GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 26, 2025

Northville Pointe Senior Living
40405 Six Mile Road
Northville, MI 48167

RE: License #: AH820236941
Investigation #: 2026A1027011
Northville Pointe Senior Living

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.

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 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 #:	AH820236941
Investigation #:	2026A1027011
Complaint Receipt Date:	11/21/2025
Investigation Initiation Date:	11/24/2025
Report Due Date:	01/20/2026
Licensee Name:	VOP Northville Pointe, LLC
Licensee Address:	Ste 200 500 N Hurstbourne Pkwy Louisville, KY 40222
Licensee Telephone #:	(734) 420-6104
Administrator:	Unknown
Licensee Designee:	Unknown
Name of Facility:	Northville Pointe Senior Living
Facility Address:	40405 Six Mile Road Northville, MI 48167
Facility Telephone #:	(734) 420-6104
Original Issuance Date:	10/10/1996
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	72
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The home lacked resident records.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/21/2025	Special Investigation Intake 2026A1027011
11/24/2025	Special Investigation Initiated - On Site
11/26/2025	Contact - Document Sent Email sent to Employee #4 requesting information
11/26/2025	Contact - Document Received Email received from Employee #4 with requesting information
11/26/2025	Contact - Document Sent Email sent to complainant requesting telephone call
11/26/2025	Contact - Telephone call received Interview conducted with complainant
11/26/2025	Contact - Document Sent Email sent to Employee #4 requesting additional information
11/26/2025	Contact - Telephone call made Telephone interview conducted with Employee #5
11/26/2025	Inspection Completed-BCAL Sub. Compliance
12/26/2025	Exit Conference Conducted by email with Kelli Davis, Mandy McCaulley, LaTasha Lee

ALLEGATION:

The home lacked resident records.

INVESTIGATION:

On November 21, 2025, the Department received allegations that emergency medical services (EMS) had been called to the facility seven times between November 1 and November 18, 2025, and that staff provided little or no resident information for transporting the resident to the hospital. The allegations specifically noted that on November 18, 2025, at approximately 8:00 p.m., EMS responded to transport a resident, but the on-duty staff could not access the facility's computer system to retrieve patient demographics, medication information, family contacts, or other essential data and were unable to reach a supervisor by phone. The complainant reported speaking with Employee #1 earlier that day, who assured them the issue had been corrected.

On November 24, 2025, I conducted an on-site inspection and interviewed staff.

Employee #2 stated the home had recently undergone a change of ownership and was in the process of transferring all resident files into a new electronic system called Alice. Employee #2 explained that staff had been trained to use documentation from the residents' physical files when needed and that the facility maintained an up-to-date resident register with face sheets containing each resident's key information, diagnoses, physicians, and emergency contacts. She further stated that medication administration records (MARs) could be printed from the new system and that all documentation from the previous licensee remained available and in use during the transition.

Employee #2 acknowledged that EMS had raised concerns with Employee #1 about difficulty locating records. She confirmed an incident on November 11, 2025, involving Resident A, during which staff could not immediately locate the resident's records (though the resident ultimately refused transport), but stated that on November 18, 2025, when EMS was called for Resident B, staff successfully provided all required records.

During the on-site visit, Employee #2 printed face sheets and Medication Administration Records (MARs) from the new Alice system for both Resident A and Resident B. These documents contained all required information except that Resident B's face sheet was missing the name and contact information for his primary medical provider. The resident census and register reviewed during the visit were accurate for 32 residents, with only two entries pending final updates.

On November 26, 2025, I conducted a telephone interview with the complainant, who reported that several instances when EMS requested resident records, either no documentation or only partial documentation was provided by facility staff. For example, a face sheet was provided for one resident, but it did not include the residents' emergency contact information. On November 18, 2025, staff informed EMS that they did not have access to the new computer system. Staff provided

copies of the resident's ID, insurance card, and medication list; however, no emergency contact information was included.

On November 26, 2025, I conducted a telephone interview with Employee #5, who reported that staff had been instructed to retrieve resident information from the physical hard charts when needed. However, not all required information was maintained in those charts, and gathering what was available took a considerable amount of time. Employee #5 further explained that staff were not yet trained or able to access and print the necessary documentation from the new Alice charting system. Employee #5 believed this contributed to the delays experienced during the third shift on November 18, 2025, when EMS responded to the facility.

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.**
For Reference:	**R 325.1942 Resident records.**

	(2) A home shall assure that a current resident record is maintained and that all entries are dated and signed. **(3) The resident record shall include at least all of the following:** **(a) Identifying information, including name, marital status, date of birth, and gender.** **(b) Name, address, and telephone number of next of kin or authorized representative, if any.** **(c) Name, address, and telephone number of person or agency responsible for the resident's maintenance and care in the home.** **(d) Date of admission.** **(e) Date of discharge, reason for discharge, and place to which resident was discharged, if known.** **(f) Health information, as required by MCL 333.20175(1), and other health information needed to meet the resident's service plan.** **(g) Name, address, and telephone number of resident's licensed health care professional.** **(h) The resident's service plan.** **(4) A home shall keep a resident's record in the home for at least 2 years after the date of a resident's discharge from the home.**
ANALYSIS:	Staff statements confirmed that, following the recent change of ownership, the facility implemented a new electronic charting system (Alice) that is still being updated and populated. In the interim, staff were directed to provide EMS with resident documentation from the physical hard charts; however, these hard charts did not contain all required information, resulting in incomplete records being provided to emergency responders. This account aligns fully with the complainant’s description of events. The facility lacked an organized and effective process to ensure complete and readily accessible resident records were available for EMS, and the alleged violation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site visit on November 24, 2025, Employee #2 reported that the former authorized representative and administrator, Princess Thompson, was no longer employed at the facility and stated that a new administrator was scheduled to begin work the following Monday. However, on November 25, 2025, the facility's licensing staff person confirmed by email that no notification of a change in the authorized representative or administrator had been submitted to the Department. Additionally, email correspondence with Employee #4 confirmed that Princess Thompson's last day of employment was October 27, 2025.

APPLICABLE RULE	
R 325.1913	**Licenses and permits; general provisions.**
	(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.
ANALYSIS:	The Department did not receive the required notification of the appointment of authorized representative and administrator changes in accordance with these regulatory requirements; therefore, a violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site review, the daily staffing schedule for November 18, 2025, was found to be largely illegible: only the handwritten names of staff were readable, while most typed information was not. Furthermore, although Employees #2 and #3 stated that the shift supervisor on that date was the first-floor medication technician, the schedule neither identified any staff member as the supervisor nor indicated who the medication technician was on duty.

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:	Based on the above information, the home was not incompliance with this rule and therefore, a violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/01/2025

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Jessica Rogers Date
Licensing Staff

Approved By:

12/26/2025

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