



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

February 10, 2023

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

RE: License #: AH580353904  
Investigation #: 2023A0585013  
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. 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,

Brender Howard, Licensing Staff  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664, Lansing, MI 48909  
(313) 268-1788  
enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AH580353904
<b>Investigation #:</b>	2023A0585013
<b>Complaint Receipt Date:</b>	12/05/2022
<b>Investigation Initiation Date:</b>	12/07/2022
<b>Report Due Date:</b>	02/04/2023
<b>Licensee Name:</b>	Vibrant Life Senior Living OC Temperance, LLC
<b>Licensee Address:</b>	5720 Williams Lake Road Waterford, MI 48329
<b>Licensee Telephone #:</b>	(734) 847-3217
<b>Administrator:</b>	Rebecca Molina
<b>Authorized Representative:</b>	Catherine Reese
<b>Name of Facility:</b>	Vibrant Life Senior Living Sterns Lodge
<b>Facility Address:</b>	667 W. Sterns Road Temperance, MI 48182
<b>Facility Telephone #:</b>	(734) 847-3217
<b>Original Issuance Date:</b>	02/20/2014
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	02/20/2022
<b>Expiration Date:</b>	02/19/2023
<b>Capacity:</b>	46
<b>Program Type:</b>	AGED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Resident A's oxygen concentrator was empty and not charged.	Yes
Additional Findings	No

## III. METHODOLOGY

12/05/2022	Special Investigation Intake 2023A0585013
12/07/2022	APS Referral Emailed referral to Adult Protective Services (APS).
12/07/2022	Special Investigation Initiated - Telephone Contacted complainant to discuss allegations.
12/09/2022	Inspection Completed On-site Completed with observation, interview and record review.
02/10/2023	Exit Conference Conducted with authorized representative Catherine Reese.

### **ALLEGATION:**

**Resident A's oxygen concentrator was empty and not charged.**

### **INVESTIGATION:**

On 11/29/2022, the department received an incident report from the administrator Rebecca Molina. The incident report read, "On 11/28/2022 at 6:38 p.m., the team leader stated that Resident A was in her wheelchair experiencing acute respiratory distress. The team leader checked her oxygen container which was empty and not charged. Immediately wheeled her to her room to charge the oxygen. The team checked vitals and Resident A continued to be in acute respiratory distress. BP 158/100 and no breath visible. The team leader called 911 as the care friend administered mouth to mouth while oxygen was charging. EMS arrived and transported resident to the hospital."

On 12/6/2022, the department received the complainant via the BCHS Online Complaint website. The complaint alleges that a staff member went to Resident A and found that her oxygen concentrator was empty and not charged. The complaint

alleges that when they checked Resident A, her blood pressure was 158 over 100 and she was no longer breathing.

On 12/7/2022, a referral was made to Adult Protective Services (APS).

On 12/8/2022, an onsite was completed at the facility. I interviewed administrator Rebecca Molina at the facility. Ms. Molina stated that they were having a problem with the concentrator. She stated that they ordered another tank and there were communication issues with the company. She stated that the concentrator would charge for a short period of time, and it needed to be charge for six hours. She stated that the concentrator was supposed to be at five and it was at three. She stated that staff are trained to pay attention to the oxygen level. She stated the wellness team are responsible for training.

On 12/8/2022, I interviewed Employee A at the facility. Employee A stated that Resident A's concentrator was broke and not working. Employee A stated that the concentrator was replaced in two days, and they now have a backup.

On 12/8/2022, I interviewed Employee B at the facility. Employee B stated that Resident A was found without her oxygen and went to the hospital. Employee B stated that she had training in the proper administration of oxygen. Employee B stated that she knows how to check to see if the concentrator is empty.

On 12/8/2022, I interviewed Employee C at the facility. Employee C stated that the oxygen concentrator did not have any oxygen in it.

The service plan for Resident A read, staff are to charge oxygen concentrator portable twice a day, there are two battery packs, one on the oxygen concentrator portable and one in resident's room in her drawer.

<b>APPLICABLE RULE</b>	
<b>R 325.1931</b>	<b>Employees; general provisions.</b>
	<b>(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.</b>
<b>R 325.1901</b>	<b>Definitions.</b>
	<b>(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the</b>

	home, or when the resident's service plan states that the resident needs continuous supervision.
	(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>ANALYSIS:</b>	Resident A was found to be experiencing respiratory distress and it was discovered by staff that her oxygen consecrator was empty and not charged. As a result, Resident A experienced respiratory distress resulting in a visit to the hospital. Therefore, the facility did not comply with this rule.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 02/10/2023, I conducted an exit conference with licensee authorized representative Catherine Reese by telephone.

**IV. RECOMMENDATION**

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

*Brender d. Howard*

02/10/2023

Brender Howard  
Licensing Staff

Date

Approved By:

*Andrea L. Moore*

02/09/2023

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

Date