GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 16, 2021

Judith Boven
AH Jenison Subtenant LLC
6755 Telegraph Rd Ste 330
Bloomfield Hills, MI 48301

RE: License #: AL700397745
Investigation #: 2021A0355019
AHSL Jenison Maplewood

Dear Mrs. Boven:

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) 356-0100.

Sincerely,

Grant Sutton, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4437

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700397745
Investigation #:	2021A0355019
Complaint Receipt Date:	01/26/2021
Investigation Initiation Date:	01/26/2021
Report Due Date:	03/27/2021
Licensee Name:	AH Jenison Subtenant LLC
Licensee Address:	One SeaGate, Suite 1500, Toledo, OH 43604
Licensee Telephone #:	(248) 203-1800
Administrator:	Theresa Bursley
Licensee Designee:	Judith Boven
Name of Facility:	AHSL Jenison Maplewood
Facility Address:	887 Oak Crest Lane, Jenison, MI 49428
Facility Telephone #:	(616) 457-3576
Original Issuance Date:	03/11/2019
License Status:	REGULAR
Effective Date:	09/11/2019
Expiration Date:	09/10/2021
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's Narcotics were missing.	Yes
Resident B's stimulus check is missing.	Yes

III. METHODOLOGY

01/26/2021	Special Investigation Intake 2021A0355019
01/26/2021	APS Referral
01/26/2021	Special Investigation Initiated - Telephone Administrator
02/05/2021	Inspection Completed On-site Interviewed staff
02/08/2021	Contact - Telephone call received Administrator
02/10/2021	Contact - Face to Face Interviewed staff on-site
02/11/2021	Exit Conference Licensee designee by telephone

ALLEGATION: Resident A's Narcotics were missing.

INVESTIGATION: On 01/26/2021, the licensee self-reported that two bottles of Resident A's medication (narcotics) were missing. The medications were discovered missing on 01/19/2021. The missing medications are 67 tablets of Hydrocodone-Acetaminophen and 41 capsules of Pr2egabalin.

On 01/26/2021, I contacted the administrator, Theresa Bursley, by telephone. Mrs. Bursely stated that Resident A is a newer resident who brought the bottles of medication when she moved in. The licensee prefers to pass medications from blister packs so when staff received the medications on the blister packs, staff Stephanie Powell contacted Resident A's son and asked him to pick up the bottled medications. Ms. Powell put the bottled medications in a bag with Resident A's name and the son's name on it and instead of keeping them in the locked medication cart, the Ms. Powell put the bag in a locked closet, telling incoming staff Stefany Benitez the medications were in the closet. Resident A's son did not

actually come in to pick up the medications for two days and it was then discovered that they were gone. A thorough search was conducted but the medications were not found. When I asked about Ottawa County Sheriff involvement, Mrs. Bursley stated when she reported the incident to a deputy, little interest was shown in opening an investigation and to date, no follow-up has occurred with the Sheriff.

On 02/05/2021, I conducted an on-site investigation and interviewed staff Stephanie Powell, Karen Ball, Jill Ruster, and One'szetta Vaughan. The administrator, Theresa Bursley and the Wellness Director, Jennifer Hicks sat in on the interviews. Investigator for the licensee, Joel Woods led the interviews via Zoom. Each of the staff interviewed worked during the time the medications went missing.

Ms. Powell stated that she is the staff who put Resident A's two bottles of medications in a bag and locked them in a closet in anticipation of Resident A's son picking them up on 01/17/2021. Ms. Powell had no explanation for putting the medications in the locked closet other than possibly for convenience for the incoming staff. Ms. Powell stated that the only staff she told about the medications being the closet was the incoming med lead staff, Stefany Benitez. Ms. Powell denied taking the bag of medications herself. Ms. Powell stated she had no knowledge of who took the medications but reiterated that Ms. Benitez was the only staff she told about the medications. Ms. Powell has worked at the facility for two years.

Ms. Ball is the home supervisor. Ms. Ball stated that she was aware of the medications when they were brought in. Ms. Ball stated that Ms. Powell checked in the medications on blister pack when received and contacted Resident A's family as reported, requesting that they pick up the bottles of medications brought in. Ms. Ball stated that the pharmacy will not destroy unused medications. Ms. Ball denied taking the medications. Ms. Ball has worked for the licensee for a little over a year.

Ms. Ruster stated that she was aware of the situation but had not had any contact with the medications. Ms. Ruster denied taking the medications and denied any knowledge of who might have taken them. Ms. Ruster has worked for the licensee for a little over a year and was filling in from another facility during the time the medications went missing.

Ms. Vaughan stated that she had heard of the medications going missing but had not touched them herself, stating that she had heard about the situation after the fact. Ms. Vaughan denied taking the medications and denied any knowledge of who did take them.

Each staff interviewed stated she would take a drug test "here and now" if the licensee requested it.

On 02/08/2021, Mrs. Burlsey contacted me by telephone to report that the medications had "reappeared" in the locked closet in a box. Mrs. Bursley stated that

none of the medications were missing and pointed out that the box was searched as part of the overall search on 01/19/2021. Mrs. Bursley reminded me that Ms. Powell had not placed them in the box when she locked the bag of medications in the closet.

On 02/10/2021, I interviewed on-site staff Diamond Walker, Kayesha Sander and Stephany Benitez. Mrs. Bursley and Mrs. Hicks sat in on the interviews. Each staff worked during the time period that the medications went missing. Mr. Woods led the interviews via Zoom.

Ms. Walker denied taking the medications and denied any involvement. When Resident A moved into the facility, Ms. Walker stated she gave the two bottles of medications to the med lead at the time who locked them in the medication cart. After that time, Ms. Walker denied any knowledge of the medications. Ms. Locker has worked at the facility for two months. Ms. Walker couldn't recall to whom she had given the medications to lock into the med cart.

Ms. Sander stated that she heard staff discussing the medications when they went missing but otherwise, Ms. Sander denied any knowledge of the situation and denied taking the medications. Ms. Sander has worked at the facility for one month.

Ms. Benitez denied any knowledge of the medications until hearing that they had gone missing. Ms. Benitez stated she did not know that the narcotics had been placed in the closet. Ms. Benitez denied taking the medications and denied bringing them back in to the locked closet. Ms. Benitez has worked at the facility for two months.

Each staff interviewed stated she would take a drug test "here and now" if the licensee requested it.

On 02/11/2021, I conducted by telephone an exit conference with the licensee designee, Judith Boven. Mrs. Boven accepted the findings of my investigation.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	67 tablets of Hydrocodone-Acetaminophen and 41 capsules of Pregabalin were discovered missing on 01/19/2021 after staff Stephanie Powell locked them in a storage closet on 01/17/2021.

	The medications were discovered back in the closet on 02/08/2021 and none were found to be missing. When the medications were placed in the closet, it removed them from the 'normal' medication location, making them no longer subject to the established methods of monitoring and oversight. The medications were left in the locked closet even after the time period that Resident A's family member was to come and pick them up, leaving them easier for a staff to take. Only a med lead would have the key to the closet on any given shift. While I can't definitively identify who took and replaced the medications, I find a preponderance of evidence to support that a rule violation has occurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident B's stimulus check is missing.

INVESTIGATION: On 01/26/2021, the licensee self-reported that a stimulus check received in the mail for Resident B was improperly stored in the medication cart on 01/14/2021 and discovered missing on 01/19/2021.

On 01/26/2021, I contacted by telephone the administrator, Theresa Bursley. Mrs. Bursley stated that the medication cart was thoroughly searched to be certain that the check had not slipped behind a drawer, etc. and it was not found.

On 02/05/2021, I conducted an on-site investigation and interviewed staff Stephanie Powell, Karen Ball, Jill Ruster, and One'szetta Vaughan. Each woman worked during the time the check was believed to be in the medication cart. The administrator, Theresa Bursley, and wellness director, Jennifer Hicks, sat in on the interviews. The investigator for the licensee, Joel Woods, led the investigation via Zoom.

Ms. Powell denied having anything to do with the missing stimulus check. Ms. Powell stated that she discovered on 01/18/2021 that the check was missing.

Ms. Ball stated that when the check arrived in the mail on 01/14/2021, she put it in the medication cart and locked it up. Ms. Ball stated that the check was still there when she worked on Sunday, 1/17/2021. Ms. Ball denied taking the check.

Ms. Ruster denied any knowledge of the missing stimulus check, denying that she'd taken it.

Ms. Vaughan stated that she heard about the stimulus check after it was missing. Ms. Vaughan denied taking the check.

On 02/10/2021, I conducted interviews on-site and interviewed staff Diamond Walker, Kayesha Sander, and Stefany Benitez. Each woman was working during the time the check was believed to have been taken. Mrs. Bursley and Ms. Hicks sat in on the interviews and Mr. Woods led the interviews via Zoom.

Ms. Walker stated that when the stimulus check came in the mail, she gave it to the med lead that day, Stephany Benitez, who locked the check in the medication cart at Ms. Ball's request. Ms. Walker denied taking the check.

Ms. Sander stated that she witnessed Ms. Benitez put the check in the medication cart. Ms. Sander denied that she had taken the check.

Ms. Benitez stated that she locked the stimulus check in the medication cart when Ms. Locker gave it to her. Ms. Benitez stated that Ms. Hall instructed Ms. Benitez to put it in the med cart. Ms. Benitez denied that she took the check.

On 02/11/2021, I conducted by telephone an exit conference with the licensee designee, Judith Boven. Mrs. Boven accepted the findings of my investigation.

APPLICABLE RULE	
R 400.15315	**Handling of resident funds and valuables.**
	(2) The care of any resident funds and valuables that have been accepted by a licensee for safekeeping shall be treated by the licensee as a trust obligation.
ANALYSIS:	All of the staff interviewed denied taking Resident B's stimulus check from the locked, medication cart. Only a med lead would have the key to the medication cart on any given shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend that the status of the license remain unchanged.

02/16/2021

Grant Sutton, Licensing Consultant Date

Approved By:

02/16/2021

Jerry Hendrick, Area Manager Date