GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 9, 2024

Jennifer Hescott
Provision Living at West Bloomfield
5475 West Maple
West Bloomfield, MI 48322

RE: License #: AH630381200
Investigation #: 2024A1019064

Dear Licensee:

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 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 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
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH630381200
Investigation #:	2024A1019064
Complaint Receipt Date:	08/16/2024
Investigation Initiation Date:	08/16/2024
Report Due Date:	10/15/2024
Licensee Name:	PVL at West Bloomfield, LLC
Licensee Address:	1630 Des Peres Road, Suite 310 St. Louis, MO 63131
Licensee Telephone #:	(314) 238-3821
Administrator:	David Ferrari
Authorized Representative:	Jennifer Hescott
Name of Facility:	Provision Living at West Bloomfield
Facility Address:	5475 West Maple West Bloomfield, MI 48322
Facility Telephone #:	(248) 419-1089
Original Issuance Date:	03/27/2019
License Status:	REGULAR
Effective Date:	09/27/2023
Expiration Date:	09/26/2024
Capacity:	113
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff are improperly passing medications to Resident A.	Yes
Additional Findings	No

III. METHODOLOGY

08/16/2024	Special Investigation Intake 2024A1019064
08/16/2024	Special Investigation Initiated - Telephone Called complainant to conduct interview, left voicemail requesting return phone call.
08/20/2024	Contact - Telephone call made Second phone call to complainant- left voicemail.
08/20/2024	Contact - Telephone call received Missed call from complainant; resident in question was identified on voicemail left by referral source.
08/21/2024	Inspection Completed On-site
08/21/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Staff are improperly passing medications to Resident A.

INVESTIGATION:

On 8/16/24, the department received a complaint alleging that staff are not following proper protocol when administering Resident A's medications. The complaint alleged that staff are not observing the resident take the medications, instead just leaving them on the counter. The complaint also alleged that medications are given at odd times (an example of this was on 7/31/24 at 12:46am) and that staff didn't administer Resident A's medications on 7/30/24.

On 8/21/24, I conducted an onsite inspection. I interviewed administrator David Ferrari and Employee 1 at the facility. Mr. Ferrari and Employee 1 reported that they had been contacted by Relative A with the same concerns and have investigated the matter. Mr. Ferrari and Employee 1 reported that there was a staffing issue, and medications were administered late to Resident A on the evening of 7/30/24, going into the morning of 7/31/24 which was an isolated issue. Mr. Ferrari and Employee 1 denied that staff failed to administer Resident A's medications on 7/30/24. Mr. Ferrari and Employee 1 reported that staff are trained to observe residents ingesting medications, but Employee 1 reported that Resident A is very independent and could be trusted to take her medications without direct observation. Mr. Ferrari and Employee 1 reported that Resident A is fully alert, oriented, a reliable historian and would be agreeable to interview.

On 8/21/24, I interviewed Resident A at the facility. Resident A reported that staff frequently administer medications to her late, or just drop them off in her room, at times when she is not even present. Resident A reported that she knows what medications she is prescribed and what times she is supposed to take them, and that staff are routinely late. Resident A stated "A lot of times I just walk down to the med tech and ask for my medications because otherwise who knows when I will get them." Resident A reported that medications being given late or left in her room is a "habitual problem".

When questioned about medication administration protocol, Employee 1 reported that the electronic MAR system they use (Matrix), automatically signals that a medication is late if it is administered more than 60 minutes outside of the scheduled time on the MAR. Employee 1 reported that staff are expected to document medications as they are passed and should not be going back and charting later. Employee 1 reported that not all residents require staff observation when taking medication, which will be identified in their service plan.

The licensee's *Medication Administration and Disposal* policy was reviewed. Excerpts from the policy are as follows:

- *It is imperative that residents get the correct medication, at the right time, and in the right dosage.*
- *Staff will be trained in the proper handling and administration of medication. Upon completion of the program, staff members will demonstrate knowledge and understanding of the medication program and will be able to supervise the taking of medication by a resident.*
- *Staff will be trained on the proper procedures and MAR/EMAR documentation including: The initials of the person who administered the medication, which shall be entered at the times the medication is given.*
- *Medications are administered at the time they are prepared. Medications are not to be prepared in advance or pre-poured unless allowable per a state's regulations.*

- *If using blister packed meds, punch out meds for that individual resident into a medication cup and remain with the resident to ensure that medication is swallowed. If bottled meds, open and put medications for that time period into a medication cup and remain with resident to ensure all medications are swallowed.*

Regarding medication administration, Resident A's service plan read "*Requires employees assist/administer medications…Certified staff will order, store, and administer medication as ordered by physician(s).*"

While onsite, I reviewed Resident A's medication administration records (MAR) for the previous 7 weeks (7/1/24-8/21/24). Facility staff documented late charting or late medication administration for one or more medications on the following dates during the timeframe reviewed: 7/1/24, 7/2/24, 7/5/24, 7/6/24, 7/7/24, 7/10/24, 7/11/24, 7/12/24, 7/14/24, 7/15/24, 7/20/24, 7/21/24, 7/22/24, 7/23/24, 7/25/24, 7/26/24, 7/27/24, 7/29/24, 7/30/24, 7/31/24, 8/1/24, 8/2/24, 8/3/24, 8/4/24, 8/5/24, 8/6/24, 8/7/24, 8/9/24, 8/10/24, 8/12/24, 8/13/24, 8/14/24, 8/16/24, 8/17/24, 8/18/24 and 8/20/24. I observed that medications were administered to Resident A on 7/30/24 contrary to what the complaint alleges, however staff documented that Resident A's 8:00pm meds weren't administered until 7/31/24 at 12:54am.

APPLICABLE RULE	
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.
ANALYSIS:	Direct interview with Resident A combined with MAR documentation reveal frequent late medication administration practices by facility staff. Review of facility policy reveals that staff are not adhering to expected protocol for medication administration and subsequent documentation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

Employee 1 reported that staff are trained to document medication passes in real time, as they occur and should not be going back later to complete their

documentation. Additionally, the licensee's *Medication Administration and Disposal* policy specifically outlines this expectation.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(b) Complete an individual medication log that contains all of the following information:** **(iv) The time when the prescribed medication is to be administered and when the medication was administered.**
ANALYSIS:	Review of MAR documentation reveals habitual practices of staff not documenting medication passes as they occur, which is inconsistent with the licensee's policy. The facility's MAR does not list the time the medications were actually given and instead, list when staff charted the med pass.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

08/28/2024

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

09/09/2024

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