GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 19, 2025

Luke Pile
Arden Courts (Sterling Heights)
11095 14 Mile Rd
Sterling Heights, MI 48312

RE: License #: AH500293047
Investigation #: 2025A1019035

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 #:	AH500293047
Investigation #:	2025A1019035
Complaint Receipt Date:	02/10/2025
Investigation Initiation Date:	02/11/2025
Report Due Date:	04/12/2025
Licensee Name:	Arden Courts of Sterling Heights MI LLC
Licensee Address:	333 N. Summit St., 16th Floor Toledo, OH 43604
Licensee Telephone #:	(419) 252-5500
Administrator:	Grace Dezern
Authorized Representative:	Luke Pile
Name of Facility:	Arden Courts (Sterling Heights)
Facility Address:	11095 14 Mile Rd Sterling Heights, MI 48312
Facility Telephone #:	(586) 795-0998
Original Issuance Date:	06/09/2009
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	56
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive her medication as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/10/2025	Special Investigation Intake 2025A1019035
02/11/2025	Special Investigation Initiated - Letter Emailed administrator requesting documentation.
02/11/2025	APS Referral
02/13/2025	Inspection Completed On-site
02/13/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A did not receive her medication as prescribed.

INVESTIGATION:

On 2/10/25, the department received an anonymous complaint alleging that Resident A was not receiving her Wellbutrin as prescribed during January 2025.

On 2/13/2025, I conducted an onsite inspection. I interviewed administrator Grace Dezern and Employee 1 at the facility. The administrator and Employee 1 acknowledged that Resident A was not administered her Wellbutrin during the month of January 2025. The administrator and Employee 1 reported that Resident A moved into the facility on 12/10/24. Employee 1 reported that upon move in, Resident A's family brought medication to the facility to administer until refills were needed and confirmed that the Wellbutrin was provided to staff and administered through the month of December 2024. Employee 1 reported that staff never indicated that the medication had run out and a refill was not requested.

Employee 1 reported that on 1/23/25, Relative A requested a copy of Resident A's medication list to take with Resident A to a medical appointment and it was noticed that the Wellbutrin was not on the list. Employee 1 reported that at the time it was brought to her attention, she went to the medication cart and saw that Resident A had the medication onsite and assumed that it was being administered. Employee 1 reported that on 1/25/25, she realized that the Wellbutrin was not on Resident A's January 2025 medication administration record (MAR) and an internal investigation was conducted.

The administrator and Employee 1 reported that the facility utilizes a paper medication record system and when staff transposed her medications onto the January MAR, the Wellbutrin was inadvertently left off. The investigation determined that due to the medication not being included on the medication administration record, staff did not administer the Wellbutrin to Resident A for the entire month of January 2025.

While onsite, I obtained physician's orders from Resident A's move in, along with a copy of her medication administration records (MAR) for the duration of her tenure. I observed that upon move in on 12/10/24, Resident A was prescribed bupropion HCL (also known as Wellbutrin) 300mg. Per the MAR instruction, the medication is to be administered to her once daily. During the month of December 2024, staff documented on Resident A's MAR that the medication was administered to her from 12/11/24-12/31/24. During the month of January 2025, staff did not document any administration of the medication, and the Wellbutrin was not listed on the MAR. During the month of February 2025, staff documented on Resident A's MAR that the medication was administered to her from 2/1/25-2/13/25.

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:** **(b) Complete an individual medication log that contains all of the following information:** **(i) The name of the prescribed medication.** **(ii) The prescribed required dosage and the dosage that was administered.**

	(iii) Label instructions for use of the prescribed medication or any intervening order. **(iv) The time when the prescribed medication is to be administered and when the medication was administered.**
ANALYSIS:	Staff inadvertently did not include Resident A's Wellbutrin on her MAR during January 2025, resulting in staff not administering the medication to her for the entire month.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

Upon review of Resident A's medication administration records, the following observations were made:

- Resident A missed a dose of mesalamine on 12/19/24, 1/5/25 and 1/19/25
- Resident A missed a dose of C-1000 on 1/7/25
- Resident A missed a dose of pravastatin on 1/7/25, 1/14/25, 1/15/25 and 2/3/25
- Resident A missed a dose of escitalopram on 2/4/25
- Resident A missed a dose of lisinopril on 2/4/25

For the above-mentioned medication administrations, Resident A's MAR was left blank and there wasn't any supporting documentation to indicate why the medications were missed.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(b) Complete an individual medication log that contains all of the following information:** **(i) The name of the prescribed medication.** **(ii) The prescribed required dosage and the dosage that was administered.** **(iii) Label instructions for use of the prescribed medication or any intervening order.**

	(iv) The time when the prescribed medication is to be administered and when the medication was administered. **(v) The initials of the individual who administered the prescribed medication.** **(vi) A record if the resident refuses to accept prescribed medication and notification as required in subdivision (c) of this subrule.**
ANALYSIS:	Resident A's MAR was left blank for several doses of medication during the timeframe reviewed. The facility lacked documentation to indicate a reason for the missed med passes.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

02/18/2025

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

02/18/2025

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