GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 19, 2022

Tami McKellar
AH Kentwood Subtenant LLC
6755 Telegraph Road Suite
Bloomfield Hills, MI 48301

RE: License #: AL410397694
Investigation #: 2022A0583036
AHSL Kentwood Riverstone

Dear Ms. McKellar:

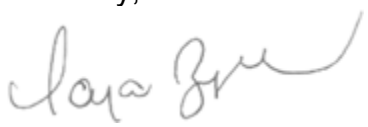
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

If you desire technical assistance in addressing these issues, please 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 (616) 356-0183.

Sincerely,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410397694
Investigation #:	2022A0583036
Complaint Receipt Date:	07/07/2022
Investigation Initiation Date:	07/08/2022
Report Due Date:	08/06/2022
Licensee Name:	AH Kentwood Subtenant LLC
Licensee Address:	One SeaGate, Suite 1500 Toledo, OH 43604
Licensee Telephone #:	(248) 203-1800
Administrator:	Tami McKellar
Licensee Designee:	Tami McKellar
Name of Facility:	AHSL Kentwood Riverstone
Facility Address:	5980 Eastern Ave SE. Kentwood, MI 49508
Facility Telephone #:	(248) 309-0257
Original Issuance Date:	01/18/2019
License Status:	1ST PROVISIONAL
Effective Date:	06/15/2022
Expiration Date:	12/14/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff failed to administer Resident A's anti-seizure medication.	Yes

III. METHODOLOGY

07/07/2022	Special Investigation Intake 2022A0583036
07/08/2022	Special Investigation Initiated - On Site Staff Tatiana Lopez, Resident A
07/11/2022	APS Referral
07/11/2022	Contact - Document Received Jennifer Hicks, Wellness Director
07/12/2022	Contact – Telephone Kavan Desai, Remedi Pharmacy
07/12/2022	Contact - Telephone Dr. Elami
07/13/2022	Contact – File Review
07/13/2022	Contact – Email Staff Tatiana Lopez
07/13/2022	Contact – Telephone Staff Laura Baca
07/18/2022	Contact – Document Received Trinity Health Medical Records
07/19/2022	Exit Conference American House Clinical Specialist Katrina Aleck

ALLEGATION: Staff failed to administer Resident A's anti-seizure medication.

INVESTIGATION: On 07/07/2022 I received an incident report and accompanying document titled "addendum to afc" from the facility via email. I reviewed the incident report was written by Wellness Director Jennifer Hicks on 07/05/2022 and stated Resident A was discovered by "med tech" on 07/05/2022 at 5:30 am "on the floor". The document indicates Resident A was observed with "emesis noted on his chin, neck, and shirt and incontinent of urine". The document further stated Resident A sustained a "tear" on his "right ear with active bleeding, abrasion on middle of his

back and cut on his right arm". The document stated Resident A was transported to the Emergency Department via Emergency Medical Transport.

The accompanying document was written on 07/07/2022 by Wellness Director Jennifer Hicks and stated the following:

'Date: 7/7/2022
Regarding: ADDENDUM TO AFC INCIDENT / ACCIDENT REPORT
For Michael McPharlin Dated 7/5/2022
Upon additional investigation the following addendum is being submitted.
ADDEMDUM TO Explain What Happened / Describe Injury (if any).
Upon further investigation it was noted that the resident did not receive his scheduled Levetiracetam on 7/3/22 at 8pm and 7/4/22 8am and 8pm. This medication was not available on the cart.
ADDENDUM TO Action taken by Staff / Treatment Given.
Laura Baca Med Tech contacted Remedi Pharmacy for a refill to be STAT delivered on 7/3/22 at 8PM. Again on 7/4/22 Med Tech Laura Baca contacted Remedi Pharmacy for a refill and the medication came in the early morning of 7/5/22.
Jennifer Hicks LPN Wellness Director called and spoke with Cindy at Remedi on 7/7/2022 at 8:30am to inquire why the medication was not sent on 7/3/22 as a STAT order was requested. Cindy from Remedi initiated an investigation and did see a note from the community on 7/4/2022 at 8 PM requesting the medication be refilled. Cindy stated that the medication was sent and received by the facility on the morning of 7/5/2022'.

On 07/08/2022 I completed an unannounced onsite investigation at the facility and privately interviewed Assistant Wellness Director Tatiana Lopez and Resident A. Ms. Lopez stated Resident A is diagnosed with a seizure disorder that necessitates the administration of an anti-seizure medication called Levetiracetam twice daily. Ms. Lopez stated she was informed from staff Laura Baca that Resident A was discovered by Ms. Baca on his bedroom floor on 07/05/2022 on 5:30 AM after Resident A suffered a seizure. Ms. Lopez stated Emergency Medical Services were contacted and Resident A was transported via ambulance to St. Mary's hospital where Resident A was hospitalized until 07/072022. Ms. Lopez stated an examination of Resident A's Medication Administration Record indicates Resident A was not administered his prescribed Levetiracetam on 07/03/2022 in the evening, 07/04/2022 in the morning, and 07/04/2022 in the evening because the facility ran out of the medication and failed to obtain a refill. Ms. Lopez stated Ms. Baca informed her that she (Ms. Baca) had called their contracted pharmacy, Remedi, on the evening of 07/03/2022 and requested a "STAT" refill of Levetiracetam. Ms. Lopez stated a "STAT" refill is typically "drop shipped" directly to the facility within "four hours". Ms. Lopez stated Resident A's Levetiracetam was not delivered to the facility on 07/04/202 as requested therefore Ms. Baca subsequently telephoned Remedi pharmacy on 07/04/2022 and again requested a "STAT refill" of Levetiracetam. Ms. Lopez stated Resident A's Levetiracetam was drop shipped to the facility on 07/05/2022 at 04:30 AM. Ms. Lopez stated the facility's electronic

Medication Administration Record has no “trigger” to alert staff when residents’ medications are running low. Ms. Lopez stated facility staff “should have” called Resident A’s “PCP” to request an emergency medication refill for Levetiracetam as a means to obtain Resident A’s anti- seizure medication before the medication ran out.

Resident A stated he has been diagnosed with a seizure disorder which is “well controlled” by the administration of his prescription medication Levetiracetam twice per day. Resident A stated he experienced a seizure on 07/05/2022 however he does not remember the exact time the episode occurred. Resident A stated he was located by an unknown facility staff on the floor of his bedroom on 07/05/2022 and was sent via emergency medical transport to St. Marys’ hospital. Resident A stated he was hospitalized at St. Mary’s hospital until he returned to the facility on 07/07/2022. Resident A stated he experienced the 07/05/2022 seizure as a result of the facility running out of and not refilling his anti-seizure medication, Levetiracetam, for two to three days.

On 07/11/2022 I emailed “complaint allegations” to Adult Protective Services Centralized Intake.

On 07/12/2022 I interviewed Kavan Dasai of Remedi Pharmacy via telephone. Mr. Dasai stated Remedi Pharmacy’s system indicates that the pharmacy was contacted via telephone on 07/04/2022 at 08:15 PM by a facility staff named “Sandy”. Mr. Dasai stated “Sandy” requested a refill of Resident A’s Levetiracetam which was delivered directly to the facility on 07/05/2022 at 04:05 AM.

On 07/12/2022 I interviewed Dr. Elami via telephone. Dr. Elami stated he is Resident A’s primary care physician and provides care to multiple residents at the facility. Dr. Elami stated Resident A has been diagnosed with a seizure disorder and is prescribed Levetiracetam for seizure control twice per day. Dr. Elami stated Resident A’s seizures are well controlled by Levetiracetam. Dr. Elami stated he “doesn’t remember” facility staff telephoning him on 07/05/2022 to alert him of Resident A’s admission to St. Mary’s hospital. Dr. Elami stated he visited the facility on 07/06/2022 and was alerted to Resident A’s 07/05/2022 hospitalization by facility staff. Dr. Elami stated facility staff never contacted him prior to Resident A’s 07/05/2022 hospitalization to request an emergency medication refill of Levetiracetam to which Dr. Elami stated he would have immediately refilled. Dr. Elami stated facility staff routinely telephone him and request emergency medication refills for residents that can be filled at a local pharmacy. Dr. Elami stated on 07/06/2022 he was informed by facility staff that Resident A “had a fall” at the facility on 07/05/2022 which caused Resident A to sustain “a cut on his ear lobe” and subsequently led to an emergency room visit. Dr. Elami stated facility staff stated that while Resident A was at St. Mary’s hospital on 07/05/2022 Resident A suffered a seizure and hospital staff discovered Resident A had not received multiple Levetiracetam doses at the facility. Dr. Elami stated facility staff did not inform him how many doses of Levetiracetam Resident A missed prior to his 07/05/2022 hospitalization. Dr. Elami stated Resident A suffering a seizure on 07/05/2022

“happens if you don’t give the meds”. Dr. Elami stated Resident A suffered his 07/05/2022 seizure as a direct result of facility staff not administering Resident A’s Levetiracetam on 07/03/2022 PM, 07/04/2022 AM, and 07/04/2022 PM.

On 07/13/2022 I completed a file review which indicates the facility is currently operating via a Provisional License issued 06/15/2022 due to multiple quality of care violation substantiations documented in Special Investigation 2022A0583027. I further observed that the facility was cited for a violation of R 400.15312 (1) on 05/26/2022 via Special Investigation 2022A0583024.

On 07/13/2022 I received Resident A’s Medication Administration Record via email from staff Tatiana Lopez. The document indicated Resident A is prescribed Levetiracetam 100 MG/ML SOLN twice daily at 08:00 AM and 06:00 PM. The document further indicated Resident A did not receive his prescribed Levetiracetam 100 MG/ML SOLN on 07/03/2022 at 06:00PM due to the medication being “Unavailable”, on 07/04/2022 at 08:00 AM due to the medication being “not aval”, and 07/04/2022 at 06:00 PM due to the medication being “Unavailable”.

On 07/13/2022 I interviewed staff Laura Baca. Ms. Baca stated she worked at the facility as the medication technician on 07/03/2022 and 07/04/2022 and observed that the facility did not have Resident A’s Levetiracetam due to running out the medication. Ms. Baca stated she worked at the facility on 07/05/2022 and at 05:30 AM she discovered Resident A lying on his bedroom with “vomit and urine on his clothing” and “drainage coming from his nose” which she believed indicated Resident A had suffered a seizure. Ms. Baca stated Resident A sustained a cut on his ear. Ms. Baca stated she sent Resident A via ambulance to St. Mary’s hospital at 06:10 AM.

On 07/18/2022 I received and reviewed Resident A’s Medical Records from Trinity Health St. Mary’s via email. The document was completed and signed by Nicholas J Liquigli, DO Neurology, PGY2 Trinity Health Grand Rapids on 07/05/2022 and stated the following:

‘Date of service: 7/5/2022 Reason for consult: Seizure Requesting physician: Marilyn Innes, MD Source history: Patient's sister, chart review History of present illness: 75 y.o. male who presents with concern for seizure. He has a past medical history of diabetes mellitus, hypertension, seizure disorder, and traumatic ICH with history of CAA. He also has documented orthostasis and peripheral neuropathy. Patient is followed by Dr. Farooq and Dr. Phillips in neuro palliative clinic. He lives in an assisted care facility where this morning during rounding at 5:30 AM he was found on the floor next to his bed. Per the report he had vomited on himself and also urinated. He was also noted to have a right ear wound and a bruise on his back. He was brought to the emergency department at St. Mary's Hospital. According to his sister when she arrived at 8:40 AM he was still confused although awake. While in the ED shortly after her arrival he had another episode of what was described as generalized tonic-clonic activity with head turned to the left with clenched Printed on

7/14/22 1:41 PM Page 59 Continuous video EEG monitoring to rule out subclinical seizure activity Rule out any underlying infection or metabolic cause, monitoring of sodium Rule out any underlying infection, will hold off LP at this time Primary team to address any other metabolic causes Sz and fall precautions The patient was seen and examined independently. I reviewed chart, labs, imaging and repeated history and physical examination myself independently. Discussed with Dr. Liquigli and agree with his documentation above. The assessment and plan documented reflects lengthy discussion between myself and Dr. Liquigli. Also discussed the case with the patient/family and questions and concerns were addressed in detail carefully. They agreed with the plan as documented. Thank you kindly for allowing me to participate in the care of your patient. Please do not hesitate to call me if you have any question. I can be reached directly at 616-397-3527 (pager). Muhammad Umar Farooq, MD, FACP, FAHA Vascular Neurologist Mercy Health Saint Mary's Trinity Health Hauenstein Neuroscience Center 220 Cherry St SE Grand Rapids MI 49503-4608 McPharlin, Michael O MRN: 100946731, DOB: 9/13/1946, Sex: M Adm: 7/5/2022, D/C: 7/7/2022 07/05/2022 - ED to Hosp-Admission (Discharged) in Trinity Health Hauenstein Neuroscience Center - Grand Rapids Campus (continued) Consults (continued) jaw and whole body shaking. He was given 2 mg of Ativan and loaded with 1500 mg of Keppra. Initial labs in the emergency department showed a lactate of 4.7, sodium of 129, and WBC count of 13.3. During evaluation by myself he appears to be asleep, snoring loudly and unarousable to voice. He does withdrawal in all 4 extremities however does not open his eyes. I was able to contact the facility that the patient came from and informed that he missed his p.m. dose of Keppra last night. His home Keppra dose is 1500 mg twice daily.

Assessment Patient is a 75 y.o. male who presents with: 1. Seizure. Patient was found down in his room having vomited and urinated on himself, and confused. While in the emergency department he had a witnessed generalized tonic-clonic seizure. He was loaded with Keppra 1500 mg as well as 2 mg of Ativan. According to his facility, he missed his nighttime dose of Keppra last night. Most likely cause of his seizure was due to missing his dose of Keppra. There is no report of recent illness however this cannot be confirmed. Seizure provoking factor such as infection and hyponatremia should be addressed given his elevated WBC count and hyponatremia on presentation. CT head was negative for acute intracranial process.'

On 07/19/2022 I completed an Exit Conference via telephone with American House Clinical Specialist Katrina Aleck via telephone. Ms. Aleck stated she agreed with the findings and would submit an acceptable Corrective Action Plan. Ms. Aleck stated the Corrective Action Plan will include a voluntary facility closure with a planned date of 08/20/2022.

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 {333.1101 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:	Resident A's Medication Administration Record indicates Resident A is prescribed Levetiracetam 100 MG/ML SOLN twice daily at 08:00 AM and 06:00 PM. Resident A's Medication Administration Record indicates Resident A did not receive his prescribed Levetiracetam 100 MG/ML SOLN on 07/03/2022 at 06:00PM due to the medication being "Unavailable", on 07/04/2022 at 08:00 AM due to being "not aval", and 07/04/2022 at 06:00 PM due to being "Unavailable". Resident A's primary care physician Dr. Elami stated Resident A suffered a seizure on 07/05/2022 as a direct result of facility staff not administering Resident A's Levetiracetam on 07/03/2022 PM, 07/04/2022 AM, and 07/042022 PM. Resident A's medical records from Trinity Health St. Mary's hospital confirm Resident A did not receive his Levetiracetam 100 MG/ML SOLN as prescribed and suffered a seizure on 07/05/2022 at the facility and a second seizure on 07/05/2022 at the hospital as a result. A preponderance of evidence was discovered during the special investigation to establish a repeat violation of the applicable rule. Facility staff failed to administer Resident A's prescribed medication, Levetiracetam on 07/03/2022 PM, 07/04/2022 AM, and 07/04/2022 PM due to the facility being out of said medication.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED 2022A0583024 05/26/2022**

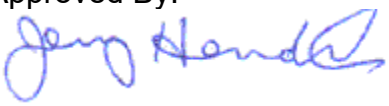
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, a continuation of the Provisional License is recommended.

07/19/2022

Toya Zylstra Date
Licensing Consultant

Approved By:



07/19/2022

Jerry Hendrick Date
Area Manager