks and stated it helps them to calm down. Staff 2 reported that she had requested a supply of snacks for the residents approximately 4 months ago and her request was not granted during her shift. Staff 2 stated she was unable to say when the snacks arrived in the building after her request was made but has noticed they have been present in the facility bistro recently.

APPLICABLE RU	LE
R 400.15313	Resident nutrition.
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based upon my investigation which consisted of interviews with Josh Reese, staff, and observations I find there is no evidence to substantiate the allegation that residents are not given snacks between meals. Therefore, the Chatherine Reese provides a minimum of 3 regular, nutritious meals daily and not more than 14 hours shall elapse between the evening and morning meals.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Residents are not showered.

INVESTIGATION: On 07/17/2024 and 07/30/2024, I completed onsite inspections. I observed residents throughout the facility, some in their bedrooms and some in common areas. All residents were observed to be dressed appropriately, lounging comfortably, showing no signs of discomfort or distress. There was no odor of urine or feces present during my inspections.

On 07/17/2024, Josh Reese stated that residents are showered at least every two days or as needed. Mr. Reese stated he had not received reports that residents were not showered.

On 07/22/2024, I conducted separate interviews with Relatives A1 and C1. Both stated they had no issues or concerns with the care staff members provide to Residents A and C. Both stated that during visits with Residents A and C both have observed to be clean and dressed appropriately. As of 08/12/2024, I have received no contact from Relative B1.

On 08/06/2024, I completed interviews with staff 1, 2, and 3. Staff 1 and 3 reported that residents have shower days and are showered on a regular basis. Staff 3 reported that at times residents refuse to shower on their assigned day, she addresses this issue by giving the residents time, asking them to shower later, and stated they will usually comply with her request. Staff 2 reported there are times that residents are not showered on their assigned days but stated all residents are showered two to three times per week. Staff 2 stated if a resident refuses to shower she will make certain she "washes them up," until they are showered.

APPLICABLE RULE	
R 400.15314	Resident hygiene.
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with Josh Reese, staff, relatives, and onsite inspections, I found no evidence to substantiate the allegations that residents are not showered. Therefore, the licensee affords the residents opportunities, and instructions for daily bathing and oral and personal hygiene. Chatherine Reese ensures that the residents are bathed at least weekly.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- Residents are served molded food.
- Facility juice machine is not cleaned Residents are served old juice.
- Meals are transported from the main kitchen in staff members personal vehicles.

INVESTIGATION: On 07/17/2024 and 07/30/2024, I inspected the facility kitchen where food and the juice machine are located. I assessed the facility refrigerator, freezer, juice machine and observed meal preparation for lunch. The refrigerator and freezer appeared to be in working order, displaying the correct temperature. The food held in the refrigerator and freezer were placed in correct containers with dates written on labels. I observed dry goods and assessed that flour, corn starch, powdered sugar, etc. were kept in airtight containers. I observed no molded food in the kitchen. I observed the meal preparation completed by staff to be appropriate.

I observed the facility juice machine to be clean and in working order. The juice dispensed from the machine was appropriate for human consumption.

On 07/17/2024, Josh Reese reported that he has a contract with Gordan Food Supply Company, and they provide the juice machine and fruit juice. Mr. Reese stated that the juice machine is cleaned daily and was recently replaced last month for an updated model. Mr. Reese stated he has not received any reports residents are old juice.

Mr. Reese also reported that food is cooked in the main kitchen and transported to the different facilities using the Cambo, meal transfer cart system. On 07/17/2024, I

observed staff transport lunch using the transfer cart system, Cambo. The system allowed for pans of food to be transported in a portable wheeled temperature-controlled container. Once the food was delivered into the facility the pans of food was transferred to a warming station and served to residents.

On 08/06/2024, Staff 1 reported that meals are transported to the facility using the cart system. Staff 2 and 3 reported that they had observed meals being transported in personal staff vehicles during the winter season. Both reported that a high amount of snow had fallen, and the cart was unable to be pushed in the snow. Neither could state if a supervisor, or Mr. Reese had been made aware that the cart system was unable to be used due to snow fall.

On 08/09/2024, I completed an interview with licensee designee, Catherine Reese. Ms. Reese reported that when the Cambo, meal transfer cart system is unable to be used, staff will transport pans of food using a portable cart system made by the Cambo company as well. The system consists of cubes, of dense plastic material, with storage for at least 4 pans of food, and a handle on top. Ms. Reese stated this system allows staff to safely transport food in an acceptable manner when weather does not permit the rolling cart system to be used. Ms. Reese provided pictures of the portable Cambo cart system.

Regarding residents being served molded food, on 07/17/2024 Mr. Reese stated there was an incident approximately a few weeks ago when residents were served breaded chicken. The chicken was fresh, the bread covering was prepared, and the chicken fried appropriately. Once the chicken was served to residents a staff member noted dark particles on the chicken. Mr. Reese informed the staff member that once a protein/meat is fried in oil it is normal for the overall part of the chicken to be a brownish color with darker particles throughout the surface. Mr. Reese stated this is what the staff observed. Mr. Reese stated the residents consumed the chicken without incident. Mr. Reese reported that Alvinia London is lead staff in the facility kitchen.

On 07/17/2024, I reviewed Alvinia London's employee file. Ms. London has completed the required employee training in 2023. Ms. London also completed SerSafe Food Handler Course and Assessment on 11/16/2023.

On 08/06/2024, I interviewed staff 1, 2, and 3. All reported they had not observed residents being served molded food but heard rumors about an incident where residents were served molded chicken. All stated they had not observed residents nor received reports that residents got sick from consuming food served to them. All reported that residents are served fresh juice.

APPLICABLE RULE	
R 400.15402	Food service.
	(2) All food shall be protected from contamination while being stored, prepared, or served and during transportation to a facility.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with licensee designee, Catherine Reese, Josh Reese, staff, relatives, and onsite inspections, I found no evidence to substantiate the allegations that residents are served molded food, facility juice machine is not cleaned, residents are served old juice, and meals are transported in personal vehicles. Per my interview with Ms. Reese, meals are transported in staff vehicles using a portable cart system when weather does not allow for the full cart system to be used. Therefore, I find that all food is protected from contamination while being stored, prepared, and transported to the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Meals are served cold.

INVESTIGATION: On 07/17/2024, Mr. Resse reported that residents are served meals at the appropriate temperature.

On 07/17/2024, I observed staff prepare lunch, which consisted of Spaghetti, Garlic Bred, Salad, and a Roll. Staff prepared the meal using clean pots/pans and used personal protection supplies (gloves and smocks). I observed staff transport the meal using the transfer cart system, Cambo. The system allowed for pans of food to be transported in a portable wheeled temperature-controlled container. Once the food was delivered into the facility the pans of food was transferred to a warming station and served to residents. I observed the residents received their meal at the appropriate temperature.

On 08/06/2024, I interviewed staff 1, 2, and 3. All reported they had observed residents being served meals at the appropriate temperature.

APPLICABLE RULE		
R 400.15402	Food service.	
	(3) All perishable food shall be stored at temperatures that	
	will protect against spoilage. All potentially hazardous food	
	shall be kept at safe temperatures. This means that all cold	

	foods are to be kept cold, 40 degrees Fahrenheit or below, and that all hot foods are to be kept hot, 140 degrees Fahrenheit or above, except during periods that are necessary for preparation and service. Refrigerators and freezers shall be equipped with approved thermometers.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews staff, Josh Reese, and onsite inspections, I found no evidence to substantiate that meals are served cold to the residents. Meals are prepared in the main kitchen by staff and transported using the transfer cart system, Cambo. The system allowed for pans of food to be transported in a portable wheeled temperature-controlled container. Therefore, all perishable food is stored at temperatures that will protect against spoilage and potentially hazardous food is kept at safe temperatures.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Couches are placed in front of the main entrance door.

INVESTIGATION: On 07/17/2024, 07/30/2024, and 08/06/2024, I observed no couches in the front of the main entrance of Vibrant Life Senior Living, Superior #1. Mr. Reese stated he neither observed nor received reports that couches are placed in front of the main entrance door of Vibrant Life Senior Living, Superior #1.

Onn 08/06/2024, I interviewed staff 1, 2, and 3. Staff 1 reported they had never observed couches being placed in front of the main entrance door. Staff 2 and 3 reported they had observed couches being placed in front of the main entrance door as a way to deter a particular resident from leaving the facility. Staff 2 stated she had observed a couch blocking the main entrance two months ago, staff 3 could not remember the last time the couch was placed in front of the main entrance.

APPLICABLE RULE		
R 400.15403	Maintenance of premises.	
	·	
	(1) A home shall be constructed, arranged, and maintained	
	to provide adequately for the health, safety, and well-being	
	of occupants.	

ANALYSIS:	Based upon my investigation, which consisted of multiple interviews staff and onsite inspections, there is enough evidence to substantiate the allegation that couches are placed in front of the main entrance door. Two of the three staff interviewed stated they had observed couches being placed in front of the main entrance door as a way to deter a particular resident from leaving the facility. Therefore, the facility is not maintained in a way that provides adequately for the safety and well-being of occupants.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Facility bathrooms and common areas are not cleaned.

INVESTIGATION: On 07/17/2024, I inspected rooms 107, 108, and 111. All rooms were observed to be neat and orderly with residents' personal effects decorated throughout. I observed the same with resident bathrooms. I observed the common area to be neat, organized. No dirt or dirty items were observed. On 07/30/2024, I inspected rooms 101, 106, and 108 and observed the same as stated above.

On 07/26/2024, I received an email from Adult Protective Services Supervisor, Joy Clegg, stating, "A large brown paper bag with writing, "Reporting No food or snacks Vibrant-Life Senior Living 8100 Geddes," was left anonymously for her at the Ypsilanti Office. Ms. Clegg stated, "Inside the bag are quite a few color pictures with pills on the floor, dirty toilets, dirty shower, no food in a cupboard and barley anything in what appears to be a refrigerator."

I picked up and reviewed the pictures on 07/30/2024. There was no identifying information on the pictures, no date, no time, no room numbers. The pictures displayed the content listed in Ms. Clegg's statement above but there is no way for me to determine the validity/integrity of the pictures themselves.

On 07/30/2024, I completed an unannounced onsite inspection and observed the following: resident snacks consisted of fruit, peanut butter, crackers, granola, etc. They are kept in the main facility kitchen and transported to Vibrant Life Senior Living, Superior 1 throughout the day. I observed resident bedrooms and bathrooms to be clean. I observed no pills on the floors of resident bedrooms. I took pictures to document my observations.

On 08/06/2024, staff 1, 2, and 3 reported that resident bedrooms and common areas are clean.

APPLICABLE RULE		
R 400.15403	Maintenance of premises.	
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.	
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews staff and onsite inspections, I found no evidence to substantiate the allegations that facility bathrooms and common areas are not clean.	
CONCLUSION:	VIOLATION NOT ESTABLISHED	

On 08/09/2024, I completed an exit conference with licensee designee, Catherine Reese, and discussed my findings with her. Ms. Reese agreed with my findings and stated she would submit a corrective action plan to address the rule violation found

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan I recommend no change in the status of the license.

Vanen Beellein	
Vanita C. Bouldin	Date: 08/12/2024
Licensing Consultant	

Approved By:

Ardra Hunter Date: 08/14/2024

Area Manager