

GRETCHEN WHITMER GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

April 5, 2023

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

> RE: License #: AH580353904 Investigation #: 2023A0585027

> > 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

Brander J. Howard

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

License #:	AH580353904
Investigation #:	2023A0585027
Complaint Receipt Date:	01/27/2023
Investigation Initiation Date:	02/01/2023
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Report Due Date:	03/26/2023
Licensee Name:	Vibrant Life Senior Living OC Temperance, LLC
Licensee Name.	Vibrant Life Gernor Living GG Temperance, LLG
Licensee Address:	5720 Williams Lake Road
	Waterford, MI 48329
Licensee Telephone #:	(734) 847-3217
•	
Administrator:	Rebecca Molina
Authorized Representative:	Catherine Reese
Name of Facility:	Vibrant Life Senior Living Sterns Lodge
Facility Address:	667 W. Sterns Road
r denity / tddreec.	Temperance, MI 48182
	(70.4) 0.47 0.047
Facility Telephone #:	(734) 847-3217
Original Issuance Date:	02/20/2014
License Status:	REGULAR
Effective Date:	02/20/2023
Expiration Date:	02/19/2024
Capacity:	46
Program Type:	AGED

II. ALLEGATION(S)

Viol	ation
Establ	lished?

Staff did not administer medication to Resident A.	Yes
Additional Findings	No

III. METHODOLOGY

01/27/2023	Special Investigation Intake 2023A0585027
02/01/2023	APS Referral Emailed referral to Adult Protective Services (APS).
02/01/2023	Special Investigation Initiated - Telephone Contacted the complainant regarding allegations.
02/07/2023	Inspection Completed On-site Completed with observation, interview and record review.

ALLEGATION:

Staff did not administer medications to Resident A.

INVESTIGATION:

On 1/27/2023, the department received a complaint via BCHS Online Complaint website.

On 2/2/2023, I interviewed the complainant by telephone. The complainant stated that for a few months, the facility did not administer the medicine that was prescribed to Resident A. The complainant stated that the facility stopped giving Resident A senna plus and did not have a reason for why they took her off it.

On 2/7/2023, an onsite was completed at the facility. I interviewed the administrator Rebecca Molina at the facility. Ms. Molina stated that Resident A did not have her medications on 11/13/2022 and 11/14/2023 because it was not on the cart. Ms. Molina stated that she did not know the reason why, but she would investigate.

On 2/7/2023, I interviewed Employee #1 at the facility. Employee #1 stated that medication is currently out, and we don't have it. Employee #1 stated that Resident A sometimes refuse to take her medication.

On 2/7/2023, I interviewed Employee #2 at the facility. Employee #2 stated, Resident A was taking blood pressure medication and she had an upper dose. Employee #2 explained that they can only pass the medication if it is in their medication administration record (MAR). Employee #2 stated that sometimes the medication is not on the cart, and they don't have it to give her. Employee #2 stated that they tried to educate the family regarding Resident A's medication. Employee #2 stated that they would send medication with the family to give her when the family take Resident A out of the facility, but they forget to give it to her.

Resident A service plan reads, "Able to communicate her needs, not prone to refusal, able to feed, toilet and bathe self." The plan, reads, "Medications are to be administered by supervisor or trained shift leader. Staff will contact the authorized representative's preferred pharmacy for any refills needed."

A review of Resident A's MAR for September, October and November of 2022 revealed the following:

September revealed: prescription of Acetaminophen 500 mg had missed doses on 9/22 through 9/27 with reason as medication not on cart.

October revealed: Anoro Ellipta 62.5-25 inhale 1 puff by mouth daily for COPD was missed on 10/6 – reason marked as medication not on cart. Atorvastatin 20 mg take 1 tablet by mouth daily – missed doses on 10/15 and 10/18 – reason not on medication cart. Acetaminophen 500 mg – missed doses on 10/5,10/6, 10/7, 10/18, 10/19 – reason: not on medication cart. Calcium with D take one by mouth every six hours – missed doses 10/19-10/21, 10/23-10/25. Lisinopril 5 mg tablets 10/3 and 10/17 – reason: not on medication cart. Venlafaxine ER 37.5 mg take by mouth daily – missed doses 10/3, 10/17. Sulfa-trim DS 800-160 mg – missed doses 10/17, 10/18, 10/21,10/22, 10/23 and 10/26 – reason: not on medication cart.

November revealed: Myrbetriq 50 mg tablets 1 tablet by mouth daily. Missed doses 11/15, 11/16, reason: not on medication cart. Bisoprolol 5 mg take one tablet by mouth daily. Missed doses 11/6 – 11/8 – Reason: not on medication cart. Acetaminophen 500 mg taken 2 tablets every six hours, missed doses 11/1, 11/10, 11/13 and 11/14 – Reason: not on medication cart – Reason: not on medication cart.

Service plan for Resident B read, "Resident is able to communicate her needs. Medications are to be administered by supervisor or trained shift leader. Staff will contact the authorized representative's preferred pharmacy for any refills needed."

Resident B's MAR revealed: (November 2022) Missed doses of Mirtazapine 7.5 mg tablet one by mouth at bedtime 11/10 – 11/20, Reason: medication not on cart. (December 2022) Missed doses of Mirtazapine 7.5 mg tablet one by mouth at bedtime 12/13, 12/27 – Reason: medication not on cart. Simvastatin 20 mg tablet. Take 1 tablet by mouth at bedtime. Missed 12/13 – Reason: medication not on cart. (January 2023) Missed doses of Losartan 50 mg tab. Take one tablet by mouth daily, missed doses 1/9, 1/11-1/19 – Reason: medication not on cart.

Service plan for Resident C read, "Resident is able to communicate her needs. Medications are to be administered by supervisor or trained shift leader. Staff will contact the authorized representative's preferred pharmacy for any refills needed."

Resident C's MAR revealed: (January 2023) Missed doses of <u>dificid</u> 200 mg tablet, take one tablet by mouth twice a day. Days missed 1/15-1/31 – Reason: medication not on cart. <u>Guaifenesin</u> 100 mg takes 10 ml by mouth every four hours as needed – Reason – medication not on cart. Days missed 1/15-1/17 <u>Probiotic</u> 14 Cap, take one capsule by mouth twice daily – Reason: medication not on cart. <u>Vancomycin</u> 125 mg capsule missed doses 1/25 – 1/31 – Reason: medication not on cart.

APPLICABLE RULE		
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.	
ANALYSIS:	Complaint alleged that Resident A was not given medication that was prescribed for her. A review of the MAR revealed that Resident A, Resident B and Resident C did not receive their medication consistently as prescribed. Therefore, the facility did not comply with this rule.	
CONCLUSION:	REPEAT VIOLATION ESTABLISHED [Ref: Special Investigation Report (SIR) 2022A0784042]	

IV. RECOMMENDATION

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

Grender J. Howard	04/05/2023
Brender Howard Licensing Staff	Date
Approved By:	
(mohed) Moore	04/05/2023
Andrea L. Moore, Manager Long-Term-Care State Licensing Se	Date