GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 12, 2025

Timothy Reardon
Novi Lakes Health Campus
41795 Twelve Mile Road
Novi, MI 48377

RE: License #: AH630362954

Dear Licensee:

Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. 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 dates 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 home for the aged 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 feel free to contact the local office at (517) 335-5985.

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
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AH630362954
Licensee Name:	Trilogy Healthcare of Oakland II, LLC
Licensee Address:	303 N. Hurstbourne Pkwy., Suite 200 Louisville, KY 40222-5158
Licensee Telephone #:	(502) 412-5847
Authorized Representative and Administrator:	Timothy Reardon
Name of Facility:	Novi Lakes Health Campus
Facility Address:	41795 Twelve Mile Road Novi, MI 48377
Facility Telephone #:	(248) 449-1655
Original Issuance Date:	08/12/2016
Capacity:	38
Program Type:	AGED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 05/06/2025

Date of Bureau of Fire Services Inspection if applicable: 12/18/2023

Inspection Type: ☐Interview and Observation ☒Worksheet ☐Combination

Date of Exit Conference: 05/12/2025

No. of staff interviewed and/or observed 13
No. of residents interviewed and/or observed 21
No. of others interviewed 0 Role

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.

- Medication(s) and medication records(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☒ No ☐ If no, explain.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.

- Fire drills reviewed? Yes ☐ No ☒ If no, explain.
  The Bureau of Fire Services reviews fire drills, however facility disaster planning procedures were reviewed.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.

- Incident report follow-up? Yes ☐ IR date/s: N/A ☒
- Corrective action plan compliance verified? Yes ☐ CAP date/s and rule/s:
  Compliance was not verified. There are numerous repeat violations are noted in this report from the previous licensure survey, CAP dated 8/25/22.
- Number of excluded employees followed up? No exclusion notices were received since the previous licensure survey N/A ☒

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

<table>
<tr><td colspan="2">This facility was found to be in non-compliance with the following administrative rules regulating home for the aged facilities:</td></tr>
<tr><td>R 325.1921</td><td>Governing bodies, administrators, and supervisors.</td></tr>
<tr><td></td><td>(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.</td></tr>
<tr><td colspan="2">I observed Resident’s A, B and C to have assistive devices affixed to their bed frames. The facility lacked physician’s orders for the devices directing their purpose and authorization for use

[REPEAT VIOLATION ESTABLISHED]</td></tr>
<tr><td>R 325.1931</td><td>Employees; general provisions.</td></tr>
<tr><td></td><td>(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.</td></tr>
<tr><td colspan="2">Review of resident service plans revealed that Resident A, B and C’s plans were void of any information pertaining to the bedside assistive devices and lacked instruction to staff on the monitoring of the residents while the devices are in use.

[REPEAT VIOLATION ESTABLISHED]</td></tr>
<tr><td>R 325.1932</td><td>Resident medications.</td></tr>
<tr><td></td><td>(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.</td></tr>
</table>

Medication administration records (MAR) were reviewed for the previous five weeks. The following observations were made:

Resident C missed a scheduled dose of cyclobenzaprine on 4/1/25, 4/2/25, 4/3/25, 4/5/25, 4/7/25, 4/8/25 and 4/10/25. Staff documented the reason for the missed doses as “drug/item unavailable”, despite staff documenting the medication was administered between doses it was listed as not in the building. When queatsioed, Employee 1 reported “*We do have a back up system that we can utilize and cyclobenzaprine is in the system. The nurses are able to pull from it- med techs are not. It could be the nurse pulled the medication from the back up system, or it could be a charting error.”*

Resident F missed a scheduled dose of omega-3 on 4/1/25, 4/2/25, 4/3/25, 4/4/25, 4/7/25, 4/12/25, 4/13/25, 4/19/25, 4/20/25, 4/21/25, 4/22/25, 4/23/25, 4/25/25, 4/26/25, 4/27/25, 5/3/25 and 5/4/25. Staff documented the reason for the missed doses as “drug/item unavailable”, despite staff documenting the medication was administered between doses it was listed as not in the building. When questioned, Employee 1 reported:

> *The residents girlfriend does supply this medication so we do rely on her to supply the facility with this med. This medication cannot be pulled from our back up system as we do not have it available. It could be an error- or possibly the staff that said it was not available were unaware of where it is kept in the medication cart. I will ensure everyone is aware of where it is kept.*

Resident G missed one or more scheduled doses of oxycodone on 4/3/25, 4/13/25 and 4/14/25. Staff documented the reason for the missed doses as “drug/item unavailable”, despite staff documenting the medication was administered between doses it was listed as not in the building. When questioned, Employee 1 reported

> *The residents girlfriend does supply this medication so we do rely on her to supply the facility with this med. This medication cannot be pulled from our back up system as we do not have it available. It could be an error- or possibly the staff that said it was not available were unaware of where it is kept in the medication cart. I will ensure everyone is aware of where it is kept.*

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.

For the timeframe reviewed, I observed that each MAR showed habitual practices of staff not documenting the medication pass at the time medications are administered and also not listing the time the medication was administered. For example, staff repeatedly would note “charted late” or “charted late given on time” but not identify what time the medication pass occurred.

For Resident B, this occurred with one or more medications on the following dates: 4/3/25, 4/4/25, 4/5/25, 4/6/25, 4/9/25, 4/11/25, 4/12/25, 4/15/25, 4/16/25, 4/17/25, 4/18/25, 4/24/25, 4/26/25, 4/28/25, 4/29/25, 4/30/25, 5/2/25, 5/3/25 and 5/5/25.

For Resident C, this occurred with one or more medications on the following dates: 4/2/25, 4/5/25, 4/17/25, 4/23/25, 4/27/25, 4/28/25, 4/29/25, 5/1/25, 5/4/25 and 5/5/25.

For Resident D, this occurred with one or more medications on the following dates: 4/2/25, 4/5/25, 4/10/25, 4/12/25, 4/18/25 and 4/24/25.

For Resident E, this occurred with one or more medications on the following dates: 4/4/25, 4/11/25, 4/15/25, 4/22/25, 4/24/25, 4/30/25 and 5/5/25.

For Resident F, this occurred with one or more medications on the following dates: 4/1/25, 4/3/25, 4/8/25, 4/11/25, 4/12/25, 4/13/25, 4/14/25, 4/15/25, 4/17/25, 4/18/25, 4/21/25, 4/22/25, 4/23/25, 4/24/25, 4/27/25, 4/29/25 and 4/30/25.

For Resident G, this occurred with one or more medications on the following dates: 4/1/25, 4/2/25, 4/3/25, 4/4/25, 4/5/25, 4/6/25, 4/9/25, 4/11/25, 4/12/25, 4/13/25, 4/14/25, 4/15/25, 4/16/25, 4/17/25, 4/18/25, 4/22/25, 4/23/25, 4/24/25, 4/25/25, 4/26/25, 4/27/25, 4/28/25, 4/29/25, 4/30/25, 5/1/25, 5/3/25, 5/4/25, 5/5/25 and 5/6/25.

When questioned, Employee 1 reported that staff are trained to document medication passes in real time and staff should not be going back and charting later. Review of the facility’s medication administration policy also confirmed the expectation that medication passes should be charted right after they occur.

[REPEAT VIOLATION ESTABLISHED]

R 325.1953	**Menus.**
	(1) A home shall prepare and post the menu for regular and therapeutic or special diets for the current week. Changes

	shall be written on the planned menu to show the menu as actually served.
The facility did not post a menu for the week and only had the menu for the current day posted. **[REPEAT VIOLATION ESTABLISHED]**	
R 325.1976	**Kitchen and dietary.**
	(6) Food and drink used in the home shall be clean and wholesome and shall be manufactured, handled, stored, prepared, transported, and served so as to be safe for human consumption.
Some perishable food items in the commercial kitchen's refrigerator and freezer were not properly stored (unsealed with packaging left open or food items left uncovered) and other items did not contain labels or dates on them identifying when the manufacturer's packing was opened or when the items were prepared. These items include but are not limited to diced potatoes, hamburger patties and sausage links. **[REPEAT VIOLATION ESTABLISHED]**	
R 325.1976	**Kitchen and dietary.**
	(8) A reliable thermometer shall be provided for each refrigerator and freezer.
A thermometer was missing from the refrigerator in resident room 405, the 400 hallway alcove, the medication room and a broken thermometer was observed in resident room 515**.** **[REPEAT VIOLATION ESTABLISHED]**	

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, renewal of the license is recommended.

05/12/2025

Elizabeth Gregory-Weil Date
Health Care Surveyor