GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 2, 2022

Catherine Reese
Vibrant Life Senior Living Sterns Lodge
667 W. Sterns Road
Temperance, MI 48182

RE: License #: AH580353904
Investigation #: 2022A0784042
Vibrant Life Senior Living Sterns Lodge

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. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH580353904
Investigation #:	2022A0784042
Complaint Receipt Date:	04/04/2022
Investigation Initiation Date:	04/12/2022
Report Due Date:	06/03/2022
Licensee Name:	Vibrant Life Senior Living OC Temperance, LLC
Licensee Address:	5720 Williams Lake Road Waterford, MI 48329
Licensee Telephone #:	(734) 847-3217
Administrator:	Rebecca Molina
Authorized Representative:	Catherine Reese
Name of Facility:	Vibrant Life Senior Living Sterns Lodge
Facility Address:	667 W. Sterns Road Temperance, MI 48182
Facility Telephone #:	(734) 847-3217
Original Issuance Date:	02/20/2014
License Status:	REGULAR
Effective Date:	02/20/2022
Expiration Date:	02/19/2023
Capacity:	46
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident was not administered prescribed medications	Yes
Additional Findings	No

III. METHODOLOGY

04/04/2022	Special Investigation Intake 2022A0784042
04/12/2022	Special Investigation Initiated - On Site
04/12/2022	Inspection Completed On-site
04/25/2022	Exit Conference Conducted with authorized representative Catherine Reese

ALLEGATION:

Resident was not administered prescribed medications

INVESTIGATION:

On 4/04/2022, the department received this online complaint.

According to the complaint, Resident A was prescribed antibiotic after discharge from the hospital on 3/21/2022 but the facility did not start to administer the medication until 3/24/2022.

On 4/12/2022, I interviewed administrator Rebecca Molina at the facility. Ms. Molina stated she was aware Resident A had a delay in receiving her antibiotic medication after having returned from the hospital. Ms. Molina stated she was not familiar with all the details, but stated it was her understanding that there was an issue with the pharmacy. Ms. Molina stated assistant wellness director Juann Adams would be more familiar with the details.

On 4/12/2022, I interviewed assistant wellness director Juann Adams at the facility. Ms. Adams stated Resident A went to the hospital on or about 3/18/2022 and returned to the facility on 3/22/2022 with a new order for an antibiotic. Ms. Adams explained that the pharmacy used by the facility, *Hometown Pharmacy*, has access to the computer system the facility uses to track and maintain resident medication

administration records (MAR). Ms. Adams stated that when the pharmacy receives a new order, they enter the order into the MAR and once the physical medication is received at the facility, staff can administer the medication. Ms. Adams stated that as a part of her responsibilities, she conducts random audits on the medication carts (med cart) used to maintain resident medications. Ms. Adams stated that on 3/24/2022, she conducted a med cart audit which revealed Resident A had been prescribed an antibiotic which staff had been noting was not in the cart. Ms. Adams stated that upon investigating she found that the original order received by the facility for Resident A was for a liquid antibiotic and that the medication the facility had in the med cart, picked up and brought to the facility by family, was a pill and not a liquid. Ms. Adams stated that because staff had been looking for a liquid medication based on the order, they did not notice the pill and noted the medication was not in the cart. Ms. Adams stated that when a medication is not in the cart, staff are supposed to notify supervision so they are aware, and something can be done to obtain the medication. Ms. Adams stated that instead of notifying her, staff just noted that the medication was not in the cart. Ms. Adams stated that when she discovered the issue with the medication, she contacted the pharmacy, on 3/24/2022, and left a message notifying them that the order needed to be changed and noted in the MAR to reflect the available medication in the pill form. Ms. Adams stated the pharmacy did not make the change until 3/26/2022, at which time she stated staff began to administer the pill form of the antibiotic. Ms. Adams stated she did not try to contact the pharmacy again after leaving a message on 3/24/2022. Ms. Adams stated that if staff would have followed facility protocol, supervision would have been notified the first time the medication was noted as not being in the cart and the situation could have been addressed quicker.

I reviewed physician orders for Resident A, provided by Ms. Molina, which were consistent with statements provided by Ms. Adams.

I reviewed Resident A’s medication administration record (MAR), provided by Ms. Molina. The MAR read consistently with statements provided by Ms. Adams. Notables are staff coding entries for 3/22/2022 to 3/26/2022 for the medication read “not in cart”.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
For Reference: R 325.1901	**Definitions**
	(14) "Medication management" means assistance with the administration of a resident's medication as prescribed by a licensed health care professional.

ANALYSIS:	The complaint alleged Resident A was prescribed an antibiotic medication which was not administered from 3/21/2022 to 3/24/2022. The investigation revealed Resident A was prescribed a new antibiotic medication on 3/22/2022 which staff did not begin to administer until 3/26/2022. While evidence indicates the facility received an order which did not match the medication brought to the facility, staff also did not report the discrepancy to supervision, as the assistant wellness director reported should have been done, leading to Resident A going without her necessary medication for several days. Based on the findings the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

Aaron L Clum 4/25/2022

Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 05/02/2022

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