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 #: AS410411560
Investigation #: 2023A0583045
Chandler Pines Unit B

Dear Ms. Sease:

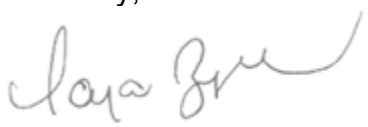
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	2023A0583045
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 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?
Facility staff falsify residents' monthly weight records.	No
Facility staff do not administer residents' medications as prescribed.	No
Multiple facility residents have significant weight loss.	No
Additional Findings	Yes

III. METHODOLOGY

09/12/2023	Special Investigation Intake 2023A0583045
09/12/2023	APS Referral
09/13/2023	Special Investigation Initiated - On Site
09/15/2023	Contact – Email Staff Sarah Sease
09/22/2023	Contact – Telephone Staff Rachell Robinson
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, and staff Guadalupe Perez were each privately interviewed.

Licensee Designee Sarah Sease and Regional Clinical Manager Bridget Lutze both stated that to their knowledge, staff are weighing residents monthly and accurately

documenting their weights. Both Ms. Sease and Ms. Lutze stated that they have no knowledge of staff "falsifying" the documentation of residents' weight records.

Staff Guadalupe Perez stated that she has worked at the facility for three months. Ms. Perez stated that the first week of each month staff weigh residents and document their weights. Ms. Perez stated she documents residents' weights accurately and has no knowledge of staff falsifying residents' weight records.

While onsite I observed staff weighing Resident D. Resident D weighed 142 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 143.1 lbs. in 07/2023, 142.2 lbs. in 08/2023, and 145 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 and staff Guadalupe Perez both reported that residents are weighed monthly, and their weights are accurately documented. While onsite I observed staff weigh Resident D and observed that Resident D weighed 144 lbs. which is consistent with facility documentation. A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate 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, and staff Guadalupe Perez were each privately interviewed.

Licensee Designee Sarah Sease, Regional Clinical Manager Bridget Lutze, and staff Guadalupe Perez each stated that to their knowledge, staff are administering residents' medications as prescribed. Each stated no resident of the facility is prescribed nasal sprays or inhalers.

While onsite I reviewed the facility's Medication Administration Record. I observed that no resident of the facility is prescribed a nasal spray or inhaler.

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 400.14312	**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:	While onsite I reviewed the facility's Medication Administration Record. I observed that no resident of the facility is prescribed a nasal spray or inhaler. 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: 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, and staff Guadalupe Perez were each privately interviewed.

Licensee Designee Sarah Sease, Regional Clinical Manager Bridget Lutze, and staff Guadalupe Perez each stated that residents are provided three healthy meals daily. Each stated that meals are of proper quality and size. Each reported that residents are weighed monthly and there are no indications of significant resident weight loss.

While onsite I observed a sufficient quantity of food in the refrigerator and cupboards. I observed the menu included appropriate nutritional guidelines.

On 09/15/2023 I received an email from Licensee Designee Sarah Sease. I observed that the email contained facility weight records labeled “Care Cardinal Belmont Weight Entry (in Pounds)”. I observed no patterns of concerning resident weight loss.

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. Facility weight records revealed no patterns of concerning resident weight loss. A preponderance of evidence was not discovered during the course of the special investigation to substantiate a rule violation.

CONCLUSION:	VIOLATION NOT ESTABLISHED

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

INVESTIGATION: On 09/13/2023 I completed an unannounced onsite investigation at the facility. Regional Clinical Manager Bridget Lutzke was interviewed. Regional Clinical Manager Bridget Lutzke and staff Rachell Robinson were each interviewed privately.

While onsite I reviewed the facility's Medication Administration Records. I observed that on 08/26/2023 Resident B did not receive her prescribed medication, Torvastatin 10MG, which is to be administered daily. I reviewed that the MAR is not initialed by a staff member, with no note indicating if the medication was unavailable or refused.

Regional Clinical Manager Bridget Lutzke stated that on 08/26/2023 staff Rachell Robinson was assigned medication administration duties. Ms. Lutzke stated Ms. Robinson no longer works at the facility therefore Ms. Lutzke is unable to determine whether or not Resident B received the medication.

On 09/22/2023 I interviewed staff Rachell Robinson via telephone. Ms. Robinson stated that on 08/26/2023 she was tasked with medication administration duties. Ms. Robinson stated that she passed Resident B's Torvastatin 10 MG but forgot to initial the Medication Administration Record.

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 and would submit an acceptable Corrective Action Plan.

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: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**

	(vi) A resident's refusal to accept prescribed medication or procedures.
ANALYSIS:	The facility's Medication Administration Records indicated that on 08/26/2023 Resident B did not receive her prescribed medication, Torvastin 10MG, which is to be administered daily. The MAR is not initialed by a staff member, with no note indicating if the medication was unavailable or refused. Staff Rachell Robinson stated that on 08/26/2023 she passed Resident B's Torvastatin 10 MG but forgot to initial the Medication Administration Record. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

09/27/2023

Toya Zylstra Date
Licensing Consultant

Approved By:

09/27/2023

Jerry Hendrick Date
Area Manager