GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 21, 2025

Timothy Van Dyk
Residential Opportunities, Inc.
1100 South Rose Street
Kalamazoo, MI 49001

RE: License #: AS390066803
Investigation #: 2025A0581024
Almena Drive AFC

Dear Timothy Van Dyk:

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 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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS390066803
Investigation #:	2025A0581024
Complaint Receipt Date:	03/31/2025
Investigation Initiation Date:	03/31/2025
Report Due Date:	05/30/2025
Licensee Name:	Residential Opportunities, Inc.
Licensee Address:	1100 South Rose Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-3731
Administrator:	Gloria Steele
Licensee Designee:	Timothy Van Dyk
Name of Facility:	Almena Drive AFC
Facility Address:	10280 Almena Drive Kalamazoo, MI 49009
Facility Telephone #:	(269) 372-1389
Original Issuance Date:	06/16/1995
License Status:	REGULAR
Effective Date:	12/19/2024
Expiration Date:	12/18/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION

	Violation Established?
On or around 03/22/2025, direct care staff sent four Xanax tablets with Resident A when she visited family for the weekend; however, Resident A's family never received this medication.	Yes

III. METHODOLOGY

03/31/2025	Special Investigation Intake - 2025A0581024
03/31/2025	Referral - Recipient Rights - ISK received allegations and is investigating.
03/31/2025	APS Referral - No allegations of abuse/neglect. No referral necessary.
03/31/2025	Special Investigation Initiated – Telephone - Interview with ISK RRO Suzie Suchyta.
04/10/2025	Inspection Completed On-site - Interviewed staff.
05/02/2025	Contact - Telephone call made - Interview with direct care staff, Autumn Hurst
05/02/2025	Contact - Telephone call made - Interview with Guardian A1
05/02/2025	Inspection Completed-BCAL Sub. Compliance
05/13/2025	Contact – Telephone call made – Interview with Administrator, Gloria Steele.
05/19/2025	Exit conference with licensee designee, Tim Van Dyk.

ALLEGATION: On or around 03/22/2025, direct care staff sent four Xanax tablets with Resident A when she visited family for the weekend; however, Resident A's family never received this medication.

INVESTIGATION: On 03/31/2025, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged on 03/22, direct care staff provided Relative A1 and Relative A2 with Resident A's medications for a leave of absence. The complaint alleged direct care staff, Autumn Hurst, packaged Resident A's medications and included Resident A's as needed or PRN Xanax medication; however, the complaint alleged neither Relative A1 nor Relative A2 received this medication.

On 03/31/2025, I interviewed Integrated Services of Kalamazoo (ISK) Recipient Rights Officer (ORR), Suzie Suchyta. Suzie Suchyta's statement was consistent with the allegations. Suzie Suchyta stated she also received the allegations and already interviewed pertinent staff. She stated the facility's Administrator, Gloria Steele, reported to her Resident A visits Relative A1 and Relative A2 almost every weekend. Gloria Steele reported to Suzie Suchyta that staff send all of Resident A's scheduled medication with her in separate zip lock baggies each labeled according to the date and time they should be administered. Gloria Steele reported to Suzie Suchyta Resident A does not display any behaviors when visiting Relative A1 and Relative A2; therefore, staff do not send her as needed Xanax medication.

Suzie Suchyta stated she interviewed staff member Autumn Hurst whose statement to her was consistent with the allegations; however, Autumn Hurst reported to Suzie Suchyta she packaged the as needed Xanax medication with the scheduled medications rather than putting the Xanax in its own as needed or PRN baggie. Suzie Suchyta stated Autumn Hurst reported that Gloria Steele instructed her to send the Xanax medication with Resident A; however, Gloria Steele reported to Suzie Suchyta that she did not provide this instruction to Autumn Hurst.

Suzie Suchyta stated she also interviewed direct care staff, Kim Quakenbush and Monique Warren, who both reported they would put PRN or as needed medications in a separate zip lock baggie and label it accordingly rather than putting it in with scheduled medications.

Suzie Suchyta sent me a copy of the text message between Kim Quakenbush and Autumn Hurst, which documented on 03/22/2025, Kim Quakenbush texted Autumn Hurst about sending Resident A with four Xanax pills. Autumn Hurst responded to Kim Quakenbush acknowledging she sent the pills and did not document it. She documented in her text to Kim Quakenbush that she sent the Xanax tablets "just in case" because Resident A had been "…having such a hard go at it the last two days". Kim Quakenbush responded to Autumn Hurst that she could sign the medications were sent on 03/23.

Suzie Suchyta stated she was unable to interview Resident A because Resident A could not answer any of her questions.

Suzie Suchyta provided a copy of Resident A's March 2025 MAR, which documented that on 03/22, Resident A's 4 pm and 8 pm medications where "sent on LOA w/[Relative A2]". Resident A's 4 pm medications included Vistaril 25 mg while her 8 pm medications included Abilify 15 mg tablet, Artane 2 mg tablet, Melatonin 10 mg tablet, Trazadone 50 mg tablet, Klonopin 1 mg tablet, Trileptal 300 mg tablet, Triamcinolone 0.1% cream and Lac-Hydrin 12% lotion.

The MAR also documented on 03/23, Resident A's 8 am medications were also sent on LOA with Relative A2. These medications included Sprintec (birth control), Vitamin D 1000 IU gummies, Zyrtec 10 mg tablet, Klonopin 1 mg tablet, Trileptal 300 mg tablet, Triamcinolone 0.1 cream, and Lac-Hydrin 12% lotion.

According to my review of Resident A's MAR provided by Suzie Suchyta, Resident A is prescribed 0.5 mg Xanax with the instruction of take two tablets by mouth twice daily as needed per Behavior Treatment Committee (BTC) protocol. Based on my review of the MAR, there was no documentation Resident A received any Xanax in March 2025. Suzie Suchyta also provided a picture of Resident A's Xanax medication in the original containers which had the same instructions as the MAR.

I reviewed a facility document titled, "Shift to Shift Narcotic Count" for Resident A's Xanax medication. According to my review of this count sheet, Resident A was sent with four Xanax tablets on 03/22 for an LOA.

I reviewed a facility document titled, "Protocol for Urgent Administration of Medication" signed by Resident A's physician on 03/19/2025, which documented Resident A can be administered "…2 tablets by mouth once a day as needed" Xanax .5 mg if she's exhibiting physical aggression or self-injurious behavior longer than 20 minutes or physical aggression presents an eminent health or safety risk to her or others.

I reviewed the facility's *AFC Licensing Division – Incident / Accident Report* (IR) which was completed by Administrator, Gloria Steele, on 03/25/2025. The content of the IR was consistent with the allegations.

On 04/10/2025, I conducted an unannounced inspection at facility. I interviewed direct care staff, Monique Warren, whose statement was consistent with her statement to Suzie Suchyta. Monique Warren stated that on 03/22, she packed Resident A's bag while Autumn Hurst prepared all of Resident A's medications. Monique Warren stated she neither saw Autumn Hurst prepare Resident A's medications nor saw what medications were put into Resident A's bag. Monique Warren stated she met Resident A's family at Resident A's dental appointment whereas she gave them Resident A's overnight bag. She stated Resident A stayed with her family one overnight starting 03/22 and returning the evening of 03/23.

Monique Warren stated she's prepared Resident A's medications before and follows the same process each time Resident A spends a weekend with her family. She stated Resident A receives her medications in individual tear off tabs, which contain her medications based upon the time of day and date the medication should be administered with pharmacy labeled instructions. Monique Warren stated these individual tear off tabs would be placed in snack baggies identified by the date and time the medications should be administered. Monique Warren stated Relative A2 is a nurse and is aware of how to administer Resident A's medications.

Monique Warren stated when she returned to the facility after taking Resident A to her dental appointment, Autumn Hurst had already left for the day. Monique Warren stated Kim Quakenbush was at the facility and reported to her that Autumn Hurst never documented administering Resident A's Xanax medication nor documented the Xanax count on the narcotic count sheet. Kim Quakenbush reported to Monique Warren Resident A's other scheduled medications had been documented as being sent with Resident A for an LOA.

Monique Warren stated Resident A's Xanax medication is utilized when Resident A displays behaviors such as significant aggression, self-injurious behaviors, and property destruction. She stated Resident A does not demonstrate these types of behaviors when visiting family, which is why the Xanax is not sent with her when she visits them.

I reviewed Resident A's Xanax medication and found no discrepancies or concerns with the medication.

Additionally, I was unable to interview or observe Resident A during my inspection because she was at her day program.

On 05/02/2025, I interviewed direct care staff, Autumn Hurst, who stated 03/22 was her first day back to work after being on leave of absence for approximately one month. She stated the facility's Administrator, Gloria Steele, called the facility's house phone the morning of 03/22 and asked her how Resident A was doing. Autumn Hurst stated Gloria Steele reported Resident A had been displaying behaviors in the facility the previous two days. Autumn Hurst stated Gloria Steele did not specify what type of behaviors Resident A was exhibiting, but she was familiar with Resident A exhibiting such behaviors as scratching, biting, screaming, and elopement. Autumn Hurst stated if Resident A was exhibiting any of these behaviors for 15 minutes or longer than staff can administer a Xanax tablet.

Autumn Hurst stated Gloria Steele did not instruct her to send any Xanax with Resident A when visiting her family that weekend. She stated she decided on her own to send the Xanax with Resident A even though Resident A had not been experiencing any behaviors on the morning of 03/22. Autumn Hurst confirmed she packed two Xanax tablets in Resident A's 8 pm baggie of controlled medication for

03/22 and two Xanax tablets in Resident A's 8 am baggie of controlled for a total of four Xanax tablets.

Autumn Hurst stated she labeled each bag with Resident A's initials, the date and the time the medication was to be administered (i.e. 8 pm or 8 am). She stated she did not identify the Xanax on either baggie. She acknowledged her error in not putting the Xanax in its own separate baggie labeled as PRN. She stated she assumed whoever administered the medication to Resident A would look at the individual blister packs before administering the medication to her.

Autumn Hurst stated Resident A's family does not sign anything documenting they received any type of medication from staff. She stated staff would only have a conversation informing Resident A's family Resident A's medications had been packaged and were in her bag.

On 05/02/2025, I interviewed Relative A2. Relative A2's statement was consistent with Monique Warren's statement to me. He stated none of the facility's staff reported to him Resident A had any significant behaviors in the week prior to 03/22. He stated Resident A's tear off tabs were packed in her overnight bag in two separate plastic baggies with each one labeled with her initials, the date and time. He stated there were no additional baggies and nothing was written on the controlled medication baggies identifying staff sent Xanax with Resident A's scheduled medication. Relative A2 stated he did not go over each medication sent with Resident A because he and Relative A1 were familiar with her medications as they had been administering her medications for a long time; however, Relative A2 expressed confidence in noticing two additional pills in each of Resident A's baggies with her scheduled medication. Relative A2 stated Resident A received all her medications that were sent for 03/22 and 03/23. He stated Resident A did not appear different that weekend and was not noticeably tired, calm, or drowsy. Relative A2 stated neither he nor Relative A1 signed any documentation acknowledging they were in receipt of Resident A's medications on 03/22.

On 05/13/2025, I interviewed the facility's Administrator, Gloria Steele. Her statement to me was consistent with Monique Warren's statement. Gloria Steele stated she contacted the facility on the morning of 03/22 and spoke to Autumn Hurst; however, she stated it was in regard to Resident B. She stated she did not discuss, inquire, or speak to Autumn Hurst about Resident A's behavior, medications, or her upcoming visit with family. Gloria Steele stated she did not instruct Autumn Hurst to send any Xanax tablets with Resident A.

Gloria Steele stated staff are expected to count narcotic medications with another staff to ensure oversight of these medications. Her statement regarding the preparation of medications prior to a resident's leave of absence was consistent with Monique Warren's and Autumn Hurst's statements.

Gloria Steele stated Autumn Hurst has since retaken medication training and Resident A's Protocol for Urgent Administration of Medication (UAM) was updated to reflect Xanax could be administered to her twice a day rather than once a day.

On 05/19/2025, I reviewed Resident A's updated UAM Protocol, dated 05/13/2025. According to this UAM Protocol, Resident A is prescribed Xanax .5 mg capsules with the instruction of "Take 2 capsule by mouth twice a day as needed". The UAM documented signs of anxiety/escalation for Resident A as the following:

- Rocking/pacing increase in intensity
- Screeching/screaming
- Refusing to move or leave, often accompanied by swearing.
- Jumping/running (hyperactivity)
- Changes to facial expression (i.e. grimacing – showing disapproval, disgust)
- SIB (e.g. bite arm or hadn, hit head with open or closed fist scratch her face).

The UAM documented if Resident A is redirectable, and staff are unable to de-escalate, and her anxiety continues for more than 20 minutes then staff can administer two tablets by mouth twice a day as needed. It also documented that staff must notify a supervisor prior to administering the medication and two staff must agree and sign off the mediation and complete an Incident /Accident Report.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** ***(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.*** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.**

ANALYSIS:	Based on my investigation, Resident A's Protocol for Urgent Administration of Medication, which was signed by her physician on 03/19/2025 documented Resident A could be administered 2 tablets of .5 mg Xanax once a day as needed if she was exhibiting physical aggression or self-injurious behavior longer than 20 minutes or physical aggression that was an eminent health or safety risk to her or others; however, a review of Resident A's March MAR documented Resident A could be administered two Xanax twice daily as needed. Consequently, the instructions on Resident A's Xanax medication and her MAR were not consistent with the physician's order dated 03/19/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	Based on my investigation, which included interviews with direct care staff, Monique Warren and Autumn Hurst, Administrator, Gloria Steele, Relative A2, and ISK RRO, Suzie Suchyta, a review of Resident A's March 2025 Medication Administration Record, and the Shift to Shift Narcotic Count for Resident A's Xanax tablets, I am able to determine four tablets of Resident A's .5 mg Xanax are unaccounted for at the time Resident A went on a leave of absence with Relative A1 and Relative A2 on 03/22. Though direct care staff, Autumn Hurst, stated she sent four Xanax tablets with Relative A1 and Relative A2, neither she nor any other direct care staff assured Relative A1 and Relative A2 were in receipt of all Resident A's medications while she was out of the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/19/2025, I conducted my exit conference with the licensee designee, Tim Van Dyk, who acknowledged an understanding of the findings. He did not have any questions.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

05/20/2025

Cathy Cushman Date
Licensing Consultant

Approved By:

5/21/2025

Michele Streeter Date
Section Manager