GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 17, 2024

Catherine Reese
Vibrant Life Senior Living, Superior Township, LLC
4488 Jackson Road Ste 2
Ann Arbor, MI 48103

RE: License #: AL810390975
Investigation #: 2024A0122019
Vibrant Life Senior Living, Superior 4

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) 284-9720.

Sincerely,

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL810390975
Investigation #:	2024A0122019
Complaint Receipt Date:	04/11/2024
Investigation Initiation Date:	04/11/2024
Report Due Date:	06/10/2024
Licensee Name:	Vibrant Life Senior Living, Superior Township, LLC
Licensee Address:	4488 Jackson Road Ste 2 Ann Arbor, MI 48103
Licensee Telephone #:	(734) 819-7790
Administrator:	Catherine Reese
Licensee Designee:	Catherine Reese
Name of Facility:	Vibrant Life Senior Living, Superior 4
Facility Address:	8100 Geddes Road Ypsilanti, MI 48198
Facility Telephone #:	(734) 484-4740
Original Issuance Date:	01/17/2019
License **Status:**	REGULAR
Effective Date:	07/17/2023
Expiration Date:	07/16/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A requested help with putting on his brief and staff member, Tshera Thomas, refused to assist him.	Yes
On 04/08/2024, staff members were late administering Resident A's medication.	No
Additional Findings	Yes

III. METHODOLOGY

04/11/2024	Special Investigation Intake 2024A0122019
04/11/2024	APS Referral
04/11/2024	Special Investigation Initiated - On Site Reviewed Resident A's file. Completed interview with Josh Reese, Quality Control Manager, Jen Delano, Facility Nurse, and Brittany Harris, medication coordinator.
04/12/2024	Contact – Telephone call made. Completed an interview with Relative A.
04/17/2024	Exit Conference Discussed findings with Catherine Reese, Licensee Designee.

ALLEGATION: Resident A requested help with putting on his brief and staff member, Tshera Thomas, refused to assist him.

INVESTIGATION: On 04/11/2024, I completed an interview with Jen Delano, facility nurse. Ms. Delano reported that an internal investigation had been completed regarding the allegations that staff member, Tshera Thomas, refused to assist Resident A when requested. Ms. Delano further reported that Resident A is diagnosed with Parkinson's and per his Occupational Therapist, Resident A should be encouraged to complete personal tasks independently as much as he can tolerate. However, no specific orders had been written for staff.

Ms. Delano stated per her interview with Ms. Thomas she felt that Ms. Thomas was intimidating and did not respond to Resident A's request appropriately so therefore she was terminated. Ms. Delano stated Resident A had to repeat his request several times to Ms. Thomas before he was given assistance. Josh Reese, Quality Control Manager, was present during this interview. He stated he was aware of the incident but maintained that Resident A eventually received assistance from Ms. Thomas.

On 04/12/2024, I completed an interview with Relative A. Relative A stated she had been made aware of the incident by another relative. Relative A felt the incident was handled appropriately once she was informed that an internal investigation had been completed and the staff member terminated. Relative A reported that she has increased her visits with her father and has no issues at this time.

On 04/17/2024, I completed an exit conference with Catherine Reese, Licensee Designee, discussing my findings with her. Ms. Reese stated she understood my findings and will submit a corrective action plan to address the rule violation found.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Resident A requested help with putting on his brief and staff member, Tshera Thomas, refused to assist him. On 04/11/2024, Jen Delano, facility nurse reported that after completing an internal investigation she found that Resident A's request for assistance from staff member, Tshera Thomas, was not handled properly. Per Ms. Delano, Ms. Thomas was intimidating towards Resident A when he made his request. On 04/11/2024, both Jen Delano and Josh Reese, Quality Control Manager, reported that staff member Tshera Thomas had been terminated based upon the internal investigation involving Resident A. Based upon my investigation I find evidence to support that Resident A's was not treated with dignity when requesting assistance from staff member, Tshera Thomas, with his personal needs. Jen Delano, facility nurse, stated Ms. Thomas was intimidating towards Resident A when he made his request.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 04/08/2024, staff members were late administering Resident A's medication.

INVESTIGATION: On 04/11/2024, I completed an interview with Jen Delano. Ms. Delano confirmed on 04/08/2024, Resident A did not receive his Sinemet 25 – 100mg medication as prescribed. Resident A is prescribed to receive Sinemet 25 – 100mg 4 times per day, however, on 04/08/2024 he missed his noon dosage as the pharmacy had not delivered the medication to the facility.

Per Ms. Delano, Resident A's Sinemet 25 – 100mg was scheduled to be delivered in full on 04/03/2024 by One Care Pharmacy. However, on 04/02/2024 a representative delivered a 5-day supply stating that the reminder of the medication would be delivered on 04/08/2024. Resident A missed his noon dose on 04/08/2024 as One Care Pharmacy did not deliver his medication until 1:00 p.m. Resident A received his medication Sinemet 25 -100mg as prescribed for the remainder of the day. On 04/11/2024, I completed an interview with Brittan Harris, medication coordinator for the facility. Ms. Harris confirmed what was reported by Ms. Delano.

On 04/11/2024, I reviewed Resident A's medication administration record and medications. All of his prescribed medications were on-site and accounted for. There was note stating that the 04/08/204, 12:00 p.m. dose of Sinemet 25 -100mg was not given as it had not been delivered by the pharmacy, however, the remainder

doses of medication were given at the appropriate intervals with consideration of the missed dose and given at the correct times in the days that followed.

On 04/12/2024, I completed an interview with Relative A. Relative A reported that she was informed of the incident by another relative. Relative A was made aware of the pharmacy issue with Resident A's medication and has no issues with Resident A receiving his medication at this time.

On 04/17/2024, I completed an exit conference with Catherine Reese, Licensee Designee, discussing my findings with her. Ms. Reese stated she agreed with my findings.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	On 04/08/2024, staff members were late administering Resident A's medication. On 04/02/2024, a pharmacy representative delivered a 5-day supply of Sinemet 25-100mg, stating that the reminder of the medication would be delivered on 04/08/2024. Resident A missed his noon dose on 04/08/2024 as One Care Pharmacy did not deliver his medication until 1:00 p.m. Resident A received his medication Sinemet 25 -100mg as prescribed for the remainder of the day. On 04/11/2024, both Jen Delano and Brittan Harris, medication coordinator for the facility confirmed that Resident A missed one dose of his medication Sinemet 25-100mg due to pharmacy not delivering the correct amount of his medication on 04/08/2024. On 04/11/2024, I observed in Resident A's medication administration record that there was note stating that the 04/08/204, 12:00 p.m. dose of Sinemet 25 -100mg was not given as it had not been delivered by the pharmacy. Based upon my investigation, I find that even though Resident A did not receive his medication Sinemet 25-100mg noon dose on 04/08/2024, it was not due to staff negligence but due to the pharmacy, One Care Pharmacy, not delivering the appropriate amount of the medication as promised on 04/08/2024.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 04/11/2024, I reviewed Resident A's medication administration records. On 03/18/2024, 03/19/2024, and 03/27/2024, I observed that staff initials were missing to verify administration of Sinemet 25 -100mg. On 03/18/2024, staff initials were missing to verify administration of the 8:00 a.m. dose of Sinemet 25 – 100mg dose, on 03/19/2024, staff initials were missing to verify administration of the 8:00 a.m. and 12:00 p.m. doses, and on 03/27/2024 staff initials were missing to verify the administration of the 8:00 a.m. dose.

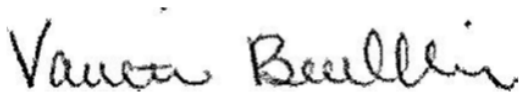
On 04/11/2024, I assessed that Resident A's medication Sinemet 25 – 100mg had the appropriate count to verify the medication had been administered as prescribed. On 04/11/2024, I completed an interview with Brittan Harris, medication coordinator, who confirmed that assigned staff did not initial the medication administration record to verify passing of Resident A's medication.

On 04/17/2024, I completed an exit conference with Catherine Reese, Licensee Designee, discussing my findings with her. Ms. Reese stated she understood my findings and will submit a corrective action plan to address the rule violation found.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she 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 administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	On 04/11/2024, I reviewed Resident A's medication administration records. On 03/18/2024, 03/19/2024, and 03/27/2024, I observed that staff initials were missing to verify administration of Sinemet 25 -100mg. On 04/11/2024, I completed an interview with Brittan Harris, medication coordinator, who confirmed that assigned staff did not initial the medication administration record to verify passing of Resident A's medication. Based upon my investigation I find evidence to support that direct care staff did not complete Resident A's medication administration record on 03/18/2024, 03/19/2024, and 03/27/2024 by initialing the record to verify the medication Sinemet 25-100mg was given.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan I recommend no change in the status of the license.



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Vanita C. Bouldin Date: 04/17/2024
Licensing Consultant

Approved By:

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Ardra Hunter Date: 04/17/2024
Area Manager