GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 25, 2026

Northville Pointe Senior Living
40405 Six Mile Road
Northville, MI 48167

RE: License #: AH820236941
Investigation #: 2026A1019039
Northville Pointe Senior Living

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 responsible party 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) 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
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH820236941
Investigation #:	2026A1019039
Complaint Receipt Date:	06/16/2026
Investigation Initiation Date:	06/17/2026
Report Due Date:	08/16/2026
Licensee Name:	VOP Northville Pointe, LLC
Licensee Address:	500 N Hurstbourne Pkwy, Suite 200 Louisville, KY 40222
Licensee Telephone #:	Unknown
Administrator:	Vacant
Authorized Representative:	Vacant
Name of Facility:	Northville Pointe Senior Living
Facility Address:	40405 Six Mile Road Northville, MI 48167
Facility Telephone #:	(734) 420-6104
Original Issuance Date:	10/10/1996
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	72
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility is mismanaging medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/16/2026	Special Investigation Intake 2026A1019039
06/17/2026	Special Investigation Initiated - Face to Face
06/17/2026	Inspection Completed On-site
06/17/2026	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: The facility is mismanaging medications.

INVESTIGATION:

On 6/16/26, the department received a complaint that alleged medications are unsecured, not being given on time, staff are pre-setting medications and staff not counting medications between shifts. The complaint did not provide names of residents affected, nor did they provide names of any medications or dates of occurrences. Due to the anonymous nature of the complaint, additional information could not be obtained.

On 6/17/26, I conducted an onsite inspection. I interviewed Employees 1 and 2 at the facility. Employee 1 reported there are two med carts at the facility. Both employees denied that medications are pre-set, left unsecured or administered outside of ordering parameters. Employee 1 specified that staff have a two-hour window to pass medications (up to 1 hour before or after the scheduled time of the medication administration record). Employee 1 reported that the med carts are always locked and narcotics are double locked. Employee 1 reported that narcotics are counted in between each with the oncoming and off going med techs, and both are required to sign off on the counts. Employee 1 reported that the narcotic count

logs are reviewed weekly by management and denied any concerns over the medication counts.

While onsite, I observed both medication carts. Both carts were locked and contained a narcotic log book. I inspected both medication carts; I found no evidence of loose or preset medications. I audited both narcotic medication logs and compared them with the narcotic medication housed on the carts, and the logs were consistent with the medications observed. Staff documented daily that narcotic medications were being counted, however some days the narcotics were counted twice (due to staff working 12-hour shifts) and other days narcotics were counted 3 times (due to staff working 8-hour shifts).

At the time of my inspection, there were 27 residents at the facility. I randomly selected five residents (Residents A, B, C, D and E) and obtained their medication administration records (MAR). Residents A and B self-administered their medications, and I reviewed their assessments and physician's orders deeming them appropriate to do so. The following observations were made in Resident C, D and E's records:

- Resident C missed a scheduled dose of lorazepam on 5/9/26, 5/14/26, 5/16/26, 5/17/26, 5/31/26 and 6/8/26.
- Resident C missed a scheduled dose of morphine on 5/11/26, 5/31/26, 6/5/26 and 6/8/26
- Resident C missed a scheduled dose of ProSource on 5/11/26
- Resident C missed a scheduled dose of tropsium on 5/11/26
- Resident C missed a scheduled dose of xarelto on 5/11/26
- Resident D missed scheduled doses of all morning medications on 6/5/26
- Resident E missed a scheduled dose of ropinirole on 5/22/26
- Resident E missed scheduled doses of all morning medications on 6/5/26 and also missed a scheduled dose of acetaminophen and valproic acid on 6/11/26

In all the above-mentioned instances, the medication administration records were blank. The medication passes were not recorded and the reason for the missed medications were not documented.

APPLICABLE RULE	
R 325.1932	**Resident's medications.**
	(2) Prescribed medication managed by the home must be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed healthcare professional.

ANALYSIS:	Through direct observation of the facility, inspection of the medication carts, staff interview and medication administration record review, there is no evidence that medications are unsecured, preset, med counts not being conducted or medications not consistently being given on time. Despite the above, review of medication administration records, it was revealed that Residents C, D, and E did not receive all medications as prescribed as evidenced by lack of documentation in their MAR.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

At the time of the onsite inspection, the administrator and authorized representative on file was Employee 3. While onsite, it was discovered that Employee 3 had been terminated on 5/22/26. The licensee failed to notify licensing staff of this termination prior to being onsite and at the time of this report, has not appointed anyone else to those designations.

APPLICABLE RULE	
R 325.1913	**Licenses and permits; general provisions.**
	(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.
ANALYSIS:	The facility's former administrator/ authorized representative ceased her employment at the facility on 5/22/26. The licensee failed to provide any notification to the department of this change prior to licensing's inquiry into this matter and has not yet appointed anyone else to the designations.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes to the status of the license.

06/18/2026

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

06/25/2026

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