GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 29, 2026

Laura Kelling
Quincy Place Senior Living
12300 Quincy Street
Holland, MI 49424

RE: License #: AH700408748
Investigation #: 2026A1028043
Quincy Place Senior Living

Dear Laura Kelling:

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

Sincerely,

Julie Viviano

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH700408748
Investigation #:	2026A1028043
Complaint Receipt Date:	03/23/2026
Investigation Initiation Date:	03/25/2029
Report Due Date:	05/22/2026
Licensee Name:	VOP Quincy Place, LLC
Licensee Address:	Ste 200 500 N Hurstbourne Pkwy Louisville, KY 40222
Licensee Telephone #:	(616) 834-0220
Authorized Representative/Administrator:	Laura Kelling
Name of Facility:	Quincy Place Senior Living
Facility Address:	12300 Quincy Street Holland, MI 49424
Facility Telephone #:	(616) 834-0220
Original Issuance Date:	09/06/2023
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	102
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was sent to the hospital on 3/22/2026 due a decline in condition and was found with two fentanyl patches on [their] body.	Yes
Additional Findings	No

III. METHODOLOGY

03/23/2026	Special Investigation Intake 2026A1028043
03/24/2026	Contact - Document Sent Sent email to facility administrator/authorized representative requesting information and documentation pertaining to this special investigation.
03/24/2026	Contact - Telephone call made Interviewed administrator/authorized representative via telephone.
03/24/2026	Contact - Telephone call made Interviewed Employee A via telephone.
03/24/2026	Contact - Document Received Received requested documentation from administrator/authorized representative via email.
03/25/2026	APS Referral
03/25/2026	Special Investigation Initiated - Letter
04/27/2026	Contact – Document Sent Emailed the facility administrator/authorized representative and Employee A requesting additional information and documentation.
04/29/2026	Contact – Document Received Received the requested information and documentation from the facility administrator/authorized representative and Employee A.
04/30/2026	Contact – Document Sent Emailed the facility administrator/authorized representative and Employee A requesting additional information.

04/30/2026	Contact – Document Received Received the requested information from Employee A.

This investigation will only address allegations pertaining to potential violations of the rules and regulations for Homes for the Aged (HFA).

ALLEGATION:

Resident A was sent to the hospital on 3/22/2026 due to a decline in condition and was found with two fentanyl patches on [their] body.

INVESTIGATION:

On 3/24/2026, the Bureau received the allegations from Adult Protective Services (APS) referral through the online complaint system.

On 3/24/2026, I interviewed the administrator/authorized representative (Admin./AR) via the telephone who reported knowledge that Resident A was sent to the hospital on 3/22/2026 due to the spouse alerting staff that Resident A was demonstrating a decline in condition. The Admin./AR reported that Resident A was assessed at the facility and emergency services were contacted and that EMS had reported to the attending staff that Resident A had 2 fentanyl patches on [them]. Resident A had no complaints of pain and did not use [their] call light pendant. Resident A's spouse was present when emergency services arrived, and Resident A's physician was notified as well. The Admin./AR reported that staff present spoke with Resident A's spouse to determine why and/or how Resident A had two fentanyl patches on [their] body since only staff administer Resident A's medications. Resident A cannot access the patches or any other medication because all of Resident A's medications are secured in the medication cart. It was alleged that Resident A may have obtained the patches from a source outside the facility somehow or may have had old fentanyl patches hidden in their room. The spouse reported Resident A knows how to apply the patches themselves. The Admin./AR reported only one patch had been applied by facility staff on 3/20/2026 prior to transport to the hospital. I requested documentation from the Admin./AR.

On 3/24/2026, I interviewed Employee A via the telephone whose statement was consistent with the Admin./AR's statement. Employee A also reported that due to the allegation that 2 fentanyl patches were found on Resident A prior to transport to the hospital, a medication audit was completed immediately of Resident A's current medication. An investigation was completed as well and it was determined that Resident A received a fentanyl patch on 3/20/2026 and at this time, this should have been the only fentanyl patch on Resident A. Employee A reported an inspection of Resident A's room was completed due to this incident, and medications were found hidden in Resident A's room. The medications were removed immediately and secured at the medication station. Resident A's family was also notified of the

findings of the investigation and room inspection and a conference with the family was requested due to these findings. Resident A's physician was also notified of the initial hospital transport incident and the subsequent findings after the investigation and inspection were completed by the facility.

On 3/24/2026, I received and reviewed the requested documentation from the facility Admin./AR which revealed the following:
Review of Resident A's service plan:

- Resident A resides in the assisted living area of the facility.
- The service plan was last updated prior to the incident on 10/20/2025 and updated again on 3/31/2026 after the incident.
- Resident A is independent with mobility, the AM routine, PM routine, and toileting.
- Resident A requires standby assistance for bathing.
- The facility manages Resident A's meals, laundry, and housekeeping.
- The facility manages Resident A's medication administration.

Review of Incident Report:

- On 3/22/2026, [Resident A's spouse] *approached a medication technician stating Resident A needed help. Upon entering the room, [Resident A] had a glazed over look and was not responding to verbal stimulation. Cold to touch. O2 was not on. [Supervisor] on duty called in. O2 stats were 71% but went up to 95% when O2 applied at 3L. Diaphoretic pupils constricted, not verbally responsive but squeezed fingers in response. 911 was called. When they arrived, two fentanyl patches were observed on resident.*
- Resident A did not complain of pain.
- Resident A did not use the call-light pendant to call for assistance.
- Resident A was transported to the hospital.

Review of facility internal investigation:

- *Scheduled day for patch to be applied was 3/16/2026 and resident was in hospital--no patches on resident and patch applied at 5pm on 3/20/2026.*
- [Resident A] *was at baseline on admission to facility. [Resident A] had no issues until Sunday evening and was returned to the ER. Resident admitted to hospital that evening—room swept on 3/22/2026 and fentanyl patches were found in [Resident A's] possession.*
- *Verified [patch] count on admission and next day with no applications.*
- *Room swept when [Resident A] left via EMS and medications were found in room and secured outside of [Resident A's] room.*
- *Family meeting scheduled for 3/25/2026 at 3pm.*
- [Resident A's] *physician notified of resident's status and events leading up to incident.*

Review of chart notes:

- On 3/15/2026 at 3:31pm, [Resident A] *had an unwitnessed fall.*

- On 3/16/2026 at 12:50pm, [Resident A] *was in scooter, going to the [dining room.] No complaints of pain after fall.*
- On 3/17/2026 at 2:11pm, [Resident A] *observed in community in electric wheelchair. Appeared to be in good spirits. No complaints.*
- On 3/18/2026, [Resident A] *walked out to vehicle at 9:18am and when [spouse returned [they] stated that [they] took [Resident A] to [hospital] because of hip pain. No [complaint of] pain to staff after fall on 3/15/2026.*
- On 3/19/2026 at 7:58pm, [Resident A's spouse] expressed that [they] have not been able to get an update on [Resident A's] condition at the hospital. [Staff] called hospital and received update. Staff gave the spouse Resident A's current status information and provided the spouse with Resident A's room number and telephone number to call Resident A at the hospital.
- On 3/20/2026 at 5:00pm, [Resident A] *was checked for any pain patches for [discharge] from hospital. No patches found. Order changed to reflect new patch placed on admission* [to the facility.]
- On 3/20/2026 at 6:34pm, [Resident A] *returned from the hospital, a bit unsteady and a little confused. O2 placed on and concentrator not working correctly, changed to other concentrator in room and seemed to work. Airway to be contacted Monday to return concentrator. New orders noted to restart Losartan on 3/23/2026 and [discharge] hydralazine. Bruising noted to right hip and still [complains of] pain in right back in kidney area--resident unsteady at times and assisted to recliner. [Resident A] refused dinner this evening.*
- On 3/22/2026 at 5:41pm, *med tech stated [spouse] stated [Resident A] needed help. Upon entering the room, [Resident A] had a glazed over look and was not responding to verbal stimulation. Cold to touch. O2 was not on. [Supervisor] on duty called in. O2 stats were 71% but went up to 95% when o2 applied at 3L. Diaphoretic pupils constricted, not verbally responsive but squeezed fingers in response. 911 was called. When they arrived, two fentanyl patches were observed on resident.*
- On 3/22/2026 at 5:50pm, [Resident A] *sent to [sic] hospital for evaluation.*

On 4/27/2026, I requested additional information via email from the facility Admin./AR and Employee A.

On 4/29/2026, I received the requested information via email from the facility Admin./AR and Employee A. Employee A also reported via email that Resident A had been on Fentanyl prior to admission to [the facility] on 10/17/2025. [Resident A] *lived in Illinois previously and [family] stated that [Resident A] had been on Fentanyl before and would forget to remove old patches before applying new ones. The pain clinic ordered patches for Resident A 2/20/2026 and [Employee A] expressed concern for the use of Fentanyl and Oxy together but the pain clinic stated [Resident A] had this before.* Employee A confirmed via email that no Fentanyl patches were missing from the facility count and that none of Resident A's medications were missing from the facility count or medication cart. All Resident A's medications were accounted for and the quantities were correct. Employee A reported it could not be determined how Resident A obtained the extra Fentanyl patch found in [their] room

and that the last patch was applied by facility staff on 3/20/26. Employee A also *reported that staff did not visualize the extra patch [on Resident A], [only] EMS did [and it was reported to staff], but [the facility's] count was correct and no one at facility applied another patch.*

On 4/30/2026, I sent an email to the Admin./AR and Employee A for clarification with Employee A responding via email with the following: "*There was a patch in an opened wrapper in the garbage, no other patches were found. The patch looked like it had been replaced on the layer that protects it prior to administration. There were many loose pills found in her chair, bottles of Tylenol, and various OTC supplements. And no staff did not notice two patches prior to that incident."*

On 4/30/2026, I reviewed the requested information which revealed the following: Review of Physician Orders for March 2026 and March 2026 Medication Administration Record (MAR):

- Resident A is to take 1 tablet of Acetaminophen 500mg by mouth once daily (scheduled for 8:00 am.) Start date: 10/13/2025.
- Resident A is to take 2 tablets of Acetaminophen 500mg by mouth at bedtime (scheduled for 8:00 pm.) Start date: 10/13/2025.
- Resident A was to take 1 tablet of Aspirin LOW DSE-81mg-TBEC by mouth once daily (scheduled for 8:00 am.) Start date was 11/11/2025 and discontinued date was 3/26/2026.
- Resident A was to take 1 tablet of Clopidogrel by mouth once daily (scheduled for 8:00 am.) Start date was 10/13/2025 and discontinued date was 3/26/2026.
- Resident A is to take 1 capsule of Duloxetine 30mg DR by mouth once daily (scheduled for 8:00 am.) Start date: was 3/27/2026.
- Resident A was to have 1 patch of Fentanyl DIS 12MCG/HR applied every 72 hours (scheduled for 12:00 pm) Start date was 2/20/2026 and discontinued date was 3/20/2026.
- Resident A was to have 1 patch of Fentanyl DIS 12MCG/HR applied every 72 hours (scheduled for 12:00 pm) Remove patch from previous application. Start date was 3/26/2026 and discontinued date was 3/31/2026.
- Resident A is to take 1 tablet of Furosemide TAB 40MG by mouth once daily (scheduled for 8:00 am.) Start date: 2/25/2026.
- Resident A is to take 1 capsule of Gabapentin CAP 300MG by mouth once daily (scheduled for 8:00 am.) Start date: was 10/13/2025.
- Resident A is to take 2 capsules of Gabapentin CAP 300MG by mouth once at bedtime (scheduled for 8:00 pm.) Start date: was 10/13/2025.
- Resident A was to take 1 tablet of Hydralazine 25MG by mouth three times daily; *Hold if SBP is <110* (scheduled for 8:00 am, 2:00 pm, and 8:00 pm.) Start date: 11/10/2025 and discontinued on 3/20/2026.
- Resident A is to take 1 tablet of Hydralazine 50MG by mouth three times daily; (scheduled for 8:00 am, 2:00 pm, and 8:00 pm.) Start date: 3/26/2026.
- Resident A is to take 1 tablet of Losartan POT TAB 50MG by mouth once daily (scheduled for 8:00 am.) Start date: 2/28/2026.

- Resident A is to take 1 tablet of Melatonin TAB 3MG by mouth once daily at bedtime (scheduled for 8:00 am.) Start date: 10/13/2025.
- Resident A is to take 1 tablet of Metoprolol TAR TAB 25MG by mouth twice daily (scheduled for 8:00 am and 8:00 pm.) Start date: 10/13/2025.
- Resident A was to take 1 gummy of Multi ADLT CHW GUMMIES by mouth once daily (scheduled for 8:00 am.) Start date: 10/23/2025 and discontinued on 3/31/2026.
- Resident A was to take 1 tablet of Oxycodone HCl Oral Tablet 10MG by mouth three times daily (scheduled for 8:00 am, 2:00 pm, and 8:00 pm.) Start date: 2/26/2026 and discontinued on 3/26/2026.
- Resident A was to take 1 tablet of Oxycodone TAB 10MG by mouth three times daily (scheduled for 8:00 am, 2:00 pm, and 8:00 pm.) Start date: 3/27/2026 and discontinued on 3/27/2026.
- Resident A was to take 1 tablet of Rosuvastatin TAB 20MG by mouth once daily (scheduled for 8:00 am.) Start date: 3/26/2026 and discontinued on 3/31/2026.
- Resident A is to inhale 2 puffs of Symbicort AER 160-4.5 by mouth twice daily (scheduled for 8:00 am and 8:00 pm.) Start date: 10/23/2025.
- Resident A is to receive application of CLOTRIM/BETA CRE 1-0.05% to skin twice daily. Route: Topical (spot on the outer surface of the body) (scheduled: apply 1ML twice daily as needed) Start date: 10/23/2025.
- Resident A is to inhale 1 puff of Ventolin HFA AER every 4 hours as needed. Start date: 3/26/2026.
- Resident A's blood pressure is to be obtained and documented 3 times daily at 8:00 am, 2:00 pm, and evening/bedtime; 30 minutes after administration of hydralazine x 4 weeks. Send to MD office after 4 weeks starting 12/8/2025.
- Resident A's vitals are to be obtained and documented monthly (scheduled for 7:00 pm.)

PPLICABLE RULE	
R 325.1932	**Resident's medications.**
	(2) Prescribed medication managed by the home must be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed healthcare professional.

ANALYSIS:	It was alleged that Resident A was sent to the hospital on 3/22/2026 due to a decline in condition and was found with two Fentanyl patches on [their] body. Interviews, investigation, and review of documentation revealed that while only one patch was witnessed by facility staff to be on Resident A's person, an additional Fentanyl patch along with other medications were found in Resident A's room on 3/22/2026 after Resident A was transported to the hospital. It cannot be determined how or when Resident A obtained the additional Fentanyl patch or other medications, but all medications found were removed immediately from Resident A's room and secured in the medication cart. There is evidence that the facility demonstrated appropriate medication administration in accordance with the physician orders for Fentanyl. However, during interviews staff admitted loose pills were found in Resident A's chair along with bottles of Tylenol, and other various over the counter supplements were found in Resident A's room on 3/22/2026. Due to this finding, it cannot be determined if staff administered the other prescribed medications for Resident A in accordance with physician orders, therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remains the same.

Julie Viviano

4/30/2026

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Julie Viviano Date
Licensing Staff

Approved By:

Andrea Moore

07/29/2026

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Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section