GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Robert Cain
University Living
2865 S. Main Street
Ann Arbor, MI 48103

December 19, 2024

RE: License #: AH810401699
Investigation #: 2025A1022006
University Living

Dear Robert Cain:

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
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH810401699
Investigation #:	2025A1022006
Complaint Receipt Date:	11/01/2024
Investigation Initiation Date:	11/01/2024
Report Due Date:	01/01/2025
Licensee Name:	Ann Arbor Senior Housing OPCO, LLC
Licensee Address:	Ste 310 One Town Center Rd Boca Raton, FL 33486
Licensee Telephone #:	(561) 300-6263
Administrator:	Kelly Hardy
Authorized Representative:	Robert Cain
Name of Facility:	University Living
Facility Address:	2865 S. Main Street Ann Arbor, MI 48103
Facility Telephone #:	(734) 669-3030
Original Issuance Date:	05/26/2021
License **Status:**	REGULAR
Effective Date:	11/26/2024
Expiration Date:	07/31/2025
Capacity:	90
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The Resident of Concern (ROC) was overmedicated with Seroquel.	Yes
The family of the ROC could not get his medical records.	No
Additional Findings	Yes

III. METHODOLOGY

11/01/2024	Special Investigation Intake 2025A1022006
11/01/2024	Special Investigation Initiated - Telephone Complainant interviewed by phone.
11/20/2024	Contact - Telephone call made Investigation conducted remotely via videoconference.
12/13/2024	Contact - Document Received Email exchange with administrator.
12/19/2024	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) was overmedicated with Seroquel.

INVESTIGATION:

On 11/01/2024, the Bureau of Community and Health Systems (BCHS) received a complaint that read in part, “Resident (the Resident of Concern/ROC) was being over medicated from July 31st into September. It is believed that resident also went without his medications which resulted in behavior issues for resident…”

On 11/01/2024, I interviewed the complainant by phone. The complainant stated that the ROC had a form of dementia that made him prone to aggressive and combative behaviors. The complainant went on to say that after a particularly aggressive episode in July 2024, the family took the ROC to a geriatric psychiatrist with the expertise to treat the ROC’s underlying medical issues. Although the geriatric psychiatrist made several recommendations to the family, the complainant

acknowledged that the geriatric psychiatrist did not contact the facility with new medication orders for the ROC.

According to the complainant, after the visit with the geriatric psychiatrist, the family was informed that the ROC needed an increase in his dose of Seroquel (an antipsychotic medication, used with dementia patients to address agitation). The complainant stated that the family agreed to this change in the medication and had it filled by their own pharmacy. They brought the medication into the facility so it could be administered to the ROC. According to the complainant, the family brought in a 90-day supply, 180 tablets, to be administered 1 tablet twice daily, on 08/05/2024.

The complainant went on to say that on 09/13/2024, the family was notified that the ROC was almost out of Seroquel and that it needed to be refilled, but she was informed by the pharmacy that it could not be refilled until 10/07/2024. Several days later, the complainant explained, the family was informed that the ROC was out of Seroquel. The complainant went on to say that the family could not understand how the ROC had gone through 90 days' worth of medication in roughly 45 days and believed that the ROC was overmedicated on the Seroquel.

On 11/20/2024, I interviewed authorized representative (AR), the executive director (ED), the regional director of operations (RDO) and the regional nurse through a videoconference.

When asked about the ROC, the ED acknowledged that he had 3 notable episodes of aggressive behaviors where he had struck out at other individuals, facility caregivers on two occasions, and another resident on a third occasions. According to the ED, on 07/02/2024, he struck a caregiver during care; on 07/24/2024, he hit a caregiver without provocation; and, on 10/04/2024 he hit another resident without provocation. The ED went on to say that on 10/11/2024, a care conference was held with the family. During this conference the family was advised of the strong possibility that the ROC would be asked to move out of the facility due to his aggression, but did not issue a 30-day discharge notice at that time.

Review of the ROC's medication administration records (MARs) revealed that on 07/26/2024, nurse practitioner (NP) #1 ordered Quetiapine (generic name for Seroquel), 25 mg tablet, take one tablet by mouth twice daily (morning and bedtime) and Quetiapine, 25 mg tablet, take ½ tablet by mouth at dinner. On 08/08/2024, NP #1 changed the order to read Quetiapine Fumarate (Seroquel extended release) 50 mg tablet, take 1 tablet by mouth two times daily.

Review of the ROC's medication administration record (MAR) for August 2024 revealed that the ROC was administered the ½ tablet of Seroquel at the dinner on 08/01/2024, but not again. He was administered the 25 mg tablet with breakfast and at bedtime on 08/01/2024 and just the breakfast dose on 08/02/2024. Then no Seroquel was administered to the ROC after that until 08/08/2024.

Review of the ROC's MAR for September 2024 revealed that the ROC was administered 50 mg of Seroquel twice daily until the bedtime dose of 09/30/2024, when the medication administration was marked "11", a notation for medication not available.

Review of the ROC's MAR for October 2024 revealed ROC was administered the 50 mg of Seroquel sporadically, with the breakfast dose marked "11" on 4 occasions, and the evening dose marked as "11" on 16 occasions.

On 12/13/2024, via an email exchange with the ED, when the ED was asked to account to account for the lapse in the ROC's medication administration for the 7 days in August 2024, she responded, "The August MARs were reviewed, and it (the documentation) does not indicate why the medication was not administered."

When the ED was asked to explain this lack of medication being available in October, she replied, "Guardian Pharmacy (the facility-contracted pharmacy vender) was not dispensing medication at the time, family was providing it. From August-October the Family was providing the medication, it was not coming from Guardian Pharmacy." The ED did not explain how the facility managed the coordination with the family to ensure that the ROC had sufficient medication on-hand.

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:	The ROC did not receive his medications as prescribed. The facility did not have an explanation for the 6 days in August 2024 when the ROC did not receive his prescribed medication. Further, the facility was not able to explain what steps had been taken by the facility when the ROC ran out of medication later in October 2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The family of the ROC could not get his medical records.

INVESTIGATION:

According to the written allegations, "Facility not providing medical documents for resident to family as requested…" The complainant explained that the ROC had

received a 30-days involuntary discharge order from the facility after the ROC had another episode of aggressive behavior on 10/04/2024 and the family wanted to know more about the situation. The complainant stated that the family member who held the ROC's power of attorney (POA) was told that she needed to apply for the ROC's records. The POA sent in the paperwork and expected to hear from the facility by the next week, 10/18/2024. The facility then told the POA that the records would be available towards the end of October 2024, but as of 11/01/2024, the family had not received the ROC's records.

According to the facility's written guidelines for the request of records, "Any request for resident records from a family member … must utilize the Authorization to Inspect and Copy Medical Records Form and must be signed by the resident's Power of Attorney with the authority to request such records … The Executive Director will confirm that the resident's Power of Attorney … has the proper authority to make such request … If the request involves Medical Records, pursuant to HIPPA, the records must be provided within 30 days..."

When asked about the ROC's family's request for his medical records, the AR stated that he believed that records were never sent because the proper document had not been received by the corporate office.

According to the ED, the form entitled "Authorization for the Release of Health Information" is provided to residents and resident families at the time of move-in to the facility and is used for obtaining medical records.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(b) An individual who is or has been a patient or resident is entitled to inspect, or receive for a reasonable fee, a copy of his or her medical record upon request in accordance with the medical records access act, 2004 PA 47, MCL 333.26261 to 333.26271.**

ANALYSIS:	The family may not have realized that they needed to use this particular form provided with move-in documents to obtain the ROC's records. The facility's procedure did not interfere with the ROC's right to his records.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

When asked about the ROC, the ED acknowledged that he had 3 notable episodes of aggressive behaviors where he had struck out at other individuals, facility caregivers on two occasions, and another resident on a third occasions. According to the ED, on 07/02/2024, he struck a caregiver during care; on 07/24/2024, he hit a caregiver without provocation; and, on 10/04/2024 he hit another resident without provocation. Review of the ROC's charting notes revealed that the ROC's aggressive episodes were not documented. When the ED was asked if any additional documentation regarding the episodes existed, no documentation was supplied.

APPLICABLE RULE	
MCL 333.20175	**Maintaining record for each patient; wrongfully altering or destroying records; noncompliance; fine; licensing and certification records as public records; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.**
	(1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization.
ANALYSIS:	The facility did not document any of the ROC's aggressive episodes in his health record.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 12/19/2024. 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.

12/19/2024

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Barbara Zabitz Date
Licensing Staff

Approved By:

12/18/2024

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