GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 27, 2022

Alicia Sieplinga
Brentwood at Niles
1147 South Third Street
Niles, MI 49120

RE: License #: AH110376315
Investigation #: 2022A1010069
Brentwood at Niles

Dear Ms Sieplinga:

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 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 (517) 241-1970

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa, NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH110376315
Investigation #:	2022A1010069
Complaint Receipt Date:	08/23/2022
Investigation Initiation Date:	08/24/2022
Report Due Date:	10/22/2022
Licensee Name:	GAHC3 Niles MI ALF TRS Sub, LLC
Licensee Address:	Suite 300 1819 Von Karman Avenue Irvine, CA 92612
Licensee Telephone #:	(971) 204-7200
Authorized Representative/ Administrator:	Alicia Sieplinga
Name of Facility:	Brentwood at Niles
Facility Address:	1147 South Third Street Niles, MI 49120
Facility Telephone #:	(269) 684-9470
Original Issuance Date:	06/04/2015
License Status:	REGULAR
Effective Date:	02/13/2022
Expiration Date:	02/12/2023
Capacity:	80
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff did not notify Resident B's responsible person after she tested positive for COVID-19.	Yes
Resident B did not receive her prescribed Paxlovid medication until a few days after her physician ordered it.	Yes

III. METHODOLOGY

08/23/2022	Special Investigation Intake 2022A1010069
08/24/2022	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
08/24/2022	APS Referral APS referral emailed to Centralized Intake
09/01/2022	Contact - Telephone call made Interviewed complainant by telephone
09/01/2022	Inspection Completed On-site
09/01/2022	Contact - Document Received Received resident service plan, MAR, and staff notes
09/14/2022	Contact – Telephone call made Interviewed staff person Kolleen Bromley by telephone
09/27/2022	Exit Conference Completed with licensee authorized representative Alicia Sieplinga

ALLEGATION:

Staff did not notify Resident B's responsible person after she tested positive for COVID-19.

INVESTIGATION:

On 8/23/22, the Bureau received the allegations from the online complaint system. The complaint read, "Brentwood at Niles did not notify the POA (out of town family member) that their resident tested positive for a potential life-threatening medical

condition on 8/10/22. The POA only learned of this after initiating a discussion with a physician assistant at Agnar, the contracted medical group. The Brentwood facility failed to initiate any communication with the POA regarding this matter, despite agreeing to provide the POA with weekly updates on the resident on 5/13/22."

On 8/24/22, I emailed an Adult Protective Services referral to Centralized Intake.

On 9/1/22, I interviewed the complainant by telephone. The complainant's statements were consistent with the written complaint. The complainant reported Resident B was tested for COVID-19 on 8/10/22 and it was positive. The complainant stated staff at the facility said resident family members and responsible persons would be notified if their loved one tested positive. The complainant reported the facility did not follow this process when Resident B tested positive.

On 9/1/22, I interviewed the facility's wellness director Kay Thomas at the facility. Ms. Thomas reported staff did notify Resident B's responsible person after she tested positive for COVID-19. Ms. Thomas stated Resident B's responsible person did not answer the telephone, therefore staff left a voicemail. Ms. Thomas said staff also notified Resident B's physician after she tested positive.

Ms. Thomas stated residents are tested for COVID-19 anytime they experience symptoms. Ms. Thomas reported Resident B had a cough, therefore she was tested for COVID-19 and was positive. Ms. Thomas said when there is a COVID-19 outbreak in the facility, residents are tested two to three days a week.

On 9/1/22, I interviewed the facility's administrator Alicia Sieplinga at the facility. Ms. Sieplinga's statements were consistent with Ms. Thomas. Ms. Sieplinga reported in addition to staff leaving Resident B's responsible person a voicemail regarding her positive COVID-19 test, staff also emailed Resident B's responsible person.

On 9/1/22, I interviewed the facility's memory care director Tina Cox at the facility. Ms. Cox's statements were consistent with Ms. Thomas and Ms. Sieplinga. Ms. Cox reported Staff Person 1 (SP1) notified Resident B's responsible person and her physician after she tested positive for COVID-19 in August.

Ms. Cox provided me with Resident B's staff *Progress Notes* for my review. A note dated 8/10/22 read, "AC covid. Resident has tested positive for covid today. She has no C/O any pain. Resident at [sic] well both meals. Resident is now in her apartment resting."

On 9/14/2022, I interviewed SP1 by telephone. SP1 reported she did not contact Resident B's responsible person after Resident B tested positive for COVID-19. SP1 said she did not work on 8/10/22 when Resident B tested because she was quarantining at home due to testing positive for COVID-19 as well. SP1 explained she did call Resident B's responsible person by telephone when she returned to work after her quarantine ended to inform them the secured memory care unit was

quarantining due to the COVID-19 outbreak in the secured memory care unit. SP1 reported she left Resident B's responsible person a voicemail and she received a call back shortly after she left a message. SP1 reported she did not know whether Resident B's responsible person or physician were notified after Resident B tested positive for COVID-19.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	The interview with SP1 revealed she did not call Resident B's responsible person regarding her positive COVID-19 test on 8/10/22. SP1 reported she was not working at the time due to testing positive for COVID-19 herself. The facility was unable to provide documentation or verification that Resident B's responsible person was notified of her positive COVID-19 test.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B did not receive her prescribed Paxlovid medication until a few days after her physician ordered it.

INVESTIGATION:

On 8/23/22, the complaint read, "Paxlovid was ordered by Agnar the evening of Friday, August 12, 2022. Agnar's pharmacy filled the prescription, and their courier delivered the prescription to Brentwood on Friday August 12, 2022, during third shift. Upon following up Saturday morning, August 13th, the POA was told the prescription was not and could not be administered because the designated person on third shift the night before had not done the necessary charting to authorize the dispensing of the meds and that treatment would have to commence once entered into system. The POA had to press for this be [sic] corrected immediately since the administration of the PAxlovid needs to begin within a five-day window after a positive Covid test. Waiting until 8/15 was not an option.

On 8/13, Brentwood confirmed the administration of the first dose of Paxlovid. On 8/17, Agnar PA informed me that 3 doses and 1 capsule of Paxlovid was left to administer. This did not make sense as if the start date was 8/13, and 2 doses

(2pills/dose) were to be given each day, then the end date should have been 8/17. Brentwood said they missed 1 pill due to Med Tech mis-reading chart. Hence Brentwood concluded that is why the last dose would be given morning of 8/19. Again the math did not line-up and Brentwood would not concede that the math did not make sense. On 8/18, the POA asked for medical records of Paxlovid and learned that the first dose was actually given on 8/15. This contradicts Brentwood's previous assertion that the first dose was provided on 8/13."

On 9/1/22, the complainant's statements were consistent with the written complaint. The complainant reported Resident B's responsible person asked her physician to prescribe Paxlovid after Resident B tested positive for COVID-19. The complainant said the facility did not request this medication for Resident B. The complainant stated the facility did not provide consistent statements regarding when Resident B's Paxlovid was administered and why she had doses left after it all should have been administered within five days.

On 9/1/22, Ms. Thomas reported Resident B got a prescription for Paxlovid from her physician on 8/12/22. Ms. Thomas stated the medication order came through to the facility during third shift. Ms. Thomas reported nursing staff are responsible for reviewing and approving resident medications before they can be administered. Ms. Thomas stated there were no nursing staff onsite at the facility or available by telephone when Resident B's Paxlovid was received from the pharmacy. Ms. Thomas said she and Ms. Sieplinga were on vacation and Ms. Cox and other staff permitted to review and approve Resident B's Paxlovid were out due to illness, which included COVID-19.

Ms. Thomas reported Resident B's Paxlovid was reviewed and approved to be administered on 8/15/22. Ms. Thomas stated Resident B began to receive her prescribed Paxlovid on 8/15/22.

On 9/1/22, Ms. Sieplinga's statements were consistent with Ms. Thomas.

On 9/1/22, Ms. Cox reported a medication technician (med tech) misread Resident B's order for Paxlovid. Ms. Cox explained Resident B was supposed to get two tablets of Paxlovid at a time, however on one occasion a med tech only administered one Paxlovid tablet to Resident B. Ms. Cox said Resident B's physician was notified of the missed dose. Ms. Cox stated Resident B's physician indicated Resident B would not suffer harm because of missing a dose.

Ms. Cox provided me with a copy of Resident B's *New Prescription Summary* order for my review. The *PRESCRIPTION AS FOLLOWS:* section of the order read, "PAXLOVID 150 MG-100 MG TABLETS IN A DOSE PACK (RENAL DOSE) (EUA) (DOSE PK(S)). Directions: Take 1 dose pk by oral route as directed. Effective date: 8/12/2022." The order was electronically signed by physician assistant Micah Dawati dated 8/12/22.

Ms. Cox provided me with a copy of Resident B's August medication administration record (MAR) for my review. The MAR read, "PAXLOVID (RENAL DOSE PACK) (Nirmatrekvir & Ritonavir) TAKE AS DIRECTED TWICE DAILY PACKAGE INSTRUCTIONS." The medication was administered at 8:00 pm on 8/15/22, at 8:00 am and 8:00 pm on 8/16/22, at 8:00 am and 8:00 pm on 8/17/22, at 8:00 am and 8:00 pm on 8/18/22, and at 8:00 am on 8/19/22.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	The interviews with Ms. Thomas, Ms. Sieplinga, and Ms. Cox, along with review of Resident B's MAR revealed her prescribed Paxlovid was ordered by her physician on 8/12/22. This medication was not started until 8/15/22 because staff were not available to review and approve it for administration. Resident B went two days without her prescribed Paxlovid as a result.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Alicia Sieplinga by telephone on 9/27/22. Ms. Sieplinga reported there is now a nurse on third shift who can check any medications that come in from the pharmacy. Ms. Sieplinga stated this will be outlined in the corrective action plan.

IV. RECOMMENDATION

09/21/2022

Lauren Wohlfert Date
Licensing Staff

Approved By:

09/26/2022

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