GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 16, 2021

Connie Clauson
Pleasant Homes I L.L.C.
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL390007090
Investigation #: 2021A0578053
Park Place Living Centre #B

Dear Mrs. Clauson:

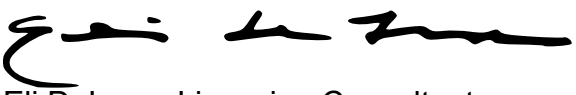
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9727.

Sincerely,



Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390007090
Investigation #:	2021A0578053
Complaint Receipt Date:	09/21/2021
Investigation Initiation Date:	09/23/2021
Report Due Date:	11/20/2021
Licensee Name:	Pleasant Homes I L.L.C.
Licensee Address:	Suite 203 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Janet White
Licensee Designee:	Connie Clauson
Name of Facility:	Park Place Living Centre #B
Facility Address:	4218 S Westnedge Kalamazoo, MI 49008
Facility Telephone #:	(269) 388-7303
Original Issuance Date:	01/01/1989
License Status:	REGULAR
Effective Date:	04/20/2021
Expiration Date:	04/19/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's narcotic medication was not safeguarded and was subsequently stolen from the facility.	No
Additional Finding:	Yes

III. METHODOLOGY

09/21/2021	Special Investigation Intake 2021A0578053
09/22/2021	Contact-Document Reviewed -*AFC Licensing Division Incident Accident Report* dated 09/21/2021.
09/23/2021	Special Investigation Initiated - On Site Interview with administrator Janet White.
09/23/2021	Contact-Document Reviewed -*Controlled Substance Count Log* for Resident A.
09/23/2021	Contact-Document Reviewed -Written statement by Ms. Mary Stager, dated 09/17/2021.
11/08/2021	Contact-Document Received -Kalamazoo Department of Public Safety Records.
11/08/2021	Contact-Document Received *-KDPS Incident/Investigation Report #21-015426.*
11/08/2021	Contact-Telephone -Kalamazoo Department of Public Safety Records.
11/08/2021	Contact-Telephone -Interview with resident care specialist Ms. Gloria Givhan, unsuccessful.
11/08/2021	Contact-Telephone -Interview with resident care specialist Ms. Mary Stager, unsuccessful.
11/09/2021	Contact-Telephone -With administrator Ms. Janet White.
11/09/2021	Contact-Telephone -Interview with resident care specialist Mary Stager.

11/10/2021	Contact-Document Received -Criminal history checks for Ms. Gloria Givhan.
11/10/2021	Exit Conference -Message left for the licensee, Ms. Connie Clauson.

ALLEGATION:

Resident A's narcotic medication was not safeguarded and was subsequently stolen from the facility.

INVESTIGATION:

On 09/21/2020, I received this complaint regarding narcotics missing from the facility on 09/17/2021. According to the complaint, Administrator Janet White reported resident care specialist Mary Stager informed her of the missing medications and was instructed to look through the entire medication cart with no success. Ms. White informed currently assigned AFC Consultant Cathy Cushman that law enforcement was notified and responded to the facility and questioned staff regarding the missing medication. The complaint further reported Ms. White clarified for Ms. Cushman that law enforcement would be contacting one staff who had left work early. Ms. White informed Ms. Cushman that designated representatives and primary physicians had been notified and additional prescriptions orders were being obtained for the missing medication. Ms. White reported to Ms. Cushman that an *AFC Licensing Division Incident Accident Report* would be forthcoming.

On 09/22/2021, I reviewed the *AFC Licensing Division Incident Accident Report* related to the allegation. This *AFC Licensing Division Incident Accident Report* was completed by Ms. Janet White and dated 09/21/2021. Ms. White documented on the *AFC Licensing Division Incident Report* that resident care specialists Mary Stager and Krystal Effinger were performing narcotics count when Ms. Effinger observed that she did not have cards for Resident A's Tramadol 50MG and Resident B's Norco 5/325MG. Ms. White documented direct care staff members were advised to search the entire medication cart and asked if the 7AM medication count was completed, which staff acknowledged was completed. Ms. White documented contacting Kalamazoo Department of Public Safety (KDPS) and requested an investigation be completed. Ms. White documented that KDPS responded to the facility and questioned staff. Ms. White documented case #21-15426.

Equipped with personal protective equipment, on 09/23/2021, I completed an unannounced investigation on-site at this facility and interviewed the administrator, Ms. Janet White regarding the allegation. Ms. Janet White acknowledged that medications for Resident A and Resident B had gone missing from the facility on or about 09/17/2021. Ms. White identified this medication as Tramadol 50MG, 36 pills,

and Norco 5/325MG, 13 pills. Ms. White clarified that she suspected that resident care specialist Gloria Givhan may be responsible as Ms. Givhan was a “no-call / no-show” for shifts she was scheduled for at the facility over the weekend and as a result was no longer employed. Ms. White added that as a newly hired staff, Ms. Givhan should never have been in possession of the medication cart keys or left alone with the medication cart. Ms. White reported that Ms. Givhan was allowed to pass eyedrops so that her documentation of medications could be observed. Ms. White added that after the medications were discovered missing, other resident care specialists during the shift made Ms. Givhan empty her purse.

Ms. White clarified that narcotics medications are typically stored inside a locked narcotics container which is then stored inside the locked medication cart. Ms. White acknowledged that on the day of the allegations, resident care specialists were unable to open the locked narcotics box and instead had to use only the locked medication cart to store these medications. Ms. White reported that Hometown pharmacy had been informed and was replacing the lock.

Ms. White denied that any resident missed their routine medication administration and reported that both narcotic medications were PRN and were not renewed. Ms. White denied that a resident may have been responsible for taking the medications and clarified that only direct care staff had keys to the medication cart. Ms. White stated that garbage cans in this facility were searched as well.

Ms. White stated only resident care specialist Ms. Mary Stager was assigned to the medication cart, and she and resident care specialist Ms. Gloria Givhan were the only staff that had access to the medication cart. Ms. White reported that Ms. Givhan was a newly hired staff but had previously worked at this facility.

While at this facility, I reviewed the criminal history checks for Ms. Mary Stager and found them to be compliant. Ms. White reported that criminal history checks for Ms. Givhan were available but would have to be obtained from another building. Ms. White reported criminal history checks for Ms. Givhan would be provided by email.

While at the facility, I reviewed the *Controlled Substance Count Log* for Resident A. The *Controlled Substance Count Log* for Resident A indicated that 36 tablets of Resident A’s Tramadol 50MG were no longer accounted for.

On 09/23/2021, I reviewed a written statement recorded on 09/17/2021 by resident care specialist Mary Stager related to the allegations. Ms. Stager documented at the start of shift, Ms. Gloria Givhan informed Ms. Stager that she had to be trained on the medication cart. Ms. Stager documented that Ms. Givhan informed her that she had worked at Park Place in building “E” many years ago and offered to pass meds while Ms. Stager watched her. Ms. Stager recorded that she informed Ms. Givhan that she would have to learn who the residents are before Ms. Givhan could pass medications. Ms. Stager documented that around 6PM, she asked Ms. Givhan to bring the medication cart to a resident room and instructed Ms. Givhan to review the

electronic medication records for residents. Ms. Stager documented that when she walked down to meet Ms. Givhan, Ms. Givhan informed her the “narc” (Narcotics) box wasn’t opening. Ms. Stager documented that she attempted to open the lock box herself, but the box would not open. Ms. Stager documented that she pulled the lock box out of the medication cart and contacted administrator, Ms. Janet White. Ms. Stager documented she then put the narcotic medication in the drawer of the medication cart where the lock box would ordinarily be stored. Ms. Stager documented that around this time, Ms. Givhan informed Ms. Stager that she needed to use the bathroom. Ms. Stager documented that she was instructed by the administrator, Ms. White, to keep the medication cart locked due to the malfunctioning lock box. Ms. Stager documented that around 9PM when counting medications, it was apparent that Tramadol and Norco for Resident A and Resident B were missing. Ms. Stager documented searching several areas of the facility with other resident care specialists and notifying the administrator, Ms. White. Ms. Stager documented requesting to search Ms. Givhan’s purse with another resident care specialist present and Ms. Givhan complied. Ms. Stager documented that Ms. Givhan commented that she had never experienced this and may not return. Ms. Stager documented being unsuccessful with locating the missing medications and being interviewed by KDPS.

On 11/09/2021, I interviewed resident care specialist Mary Stager regarding the allegations. Ms. Stager acknowledged and confirmed her written statement on 09/17/2021. Ms. Stager added that she found out later that Ms. Gloria Givhan was never instructed to train on medications. Ms. Stager clarified that when she completed medication counts at the beginning of the shift, she had no problems opening the locked narcotics lock box. Ms. Stager clarified there are two medication cart keys, one to the medication cart and one to the narcotics lock box. Ms. Stager acknowledged that Ms. Givhan had commented that she was unable to open the locked narcotics box even though Ms. Givhan was only asked to review resident medications on the electronic medical records. Ms. Stager clarified that Ms. Givhan had both sets of keys as she walked down a hallway but was visible by staff and Ms. Stager regained the keys when Ms. Givhan reported the lock box was broken. Ms. Givhan clarified that the locked narcotics box was no longer bolted to the inside drawer of the medication cart and appeared to have something in the keyhole which made the lock difficult to open. Ms. Stager reported that only she and Ms. Givhan were present when she took medications from the narcotics lock box and placed them in the medication cart. Ms. Stager reported taking pictures of the medications in the narcotics lock box before transferring these medications to the medication cart. Ms. Stager reported that Ms. Givhan would have had no other opportunity then to have taken the medications at this time as she was not left alone with the medication cart after this event. Ms. Stager elaborated that Ms. Givhan did not return to work at the facility after this incident. Ms. Stager reported that another resident care specialist pointed out to Ms. Stager that Ms. Givhan had an additional personal bag in her possession that was not searched.

On 11/08/2021, I reviewed *KDPS Incident/Investigation Report #21-015426* related to the allegations. *KDPS Incident/Investigation Report #21-015426* was completed by Kalamazoo public safety officer (PSO) Eric Zapata. PSO Zapata documented interviewing resident care specialist Mary Stager regarding the allegations. PSO Zapata documented that Ms. Stager had reported carrying out her normal duties as a medication handler. PSO Zapata documented that Ms. Stager identified Ms. Gloria Givhan as a trainee who was not supposed to be with her or handling any medication. PSO Zapata documented that Ms. Stager denied observing Ms. Givhan or anyone else take any medication at any time and had no additional information.

PSO Zapata documented interviewing Ms. Gloria Givhan by telephone regarding the allegations. PSO Zapata documented that Ms. Givhan reported she could not access the medication due to the medication key not working. PSO Zapata documented that Ms. Givhan denied observing any suspicious activity and clarified that once the medication was determined missing, staff all “scrambled” to help locate the medications. PSO Zapata documented that Ms. Givhan reported that she believed the medication was still in the building and may have been misplaced by accident. PSO Zapata documented that Ms. Givhan denied taking the medication and stated that she did not believe any of the other staff would deprive residents of their medication.

PSO Zapata documented informing Ms. Givhan that management at this facility suspected that she was in possession of the medication and PSO Zapata recorded that Ms. Givhan was quick to deny this. PSO Zapata documented that Ms. Givhan denied having any additional information.

PSO Zapata documented on *KDPS Incident/Investigation Report #21-015426* no known suspects at the time of this report. PSO Zapata documented that all involved parties have been interviewed, and the conclusion of *KDPS Incident/Investigation Report #21-015426*, it was undetermined if the medications were stolen, misplaced, or taken by a resident.

On 11/18/2021, I reviewed the details of *KDPS Incident/Investigation Report #21-015426* with KDPS records coordinator Aleshia Wolthius. Ms. Wolthius acknowledged *KDPS Incident/Investigation Report #21-015426* was not closed by KDPS but was also not referred to the prosecuting attorney’s office. Ms. Wolthius confirmed this was the only reported associated with the allegations.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.

ANALYSIS:	During interviews, administrator Ms. Janet White and resident care specialist Mary Stager acknowledged that *Controlled Substance Count Logs* were utilized and accurate at the beginning of the shift on 09/17/2021 Ms. White and Ms. Stager acknowledged the facility utilized a lock box for controlled substances and locking medication cart with limited staff access prior to the occurrence of missing medications on 09/17/2021. After the occurrence of missing medications, Ms. Stager confirmed that staff attempted to locate the missing medications by searching the facility as well as a resident care specialist's belongings that was suspected of taking the medications. Ms. White reported that all designated representatives and physicians were contacted in addition to this department. Ms. White also reported the occurrence of missing medications to the Kalamazoo Department of Public Safety and requested an investigation regarding the missing medication. I reviewed *KDPS Incident/Investigation Report #21-015426*, where PSO Zapata documented that he was unable to determine if the medications were stolen, misplaced, or taken by a resident. Efforts to interview resident care specialist Gloria Givhan were unsuccessful and Ms. Givhan never returned to work at this facility. As such, even though it is not clear what happened to the medication, the medication remained missing and was not secured to ensure it was not used by another person.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

On 11/10/2021, Ms. Janet White reported that criminal record checks and *Michigan Workforce Background Check* for Ms. Gloria Givhan were completed in 2019 during a previous employment and not after Ms. Givhan's most recent employment in September 2021. Ms. White provided documentation of the 2019 criminal record checks for Ms. Gloria Givhan.

On 11/10/2021, I reviewed the *Michigan Workforce Background Check* for Ms. Gloria Givhan and found it to be completed in April 2019.

APPLICABLE RULE	
400.734b	**Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(4) Upon receipt of the written consent and identification required under subsection (3), the adult foster care facility that has made a good faith offer of employment or independent contract shall make a request to the department of state police to conduct a criminal history check on the individual and input the individual's fingerprints into the automated fingerprint identification system database, and shall make a request to the relevant licensing or regulatory department to perform a check of all relevant registries established according to federal and state law and regulations for any substantiated findings of abuse, neglect, or misappropriation of property. The request shall be made in a manner prescribed by the department of state police and the relevant licensing or regulatory department or agency. The adult foster care facility shall make the written consent and identification available to the department of state police and the relevant licensing or regulatory department or agency. If the department of state police or the federal bureau of investigation charges a fee for conducting the initial criminal history check, the charge shall be paid by or reimbursed by the department. The adult foster care facility shall not seek reimbursement for a charge imposed by the department of state police or the federal bureau of investigation from the individual who is the subject of the initial criminal history check. The department of state police shall conduct an initial criminal history check on the individual named in the request. The department of state police shall provide the department with a written report of the criminal history check conducted under this subsection that contains a criminal record. The report shall contain any criminal history record information on the individual maintained by the department of state police.

ANALYSIS:	On 11/10/2021, Ms. Janet White reported that criminal record checks and *Michigan Workforce Background Check* for Ms. Gloria Givhan were completed in 2019 for a previous employment and not after Ms. Givhan's most recent employment in September 2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

11/10/2021

Eli DeLeon Date
Licensing Consultant

Approved By:

11/16/2021

Dawn N. Timm Date
Area Manager