



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

August 23, 2022

Allison Morrow  
Arden Courts (Livonia)  
32500 W. Seven Mile Rd.  
Livonia, MI 48152

RE: License #: AH820292968 Arden Courts (Livonia)  
Investigation #: 2022A1011001

Dear Ms. Morrow:

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 licensee 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 (517) 284-9730.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrea Krausmann".

Andrea Krausmann, Licensing Staff  
Bureau of Community and Health Systems  
611 W. Ottawa Street - P.O. Box 30664  
Lansing, MI 48909  
(586) 256-1632

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AH820292968
<b>Investigation #:</b>	2022A1011001
<b>Complaint Receipt Date:</b>	06/27/2022
<b>Investigation Initiation Date:</b>	06/28/2022
<b>Report Due Date:</b>	08/27/2022
<b>Licensee Name:</b>	Arden Courts of Livonia MI, LLC
<b>Licensee Address:</b>	32500 W. Seven Mile Rd. Livonia, MI 48152
<b>Licensee Telephone #:</b>	(419) 252-5500
<b>Administrator:</b>	Chanda Pantano
<b>Authorized Representative:</b>	Allison Morrow
<b>Name of Facility:</b>	Arden Courts (Livonia)
<b>Facility Address:</b>	32500 W. Seven Mile Rd. Livonia, MI 48152
<b>Facility Telephone #:</b>	(248) 426-7055
<b>Original Issuance Date:</b>	05/21/2009
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	05/20/2022
<b>Expiration Date:</b>	05/19/2023
<b>Capacity:</b>	60
<b>Program Type:</b>	AGED ALZHEIMERS

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Resident A's service plan has not been updated since 2019.	Yes
Resident A's service plan provides no information regarding the use of PRN, as needed, medication.	Yes
Resident A was given Ativan on 5/29/2022 for unknown reason.	Yes
Added to this complaint on 6/28/2022: Pills were found on Resident A's floor on 6/27/2022.	Yes
Added to this complaint on 7/28/2022: Pills were found on Resident A's floor on 7/5/2022.	Yes
Additional Findings	Yes

## III. METHODOLOGY

06/27/2022	Special Investigation Intake 2022A1011001
06/28/2022	Special Investigation Initiated - Telephone Left voice mail for complainant requesting return call for more information.
06/28/2022	Contact - Telephone call received Complainant returned my call. Interview conducted.
06/28/2022	APS Referral Sent to APS centralized intake via email.
06/28/2022	Contact - Telephone call received HFA licensing staff Aaron Clum forwarded a voice mail from the complainant of pills found on Resident A's floor on 6/27/22, but it was not reported to anyone in the facility.
07/11/2022	Contact - Document Received Letter dated 6/28/22 from adult protective services (APS) Complaint Coordinator adult services, no name listed, that APS denied investigation of my referral.

07/28/2022	Contact - Telephone call received Complainant left voice mail. Seroquel found on resident room floor on 7/5/22 matched medication found on 6/27/22.
08/01/2022	Contact - Telephone call made Returned call to complainant - unavailable. Left voice mail.
08/01/2022	Contact - Telephone call received Complainant called back - interview conducted.
08/09/2022	Inspection Completed On-site Interviews completed, observations made, records reviewed.
08/10/2022	Contact - Telephone call made Interviewed Staff #2 by telephone.
08/23/2022	Exit Conference – Conducted with authorized representative Allison Morrow via telephone.

**ALLEGATION:**

**Resident A’s service plan has not been updated since 2019.**

**INVESTIGATION:**

On 6/27/2022, home for the aged licensing staff, Aaron Clum, received a telephone call from the complainant reporting these allegations. Mr. Clum forwarded the allegations via email and on 6/28/2022, Mr. Clum forwarded the complaint’s voice mail.

On 6/28/2022, I interviewed the complainant by telephone and made a referral to adult protective services via email.

Arden Courts (Livonia) is a home for the aged designed to provide care to residents with memory deficits. The complainant explained that due to cognitive decline, Resident A would not be a reliable source of information.

On 8/9/2022, I went to the facility unannounced, and was told that neither authorized representative Allison Morrow nor administrator Chanda Pantano was on the premises. I interviewed Eugenia “Gena” Hickman, Resident Services Coordinator at the facility. Ms. Hickman requested Staff # 1 make a copy of Resident A’s service plan, from Resident A’s records that are available to the staff. The service plan appeared to be signed by administrator Chanda Pantano, and the signature was dated 1/27/2021.

When asked why the service plan was more than a year old, Ms. Hickman replied there had been a recent meeting with Resident A's authorized representative, Relative A1, and the service plan has been updated but not yet signed by the authorized representative.

Ms. Hickman then checked the computer system and printed a copy of a service plan for Resident A that was not signed nor dated by facility staff. Ms. Hickman said this is the most current service plan because various services listed "Target" dates of 6/17/2022. Ms. Hickman affirmed this service plan was not yet available to staff because Relative A1 had not yet "approved" this service plan nor signed it. This computerized plan included updates from the previous 1/27/2021 plan such as:

In the previous service plan, Resident A was independent with dressing. This updated service plan instructs staff to play music on *Alexa* if Resident A resists being dressed; Previously, Resident A requiring one person to assist with toileting to now Resident A can be resistant with toileting care and hit, kick, punch or bite, and wearing pull-ups; Previously, medication was administered by staff to now staff are to observe Resident A swallow her medications; occasionally known to spit medications out. As of 8/9/2022, revisions such as these updates were not yet made available to the staff that provide her care.

<b>APPLICABLE RULE</b>	
<b>R 325.1922</b>	<b>Admission and retention of residents.</b>
	<b>(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.</b>
<b>For reference: R 325.1901</b>	<b>Definitions.</b>
	<b>(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.</b>
<b>For reference: R 325.1942</b>	<b>Resident records.</b>
	<b>(2) A home shall assure that a current resident record is maintained and that all entries are dated and signed.</b>

<b>For reference: R 325.1942</b>	<b>Resident records.</b>
	<b>(3) The resident record shall include at least all of the following: (h) The resident's service plan.</b>
<b>ANALYSIS:</b>	Resident A's 1/27/21 service plan that Staff #1 presented, was the most current printed copy in the Resident A's record, signed and dated, and available to staff. It was more than a year old and did not contain relevant changes for her care.  The service plan Ms. Hickman printed from the computer was not signed and dated by staff, nor did it indicate that the changes were communicated to the resident and her authorized representative. As of 8/9/2022, the revised service plan was not available for implementation by staff.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**Resident A's service plan provides no information regarding the use of PRN, as needed, medication.**

**INVESTIGATION:**

Both, Resident A's 1/27/21 service plan and the service plan printed off the computer by Ms. Hickman, made no reference to the use of PRN, as needed, medication that Resident A is prescribed.

According to the medication administration records (MAR) presented by Staff #1, in May 2022, Resident A was prescribed Tylenol 325mg two tablets every four hours as needed, Lorazepam (Ativan) 0.5 mg tablet every four hours as needed, and Aspercreme Lidocain 4% cream apply topically to affected areas every eight hours as needed.

In June 2022, the order for these three medications continued until 6/23/2022, when the physician discontinued the Tylenol and Lorazepam orders. On 6/23/2022, Resident A was prescribed Quetiapine 25 mg. take ½ tablet every eight hours as needed, and Acetaminophen 500 mg one tablet three times a day as needed "pain/fever" written as the instructions on the MAR. Aspercreme Lidocain 4% cream was also continued.

Resident A's service plans made no reference to these medications nor provided staff with the circumstances that would indicate these medications were needed.

Resident A's 1/27/2021 service plan made generalized statements such as Resident will be supported to take/store medications safely and as ordered. Medication administered by certified medication technician under supervision of nurse.

The computerized service plan read, Will maintain lab values in therapeutic range. Observe for and report any significant changes in weight, appetite, sleeping pattern, stamina, etc. This computerized service plan also included, Will express that pain management is within acceptable limits. Observe body language, facial and verbal expression, for indications of pain. Observe for behavior, agitation, sleeplessness, swelling & bruising. But made no reference to Acetaminophen being available as needed for "pain/fever" nor Aspercreme Lidocain prescription which might be for pain as well, although not documented/specified in the physician's order.

<b>APPLICABLE RULE</b>	
<b>R 325.1932</b>	<b>Resident medications.</b>
	<b>(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.</b>
<b>ANALYSIS:</b>	Of the two service plans for Resident A, one dated 1/27/2021 in Resident A's record and the one Ms. Hickman printed from the computer, neither addressed the giving, taking, or applying the PRN, as needed, medications and the circumstances of which they would be administered.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**Resident A was given Ativan on 5/29/2022 for unknown reason.**

**INVESTIGATION:**

According to the complainant, staff administered Ativan to Resident A on 5/29/2022 for an unknown reason, and on the same day Resident A suffered a fall, possibly related to having taken the Ativan. Review of Resident A's May 2022 MAR revealed no Ativan administered on 5/29/2022.

However, the MAR did reveal staff initials and times written by staff indicating Ativan was administered on 5/11/2022 at 6 pm and on 5/21/2022 at 6 pm, but staff did not write the reason for administering the medication on either of these dates. Ms. Hickman said staff are expected to write the reason for administering PRN, as needed, medications on the backside of the MAR. The back of the MAR did not include this information.

The home also maintains an *Individual Resident Controlled Drug Record* for Resident A's, where staff document the number of tablets that are used each time they are administered. This maintains an ongoing account of the number of controlled medications available. Resident A's *Controlled Drug Record* revealed staff utilized one Ativan tablet on 5/11/22 at 8 pm, one tablet on 5/21/22 at 10 am, one tablet on 5/21/22 at 6 pm, one tablet on 5/?/2022 (digit of the exact day was scribbled and illegible) at 9 am. The accounting of the Ativan used did not correspond to the documentation on Resident A's MAR of the Ativan that was administered.

Of the four Ativan tablets utilized in May 2022 according to the *Controlled Drug Record*, only one dose corresponded specifically to staff initials on the MAR and that was the 5/21/2022 6pm dose.

The MAR also revealed documentation by staff on 5/11/22 that Ativan was administered at 6 pm, whereas the *Controlled Drug Record* indicated it was given at 8 pm that day. There are no staff initials on the MAR to confirm the administration of the Ativan to Resident A on 5/21/22 at 10 am nor the one tablet used on 5/?/2022 (digit of the exact day scribbled) at 9 am in accordance with the *Controlled Drug Record*. If they were not administered, it is unknown what purpose these Ativan tablets were utilized.

Ms. Hickman said staff are expected to initial the MAR each time a medication is administered but they may have forgotten to initial the MAR since they already documented using the tablets on the *Controlled Drug Record*.

In addition, the May 2022 MAR revealed staff initials indicating Resident A's Acetaminophen 325 mg. two tablets ordered as needed were administered on 5/3, 5/6, 5/13, 5/14, 5/15, 5/21, and 5/23/2022. However, there were no reasons recorded for administering this as needed medication on the backside of the MAR for these dates. On 5/22/2022, staff initialed the MAR for having administered the Acetaminophen and wrote the reason for administering on the back as, "on order". The order only instructs to administer as needed with no explanation of what would circumstances indicate this medication is needed.

<b>APPLICABLE RULE</b>	
<b>R 325.1932</b>	<b>Resident medications.</b>
	<p><b>(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></p> <p><b>(b) Complete an individual medication log that contains all of the following information:</b></p>

	<b>(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given.</b>
<b>ANALYSIS:</b>	According to Resident A's <i>Individual Resident Controlled Drug Record</i> staff utilized one Ativan tablet on 5/11/22 at 8 pm, one tablet on 5/21/22 at 10 am, one tablet on 5/?/2022 (digit of the exact day was scribbled and illegible) at 9 am. There are no corresponding staff initials on Resident A's MAR to account for the use of Ativan on these dates/times.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 325.1932</b>	<b>Resident medications.</b>
	<b>(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>  <b>(c) Record the reason for each administration of medication that is prescribed on an as-needed basis.</b>
<b>ANALYSIS:</b>	Resident A's May 2022 medication administration record revealed staff did not record the reason for administration of Ativan, that was ordered as needed, on 5/11/22 at 6 pm and 5/21/22 at 6 pm.  Staff also did not record the reason for administering Resident A's Acetaminophen, that was ordered as needed, on 5/3, 5/6, 5/13, 5/14, 5/15, 5/21, and 5/23/2022. On the back of Resident A's May 2022 MAR, staff documented the "reason" for administering Resident A's Acetaminophen on 5/22/2022 as "on order" rather than an actual reason for having administered.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

Added to this complaint on 6/28/2022:

**Pills were found on Resident A's floor on 6/27/2022.**

Added to this complaint on 7/28/2022:

**Pills were found on Resident A's floor on 7/5/2022.**

### **INVESTIGATION:**

On 6/28/2022, the complainant reported having discovered three pills and a red sparkly bead on Resident A's floor. The complainant did not report finding the items to anyone in the facility and removed the items from the room.

On 7/28/2022, in a voice mail message, and in a follow-up phone call on 8/1/2022, the complainant reported having again found three pills on Resident A's floor, one being a Seroquel pill, on 7/5/2022. The complainant said Resident A did not have an order for Seroquel until 7/8/2022, therefore, it was unknown how Resident A would have received the medication. The complainant said the medications appeared wet as though they had been spat out. The complainant agreed that it was possible that another resident in the memory care unit may have entered the room and spit the medications on Resident A's floor. The complainant notified Staff #2 when the medications were discovered on 7/5/2022, but the complainant did not believe Staff #2 informed Ms. Hickman, because Ms. Hickman seemed unaware of the incident when told in a recent meeting on 7/14/2022.

Review of Resident A's MAR revealed she was prescribed Quetiapine (brand name Seroquel) since 6/23/2022, and therefore, could have been Resident A's medication on the floor.

Ms. Hickman affirmed she was informed of the medications discovered on the floor on 7/5/2022 during the 7/14/2022 meeting. Ms. Hickman said Staff #2 did not notify her of the pills found on Resident A's floor, and it would have been expected that Staff #2 would notify her superiors of such an incident.

On 8/10/2022, I interviewed Staff #2 by telephone. Staff #2 affirmed having been told by Resident A's family member of the pills found on Resident A's floor on 7/5/2022. Staff #2 said she recognized them as being Resident A's evening pills, that she would have received the night before. Staff #2 said she did notify her superior, a nurse on duty at that time, but she could not remember which nurse, and said it may have been an agency nurse. Staff #2 explained that due to staffing shortages, the facility was using a number of agency nurse staff at that time, and an agency nurse might not have notified Ms. Hickman. Staff #2 could not remember the name of the nurse that she notified.

As noted previously, Staff #1 presented the 1/27/2021 service plan version as that being available to staff. That service plan did not address the incident of having found medications on Resident A's floor.

Resident A's service plan was updated since the 1/27/21 version but the new version has not been made available to staff that provide care. The updated service

plan in the computer has instructions for staff to observe Resident A “swallowing her medications; occasionally known to spit medications out in the past”, with an initiation date of 7/18/2022. As of 8/9/2022, Ms. Hickman confirmed the updated service plan is still in the computer and not yet available to staff.

<b>APPLICABLE RULE</b>	
<b>R 325.1932</b>	<b>Resident medications.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	<p>Medications were discovered on Resident A’s floor and reported to staff on 7/5/2022. Resident A’s service plan was updated on 7/18/2022, for staff to observe Resident A swallow her medications, but as of 8/9/2022, the updated service plan was not made available to staff to prevent this incident from recurring.</p> <p>Therefore, the home did not take reasonable precautions to ensure Resident A does not spit out her medications, which could then be used by another person in the memory care facility.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

Resident A’s June 2022 MAR listed PRN medications as follows:

Lorazepam (Ativan) 0.5 mg Take 1 tablet by mouth every 4 hours as needed.

Quetiapine (Seroquel) 25 mg Take ½ tablet by mouth every 8 hours as needed. Hold if sedated.

Acetaminophen (Tylenol) 325mg Take 2 tablets every 4 hours as needed. This order was discontinued on 6/23/2022 and replaced with:

Acetaminophen (Tylenol) 500 mg Take 1 tablet by mouth three times a day as needed pain/fever. Do not exceed 3g/24 hours.

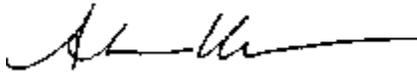
The orders for Lorazepam, Quetiapine, and the initial 325 dose of Acetaminophen provided no instructions as to the circumstances or parameters to alert and inform staff when any of these medications would be “needed”. Resident A’s service plans also did not include instructions for the use of these medications. There was no instruction whether these three medications may be administered together, separately, in tandem or one instead of another.

<b>APPLICABLE RULE</b>	
<b>R 325.1932</b>	<b>Resident medications.</b>
	<p><b>(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></p> <p><b>(e) Adjust or modify a resident's prescription medication with instructions from a prescribing licensed health care professional who has knowledge of the medical needs of the resident. A home shall record, in writing, any instructions regarding a resident's prescription medication.</b></p>
<b>ANALYSIS:</b>	<p>The home did not obtain instructions from the prescribing health care professional, for prescription medications Lorazepam, Quetiapine, and Acetaminophen 325 mg. medications ordered as needed, that would alert and inform staff when these medications would be “needed”.</p> <p>In addition, the home did not obtain sufficient instructions regarding Resident A’s Acetaminophen 500 mg. order and the Lorazepam and Quetiapine orders, as to whether these three medications may be administered together, separately, in tandem, or one instead of the other.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 8/23/2022, I reviewed the findings of this report with licensee authorized representative Allison Morrow via telephone.

#### **IV. RECOMMENDATION**

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



8/17/2022

---

Andrea Krausmann  
Licensing Staff

Date

Approved By:



08/23/2022

---

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

Date