GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 31, 2024

Jennifer Hescott
Provision Living at West Bloomfield
5475 West Maple
West Bloomfield, MI 48322

RE: License #: AH630381200
Investigation #: 2025A1019005

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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the authorized representative and a date.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630381200
Investigation #:	2025A1019005
Complaint Receipt Date:	10/18/2024
Investigation Initiation Date:	10/22/2024
Report Due Date:	12/17/2024
Licensee Name:	PVL at West Bloomfield, LLC
Licensee Address:	1630 Des Peres Road, Suite 310 St. Louis, MO 63131
Licensee Telephone #:	(314) 238-3821
Administrator:	David Ferreri
Authorized Representative:	Jennifer Hescott
Name of Facility:	Provision Living at West Bloomfield
Facility Address:	5475 West Maple West Bloomfield, MI 48322
Facility Telephone #:	(248) 419-1089
Original Issuance Date:	03/27/2019
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	113
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident C received the wrong medications.	Yes
Additional Findings	No

III. METHODOLOGY

10/18/2024	Special Investigation Intake 2025A1019005
10/22/2024	Special Investigation Initiated - Face to Face
10/22/2024	Inspection Completed On-site
10/22/2024	Inspection Completed-BCAL Sub. Compliance
10/22/2024	APS Referral

ALLEGATION:

Resident C received the wrong medications.

INVESTIGATION:

On 10/18/24, the department received a complaint alleging that on 10/10/24 Resident C was given several medications that were not prescribed to him. The complaint alleged that facility staff failed to inform Resident C's physician that this occurred, and that Resident C was "affected negatively" by taking the wrong medications.

On 10/22/24, I conducted an onsite inspection. I interviewed administrator David Ferreri and Employee 1 at the facility. Mr. Ferreri and Employee 1 confirmed that Employee 2 massed the incorrect medications to Resident C on the evening of 10/10/24. Employee 1 reported that Employee 2 realized immediately following the administration of the medication to Resident C that they were for the wrong resident and that Employee 2 came to her to report the incident right away. Employee 1 reported that she notified Relative C of the medication error and monitored Resident C closely for adverse effects; Employee 1 denied any were observed except for some constipation, which Resident C has experienced in the past. Employee 1

reported that she notified the physician on 10/15/24 and left a message at their office but did not receive a call back.

Employee 1 reported that the medications given to Resident C in error are as follows:

- Aripiprazole 2mg
- Finasteride 5mg
- Melatonin 3mg

Employee 1 provided a copy of the incident report completed on the event. The incident report read:

> *Med tech notified DON of medication error. Resident was given the wrong medications. Family notified MD of error. Resident and family were notified of error. DON informed family of medications given and the usage. No contraindications were noted. No adverse reactions noted. DON monitored resident and assessed for changes and none noted. DON administered correct medication except melatonin 10mg.*

Employee 2 was not present during my onsite, but provided a statement that read, in part:

> *That Thursday night around 7:30pm, I was prepping the medication and mistakenly took another patients medication and gave to [Resident C]. It was wrong dose and incorrect medication. I mixed the cups and how I know is because when I went back to the med cart I seen [sic] [Resident C's] correct medication. After that I immediately notified [Employee 1], the Director of Nursing. She made sure he wasn't allergic to any of the medications. We went to inform the patient and family and monitored the patient closely to see if they were any side effects. The outcome so far is that he is constipated, he also had some constipation issues in the past. Other than that he is fine but is closely observed.*

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. **(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following:**

	(c) Contact the appropriate licensed health care professional when the prescribed medication has not been administered in accordance with the label instruction, an order from a health care professional, medication log, or a service plan.
ANALYSIS:	On 10/10/24, staff administered three medications to Resident C that were not prescribed to him. Resident C's physician was not notified by the licensee in a timely manner when he was administered the incorrect medication.
CONCLUSION:	**VIOLATION ESTABLISHED, REPEAT VIOLATION ESTABLISHED for R 325.1932 (2)**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes to the status of the license.

10/23/2024

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Elizabeth Gregory-Weil/ Date
Licensing Staff

Approved By:

10/30/2024

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