GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 4, 2025

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

RE: License #: AM390382558
Investigation #: 2025A0581028
Wisner House

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 #:	AM390382558
Investigation #:	2025A0581028
Complaint Receipt Date:	04/25/2025
Investigation Initiation Date:	04/25/2025
Report Due Date:	06/24/2025
Licensee Name:	Residential Opportunities, Inc.
Licensee Address:	1100 South Rose Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-3731
Administrator:	Diane Fidler
Licensee Designee:	Timothy Van Dyk
Name of Facility:	Wisner House
Facility Address:	2208 East Cork Street Kalamazoo, MI 49001
Facility Telephone #:	(269) 381-1455
Original Issuance Date:	10/15/2018
License Status:	REGULAR
Effective Date:	04/14/2025
Expiration Date:	04/13/2027
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION

	Violation Established?
Resident I received incorrect doses of the prescribed medication, Myfortic, from 03/01/2025 through 03/06/2025.	Yes

**** To maintain the coding consistency of residents across special investigations the residents in this special investigation report are not identified in sequential order.*

III. METHODOLOGY

04/25/2025	Special Investigation Intake - 2025A0581028
04/25/2025	Referral - Recipient Rights - Integrated Services of Kalamazoo investigating. No referral necessary.
04/25/2025	Special Investigation Initiated – Letter - Email from ISK RRO, Kate Koyak.
05/05/2025	Inspection Completed On-site - Interview with direct care staff and Resident I.
06/03/2025	Inspection Completed-BCAL Sub. Compliance
06/03/2025	APS Referral
06/04/2025	Contact – Telephone call made – Interview with direct care staff and identified Assistant Program Coordinator, Jessica Sunberg.
06/04/2025	Exit conference with licensee designee, Timothy Van Dyk.

ALLEGATION: Resident I received incorrect doses of the prescribed medication, Myfortic, from 03/01/2025 through 03/06/2025.

INVESTIGATION: On 04/25/2025, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged Resident I received an incorrect dose of Myfortic from 03/01/2025 through 03/06/2025. The complaint alleged Integrated Services of Kalamazoo (ISK) Recipient Rights Officer (RRO), Kate Koyak, also received the allegations and was investigating.

On 04/25/2025, Kate Koyak documented in her email to me she had already interviewed three of the facility's Assistant Program Coordinators (APC). She documented none of the APCs made sure Resident I's March 2025 Medication

Administration Record (MAR) was correct when it was delivered to the facility. Subsequently, Kate Koyak documented Resident I received the wrong dosage of Myfortic medication for approximately six days. Kate Koyak documented Resident I had been at a "…low risk of harm as the doctor had instructed them to titrate down the Myfortic that he'd been on for years after a transplant and they just gave him the old dose instead of lowering it."

Kate Koyak documented in her email Resident I's doctor lowered his Myfortic dosage in December 2024 and sent the prescription to the pharmacy; however, Kate Koyak documented the pharmacy never updated Resident I's MAR to reflect the new dosage. Subsequently, Kate Koyak documented the facility's staff were handwriting on the MAR the new dosage. Kate Koyak documented when Resident I's March MAR was delivered by the pharmacy the APCs did not cross check the previous month's MARs with the current MAR; therefore, staff administered Resident I's original dosage rather than the correct dosage.

Kate Koyak documented the current Myfortic instructions were to administer once per day while the old instructions were to administer the Myfortic twice per day. Kate Koyak documented the "…the AM staff assumed they were giving it to [Resident I] once a day and the PM staff assumed they were giving it once a day and neither realized he was getting it twice a day."

Kate Koyak forwarded me the prescription for Resident I's Myfortic medication, dated 12/11/2024. The instructions on the prescription documented, "Take 1 tablet (360 mg total) by mouth once daily".

Kate Koyak forwarded me a copy of the licensee's document titled "Report of Consultation", dated 12/11/2024, along with Resident I's After Visit Summary, dated 12/11/2024, which also documented the new instructions to the Myfortic medication of taking one tablet by mouth once daily.

Kate Koyak also forwarded me a copy of Resident I's January, February, and March 2025 MARs. According to my review of the January and February MARs, Resident A received one 360 mg tablet of Myfortic once per day at 8 am. These two MARs documented the original instructions of "Take 1 tablet by mouth twice daily", but the MAR; however, documented staff crossed out "twice" and wrote in "once" and also crossed off the administration time of 8 pm.

The March MAR documented one Myfortic tablet was administered at both 8 am and 8 pm to Resident I on 03/01, 03/02, 03/03, 03/04, 03/05, and 03/06. The March MAR documented starting 03/07 at 8 am Resident I only received one tablet of Myfortic, as required.

On 05/05/2025, I conducted an unannounced inspection at the facility. I interviewed direct care staff and identified Assistant Program Coordinator, Anthony Williams. Anthony Williams' statement was consistent with what Kate Koyak documented in

her email to me. Anthony Williams stated he administered the incorrect dosage to Resident I multiple times before realizing he administered the incorrect dosage. Anthony Williams stated Resident I did not experience any physical issues from receiving the incorrect Myfortic dosage.

I interviewed Resident I who stated he receives all his medications, as required, and identified no concerns relating to his medications.

I reviewed Resident I's May 2025 MAR, which documented the pharmacy put the correct instructions on Resident I's MAR for his Myfortic medication; therefore, there was no need for staff to cross out or add in any additional instructions relating to the medication. The instructions were documented as take one tablet by mouth once daily.

On 06/04/2025, I interviewed direct care staff and identified Assistant Program Coordinator, Jessica Sunberg. Her statement was consistent with what was documented to me by Kate Koyak and reported by Anthony Williams. She stated not catching the error on Resident I's March MAR was a mistake on behalf of the staff at the facility. She stated moving forward, new monthly MARs are reviewed in the medication room whereas before staff could remove them and review them elsewhere in the facility. She stated this process allows staff to review the medication room's white board which is where staff also document resident medication changes.

According to SIR # 2024A0581021, 03/11/2024, the facility was in violation of Adult Foster Care administrative Rule 400.14312(2) when it was determined a direct care staff administered incorrect medications to a resident on 12/20/2023 at 8 pm.

The facility's approved Corrective Action Plan (CAP), dated 03/25/2024, documented the staff involved with passing the incorrect medication was formally disciplined and the facility's Administrator retrained all facility staff about following the licensee's "Medication Passing Procedures" on 03/01/2024.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based on my investigation, which included email correspondence with Integrated Services of Kalamazoo Recipient Rights Officer, Kate Koyak, an interview with direct care staff, Anthony Williams, and a review of the Myfortic prescription dated 12/11/2024, Resident I's After Visit Summary, dated 12/11/2024, and Resident I's January, February, and March 2025 Medication Administration Records, there is supporting evidence Resident A received the incorrect dosage of his Myfortic medication from 03/01 through 03/06 when direct care staff administered one tablet twice per day rather than one tablet once per day. Subsequently, Resident I did not receive his Myfortic medication per the physician's order dated 12/11/2025, as required
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[SEE SIR 2024A0581021, DATED 03/11/2024, CAP DATED 03/25/2024]**

On 06/04/2025, I conducted the exit conference with the licensee designee, Tim Van Dyk via email informing him of my findings.

IV. RECOMMENDATION

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

06/04/2025

_____

Cathy Cushman Date
Licensing Consultant

Approved By:

06/04/2025

_____

Dawn N. Timm Date
Area Manager