GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 4, 2025

Zeta Francosky, Licensee Designee
Turning Leaf Res Rehab Svcs., Inc.
P.O. Box 23218
Lansing, MI 48909

RE: License #:	AM410409791
Investigation #:	2025A0356022
	Kentwood Cottage

Dear Ms. Francosky:

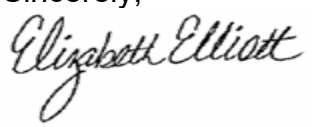
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM410409791
Investigation #:	2025A0356022
Complaint Receipt Date:	02/07/2025
Investigation Initiation Date:	02/10/2025
Report Due Date:	04/08/2025
Licensee Name:	Turning Leaf Res Rehab Svcs., Inc.
Licensee Address:	621 E. Jolly Rd., Lansing, MI 48909
Licensee Telephone #:	(517) 393-5203
Administrator:	CJ Ver Hey
Licensee Designee:	Zeta Francosky
Name of Facility:	Kentwood Cottage
Facility Address:	4345 36th St. SE, Kentwood, MI 49512
Facility Telephone #:	(517) 393-5203
Original Issuance Date:	05/25/2022
License Status:	REGULAR
Effective Date:	11/25/2024
Expiration Date:	11/24/2026
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, AGED, MENTALLY ILL, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A's medications were not administered as prescribed.	Yes

III. METHODOLOGY

02/07/2025	Special Investigation Intake 2025A0356022
02/10/2025	Special Investigation Initiated - Telephone RS-Network 180 case manager, Josh Yonker.
02/11/2025	Contact - Document Received Josh Yonker supports coordinator.
02/11/2025	Contact - Telephone call received Josh Yonker, NW 180 mental health case manager.
02/28/2025	Contact – Face to Face CJ Verhey, administrator.
03/10/2025	Inspection Completed On-site
03/10/2025	Contact - Face to Face Shae Green, home manager, Terah Earvin, Direct Care Worker, Resident A.
03/10/2025	Contact - Document Received MAR, facility documents.
04/03/2025	Contact - Telephone call made Josh Yonker, case manager, for Jennifer Wyngarden, nurse.
04/03/2025	Contact - Telephone call made Jennifer VanWyngarden, nurse Network 180. Mackenzie Wanezel-Network 180
04/04/2025	Exit Conference-Zeta Francosky, Licensee Designee.

ALLEGATION: Resident A's medications were not administered as prescribed.

INVESTIGATION: On 02/07/2025, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community and Health Systems) online complaint. The complainant reported Resident A is prescribed Clozapine that requires regular

lab draws, currently every other week. Resident A completed his regular lab draw on 11/21/2024, but did not receive his next lab draw until 12/09/2024, four days late. As a result, Resident A's pharmacy did not send his Clozapine, and Resident A missed the medication from 12/08/2024-12/15/2024. The complainant reported upon Resident A's Clozapine being delivered, staff administered Resident A his full dose. Clozapine is a medication that requires titration after several missed doses to avoid potential serious side effects. Resident A was then late again to obtain his labs in January 2025, leading to missed doses of clozapine on 01/15/2025-01/18/2025.

On 02/10/2025, I interviewed Josh Yonker, Net Work 180 case manager via telephone. Mr. Yonker stated Resident A reported that staff at the facility take him to his doctor's appointments and lab draws, however, due to a lack of communication, Net Work 180 was not informed that Resident A missed his Clozapine medication for several dates in December 2024 and January 30, 2025. Mr. Yonker stated the Network 180 RN (registered nurse); Jennifer Van Wyngarden wrote in her notes on 01/30/2025 that she was at the facility and discovered Resident A did not get his medication clozapine for a period of time and Resident A confirmed that he did not get this medication. Mr. Yonker stated in December 2024 Resident A missed a blood draw and the pharmacy would not dispense the medication and then again in January 2025 he missed another blood draw so the pharmacy would not dispense the medication again.

On 02/28/2025, I interviewed CJ Ver Hey, administrator and she acknowledged that Resident A missed 7 days of Clozaril during 2nd shift hours. Ms. Ver Hey stated multiple staff did not pass the medication, they did not tell anyone, nor did they write up an IR (incident report).

On 03/10/2025, I conducted an unannounced inspection at the facility and interviewed Shae Green, home manager and 1st shift staff, Terrah Earvin. Ms. Green acknowledged the information in the allegations occurred. She stated there was a breakdown in their system. Ms. Green stated she was alerted by a 2nd shift staff that the medication was running low and if its not available an IR is to be written. Ms. Earvin stated she usually took Resident A for his blood draw but in December 2024, there were a lot of staffing shortages which contributed to them missing the blood draw. Ms. Earvin stated at that time Resident A's blood draws were weekly and then they changed to bi-weekly, and the blood draw is a standing order so there are no appointments set. She said staff just went when they could go but with low staffing, it was overlooked. Ms. Green stated she saw a sticky note from staff that said to call the pharmacy to let them know Resident A's Clozaril was running out and that is how she realized there was an issue. Ms. Green stated the medication Resident A missed was always on 2nd shift, but they would just write information on sticky notes when medications were low and "that is not effective." Ms. Green stated Resident A told Network 180 he missed his Clozapine, but luckily Resident A did not suffer any ill effects from the missed medications.

Ms. Green stated it was a breakdown in communication, and it was she and Ms.

Earvin's failure to follow-up, but it has brought about a change in their system to communicate with one another and to write IR's. Ms. Green showed me a metal folder hanging on the wall in the office for staff to put IR's in so information is passed from one to shift to the next and she will see the IR and make sure Resident medication issues are addressed. Ms. Green stated with the bi-weekly blood draws she makes sure the facility is staffed accordingly, and he always gets to the lab.

On 03/10/2025, I interviewed Resident A at the facility. Resident A stated he missed some of his doses of Clozapine but now everything is good, and he gets his medication and goes for blood draws every other week.

On 03/10/2025, I reviewed the Resident Care Agreement (RCA) for Resident A. The RCA documented 'the basic fee includes the following basic services: Rent, all utilities, transportation to and from all medical/legal appointments, hygiene products, 3 well balanced meals and 2 snacks per day.' The RCA is dated 10/15/2024 and signed by Ms. Ver Hey and Resident A's legal guardian, Rich Karelse.

On 03/10/2025, I reviewed Resident A's MAR (medication administration records) for December 2024 and January 2025.

- The December MAR documented the medication Clozapine Tab 100MG, give 2 ½ tabs (250MG) by mouth at bedtime prescribed by Dr. Norma Cruz Luna. Resident A's Clozapine is marked by staff initials on all days of the month as administered except for 12/8/2024, 12/09/2024, 12/10/2024, 12/11/2024, 12/12/2024, 12/13/2024, 12/14/2024 and 12/15/2024. Those dates have staff initials with a circle around them. The exceptions page of the MAR documented the medication was not available.
- The January 2025 MAR documented the medication Clozapine Tab 100MG, give 2 ½ tabs (250MG) by mouth at bedtime prescribed by Dr. Norma Cruz Luna. Resident A's Clozapine is marked by staff initials on all days of the month as administered except for 01/15/2025, 01/16/2025 and 01/17/2025. Those dates have staff initials with a circle around them. The exceptions page documented the medication was not available on 01/15/2025 and 01/17/2025 but on 01/16/2025, the explanation was Resident A was out of the facility.

On 04/03/2025, I interviewed Mackenzie Wanezel, Network 180, Delta Team. Ms. Wanezel reviewed notes written by Jennifer Van Wyngarden, Delta Team nurse. Ms. Wanezel stated Ms. Van Wyngarden documented on 01/30/2025, Resident A went approximately 1.5 weeks without his Clozaril medication from 12/08/2024-12/15/2024 and again on 01/15/2025-01/17/2025. Ms. Wanezel reported staff at the facility did not take Resident A to his blood draws and therefore the medication could not be refilled, there is no explanation as to why staff failed to take Resident A to the blood draws as it is their responsibility to get the lab work done. Ms. Wanezel reported that Ms. Van Wyngarden documented once the medications were available at the facility, staff administered Resident A's full dose of Clozaril without notifying Network 180 staff or the psychiatrist because they administered the entire amount

when this medication should be titrated up to the amount prescribed. If the medication is not titrated the Resident runs the risk of severe adverse side effects. Ms. Wanezel stated Resident A did not report any adverse side effects. Ms. Wanezel stated the only way staff may have known they needed to titrate the medication is if they communicated with the Delta team, the pharmacy, the nurse or the psychiatrist.

On 04/04/2025, I conducted an exit conference with Zeta Francosky, Licensee Designee. Ms. Francosky stated they acknowledge this was an issue, and steps have been taken to make sure this does not occur in the future. Ms. Francosky stated she will submit an acceptable corrective action plan.

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:	Resident A required blood draws for his Clozapine medication to be refilled and staff failed to take Resident A in for the required blood draws, causing the medication to run out in December 2024 and again in January 2025. Staff did not administer Resident A's Clozaril medication for 8 days in December 2024 and 3 days in January 2025 because they were out of the medication. A violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

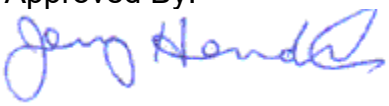
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

04/04/2025

Elizabeth Elliott, Licensing Consultant Date

Approved By:



04/04/2025

Jerry Hendrick, Area Manger Date