GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Ronisha Robinson
Cliffside Company
3905 Lorraine Path
St. Joseph, MI 49085

July 21, 2025

RE: License #: AL110087629
Investigation #: 2025A0790028
Caretel Inns of Royalton - Bristol

Dear Ronisha Robinson:

Attached is the Addendum to 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 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

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 #:	AL110087629
Investigation #:	2025A0790028
Complaint Receipt Date:	05/21/2025
Investigation Initiation Date:	05/21/2025
Report Due Date:	07/20/2025
Licensee Name:	Cliffside Company
Licensee Address:	3905 Lorraine Path St. Joseph, MI 49085
Licensee Telephone #:	(947) 282-7555
Administrator:	Ronisha Robinson
Licensee Designee:	Ronisha Robinson
Name of Facility:	Caretel Inns Of Royalton - Bristol
Facility Address:	3905 Lorraine Path Saint Joseph, MI 49085
Facility Telephone #:	(269) 363-1906
Original Issuance Date:	11/03/2000
License Status:	REGULAR
Effective Date:	12/11/2023
Expiration Date:	12/10/2025
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive her medications as prescribed.	No

III. METHODOLOGY

05/21/2025	Special Investigation Intake 2025A0790028
05/21/2025	APS Referral is not necessary because the alleged victim is deceased, and Adult Protective Services does not investigate allegations involving a vulnerable adult that has passed away.
05/21/2025	Contact - Telephone call made to Complainant to confirm the allegations provided were accurate and comprehensive.
05/21/2025	Special Investigation Initiated - On Site
05/21/2025	Inspection Completed On-site Interviewed direct care staff member Keymariye Bethea and licensee designee Ronisha Robinson.
05/21/2025	Contact - Telephone call made I called Relative A1. I left a voicemail message requesting a return call.
05/22/2025	Contact - Telephone call received I interviewed Relative A1.
05/27/2025	Contact - Document Sent I emailed a SIR Letter to the Complainant for review.
06/09/2025	Special Investigation Full Compliance
06/11/2025	Exit Conference with licensee designee Ronisha Robinson.

ALLEGATION:

Resident A did not receive her medications as prescribed.

INVESTIGATION:

On 5/21/25, I reviewed a Michigan Department of Licensing and Regulatory Affairs – Bureau of Community and Health Systems (LARA-BCHS) Online Complaint Form dated 5/19/25. The complaint indicated Resident A did not receive the proper dosage of the medication Eliquis for approximately 75 days while living at Caretel Inns of Royalton – Bristol, which resulted in an acute embolic stroke and death two weeks later.

The complaint indicated there was a previous occasion when Resident A was not receiving her prescribed medication metoprolol. The complaint indicated relatives were told by direct care staff members (DCSMs) that Resident A ran out of metoprolol and the individual responsible for ordering the residents' medications was on vacation.

On 5/21/25, I conducted an unannounced onsite investigation. I interviewed DCSM Keymariye Bethea who is trained in medication administration and functions as a medication technician at the facility.

Ms. Bethea stated she remembers administering medications to Resident A and always administered Resident A's medications as prescribed. She said she specifically remembers Resident A receiving Eliquis while administering medications at 5:00 p.m.

Ms. Bethea said she remembers Resident A's family member(s) always having issues with Resident A's medications. She stated Resident A's family member(s) would routinely complain to Resident A's primary care physician (PCP) and to licensee designee (LD) Ronisha Robinson regarding issues pertaining to the type and number of medications Resident A was receiving.

Ms. Bethea stated she knows and is confident that Resident A was given Eliquis and metoprolol as prescribed while living at the facility.

On 5/21/25, I interviewed licensee designee Ronisha Robinson. Ms. Robinson indicated Resident A received all the medications prescribed by her PCP while living at the facility. Ms. Robinson stated Resident A was taking Eliquis daily until 1/25/25 when she was hospitalized. She said while hospitalized on this occasion, Resident A's prescription for Eliquis was discontinued because she was bleeding and received a do not treat (DNT) order. Ms. Robinson stated after Resident A's hospital

stay, she returned to the facility. Ms. Robinson indicated Resident A later resumed taking Eliquis per her PCP's order in 2/25, but the prescription was for five days only.

Ms. Robinson stated Resident A received her prescriptions for metoprolol as prescribed while living at the facility. She explained Resident A had two different prescriptions for metoprolol while living at the facility. Ms. Robinson said Resident A's prescription for metoprolol increased from 25 MG tablets twice a day to 37.5 MG tablets twice a day on 2/6/25.

I reviewed Resident A's *resident records.* I specifically reviewed Resident A's admission record to the facility and found that Resident A's original admission date to the facility was 10/4/24 and date of discharge was 4/21/25.

I reviewed Resident A's physician's orders pertaining to her prescriptions for Eliquis (apixaban). I observed a physician's order dated 1/30/25 to discontinue Resident A's prescription for Eliquis (apixaban) 2.5 mg tablets. I reviewed physician's orders dated 2/6/25. One of the orders was an order for Eliquis (apixaban) the order indicated it was to be administered as part of a five-day anticoagulant therapy.

I reviewed Resident A's *Medication Administration Records* for 2025. I observed that Resident A received Eliquis (apixaban) 2.5 mg tablets twice a day as prescribed until the morning of 1/29/25. I observed Resident A received Eliquis (apixaban) 5 mg tablets twice daily as prescribed from the evening of 2/6/25 to morning of 2/11/25.

I observed Resident A's medication list and physician's prescription orders dated 2/6/25. The medication list and physician's prescription orders included metoprolol tartrate 37.5 mg tablets twice daily begin on 2/6/25.

While reviewing Resident A's *MARs, I observed* that Resident A received metoprolol tartrate 25 mg tablets twice daily until 2/6/25. I observed the evening of 2/6/25, Resident A began receiving metoprolol tartrate 37.5 mg tablets twice daily from 2/6/25 through 2/28/25. I did not find any evidence of Resident A not receiving any of her prescribed medications as prescribed.

I reviewed all documentation received by the Complainant, including Resident A's physician's orders dated 2/6/25 for Eliquis (apixaban) 5 mg tablets twice daily and metoprolol tartrate 37.5 mg tablets twice daily, and found no evidence of Resident A not receiving any of her prescribed medications as prescribed.

On 5/22/25, I interviewed Relative A1 via phone. Relative A1 stated she was at the facility on an unknown date when Resident A's medications were delivered and Resident A's prescription for metoprolol was not delivered. Relative A1 stated an

unknown DCSM informed her they did not have more metoprolol and that the DCSM who orders the residents' medications was on vacation.

Relative A1 indicated she was informed Resident A was prescribed Eliquis in 02/25 and was to continue receiving the medication. Relative A1 stated she does not currently have evidence that Eliquis was prescribed on an ongoing basis in 02/25, but she would investigate and contact if she is able to obtain this information.

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 the Complainant, Ms. Bethea, Ms. Robinson, and Relative A1 there was no evidence found indicating Resident A did not receive her medications as prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 6/11/25, I conducted an exit conference with LD Ronisha Robinson. Ms. Robinson was informed of the outcome of this special investigation and did not dispute the findings.

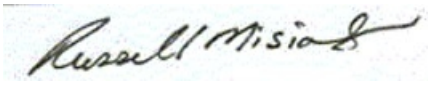
IV. RECOMMENDATION

I recommend that the status of the license remains the same.

6/11/25

Rodney Gill Date
Licensing Consultant

Approved By:



6/11/25

Russell B. Misiak Date
Area Manager

ADDENDUM TO SPECIAL INVESTIGATION
#2025A0790028

METHODOLOGY

On 6/18/25	The Complainant provided additional evidence via email.
On 7/2/25	I visited the facility and spoke with human resources director Sara Flowers and interviewed direct care staff member Elizabeth Barahona.
On 7/16/25	Licensee designee Ronisha Robinson emailed additional supporting documentation that I requested.
On 7/17/25	Case conference with direct supervisor Russell Misiak.
On 7/22/25	Inspection Completed-BCAL Sub. Compliance
On 7/23/25	Exit Conference with Ms. Robinson.
On 7/23/25	Special Investigation Report Sent
On 8/6/25	Corrective Action Plan Requested and Due on

INVESTIGATION:

On 6/18/25, I listened to a recording and reviewed additional evidentiary documentation provided via email by the Complainant. I also reviewed evidentiary documentation previously provided by the Complainant and Ms. Robinson.

The recording was from 6/18/25, and was a call placed to MedWiz Pharmacy. In the recording, agent Daniel Last Name Unknown confirmed that on 2/10/25, sixty-5 mg Eliquis tablets were delivered to the facility and signed in by DCSM Elizabeth Barahona.

On 6/18/25, I reviewed Discharge Summary Notes from Corewell Health Lakeland Hospital for Resident A dated 2/1/25. The notes contained a doctor's order for apizaban (Eliquis) 5 mg tablets. The order indicated that Resident A was to begin taking two Eliquis 5 mg tablets by mouth twice daily for five days, then one tablet by mouth two times daily.

On 6/18/25, I reviewed an invoice for Resident A from MedWiz Pharmacy dated 2/28/25. The invoice indicated that on 2/10/25, sixty-5 mg Eliquis tablets were dispensed to the facility for Resident A's use.

On 6/18/25, I reviewed Resident A's medication administration record (MAR) for 2/25. The MAR indicated that Resident A received two Eliquis 5 mg tablets by mouth twice daily for five

Days beginning on 2/6/25, but did not receive one tablet two times daily after that as the doctor's order indicated.

On 5/21/25, during a face-to-face interview at the facility, licensee designee (LD) Ronisha Robinson disclosed that Resident A was taking Eliquis daily until 1/25/25 when she was hospitalized. Ms. Robinson said while hospitalized on this occasion, Resident A's prescription for Eliquis was discontinued because she was bleeding and received a do not treat (DNT) order. Ms. Robinson said after the hospital stay Resident A returned to the facility. She indicated Resident A later resumed taking Eliquis per doctor's order, but the prescription was for five days only. Ms. Robinson said she did not receive a prescription for Resident A to continue taking one tablet two times daily.

On 7/2/25, I visited the facility and spoke with human resources director Sara Flowers and interviewed direct care staff member (DCSM) Elizabeth Barahona.

Ms. Barahona stated she is trained in medication administration, and her main duty at the facility is administering medications to the residents. She said one of her responsibilities is to sign for the residents' medications when delivered by MedWiz Pharmacy as well as other pharmacies.

Ms. Barahona said so many medications are delivered that she cannot remember signing for Resident A's medication on 2/10/25, which was sixty Eliquis 5 mg tablets.

On 7/16/25, I reviewed a Packing Slip Proof of Delivery from MedWiz Pharmacy of Illnois LLC provided by Ms. Robinson. The Packing Slip was dated 2/10/25 and indicated sixty-5mg Eliquis tablets were delivered to the facility for Resident A. The Packing Slip was signed for by DCSM Elizabeth Barahona.

On 7/16/25, I reviewed a Packing Slip Proof of Delivery from MedWiz Pharmacy of Illnois LLC provided by Ms. Robinson. The Packing Slip was dated 2/8/25 and indicated twenty-5 mg Eliquis tablets were delivered to the facility for Resident A. The Packing Slip was signed by DCSM Kelly Maben.

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 the Complainant, Ms. Barahona, and Ms. Robinson there was sufficient evidence found indicating Resident A did not receive her medications as prescribed.

CONCLUSION:	VIOLATION ESTABLISHED

On 7/22/25, I conducted an exit conference with LD Ronisha Robinson. Ms. Robinson was informed of the outcome of this special investigation and did not dispute the findings. Ms. Robinson was asked to provide an acceptable Corrective Action Plan (CAP) within the required timeframe.

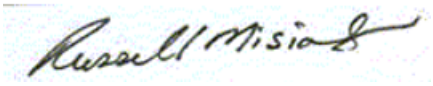
RECOMMENDATION

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

7/22/25

Rodney Gill — Date
Licensing Consultant

Approved By:



7/22/25

Russell B. Misiak — Date
Area Manager