GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 29, 2022

Theresa Bursley
AH Jenison Subtenant LLC
6755 Telegraph Rd Ste 330
Bloomfield Hills, MI 48301

RE: License #: AL700397748
Investigation #: 2022A0467054
AHSL Jenison Sandalwood

Dear Mrs. Bursley:

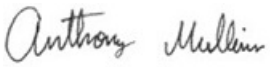
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700397748
Investigation #:	2022A0467054
Complaint Receipt Date:	08/01/2022
Investigation Initiation Date:	08/02/2022
Report Due Date:	09/30/2022
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:	Theresa Bursley
Name of Facility:	AHSL Jenison Sandalwood
Facility Address:	861 Oak Crest Lane Jenison, MI 49428
Facility Telephone #:	(616) 457-3576
Original Issuance Date:	03/11/2019
License Status:	REGULAR
Effective Date:	09/11/2021
Expiration Date:	09/10/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A missed several scheduled medications in late April. Resident A also received more morphine than prescribed in May.	Yes
The facility did not have adequate staff to address Resident A's needs, resulting in medication errors in April and May 2022.	No
Additional Findings	Yes

III. METHODOLOGY

08/01/2022	Special Investigation Intake 2022A0467054
08/01/2022	I sent the complainant an email requesting a call to discuss the allegations. The complainant was unavailable via phone until 08/06/2022 due to her schedule.
08/02/2022	I sent the complainant an email requesting information related to the hospice agency involved. The complainant provided me with the requested information.
08/02/2022	Special Investigation Initiated - On Site
08/02/2022	Interview with licensee designee, Theresa Bursley.
08/02/2022	Contact – Document Received Received Resident A's MAR and the staff's schedule for April.
08/15/2022	Spoke to Wellness Director, Jennifer Hicks via phone.
09/19/2022	Spoke to Spectrum Health Hospice staff, Patricia G and Alison Dickenson.
09/20/2022	Spoke to Alison Dickenson with Spectrum Health Hospice.
09/21/2022	Spoke to Alison Dickenson and Jennifer Vanderveen with Spectrum Health Hospice.
09/22/2022	APS Referral – A referral was not sent to APS due to Resident A being deceased.

09/29/2022	Exit conference completed with licensee designee, Theresa Bursley.

ALLEGATION: Resident A missed several scheduled medications in late April. Resident A also received more morphine than was prescribed in May.

INVESTIGATION: On 08/01/22, I received a BCAL online complaint. The complaint stated that in late April 2022, Resident A's hospice nurse discovered that it had been at least a week since he had received any of his required medications from facility staff. It also alleged that it was possibly longer than a week that Resident A went without his medications. The complaint stated that Resident A suffered from a significant fall resulting in a head injury approximately three weeks after not receiving his medication and passed away nearly a week after his fall. The complaint also stated that in Resident A's final days, he was prescribed morphine by his hospice care team and American House staff dispensed the wrong amount of morphine. The complaint stated that American House records were inconsistent regarding Resident A's dosages as it reflected amounts of morphine dispensed that did not add up to what was taken from the supply, indicating either an over-dosage or a misplacement of Morphine.

On 08/01/22, I sent the complainant an email requesting a call to discuss the complaint. The complainant and I were unable to connect via phone. However, on 8/2/22, the complainant provided me with information related to Resident A's hospice care team (Spectrum) and his nurse via email.

On 08/02/22, I made an unannounced onsite investigation to the facility. Upon arrival, I spoke to the Wellness Director, Jennifer Hicks. Ms. Hicks stated that the Executive Director, Theresa Bursley was at another facility. Ms. Hicks and I discussed the allegations.

I explained to Ms. Hicks that it was alleged that Resident A went at least seven days without receiving his required medications while at the facility in April. Ms. Hicks recalled this incident. However, Ms. Hicks believed that it was only one medication that Resident A did not receive for a week as opposed to multiple medications. Ms. Hicks did not recall the specific name of the medication, but she believed it to be his Memantine medication, which she stated is used to slow down the progression of dementia. When asked why Resident A went a week without receiving his prescribed medication, Ms. Hicks stated that it could have been due to an issue with the pharmacy and "us," referring to staff at American House. Ms. Hicks stated that it is possible that someone within the facility accepted the medication without having a discharge order to be able to take it out of their system. Ms. Hicks expanded on this statement by sharing that if a medication was due for a refill and the pharmacy was unable to get ahold of the doctor, it would be discontinued. She also added that if a new order is received, staff discontinue the old order and start the medication based on the new order. Ms. Hicks stated that another possibility is that the pharmacy

stopped filling the medication and there was a lack of follow through by American House staff. Regardless of who caused the mistake, Ms. Hicks acknowledged that American House staff are responsible for the final check.

Ms. Hicks confirmed that American House management held a care conference with Resident A's family and apologized for not giving him his medication for a week. Present in the care conference was Ms. Hicks, Ms. Bursley, Angie Nelson (wellness assistant), Jill Ruster (Manor coordinator), Spectrum Hospice staff, and the family of Resident A. Ms. Hicks stated that American House planned to re-educate staff to prevent a similar situation from occurring. Ms. Hick's stated that the family appeared to be receptive of the plan moving forward. However, Ms. Hicks acknowledged that the family was worried about Resident A, as well as other residents in the facility due to the medication issue.

Ms. Hicks stated that Resident A passed away at the facility on 5/31/22. I reviewed an incident report, which confirms this statement. I asked Ms. Hicks for a copy of Resident A's MAR for the month of April. She was unable to print it during this onsite investigation due to a system issue but agreed to send it to me via email later today.

I explained to Ms. Hicks that there was also a concern regarding Resident A receiving too much morphine prior to his death in May 2022. Ms. Hicks stated that when the hospice nurse wrote the order for morphine, the dosage was prescribed in MG as opposed to ML. Ms. Hicks stated that Hospice is always asked to measure dosage in ML as opposed to MG as this can be confusing for non-medical staff at the AFC. Ms. Hicks provided me with an order signed on 5/27/22 by Jennifer Vanderveen, RN with Spectrum Hospice. The order included 10mg of morphine every 1 hour, which equates to 0.5ML. Despite the order stating 10mg (or 0.5ML) every hour, Ms. Hicks stated that someone at American House entered the order as 1ML per hour instead of 0.5ML. Ms. Hicks stated that this order was likely entered by the manor coordinator, Jill Ruster. Ms. Hicks stated that she spoke to the hospice doctor, Colleen Tallen and she informed her that the risk of harm to Resident A after receiving more morphine than scheduled was minimal.

Regardless of the risk of harm, the facility failed to provide Resident A with the appropriate dosage of medication. Ms. Hicks confirmed that the facility did run out of morphine for Resident A, but a new prescription was filed at the local Walgreens. Therefore, Resident A never missed a dose of this medication.

Ms. Hicks provided me with a copy of Resident A's MAR for the month of May 2022 which confirmed that he received 1ML of morphine as opposed to 0.5ML. Ms. Hicks stated that she has a progress note regarding her communication with Dr. Colleen Tallen but she was unable to locate it. Ms. Hicks provided me with a copy of Resident A's assessment plan and health care appraisal, which did not list any concerning details related to this medication issue.

Ms. Hicks stated that Resident A was declining prior to his fall on 5/23/22 when he was sitting in the dining room and fell out of his chair. Resident A was reportedly hallucinating, and the fall was unwitnessed. Ms. Hicks stated that she had no indication from American House or the Spectrum's Hospice team that Resident A's fall sped up his process of passing away. Resident A's assessment plan indicated that he had a history of frequent falls, in addition to medical conditions that affect his balance and mobility. Resident A did not require a two-person assist.

On 08/02/22, I made an announced onsite visit to AHSL Kentwood to speak to licensee designee, Theresa Bursley. I explained the allegations to Ms. Bursley, and she was unable to recall how many medications Resident A missed. However, she confirmed that she knows Resident A missed a medication for a week, and possibly more. Ms. Bursley also confirmed a care conference was scheduled with Resident A's family and that American House apologized to the family for Resident A missing his prescribed medication. Ms. Bursley stated that the family appeared be receptive of the meeting and what was discussed. Ms. Bursley was unable to recall the name of the medications that were missed or how many.

Regarding Resident A being given too much morphine, Ms. Bursley stated that she was unsure if Resident A ran out of morphine, but she did hear that he was given an incorrect dosage due to confusion on how the order was written. The order was writing in MG as opposed to ML. Ms. Bursley was unsure as to when Resident A signed onto hospice. Ms. Bursley stated that the family was upset about Resident A not receiving his medication. Ms. Bursley was unable to recall Resident A's fall being a week prior to his passing. Ms. Bursley was aware that Resident A was a fall risk.

On 08/02/22, Ms. Hicks sent me an email with Resident A's MAR for April 2022. Ms. Hicks stated that the medications that Resident A missed in April of 2022 were Donepezil and Duloxetine as the medications stopped coming from the pharmacy.

On 08/15/22, I spoke to Ms. Hicks via phone to verify the name of the medications and the number of days the medications were not passed in the month of April. Ms. Hicks confirmed that Resident A missed the following medications in April:

Donepezil 10MG tablet: Missed on 4/22 and 4/24-4/26 due to the medication being unavailable.

Duloxetine HCl capsule delayed release particles 30 MG: Missed on 4/22, 4/24, and 4/26-4/29 due to being unavailable or "not yet on cart" due to not receiving it from the pharmacy.

Quetiapine Tab 25MG (2 tablets by mouth one time a day): Missed on 4/2 due to medication being unavailable.

Quetiapine Tab 25MG (2 tablets by mouth one time a day). On 4/3, Resident A only received half of the scheduled dose due to the facility not having more medication in stock.
Senna – Plus Oral Tablet 8.6-50MG: Missed on 4/20-4/24 and 4/26 due to the medication being unavailable and not on the cart.

On 09/19/22, I called Spectrum Health Hospice and requested to speak to Jennifer Vanderveen, RN. The hospice Aid, Patricia G. stated that she will relay the message to Ms. Vanderveen and have her get back to me as soon as possible.

On 09/19/22, I received a call from Alison Dickenson, assistant administrator for Spectrum Health Hospice. Ms. Dickenson is also a nurse. She notified me that Ms. Vanderveen is unavailable for the next few weeks. I explained to Ms. Dickenson the allegations listed above and why I need to speak to Ms. Vanderveen. Ms. Dickenson stated that Ms. Vanderveen will be available tomorrow and she will have her call me.

On 09/20/22, I received a call from Ms. Dickenson. Ms. Dickenson stated that Ms. Vanderveen is available tomorrow at 2:00 pm to talk with me regarding the allegations.

On 09/21/22, I spoke to Ms. Dickenson and Ms. Vanderveen via phone. Ms. Vanderveen stated that American House staff member, Jill Ruster informed her that Resident A's Aricept (Donepezil) and Cymbalta (Duloxetine) was out for "7 days" and that his Seroquel (Quetiapine) medication never arrived. Ms. Vanderveen stated that she spoke to Dr. Colleen Tallen and she approved discontinuing Resident A's Aricept medication with his family's approval. Ms. Vanderveen stated that Resident A's Cymbalta and Seroquel were filled at the pharmacy. Ms. Vanderveen stated that she did not have knowledge of Resident A missing any other medications as she did not have access to his MAR from American House.

I then asked Ms. Vanderveen if she was aware of Resident A receiving more morphine than he was prescribed in his final days. Ms. Vanderveen stated that she did hear about this and believed it occurred over Memorial Day weekend, which she did not work. Ms. Vanderveen was aware that American House staff confused the morphine dosage (MG to ML) and ultimately Resident A received more morphine than prescribed. Ms. Vanderveen stated that 10MG is the equivalent of 0.5ML. Ms. Vanderveen confirmed that if Resident A received 1ML of morphine every hour as opposed to his scheduled 0.5ML, the concerns are minimal.

On 09/22/22, I spoke to Ms. Dickenson via phone. She confirmed that Resident A receiving 1ML of morphine as opposed to 0.5ML did not have an impact on Resident A's demise. Ms. Dickenson stated that residents with similar medical cases receive more morphine than Resident A did. Ms. Dickenson was thanked for her time.

On 09/26/22, I spoke to staff member Daveonna Adams. Ms. Adams stated that she worked with Resident A approximately three times, mostly on 2nd shift. Ms. Adams

stated that she always offered Resident A his medications. She denied having any knowledge of Resident A not receiving his medication from other staff. Ms. Adams stated that the only time she was aware of Resident A not receiving his medications is when he refused. Ms. Adams confirmed that Resident A liked to walk, stand, and wander although he was unstable on his feet. Ms. Adams stated that Resident A had assistive devices and staff had to redirect him to use them, but he would often refuse.

On 09/27/22, I spoke to Manor coordinator, Jill Ruster via phone. Ms. Ruster recalled working with Resident A during his time at the facility. Ms. Ruster recalled Resident A not receiving some of his medications in April of 2022. However, she could not recall the name of the medications. Ms. Ruster stated that American House is struggling with their in-house pharmacy, which is Remedi Senior Care Pharmacy based out of Plymouth, MI. Ms. Ruster stated that every time American House staff fax an order to the pharmacy, they were told that it could take three or more days to get the medications to the facility. When American House staff requested a stat order from Remedi Senior Care Pharmacy, the pharmacy was supposed to do a “drop ship,” which means they partner with a courier to have the medications delivered to the facility within 4-6 hours. However, they were not always able to achieve this. Due to ongoing issues with Remedi Senior Care Pharmacy, American House staff used the pharmacy that Spectrum Health Hospice uses to get the medication sooner. They also use the local Walgreens pharmacy to get medications filled. Ms. Ruster stated that American House corporate is aware of the issue with Remedi Senior Care Pharmacy and plans to make adjustments when it’s time to renew their contract.

In addition to the medication issue in April 2022, Ms. Ruster acknowledged that Resident A received more morphine than he was prescribed in May 2022. Ms. Ruster stated that Resident A received more morphine due to their being a mix-up based on how the order was written by Spectrum Hospice. Ms. Ruster stated that she is unsure if the medication error is a result of herself, the director of nursing, or the director of nursing assistant that placed the order in the system incorrectly. After this issue occurred, Ms. Ruster stated that hospice now documents the concentration and the dosage clearly to prevent a similar situation from occurring.

On 09/27/22, I spoke to staff member Nancy Groelsma. She denied any knowledge of Resident A not receiving his prescribed medication. It should be noted that Ms. Groelsma works 3rd shift and medications are primarily given to residents on first and second shift.

On 09/29/22, I conducted an exit conference with licensee designee, Theresa Bursley. She was informed of the investigative findings and agreed to complete a corrective action plan.

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:	Ms. Hicks confirmed that Resident A missed multiple days of the medications Donepezil, Duloxetine, Quetiapine, Senna in April 2022. Ms. Ruster confirmed that Resident A missed medications in April 2022 and received an overage of morphine in May 2022. Spectrum Health Hospice RN, Jennifer Vanderveen stated that American House staff member, Jill Ruster informed her that Resident A was out of Donepezil and Duloxetine for seven days and that her Quetiapine medication never arrived. Ms. Hicks also confirmed that Resident A received 1ML of morphine from 5/27 to 5/29 as opposed to 0.5ML due to staff entering the order incorrectly. This resulted in Resident A receiving a surplus of morphine. Hospice RN's, Jennifer Vanderveen and Alison Dickenson stated that although Resident A received more morphine than prescribed, it did not impact Resident A's demise. Based on the information provided, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The facility did not have adequate staff to address Resident A's needs, resulting in medication errors in April and May 2022.

INVESTIGATION: On 8/2/22, I spoke to licensee designee, Theresa Bursley. She provided me with the census for AHSL Sandalwood for the month of April, which indicated that there were 19 residents and 1 guest.

On the same day, I also spoke to the wellness director, Jennifer Hicks regarding staffing. Ms. Hicks informed me that the facility has at least two residents who require a two-person assist. Therefore, there should be a minimum of two staff members on each shift every day. Ms. Hicks emailed the staff schedule for American House Sandalwood for April 2022. I reviewed the schedule, and it indicated that there were at least two staff members scheduled to work each shift.

On 9/22/22, I emailed Ms. Bursley and Ms. Hicks, requesting a copy of the staff schedule for May 2022. On 9/23/22, I received a copy of the schedule and it indicated there were at least two staff members scheduled to work each shift.

On 09/26/22, I spoke to staff member Daveonna Adams via phone. Ms. Adams stated that she worked with Resident A approximately three times. Each time Ms. Adams worked with Resident A, she stated that his care needs were met. During her time working in the facility, Ms. Adams stated that there were always three staff members working in the building (1 med tech and 2 aides) to address residents' needs. Ms. Adams denied having any concern related to the care that Resident A received during his time at the facility.

On 09/27/22, I spoke to manor coordinator, Jill Ruster. Ms. Ruster recalled working with Resident A during his time at the facility. Ms. Ruster spoke highly of Resident A and stated that staff missed him after his passing. Ms. Ruster stated that Resident A's family did a great job of advocating for him and asking questions. Ms. Ruster stated that Resident A's family expressed concerns anytime there was a change in his condition and Ms. Ruster and staff provided education on his decline and the medication recommendations for him. Despite Resident A's family expressing concern and pushing back on some of the recommendations for him, Ms. Ruster was adamant that his care needs were being met.

Ms. Ruster stated that on first and second shift, there were always three staff members working and on third shift, there were always two staff members working. Ms. Ruster stated that Resident A was supposed to use his assistive devices. However, he would wander the facility without them and was a known fall risk. Ms. Ruster stated that there were nearly 20 residents in the facility and multiple residents that required staff assistance with tasks. Therefore, there were times that staff would be addressing the needs of another resident and Resident A would move throughout the facility without his assistive devices.

On 09/27/22, I spoke to staff member Nancy Groelsma via phone. Ms. Groelsma recalled working with Resident A during his time at the facility. Ms. Groelsma is a 3rd shift staff member and stated that Resident A was asleep for most of her shifts. Ms. Groelsma stated that every "once in a while," Resident A would wake up and forget where he was and where he needed to go. Ms. Groelsma stated that she would redirect him to where he needed to be, such as the bathroom. Ms. Groelsma stated that Resident A did wander from his room at times, but he never went too far. Towards the end of his time in the facility, Ms. Groelsma stated that Resident A was

a known fall risk. Ms. Groelsma confirmed that there were at least two staff members working on 3rd shift during Resident A's time at the facility. Ms. Groelsma stated that during her time working with Resident A, his needs were being met. Ms. Groelsma denied having any concern regarding the care that her peers provided to Resident A.

On 09/29/22, I conducted an exit conference with licensee designee, Ms. Bursley. She was informed of the investigative findings and denied having any questions.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	The staff schedule for April and May of 2022 indicated at least two staff members were scheduled to work on each shift during this month. Ms. Adams, Ms. Ruster, and Ms. Groelsma all confirmed that Resident A's needs were met and that there were at least two people always working in the facility. Therefore, there is not a preponderance of evidence to support the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION: While investigating the allegations listed above, I observed Resident A's assessment plan was not signed by Resident A. The assessment plan was also not signed by the licensee designee.

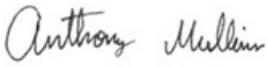
On 09/29/22, I conducted an exit conference with licensee designee, Theresa Bursley. She was informed of the investigative findings and agreed to complete a corrective action plan.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**

	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A's assessment plan was not signed by himself or his legal representative. It was also not signed by the licensee designee. Therefore, there is a preponderance of evidence to support this violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



09/29/2022

Anthony Mullins Date
Licensing Consultant

Approved By:

09/29/2022

Jerry Hendrick Date
Area Manager