GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 31, 2024

Meridee Watt
AH Holland Subtenant LLC
Ste 1600
1 Towne Sq
Southfield, MI 48076

RE: License #: AL700397730
Investigation #: 2024A0467050
AHSL Holland Beachside

Dear Ms. Watt

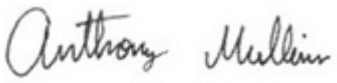
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700397730
Investigation #:	2024A0467050
Complaint Receipt Date:	07/08/2024
Investigation Initiation Date:	07/08/2024
Report Due Date:	09/06/2024
Licensee Name:	AH Holland Subtenant LLC
Licensee Address:	Ste 1600 1 Towne Sq Southfield, MI 48076
Licensee Telephone #:	(616) 283-9221
Administrator:	Meridee Watt
Licensee Designee:	Meridee Watt
Name of Facility:	AHSL Holland Beachside
Facility Address:	11821 James Street Holland, MI 49423
Facility Telephone #:	(616) 392-1007
Original Issuance Date:	03/21/2019
License Status:	REGULAR
Effective Date:	09/21/2023
Expiration Date:	09/20/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Staff overdosed Resident A on “Oxy” on 7/3/24.	No
Additional Findings	Yes

III. METHODOLOGY

07/08/2024	Special Investigation Intake 2024A0467050
07/08/2024	APS Referral Complaint received by Ottawa County APS worker, Erin Wallace
07/08/2024	Special Investigation Initiated - On Site
07/31/2024	Exit conference with licensee designee, Meridee Watt

ALLEGATION: Staff overdosed Resident A on “Oxy” on 7/3/24.

INVESTIGATION: On 7/8/24, I received a complaint from Ottawa County Adult Protective Services (APS) worker, Erin Wallace. The complaint alleged that on 7/3/24, staff members overdosed Resident A on Oxy, then gave her Narcan. Resident A was not sent to the hospital.

APS worker Ms. Wallace stated that her colleague was on-call and made contact with Resident A’s Durable Power of Attorney (DPOA), and she informed her that Resident A was reportedly given 5mg of her PRN (as needed) pain med (Oxy) on 7/3, then she was given her scheduled dose of 10mg Oxy at 6:00 am. Staff reported that Resident A was acting tired and her speech was slurred, leading them to believe that she had overdosed on her medication, which prompted staff to administer Narcan. Ms. Wallace and I agreed to meet at the facility today at approximately 10:15 am to conduct a joint investigation.

On 7/8/24, Ms. Wallace and I made an unannounced onsite investigation at the facility. Upon arrival, entry was made into the facility and introductions were made with Resident A in her bedroom. Resident A stated that she is “doing okay, so far, so good.” Resident A agreed to discuss the allegations surrounding a medication concern on 7/3/24. Resident A stated that, “they (staff) said I had overdosed.” Resident A stated, “how do you overdose on something that is controlled by someone else?” Resident A stated that staff gave her a dosage of her pain med. Later that same day, “they gave me another one.” Resident A confirmed that she was not given the pain meds at the same time. Due to reportedly overdosing on the medication, Resident A stated that staff gave her Narcan. Resident A stated, “it was a horrible thing. It was a bad situation.” After receiving Narcan, Resident A stated that she was not seen by medical professionals, and she was not taken to the

hospital. Resident A initially thought that staff member, Paulisha (last name unknown) gave her the pain medication. However, she shared that Paulisha left at 3 o'clock, so she believes that someone else provided her with the medication. Resident A stated that no one contacted her daughter, who is her guardian.

Resident A stated that approximately one month ago, she fell in the bathroom and nearly broke her tail bone, which led to her being prescribed pain medications. As a result of her injury, Resident A stated that she is working with Holland Home Health. Resident A stated that sometime in the past, staff told her that her doctor wanted her to try a medication for sleeping, but staff never relayed this to her. As a result of taking the medication, Resident A stated, "I was out of it, fell out of bed and cracked my nose." Resident A stated that it took 5-6 days to get back to baseline. Resident A believed the medication she was given in the past was Xanax. It should be noted that the previously prescribed Xanax medication and fall is unrelated to the current allegation of Resident A overdosing. Resident A confirmed that she has a meeting today with her daughter/guardian and management at the facility. Resident A stated that she is hoping to return home with her family as opposed to being at the facility.

APS worker Ms. Wallace and I then interviewed assistant wellness director, Shay Duflo regarding the allegation. Ms. Duflo shared that Resident A was not overdosed on her pain medications. Ms. Duflo stated that staff member, Ambria Hernandez planned to give Resident A her PRN 5MG Oxycodone at or around 3:00 am. However, she destroyed it and gave her the 6am dose of Oxycontin ER 10MG due to the dose being higher. Per Ms. Duflo, Resident A was "out of it, slurring her words, shaky" and had no appetite. Ms. Duflo stated that it did look as if Resident A was given too much of her pain medication.

Ms. Duflo stated that towards the end of the shift on 7/3/24, Resident A was still not back to baseline. As a result, staff member Emma Evans gave Resident A Narcan at the request of the wellness director, Shawn Jenkins since she looked as if she needed it. Ms. Duflo stated that Resident A was back to baseline after receiving the Narcan. Ms. Duflo also added that Resident A's daughter believed her symptoms could have been related to pneumonia.

Ms. Duflo provided me with a copy of Resident A's Medication Administration Record (MAR) for the month of July. The MAR indicates that Resident A received her PRN Oxycodone 5MG tab at 3:48 am on 7/3/24, in addition to her scheduled Oxycontin 10MG Tab at 6:00 am. Ms. Duflo was under the impression that if both medications were given to Resident A, a medication error occurred, despite one medication being prescribed as a PRN and one being scheduled.

After speaking to Ms. Duflo, I then spoke to Shawn Jenkins, wellness director and Shelli Endline, Nurse Practitioner through Careline Physician Services. Ms. Jenkins stated that Resident A is **"**narcotic seeking**"** and constantly complains about lower back pain. Ms. Jenkins stated that Resident A has been sent to the hospital for her

complaints and returned to the facility after medical professionals have determined there are no concerns.

Ms. Jenkins stated that she worked on the day in question (7/3/24). Ms. Jenkins stated that Resident A has Oxycontin 10MG tab scheduled and 5mg Oxycodone tab as needed. Ms. Jenkins stated that Resident A was administered her PRN 5MG Oxycodone on 7/3/24 around 3:00 am, in addition to her scheduled Oxycontin 10MG at 6:00 am. Ms. Jenkins stated that the two medications likely caused Resident A to be “loopy.” Around 4:00 pm, Ms. Jenkins stated that she was informed that Resident A was “not acting right.” This led to Ms. Jenkins instructing her employee, Emma Evans to assess Resident A and provide her with Narcan if needed. Narcan was given to Resident A and she was reportedly back to baseline. Due to Resident A returning to baseline, Ms. Jenkins stated that she did not feel the need to send Resident A to the hospital. Ms. Jenkins stated that Narcan is prescribed as needed and can be given every 2-3 minutes as needed until the patient is responsive or EMS arrives. Resident A’s MAR was reviewed and confirmed the instructions given by Ms. Jenkins.

Nurse Practitioner, Shelli Endline through Careline Physician Services confirmed that Resident A seeks pain medications. Despite having a PRN and scheduled pain medication, Ms. Endline stated that Resident A often requests pain medications before staff can legally provide them to her. Ms. Endline stated that Resident A’s daughter requested the long-acting narcotic (Oxycontin 10MG Tab) despite the PRN 5MG Oxycodone med. Ms. Endline and Ms. Jenkins both confirmed that the long-acting narcotic (oxycontin ER 10MG Tab) is given to Resident A regardless of when the PRN Oxycodone 5MG Tab is given. Due to concerns of a Resident A possibly overdosing, despite staff given her pain medications as prescribed/as needed (per her MAR), the long-acting pain medications (ER 10MG Oxycontin Tab) has been discontinued. Resident A can still receive her PRN 5MG Oxycodone as needed. It should be noted that Resident A also has a PRN 500 MG Acetaminophen Tab she can take every six hours if needed.

On 7/18/24, I spoke to former staff member, Ambria Hernandez via phone. Ms. Hernandez stated that she has never seen Resident A overdosed. She also stated, “I don’t know how she could overdose when we’re the ones that give her the medication.” Ms. Hernandez stated that Resident A has “little spells” that cause her to act “groggy.” Despite this, Ms. Hernandez stated that she does not believe this is related to her medications since the spells occur sporadically. Ms. Hernandez stated that when she left the facility on 7/3/24, Resident A was “fine.” When she returned to the facility later that day at or around 6:30 pm, “they (staff) were giving her Narcan.”

Ms. Hernandez confirmed that she planned to give Resident A her PRN 5MG Oxycodone. However, she was due for her scheduled ER 10MG Oxycontin in an hour. At the request of Resident A, Ms. Hernandez did not give Resident A her PRN pain medication. Instead, she gave her the scheduled ER 10MG Oxycontin at 6:00 am since it was double the dose of her PRN pain medication. Ms. Hernandez stated

that she discarded the PRN pain medication, “so I don’t know how she could have overdosed.” Ms. Hernandez stated that she relayed this to the assistant wellness director, Shay Duflo.

On 07/31/24, I conducted an exit conference with licensee designee, Meridee Watt. She was informed of the investigative findings and denied having any questions.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A stated staff told her that she overdosed on her pain medication on 7/3/24. Resident A stated that she was given her pain medication two different times on 7/3/24. Per Resident A’s MAR, she is scheduled to receive Oxycontin ER 10MG Tab 3 times a day, in addition to any PRN Oxycodone tabs she takes. Ms. Hernandez stated that at the request of Resident A, she did not give her the PRN 5MG Oxycodone on the morning of 7/3/24. She did, however, provide her with her scheduled ER 10MG Tab Oxycontin at 6:00 am. Wellness Director Ms. Jenkins stated that both the PRN Oxycodone and scheduled Oxycontin were given on the morning of 7/3/24. There appears is a discrepancy as to if/when the PRN medication was given. However, it is not considered an overdose due to Nurse Practitioner, Shelli Endline confirming that Resident A’s PRN and scheduled pain medication can be given simultaneously. Therefore, there is not a preponderance of evidence to support the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION: While investigating the allegation listed above, assistant wellness director, Shay Duflo informed me that staff member, Ambria Hernandez documented in Resident A’s MAR that she gave her a PRN 5MG Oxycodone Tab at 3:48 am on the morning of 7/3/24. I reviewed Resident A’s MAR, which clearly indicates this occurred. However, Ms. Hernandez informed Ms. Duflo that she didn’t

give the medication despite documenting that she did. Ms. Duflo stated that she had a conversation with Ms. Hernandez to prevent this from occurring again.

On 7/17/24, I spoke to Ms. Hernandez via phone. Ms. Hernandez confirmed that she discarded the PRN 5MG Oxycodone Tab on 7/3/24, despite documenting that she passed the medication. Ms. Hernandez stated that “it was a hectic night” and she let Ms. Duflo know of the error she made on Resident A’s MAR. Ms. Hernandez added that after I conducted my onsite inspection at the facility on 7/8/24, Ms. Jenkins called her and asked her to do her a favor. Ms. Hernandez stated that Ms. Jenkins asked her to tell me as the licensing consultant that she passed Resident A’s PRN 5MG Oxycodone on 7/3/24 to prevent the facility from “getting in trouble”. Ms. Hernandez stated that Ms. Jenkins also told her not to tell me that she asked for this favor. Ms. Hernandez responded by stating “absolutely not” to Ms. Jenkins. Ms. Hernandez stated that the following day, management tried to suspend her. Instead, Ms. Hernandez quit.

On 7/31/24, I spoke to Ms. Jenkins via phone and asked her about the statement Ms. Hernandez made. Ms. Jenkins immediately denied telling Ms. Hernandez to lie regarding the allegations. Ms. Jenkins stated that she told Ms. Hernandez that if she administered the medication to Resident A, then she should relay that to licensing. Ms. Jenkins told Ms. Hernandez that if she didn’t administer the medication, she should have adjusted Resident A’s MAR to accurately reflect what occurred. Ms. Jenkins stated that the purpose of the call to Ms. Hernandez was to inquire about her documenting “med not given or wasted” in the narcotics book two days after the alleged incident. Ms. Jenkins stated that Ms. Hernandez didn’t specify how the medication was discarded, and she didn’t have a witness present, which is standard practice for them. Ms. Jenkins stated that Ms. Hernandez has been terminated.

On 07/31/24, I conducted an exit conference licensee designee, Meridee Watt. She was informed of the investigative findings and agreed to complete a corrective action plan within 15 days of receipt of report.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.**

	(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Ms. Hernandez confirmed that she documented on Resident A's MAR that Resident A received her PRN 5MG Oxycodone on 7/23/24, despite not administering the medication. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: While investigating the allegations listed above, all interviewed parties confirmed that Resident A received Narcan on 7/3/24. Despite this, Resident A's MAR does not reflect that the medication was administered.

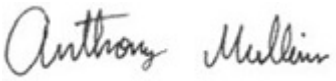
On 07/31/24, I conducted an exit conference with licensee designee, Meridee Watt. She was informed of the investigative findings and agreed to complete a corrective action plan within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**

ANALYSIS:	Resident A's MAR does not reflect that she was administered Narcan on 7/3/24. Therefore, a preponderance of evidence exists to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

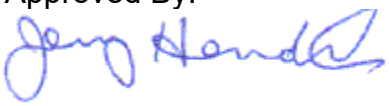
Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.



07/31/2024

Anthony Mullins Date
Licensing Consultant

Approved By:



07/31/2024

Jerry Hendrick Date
Area Manager