

GRETCHEN WHITMER GOVERNOR STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

MARLON I. BROWN, DPA ACTING DIRECTOR

October 17, 2023

Julie Norman Farmington Hills Inn 30350 W. Twelve Mile Road Farmington Hills, MI 48334

RE: License #: AH630236784

Dear Licensee:

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 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 #:	AH630236784
Licensee Name:	Alycekay Co.
Licensee Address:	30350 W 12 Mile Rd.
	Farmington Hills, MI 48334
Licensee Telephone #:	(248) 851-9640
Authorized Representative and Administrator:	Julie Norman
Name of Facility:	Farmington Hills Inn
Facility Address:	30350 W. Twelve Mile Road
	Farmington Hills, MI 48334
Facility Telephone #:	(248) 851-9640
Original Issuance Date:	12/29/2000
Capacity:	137
Program Type:	AGED
	ALZHEIMERS

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 10/17/2023

Date of Bureau of Fire Services Inspection if applicable: 07/31/2023

Inspection Type:	Interview and Observation Combination	Worksheet
Date of Exit Conference:	10/17/2023	
No. of staff interviewed an No. of residents interviewe No. of others interviewed	-	19 48
Medication pass / sim	ulated pass observed? Yes 🔀	No 🗌 If no, explain.
 explain. Resident funds and as Yes X No I If no, or 	dication records(s) reviewed? Y ssociated documents reviewed f explain. vice observed? Yes 🔀 No 🗌	or at least one resident?
The Bureau of Fire Se procedures were revie	Yes 🗌 No 🔀 If no, explain. ervices reviews fire drills, howeve ewed. hecked? Yes 🔀 No 🗌 If no, e	
Corrective action plan	IP? Yes	CAP date/s and rule/s:

• Number of excluded employees followed up? 1 N/A

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following administrative rules regulating home for the aged facilities:

R 325.1922	Admission and retention of residents.
	(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.

Resident A's service plan was overdue for an annual review. The service plan on file for Resident A was dated 9/19/22.

[REPEAT VIOLATION ESTABLISHED]

R 325.1932	Resident medications.
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.

Resident A is scheduled to receive peridex twice daily. Staff documented that Resident A missed her afternoon dose of the medication on 9/5/23, 9/6/23, 9/10/23, 9/15/23, 9/19/23, 9/23/23, 9/24/23, 9/25/23, 9/28/23, 104/23, 10/6/23, 10/7/23, 10/8/23, 10/14/23 and 10/15/23. Facility staff documented the reason for the missed doses as "med in transit from pharmacy", however staff documented at all of the morning doses of the medication were administered. It is not reasonable to assume that the medication can be administered in-between dates and/or shifts that staff documented the medication was not available. This is likely the result of a repeated documentation error.

[REPEAT VIOLATION ESTABLISHED]

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.

A medication cart located in the 300 hallway was found unlocked and had the keys sticking out of one of the drawers. The medications held within the cart were not secured and could easily be intercepted by a resident, staff or visitor of the facility.

[REPEAT VIOLATION ESTABLISHED]

R 325.1944	Employee records and work schedules.
	(1) A home shall maintain a record for each employee which shall include all of the following:
	(d) Summary of experience, education, and training.

Employee 1 is a medication passer and was hired on 10/15/22. Her employee file lacked proof of medication administration training that she completed at the facility.

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 have a weekly menu posted.

[REPEAT VIOLATION ESTABLISHED]

IV. RECOMMENDATION

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

10/17/2023

Elizabeth Gregory-Weil Licensing Consultant

Date