GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 4, 2024

Jessica Kross
Pine Rest Christian Mental Health Services
300 68th Street SE
Grand Rapids, MI 49548

RE: License #: AS390304501
Investigation #: 2024A1024049
Centerpointe Recovery Center I

Dear Jessica Kross:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On August 27, 2024, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390304501
Investigation #:	2024A1024049
Complaint Receipt Date:	08/12/2024
Investigation Initiation Date:	08/12/2024
Report Due Date:	10/11/2024
Licensee Name:	Pine Rest Christian Mental Health Services
Licensee Address:	300 68th Street SE Grand Rapids, MI 49548
Licensee Telephone #:	(616) 455-5000
Administrator:	Jessica Kross
Licensee Designee:	Jessica Kross
Name of Facility:	Centerpointe Recovery Center I
Facility Address:	1145 Oakland Dr. Kalamazoo, MI 49008
Facility Telephone #:	(269) 382-3865
Original Issuance Date:	10/06/2009
License Status:	REGULAR
Effective Date:	05/22/2024
Expiration Date:	05/21/2026
Capacity:	5
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff did not administer medications to Resident A.	Yes

III. METHODOLOGY

08/12/2024	Special Investigation Intake 2024A1024049
08/12/2024	Special Investigation Initiated – Telephone with Recipient Rights Officer (RRO) Elena Tricoci
08/13/2024	Inspection Completed On-site with direct care staff member Delanie Stec and Johnny Gettle
08/13/2024	Contact - Telephone call received with direct care staff member Maria Hulson
08/13/2024	Contact - Document Received Resident A's MAR and *AFC Care Agreement*
08/14/2024	Contact - Telephone call made with facility's nurse Yvon Mukunzie
08/16/2024	Exit Conference with licensee designee Jessica Kross
08/16/2024	Inspection Completed-BCAL Sub. Compliance
8/16/2024	Corrective Action Plan Requested and Due on 08/16/2024
08/27/2024	Corrective Action Plan Received
08/27/2024	Corrective Action Plan Approved
10/01/2024	APS Referral not warranted

ALLEGATION: Staff did not administer medications to Resident A.

INVESTIGATION:

On 8/12/2024, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged direct care staff did not administer medications to Resident A.

On 8/12/2024, I conducted an interview with Recipient Rights Officer (RRO) Elena Tricoci who stated that she was also investigating this allegation and had determined direct care staff members did not record all Resident A's medications during her admission process and consequently had to wait 24 hours before they could administer Resident A her medications causing her to go a day without taking her medications.

On 8/13/2024, I conducted an onsite investigation at the facility with direct care staff members Delanie Stec and Johnny Gettle. Delanie Stec stated that Resident A came to the facility on 7/30/24 with all her belongings including her medications. Delanie Stec stated Resident A completed the admission process with their clinical team and only stayed for a little over a week. Delanie Stec stated she has no knowledge if Resident A missed taking any medications during her stay.

Johnny Gettle stated he is part of the clinical team and was notified that there was an error in the admission process involving Resident A's medications which led to Resident A not receiving those medications the first day she arrived on 7/30/2024. Johnny Gettle stated he believes nurse Yvon Mukunzie who is an employee of the licensee, was responsible for ensuring that Resident A's medications were documented and at the facility for staff to administer to Resident A once she was admitted. Johnny Gettle stated all Resident A's medications were not accurately documented by the nurse at admission but this error was not discovered and rectified until 24 hours after Resident A was admitted. Johnny Gettle stated this is a rare occurrence and residents usually do not experience any issues with getting their medications once their admitted to the facility.

On 8/13/2024, I conducted an interview with direct care staff member Maria Hulson who stated that she is the home manager of the facility and was notified that the facility's nurse did not order Resident A's medications during her admission process therefore Resident A was not administered her medications until 7/31/2024 causing her to miss taking her medications for one day. Maria Hulson stated the nurse was issued a disciplinary notice and received additional training to ensure residents can take their medications as prescribed upon admission.

On 8/13/2024, I reviewed Resident A's MAR for the month of July 2024 which showed that Resident A did not receive any of her medications on 7/30/2024 but was administered her medications beginning on 7/31/2024. I also reviewed Resident A's *AFC Care Agreement* which showed that Resident A was admitted on 7/30/2024.

On 8/14/2024, I conducted an interview with the facility's nurse Yvon Mukunzie who stated that he is the responsible nurse that completed Resident A's admission process on 7/30/2024. Yvon Mukunzie stated Resident A arrived at the facility in the late morning and brought in her prescribed medications with her belongings. Yvon Mukunzie stated unfortunately he did not record Resident A's medications on the MAR for the staff members to have therefore staff did not administer any medications to Resident A on the first day of her arrival due to not having a MAR for Resident A. Yvon Mukunzie stated on 7/31/2024, another nurse discovered his error and completed Resident A's MAR along with ensuring all her medications were at the facility. Yvon Mukunzie stated

he is new to the facility and has received additional training as part of the disciplinary action that was taken against him from the licensee therefore, he does not anticipate any further medication errors from him.

APPLICABLE RULE	
R 400.14312	**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 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:	Based on my investigation which included interviews with direct care staff members Delanie Stec, Johnny Gettle, Maria Hulson, facility's nurse Yvon Mukunzie, RRO Elena Tricoci, review of Resident A's MAR, and Resident A's AFC care agreement there is evidence to support direct care staff members did not administer medications to Resident A. According to Johnny Gettle, and Maria Hulson Resident A was admitted to the facility on 7/30/2024 however was not administered her medications until 7/31/2024 due to an error with Resident A's medications in the admission process. Yvon Mukunzie stated he did not record Resident A's medications on the MAR for the staff members to have therefore staff did not administer any medications to administer to Resident A on 07/30/2024. Yvon Mukunzie stated on 7/31/2024, another nurse discovered his error and completed Resident A's MAR along with ensuring all her medications were at the facility. I reviewed Resident A's MAR which documented Resident A did not receive any of her medications on 7/30/2024 but was administered her medications beginning on 7/31/2024. Prescribed medications for Resident A were not administered as prescribed on 07/30/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/16/2024, I conducted an exit conference with licensee designee Jessica Kross. I informed Jessica Kross of my findings and allowed her an opportunity to ask questions and make comments.

On 8/27/2024, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action plan was approved therefore I recommend the current license status remain unchanged.

10/01/2024

Ondrea Johnson
Licensing Consultant

Date

Approved By:

10/04/2024

Dawn N. Timm
Area Manager

Date