GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 4, 2022

Timothy Reardon
Novi Lakes Health Campus
41795 Twelve Mile Road
Novi, MI 48377

RE: License #: AH630362954
Novi Lakes Health Campus

Dear Mr. Reardon:

Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. If you fail to submit an acceptable corrective action plan, disciplinary action will result. 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 dates 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 home for the aged 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 feel free to 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
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AH630362954
Licensee Name:	Trilogy Healthcare of Oakland II, LLC
Licensee Address:	Suite 200 303 N. Hurstbourne Pkwy. Louisville, KY 40222-5158
Licensee Telephone #:	(502) 412-5847
Authorized Representative and Administrator:	Timothy Reardon
Name of Facility:	Novi Lakes Health Campus
Facility Address:	41795 Twelve Mile Road Novi, MI 48377
Facility Telephone #:	(248) 449-1655
Original Issuance Date:	08/12/2016
Capacity:	38
Program Type:	AGED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 07/28/2022

Date of Bureau of Fire Services Inspection if applicable: 12/21/2021

Inspection Type: ☐ Interview and Observation ☒ Worksheet ☐ Combination

Date of Exit Conference: 08/04/2022

No. of staff interviewed and/or observed 17
No. of residents interviewed and/or observed 21
No. of others interviewed 0 Role

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.

- Medication(s) and medication records(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☒ No ☐ If no, explain.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.

- Fire drills reviewed? Yes ☐ No ☒ If no, explain.
  The Bureau of Fire Services is responsible for reviewing fire drills, however facility disaster planning procedures were reviewed.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.

- Incident report follow-up? Yes ☐ IR date/s: N/A ☒
- Corrective action plan compliance verified? Yes ☒ CAP date/s and rule/s: Reviewed past CAP for 1/23/20 renewal inspection. THe CAP reviewed was dated 2/17/20. Rules 325.1921 (1) (b), 325.9131 (2) and 325.1979 (1) were reviewed. Compliance has not been maintained with all, some repeat violations have occurred.
- Number of excluded employees followed up? N/A ☒

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following rules:	
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.**
At the time of my on-site inspection, I observed that eleven residents (Residents A, B, C, D, E, F, G, H, I, J and K) had assistive devices affixed to their bed frames in the form of bed rails, assist bar or halo ring. Many of the devices were loose and contained gapping large enough to pose risk of entrapment. Residents A and B were the only residents that had a physician's order for their device. **REPEAT VIOLATION ESTABLISHED**	
R 325.1922	**Admission and retention of residents.**
	(2) The admission policy shall specify all of the following: **(d) That the home has developed and implemented a communicable disease policy governing the assessment and baseline screening of residents.**
The facility did not provide a communicable disease policy addressing the assessment and screening of residents for communicable diseases.	
R 325.1922	**Admission and retention of residents.**
	(7) An individual admitted to residence in the home shall have evidence of tuberculosis screening on record in the home which consists of an intradermal skin test, chest x-ray, or other methods recommended by the local health authority performed within 12 months before admission.

Resident C was allowed to move into the facility without a TB screen completed within the previous twelve months. Resident C was admitted to the facility on 3/4/22 and his TB screen was not completed until 3/23/22. Resident D was admitted to the facility on 3/30/20 and his TB screen was not completed until 8/5/21. Resident E was admitted to the facility on 8/19/21 and her TB screen wasn't completed until 8/20/21. Resident F was admitted to the facility on 2/28/20 and his TB screen was not completed until 8/5/21. Resident L was admitted to the facility on 9/3/19 and her TB screen was not completed until 9/11/19.

R 325.1923	**Employee's health.**
	(1) A person on duty in the home shall be in good health. The home shall develop and implement a communicable disease policy governing the assessment and baseline screening of employees.

The facility did not provide a communicable disease policy addressing the assessment and screening of employees for communicable diseases.

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.

As previously mentioned, eleven residents were observed to have assistive devices affixed to their bedframes. Review of resident service plans revealed that all plans were void of any information pertaining the devices and lacked instruction to staff on the monitoring of the residents while the devices are in use.

REPEAT VIOLATION ESTABLISHED

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.

Facility schedules were reviewed for the month of July 2022. The schedules did not specifically identify who the supervisor of resident care during each shift.

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.

Medication administration records (MAR) were reviewed for Residents C, D, E, F, L, M and N for June and July 2022 and the following observations were made. Staff documented that Resident E missed one or more doses of scheduled medication on 7/6/22, 7/18/22 and 7/24/22. The reason for the missed doses was documented as “not administered: due to condition”. There was no additional information regarding the “condition” that prevented the medication to be administered therefore the rationale could not be verified. Resident F missed one or more scheduled doses of medication on 7/22/22 and staff documented the reason for the missed dose as “not administered: due to condition”. Additional information regarding the “condition” that prevented the medication to be administered was not provided, therefore the rationale could not be verified. Resident F also missed one or more doses of the medication Magnesium oxide on 7/15/22, 7/16/22, 7/23/22 and 7/26/22. Staff documented the reason for the missed doses as “not administered: drug/item unavailable” despite also documenting that the medication had been administered in between dates and/or shifts that it was marked as unavailable. This is likely the result of a documentation error. Resident L missed seven doses of scheduled Xanax from 7/12/22-7/15/22. Staff documented the reason for the missed doses as “not administered: drug/item unavailable” despite also documenting that the medication had been administered in between dates and/or shifts that it was marked as unavailable and is likely, in part, due to a documentation error. Employee A stated that medications are reordered several days prior to running out and confirmed that their contracted pharmacy makes deliveries to the facility daily. Resident M missed thirteen doses of scheduled Ranolazine from 6/26/22-7/8/22. Staff documented the reason for the missed doses as “not administered: drug/item unavailable” despite also documenting that the medication had been administered in between dates and/or shifts that it was marked as unavailable and is likely, in part, due to a documentation error. Resident M missed one or more doses of scheduled Simethicone on 7/7/22, 7/8/22, 7/10/22, 7/11/22, 7/26/22 and 7/27/22. Staff documented the reason for the missed doses as “not administered: drug/item unavailable” despite also documenting that the medication had been administered in between dates and/or shifts that it was marked as unavailable and is likely, in part, due to a documentation error. Resident N missed one or more scheduled doses of cholestyramine on 7/13/22, 7/18/22 and 7/19/22. Staff documented the reason for the missed doses as “not administered: other”. I was unable to confirm a valid reason for the missed medication administrations based on staff’s explanation.

Resident M missed scheduled doses of Rybelsus on 7/9/22, 7/10/22, 7/11/22 and 7/24/22. Staff documented the reason for the missed doses as “not administered: drug/item unavailable”. It is not clear why the medication was not onsite to be administered if proper medication protocol was followed. While onsite, I observed Employee B completing a medication pass on Resident M. I observed Employee B remove the medication cards out of the med cart, pop the medications out of their blister packs and put the individual pills in two separate medication cups. Employee B proceeded to take both cups containing the medication into Resident M’s room and set them on a table alongside of where the resident was seated. After engaging in a brief dialogue, Employee B walked out of the room without witnessing or confirming that the resident took the medications as prescribed.	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**

For the timeframe reviewed, I observed that each resident MAR reviewed showed habitual practices of staff not documenting the medication pass at the time medications are administered. For example, staff repeatedly would cite “charted late”, with some staff charting the med pass on a different shift from when it occurred noting “given on previous shift”. For Resident C, this occurred for one or more medications on the following dates: 6/2/22, 6/4/22, 6/5/22, 6/6/22, 6/9/22, 6/11/22, 6/16/22, 6/17/22, 6/21/22, 6/23/22, 6/28/22, 6/29/22, 7/1/22, 7/5/22, 7/9/22, 7/12/22, 7/21/22, 7/22/22, 7/23/22, 7/24/22, 7/25/22, 7/26/22, 7/27/22 and 7/28/22. For Resident D, this occurred for one or more medications on the following dates: 6/2/22, 6/4/22, 6/5/22, 6/7/22, 6/8/22, 6/9/22, 6/11/22, 6/13/22, 6/16/22, 6/21/22, 6/28/22, 6/29/22, 7/5/22, 7/9/22, 7/12/22, 7/14/22, 7/17/22 and 7/23/22. For Resident E, this occurred for one or more medications on the following dates: 6/1/22, 6/2/22, 6/4/22, 6/5/22, 6/6/22, 6/9/22, 6/11/22, 6/14/22, 6/16/22, 6/17/22, 6/21/22, 6/28/22, 6/29/22, 7/5/22, 7/9/22, 7/11/22, 7/12/22, 7/20/22, 7/21/22, 7/23/22, 7/24/22, 7/25/22 and 7/26/22. For Resident F, this occurred for one or more medications on the following dates: 6/10/22, 6/11/22, 6/12/22, 6/13/22, 6/15/22, 6/16/22, 6/17/22, 6/18/22, 6/19/22, 6/20/22, 6/21/22, 6/22/22, 6/23/22, 6/24/22, 6/25/22, 6/26/22, 6/27/22, 6/28/22, 6/29/22, 6/30/22, 7/1/22, 7/2/22, 7/3/22, 7/4/22, 7/5/22, 7/6/22, 7/7/22, 7/8/22, 7/9/22, 7/10/22, 7/12/22, 7/13/22, 7/17/22, 7/15/22, 7/16/22, 7/17/22, 7/18/22, 7/19/22, 7/20/22, 7/21/22, 7/22/22, 7/23/22, 7/24/22, 7/25/22, 7/26/22 and 7/27/22. For Resident L, this occurred for one or more medications on the following dates: 6/1/22, 6/2/22, 6/3/22, 6/4/22, 6/6/22, 6/7/22, 6/8/22, 6/9/22, 6/11/22, 6/12/22, 6/13/22, 6/14/22, 6/15/22, 6/16/22, 6/17/22, 6/18/22, 6/20/22, 6/21/22, 6/25/22, 6/26/22, 6/28/22, 6/29/22, 6/30/22, 7/1/22, 7/3/22, 7/5/22, 7/7/22, 7/8/22, 7/9/22, 7/10/22, 7/11/22, 712/22, 7/14/22, 7/16/22, 7/17/22, 7/18/22, 7/19/22, 7/20/22, 7/22/22, 7/23/22, 7/24/22, 7/25/22, 7/26/22 and 7/28/22. For Resident M, this occurred for one or more medications on the following dates: 6/1/22, 6/2/22, 6/3/22, 6/4/22, 6/5/22, 6/6/22, 6/7/22, 6/8/22, 6/9/22, 6/10/22, 6/11/22, 6/12/22, 6/13/22, 6/14/22, 6/15/22, 6/16/22, 6/17/22, 6/18/22, 6/19/22, 6/25/22, 6/26/22, 6/27/22, 6/28/22, 6/29/22, 6/30/22, 7/1/22, 7/5/22, 7/6/22, 7/7/22, 7/9/22, 7/10/22, 7/11/22, 7/12/22, 7/13/22, 7/14/22, 7/17/22, 7/18/22, 7/20/22, 7/24/22, 7/22/22 and 7/28/22. For Resident N, this occurred for one or more medications on the following dates: 7/9/22, 7/12/22, 7/16/22, 7/17/22 and 7/23/22.

While observing Employee B complete a medication pass for Resident M around 12:00pm, I observed that Employee B had electronically documented that Resident B’s Gabapentin was administered to the resident at 8:44am on 7/28/22. When reviewing the narcotic log, the gabapentin was not documented as administered that morning, resulting in an inaccurate count. Employee B admitted that he had not documented that the medication was given in the narcotic log per facility protocol and stated he should have documented it when the medication was given and not later on in the day.

R 325.1953	**Menus.**

	(1) A home shall prepare and post the menu for regular and therapeutic or special diets for the current week. Changes shall be written on the planned menu to show the menu as actually served.
The facility did not post a menu for the week and only had the menu for the current day and the specials menu posted. Per Employee C, the facility operates on a five week rotating menu. The menu that I was given (that was not posted) for the current week contained dates that did not coincide with the week I was onsite. The menu read “Spring Summer Midwest 2019” with the dates Mar 28-Apr 3, May 02-May 08, Jun 06-June 12, Jul 11-Jul 17, Aug 15-Aug 21 and Sept 19-Sept 25.	
R 325.1972	**Solid wastes.**
	All garbage and rubbish shall be kept in leakproof, nonabsorbent containers. The containers shall be kept covered with tight-fitting lids and shall be removed from the home daily and from the premises at least weekly.
Several garbage containers located in the commercial kitchen and activities room did not contain lids.	
R 325.1973	**Heating.**
	(1) A home shall provide a safe heating system that is designed and maintained to provide a temperature of at least 72 degrees Fahrenheit measured at a level of 3 feet above the floor in rooms used by residents.
A thermostat located in the 400 resident hallway was set to 71 degrees Fahrenheit and the air temperature was also at 71 degrees.	
R 325.1976	**Kitchen and dietary.**
	(6) Food and drink used in the home shall be clean and wholesome and shall be manufactured, handled, stored, prepared, transported, and served so as to be safe for human consumption.

Perishable food items were observed in the walk in refrigerator and freezer that lacked proper labeling, dating or sealing. The items observed included various breads, frozen protein products (fish filets and hamburger patties), premade shredded chicken and produce. Several pieces of raw chicken was also observed uncovered on a shelving unit.	
R 325.1976	**Kitchen and dietary.**
	(8) A reliable thermometer shall be provided for each refrigerator and freezer.
A thermometer was missing from the refrigerator in resident room 409**.**	
R 325.1976	**Kitchen and dietary.**
	(13) A multi-use utensil used in food storage, preparation, transport, or serving shall be thoroughly cleaned and sanitized after each use and shall be handled and stored in a manner which will protect it from contamination.
According to Employee C, the facility uses a chemical sanitizing commercial dish machine to wash cookware, serve ware and utensils. Employee C stated that test strips should be used daily to ensure the chemicals used are at the levels needed to adequately clean the dishes. Employee C stated that the test strips results should be documented in a binder, however the binder did not contain those results and the facility could not provide evidence that this protocol was being followed.	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
A cabinet located underneath the sink in the 400 hallway was missing its handle. Additionally, there was a very strong odor of rotten food upon opening the refrigerator in resident room 410. I observed a brown, sticky residue covering the shelves that had started to harden and form a crust over some of the food items. Overall, the refrigerator was very cluttered and appeared to need cleaning and sanitizing.	

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan and receipt of your annual fee payment, renewal of the license is recommended.

08/04/2022

Elizabeth Gregory-Weil Date
Licensing Consultant