GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 12, 2025

David Ferreri
Provision Living at West Bloomfield
5475 West Maple
West Bloomfield, MI 48322

RE: License #: AH630381200
Investigation #: 2025A1027041
Provision Living at West Bloomfield

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated by the authorized representative.

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.
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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630381200
Investigation #:	2025A1027041
Complaint Receipt Date:	03/28/2025
Investigation Initiation Date:	04/01/2025
Report Due Date:	05/27/2025
Licensee Name:	PVL at West Bloomfield, LLC
Licensee Address:	Suite 310 1630 Des Peres Road St. Louis, MO 63131
Licensee Telephone #:	(314) 238-3821
Authorized Representative/ Administrator:	David Ferreri
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?
Residents A and B lacked care consistent with their service plans, and had falls with injuries.	No
Resident B's medications were not administered as prescribed by the licensed healthcare provider.	Yes
The memory care unit was understaffed.	No
There was no shift supervisor on duty.	Yes
Staff were sleeping while on duty. Staff smelled of marijuana and administered medications.	No
Residents' A and B's records were not provided to their authorized representative.	No
Additional Findings	No

III. METHODOLOGY

03/28/2025	Special Investigation Intake 2025A1027041
04/01/2025	Special Investigation Initiated - Telephone Telephone interview conducted with complainant
04/02/2025	Inspection Completed On-site
04/03/2025	Contact - Document Received Received additional information and documentation from the complainant
04/07/2025	Contact - Document Sent Email sent to David Ferreri and Employee #1 requesting additional information
04/07/2025	Contact - Document Received Email received from Employee #1 with requested information and documentation
04/09/2025	Inspection Completed-BCAL Sub. Compliance
04/11/2025	Contact – Telephone Call Made Voicemail left with Resident B's former hospice nurse

04/16/2025	Contact – Telephone Call Received Interview conducted with Resident B's former hospice nurse
04/23/2025	Contact – Document Received Additional allegations were received
05/12/2025	Exit Conference Conducted by email with David Ferreri

ALLEGATION:

Residents A and B lacked care consistent with their service plans, and had falls with injuries.

INVESTIGATION:

On 3/28/2025, the Department received allegations regarding two incidents involving residents at the facility. The first allegation read that on 9/11/2024, Resident A fell out of his wheelchair, suffered a head injury, and ultimately died a month later. The second allegation, received on 3/31/2025, read that Resident B fell out of her bed because she was placed too close to the edge, and the fall mat was not in place. Resident B reportedly sustained injuries to her face and arms in the fall.

On 4/1/2025, I conducted a telephone interview with the complainant, whose statements were consistent with the allegations. The complainant explained that Resident A had received physical therapy services in July 2024, at which point he was walking and communicating clearly. The complainant stated that in July 2024, Resident A fell out of his wheelchair in the dining area. Additionally, she mentioned that Resident A had another fall on 8/20/2024 or 8/21/2024, around 2:40 AM, when Employee #1 informed her that Resident A had sat on the side of his bed and then slid to the floor. The complainant also stated that Resident A was hospitalized after his fall on 9/11/2024.

The complainant further stated that Resident B was under hospice care and had developed a blister on her foot, which was not reported to the hospice team until it had burst on 11/2/2024. The complainant mentioned that on 11/8/2024, Resident A’s call pendant malfunctioned, was removed, but not replaced immediately. The complainant added that Resident B was immobile and unable to move on her own. On 12/7/2024, staff reportedly placed Resident B too close to the edge of the bed, causing her to fall and sustain a cut to her eye that required steri-strips, along with injuries to her arms.

On 4/2/2025, I conducted an on-site inspection and interviewed staff.

Employee #1 confirmed that Resident A had a history of falls prior to moving into the facility. Employee #1 also stated that Resident A had been enrolled in hospice services and passed away on 10/15/2024. Regarding Resident B, Employee #1 confirmed that she passed away on 12/23/2024, and that Resident B had already been enrolled in hospice services when the blister developed. Employee #1 also mentioned that the hospice team conducted their own body assessments at their visits.

On 4/8/2025, I conducted a telephone interview with Employee #3, who confirmed that resident care was tailored to residents' service plan. She also stated that staff were required to complete an incident report whenever a resident was injured, or emergency services were called.

On 4/16/2025, I conducted a telephone interview with Resident B's former hospice nurse, who confirmed that Resident B had experienced a fall while at the home and expressed concerns that staff were not checking on her frequently.

A review of Resident A's face sheet revealed he moved into the home on 6/28/2024 and discharged on 10/15/2024. His service plan, dated 7/30/2024, indicated that he resided in memory care, was alert and oriented to self and time with some confusion, and required one-person assistance with activities of daily living. It noted that Resident A used a wheelchair, could self-propel over short distances, and required staff assistance for longer distances. The report also indicated that he had experienced several falls prior to arrival at the home.

Chart notes from admission to discharge were consistent with the allegations, and the service plan. For example, a note from 6/30/2024 indicated that Resident A was found on the floor in the common area, with no injuries, and the director of nursing, Resident A's daughter, and his physician were notified. A note from 8/11/2024 documented another fall where Resident A was found on the floor in the memory care common area next to his wheelchair, with no injuries, and vital signs were taken. The director of nursing, Resident A's daughter, and the nurse practitioner were notified. On 8/21/2024, Resident A fell again, this time on top of a pillow and entangled in sheets, but with no injuries, and similar notifications were made. A note from 9/11/2024 documented that Resident A fell to his right side in the dining room, resulting in a small tear on his elbow and head. Emergency services were contacted, and Resident A was taken to the hospital. An incident report from 9/11/2024 at 10:10 AM was consistent with the chart note, detailing that Resident A had fallen asleep in his wheelchair, then fell forward and to the side, hitting his head on the floor and sustaining a skin tear on his right temporal lobe and elbow. The report also noted that the director of nursing and Resident A's daughter were notified. Corrective measures read staff were to continue to monitor each resident frequently.

A review of Resident B's face sheet revealed she moved into the home on 6/28/2024. Her service plan, updated 9/25/2024, read she resided assisted living,

was "*alert and orientated x 3*," with periods of short-term memory loss. The plan indicated that she required two-person assistance for activities of daily living and was unable to bear weight, possibly due to a fear of falling. The plan noted Resident B required a Hoyer lift for transfers.

A progress note for Resident B dated 12/7/2024 at 3:44 AM recorded that Foresite alerted staff to her fall, during which she rolled out of her hospital bed and landed on her right side and face. She sustained a skin tear on her right elbow and bruising of her nose, and she expressed pain. Staff contacted Brighton Hospice to inform them of the fall and requested a nurse assessment, along with notifying her daughter. Emergency medical services were contacted for further assessment after receiving no response from the hospice agency, in which they dressed her wounds and confirmed that her nose was not broken. Two-hour wellness checks were initiated. An incident report from 12/7/2024 at 3:20 AM was consistent with the progress note, and corrective measures read staff were reminded to ensure that the fall mat was in place and that Resident B was positioned in the center of the bed.

A review of Resident B's pendant logs from 11/1/2024 to 11/30/2024 showed that the call pendant alarm activated once or more each day, except for 11/28/2024 and 11/30/2024.

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:	A review of records for Residents A and B found insufficient evidence to determine a lack of care. Staff attestations indicated that the home maintained incident reports for injuries, and both Residents A and B's files contained reports consistent with the allegations. These reports also outlined corrective measures to address or prevent recurrence which included ensuring the fall was in place. As a result, these allegations could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B's medications were not administered as prescribed by the licensed healthcare provider.

INVESTIGATION:

On 3/28/2025, the Department received allegations which alleged Resident B's comfort medications were not administered correctly and there were missed medications.

On 4/1/2025, I conducted a telephone interview with the complainant who stated on 11/11/2024, Resident B's Lasix was discontinued for an unknown reason. The complainant stated Resident B's comfort medications were not administered correctly in December 2024.

On 4/2/2025, I conducted an on-site inspection and interviewed staff.

Employee #1 stated Resident B received hospice services, and eventually she received medications every hour.

On 4/16/2025, I conducted a telephone interview with Resident B's former hospice nurse who stated Resident B had not received her medications as ordered and expressed concerns regarding her pain control at end of life.

Review of Resident B's November and December 2024 medication administration records (MARs) revealed she was prescribed:

Furosemide (Lasix), take one tablet by mouth once daily, started on 11/4/2024 and discontinued 11/14/2024, along with another order which started 11/12/2024 and discontinued 12/12/2024. The MAR read staff initialed Resident B's medication as administered once daily, including 11/12/2024, 11/13/2024, and 11/14/2024 for the overlap in orders. The MAR read staff documented the reason why the medication was not administered, such as on 11/16/2024, 11/25/2024 and 11/30/2024 when Resident B refused.

Furosemide (Lasix), take one tablet by mouth twice daily as needed for edema, started on 10/4/2024 and discontinued 11/5/2024. The MAR read no doses of the as needed medication were administered in November 2024.

Hydroxyzine, take on tablet by mouth at bedtime, started 8/6/2024 and discontinued 12/12/2024. The November 2024 MAR read staff initialed the medication as administered on 11/1/2024 through 11/3/2024; however, 11/4/2024 through 11/6/2024, 11/10/2024 through 11/15/2024, 11/17/2024, 11/18/2024, 11/20/2024 through 11/27/2024, and 11/29/2024, 11/30/2024 the medication was not administered due to being unavailable and waiting on the medication order. On all other days, the medication was initialed by staff as administered.

The December 2024 MAR read Resident B was prescribed Lorazepam, crush one tablet and administer every four hours starting 12/18/2024, and discontinued 12/23/2024 in which staff did not initial it as administered and it was left blank on 12/28/2024 at 2:00 AM, 12/21/2024 at 6:00 PM, and 12/22/2024 at 10:00 PM.

Additionally, she was prescribed Morphine every four hours in which a dose was left blank on 12/18/2024 at 2:00 AM, as well as prochlorperazine maleate, triamcinolone cream, ursodiol, in which doses were left blank on 12/2/2024 at 7:00 PM.

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.
ANALYSIS:	Review of the November and December 2024 medication administration records for Resident B revealed there were instances when medications were not administered as prescribed by the licensed healthcare professional including ensuring her prescription was available for administration, and not initialing the medication as administered. Thus, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The memory care unit was understaffed.

INVESTIGATION:

On 3/28/2025, the Department received allegations that the memory care unit was understaffed.

On 4/1/2025, I conducted a telephone interview with the complainant, who stated Resident B fell out of his wheelchair in September 2024 due to lack of supervision.

On 4/2/2025, I conducted an on-site inspection and interviewed staff.

Employee #1 explained that in September 2024, there were seven memory care residents, one of whom required a Hoyer lift and two-person assistance. She stated that staff worked 12-hour shifts from 6:45 AM to 7:00 PM and from 6:45 PM to 7:00 AM, with a 15-minute overlap between shifts for report handoff. Employee #1 also mentioned that some staff worked partial shifts in the morning and evening to provide additional assistance as needed. Employee #1 stated there were minimally two staff members assigned for each shift.

During my on-site inspection, I observed the memory care unit, where two staff members were working that day. I observed ten residents, all of whom appeared well-groomed and dressed in clean clothing.

On 4/8/2025, an interview with Employee #3 confirmed the statements made by Employee #1.

I reviewed the September 2024 staff schedule, which aligned with Employee #1's statements.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Staff testimonies were consistent with the staff schedule; therefore, this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There was no shift supervisor on duty.

INVESTIGATION:

On 3/28/2025, the Department received allegations that there was no shift supervisor on duty.

On 4/1/2025, I conducted a telephone interview with the complainant, who stated that the home lacked a shift supervisor on duty.

On 4/2/2025, I conducted an on-site inspection and interviewed staff.

Interviews with the authorized representative and administrator, David Ferreri, as well as Employee #1, confirmed that shift supervisors were assigned for each shift in On-Shift, the home's staff scheduling program.

Review of the On-Shift schedule from 9/8/2024 to 9/15/2024 revealed that multiple instances occurred where two or three shift supervisors were scheduled for each shift.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(3) The home shall designate 1 person on each shift to be supervisor of resident care during that shift. The supervisor of resident care shall be fully dressed, awake, and on the premises when on duty.
ANALYSIS:	Staff testimonies confirmed that shift supervisors were generally assigned; however, a review of records showed that more than one shift supervisor was scheduled for each shift. As a result, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff were sleeping while on duty. Staff smelled of marijuana and administered medications.

INVESTIGATION:

On 3/28/2025, the Department received allegations that staff were sleeping with blankets and heaters in the auditorium and memory care unit.

On 4/1/2025, I conducted a telephone interview with the complainant, who stated that on 12/19/2024, a medication technician smelled like marijuana while assigned to administer medications to Resident B. The complainant did not know the name of the medication technician. The complainant further stated that Employee #1 was notified about the situation and informed the complainant that there was no policy regarding odors or drug testing. The complainant also mentioned that the medication technician was reassigned to administer medications on the first floor.

On 4/2/2025, I conducted an on-site inspection and interviewed staff.

During an interview with the administrator and authorized representative, David Ferreri, he explained that any staff found sleeping on the job would be immediately terminated. He further stated that there had been two or three instances in the previous year when staff had been terminated for this reason. In the event of suspected drug abuse, the staff member would be sent for a drug test.

Employee #1 confirmed that on 12/19/2024, she was alerted by Resident A's family that Employee #2 on duty smelled like marijuana. Employee #1 stated that when she arrived at the home, she confirmed that Employee #2's jacket had a marijuana odor, but the smell was no longer present when the jacket was

removed. She noted that Employee #2's eyes appeared clear, and she was speaking appropriately. Employee #1 also stated that Employee #2 was reassigned to a different floor that night.

On 4/7/2025, email correspondence with Employee #1 revealed that Employee #2 was hired on 7/17/2024. Her workforce background check, dated 7/20/2024, indicated she was eligible for employment, and her file contained no records of any disciplinary action since her hire date.

A review of the employee handbook showed that it was consistent with the administrator's statements. The handbook outlined that if staff were found to be "*sleeping or inattentive*," the home required all staff to be alert while on duty and would not tolerate sleeping, malingering, or inattention. The handbook read that any employee who was caught sleeping while on duty would be separated from the position on the first offense.

Additionally, the handbook highlighted a zero-tolerance policy for drug and alcohol use. Employees are prohibited from coming to work while impaired, and the home may require drug testing if there is reasonable suspicion of a policy violation, if an employee suffers a reportable on-the-job injury, if an employee is involved in an accident, or as part of any random testing program the home may implement (for drugs only).

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	The home maintained an employee handbook and a drug and alcohol use policy, which staff attestations confirmed had been followed. A review of Employee #2's file showed that she was eligible for employment and had no records of disciplinary actions. Based on this information an organized program was maintained, and this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents' A and B's records were not provided to their authorized representative.

INVESTIGATION:

On 4/23/2025, additional allegations were received indicating that the complainant had been attempting to obtain medical records for Residents A and B since 3/31/2025. The home stated that all required documentation had been provided twice; however, this was disputed. A third request was currently under review.

On the same date, email correspondence with the administrator confirmed that authorization forms dated 4/1/2025, had been submitted for the records. It was also noted that the authorized representative picked up records for both residents on 4/16/2025. The email clarified that the authorization form allows the facility up to 30 days from the request date to fulfill the request.

The authorization form for Resident A requested all records, including video footage of a fall on 9/11/2024. The form for Resident B similarly requested all records related to their care.

A pick-up acknowledgment form dated 4/16/2025, at 3:45 PM, was signed by Relative A2.

On 4/28/2025, email correspondence from the home read that all requested documentation had been provided to the complainant.

APPLICABLE RULE	
333.20175	**Maintaining record for each patient; confidentiality; wrongfully altering or destroying records; noncompliance; fine; licensing and certification records as public records; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.**
	Sec. 20175. (1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization. If a medical service provided to a patient on or after the effective date of the amendatory act that added this sentence involves the vaginal or anal penetration of the patient, a health facility or agency shall ensure that the patient's medical record expressly states that vaginal or anal penetration was performed unless the medical service meets any of the circumstances described in

	subsection (2)(b)(i)(A), (B), (C), or (D). **(3) A health facility or agency shall maintain the records required under subsection (1) in such a manner as to protect their integrity, to ensure their confidentiality and proper use, and to ensure their accessibility and availability to each patient or the patient's authorized representative as required by law.** **(5) As used in this section:** **(a) "Medical record" or "record" means information, oral or recorded in any form or medium, that pertains to a patient's health care, medical history, diagnosis, prognosis, or medical condition and that is maintained by a licensee in the process of providing medical services.**
ANALYSIS:	Review of the records confirmed that the complainant had been provided with the medical records for Residents A and B; therefore, this allegation was unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of the email correspondence with the complainant and David Ferreri dated 4/17/2025, revealed provider notes concerning residents other than Residents A and B.

On 4/25/2025, communication with the home's Regional Vice President of Operations read that they had recent software system switch and records were inadvertently filed incorrectly. After identification of the issue, the home addressed the situation by ensuring that each page released would be reviewed for accuracy prior to releasing resident records.

APPLICABLE RULE	
333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**

	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: (c) A patient or resident is entitled to confidential treatment of personal and medical records, and may refuse their release to a person outside the health facility or agency except as required because of a transfer to another health care facility, as required by law or third party payment contract, or as permitted or required under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164.
ANALYSIS:	Review of records provided by the home revealed that medical records for residents other than Residents A and B were released to the complainant; however, the home immediately rectified the deficient practice.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

05/12/2025

_____

Jessica Rogers Date
Licensing Staff

Approved By:

05/12/2025

_____

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