GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 28, 2023

Sarah Schmidt
Chandler Pines, LLC
1435 Coit Ave NE
Grand Rapids, MI 49505

RE: License #: AS410411560
Investigation #: 2023A0583033
Chandler Pines Unit B

Dear Mrs. Dillon:

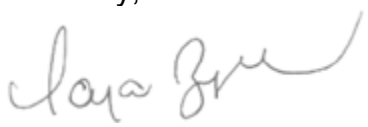
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS410411560
Investigation #:	2023A0583033
Complaint Receipt Date:	06/14/2023
Investigation Initiation Date:	06/15/2023
Report Due Date:	07/14/2023
Licensee Name:	Chandler Pines, LLC
Licensee Address:	1435 Coit Ave NE Grand Rapids, MI 49505
Licensee Telephone #:	(616) 745-4675
Administrator:	Sarah Schmidt
Licensee Designee:	Sarah Schmidt
Name of Facility:	Chandler Pines Unit B
Facility Address:	7555 Chandler Dr. NE Belmont, MI 49306
Facility Telephone #:	(616) 204-7598
Original Issuance Date:	05/18/2022
License Status:	REGULAR
Effective Date:	11/18/2022
Expiration Date:	11/17/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, AGED, DEVELOPMENTALLY DISABLED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
90 tablets of Resident A's prescribed medication, Tramadol, are missing.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/14/2023	Special Investigation Intake 2023A0583033
06/15/2023	Special Investigation Initiated - Telephone Licensee Designee Sarah Schmidt
06/16/2023	Inspection Completed On-site
06/16/2023	APS Referral
06/16/2023	Contact - Document Sent Kent County Sheriff Dept.
06/18/2023	Contact - Document Received Licensee Designee Sarah Schmidt
06/21/2023	Contact - Telephone call made Detective Jared Wierda
06/22/2023	Contact - Telephone call made Detective Jared Wierda
06/22/2023	Contact - Telephone call made Staff Stacie Crider
06/22/2023	Contact - Telephone call made Mikayla Krawcyzk
06/22/2023	Contact - Telephone call made Staff Grace Boyd
06/22/2023	Contact - Telephone call made Staff Rose Robinson
06/27/2023	Exit Conference Sarah Schmidt

ALLEGATION: 90 tablets of Resident A's prescribed medication, Tramadol, are missing.

INVESTIGATION: On 06/16/2023 I completed an announced onsite investigation at the facility. I interviewed Licensee Designee Sarah Schmidt and staff Jaycee Schuberg. Chief Operating Officer Lisa Sikes and Regional Clinical Manager Bridget Lutzke were present during the interviews. Residents were not interviewed as a result of their limited cognitive abilities.

Licensee Designee Sarah Schmidt explained that the facility is located in the lower level of the same building as Chandler Pines AM410390297 and the two facilities are separated by a door and staircase. Ms. Schmidt stated that on 05/30/2023 staff Stacie Crider worked from 3:00 PM until 7:00 PM on 05/30/2023 and staff Jaycee Schuberg worked from 7:00 PM 05/30/2023 until 7:00 AM 05/31/2023. Ms. Schmidt stated that staff Rose Robinson worked at the facility on 05/31/2023 from 7:00 AM until 7:00 PM. Ms. Schmidt stated that on 05/30/2023 staff Stacie Crider worked from 7:00 AM until 3:00 PM, staff Mikayla Krawczyk worked from 7:00 AM until 7:00 PM, and staff Grace Boyd worked from 3:00 PM until 11:00 AM at Chandler Pines AM410390297. Ms. Schmidt stated that on 05/31/2023 at approximately 7:15 AM staff Rose Robinson telephoned Ms. Schmidt and reported that the narcotics count for Resident A's Tramadol were "off". Ms. Schmidt stated she entered the facility at approximately 10:00 AM 05/31/2023 and examined the "Narc Count Sheet" which displayed staff Mikayla Krawczyk's name as the staff who signed Resident A's Tramadol into the facility at 7:00 PM. Ms. Schmidt stated she observed that Resident A's Tramadol were missing and they have not been located. Ms. Schmidt stated that the delivery slip and "Narc Count Sheet" have all "disappeared" since 05/31/2023 and have not been located. Ms. Schmidt stated she was able to determine that 90 tablets of Resident A's Tramadol were delivered to Chandler Pines AM410390297 on 05/30/2023 at 3:33 PM by Mercy Long Term Health Pharmacy and Ms. Boyd was identified by the pharmacy as the staff who signed for receipt of the delivery. Ms. Schmidt stated said medication is a PRN (administered as needed) and Resident A did not run out of said medication. Ms. Schmidt stated she was unaware of who ordered the shipment of Tramadol given Resident A was not out of said medication. Ms. Schmidt stated the pharmacy delivers the facility's medications to Chandler Pines AM410390297 and the delivery company does not check ID or signatures.

Ms. Schmidt stated on 05/31/2023 at 7:00 AM all 90 tablets of Tramadol were observed by Ms. Robertson as missing and when Ms. Schmidt subsequently visited to the facility; the narcotics tracking sheets and delivery slips were missing. Ms. Schmidt stated she spoke to Ms. Schuberg who confirmed that she completed accurate narcotics count with Ms. Crider on 05/30/2023 at 7:00 PM and Ms. Schuberg confirmed that she observed Resident A's Tramadol in the medication cart on 05/30/2023. Ms. Schmidt stated she spoke to Ms. Krawczyk regarding the missing medications and Ms. Krawczyk reported that she had transported Resident A's Tramadol from Chandler Pines AM410390297 to the facility at on 05/30/2023 at

approximately 7:00 PM and placed said medications into the medication cart. Ms. Schmidt stated she did not report the missing Tramadol to law enforcement or LARA.

Staff Jaycee Schuberg stated she worked at the facility on 05/30/2023 from 7:00 PM until 05/31/2023 at 7:00 AM. Ms. Schuberg stated when she arrived staff Stacie Crider had worked at the facility until 7:00 PM 05/30/2023; therefore Ms. Schuberg completed an accurate narcotics count with Ms. Crider. During the narcotics count Ms. Schuberg stated she observed Resident A's 90 Tramadol tablets and 05/30/2023 "pharmacy slips" located in the "pharmacy book". Ms. Schuberg stated staff Rose Robertson started her shift on 05/31/2023 at 7:00 AM and Ms. Schuberg left on 05/31/2023 at 7:00 AM without completing a narcotics count with Ms. Robertson because Ms. Schuberg was "tired". Ms. Schuberg stated as she was leaving the facility Ms. Schuberg observed Ms. Crider was working at Chandler Pines AM410390297 and Ms. Crider entered the facility and requested the medication cart key from Ms. Robertson. Ms. Schuberg stated she observed Ms. Robertson provide the facility's medication cart key to Ms. Crider although Ms. Crider was not technically working at the facility.

While onsite I observed that Resident A's Medication Administration Record indicated Resident A is prescribed 50 MG Tramadol PRN.

On 06/16/2023 I emailed the complaint allegations to Adult Protective Services Centralized Intake.

On 06/16/2023 I emailed the complaint allegations to the Kent County Sheriff's Office.

On 06/20/2023 I received an email from Licensee Designee Sarah Schmidt which stated the following: *'Rose called me approximently 715am at the start of her shift. She said count was off and wanted to report it. I came in around 10 am because I was at the hospital doing an assessment for a new move in. When I arrived we went through the Narc Count Sheet. It had Mikaylas name signing in the meds at 7pm but the narcs arrived around 3. Shift change happened at 7pm Stacie was down stairs from 3-7. I talked to Rose first, than Jaycee she admitted she didn't do narc count but didn't recall seeing additional meds in the drawer. I then tried talking to Stacie. Stacie was unreasonable she was very upset stating I needed to fire Rose for being a "crackhead" I told her that I needed to know what time the meds came and who signed for them She became very flustered than brought Mikayla down with her and they both were telling me they rubberband the meds together and put them in the drawer. I asked several times where the narc sheets were she stated she added them to the book but they were not there. I then pulled the inventory sheet that Staci signed for. I asked Stacie if she did Narc count with Jaycee when she had said no I told her that the medications were her responsibility she started to cry and hyperventilate. She was again unreasonable to talk to. Mikalyla's response was the same that she saw them in the drawer but couldn't help*

account for time or anything else when I asked about details like why she signed them in the book when staci was downstairs. This was an all day investagtion of several emotional outburst from Staci. Staci signed the inventory at 3 something that paper is now gone I do not recall the exact times but I did investage and ask everyone the same questions. The conversations regarding the missing narcotics happened on the 31st the day after the incendent but the day that it was reported.'

On 06/22/2023 I interviewed Detective Jared Wierda. Detective Wierda stated he is in the process of interviewing facility staff however it will prove difficult to identify who stole Resident A's Tramadol given the number of staff with access to the facility's medication cart.

On 06/22/2023 I interviewed staff Stacie Crider via telephone. Ms. Crider stated she was recently "fired" from the facility on "06/05/2023". Ms. Crider stated that on 05/30/2023 she worked at Chandler Pines AM410390297 from 7:00 AM until 3:00 PM and subsequently worked at the facility on 05/30/2023 from 3:00 PM until 7:00 PM. Ms. Crider stated that on 05/30/2023 at approximately 6:30 PM staff Grace Boyd brought Resident A's 90 tablets of Tramadol from Chandler Pines AM410390297 to Ms. Crider while she was working at the facility. Ms. Crider stated she immediately placed the medication into the medication cart. Ms. Crider stated that at 7:00 PM staff Jaycee Schuberg started her shift and subsequently Ms. Schuberg and Ms. Crider completed the customary "narcotics count" jointly. Ms. Crider stated Ms. Schuberg counted Resident A's Tramadol and documented the count on a "narc" sheet. Ms. Crider stated she "didn't pay attention" as Ms. Schuberg counted the medication and documented the count. Ms. Crider stated staff Mikayla Krawczyk was "off work" during the time Ms. Crider and Ms. Schuberg counted Resident A's Tramadol but watched as Ms. Crider and Ms. Schuberg counted said medication. Ms. Crider denied stealing Resident A's Tramadol.

On 06/22/2023 I interviewed staff Mikayla Krawczyk via telephone. Ms. Krawczyk stated that the worked at Chandler Pines AM410390297 on 05/30/2023 from 7:00 AM until 7:00 PM. Ms. Krawczyk stated that at 3:33 PM she observed staff Grace Boyd accept the delivery of Resident A's 90 tablets of Tramadol and then immediately bring the medication downstairs to the facility. Ms. Krawczyk stated she also went downstairs to the facility to ask staff Stacie Crider a question as Ms. Crider was working downstairs at the facility. Ms. Krawczyk stated she observed Ms. Crider accept the medication from Ms. Boyd and Ms. Crider placed the medication in the medication cart. Ms. Krawczyk stated she does not know who stole Resident A's 90 tablets of Tramadol.

On 06/22/2023 I interviewed staff Grace Boyd via telephone. Ms. Boyd stated she worked at Chandler Pines AM410390297 on 05/30/2023 from 7:00 AM until 7:00 PM. Ms. Boyd stated on 05/30/2023 at 3:33 pm she accepted Resident A's Tramadol from the delivery driver. Ms. Boyd stated the medication was delivered to the front door of Chandler Pines AM410390297 and Ms. Boyd signed for the delivery of the medication with the delivery driver. Ms. Boyd stated she opened the package

and observed that the delivery contained 90 tablets of Tramadol belonging to Resident A. Ms. Boyd stated she immediately took the medication downstairs to the facility and gave said medication to staff Stacie Crider. Ms. Boyd stated she has no further information regarding the loss of the medication and she does not know who may have stolen it.

On 06/22/2023 I interviewed staff Rose Robinson via telephone. Ms. Robinson stated she worked at the facility on 05/31/2023 from 7:00 AM until 7:00 PM. Ms. Robinson stated staff Jaycee Schuberg worked at the facility on 05/30/2023 from 7:00 PM until 7:00 AM 05/31/2023. Ms. Robinson stated Ms. Schuberg left the facility before completing the customary joint "narc count" with Ms. Robinson. Ms. Robinson stated Ms. Schuberg placed her "keys on the med cart and left". Ms. Robinson stated she completed her own "narc count" at 7:00 AM and observed that 90 of Resident A's Tramadol tablets were missing. Ms. Robinson stated she telephoned Licensee Designee Sarah Schmidt immediately after observing Resident A's missing Tramadol tablets. Ms. Robinson stated she did not steal Resident A's 90 Tramadol tablets and does not know who may have done so.

On 06/27/2023 I completed an Exit Conference with Licensee Designee Sarah Schmidt. Ms. Schmidt stated she agreed with the findings and would submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14312	**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:	Resident A is prescribed Tramadol 50 MG PRN and 90 tablets of this medication is unaccounted for. Multiple staff from two separate facilities have access to residents' medications and multiple staff are reportedly unable to identify what happened to Resident A's 90 tablets of Tramadol. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate a violation of the applicable rule; reasonable precautions were not taken to safeguard Resident A's 90 tablets of Tramadol.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Residents are not receiving their medications as prescribed.

INVESTIGATION: While onsite on 06/13/2023, I reviewed the Medication Administration Records for Residents A, Resident B, Resident C, Resident D, and Resident E. I observed that Resident A did not receive her prescribed Acetaminophen 500 MG on 06/01/2023, 06/02/2023, 06/03/2023, 06/04/2023, 06/05/2023, 06/06/2023, 06/07/2023, and 06/08/2023 at midnight and 6:00 AM and on 06/10/2023, 06/11/2023, 06/12/2023, 06/13/2023, 06/14/2023, and 06/15/2023 at 6:00 AM and Midnight. I observed that Resident B did not receive her prescribed Crest Pro Health Rinse, Clyndamycin Phosphate Gel, Seroquel 25 MG, Systane Complete Solution .6% each at 8:00 PM on 06/04/2023. I observed that Resident C did not receive her prescribed Lantus Solostar 100 UNITS/M, Melatonin 5MG, and Olanzapine 7.5 MG on 06/02/2023.

On 06/27/2023 I completed an Exit Conference with Licensee Designee Sarah Schmidt. Ms. Schmidt stated she agreed with the findings and would 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 {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:	According to the Medication Administration Records, Resident A did not receive her prescribed Acetaminophen 500 MG on 06/01/2023, 06/02/2023, 06/03/2023, 06/04/2023, 06/05/2023, 06/06/2023, 06/07/2023, and 06/08/2023 at midnight and 6:00 AM and on 06/10/2023, 06/11/2023, 06/12/2023, 06/13/2023, 06/14/2023, and 06/15/2023 at 6:00 AM and Midnight. In addition, Resident B did not receive her prescribed Crest Pro Health Rinse, Clyndamycin Phosphate Gel, Seroquel 25 MG, Systane Complete Solution .6% each at 8:00 PM on 06/04/2023 or her prescribed Lantus Solostar 100 UNITS/M, Melatonin 5MG, and Olanzapine 7.5 MG on 06/02/2023.

	A preponderance of evidence was discovered during the course of the Special Investigation to substantiate a violation of the applicable rule; the facility's Medication Administration Record indicates residents are not receiving their medications as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

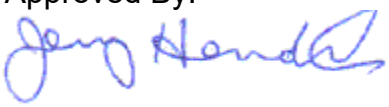
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.

06/27/2023

Toya Zylstra — Date
Licensing Consultant

Approved By:



06/28/2023

Jerry Hendrick — Date
Area Manager