

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

MARLON I. BROWN, DPA DIRECTOR

July 1, 2025

Michelle Aylor-Robbins Burcham Hills Retirement Center II 2700 Burcham Drive East Lansing, MI 48823

> RE: License #: AH330236746 Investigation #: 2025A1021057

> > Burcham Hills Retirement Center II

Dear Michelle Aylor-Robbins:

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 authorized representative 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,

Kinveryttoox

Kimberly Horst, Licensing Staff Bureau of Community and Health Systems 611 W. Ottawa Street Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH330236746	
Investigation #:	2025A1021057	
Complaint Receipt Date:	05/30/2025	
Complaint Neceipt Date.	03/30/2023	
Investigation Initiation Date:	06/03/2025	
Report Due Date:	07/29/2025	
Licensee Name:	Burcham Hills Retirement Center II	
Licensee Address:	2700 Burcham Drive	
Licensee Address.	East Lansing, MI 48823	
	3,	
Licensee Telephone #:	(517) 351-8377	
Administrator/ Authorized	Michelle Aylor-Robbins	
Representative:		
Name of Facility:	Burcham Hills Retirement Center II	
Traine or Lacinity.		
Facility Address:	2700 Burcham Drive	
	East Lansing, MI 48823	
Facility Talanda and W	(547) 054 0077	
Facility Telephone #:	(517) 351-8377	
Original Issuance Date:	07/01/1999	
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License Status:	REGULAR	
Effective Date:	08/01/2024	
Expiration Data:	07/24/2025	
Expiration Date:	07/31/2025	
Capacity:	266	
Program Type:	AGED	
	ALZHEIMERS	

II. ALLEGATION(S)

Violation			
Estab	ished?		

Resident A missed medications on 05/28/2025.	Yes
Additional Findings	No

III. METHODOLOGY

05/30/2025	Special Investigation Intake 2025A1021057
06/03/2025	Special Investigation Initiated - Face to Face Initiated on site
06/03/2025	Contact - Telephone call made interviewed Central Pharmacy
06/03/2025	Contact-Telephone call made Interviewed One Care Pharmacy
07/01/2025	Exit Conference

ALLEGATION:

Resident A missed medications on 05/28/2025.

INVESTIGATION:

On 05/30/2025, the licensing department received a complaint with allegations Resident A missed morning medications on 05/28/2025.

On 06/03/2025, I interviewed administrator Michelle Aylor-Robbins at the facility. The administrator reported Resident A has resided at the community since 02/24/2025. The administrator reported on 04/02/2025, Resident A changed from a local pharmacy, Central Pharmacy, to the facility preferred pharmacy, One Care Pharmacy. Administrator reported with this change in pharmacy, there has been confusion as to what pharmacy Resident A is using.

On 06/03/2025, I interviewed staff person 1 (SP1) at the facility. SP1 reported on 05/28/2025 she was notified that Resident A did not have Diltiazem medication. SP1 reported Resident A's family was going to Central Pharmacy to obtain the needed medication. SP1 reported Central Pharmacy will deliver medications but could not deliver medications on that day. SP1 reported in May 2025, Resident A had signed

on with One Care Pharmacy and some medications were delivered by this pharmacy to Resident A. SP1 reported she is not aware why the Diltiazem medication was not delivered. SP1 reported if a medication technician administers the last medication tablet, they are to contact the care coordinator to request a refill on the medication. SP1 reported she is not certain if this occurred with this medication. SP1 reported this conversation is typically not documented.

I reviewed Resident A's progress notes. The note read,

"05/28/2025: Returned phone call related to resident medications diltiazem needing a refill. Resident daughter explains that there was a confusion with reordering from central pharmacy and onecare last month. She explains that she is having a family friend pick up this medication today from central pharmacy as she has ran out of this medication."

I reviewed Resident A's medication administration record (MAR) for May 2025. The MAR revealed on 05/28/2025, Resident A did not receive the following medications: Diltiazem HCI Tablet Hydrochlorothiazide Oral Tablet Potassium Chloride Tablet Vitamin D3

On 06/04/2025, I interviewed Central Pharmacy by telephone. Central Pharmacy reported Resident A's medications were delivered on 04/22/2025 to the facility. Central Pharmacy reported it was documented that Resident A would then be going through a different pharmacy and would be leaving Central Pharmacy. Central Pharmacy reported on 05/28/2025, additional medications were picked up by Resident A's family due to not having medications at the facility.

On 06/04/2025, I interviewed One Care Pharmacy by telephone. One Care Pharmacy reported on 05/19/2025, some of Resident A's medications were delivered to the facility. One Care Pharmacy reported it was documented that Resident A would be using up the current supply for Diltiazem HCI Tablet, Hydrochlorothiazide Oral Tablet, Potassium Chloride Tablet, and Vitamin D3. One Care Pharmacy reported these medications were "profile only" and were not to be delivered to the facility.

APPLICABLE RULE		
R 325.1932	Resident medications.	
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.	

ANALYSIS:	Interviews conducted revealed per facility policy, when the last medication tablet has been administered the care coordinator is to be contacted to arrange for a refill from the pharmacy. Review of documentation revealed Resident A's last medication tablets were administered on 05/27/2025. However, the pharmacy was not contacted until 05/28/205 for a refill. By not contacting the pharmacy in a timely manner, Resident A missed medications.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

KimberyHood	06/04/2025
Kimberly Horst Licensing Staff	Date
Approved By:	
(moheg) more	06/30/2025
Andrea L. Moore, Manager Date Long-Term-Care State Licensing Section	