GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 5, 2025

Timothy Rantz
Ferny AFC Home, LLC
1564 N. M 63
Benton Harbor, MI 49022

RE: License #: AL110388345
Investigation #: 2025A0790021
Golden Shore

Dear Mr. Rantz:

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 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 party responsible and a date.

If you desire technical assistance in addressing these issues, please feel free to 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Rodney Gill, 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 #:	AL110388345
Investigation #:	2025A0790021
Complaint Receipt Date:	04/17/2025
Investigation Initiation Date:	04/17/2025
Report Due Date:	06/16/2025
Licensee Name:	Ferny AFC Home, LLC
Licensee Address:	1564 N. M 63 Benton Harbor, MI 49022
Licensee Telephone #:	(269) 449-5400
Administrator:	Timothy Rantz
Licensee Designee:	Timothy Rantz
Name of Facility:	Golden Shore
Facility Address:	1564 N. M 63 Benton Harbor, MI 49022
Facility Telephone #:	(269) 449-5400
Original Issuance Date:	11/07/2017
License Status:	REGULAR
Effective Date:	12/02/2024
Expiration Date:	12/01/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is not getting his pain medication as prescribed.	Yes

III. METHODOLOGY

04/17/2025	Special Investigation Intake 2025A0790021
04/17/2025	APS Referral is not necessary because the allegation does not meet assignment criteria for Adult Protective Services. There is no evidence of abuse or neglect. The allegation pertains to a licensing rule violation.
04/17/2025	Special Investigation Initiated - On Site I interviewed direct care staff members (DCSMs) Kinyashi Mnyone, Ebony Evans, and Resident A.
04/17/2025	Inspection Completed On-site
04/17/2025	Contact - Telephone call made I interviewed DCSM Kim Davis.
04/22/2025	Contact - Telephone call made I interviewed licensee designee Timothy Rantz. Requested Documentation.
04/29/2025	Contact - Telephone call made to licensee designee Timothy Rantz requesting additional supporting documentation.
04/30/2025	Contact - Face to Face I interviewed DCSMs Kim Davis, Pat Zahui, and licensee designee Timothy Rantz at the facility.
04/30/2025	Exit Conference with licensee designee Timothy Rantz.
05/05/2025	Inspection Completed-BCAL Sub. Compliance
05/05/2025	Corrective Action Plan Requested and Due on 05/15/2025

05/05/2025	Corrective Action Plan Received
05/05/2025	Corrective Action Plan Approved.
05/05/2025	Contact - Document Sent I emailed the Corrective Action Plan (CAP) Approval Letter to licensee designee Timothy Rantz.

ALLEGATION:

Resident A is not getting his pain medication as prescribed.

INVESTIGATION:

On 4/17/25, I reviewed a LARA-BCHS Online Complaint Form dated 4/15/25. The complaint indicated Relative A1 received a text message from Resident A alleging he had not received his pain medication that morning and was not told when he would be receiving it.

The complaint indicated on 4/15/25, licensee designee Timothy Rantz was contacted via phone to discuss the allegation. Mr. Rantz disclosed he investigated the allegation and found he and direct care staff members (DCSMs) working at the facility did not notify the pharmacy that Resident A needed a refill of his pain medication in time and Resident A ran out. The complaint indicated Mr. Rantz guaranteed Resident A's pain medication would be delivered and available to Resident A at 3:00 p.m. today.

On 4/17/25, I conducted an unannounced onsite investigation. I interviewed direct care staff member (DCSM) Kinyashi Mnyone. Ms. Mnyone stated he was not aware Resident A ran out of his pain medication on 4/15/25. Mr. Mnyone said he last worked this past weekend and did not hear that Resident A ran out of his pain medication.

On 4/17/25, I interviewed DCSM Ebony Evans. Ms. Evans stated she did not work on 4/15/25 and was not made aware of Resident A running out of his pain medication.

On 4/17/25, I interviewed Resident A. Resident A confirmed he ran out of his main pain medication on 4/15/25 and was told the pain medication had not been ordered timely to avoid running out. Resident A explained he was told the pain medication ran out the night before and was ordered the next day. Resident A stated DCSMs gave him Tylenol as prescribed until the pain medication came in. Resident A said

he did experience a greater level of pain than usual during this period but with the Tylenol given he was able to cope.

On 4/17/25, I interviewed DCSM Kim Davis via phone. Ms. Davis indicated she did not work on 4/15/25. She said she was informed that Resident A's pain medication hydrocodone / acetaminophen had not been ordered timely and Resident A ran out the night before 4/14/25. Ms. Davis indicated Resident A is to take 15 ML via g-tube three times daily.

On 4/22/25, I interviewed licensee designee Timothy Rantz and requested documentation be sent to me via email. Mr. Rantz admitted Resident A ran out of his pain medication hydrocodone / acetaminophen the night of 4/14/25 because the pharmacy was not contacted requesting a refill timely.

On 4/30/25, I made an unannounced visit to the facility. I interviewed DCSM Kim Davis. Ms. Davis reiterated that Resident A ran out of his pain medication hydrocodone / acetaminophen the night of 4/14/25. She indicated DCSM Sandy Pullins who is responsible for much of the administrative work, orders the residents' medications. Ms. Davis said DCSMs are to inform Ms. Pullins when a resident's medication needs to be refilled.

On 4/30/25, I interviewed DCSM Pat Zahui. Ms. Zahui said she worked second shift on 4/14/25 and was responsible for administering the residents' medications. Ms. Zahui stated Resident A had 10 ML of his pain medication hydrocodone / acetaminophen left when giving his 9:00 p.m. dose. She explained Resident A is supposed to get 15 ML of hydrocodone / acetaminophen three times a day. Ms. Zahui stated she administered the 10 ML of hydrocodone / acetaminophen and let Sandy Pullins know Resident A had run out of the medication. She said Ms. Pullins contacted the pharmacy that night requesting a refill of the medication and it arrived sometime the next day on 4/15/25.

On 4/30/25, I again interviewed licensee designee Timothy Rantz. Mr. Rantz was reviewing Resident A's *medication administration record (MAR)* and admitted that according to the *MAR,* Resident A did not receive a full dose of his prescribed pain medication hydrocodone / acetaminophen the night of 4/14/25 or any of his prescribed morning dose of hydrocodone / acetaminophen on 4/15/25. Mr. Rantz stated a refill of this medication was not ordered timely causing Resident A to miss part of his dose the night of 4/14/25 and all of his dose the morning of 4/15/25.

On 4/30/25, I reviewed Resident A's *MAR.* I found Resident A is prescribed 15 ML of hydrocodone / acetaminophen three times a day. Resident A is prescribed to receive this medication at 9:00 a.m., 3:00 p.m., and 9:00 p.m. Resident A is also prescribed 15 ML of hydrocodone / acetaminophen on an as needed (PRN) basis at 3:00 a.m.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interviews with DCSMs Mr. Mnyone, Ms. Evans, Resident A, DCSMs Ms. Davis, Ms. Zahui, and licensee designee Mr. Rantz there was sufficient evidence found indicating Resident A did not receive the full dose of his non-life-threatening prescribed medication hydrocodone / acetaminophen 15 ML at 9:00 p.m. on 4/14/25 and also did not receive hydrocodone / acetaminophen at 9:00 a.m. on 4/15/25 as prescribed. Resident A did not receive this prescribed medication because a refill was not requested timely.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/30/25, I conducted an exit conference with licensee designee Timothy Rantz. Mr. Rantz did not dispute the findings or recommendations and agreed to complete a Corrective Action Plan (CAP) within the requested timeframe.

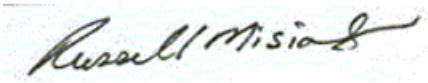
IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

5/19/25

Rodney Gill Date
Licensing Consultant

Approved By:



5/20/25

Russell B. Misiak Date
Area Manager