GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 27, 2023

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

RE: License #: AM410390297
Investigation #: 2023A0583044
Chandler Pines

Dear Ms. Sease:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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 #:	AM410390297
Investigation #:	2023A0583044
Complaint Receipt Date:	09/12/2023
Investigation Initiation Date:	09/13/2023
Report Due Date:	10/12/2023
Licensee Name:	Chandler Pines, LLC
Licensee Address:	1435 Coit Ave NE Grand Rapids, MI 49505
Licensee Telephone #:	(616) 450-1279
Administrator:	Sarah Sease
Licensee Designee:	Sarah Sease
Name of Facility:	Chandler Pines
Facility Address:	Unit A 7555 Chandler Dr. NE Belmont, MI 49306
Facility Telephone #:	(616) 450-1279
Original Issuance Date:	04/22/2019
License Status:	1ST PROVISIONAL
Effective Date:	07/11/2023
Expiration Date:	01/10/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, AGED, DEVELOPMENTALLY DISABLED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility staff falsify residents' monthly weight records.	No
Facility staff do not administer residents' medications as prescribed.	Yes
Multiple facility residents have experienced significant weight loss.	No
Additional Findings	Yes

III. METHODOLOGY

09/12/2023	Special Investigation Intake 2023A0583044
09/12/2023	APS Referral
09/13/2023	Special Investigation Initiated - On Site
09/15/2023	Contact - Document Received Licensee Designee Sarah Sease
09/18/2023	Contact - Document Received Licensee Designee Sarah Sease
09/20/2023	Contact – Document Received Clinical Regional Director Bridget Lutzke
09/20/2023	Contact – Telephone call made Staff Ariana Gray
09/20/2023	Contact – Telephone Care Resources Nancy Baker, RN, MSM Clinic and Day Center Manager
09/22/2023	Contact – Telephone Ryan Fisher of Hospice of Michigan, RN
09/23/2023	Contact – Telephone call received Staff Ariana Gray
09/25/2023	Contact – Telephone call made Staff Ariana Gray
09/26/2023	Contact – Telephone call made Staff Ariana Gray

09/27/2023	Exit Conference Licensee Designee Sarah Sease

ALLEGATION: Facility staff falsify residents' weight records.

INVESTIGATION: On 09/12/2023 complaint allegations were received from the BCAL online reporting system. The complaint alleged that, "staff falsify weights" and, "if you have them weigh a resident in front of you, you will see there is a discrepancy".

On 09/12/2023 I emailed the complaint allegations to Adult Protective Services Centralized Intake.

On 09/13/2023 I completed an unannounced onsite investigation at the facility. Adult Protective Services Drew Blackall was present. Licensee Designee Sarah Sease, Regional Clinical Manager Bridget Lutzke, staff Ruby Romero, staff Jillaine Naffziger, Resident D, and Resident E were each privately interviewed.

Licensee Designee Sarah Sease and Regional Clinical Manager Bridget Lutze each stated that to their knowledge, staff are weighing residents monthly and accurately documenting their weights. Each stated that they have no knowledge of staff "falsifying" the documentation of residents' weight records.

Staff Ruby Romero stated that the first week of each month staff weigh residents and document their weights. Ms. Romero stated she documents residents' weights accurately and has no knowledge of staff falsifying residents' weight records.

Staff Jillaine Naffziger stated that the first week of each month staff weigh residents and document their weights. Ms. Naffziger stated she weighed and accurately documented residents' weight records in 07/2023 and 08/2023.

While onsite I observed staff weigh Resident D. Resident D weighed 182 lbs. I also observed staff weigh Resident E. Resident E weighed 138 lbs.

On 09/15/2023 I received an email from Licensee Designee Sarah Sease. The email contained facility weight records labeled "Care Cardinal Belmont Weight Entry (in Pounds)". I observed that Resident D was recorded as weighing 196 lbs. in 04/2023, 194 lbs. in 05/2023, 199 lbs. in 06/2023, 190.7 lbs. in 07/2023, 188.4 lbs. in 08/2023, and 189 lbs in 09/2023. I observed that Resident E was recorded as weighing 142 lbs. in 04/2023, 145 lbs. in 05/2023, 144.7 lbs. in 06/2023, 144.2 lbs. in 07/2023, 143 lbs. in 08/2023, and 144.5 lbs. in 09/2023.

On 09/27/2023 I completed an Exit Conference with Licensee Designee Sarah Sease via telephone. Ms. Sease stated that she agreed with the Special Investigation findings.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	Licensee Designee Sarah Sease, staff Ruby Romero and staff Jilaine Naffziger each reported that residents are weighed monthly, and their weights are accurately documented. While onsite I observed staff weigh Resident D. Resident D weighed 182 lbs. I also observed staff weigh Resident E. Resident E weighed 138 lbs. These weights are consistent with documented facility weight records. A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate a violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Facility staff do not administer residents' medications as prescribed.

INVESTIGATION: On 09/12/2023 complaint allegations were received from the BCAL online reporting system. The complaint alleged that facility staff do not administer residents' medications as prescribed. The complaint stated that residents' "inhalers and nose sprays" are not being administered as prescribed and therefore these medications, "shouldn't last for several months if a resident receives them twice a day".

On 09/13/2023 I completed an unannounced onsite investigation at the facility. Adult Protective Services Drew Blackall was present. Licensee Designee Sarah Sease, Regional Clinical Manager Bridget Lutzke, staff Ruby Romero, and staff Jillaine Naffziger were each privately interviewed.

Licensee Designee Sarah Sease and Regional Clinical Manager Bridget Lutze stated that to their knowledge; staff are administering residents' nasal sprays and inhalers as prescribed.

While onsite I reviewed the facility's Medication Administration Record. Resident J is prescribed Trelegy Ellipta 100 mg inhale 1 puff daily. I observed that the MAR indicates this medication contains a quantity of 60 puffs, dispensed 05/19/2023, and first administered on 05/21/2023. I observed that the MAR indicates that on

08/31/2023, 09/05/203, 09/07/2023, 09/09/2023, 09/10/2023, and 09/11/2023 this medication was not administered due to the medication not being available. I observed that the MAR indicates that on 08/31/2023 staff Ruby Romero did not administer this medication and on 09/05/2023, 09/07/2023, 09/09/2023, 09/10/2023, and 09/11/2023 staff Ariana Gray did not administer this medication.

While onsite I observed Resident J's Trelegy Ellipta was dated as being dispensed on 05/19/2023 and contained a quantity of 60 puffs. I verified via the MAR that the medication is prescribed to be dispensed as one puff daily; therefore, the medication should be emptied in approximately two months.

Staff Ruby Romero stated that she independently administered residents' medications on 08/31/2023. Ms. Romero stated that 08/31/2023 was her first experience administering residents' medications independently and she could not locate Resident J's Trelegy Ellipta in the facility's medication cart therefore the medication was not administered. Ms. Romero stated that on 08/31/2023 she documented Resident J's Trelegy Ellipta as "not available" in the MAR.

Staff Jillaine Naffziger stated that she administers residents' medications as prescribed. Ms. Naffziger stated that she recently reviewed Resident J's MAR and observed that staff Ariana Gray did not administer Resident J's Trelegy Ellipta on 09/05/2023, 09/07/2023, 09/09/2023, 09/10/2023, and 09/11/2023. Ms. Naffziger stated that Ms. Gray reported that she (Ms. Gray) did not know where the medication was located therefore the medication was not administered. Ms. Naffziger stated that she informed Ms. Gray that the medication was located in the facility's medication cart and physically showed the medication to Ms. Gray.

On 09/26/2023 I interviewed staff Ariana Gray via telephone. Ms. Gray stated that on 09/05/203, 09/07/2023, 09/09/2023, 09/10/2023, and 09/11/2023 she could not locate Resident J's Trelegy Ellipta and therefore Resident J did not receive that medication.

On 09/26/2023 I completed a licensing file review. I observed that the facility was cited for violation of R 400.14312 (1) per Special Investigation 2023A0583028 on 04/27/2023 and again in Special Investigation 2023A0583031 on 06/22/2023 as a result of residents not being administered their medications as prescribed. As a result, the facility was issued a Provisional License effective 07/11/2023.

On 09/27/2023 I completed an Exit Conference with Licensee Designee Sarah Sease via telephone. Ms. Sease stated that she agreed with the Special Investigation findings. Ms. Sease stated that the violation was "black and white" and supported by a preponderance of evidence. Ms. Sease stated that she would request a Compliance Conference and bring to the table a robust Plan of Correction.

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:	A review of the facility's Medication Administration Records indicates that Resident J is prescribed Trelegy Ellipta 100 mg inhale 1 puff daily. The MAR indicates this medication contains a quantity of 60 puffs dispensed 05/19/2023, and first administered 05/21/2023. The MAR indicates that on 08/31/2023, 09/05/203, 09/07/2023,09/09/2023, 09/10/2023 and 09/11/2023 the medication was not administered due to "not being available". While onsite I observed Resident J's Trelegy Ellipta was dated as being dispensed on 05/19/2023. Staff Ruby Romero acknowledged that 08/31/2023 she could not locate Resident J's Trelegy Ellipta in the facility's medication cart. Ms. Romero stated she initialed Resident J's 08/31/2023 MAR and documented Resident J' Trelegy Ellipta was "not available". Saff Ariana Gray stated that on 09/05/203, 09/07/2023, 09/09/2023, 09/10/2023, and 09/11/2023 she could not locate Resident J's Trelegy Ellipta and therefore Resident J did not receive the medication. Ms. Gray stated that the medication was in the facility, but she could not locate it. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate a violation of the applicable rule. Resident J did not receive his medication, Trelegy Ellipta, as prescribed.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Special Investigation 2023A0583031 (06/22/2023)** **Special Investigation 2023A0583028 (04/27/2023)**

ALLEGATION: Multiple facility residents have experienced significant weight loss.

INVESTIGATION: On 09/12/2023 complaint allegations were received from the BCAL online reporting system. The complaint alleged that "multiple residents display "significant weight loss".

On 09/13/2023 I completed an unannounced onsite investigation at the facility. Adult Protective Services Drew Blackall was present. Licensee Designee Sarah Sease, Regional Clinical Manager Bridget Lutzke, staff Ruby Romero, staff Jillaine Naffziger, Resident D, and Resident E were each privately interviewed.

Licensee Designee Sarah Sease and Regional Clinical Manager Bridget Lutze both stated that residents are provided three healthy meals daily. Both Ms. Sease and Ms. Lutze stated that meals are of proper quality and size. Both reported that residents are weighed monthly and there have been no indications of significant resident weight loss.

Staff Ruby Romero stated that residents are weighed monthly and there are no indications that residents are losing significant amounts of weight. Ms. Romero stated that residents are provided three nutritious meals and snacks daily.

Staff Jillaine Naffziger stated that residents are weighed monthly and there are no indications of significant weight loss. Ms. Naffziger stated that residents are provided three nutritious meals and snacks daily.

Resident D and Resident E both reported that they are provided appropriate meals daily and they are happy with the care provided.

While onsite I observed a plentiful quantity of food in the refrigerator and cupboards. I observed the facility menu was nutritionally adequate.

On 09/15/2023 I received an email from Licensee Designee Sarah Sease. The email contained facility weight records labeled, "Care Cardinal Belmont Weight Entry (in Pounds). I observed Resident I weighted 162.6 lbs. in 06/23, 154.6 lbs. in 07/23, 143.9 lbs. in 08/23, and 146.9 lbs. in 09/23. Therefore, between 06/23 and 08/23 Resident I lost approximately 19 lbs. in a two-month time period. I observed Resident J weighed 210.8 lbs. in 06/23 and 189 lbs. in 09/23, Therefore, Resident J lost approximately 21 lbs. in a three-month time period. I did not observe weight loss patterns with the remaining residents.

On 09/20/2023 I received an email from Regional Clinical Manger Bridget Lutke which stated, "(Resident I) has been on Hospice services since admission" and "His appetite has decreased, and he has shown an overall decline". Ms. Lutke stated Resident I "at times needs to be fed by staff r/t his confusion and inability to feed self" and "this upsets him during these times". Ms. Lutzke stated that Resident J

“has many refusals of meals and a lengthy Psych stay at Doctors of Neuropsychiatric Hospital in Indiana” occurred “from 07/26/2023- 8/07/2023”. Ms. Lutzke stated that Resident J “has shown a decline since admission as well” and staff “have been in close contact with Care Resources on his plan of care”.

On 09/22/2023 I interviewed Care Resources Nancy Baker, RN, MSM Clinic and Day Center Manager via telephone. Ms. Baker stated Care Resources Dietician Denise Kesterke follows Resident J. Ms. Baker stated Ms. Kesterke documented in Resident J’s medical notes that Resident J’s weighted 207.2 lbs. on 03/29/2023, 180 lbs. on 07/15/2023 (hospital recorded weight), 207 lbs. on 07/26/2023 (hospital recorded weight), and 180 lbs. on 08/11/2023 (hospital recorded weight). Ms. Baker stated that Ms. Kesterke’s medical notes further stated, “called Care Cardinal today and spoke with caregiver Sarah” who reported “August weight of 206.5 lbs.” Ms. Baker stated there are discrepancies in Resident J’s weight records between hospital weights and Care Resources weight records. Ms. Baker stated that at this time Care Resources is not concerned with Resident J’s weight loss.

On 09/22/2023 I interviewed Ryan Fisher of Hospice of Michigan, RN. Mr. Fisher stated that he is the assigned hospice care nurse for Resident I. Mr. Fisher stated he has only observed Resident I on one occasion at the facility. Mr. Fisher stated during the visit Resident I had just finished a meal. Mr. Fisher acknowledged that Resident I has experienced, “significant weight loss” however Mr. Fisher is “not necessarily concerned” because Resident I is “plateauing” in weight loss. Mr. Fisher stated that Resident I is most likely “refusing meals and is disinterested in eating” given Resident I’s “decline in overall health”.

On 09/27/2023 I completed an Exit Conference with Licensee Designee Sarah Sease via telephone. Ms. Sease stated that she agreed with the Special Investigation Findings.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	While onsite I observed a sufficient quantity of food in the refrigerator and cupboards. Resident D and Resident E both reported that they are provided appropriate meals each day and they are happy with the care provided.

	A review of facility weight records indicated Resident I weighed 162.6 lbs. in 06/23, 154.6 lbs. in 07/23, 143.9 lbs. in 08/23, and 146.9 lbs. in 09/23. Therefore, between 06/23 and 08/23 Resident I lost approximately 19 lbs. in a two month time period. I observed Resident J weighed 210.8 lbs. in 06/23 and 189 lbs. in 09/23. Therefore, he lost approximately 21 lbs. in a three month time period. I did not observe weight loss patterns with the remaining residents. Regional Manager Bridget Lutzke reported that Resident I is receiving Hospice services and Resident J displays a history of meal refusal. Care Resources Nancy Baker, RN, MSM Clinic and Day Center Manager stated that at this time Care Resources is not concerned with Resident J's weight loss. Ryan Fisher of Hospice of Michigan, RN stated that he is "not necessarily concerned" because Resident I is "plateauing" in weight loss. Mr. Fisher stated that Resident I is most likely "refusing meals and is disinterested in eating" given Resident I's "decline in overall health". A preponderance of evidence was not discovered during the course of the special investigation to substantiate the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING: Facility staff did not notify Resident J's physicians after a prescribed medication was not administered.

INVESTIGATION: On 09/13/2023 I completed an unannounced onsite investigation at the facility. Adult Protective Services Drew Blackall was present. Licensee Designee Sarah Sease, Regional Clinical Manager Bridget Lutzke, and staff Ruby Romero were each interviewed privately.

While onsite I reviewed the facility's Medication Administration Record. I observed that Resident J is prescribed Trelegy Ellipta 100 mg inhale 1 puff daily and was first administered 05/21/2023. I observed that the MAR indicates that on 08/31/2023, 09/05/203, 09/07/2023, 09/09/2023, 09/10/2023, and 09/11/2023 the medication was not administered due to being labeled as not "available". I observed that the MAR indicates that on 08/31/2023 staff Ruby Romero did not administer the medication and on 09/05/2023, 09/07/2023, 09/09/2023, 09/10/2023, and 09/11/2023 staff Ariana Gray did not administer the medication.

Licensee Designee Sarah Sease and Regional Clinical Manager Bridget Lutze both stated that to their knowledge, staff are administering residents' nasal sprays and inhalers as prescribed and documenting appropriately.
Staff Ruby Romero stated that she independently administered residents' medications on 08/31/2023. Ms. Romero stated that 08/31/2023 was her first experience administering residents' medications independently and she could not locate Resident J's Trelegy Ellipta in the facility's medication cart. Ms. Romero stated she initialed Resident J's 08/31/2023 MAR and documented Resident J's Trelegy Ellipta as "not available".

On 09/20/2023 I interviewed staff Ruby Romero via telephone. Ms. Romero acknowledged that on 08/31/2023 she did not contact a health care professional regarding not administering Resident J's Trelegy Ellipta.

On 09/21/2023 I interviewed Regional Director Bridget Lutzke via telephone. Ms. Lutzke stated that no facility staff contacted Resident J's physician or applicable health care professional after Resident J did not receive his prescribed Trelegy Ellipta on 08/31/2023, 09/05/203, 09/07/2023, 09/09/2023, 09/10/2023, and 09/11/2023.

On 09/26/2023 I interviewed staff Ariana Gray via telephone. Ms. Gray stated that on 09/05/203, 09/07/2023, 09/09/2023, 09/10/2023, and 09/11/2023 she could not locate Resident J's Trelegy Ellipta and therefore Resident J did not receive this medication. Ms. Gray stated that the medication was in the facility, but she could not locate it at the time. Ms. Gray stated she did not inform Resident J's primary care physician or a health care provider regarding Resident J not receiving the medication on 09/05/2023, 09/07/2023, 09/09/2023, 09/10/2023, and 09/11/2023.

On 09/27/2023 I completed an Exit Conference with Licensee Designee Sarah Sease via telephone. Ms. Sease stated that she agreed with the Special Investigation findings. Ms. Sease stated that the violation was "black and white" and supported by a preponderance of evidence. Ms. Sease stated that she would request a Compliance Conference and bring to the table a robust Plan of Correction.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**

ANALYSIS:	Regional Director Bridget Lutzke stated that no facility staff contacted Resident J's physician or applicable health care professional after Resident J did not receive his prescribed Trelegy Ellipta on 08/31/2023, 09/05/203, 09/07/2023, 09/09/2023, 09/10/2023, and 09/11/2023. A preponderance of evidence was discovered during the course of the special investigation to substantiate that Resident J did not receive his prescribed medication, Trelegy Ellipta, and a healthcare professional was not notified.
CONCLUSION:	**VIOLATION ESTABLISHED**

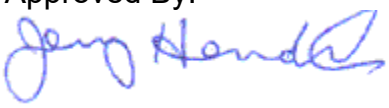
IV. RECOMMENDATION

Revocation of the license is recommended due to the above noted quality of care violations.

09/27/2023

Toya Zylstra — Date
Licensing Consultant

Approved By:



09/27/2023

Jerry Hendrick — Date
Area Manager