GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 26, 2022

Tami McKellar
AH Kentwood Subtenant LLC
6755 Telegraph Road Suite
Bloomfield Hills, MI 48301

RE: License #: AL410397694
Investigation #: 2022A0583024
AHSL Kentwood Riverstone

Dear Ms. McKellar:

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) 356-0183.

Sincerely,

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410397694
Investigation #:	2022A0583024
Complaint Receipt Date:	04/26/2022
Investigation Initiation Date:	04/26/2022
Report Due Date:	05/26/2022
Licensee Name:	AH Kentwood Subtenant LLC
Licensee Address:	One SeaGate, Suite 1500 Toledo, OH 43604
Licensee Telephone #:	(248) 203-1800
Administrator:	Tami McKellar
Licensee Designee:	Tami McKellar
Name of Facility:	AHSL Kentwood Riverstone
Facility Address:	5980 Eastern Ave SE. Kentwood, MI 49508
Facility Telephone #:	(248) 309-0257
Original Issuance Date:	01/18/2019
License Status:	REGULAR
Effective Date:	07/18/2021
Expiration Date:	07/17/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was administered Resident B's prescribed medications.	Yes
The facility is unclean.	No

III. METHODOLOGY

04/26/2022	Special Investigation Intake 2022A0583024
04/26/2022	Special Investigation Initiated - Telephone Staff Michelle Peel
04/26/2022	Contact - Document Received Staff Mischelle Peel
04/26/2022	APS Referral
04/27/2022	Inspection Completed On-site Licensee Designee Tami McKellar, Staff LaTasha Johnson Resident A, Resident B
05/26/2022	Exit Conference Katrina Aleck, American House Clinical Specialist Laura Kelling, Executive Director American House Wyoming

ALLEGATION: Resident A was administered B's prescribed medications.

INVESTIGATION: On 04/26/2022 complaint allegations were received from the BCAL online reporting system. The complaint alleged that Resident A received Resident B's medications in error.

On 04/26/2022 I interviewed staff Mischelle Peel via telephone. Ms. Peel stated she worked at the facility for three weeks as the "Wellness Director" until she resigned on 04/22/2022. Ms. Peel stated she resigned because she did not feel that the facility was adequately servicing the needs of facility residents. Ms. Peel stated it was her job responsibly to act as the "director of nursing" for the facility. Ms. Peel stated she observed at least one medication error which involved Resident A receiving Resident B's prescribed medications in error from staff Duane Brown.

On 04/26/2022 I emailed complaint allegations to Adult Protective Services Centralized intake.

On 04/27/2022 I completed an unannounced onsite investigation at the facility. I privately interviewed Licensee Designee Tami McKellar, Resident A and Resident B.

Licensee Designee Tami McKellar confirmed that an “incident report” was completed regarding staff Duane Brown administering Resident B’s “08:00 AM medications on 04/13/2022” to Resident A in error. Ms. McKellar provided me with a copy of Resident B’s AM medications which I observed included the following medications: Aspirin Chew tab 81 milligrams, Bumetanide Tab 0.5 milligrams, Citalopram Tab 20 milligrams, Ferrous Gluc Tab 324 milligrams, Januvia Tab 100 milligrams, Losartan Tab 100 milligrams, Losartan tab 50 milligrams, Magnesium Ox Tab 400 milligrams, Multivitamin Tab, Pioglitazone Tab 45 milligrams, Potassium CL ER Cap 10 meq, Potassium CL ER Cap 10 Meq, Senna-S Tab, Vitamin C Tab 500 milligrams, Vitamin D3 Cap 1000U. Ms. McKellar stated Resident A’s Primary Care Physician was notified of the medication error and no ill effects were observed. Ms. McKellar confirmed staff Duane Brown is no longer employed at the facility.

While onsite I reviewed Resident A and Resident B’s Medication Administration Records and noted they do not contain a record of the 04/13/2022 medication administration error.

I interviewed Resident A and Resident B, both privately regarding the 04/13/2022 medication administration error and neither resident stated that they recalled the incident occurred.

On 05/06/2022 I received an email from Licensee Designee Tami McKellar which contained an Incident Report signed by Ms. McKellar on 05/06/2022. The Incident Report documented that on 04/13/2022; “another resident refused their medication. Duane then placed cup of medications on top of cart and prepared (Resident A’s) medications. Duane then picked up the wrong medication cup and administered to (Resident A). When Duane arrived back to cart, he observed the wrong medications were given to (Resident A)”. The Incident Report further documented; “Nursing director educated medtech on the dangers of presetting medications”.

On 05/26/2022 I completed an Exit Conference with Katrina Aleck, American House Clinical Specialist, and Laura Kelling, Executive Director American House Wyoming. Ms. Aleck stated she agreed with the findings and would submit an acceptable Corrective Action Plan. Ms. Aleck stated Licensee Designee Tami McKellar is no longer employed at the facility.

APPLICABLE RULE	
R 400.15312	**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 {333.1101 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:	Licensee Designee Tami McKellar confirmed that an incident report was completed regarding staff Duane Brown administering Resident B's 8:00 AM medications on 04/13/2022 to Resident A in error. An Incident Report was completed which confirmed this medication error. A preponderance of evidence was discovered through this Special Investigation to substantiate a violation of the applicable rule. Resident A was administered Resident B's prescribed medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The facility is unclean.

INVESTIGATION: On 04/26/2022 complaint allegations were received from the BCAL online reporting system. The complaint alleged that the facility is unclean.

On 04/26/2022 I interviewed staff Mischelle Peel via telephone. Ms. Peel stated that the facility was routinely observed to be unclean as evidenced by "dirt on the floors", "urine on the floors", and "overflowing trash" in resident bedrooms. Ms. Peel stated the facility previously employed a staff member to complete "housekeeping" throughout the facility however the facility has been without housekeeping staff since Ms. Peel's employment April 2022.

On 04/27/2022 I completed an unannounced onsite investigation at the facility. I privately interviewed Licensee Designee Tami McKellar. Ms. McKellar stated she has not observed the conditions of every resident bedroom and bathroom recently however the rooms she has observed appear clean and sanitary. Ms. McKellar acknowledged the facility was without housekeeping staff from 04/23/2002 until recently and the facility currently has employed a dedicated "housekeeping" staff. Ms. McKellar stated resident care staff completed facility cleaning while the facility was without dedicated "housekeeping" staff.

While onsite I completed a visual inspection of the facility specifically observing the sanitation and cleanliness. I observed the facility's resident bedrooms, bathrooms, and common areas to be clean and sanitary.

On 05/26/2022 I completed an Exit Conference with Katrina Aleck, American House Clinical Specialist, and Laura Kelling, Executive Director American House Wyoming. Ms. Aleck stated she agreed with the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	While onsite I completed a visual inspection of the facility specifically observing the sanitation and cleanliness. I observed the facility's resident bedrooms, bathrooms, and common areas to be clean and sanitary. A preponderance of evidence was not discovered during the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change in the license.

05/26/2022

Toya Zylstra Date
Licensing Consultant

Approved By:

05/26/2022

Jerry Hendrick Date
Area Manager