GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 6, 2025

Hemant Shah
Cranberry Park West Bloomfield LLC, Suite 230
25500 Meadowbrook Rd
Novi, MI 48375

RE: License #: AH630402042
Investigation #: 2025A1019029
Cranberry Park of West Bloomfield

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 #:** | AH630402042 |
| | |
| **Investigation #:** | 2025A1019029 |
| | |
| **Complaint Receipt Date:** | 01/18/2025 |
| | |
| **Investigation Initiation Date:** | 01/21/2025 |
| | |
| **Report Due Date:** | 03/17/2025 |
| | |
| **Licensee Name:** | Cranberry Park West Bloomfield LLC |
| | |
| **Licensee Address:** | 25500 Meadowbrook Rd, Suite 230<br>Novi, MI 48375 |
| | |
| **Licensee Telephone #:** | (248) 692-4355 |
| | |
| **Administrator:** | Pamela Skatzka |
| | |
| **Authorized Representative:** | Hemant Shah |
| | |
| **Name of Facility:** | Cranberry Park of West Bloomfield |
| | |
| **Facility Address:** | 2450 Haggerty Rd<br>West Bloomfield, MI 48323 |
| | |
| **Facility Telephone #:** | (248) 671-4204 |
| | |
| **Original Issuance Date:** | 03/10/2022 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/01/2024 |
| | |
| **Expiration Date:** | 07/31/2025 |
| | |
| **Capacity:** | 53 |
| | |
| **Program Type:** | ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A did not receive her pain medication as prescribed. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 01/18/2025 | Special Investigation Intake<br>2025A1019029 |
| 01/18/2025 | Comment<br>Complaint was forwarded to LARA from APS. APS is investigating the allegations. |
| 01/21/2025 | Special Investigation Initiated - Letter<br>Emailed APS worker for additional information. |
| 01/23/2025 | Inspection Completed On-site |
| 01/23/2025 | Inspection Completed-BCAL Sub. Compliance |

**ALLEGATION:**

Resident A did not receive her pain medication as prescribed.

**INVESTIGATION:**

On 1/18/25, the department revied a complaint forwarded from Adult Protective Services (APS) that alleged Resident A ran out of her pain medication on 12/14/24 and did not receive it until 12/18/24. Per the complaint, Resident A takes the medication three times daily and multiple doses were missed.

On 1/23/25, I conducted an onsite inspection. The administrator Pam Skatzka was not present. Employee 1 was interviewed at the facility. Employee 1 reported that Resident A moved into the facility on 11/4/24 with a physician's order for tramadol for pain, prescribed every eight hours on an "as needed" or PRN basis.

Employee 1 reported Resident A ran out of her tramadol sometime in December 2024. While onsite, Employee 1 provided documentation demonstrating that the medication was reordered on 12/13/24 and pharmacy delivery receipts confirming

that the medication was delivered to the facility on 12/17/24. In the interim, Employee 1 reported that she reached out to Resident A's physician to ensure that the medication was reordered. Employee 1 reported that the facility's contracted pharmacy typically delivers medications within 24 hours after they are ordered and is unsure why there was a delay in receiving Resident A's tramadol.

Additionally, while onsite, I obtained a copy of Resident A's physician's orders, medication administration records (MAR) and her controlled drug receipt/record/disposition form that staff document narcotic counts on. The physician's order for tramadol instructed "*take 1 tablet by mouth every 8 hours as needed for pain*". During the month of December 2024, staff documented on the MAR that Resident A was administered tramadol on the following dates: 12/2/24, 12/19/24, 12/22/24, 12/24/24, 12/26/24 (two administrations), 12/28/24 (two administrations), 12/29/24 (three administrations) and 12/31/24 (two administrations). During the month of December, staff documented on the controlled drug receipt/record/disposition form that Resident A was administered tramadol on the following dates: 12/1/24 (two administrations), 12/2/24 (two administrations), 12/3/24 (two administrations), 12/4/24 (two administrations), 12/5/24 (two administrations), 12/6/24 (two administrations), 12/7/24 (two administrations), 12/8/24 (two administrations). 12/9/24 (two administrations), 12/10/24 (two administrations), 12/11/24 (two administrations), 12/12/24 (two administrations), 12/13/24 (two administrations) 12/14/24 and 12/15/24. On 12/15/24, staff documented on the disposition form that Resident A had zero pills left on 12/15/24. On 12/17/24, staff documented on the disposition form that 90 pills were delivered from the pharmacy. After receiving the medication from the pharmacy, during the remainder of December, staff documented on the disposition form that Resident A was administered tramadol on the following dates: 12/17/24 (two administrations), 12/18/24 (two administrations), 12/19/24 (three administrations) 12/20/24 (two administrations), 12/21/24 (three administrations), 12/22/24 (two administrations), 12/23/24 (two administrations), 12/24/24 (three administrations), 12/25/24 (two administrations), 12/26/24 (two administrations), 12/27/24 (two administrations), 12/28/24 (three administrations), 12/29/24 (three administrations), 12/30/24 (three administrations) and 12/31/24 (two administrations).

| **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:** | Resident A is prescribed tramadol on an as needed/ PRN basis and can receive it up to three times daily. Resident A's tramadol ran out on 12/15/24 and was delivered to the facility by the pharmacy on 12/17/24. Facility staff provided evidence that the medication was reordered on 12/13/24 and follow up correspondence was made in efforts to obtain the medication. The failure of the pharmacy to deliver the medication timely is not the fault of the facility and the allegation is not substantiated. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDING:**

**INVESTIGATION:**

Resident A's tramadol order reads "*take 1 tablet by mouth every 8 hours as needed for pain*". Employee 1 reported that prior to administering the medication, staff are to ask Resident A what her pain level is on a scale of 0-10 and document her response on the MAR. Employee1 reported that Resident A does not typically ask for the medication to be administered herself and often reports her pain levels as being low, or at a "0", but Resident A's family will frequently insist that she needs the medication every eight hours regardless and staff comply.

During the month of December 2024, staff documented on the following eight separate occasions that Resident A had no pain, but still administered her tramadol: 12/26/24 (two administrations), 12/28/24 (two administrations), 12/29/24 (two administrations) and 12/31/24 (two administrations).

| **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:** | Facility staff repeatedly administered a narcotic pain medication to Resident A despite verbalizing she was not in pain. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDING:**

**INVESTIGATION:**

As listed above, staff documented on Resident A's controlled substance disposition form that she was administered tramadol daily for the entire month of December, except on 12/16/24, before the pharmacy delivered her last order. Staff failed to document on Resident A's MAR all the above-mentioned tramadol administrations apart from the following dates: 12/2/24, 12/19/24, 12/22/24, 12/24/24, 12/26/24 (two administrations), 12/28/24 (two administrations), 12/29/24 (three administrations) and 12/31/24 (two administrations).

When questioned about the discrepancy in the documentation, Employee 1 reported that she constantly reminds staff to document their med passes and to complete their medication reports before the end of their shift, but it is evident that is not being done.

| **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:**<br><br>**(b) Complete an individual medication log that contains all of the following information:**<br><br>**(v) The initials of the individual who administered the prescribed medication.** |
| **ANALYSIS:** | During the month of December 2024, staff administered tramadol to Resident A 30 out of 31 days but only documented that medication administrations occurred on eight days. For numerous days throughout the month staff failed to initial the MAR when the medications were given to Resident A. In total, staff failed to document 51 tramadol administrations during the timeframe reviewed. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon approval of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

01/23/2025

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

02/06/2025

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