GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 28, 2025

David Zebley
Cambrian Senior Living
52365 W. 10 Mile Road
South Lyon, MI 48178

RE: License #: AH630375650

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 #:	AH630375650
Licensee Name:	Cambrian Of Lyon, LLC
Licensee Address:	52365 W. 10 Mile Road South Lyon, MI 48178
Licensee Telephone #:	(517) 423-5300
Authorized Representative:	David Zebley
Administrator:	Amy Murphy
Name of Facility:	Cambrian Senior Living
Facility Address:	52365 W. 10 Mile Road South Lyon, MI 48178
Facility Telephone #:	(248) 344-0001
Original Issuance Date:	02/27/2017
Capacity:	90
Program Type:	ALZHEIMERS AGED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 07/24/2025

Date of Bureau of Fire Services Inspection if applicable: 11/19/2024

Inspection Type: ☐ Interview and Observation ☒ Worksheet ☐ Combination

Date of Exit Conference: 07/24/2025

No. of staff interviewed and/or observed 19
No. of residents interviewed and/or observed 57
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. The facility does not hold resident funds in trust.
- 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: CAP dated 10/2/23, R 325.1922 (5)
- Number of excluded employees followed up? N/A ☒

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following administrative rules regulating home for the aged facilities:	
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. **(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following:** **(a) Be trained in the proper handling and administration of the prescribed medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The name of the prescribed medication.** **(ii) The prescribed required dosage and the dosage that was administered.** **(iii) Label instructions for use of the prescribed medication or any intervening order.** **(iv) The time when the prescribed medication is to be administered and when the medication was administered.** **(v) The initials of the individual who administered the prescribed medication.** **(vi) A record if the resident refuses to accept prescribed medication and notification as required in subdivision (c) of this subrule.** **(vii) A record of the reason for administration of a prescribed medication that is on an as-needed basis.** **(c) Contact the appropriate licensed health care professional when the prescribed medication has not been administered in accordance with the label instruction, an order from a health care professional, medication log, or a service plan.**

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

Resident A missed a scheduled dose of eucerin on 6/5/25, preparation H on 6/5/25, 6/6/25 and 7/14/25 and docusate on 6/27/25. Staff documented the missed medication as “OTH”, meaning “other”. Per Employee 1, staff are to type in a reason for the missed medication in the “notes” section on the MAR, but in all instances the notes were left blank and staff did not indicate why the medications were missed.

Resident B missed a scheduled dose of carvedilol on 6/10/25, docusate on 6/11/25, famotidine on 6/11/25, acetaminophen on 6/12/25, 6/13/25 and 7/11/25. In all instances, staff documented that the medications were unavailable. Per Employee 1, these medications were not reordered prior to Resident B running out. Resident B also missed a scheduled lidocaine patch on 7/9/25. Staff documented the missed medication as “OTH”, meaning “other”, however staff failed to indicate why the medication was missed.

Resident C missed a scheduled dose of ketoconazole on 6/1/25, 6/9/25, 6/14/25, 6/19/25, 6/20/25, 6/23/25, 6/24/25, 6/28/25, 6/29/25, 7/3/25, 7/7/25, 7/8/25, 7/12/25, 7/13/25, 7/17/25, 7/18/25 and 7/22/25. Staff documented the missed medication as “OTH”, meaning “other”, however staff failed to indicate why the medications were missed.

Resident D missed a scheduled dose of acetaminophen on 6/1/25, 6/2/25 and 6/3/25. In all instances, staff documented that the medications were unavailable. Per Employee 1, Resident D’s family supplies the medications, and they were not brought in to the facility timely due to the family being on vacation. Resident D missed a scheduled dose of quetiapine on 7/1/25, 7/2/25, 7/4/25, 7/5/25, 7/6/25, 7/7/25, 7/8/25, 7/12/25, 7/13/25, 7/16/25, 7/18/25, 7/21/25, 7/22/25 and 7/23/25. In all instances, staff documented that the medications were unavailable. Per Employee 1, Resident D’s son wanted the medication discontinued. Despite the medication being unavailable, on 7/3/25, 7/9/25, 7/10/25, 7/11/25, 7/14/25, 7/15/25, 7/17/25, 7/19/25, and 7/20/25, staff documented that Resident D refused the medication. These instances are considered to be documentation errors since the medication was not in the building for the resident to refuse.

Resident E missed a scheduled dose of nystatin on 6/1/25, 6/9/25, 6/14/25, 6/15/25, 6/19/25, 6/20/25, 6/23/25, 6/24/25, 6/28/25, 6/29/25, 7/3/25, 7/7/25, 7/8/25, 7/12/25, 7/13/25, 7/17/25, 7/18/25 and 7/21/25. Staff documented the missed medication as “OTH”, meaning “other”, however staff failed to indicate why the medications were missed.

Resident F missed a scheduled dose of linzess on 6/6/25, 6/7/25 and 6/9/25. In all instances, staff documented that the medications were unavailable. Per Employee 1, Resident F required a new prescription, which was requested on 6/6/25 and delivered to the facility on 6/10/25. Per Employee 1, these medications were not

reordered prior to Resident F running out. Additionally, staff documented on 6/8/25 that this medication was administered to Resident F. This is considered to be a documentation error since the medication was not in the building to be administered. Resident F missed a dose of vitamin D3 on 6/18/25. Staff documented that the medication was unavailable. Per Employee 1, Resident F's family supplies this medication. Resident F missed a scheduled dose of polyethylene on 6/27/25. Staff documented that the medication was unavailable. Per Employee 1, Resident F was not out of the medication, and it is unclear why it was marked as unavailable and is considered to be a documentation error. Resident F missed a scheduled dose of vitamin B12 on 7/7/25 and 7/11/25. Staff documented that the medication was unavailable. Per Employee 1, this medication was ordered from the pharmacy on 7/11/25. Additionally, staff documented on 7/9/25 that this medication was administered to Resident F. This is considered to be a documentation error since the medication was not in the building to be administered. Resident F missed a scheduled dose of magnesium oxide on 7/7/25, 7/8/25, 7/9/25, 7/10/257/10/25, 7/11/25, 7/12/25, 7/13/25, 7/15/25 and 7/16/25. Staff documented that the medications were unavailable. Per Employee 1, Resident F's family supplies this medication and reported it was brought to the facility on 7/17/25. Additionally, staff documented that this medication was refused by Resident F on 7/13/25 and administered twice on 7/14/25. These are considered to be documentation errors since the medication was not in the building to be administered. Resident F missed a scheduled dose of senna on 7/8/25. Staff documented that the medication was unavailable. Per Employee 1, this medication was not reordered timely prior to Resident F running out.

Resident G missed a scheduled dose of Memantine on 6/1/25, 6/2/25, 6/3/25, 6/4/25, 6/6/25, 6/8/25, 6/9/25, 6/10/25, 6/12/25, 6/13/25, 6/14/25, 6/15/25, 6/17/25-6/24/25. Per Employee 1, this medication was initially supplied by Resident G's family, and when they attempted to order it from the pharmacy it was too soon to refill. Employee 1 confirmed the medication was delivered to the facility on 6/24/25. Additionally, staff documented that this medication was administered Resident G on 6/5/25, 6/7/25, 6/11/25 and 6/16/25. These are considered to be documentation errors since the medication was not in the building to be administered. Resident G missed a scheduled dose of sertraline on 6/16/25. Staff documented that the medication was unavailable. Per Employee 1, this medication was not reordered prior to Resident G running out.

R 325.1972	**Solid wastes.**
	All garbage and rubbish shall be kept in leakproof, nonabsorbent containers. The containers shall be kept covered with tight-fitting lids and shall be removed from the home daily and from the premises at least weekly.

Numerous garbage containers throughout the facility were observed to be uncovered without lids, including several in the commercial kitchen.	
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 and freezer in resident rooms 25, 30 and 33.	
R 325.1979	**General maintenance and storage.**
	(3) Hazardous and toxic materials shall be stored in a safe manner.
Hazardous and toxic material such as cleaning agents and detergents were located in unsecured areas of the building, including the garden terrace café and assisted living dining room. These items pose unnecessary ingestion and subsequent poisoning risk to those residents that lack safety awareness.	

IV. RECOMMENDATION

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

07/28/2025

Elizabeth Gregory-Weil Date
Licensing Consultant