GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 5, 2025

Violet Bettig
Guardian Angel Homes LLC
725 N. Dettman Rd.
Jackson, MI 49201

RE: License #: AS380389381
Investigation #: 2025A0007005
Saint Gabriel

Dear Violet Bettig:

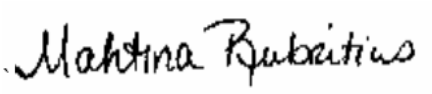
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9720.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380389381
Investigation #:	2025A0007005
Complaint Receipt Date:	12/09/2024
Investigation Initiation Date:	12/09/2024
Report Due Date:	02/07/2025
Licensee:	Guardian Angel Homes LLC
Licensee Address:	725 N. Dettman Rd. Jackson, MI 49201
Licensee Telephone #:	(269) 363-1670
Administrator:	Violet Bettig
Licensee Designee:	Violet Bettig
Name of Facility:	Saint Gabriel
Facility Address:	1038 Woodbridge Jackson, MI 49202
Facility Telephone #:	(517) 914-0584
Original Issuance Date:	02/23/2018
License Status:	REGULAR
Effective Date:	08/07/2024
Expiration Date:	08/06/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Improper care provided for Resident A, as he has been out of medication for 4 days, causing him to act out. Resident A is currently hospitalized.	No
Additional Findings	Yes

III. METHODOLOGY

12/09/2024	Special Investigation Intake - 2025A0007005
12/09/2024	APS Referral Received.
12/09/2024	Special Investigation Initiated – Telephone Interview with Aubrey Lee, APS Worker.
12/10/2024	Contact - Telephone call received from Aubrey Lee, APS Worker. Case discussion.
12/11/2024	Contact - Telephone call received from Violet Bettig, Licensee Designee. Case discussion regarding incidents and issues in the home. Kurestin Pennington will be the new home manager.
12/11/2024	Inspection Completed On-site - Unannounced - Face to face contact with Bill Roberts, DCW, Timothy Bauer, DCW, Andrew Richman, DCW, Portia Ryan, DCW, Resident A and Resident C.
01/08/2025	Contact - Face to Face with Aubrey Lee, APS Worker. Case discussion.
01/30/2025	Contact - Face to Face with Aubrey Lee, APS Worker. He will be helping Resident A's parents, at least one of them, to get guardianship. In addition, he would like to have a backup guardian if needed.
02/03/2025	Contact - Document Sent Email to Rachel Henry, ORR, status update requested. Email from Rachel Henry, status report provided.
02/03/2025	Contact - Document Received- Copy of ORR Report.

02/04/2025	Contact - Telephone call made to facility. I spoke with John Miatech, DCW. Discussion. Bill Roberts and Kurestin Pennington no longer work in the facility.
02/04/2025	Contact – Telephone call made to Violet Bettig, Licensee Designee. I requested a returned phone call to conduct the exit conference.
02/04/2025	Contact – Document Sent – Email to Violet Bettig, Licensee Designee. I requested a returned phone call to conduct the exit conference.
02/05/2025	Exit Conference conducted with Violet Bettig, Licensee Designee.

ALLEGATION: Improper care provided for Resident A, as he has been out of medication for 4 days, causing him to act out. Resident A is currently hospitalized.

INVESTIGATION:

As a part of this investigation, I reviewed the written complaint, and the following additional information was noted:
Resident A (39) resides at Saint Gabriell AFC. Resident A is on the autism spectrum and has schizophrenia. Resident A does not have a guardian or POA. On 12/7/2024, Resident A assaulted a direct care staff member, as he bit, slapped, and grabbed her hair. The direct care staff member has a bite mark on her arm. This has happened on numerous occasions. There are concerns that Saint Gabriel AFC home is not providing proper care for Resident A because he has been out of his medication for 4 days. Resident A is being petitioned and was taken to Henry Ford Hospital in Jackson, MI.

It should be noted that subsequent allegations were received on December 10, 2024; however, the allegations were not investigated, as there were no alleged rule violations.

On December 9, 2024, I spoke with Aubrey Lee, APS Worker. Aubrey Lee stated that he had spoken to Rachel Henry, Office of Recipient Rights, and Resident A's parents have Power of Attorney. Aubrey Lee had also spoken to Resident A's case manager, Justin Burke, who reported that Resident B's guardian, Guardian B1, (who is also a previous employee) may also be attempting to get guardianship of Resident A; however, this is not a good idea given the history of issues in the past. Aubrey Lee stated that Resident A had run out of medications and that may have been a contributing factor for the incident, as Resident A usually did not have behaviors when taking his medications as prescribed. Aubrey Lee informed that me Resident

A's medications were prescribed through CMH or Center for Family Health. Aubrey Lee stated that he would be going to the facility that day to investigate.

On December 10, 2024, I spoke with Aubrey Lee, APS, who reported to review Resident A's medications, and his PRN medication was the one missing, as all the other medications were there. In addition, that there was an issue with the pharmacy filling the medications.

On December 11, 2024, I conducted an unannounced on-site investigation and made face to face contact with Bill Roberts, DCW, Timothy Bauer, DCW, Andrew Richman, DCW, Portia Ryan, DCW, Resident A and Resident C.

I interviewed Bill Roberts, direct care worker, who also reported to have the role of assistant to the home manager, Kurestin Pennington. Bill Roberts reported that Resident A was utilizing his PRN medications more often, due to the holidays (struggling with the holiday season). Bill Roberts stated that Kurestin Pennington, DCW, who also had the role of home manager, tried to refill the medication but the pharmacy would not refill it. According to Bill Roberts, the psychiatric doctor did not know why the pharmacy would not refill the medication. Bill Roberts stated that it would not happen again. Bill Roberts stated that Resident A went after, and physically attacked Portia Ryan, DCW.

I interviewed Portia Ryan, DCW, who reported that on Sunday, December 8, 2024, around 8:00 p.m., Resident A acted like he was going to vomit. Staff directed him to go to the bathroom and vomit. Portia Ryan stated that she went to assist Resident A, he jumped up and lunged at her. Portia Ryan stated that she redirected him and assisted Resident A back to his room. This is when Resident A grabbed her arms, he tried to dig into her wrists, and he pulled her braids. Portia Ryan stated that Resident A also tried to scratch her face. Resident A then bit her on the right arm, between her wrist and elbow. Kurestin Pennington was there, she stepped in and assisted and tried to get Resident A away from Portia Ryan. Portia Ryan then went outside, attempting to calm down from the attack. Bill Roberts then contacted the police. Portia Ryan reported that Resident A was getting all his medications as prescribed, but he did not get the PRN, because they didn't have the medication. Portia Ryan stated that Resident A would say "I'm going eyes up." Which usually meant that he was about to go into a behavior. When staff administered the PRN medications, they had to document why the PRN was administered. During the interview with Portia Ryan, I observed, and with permission, took a picture of the bite mark on her arm for the file.

While at the facility, I reviewed Resident A's medications and medication logs. I reviewed the December medication logs and noted that Resident A was prescribed Klonopin (or Clonazepam) 0.5 mg tablet. The instructions were for Resident A to take one tablet by mouth at bedtime. I reviewed the medication logs from December 8, 2024, back to December 1, 2024, and staff documented that Resident A received this medication (Klonopin 0.5 mg tablet), daily. Resident A was also prescribed Clonazepam 1 mg (Generic for Klonopin), as a PRN. Resident A was to receive a

1/2 tablet, by mouth daily, as needed, for anxiety or irregular eye movements. For this PRN medication (Klonopin), there was a line through the dates from December 1, 2024, to December 10, 2024.

There was a new bubble pack for the PRN medication, Clonazepam 1 mg, with a start date of 12/11/2024. The medication was prescribed to Resident A, and staff were to administer 1/2 tablet, by mouth daily, as needed, for anxiety or irregular eye movements. Bill Roberts, DCW, documented on the back of the December medication log that the Clonazepam was administered on 12/11/24, and he initialed the bubble pack. The front of the medication log had not been initialed.

The November medication log reflected that staff administered the PRN medication (Clonazepam 1 mg) on 11/9, 11/19, and 11/27/24.

Based upon the review of the December medication logs, it appeared that Resident A received his medications, with the exception of the PRN Klonopin. It was also noted that for Resident A's Trazodone 100 MG, the staff did not clearly mark when this medication was administered for December 3, 2024 to December 8, 2024.

On January 8, 2025, I made face to face contact with Aubrey Lee, APS Worker. He informed me that Jasmine Smith had returned to the home, acting as home manager. He would be continuing to work on the guardianship for Resident A. He also informed me that when he spoke to Kurestin Pennington, she reported that they were trying to get the PRN prescription filled but the pharmacy did not fill the prescription. It appeared that the pharmacy may have dropped the ball. When he reviewed Resident A's medications, they were being administered.

I reviewed the *Office of Recipient Rights Report of Investigative Findings*, authored by Rachel Henry.

> It was noted that Resident A's Medication orders for the week of 12/07/2024 were reviewed. It was noted that Markus Donovan, Clinic Manager, had sent a message to the Center for Family Health (clinic) regarding Resident A's medication refills. The clinic did not respond to the refill request.
>
> It was also noted that Kurestin Pennington reported to have difficulties with getting medications refilled for Resident A. Kurestin Pennington reported to ORR that Resident A's PRN medications were filled every ten days, and they had changed it to a 20-day supply because they kept running out. When Kurestin Pennington contacted the pharmacy for another refill, she was informed there was no refill available. Kurestin Pennington informed ORR that she had gone to the pharmacy to get refills; in addition, that she had gone to Lifeways once to discuss refills for his Klonopin. According to the report, Kurestin Pennington "reported that she had communicated with the pharmacy and the office in an attempt to get a new refill for [Resident A]." Gail Stockard, MA, sent a message to Adam Colden, filling the request from Kurestin Pennington, which stated Klonopin .5mg. Adam Colden, Nurse Practitioner informed ORR that Resident A

was prescribed Klonopin “as both a regular daily medication and as an as needed medication.” Resident A’s daily medication was dosed at 0.5 mg. Adam Colden reported that when he received the message about the refill for Klonopin 0.5 mg, he reviewed Resident A’s chart and noted that he was not due for refills on his daily dosage of Klonopin. It was also noted that Adam Colden reported that they have a formal policy for medication refill requests, which would go through a consultation note in the EMR system. He stated he did not receive a specific request for the PRN refill to be completed. He stated that to his knowledge, there had been no communication regarding the refill for the PRN medication. It was determined that there appeared to be a misunderstanding about dosage requested from Kurestin Pennington to Gail Stockard, MA. It was determined that Resident A had enough of the daily dosage of Klonopin, as well as the 20 days’ supply of the PRN. The allegations were not supported by a preponderance of the evidence.

On February 5, 2025, I conducted the exit conference with Violet Bettig, Licensee Designee. We discussed the investigation and my recommendations. She concurred with the conclusion of the investigation.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon my investigation, which consisted of an onsite investigation, review of pertinent documentation, and interviews with facility staff members, it has been established that Resident A received his medications as prescribed, with the exception of the PRN Klonopin. Resident A was prescribed Klonopin “as both a regular daily medication and as an as needed medication.” Kurestin Pennington reported to ORR to have difficulties with getting medications refilled for Resident A, and when the request was submitted, there appeared to be a misunderstanding regarding the request. Based upon this information, it’s concluded that there is not a preponderance of the evidence to support the allegations that Resident A did not receive his prescribed medications for four days, causing him to act out.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

A review of the November medication logs for Resident A reflected that there were no staff initials for 11/24, 11/25, and 11/26/24. I spoke with John Miatech, DCW, and inquired if Resident A was out of the home for the holidays. He stated that Resident A was in the facility; however, they had a new home manager (Kurestin Pennington) and there was some confusion about the paperwork, which resulted in the documentation not being done properly or timely.

It was also noted in this investigation that Bill Roberts, DCW, documented on the back of the December medication log that the Clonazepam was administered on 12/11/24; and he initialed the bubble pack. The front of the medication log had not been initialed.

Based upon the review of the December medication logs, it was also noted that for Resident A's Trazodone 100 MG, the staff did not clearly mark when this medication was administered for December 3, 2024 to December 8, 2024. There were some initials and information on the log for this medication, but the initials were not clearly marked in each box. The staff initials were also missing for the evening medications on December 10, 2024.

On February 5, 2025, I conducted the exit conference with Violet Bettig, Licensee Designee. We discussed the investigation and my recommendations. She agreed to submit a written corrective action plan to address the established violation.

APPLICABLE RULE	
R 400.14312	**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: **(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:	Based upon review of the November and December medication logs, it's concluded that the direct care staff on duty did not fully complete the individual medication logs, for Resident A, as required by the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.

2/4/2025

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Mahtina Rubritius Date
Licensing Consultant

Approved By:

02/05/2025

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Dawn N. Timm Date
Area Manager