GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 5, 2023

Patti Holland
801 W Geneva Dr.
Dewitt, MI 48820

RE: License #: AS330341802
Investigation #: 2023A0790048
Lansing Adult Foster Care

Dear Patti Holland:

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. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330341802
Investigation #:	2023A0790048
Complaint Receipt Date:	05/19/2023
Investigation Initiation Date:	05/19/2023
Report Due Date:	07/18/2023
Licensee Name:	Patti Holland
Licensee Address:	801 W Geneva Dr. Dewitt, MI 48820
Licensee Telephone #:	(517) 669-8457
Administrator:	Patti Lynn Holland
Licensee Designee:	N/A
Name of Facility:	Lansing Adult Foster Care
Facility Address:	3600 Simken Drive Lansing, MI 48910
Facility Telephone #:	(517) 203-5249
Original Issuance Date:	01/10/2014
License Status:	REGULAR
Effective Date:	07/08/2022
Expiration Date:	07/07/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff member (DCSM) Chastidy Johnston, who functions as the house manager, gave Resident A medication she was not prescribed.	Yes

III. METHODOLOGY

05/19/2023	Special Investigation Intake 2023A0790048
05/19/2023	Special Investigation Initiated – Telephone call made. Interviewed direct care staff member (DCSM) Chastidy Johnston who functions as the house manager.
05/22/2023	APS Referral not necessary because Resident A is deceased.
05/25/2023	Contact - Document Sent- Emailed complainant a Complainant Letter.
05/25/2023	Contact - Telephone call made. Interviewed Complainant.
05/25/2023	Contact - Telephone call made. Interviewed Relative A1.
05/25/2023	Inspection Completed On-site. Interviewed DCSM Lori Robbins.
05/25/2023	Contact - Telephone call received from Ms. Johnston.
06/20/2023	Contact - Document Received- AFC Licensing Division - Incident / Accident Report (IR) received via email from Ms. Johnston.
06/21/2023	Inspection Completed-BCAL Sub. Compliance
06/21/2023	Corrective Action Plan Requested and Due on 07/07/2023.
06/26/2023	Contact – Telephone call made. Interviewed licensee Patti Holland.
06/26/2023	Exit Conference with licensee Patti Holland.

ALLEGATION:

Direct care staff member (DCSM) Chastidy Johnston who functions as the house manager gave Resident A medication she was not prescribed.

INVESTIGATION:

I interviewed Ms. Johnston via phone on 05/19/2023. Ms. Johnston confirmed she gave Resident A an unprescribed medication once on 05/14/2023 and again on 05/15/2023. Ms. Johnston said Resident A ran out of her prescribed Alprazolam (Xanax) .05 mg on 05/14/2023 and was extremely agitated. She said the pharmacy the facility uses is not open on weekends, so she was unable to call and request a refill and was concerned for Resident A's wellbeing given her agitated state. Ms. Johnston said she administered an unprescribed medication to Resident A and this medication belonged to another resident who lived at the AFC. She stated she gave Resident A half of a Klonopin tablet which was .5 mg to assist with calming her down. Ms. Johnston said Resident A's physician Doctor Edgar A. Pou had recently indicated he was going to prescribe Resident A Klonopin during his scheduled visit with Resident A at the facility on 05/16/2023. Ms. Johnston clarified that Dr. Pou had not prescribed Klonopin to Resident A at the time Ms. Johnston had given the medication to Resident A.

Ms. Johnston stated Dr. Pou did prescribe the medication during his visit with Resident A on 05/16/2023 but Resident A passed away on 05/17/2023 according to Ms. Johnston. Ms. Johnston stated the cause of Resident A's death is unknown at this time. She said she is unaware whether an autopsy will be completed.

I reviewed a BCAL Online Complaint dated 05/22/2023. The complaint indicated on 05/17/23 Resident A passed away. The complaint stated DCSM Chastidy Johnston indicated Resident A ran out of her Alprazolam (Xanax) .05 mg on 05/14/2023. On 05/17/2023 Ms. Johnston admitted she gave Resident A an unprescribed controlled substance. The complaint indicated Ms. Johnston admitted to giving Resident A Clonazepam (Klonopin) .5 mg once on 05/14/2023 and again on 05/15/2023 and borrowed the medication from another resident whose name was unknown.

I interviewed Complainant via phone on 05/25/2023. Complainant confirmed the allegations provided are accurate and comprehensive.

I interview Relative A1 via phone on 05/25/2023. Relative A1 stated a new doctor examined Resident A on 05/16/2023 and prescribed Clonazepam (Klonopin) 1 mg. Relative A1 explained the doctor had never seen or worked with Resident A prior to the visit on 05/16/2023. Relative A1 said on 05/17/2023, a DCSM, whose name Relative A1 did not know, disclosed Resident A may have been given a dose of Alprazolam (Xanax) and Clonazepam (Klonopin) at the same time on 05/14/2023 and/or 05/15/2023 and DCSM stated to Relative A1 it may have been too much for her.

Relative A1 said he was informed Resident A's prescription for Clonazepam (Klonopin) had not been delivered yet on 05/17/2023 and was not listed on her *medication administration record (MAR)*. Relative A1 stated on 05/17/2023 he was contacted via phone by DCSM Chastidy Johnston who functions as the house manager and Ms. Johnston disclosed, she administered Clonazepam (Klonopin) .5 mg once on 05/14/2023 and again on 05/15/2023 to Resident A because Resident A had run out of her Alprazolam (Xanax) and the pharmacy they use was closed on weekends. Relative A1 stated Ms. Johnston admitted she borrow the Clonazepam (Klonopin) from another resident, whose name was unknown, because Resident A was not prescribed the medication.

Relative A1 said Ms. Johnston disclosed she broke the Clonazepam (Klonopin) tablet in half and administered a half of a tablet or .5 mg to Resident A to see how Resident A would react to the medication and to ensure Resident A did not receive too high of a dose. Relative A1 said Ms. Johnston explained she would never give Resident A something she knew would be bad for her. Relative A1 disclosed he recorded the conversation with Ms. Johnston and will email the recording to the Bureau of Community and Health Systems – Michigan Department of Licensing and Regulatory Affairs (BCHS – LARA).

On 05/25/2023 I listened to the recording of Relative A1's conversation with Ms. Johnston and confirmed the information provided by Relative A1 to be accurate. Relative A1 disclosed Resident A passed away the morning of 05/17/2023. Relative A1 said he contacted the medical examiner Dan, last name unknown, to ask if Resident A taking the unprescribed Clonazepam (Klonopin) .5 mg on 05/14/2023 and 05/15/2023 could have contributed to Resident A's death. Relative A1 stated the medical examiner informed him he spoke to the pathologist involved and the pathologist indicated Resident A receiving the unprescribed Clonazepam (Klonopin) half a tablet or .5 mg on 05/14/2023 and again on 05/15/2023 would not have contributed to Resident A's cause of death. Relative A1 said Resident A's death certificate indicates Resident A died of natural causes.

Relative A1 stated he considered having an autopsy conducted on Resident A to find out additional information regarding her cause of death but determined it unnecessary after speaking to the medical examiner.

I conducted an unannounced onsite investigation on 05/25/2023 with area manager Dawn Timm. I interviewed DCSM Lori Robbins who indicated she was not working when Ms. Johnston gave Resident A medication she was not prescribed. Ms. Robbins said she subsequently heard from other DCSMs confirming this occurred. Ms. Robbins said on 05/15/2023 the pharmacy did send the prescription for Resident A's Alprazolam (Xanax) and she had her afternoon/evening dose. Ms. Robbins stated after Resident A passed away on 05/17/2023 all her medications were disposed of per protocol.

I reviewed Resident A's *Resident Records.* I reviewed Resident A's *medication administration record (MAR)* for the month of May 2023. I found Resident A was

prescribed Alprazolam (Xanax) .5 mg per tablet. Resident A was prescribed one tablet by mouth three times daily as needed for severe anxiety or panic. Resident A's *MAR* had an X entered instead of a DCSM's initials for all three entries on 05/14/2023 and 05/15/2023. A new prescription for Alprazolam (Xanax) .5 mg per tablet was entered on Resident A's *MAR* below the old prescription showing Resident A began receiving Alprazolam (Xanax) .5 mg again in the afternoon/evening of 05/15/2023.

On 05/25/2023 I spoke to Ms. Johnston via phone. Ms. Johnston admitted she took the Clonazepam (Klonopin) given to Resident A from Resident B. Ms. Johnston stated she did not document giving Resident A, Resident B's Clonazepam (Klonopin) on a *MAR* or on any other document.

I reviewed Resident B's *Resident Records* and found no evidence Clonazepam (Klonopin) had been administered to Resident A on 05/14/2023 and again on 05/15/2023. I reviewed Resident B's *MAR* for the month of May and found Resident B is prescribed Clonazepam (Klonopin) 1mg tablets and is to take a half tablet by mouth every morning, one tablet at noon, and one tablet at 3:00 p.m.

There were three entries where a DCSM had not initialed indicating Resident B received his prescribed dose of Clonazepam (Klonopin). There was no initial indicating Resident B received Clonazepam (Klonopin) 1 tablet at noon on 05/16/2023 and no initials indicating Resident B received his Clonazepam (Klonopin) 1 tablet at noon or at 3:00 p.m. on 05/17/2023.

On 06/20/2023 I reviewed an AFC Licensing Division – Incident / Accident Report (IR) dated 05/14/2023. The IR provided the following information. On 05/14/2023 Ms. Johnston was contacted via phone by the DCSM but the name was not listed. The DCSM informed Ms. Johnston Resident A ran out of her Alprazolam (Xanax) .05 mg. According to the IR Ms. Johnston drove to the facility and upon her arrival witnessed Resident A in an anxious state. Ms. Johnston said Resident A was shaking and repeating, "I need my Xanax." Ms. Johnston indicated Resident A had issues with shaking the past couple of months and had been referred to see a neurologist. Ms. Johnston said the neurologist indicated Resident A's shaking was an anxiety issue and needed to see her psychiatrist. According to the IR on 05/14/2023 Ms. Johnston said she was able to calm Resident A down somewhat while talking with her. Ms. Johnston stated she agreed to give Resident A Clonazepam (Klonopin) .5 mg even though Resident A was not prescribed this medication. Ms. Johnston said Resident A had asked her PCP to switch her from Alprazolam (Xanax) to Clonazepam (Klonopin) the month prior. Ms. Johnston said Resident A had a doctor's appointment scheduled for 05/16/2023, had previously been prescribed Clonazepam (Klonopin), and was anticipating being prescribed the medication once gain.

According to the IR Ms. Johnston said she gave Resident A Clonazepam (Klonopin) .5 mg at 7:30 p.m. on 05/14/2023 and again on 05/15/2023 at 9:30 a.m. She stated the Clonazepam (Klonopin) was given to Resident A in place of Alprazolam (Xanax).

According to the IR, Ms. Johnston admitted she took the Clonazepam (Klonopin) from another resident later informed to be Resident B. According to the IR Ms. Johnston stated on 05/15/2023 Resident A's Alprazolam (Xanax) was delivered, and that afternoon/evening Resident A began taking her prescribed medication again. According to the IR, Ms. Johnston said Resident A had a doctor's visit with Dr. Edgar A. Pou on 05/16/2023, and the doctor prescribed Resident A Clonazepam (Klonopin) 1mg.

I interviewed licensee Patti Holland on 06/26/2023 via phone and Ms. Holland disclosed Ms. Johnston admitted to her she gave Resident A medication she was not prescribed. Ms. Holland said Ms. Johnston informed her she gave Resident A medication prescribed to Resident B after Resident A ran out of her prescribed Alprazolam (Xanax) on 05/14/2023, was in an anxious state, and the pharmacy was closed. Ms. Holland said Ms. Johnston has worked for her more than a decade and this is the first incident involving Ms. Johnston giving an unprescribed medication to a resident. Ms. Holland stated she suspended Ms. Johnston for three days and Ms. Johnston was required to retake the class on medication administration. Ms. Holland said Ms. Johnston has assured her she will never give another resident an unprescribed medication and provided a signed document indicating she will never do so. Ms. Holland stated she has subsequently assigned a specific DCSM to ensure all medications are ordered in a timely manner, so no resident runs out of medication in the future.

I conducted an exit conference with licensee Patti Holland on 06/26/2023 informing her there were rule violations established because of this special investigation and a Corrective Action Plan (CAP) is required within 15 days of receipt of this Special Investigation Report (SIR).

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	Based on the information gathered during this special investigation through review of documentation, an audio recording, and interviews with DCSMs Ms. Johnston, Ms. Robbins, Relative A1, and licensee Patti Holland there is evidence indicating Ms. Johnston gave Resident A medication she was not prescribed. Ms. Johnston admitted she gave Resident A medication prescribed to Resident B on 05/14/2023 and again on 05/15/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation, an audio recording, and interviews with DCSMs Ms. Johnston, Ms. Robbins, Relative A1, and licensee Patti Holland there is evidence indicating Ms. Johnston did not complete an individual medication log containing the medication, the dosage, label instructions for use, time administered, or her initials entered at the time she administered Resident A medication not prescribed to her.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**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:	Direct care staff member Chastity Johnston knowingly gave Resident A medication that was not prescribed to her after Resident A's as-needed anxiety medication ran out. Facility direct care staff members and administration did not take preventative action to assure Resident A's medications were refilled timely so she did not have to go without medication and risk being given medication belonging to another resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

06/22/2023

Rodney Gill Date
Licensing Consultant

Approved By:

07/05/2023

Dawn N. Timm Date
Area Manager