GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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

October 23, 2024

RE: License #: AH630381200
Investigation #: 2024A1022073
Provision Living at West Bloomfield

Dear Jennifer Hescott:

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.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630381200
Investigation #:	2024A1022073
Complaint Receipt Date:	08/06/2024
Investigation Initiation Date:	08/06/2024
Report Due Date:	10/05/2024
Licensee Name:	PVL at West Bloomfield, LLC
Licensee Address:	Suite 310 1630 Des Peres Road 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:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	113
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Medications are administered late because not enough medication technicians (med techs) are scheduled to pass medications to residents.	Yes
There is a problem with laundry processing.	No

III. METHODOLOGY

08/06/2024	Special Investigation Intake 2024A1022073
08/06/2024	Special Investigation Initiated - Telephone Complainant identified and interviewed by phone.
08/13/2024	Inspection Completed On-site
10/23/2024	Exit Conference

ALLEGATION:

Medications are administered late because not enough medication technicians (med techs) are scheduled to pass medications to residents.

INVESTIGATION:

On 08/06/2024, the Bureau of Community and Health Systems (BCHS) received a complaint that in part read, "…tonight (08/04/2024) I (the complainant) was told that there was no one in the facility to dispense meds (medications). I became concerned because my relative's meds are essential. I walked down the hall to the med cart, and there were no med techs around but there was an aide there who told me that it would be "a very long time" before my relative would receive his meds because someone had called off… At 9:42 PM, he (the Resident of Concern/ROC) still had not received his 7:30 meds. An aide delivered them at 10:10 PM and said that only a select few residents were getting their meds tonight…"

On 08/06/2024, I interviewed the complainant by phone. The complainant stated that there was a shortage of medication technicians (med techs) that was especially acute on the weekends. The complainant went on to say that residents were administered their medications hours late on a regular basis because of this.

On 08/13/2024, at the time of the onsite visit, I interviewed the administrator and the wellness director. When asked about medication administration, the wellness director acknowledged that there had been complaints regarding medications being administered late. According to the wellness director, med techs in the facility worked 12-hour shifts. For the day shift, the facility staffed 4 med techs for the morning shift (6:45 am to 7:00 pm) and 3 for the evening shift (6:45 pm to 7:00 am).

Review of the med tech schedule for 08/04/2024 through 08/10/2024 revealed that the schedule conformed to the wellness director's description with the exception of the 6:45 pm to 7:00 am shift on Sunday, 08/04/2024, consistent with the complainant's allegation. On the day and shift, the memory care unit was assigned a med tech, who was there the entire shift. On the unit designated AL-1 (Assisted Living 1), med tech #1, who had the morning 6:45 am to 7:00 pm shift, stayed over until 9:00 pm. On the unit designated AL-2, med tech #2 did not come in until 10:30 pm and remained in the building until the end of the shift.

Further review of the med tech staffing from 07/21/2024 through 08/03/2024 revealed that on both Sunday, 07/21/2024 and Monday, 07/22/2024, there were only 3 med techs working the morning shift. For Monday, 07/22/2024, there were only 2 med techs working on the evening shift from 11 pm until 7:00 am the next day. On Saturday, 07/27/2024, there were only 3 med techs working on the morning shift, 3:00 pm until 7:00 pm. On Tuesday, 07/30/2024, there were only 2 med techs working on the evening shift from 7:00 pm until 10:30 pm. On Wednesday, 07/31/2024, while there were 5 med techs on the morning shift from 6:45 am until 2:30 pm, there were on 3 med techs from 3:00 pm until the end of shift at 7:00 pm.

The facility provided the medication administration records (MARs) for the ROC, for Resident A and for Resident B. According to Resident A's, MAR, only 1 medication for scheduled for administration for after the beginning of the 6:46 pm to 7:00 am shift: Mupirocin ointment to be applied at 8:00 pm. According to the MAR, Resident A was administered that medication on time for the 6:45 pm to 7:00 am shift on 08/04/2024.

According to his MAR, Resident B had no medications scheduled for administration after 6:45 pm.

The ROC had multiple medications scheduled for administration after 6:45 pm:

- Carbidopa-Levodopa (treatment for Parkinson's Disease) scheduled for 7:30 pm and again at 11:30 pm
- Entacapone, to be administered in combination with the medication Carbidopa-Levodopa, at 7:30 pm
- Metformin (for diabetes) at 8:00 pm
- Simvastatin (for elevated cholesterol levels) at 8:00 pm

For each of these medications, the MAR was documented as "Charted date: 08/04/2024 11:24 pm; Reasons/Comments: Late administration: charted late;

comment: assisting with care". The time of the "charted date" was consistent with the complainant's allegation.

According to the ROC's MAR, on 08/04/2024 at 11:24 pm, his medications were administered by caregiver #3, who was in the building working as a caregiver, but was qualified to administer medications. This is also consistent with the complainant's allegations.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
For Reference: R325.1901	**Definitions.**
	(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.
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:	The ROC did not receive his medications at the appropriate time on 08/04/2024. However, a similar violation of Administrative Rule 325.1932(2) was cited in investigation 2024A1019064, conducted in a similar time frame to this investigation. The corrective action plan of investigation 2024A1019064 will address the ROC not receiving medications. For the evening shift on 08/04/2024, there were not enough medication technicians working to ensure that the ROC received his medications at the time indicated by the prescribing health professional. In the two weeks prior to this incident on 08/04/2024, there were 4 morning shifts (07/21, 07/22, 07/27, and 07/31/2024) and 1 evening shift (07/30/2024) that did not have adequate med techs working for the entire shift. Therefore, a pattern of staffing levels below facility standard has been identified.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There is a problem with laundry processing.

INVESTIGATION:

According to the written complaint, “Also, last weekend they ran out of laundry detergent… (residents were) wearing soiled clothes because there were no laundry pods. They don't change the bedding unless asked… About every other day, there's a disgusting odor of sewage backup in the entire building. It seems to come from the laundry room…”

The complainant stated that until recently, there were laundry detergent dispensers in the laundry room, but the facility had discontinued the use of the dispensers and switched to using the pre-packaged detergent pods. However, there were not enough pods in supply to keep up with the demands of the laundry use. The complainant went on to describe the foul odor that seemed to be coming from the laundry room but acknowledged that the odor was not consistent. It came and went.

When the administrator and the wellness director were asked about whether caregivers, residents and resident families had enough supplies to do laundry, they explained that both detergent pods as well as liquid laundry detergent were available; however, in most of the laundry rooms in the facility, the automatic detergent dispensers were inadvertently disabled by users, including caregivers. The dispenser could be reset, but most of the caregivers, families and residents had not

mastered this ability, so most of the dispensers remained disabled. In its place, the facility made the detergent pods available, but they were not kept in the laundry rooms. There were available from the med tech or in the wellness director's office.

At the time of the onsite visit, the administrator took me to each unit to see all of the laundry areas. No foul odors were detected in the facility. The automatic detergent dispensers were visible in each laundry room, but almost all of the dispenser pumps had air in their lines and could not be used unless they were reset. Detergent pods were available from the med techs on each unit.

At the time of the onsite visit, the ROC was observed in a common area on the first floor. When asked if there was anything wrong with getting his laundry, he stated that the laundry service was just fine.

Resident A was observed seated in the memory care (MC) unit common area. Resident A was unable to reliably answer questions. The med tech on the unit provided a log that indicated when each resident who lived in the MC unit had their laundry done. The log indicated the number of detergent pods used. Resident A had clean laundry in her room and her laundry basket had just a few soiled items.

Resident B was in his apartment with his wife, who was also a resident. When Resident B and his wife were asked about his laundry, his wife answered and stated that there were no problems with laundry getting done.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	There was no evidence that there was any issue with laundry processing in the building.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 10/23/2024. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change to the status of the license.

10/23/2024

Barbara Zabitz Date
Licensing Staff

Approved By:

10/16/2024

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