GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 12, 2024

Megan Burch
AH Kentwood Subtenant LLC
6755 Telegraph Road Suite
Bloomfield Hills, MI 48301

RE: License #: AL410397696
Investigation #: 2024A0340008
AHSL Kentwood Fieldstone

Dear Ms. Burch:

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,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410397696
Investigation #:	2024A0340008
Complaint Receipt Date:	12/05/2023
Investigation Initiation Date:	12/05/2023
Report Due Date:	02/03/2024
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:	Megan Burch
Name of Facility:	AHSL Kentwood Fieldstone
Facility Address:	5980 Eastern Ave SE. Kentwood, MI 49508
Facility Telephone #:	(616) 455-1357
Original Issuance Date:	01/22/2019
License Status:	REGULAR
Effective Date:	07/22/2023
Expiration Date:	07/21/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was not given his medication.	Yes

III. METHODOLOGY

12/05/2023	Special Investigation Intake 2024A0340008
12/05/2023	Special Investigation Initiated - Telephone APS Emily Pierce
12/05/2023	APS Referral
12/27/2023	Inspection Completed On-site
12/27/2023	Exit Conference Megan Burch

ALLEGATION: Resident A was not given his medication.

INVESTIGATION: On December 5, 2023, a complaint was received with the BCAL Online Complaints. It stated Resident A was not given his medication on 11/16/23. It also stated that on 11/22/23 Resident A's medication had run out and was not refilled. It was reported that if Resident A goes three days without his Risperidone he will begin hallucinating.

On December 5, 2023, I contacted Adult Protective Services (APS) to report the allegation.

On December 5, 2023, I spoke with APS Manager Emily Pierce who informed me the complaint had not been assigned for investigation.

On December 27, 2023, I conducted an unannounced home inspection. I met with Director Megan Burch and Wellness Director Jason Myers. I explained the reason for my visit and asked to see the Medication Administration Record (MAR) for Resident A.

I reviewed the MAR for Resident A for the month of November. It showed that medications were passed as prescribed except for his Risperidone 0.5 MG ODT. In the month of November, Resident A was not given this medication on ten different occasions: 11/3, 11/4, 11/5, 11/11, 11/12, 11/16, 11/22, 11/26, 11/27 and 11/28. Mr. Myers explained that Risperidone is an anti-psychotic medication. Neither Ms.

Burch or Mr. Myers were aware that Resident A's Risperidone had not been passed. They expressed concern that staff used incorrect coding, suggesting Resident A was out of the home on the days it states the medication was not passed.

We reviewed the coding on the MAR which was either "med not available", "no med", "not available", or the box on the form was blank. I questioned that I did not know how else to interpret the coding other than to indicate the medication had not been passed.

Ms. Burch and Mr. Myers explained there had been issues with the family attempting to change Resident A's medications because they felt a different one would work better for him. This was occurring without the involvement of American House staff or the pharmacy they use for Resident A's medication. The family utilized another pharmacy who did not consult with the other and were attempting to duplicate anti-psychotic medications with Xanax. The family members reportedly became angry when they would bring in the medication and staff would tell them they could not administer because it was not on the MAR.

Ms. Burch and Mr. Myers stated they have met with the family and explained that they cannot drop off medication and expect it to be given to Resident A without a doctor prescription and communication with the other provider. This reportedly angered the family and they are currently seeking a new home to move Resident A. I explained to Ms. Burch and Mr. Myers that it did not explain why the Risperidone was not given to Resident A.

I interviewed Resident A privately in his room. I identified myself and the reason for my visit. He stated that he feels things are getting better now that new management has taken over the home. When I asked him about his medication, the only complaint he had was that he doesn't know what medications he takes. He is given pills and he takes them. Sometimes it is less pills than other times but he doesn't know what any of them are.

I followed-up with Ms. Burch and Mr. Myers. I suggested that staff inform Resident each medication he is being given at a time so that he can be informed.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	The allegation was made that Resident A was not being given his prescription medication. The MAR showed that on 10 different occasions Resident A was not given his prescribed Risperidone.

	Ms. Burch and Mr. Myers did not have an explanation as to why this occurred and Resident A did not know what medications he receives. A preponderance of evidence was discovered to confirm that Resident A did not receive his medication Risperidone as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

On December 27, 2023, I conducted an exit conference with Ms. Burch. We discussed the violation which she understood. I requested a Corrective Action Plan which she agreed to send. She had no further questions.

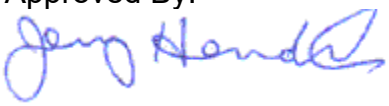
IV. RECOMMENDATION

Upon receipt of an approved Corrective Action Plan, I recommend no change to the current license status.

January 12, 2024

Rebecca Piccard — Date
Licensing Consultant

Approved By:



January 12, 2024

Jerry Hendrick — Date
Area Manager