GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 17, 2022

Sharon Cuddington
Trinity Continuing Care Services
Suite 200
17410 College Parkway
Livonia, MI 48152

RE: License #: AL810261123
Investigation #: 2022A0122026
St. Joseph's Village #2

Dear Ms. Cuddington:

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. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9720.

Sincerely,

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL810261123
Investigation #:	2022A0122026
Complaint Receipt Date:	05/10/2022
Investigation Initiation Date:	05/11/2022
Report Due Date:	07/09/2022
Licensee Name:	Trinity Continuing Care Services
Licensee Address:	Suite 200 17410 College Parkway Livonia, MI 48152
Licensee Telephone #:	(301) 557-1401
Administrator:	Sue Johnson
Licensee Designee:	Sharon Cuddington
Name of Facility:	St. Joseph's Village #2
Facility Address:	2nd Floor 5341 McAuley Dr. Ypsilanti, MI 48197
Facility Telephone #:	(734) 712-1600
Original Issuance Date:	03/31/2005
License **Status:**	REGULAR
Effective Date:	10/10/2021
Expiration Date:	10/09/2023
Capacity:	19
Program Type:	PHYSICALLY HANDICAPPED

	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive her medications as prescribed.	Yes

III. METHODOLOGY

05/10/2022	Special Investigation Intake 2022A0122026 APS Referral
05/11/2022	Special Investigation Initiated - On Site Completed interview with Resident A, Tori Dober, Pending Administrator, and Tabitha Green, Nurse. Reviewed Resident A's medications and medications administration sheets.
05/11/2022	Contact – Telephone call made Completed interview with Relative A.
05/12/2022	Exit Conference Discussed findings with Sharon Cuddington, Licensee Designee.

ALLEGATION: Resident A did not receive her medications as prescribed.

INVESTIGATION: On 05/11/2022, I completed an interview with Resident A. Resident A stated in April 2022 she did not receive her pain medications as prescribed as the actual medication was not onsite and a new prescription was needed from her physician. Resident A stated currently she receives all medications as prescribed, and she is feeling fine. Resident A stated she has no issues and/or concerns with the care she is receiving from staff members of St. Joseph's Village #2.

On 05/11/2022, I completed interviews with Tori Dober, Pending Administrator, and Tabitha Green, Nurse for the facility. Both Mr. Dober and Ms. Green admitted that in April 2022 Resident A did not receive the pain medication, Gabapentin, as prescribed. Ms. Green stated that Resident A was admitted in late March 2022 and in April 2022 the prescription for the medication, Gabapentin, ran out and therefore it was not administered as prescribed.

Per Ms. Green, she contacted the physician that prescribed the medication, and it took several days before a representative from his office contacted the pharmacy to renew the prescription.

On 05/11/2022, I reviewed Resident A's Medication Administration Records dated April 2022 which documents that Resident A did not receive "Gabapentin 300mg 1 capsule by mouth every 8 hours" due to the "medication not being available" from the period of 04/03/2022 through 04/11/2022.

On 05/11/2022, I completed an interview with Relative A. Relative A confirmed that Resident A did not receive her pain medication, Gabapentin, as prescribed due to the medication not being available to administer. He also confirmed that Nurse, Tabitha Green, worked with physician representative to get the new prescription to the pharmacy. Relative A also stated that he has worked with Mr. Dober to discuss when he would like to be contacted regarding issues with Resident A. Relative A reported that Resident A is doing well, and he currently has no issues and/or concerns with the care she is currently receiving.

On 05//2022, I completed an exit conference with Sharon Cuddington, Licensee Designee. Ms. Cuddington stated she understood and agreed with my findings. Ms. Cuddington stated she would submit a corrective action plan to address the rule violation found in this investigation.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	Resident A did not receive the medication, Gabapentin 300mg 1 capsule by mouth every 8 hours" due to the "medication not being available" from the period of 04/03/2022 through 04/11/2022 according to her Medication Administration Records dated April 2022. On 05/11/2022, Resident A, Relative A, Nurse, Tabitha Green, and Pending Administrator, Tori Dober admitted that Resident A did not receive her pain medication, Gabapentin, as prescribed. Based upon my investigation I find there is evidence to support the allegation that Resident A did not receive prescription medication as prescribed by a licensed physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt and approval of a corrective action plan I recommend no change to the status of the license.

Vanita C. Bouldin
Licensing Consultant
Date: 05/12/2022

Approved By:

Ardra Hunter
Area Manager
Date: 05/17/2022