GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 12, 2022

Nirmal Kesavan
Orchard Grove Health Campus
71150 Orchard Crossing Ln
Romeo, MI 48065

RE: License #: AH500367787

Dear Mr. Kesavan:

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#:	AH500367787
Licensee Name:	Trilogy Healthcare of Romeo, LLC
Licensee Address:	#200 303 N. Hurstbourne Pkwy. Louisville, KY 40222
Licensee Telephone #:	(502) 412-5847
Authorized Representative and Administrator:	Nirmal Kesavan
Name of Facility:	Orchard Grove Health Campus
Facility Address:	71150 Orchard Crossing Ln Romeo, MI 48065
Facility Telephone #:	(586) 336-0102
Original Issuance Date:	01/05/2017
Capacity:	38
Program Type:	AGED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 08/10/2022

Date of Bureau of Fire Services Inspection if applicable: 09/15/2021

Inspection Type: ☐ Interview and Observation ☒ Worksheet ☐ Combination

Date of Exit Conference: 08/10/2022

No. of staff interviewed and/or observed 14
No. of residents interviewed and/or observed 17
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. Per authorized representative Nirmal Kesavan, no resident funds have been held by licensee in the past twelve months.
- 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: 8/2/2018 renewal LSR CAP, R 325.1913, R325.1921 (2) (b) and R 325.1922(5). Compliance was not maintained, repeat violations have occurred.
- Number of excluded employees followed up? 1 N/A ☐

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

<table>
<tr><td colspan="2">This facility was found to be in non-compliance with the following rules:</td></tr>
<tr><td>R 325.1921</td><td>Governing bodies, administrators, and supervisors.</td></tr>
<tr><td></td><td>(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.</td></tr>
<tr><td colspan="2">At the time of my on-site inspection, I observed that Resident A had a device on her bed commonly referred to as a “bed assist” that slid underneath the mattress. The device poses a serious risk of entrapment and was not affixed or secured to the bed frame.

REPEAT VIOLATION ESTABLISHED</td></tr>
<tr><td>R 325.1922</td><td>Admission and retention of residents.</td></tr>
<tr><td></td><td>(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.</td></tr>
<tr><td colspan="2">Residents A, B, C, D, E, and F had assistive devices on or about their bed. At the time of my inspection, none of the resident service plans were updated to include the devices or the instruction(s) for their use.

REPEAT VIOLATION ESTABLISHED</td></tr>
<tr><td>R 325.1923</td><td>Employee's health.</td></tr>
<tr><td></td><td>(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.</td></tr>
</table>

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.**
	(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 and they did not specifically identify the supervisor of resident care for 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 B, C, H, I, J and K from 7/1/22-8/10/22 (date of inspection). The following observations were made. Staff documented that Resident B received medications outside of the written parameters on 7/16/22, 7/20/22, 7/25/22, 7/26/22, 7/30/22, 7/31/22, 8/3/22, 8/4/22, 8/5/22 and 8/8/22. Resident B missed five doses of latanoprost from 7/16/22-7/20/22 due to it not being available. Resident B missed four doses of voltaren on 7/21/22, 7/22/22, 7/26/22 and 7/28/22. Staff documented the reason for the missed doses as “not administered: left by previous shift”. Staff documented that Resident C received medications outside of the written parameters on 7/6/22, 7/10/22, 7/13/22, 7/21/22, 7/25/22, 7/26/22, 7/28/22, 7/30/22 and 8/5/22. Resident C missed doses of isosorbide mononitrate and lisinopril on 7/21/22 and 7/26/22 and metformin on 7/15/22. Staff documented the reason for the missed doses as “not administered: due to condition” but did not indicate the condition for which the medication could not be given. Staff documented that Resident H received medications outside of the written parameters on 7/21/22, 7/23/22, 7/24/22, 7/26/22, 7/28/22, 7/29/22, 8/2/22, 8/5/22, 8/6/22, 8/7/22, 8/8/22 and 8/9/22. Staff documented that Resident I received medications outside of the written parameters on 7/27/22 and 7/28/22. Staff documented that Resident J received medications outside of the written parameters on 7/5/22, 7/9/22, 7/13/22, 7/23/22, 8/3/22 and 8/5/22. Resident J missed thirteen doses of gabapentin from 7/28/22-8/9/22 due to it not being available. The MAR gave no instruction to withhold the medication. Staff documented that Resident K received medications outside of the written parameters on 7/6/22 and 8/6/22. By giving medication outside the timeframe identified in the MAR, staff were not giving the medication pursuant their instructions.	

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 B, this occurred for one or more medications on the following dates: 7/8/22, 7/11/22, 7/12/22, 7/15/22, 7/17/22, 7/19/22, 7/20/22, 7/22/22, 7/23/22, 7/25/22, 7/27/22, 7/31/22, 8/1/22, 8/4/22, 8/5/22, 8/6/22, 8/9/22 and 8/10/22. For Resident C, this occurred for one or more medications on the following dates: 7/1/22, 7/2/22, 7/3/22, 7/4/22, 7/6/22, 7/7/22, 7/8/22, 7/9/22, 7/10/22, 7/11/22, 7/13/22, 7/14/22, 7/15/22, 7/20/22, 7/21/22, 7/22/22, 7/23/22, 7/24/22, 7/25/22, 7/26/22, 7/27/22, 7/28/22, 7/30/22, 7/31/22, 8/1/22, 8/3/22, 8/5/22, 8/6/22, 8/7/22, 8/9/22 and 8/10/22. For Resident H, this occurred for one or more medications on the following dates: 7/22/22, 7/25/22, 7/27/22. For Resident I, this occurred for one or more medications on the following dates: 7/3/22, 7/24/22 and 8/2/22. For Resident J, this occurred for one or more medications on the following dates: 7/2/22, 7/3/22, 7/7/22, 7/8/22, 7/11/22, 7/13/22, 7/14/22, 7/15/22, 7/17/22, 7/20/22, 7/22/22, 7/23/22, 7/28/22 and 8/10/22. For Resident K this occurred for one or more medications on the following dates: 7/3/22, 7/4/22, 7/7/22, 7/11/22, 7/13/22, 7/14/22, 7/17/22, 7/20/22, 7/22/22, 7/24/22, 7/27/22, 7/30/22, 8/2/22, 8/5/22, 8/6/22 and 8/8/22.

R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
The medication cart located in the 400 hallway was left unlocked, I was able to open all drawers and access medications for several residents; no staff was present near the cart or in the hallway during this time. I also observed medications for Residents A, G and L set on top of the medication cart, completely unsecured.	
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. A menu was located inside the commercial kitchen and that “Spring Summer Midwest 2019”. The menu lacked any dates that correlated to when the food was to be served.	
R 325.1964	**Interiors.**
	(9) Ventilation shall be provided throughout the facility in the following manner: **(a) A room shall be provided with a type and amount of ventilation that will control odors and contribute to the comfort of occupants.** **(b) Bathing rooms, beauty shops, toilet rooms, soiled linen rooms, janitor closets, and trash holding rooms shall be provided with a minimum of 10 air changes per hour of continuously operated exhaust ventilation that provide discernable air flow into each of these rooms.**

The continuous exhaust ventilation was not functioning properly in the 400 hallway soiled linen room and resident rooms 402, 407, 411 and 510.	
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.
Some perishable food items located in the walk in refrigerator and freezer lacked labeling or dating. The items in question had been removed from the manufacturer's packaging and the ages of the items could not be determined.	

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, renewal of the license is recommended.

08/12/2022

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Elizabeth Gregory-Weil Date
Licensing Consultant