GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 6, 2024

Megan Burch
AH Kentwood Subtenant LLC
6755 Telegraph Road Suite
Bloomfield Hills, MI 48301

RE: License #: AL410397696
Investigation #: 2024A0467033
AHSL Kentwood Fieldstone

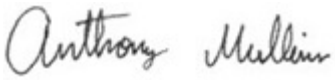
Dear Ms. Burch:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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.

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 #:	AL410397696
Investigation #:	2024A0467033
Complaint Receipt Date:	05/01/2024
Investigation Initiation Date:	05/01/2024
Report Due Date:	06/30/2024
Licensee Name:	AH Kentwood Subtenant LLC
Licensee Address:	One SeaGate, Suite 1500 Toledo, OH 43604
Licensee Telephone #:	(248) 203-1800
Administrator:	Megan Burch
Licensee Designee:	Megan Burch
Name of Facility:	AHSL Kentwood Fieldstone
Facility Address:	5980 Eastern Ave SE. Kentwood, MI 49508
Facility Telephone #:	(616) 455-1357
Original Issuance Date:	01/22/2019
License Status:	REGULAR
Effective Date:	07/22/2023
Expiration Date:	07/21/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive his Tylenol medication as scheduled on Saturday 4/27/24.	No
Additional Findings	Yes

III. METHODOLOGY

05/01/2024	Special Investigation Intake 2024A0467033
05/01/2024	Special Investigation Initiated - On Site
05/01/2024	Contact - telephone call made AFC staff member, Samantha Pratt
05/06/2024	Exit conference with licensee designee, Megan Burch.
05/06/2024	APS Referral – sent via email

ALLEGATION: Resident A did not receive his Tylenol medication as scheduled on Saturday 4/27/24.

INVESTIGATION: On 5/1/24, I received a BCAL online complaint stating that Resident A did not receive his Tylenol medication as scheduled on 4/27/24. The complainant stated that the Med Tech on Saturday was unable to find Resident A's Tylenol although it was available the following morning. The complainant stated that Resident A was "screaming in pain" due to not receiving his scheduled medication.

On 5/1/24, I made an unannounced onsite investigation to the facility. Upon arrival, I spoke to licensee designee, Megan Burch and assistant wellness director, Kanisha Sanders. They were interviewed in the office. Ms. Sanders confirmed that Resident A received his Tylenol as scheduled this past Saturday, 4/27/24. Ms. Sanders confirmed that Resident A's Tylenol is scheduled daily at 8:00 am and 5:00 pm. In addition to his scheduled Tylenol, Resident A can also receive the medication as needed (PRN). The PRN can be given 4-6 hours before or after his scheduled doses. Ms. Burch and Ms. Sanders provided me with Resident A's medication administration record (MAR), which confirmed that he did receive his Tylenol as scheduled on 4/27/24. Ms. Sanders stated that AFC staff member, Samantha Pratt worked this Saturday and documented that Resident A received his medication. Ms. Burch provided me with Ms. Pratt's phone number to follow-up with her.

Ms. Sanders was asked about Resident A reportedly screaming due to being in pain. Ms. Sanders stated that Resident A doesn't really scream, but he will yell if he needs

to be changed or wants food or water. Ms. Sanders was adamant that she has never heard Resident A yelling due to being in pain. She did share that Resident A will yell to get a staff member's attention. Ms. Burch stated that Resident A can hear certain staff member's voice and often yells for them. Ms. Burch denied any knowledge of Resident A screaming because he's in pain from not receiving his scheduled Tylenol medication. Ms. Burch assisted me to Resident A's room so I could interview him. This was unsuccessful due to Resident A sleeping in his lounge chair.

On 5/1/24, I spoke to staff member, Samantha Pratt via phone and she agreed to discuss the allegation. Ms. Pratt confirmed that she worked a double shift on Saturday, 4/27/24 from 7:00 am to 11:00 pm. Ms. Pratt was adamant that Resident A received his Tylenol medication as scheduled on Saturday, which the MAR confirmed. Ms. Pratt stated that she has never had any issues with Resident A's medication while working at the facility. Ms. Pratt was asked if she heard Resident A screaming for medication due to being in pain. Ms. Pratt denied this. Ms. Pratt stated that Resident A's family was at the facility on the day in question and she told them that he had a great day with no issues or concerns.

Ms. Pratt was asked about Resident A screaming or yelling. Ms. Pratt confirmed that she has heard Resident A screaming in the past for help to go to the bathroom or due to being lost since he is blind. Ms. Pratt was adamant that anytime Resident A screams for assistance, he is helped by herself or other staff members. Ms. Pratt denied observing Resident A screaming or yelling due to not receiving a medication or being in pain. Ms. Pratt has no idea why someone would file a complaint alleging this.

On 05/06/2024, I conducted an exit interview with licensee designee, Megan Burch. She was informed of the investigative findings and denied having any questions.

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 S333.1101 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. Burch, Ms. Sanders and Ms. Pratt all confirmed that Resident A received his Tylenol as scheduled. I reviewed

	Resident A's MAR and it also confirmed that he received his Tylenol as scheduled. Therefore, there is not a preponderance of evidence to support the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION: While investigating the allegation listed above, I reviewed Resident A's Medication Administration Record (MAR) for April 2024 and determined that he missed the following medications: Alprazolam 0.5MG on 4/10/24 due to "resident out with family/appointment." Ms. Burch confirmed that this is not typical, and that the medication should have been given to Resident A or his family prior to leaving the facility. Zinc Oxide 20% Ointment on 4/11/24 due to "pharmacy dropped off after med pass." Proctozone (Hydrocort 2.5%) on 4/11/24 - 4/12/24 due to medication not available. Polyethylene Glycol 3350 PO on 4/26/24 due to "not in med cart." Ms. Sanders stated that the staff member was unable to locate the medication. Ms. Sanders stated that she had to show the staff member that the medication was in the cart, and the medication was passed to Resident A. I explained to Ms. Sanders that the MAR needs to accurately reflect this. Ms. Sanders also stated that med techs are supposed to call to get medications filled when the stock is low.

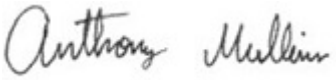
On 05/06/2024, I conducted an exit conference with licensee designee, Megan Burch via phone. She was informed of the investigative findings and agreed to complete a CAP within 15 days of receipt of this report.

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 S333.1101 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:	Resident A's April 2024 MAR indicated that he missed five doses of a scheduled medication during the month. None of the

	explanations provided on the MAR are acceptable. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no changes to the current license status.



05/06/2024

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Anthony Mullins Date
Licensing Consultant

Approved By:

05/06/2024

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Jerry Hendrick Date
Area Manager