GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 3, 2024

Megan Burch
AH Kentwood Subtenant LLC
Ste 1600
1 Towne Sq
Southfield, MI 48076

RE: License #: AL410397693
Investigation #: 2024A0583047
AHSL Kentwood Cobblestone

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 #:	AL410397693
Investigation #:	2024A0583047
Complaint Receipt Date:	07/30/2024
Investigation Initiation Date:	07/31/2024
Report Due Date:	08/29/2024
Licensee Name:	AH Kentwood Subtenant LLC
Licensee Address:	Ste 1600 1 Towne Sq Southfield, MI 48076
Licensee Telephone #:	(248) 203-1800
Administrator:	Tami McKellar
Licensee Designee:	Tami McKellar
Name of Facility:	AHSL Kentwood Cobblestone
Facility Address:	5960 Eastern Ave SE. Kentwood, MI 49508
Facility Telephone #:	(616) 455-1357
Original Issuance Date:	01/18/2019
License Status:	REGULAR
Effective Date:	07/18/2023
Expiration Date:	07/17/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Facility staff failed to seek timely medical care for Resident A.	Yes
Facility staff failed to administer Resident A's medication as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/30/2024	Special Investigation Intake 2024A0583047
07/30/2024	APS Referral
07/31/2024	Special Investigation Initiated - On Site
09/03/2024	Exit Conference Licensee designee Megan Burch

ALLEGATION: Facility staff failed to seek timely medical care for Resident A.

INVESTIGATION: On 07/30/2024 complaint allegations were received from the BCAL online reporting system from Adult Protective Services staff Kevin Souser. The complaint stated that "Resident A is approximately 82-years old" and "has a cognitive impairment and various medical issues". The complaint alleged that "on 07/26/2024 in the a.m., Resident A tripped and fell over oxygen tubing in her bedroom" and "was experiencing extreme pain and was not able to bear weight on her left leg". The complaint further alleged that Resident A did not receive medical treatment until 07/27/2024 at approximately 5:15 pm and was ultimately diagnosed with a left femur fracture requiring hospitalization.

On 07/31/2024 I completed an unannounced onsite investigation at the facility and privately interviewed licensee designee Megan Burch, Wellness Director Kenisha Sanders, and staff Alexis Ewing.

Licensee designee Megan Burch stated that Resident A uses a walker to ambulate "when she wants" and is independent in her mobility. Ms. Burch stated that she observed Resident A in her bedroom walking on 07/26/2024 from 2:30-3:00 PM. Ms. Burch stated that Resident A did not exhibit signs of pain or distress while she interacted with Resident A on 07/26/2024 from 2:30-3:00 PM. Ms. Burch stated that on 07/27/2024, Resident A reported to staff Kyndyl Kirkland that Resident A had fallen on 07/26/2024 in her bedroom causing leg pain and lack of mobility. Ms. Burch stated that on the evening of 07/27/2024 Resident A was sent to the hospital by facility staff and ultimately diagnosed with a fractured left femur. Ms. Burch stated that Resident A's fall was not observed by any staff members.

Wellness Director Kenisha Sanders stated that she did not work at the facility on 07/26/2024 and 07/27/2024. Ms. Sanders stated that on 07/27/2024 at 4:23 PM staff Kendyl Kirkland telephoned her and stated that Resident A's PRN "Tylenol" was not in the medication cart's drawer. Ms. Kirkland further reported that Resident A was in pain, and it was determined that she should be sent to the emergency room. Ms. Sanders stated that she observed a "Daily Living Log" note drafted on 07/26/2024 at 10:27 PM by staff Lanetrich Wilks which indicated that Resident A was in a great amount of pain and was having trouble walking. Ms. Sanders stated that she observed a second "Daily Living Log" drafted on 07/27/2024 at 9:57 AM drafted by staff Samantha Pratt which indicated that Resident A refused to shower and was still in pain. Ms. Sanders stated that Resident A was not sent for medical treatment until 07/27/2024 at approximately 4:39 PM. Ms. Sanders stated that Ms. Wilks should have contacted "management" and informed management of Resident A's pain on 07/26/2027. Ms. Sanders stated that staff "went too long" before obtaining medical care for Resident A's injury.

Staff Alexis Ewing stated that she worked at the facility on 07/27/2024 from 7:00 AM until 3:00 PM. Ms. Ewing stated that when she started her shift no-one told her that Resident A was in pain. Ms. Ewing stated that she reviewed the Daily Living Log which did not document that Resident A was in pain but did document that Resident A "needed more assistance" which was not uncommon for her. Ms. Ewing stated that Resident A "was in bed all day" which also was not uncommon for her. Ms. Ewing stated that she completed face-to-face checks on Resident A every two hours and Resident A was "asleep every time". Ms. Ewing stated that Resident A ate her breakfast in her bedroom and "ate about 25% of her oatmeal". Ms. Ewing stated that Resident A ate her lunch in her bedroom and at approximately 2:00-2:30 PM she entered Resident A's bedroom to "grab her lunch tray". Ms. Ewing stated that she observed that Resident A's bedroom smelled "like urine" and her bed was wet. Ms. Ewing stated that Resident A complained that her leg hurt. Ms. Ewing stated that she tried to get Resident A out of her bed however Resident A complained of leg pain and was "limping". Ms. Ewing stated that she had to request for a staff member from another facility to come assist her with helping Resident A walk to the bathroom. Ms. Ewing stated that she helped Resident A change her clothing, clean her bed, and get back into bed. Ms. Ewing stated that Resident A told her that she has fallen the previous night and a staff member had helped her up. Ms. Ewing stated that Resident A could not remember the name of the staff member that helped her up after the fall. Ms. Ewing stated that staff Kendyl Kirkland entered the facility at 3:00 PM for her second shift and Ms. Ewing directed Ms. Kirkland to check on Resident A due to her mobility issue and leg pain.

On 08/01/2024 I interviewed Adult Protective Services staff Kevin Souser. Mr. Souser stated that Resident A is currently at the University of Michigan West hospital and is recovering from a fractured left leg. Mr. Souser stated that he interviewed Resident A face-to-face on 07/30/2024 and Resident A was "loopy" due to her pain medication.

On 08/01/2024 I received an email from Adult Protective Services staff Kevin Souser. The email stated the following:

'Here is my contact from 7/30 at 2:55 PM
FtF contact made with (Resident A) at U of M West Hospital, Rm. 326. APS entered the facility and made their way to her room. APS knocked on the door and a woman said come in. APS identified themself and spoke with (Resident A). APS observed (Resident A) lying in her hospital bed, eyes were shut initially. (Resident A) did open her eyes once talking with APS. APS noted (Resident A) might be under the influence of pain medication due to her somewhat slurred talking and her eyes were half shut. APS informed (Resident A) that they had received a referral with some concerns. (Resident A) stated her date of birth is 4/25/1942. (Resident A) stated her first name is (Resident A), one word. (Resident A) stated she has lived at the facility for about a year. (Resident A) stated she is her own decision maker but does have a POA, who makes some decisions also. APS discussed the allegations with (Resident A). (Resident A) stated she was going across her room and her legs got caught in her "oxygen wires" and she fell. (Resident A) stated she is not sure what time of day it was. (Resident A) stated they did ask her about going to the hospital on Friday, which would have been 7/26. (Resident A) stated she said she didn't know if she needed to go to the hospital and would see how it went. (Resident A) stated she was on the floor for a long time before staff came and helped her up. (Resident A) stated there is only one person for the entire building. (Resident A) stated she is unsure who came and helped her up. APS asked about her medication, specifically, acetaminophen. (Resident A) stated she did request her pain medications on both days. (Resident A) stated she was told they were "low" and then told they didn't have any. (Resident A) stated she was told they had to order more. (Resident A) stated she will be going to rehab but is unsure where.'

On 07/31/2024 I received an email from licensee designee Megan Burch. The email contained the following documents: "Daily Living Log 07/26/2024 to 07/27/2024", "Incident Form 7/27/2024", and "Services Plan 4/7/2024".

The "Daily Living Log" indicated that on 07/26/2024 at 10:27 PM staff Lanetrich Wilks documented that Resident A, *'states that she in a lot out of pain and was having trouble walking to her bed. Helped to with getting too bed tonight'.* The Daily Living Log indicated that on 07/27/2024 at 9:57 AM staff Samantha Pratt documented that Resident A, *'refused shower saying her legs hurt and she can't walk to shower room'*. On 07/27/2024 at 8:11 PM staff Kendyl Kirkland documented that, *'Nurse Karen from Metro Hospital called to advise that resident is being admitted to the hospital due to a femur fracture of her left leg'.*

The 07/27/207 Incident Form was completed by staff Kendyl Kirkland and documented the following: *'When med tech entered the residents room for safety check. Resident stated she had fell Yesterday morning when she tripped over her oxygen tubing. Resident c/o leg and pelvic pain being 8/10. Med tech notified Doctor and pharmacy. Alicia at Careline stated to send resident to ER'.*

Resident A’s Services Plan is dated 04/07/2024 and lacks all required signatures. The document indicates that Resident A, *‘is able to walk but utilizes a walker’.*

On 08/22/2024 I interviewed staff Kendyl Kirkland via telephone. Ms. Kirkland stated that she worked at the facility on 07/17/2024 from 3:00 PM until 7:00 PM. Ms. Kirkland stated that staff Alexis Ewing had worked from 7:00 AM until 3:00 PM that same day and provided Ms. Kirkland with a brief resident status update before ending her shift and leaving the facility. Ms. Kirkland stated that Ms. Ewing indicated that Resident A had “refused to get out of bed, complained of leg pain, and could not ambulate and/or toilet herself”. Ms. Kirkland stated that Ms. Ewing reported to have recently changed Resident A’s adult brief. Ms. Kirkland stated that Ms. Ewing indicated that she was not worried about Resident A’s leg pain and lack of ambulation and believed that Resident A was “playing up” the situation to stay in bed. Ms. Kirkland stated that after Ms. Ewing left the facility Ms. Kirkland started her “rounds”. Ms. Kirkland observed Resident A at approximately 4:00 PM and immediately identified that “something was seriously wrong” with Resident A. Ms. Kirkland stated that Resident A reported that she was experiencing severe leg pain that increased with movement. Ms. Kirkland stated that she observed slight bruising and scratches to her left knee and leg. Ms. Kirkland stated that Resident A reported she had fallen in her bedroom the morning of 07/16/2024. Resident A informed Ms. Kirkland that “two black female staff” helped Resident A off her bedroom floor on 07/16/2024 however Resident A could not recall the names of the staff who assisted her. Ms. Kirkland stated that she had requested her PRN Acetaminophen from multiple staff since the fall, but staff could not locate it. Ms. Kirkland stated that after speaking to Resident A, Ms. Kirkland telephoned the office of Resident A’s Primary Care Physician and spoke to a nurse. Ms. Kirkland stated that the nurse directed Ms. Kirkland to send Resident A to the Emergency Department for medical treatment of her leg. Ms. Kirkland then proceeded to telephone Wellness Director Kenisha Sanders and informed her that Resident A required immediate medical attention and requested permission to send Resident A to an Emergency Department. Ms. Kirkland stated it is facility protocol to receive permission to “send residents out” of the facility for emergency medical treatment. Ms. Kirkland stated that she was granted permission to send Resident A to an Emergency Department for treatment. Ms. Kirkland stated that she dialed “911” at approximately “4:39 PM” and Resident A was transported to University of Michigan West Emergency Medical Center by Emergency Medical Staff. Ms. Kirkland stated that Resident A had displayed severe pain and lack of ambulation that had been observed by multiple staff from 07/16/2024 until 07/17/2024.

On 09/03/2024 I completed an Exit Conference with licensee designee Megan Burch via telephone. Ms. Burch stated that she did not dispute the Special Investigation findings. Ms. Burch stated that the facility is voluntarily closing their license due to operating issues relating to a fire on the same campus that the facility resides on. Ms. Burch stated that no residents are currently in the facility. Ms. Burch stated that she will submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	On 07/27/2024 at approximately 4:39 PM Resident A was transported to the University of Michigan West hospital for treatment of a fractured left leg. The “Daily Living Log” indicated that on 07/26/2024 at 10:27 PM staff Lanetrich Wilks documented that Resident A “states that she in a lot out of pain and was having trouble walking to her bed. Helped to with getting too bed tonight”. The Daily Living Log indicated that on 07/27/2024 at 9:57 AM staff Samantha Pratt documented that Resident A “refused shower saying her legs hurt and she can’t walk to shower room”. Staff Alexis Ewing stated that she worked at the facility on 07/27/2024 from 7:00 AM until 3:00 PM. Ms. Ewing stated that when she started her shift no-one communicated that Resident A was in pain. Ms. Ewing stated that Resident A “was in bed all day which was not uncommon”. Ms. Ewing stated that she observed that Resident A’s bedroom smelled “like urine” and her bed was wet and Resident A complained that her leg hurt. Ms. Ewing stated that she tried to get Resident A up and out of her bed however Resident A complained of leg pain and was “limping”. Wellness Director Kenisha Sanders stated that Ms. Wilks should have contacted and informed “management” of Resident A’s pain on 07/26/2027. Ms. Sanders stated that staff “went too long” before obtaining medical care for Resident A’s injury. A preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule. Staff documentation indicates that Resident A complained of pain as early as 07/26/2024 10:27 PM. On 07/27/2024 from 7:00 AM until 3:00 PM, staff Alexis Ewing observed that Resident A was in pain and limping. Resident A was not sent for medical treatment of a fractured leg until 07/27/2024 until 4:39 PM. Resident A did not receive timely medical treatment.

CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Facility staff failed to administer Resident A's medication as prescribed.

INVESTIGATION: On 07/30/2024 complaint allegations were received via the BCAL online reporting system from Adult Protective Services staff Kevin Souser. The complaint stated that on 07/26/2024 in the a.m., Resident A tripped and fell over oxygen tubing in her bedroom and despite extreme pain and lack of ambulation Resident A was not sent for medical treatment until 07/27/2024 at 4:39 PM. The complaint alleged that Resident A had requested her PRN acetaminophen for pain from facility staff on 07/26/2027 and 07/27/2024 however the medication "was misfiled" and Resident A never received her medication.

On 07/31/2024 I completed an unannounced onsite investigation at the facility and privately interviewed licensee designee Megan Burch.

Licensee designee Megan Burch stated that Resident A is prescribed PRN acetaminophen 325 MG take 2 tablets every six hours for pain as needed. Ms. Burch confirmed that Resident A did not receive her PRN dose of this medication on 07/26/2024 or 07/27/2024.

On 07/31/2024 I received an email from licensee designee Megan Burch. The email contained Resident A's Daily Living Log 07/26/2024 to 07/27/2024. This document indicated that staff Kendyl Kirkland documented on 07/27/2024 at 8:22 PM, *'while looking for resident's PRN acetaminophen 325 mg for the fourth time, I found it filed with another resident's medications and returned it to the residents' medication location in the cart'.*

On 08/01/2024 I received an email from Adult Protective Services staff Kevin Souser. The email contained Mr. Souser's face-to-face interview with Resident A that occurred on 07/30/2024. During the interview Resident A, *'stated she did request her pain medications on both days but she was told they were low and then told they didn't have any'.*

On 08/19/2024 I received and reviewed an email from licensee designee Megan Burch. The email contained Resident A's Medication Administration Record, which indicates Resident A did not receive a dose of her PRN acetaminophen on 07/16/2024 and/or 07/17/2024.

On 08/22/2024 I interviewed staff Kendyl Kirkland via telephone. Ms. Kirkland stated that on 07/27/2024 Resident A reported that she had requested her PRN acetaminophen from multiple staff on 07/26/2024 and 07/27/204 to address her severe leg pain. Resident A stated that staff dismissed her pain and stated that the PRN could not be located in the medication cart. Ms. Kirkland stated that she could

not locate the medication in the medication until 07/27/2024 after Resident A had been sent to the hospital for medical treatment. Ms. Kirkland stated that Resident A's medication had been misfiled in the medication cart.

On 09/03/2024 I completed an Exit Conference with licensee designee Megan Burch via telephone. Ms. Burch stated that she did not dispute the Special Investigation findings. Ms. Burch stated that the facility is voluntarily closing their license due to operating issues relating to a fire on the same campus that the facility resides on. Ms. Burch stated that no residents are currently in the facility. Ms. Burch stated that she will submit an acceptable Corrective Action Plan.

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 Page 21 Courtesy of Michigan Administrative Rules 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 S333.1101 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:	Information provided by Adult Protective Services worker Kevin Souser indicates that Resident A stated she requested her pain medications on 07/16/2027 and 07/17/2024 but was told they didn't have any. Staff Kendyl Kirkland stated that on 07/27/2024 Resident A reported that she had requested her PRN acetaminophen from multiple staff on 07/26/2024 and 07/27/204 to address her severe leg pain. Resident A stated that staff dismissed her pain and told her the PRN could not be located in the medication cart. Ms. Kirkland stated that she could not locate the medication until 07/27/2024 after Resident A had been sent to the hospital for medical treatment. Ms. Kirkland stated that Resident A's medication had been misfiled in the medication cart. Resident A's Medication Administration Record indicates Resident A did not receive a dose of her PRN acetaminophen on 07/16/2024 and/or 07/17/2024.

	A preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule. On 07/26/2024 and 07/27/2024 Resident A requested a dose of her PRN acetaminophen for leg pain and was denied the medication because staff were unable to locate it.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Resident A's Assessment Plan lacks all required signatures.

INVESTIGATION: On 07/31/2024 I received an email from licensee designee Megan Burch. The email contained Resident A's Services Plan which was dated 4/7/2024. This document lacked all of the required signatures.

On 07/31/2024 I received an email from licensee designee Megan Burch which confirmed that Resident A's Service Plan is not signed.

On 09/03/2024 I completed an Exit Conference with licensee designee Megan Burch via telephone. Ms. Burch stated that she did not dispute the Special Investigation findings. Ms. Burch stated that the facility is voluntarily closing their license due to operating issues relating to a fire on the same campus that the facility resides on. Ms. Burch stated that no residents are currently in the facility. Ms. Burch stated that she will submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	I observed that Resident A's Services Plan lacks all of the required signatures. A preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule. Resident A's is incomplete because said document lacks all required signatures.

CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

09/03/2024

Toya Zylstra Date
Licensing Consultant

Approved By:

09/03/2024

Jerry Hendrick Date
Area Manager