GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 27, 2026

Lance Davis
Lake (Bloomfield) TRS LLC
Suite 1600
6688 N.Central Expressway
Dallas, TX 75206

RE: License #: AH630409730
Investigation #: 2026A1027043
The Avalon of Bloomfield Township

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.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
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 #:	AH630409730
Investigation #:	2026A1027043
Complaint Receipt Date:	05/28/2026
Investigation Initiation Date:	06/01/2026
Report Due Date:	07/27/2026
Licensee Name:	Lake (Bloomfield) TRS LLC
Licensee Address:	Suite 1600 6688 N.Central Expressway Dallas, TX 75206
Licensee Telephone #:	(214) 754-8623
Authorized Representative/ Administrator:	Lance Davis
Name of Facility:	The Avalon of Bloomfield Township
Facility Address:	100 W Square Lake Rd Bloomfield Twp, MI 48302
Facility Telephone #:	(248) 480-7343
Original Issuance Date:	09/30/2022
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	158
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents A, B, and C did not receive their medications as prescribed.	Yes
Additional Findings	No

The anonymous complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

In accordance with administrative rule 325.1918(6)(b), some allegations in the anonymous complaint lacked sufficient detail to allow for investigation; therefore, this report includes only those within the licensing scope that were supported by adequate information.

III. METHODOLOGY

05/28/2026	Special Investigation Intake 2026A1027043
05/28/2026	Contact - Document Received Anonymous allegations initially received, and combined with these allegations
06/01/2026	Special Investigation Initiated - On Site
06/05/2026	Inspection Completed-BCAL Sub. Compliance
06/12/2026	Exit Conference Conducted by email with Lance Davis
06/15/2026	Contact – Document Received Email received from complainant with additional information
06/16/2026	Contact – Document Sent Email sent to Lance Davis requesting additional information and documentation
06/18/2026	Contact – Document Received Email received from Lance Davis with some of the requested information
06/22/2026	Contact – Document Sent

	Email sent to Lance Davis requesting additional information and documentation
06/26/2026	Contact – Document Received Email received from Lance Davis with requested information and documentation
06/26/2026	Contact – Telephone Call Made Telephone interview conducted with the Administrator and Employee #3
06/30/2026	Contact – Document Received Email received from Lance Davis with requested information and documentation
07/14/2026	Contact – Document Received Email received with additional documentation
07/27/2026	Exit Conference Conducted via email with Lance Davis

ALLEGATION:

Residents A, B, and C did not receive their medications as prescribed.

INVESTIGATION:

On May 28, 2026, the Department received anonymous allegations which read that Residents A, B, and C did not receive their medications on May 26, 2026. It was also alleged that the narcotic count log was incomplete.

That same day, the Department received additional allegations specific to Resident A in which read that on May 1, 2026, staff attempted to administer Resident A an incorrect medication, which she declined. It was further alleged that staff handled the incorrect medication without wearing gloves. Additional concerns included Resident A not receiving her evening medications until 10:00 PM on May 5, 2026, and not receiving her evening medications on May 26, 2026, until 11:47 PM.

On June 1, 2026, I conducted an on-site inspection and interviewed staff.

Authorized representative and administrator Lance Davis stated he was aware of medication-related concerns for Resident A and was actively working to address them. He reported that a staff member initially brought an incomplete set of medications to Resident A, which she refused. The medication technician then returned to the medication cart to obtain the remaining medications before administering them.

Regarding medication administration times, the administrator stated the home set the times for residents' medications to be administered. The administrator stated

that the facility's policy is for medications to be administered within one hour before or after the scheduled time. He also noted that recent medication-administration training had been provided and that two nurses were on staff to ensure medications were administered as prescribed.

The administrator further reported that Resident C passed away on May 30, 2026, while receiving hospice services.

During the on-site inspection, I reviewed the first-floor medication cart. Employee #1 explained that staff are required to sign in and out when completing the narcotic count. Review of the first-floor narcotic count log revealed several dates in May 2026 where staff did not sign in or out to verify the completion of the count.

Review of Resident A's May 2026 Medication Administration Record (MAR) showed that her scheduled 8:00 PM medications were administered at 9:59 PM on May 5, 2026, and at 11:49 PM on May 26, 2026. The MAR also reflected that her 8:00 PM medications were administered on time on May 1, 2026. Staff documentation for the late administration on these dates and others often noted "given as directed," "given as ordered," or "late entry."

Resident B's May 2026 MAR showed that on May 26, 2026, his 8:00 PM evening medications were administered at 12:04 AM on May 27, 2026. Most other medications for the month were administered within the one-hour window, except his scheduled 8:00 PM medication on May 22, 2026 (administered at 9:43 PM), and May 30, 2026 (administered at 9:36 PM). The MAR notes for late medication administration were consistent with those documented for Resident A.

Resident C's May 2026 MAR indicated that on May 26, 2026, her scheduled Lorazepam for 4:00 PM and 8:00 PM was administered at 5:40 PM and 9:16 PM, respectively. All other medications were administered within the scheduled timeframe or included documentation explaining the reason they were not administered.

Review of the Medication System – AL policy and procedure manual (dated August 12, 2015) indicated that narcotics must be recorded on a declining balance sheet for each individual medication and counted by staff at every shift. The staff member responsible is required to sign the start-of-shift count form each shift. The policy did not reference the use of gloves during medication administration.

The Infection Control policy (dated March 2025) stated that standard precautions apply whenever there is potential exposure to blood, bodily fluids, non-intact skin, or mucous membranes. These precautions include proper hand hygiene and the use of appropriate personal protective equipment, such as gloves.

On June 15, 2026, after receiving the final investigation report, the complainant emailed the Department a video in which Employee #2 can be heard confirming that she administered the wrong medication to Resident A at approximately 5:10 PM on May 1, 2026. The complainant stated this same video had previously been provided to Employee #3. The email also alleged that Employee #2 was not wearing gloves

during the administration; however, this concern had already been addressed, and glove use is not required for oral medication administration under administrative rules or the home's policy.

On June 16, 2026, the complainant reported via email that the medication error, lack of glove use, and late medication passes had been verbally reported to Employee #3 on May 10, 2026, and that Employee #3 requested the related videos. The complainant downloaded and forwarded the videos on May 11, 2026, at 1:06 PM. The complainant stated she was informed that temporary medication technicians would no longer administer medication to Resident A; however, on May 26, 2026, a temporary medication technician administered Resident A's evening medications close to midnight.

The Department does not have authority over the home's use of agency staffing; thus, concerns related to staffing decisions fall outside the Department's investigatory purview.

On June 18, 2026, the administrator confirmed via email that the home was aware of video surveillance inside Resident A's apartment and that signage was posted outside of the unit. The administrator also confirmed that Employee #2 was the staff person who administered Resident A's medications on May 1, 2026, and explained that the timestamp on the video was set to west coast time, making the actual time of the incident approximately 8:10 PM.

On June 26, 2026, the administrator provided additional information via email stating that Employee #2 was hired directly by the home on December 24, 2024, and was not an agency staff person. When Relative A1 originally reported the incident to Employee #3 several weeks after it occurred, she had stated that the staff person involved was from an agency. Based on this information, the home elected to discontinue the use of temporary staff as medication technicians.

On June 26, 2026, a telephone interview was conducted with the Administrator and Employee #3. They reported that Relative A1 had requested agency staff not administer medications to Resident A. They denied receiving the video showing Employee #2 administering the wrong medication and had been verbally informed that the staff member involved was an agency employee. The Administrator subsequently discontinued agency medication technicians from working in the home, permitting only agency care staff. They stated Employee #2 acknowledged bringing the wrong medication to Resident A, though she did not recall details of the incident. They reiterated that any incorrect medication must be wasted and cannot be administered to another resident, and therefore gloves would not have been worn.

On June 30, 2026, email documentation confirmed that Employee #2 would receive medication administration counseling.

On July 8, 2026, Employee #2 received a behavioral change notice related to the May 1, 2026, incident shown in the video. She was re-educated on medication administration and confirmed she would remain diligent in verifying medications going forward.

A review of Resident A's May 2026 MARs showed that Employee #2 administered a prescribed PRN Hydrocodone at 8:01 PM on May 1, 2026.

Employee #2's personnel file documented medication competency training dated September 18, 2025, and updated medication technician training on March 30, 2026, which included instruction on the six rights of medication assistance.

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:	The investigation confirmed that Residents A, B, and C did not consistently receive their medications as scheduled. Although the administrator acknowledged medication-related concerns and stated that medications should be given within one hour of the scheduled time, the MARs for all three residents showed late administrations outside the timeframe indicated. Documentation frequently included vague notes such as “late entry” or “given as ordered,” without sufficient explanation for delays. Additionally, review of the narcotic count log showed incomplete entries, indicating that required verification procedures were not consistently followed as per their policy. The complainant asserted that the medtech was not wearing gloves during medication administration on May 1, 2026, and that Resident A was handed incorrect medication, as shown in the video footage submitted to the Department on June 15, 2026. Review of the home’s policy confirmed that glove use is not required for routine oral medication administration, and medications dropped on the floor are to be disposed of. Therefore, the absence of gloves during this interaction did not violate the home’s stated policy. Email documentation indicated Employee #3 received the video footage from the Complainant on May 11, 2026, at 1:06 PM PDT. Employee #3 denied receiving the video footage and reported that the staffing changes she initiated were based on Relative A1’s observation of video. The administrator subsequently limited medication administration duties to staff hired directly by the home. Review of Employee #2’s file showed she had received medication administration training at time of hire and retraining in March 2026. Although the administrator confirmed Employee #2 would receive counseling after reviewing the incident, the Department expects the home to verify the staff involved before implementing corrective measures and to provide counseling at the time administrative staff are notified. Administrative rule requires prescribed medications managed by the home to be given, taken, or applied pursuant to labeling instructions and orders from the prescribing licensed healthcare professional. Video evidence and record review confirmed that Residents A, B, and C did not receive their medications as prescribed. For this violation, the Department expects the home

	to conduct staff retraining in a manner distinctly different from previously implemented corrective actions. Based on these findings, this violation stands.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[For reference, see licensing study report dated 2/24/2026, corrective action plan (CAP) dated 3/19/2026]**

IV. RECOMMENDATION

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

06/11/2026, Updated 07/14/2026

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Jessica Rogers Date
Licensing Staff

Approved By:

06/11/2026, Updated 07/27/2026

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