GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 10, 2025

Catherine Reese
New Friends Dementia Community, LLC
3700 W Michigan Ave
Kalamazoo, MI 49006

RE: License #: AL390299685
Investigation #: 2025A1024018
Vibrant Life Senior Living Kalamazoo Lodge 1

Dear Catherine 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 was required. On April 2, 2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390299685
Investigation #:	2025A1024018
Complaint Receipt Date:	02/18/2025
Investigation Initiation Date:	02/19/2025
Report Due Date:	04/19/2025
Licensee Name:	New Friends Dementia Community, LLC
Licensee Address:	3700 W Michigan Ave Kalamazoo, MI 49006
Licensee Telephone #:	(269) 372-6100
Administrator:	Laurel Space
Licensee Designee:	Catherine Reese
Name of Facility:	Vibrant Life Senior Living Kalamazoo Lodge 1
Facility Address:	3700 W. Michigan Ave. Kalamazoo, MI 49006
Facility Telephone #:	(269) 372-6100
Original Issuance Date:	06/21/2011
License Status:	REGULAR
Effective Date:	12/21/2023
Expiration Date:	12/20/2025
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff did not administer Resident A's Norco medication as prescribed for pain.	Yes

III. METHODOLOGY

02/18/2025	Special Investigation Intake 2025A1024018
02/19/2025	APS Referral already involved
02/19/2025	Contact - Telephone call made with Adult Protective Service (APS) Specialist Lauren Crock.
02/21/2025	Inspection Completed On-site with direct care staff member Alexis Craft, Lomachia Cox and Resident A
02/21/2025	Contact - Telephone call made with direct care staff member Hailey Nichols
02/21/2025	Contact - Document Received-*Controlled Substance Log* and *Disciplinary Notice* emailed from Alexis Craft
03/06/2025	Inspection Completed-BCAL Sub. Compliance
03/06/2025	Exit Conference with licensee designee Catherine Reese and administrator Laurel Space
03/06/2025	Corrective Action Plan Received Corrective Action Plan Requested and Due on 04/12/2025
04/02/2025	Corrective Action Plan Approved Corrective Action Plan Received
04/02/2025	Corrective Action Plan Approved

ALLEGATION: Staff did not administer Resident A's Norco medication as prescribed for pain.

INVESTIGATION:

On 2/18/2025, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged direct care staff did not administer Resident A's Norco medication as prescribed for pain.

On 2/19/2025, I conducted an interview with APS Specialist Lauren Crock who stated she also investigated this allegation and found no substantial evidence to support neglect or abuse because Resident A was not given her Norco medication as prescribed. APS Specialist Lauren Crock stated this occurred because the facility ran out of the medication to give to Resident A.

On 2/21/2025, I conducted interviews with direct care staff members Alexis Craft and Lomachia Cox. Alexis Craft stated that Resident A requested to take her Norco medication because she was experiencing pain at which time direct care staff noticed this medication had run out and was not refilled. Alexis Craft stated Resident A was then sent out to the hospital per Resident A's request where she was given a new prescription for this medication. Alexis Craft stated the medication was eventually delivered to the facility on the evening of 2/12/2025 after Resident A returned from the hospital. Alexis Craft stated Resident A was out of her medication beginning 2/4/2025 until 2/12/2015 and this is a medication that she is supposed to take every day. Alexis Craft further stated staff members failed to follow facility medication protocol by not notifying her so she could contact the pharmacy and Resident A's primary care physician to get a new physician prescription refill prior to Resident A running out of the medication.

Lomachia Cox stated she worked with Resident A on 2/12/2025 and was aware that Resident A did not have any Norco medications left beginning 2/4/2025. Lomachia Cox stated since Resident A did not have the medication she could not administer it. Lomachia Cox stated she was told by another staff member that they were waiting for someone to request a new physician prescription for this medication however Lomachia Cox later learned that staff member Alexis Craft, who oversees medications, was never notified that Resident A was running low or had run out of this medication. Lomachia Cox stated this is the facility procedure to ensure resident medications are regularly refilled and kept in the facility. Lomachia Cox stated Resident A was sent to the hospital on 2/12/2025 due to being in pain and her Norco medication was eventually delivered to the facility after Resident A returned from the hospital.

While at the facility, I observed Resident A sleeping in her bedroom therefore she was not interviewed.

While at the facility, I also observed Resident A's medication administration record (MAR) for the month of February 2025 which documented that Resident A takes

Hydrocodone-Acetaminophen (Norco) 5-325 MG by mouth every 8 hours for pain and Resident A did not receive this medication from 2/4/2025 to 2/12/2025.

On 2/21/2025, I conducted an interview with direct care staff member Hailey Nichols who stated that Resident A regularly takes Norco medication for pain every day however Resident A had run out of this medication for a few days and staff members were allegedly working on getting this medication refilled. Hailey Nichols stated Resident A asked for this medication on 2/12/2025 because she was in pain and was sent to the hospital since staff was not able to give this medication to her. Hailey Nichols stated direct care staff failed to follow medication refill procedures by not notifying Alexis Craft that Resident A was out of her medication. Hailey Nichols stated Alexis Craft processes medication refills or notifies physician's for new prescriptions.

On 2/21/2025, I reviewed the facility's *Controlled Substance Log* which documented Resident A ran out of her Norco medication on 2/4/2025 and the medication was not refilled until 2/13/2025.

I also reviewed the facility's *Disciplinary Notice* that documented Lomachia Cox received a disciplinary notice issued by Alexis Craft on 2/12/2025 for having a medication error and will be provided further education.

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:	Based on my investigation which included interviews with direct care staff members Alexis Craft, Lomachia Cox, and Hailey Nichols, Resident A, APS Specialist Lauren Crock, along with a review of facility's controlled substance log, disciplinary notice, and Resident A's MAR there is evidence direct care staff did not administer Resident A her Norco medication as prescribed for pain. Alexis Craft, Lomachia Cox and Hailey Nichols all stated that staff failed to follow facility medication refill procedures therefore Resident A's Norco medication was not refilled timely resulting in Resident A going without this medication for nine days. According to Resident A's MAR, Resident A is prescribed Hydrocodone-Acetaminophen (Norco) 5-325 MG to take by mouth every 8 hours for pain and Resident A did not receive this medication from 2/4/2025 to 2/12/2025. Resident A was not administered her medication as prescribed due to her medication not being available at the facility for Resident A to take.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/6/2025, I conducted an exit conference with licensee designee Catherine Reese and administrator Laurel Space. I informed Catherine Reese and Laurel Space of my findings and allowed them an opportunity to ask questions and make comments. On 4/2/2025, I approved an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action plan was received therefore I recommend the current license status remain unchanged.

Ondrea Johnson

4/8/2025

Ondrea Johnson
Licensing Consultant

Date

Approved By:

Dawn Timm

04/10/2025

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Dawn N. Timm
Area Manager

Date