GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 28, 2023

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

RE: License #: AL390007090
Park Place Living Centre #B
4218 S Westnedge
Kalamazoo, MI 49008

Dear Connie Clauson:

Attached is the Renewal Licensing Study Report for the facility referenced above. The study has determined substantial violations of applicable licensing statutes and administrative rules. Therefore, refusal to renew the license is recommended. You will be notified in writing of the Department's intention and your options for resolution of this matter.

Please contact me with any questions. In the event that I am not available and you need to speak to someone immediately, you may contact the local office at (517) 284-9730.

Sincerely,

Cathy Cushman

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AL390007090
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
Licensee Designee:	Connie Clauson
Administrator:	Janet White
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
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. METHODS OF INSPECTION

Date of On-site Inspections: 11/15/2023 and 10/13/2023 (interim inspection)

Date of Bureau of Fire Services Inspection if applicable: 05/01/2023

Date of Health Authority Inspection if applicable: N/A

No. of staff interviewed and/or observed 3
No. of residents interviewed and/or observed 14
No. of others interviewed 1 Role: Administrator

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.
- Medication(s) and medication record(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☒ No ☐ If no, explain.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.
- Fire drills reviewed? Yes ☒ No ☐ If no, explain.
- Fire safety equipment and practices observed? Yes ☒ No ☐ If no, explain.
- E-scores reviewed? (Special Certification Only) Yes ☐ No ☐ N/A ☒ If no, explain.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.
- Incident report follow-up? Yes ☒ No ☐ If no, explain.
- Corrective action plan compliance verified? Yes ☒ CAP date/s and rule/s: Renewal Licensing Study Report, dated 04/19/2023, CAP dated 06/02/2023, R403(10), R403(2), R407(1), R408(4) N/A ☐
- Number of excluded employees followed-up? 3 N/A ☐
- Variances? Yes ☒ (please explain) No ☐ N/A ☐
  The licensee was granted a variance to R 400.15315(3) on 06/15/2023 to use their own electronic system to track Adult Foster Care payments rather than the Department's Resident Funds II form.

  A variance was granted on 12/03/2010 for the R 400.15304(1)(b)(2) allowing the facility to have a secured fence. Residents or their designated responsbile person are required to sign a form consenting to their placement in a secured facility.

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following rules:

****To maintain the coding consistency of residents across past investigations and the current renewal, the residents in this renewal licensing report are not identified in sequential order.*

R 400.15205 Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.

(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the physician's knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.

FINDING: Direct care staff, Earlinia Moore, was hired on 09/18/2023; however, there was no statement signed by a licensed physician attesting to the physician's knowledge of Ms. Moore's physical health within 30 days of Ms. Moore's employment or assumption of duties.

REPEAT VIOLATION [SEE RENEWAL LICENSING STUDY REPORT, DATED 04/19/2023, CAP DATED 06/02/2023]

R 400.15208 Direct care staff and employee records.

(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information:
(f) Verification of reference checks.

FINDING: There were no verification of reference checks for direct care staff, Isabell Smith.

R 400.15312 Resident medications.

(2) Medication shall be given, taken, or applied pursuant to label instructions.

FINDING: Upon review of multiple resident's October 2023 electronic Medication Administration Records (eMARs), residents were not receiving their medications, as required, because medications were not in the facility, as required.

According to documentation on Resident B's generated October, she was prescribed the following medication, but the eMAR notation such as "out has been reordered" and "on order" indicated the medication was not administered:

> • Trazadone 50 mg tablet, to be administered by giving 1 tablet by mouth at bedtime. This medication was not administered to Resident B on 10/05 or 10/06.

According to documentation on Resident F's generated October eMAR, he was prescribed the following medication, but eMAR notations of "med in[*sic*] order", and "waiting for a new script" indicated the medication was not administered:

> • Prozac 20 mg capsule, to be administered by giving 1 capsule orally once a day. This medication was not administered to Resident F on 10/19, 10/20, 10/21, 10/22, 10/23, 10/24, or 10/25.

According to documentation on Resident J's generated October eMAR, she was prescribed the following medication, but eMAR notation of "on order" indicated the medication was not administered:

> • Melatonin CR 10 mg tablet, to be administered by giving 1 tablet by mouth at bedtime. This medication was not administered to Resident J on 10/24, 10/25 or 10/26.

According to documentation on Resident O's generated October eMAR, she was prescribed the following medication, but eMAR notations of "has none", "out of", and "on order" indicated the medication was not administered:

> • Lisinopril – HCTZ 20-12.5 mg, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident O on 10/05, 10/06, 10/07, and 10/08.

According to documentation on Resident P's generated October eMAR, he was prescribed the following medication, but eMAR notations of "meds not in", and "waiting for doctor" indicated the medication was not administered:

> • Quetiapine Fumarate 25 mg tablet, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident P on 10/01, 10/02, 10/03, 10/04, or 10/13.

According to documentation on Resident Q's generated October eMAR, she was prescribed the following medication, but eMAR notations of "on order", "out has been reordered", and "not in cart" indicated the medication was not administered:

• Latanoprost 0.005% eye drops, to be administered by instilling 1 drop into both eyes at bedtime. This medication was not administered to Resident Q on 10/01, 10/04, 10/05 or 10/06.

• Eliquis 2.5 mg tablet, to be administered by giving 2 tablets to equal 5 mg by mouth twice daily. This medication was not administered to Resident Q at 8 am on 10/30, 8 pm on 10/30, or 8 pm on 10/31.

According to documentation on Resident R's generated October eMAR, she was prescribed the following medication, but eMAR notations of "on order", "med on order", "empty" indicated the medication was not administered:

• Atorvastatin 20 mg tablet, to be administered by taking 1 tablet by mouth at bedtime. This medication was not administered to Resident R on 10/01, 10/02, 10/04, 10/05, 10/06, 10/08, 10/09, 10/10, 10/11, 10/13, 10/14, 10/15, 10/16, 10/17, 10/19, 10/20, 10/21, 10/23, 10/24, 10/25, 10/26, 10/27, 10/28, 10/29 or 10/31.

*It should also be noted that upon further review of Resident R's Atorvastatin medication bubble packs, a bubble pack for the medication had been delivered to the facility on 10/10/2023 indicating the medication was onsite at the facility.

According to documentation on Resident U's generated October eMAR, she was prescribed the following medication, but eMAR notations of "on order", "out has been reordered" indicated the medication was not administered:

• Atorvastatin 10 mg tablet, to be administered by taking 1 tablet by mouth at bedtime. This medication was not administered to Resident U on 10/01, 10/02, 10/03, 10/04, 10/05, 10/06, 10/27, 10/28, 10/30 or 10/31.

• Risperidone 1 mg tablet, to be administered by taking 1 tablet by mouth daily at night, along with a ½ tablet to equal 1.5 mg. This medication was not administered to Resident U on 10/01, 10/04, 10/05, or 10/06.

• Azelastine eye drops 0.05%, to be administered by instilling 1 drop into both eyes every 12 hours. This medication was not administered to Resident U on 10/24, 10/26, or 10/27.

REPEAT VIOLATION [SEE SIR 2023A0581021, DATED 04/06/2023, CAP DATED 05/10/2023.

SEE RENEWAL LICENSING STUDY REPORT, DATED 04/19/2023, CAP DATED 06/02/2023].

R 400.15316 Resident records.

(1)(d) Health care information, including all of the following:
(i) Health care appraisals.
(ii) Medication logs.
(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.
(iv) A record of physician contacts.
(v) Instructions for emergency care and advanced medical directives.

FINDING: Direct care staff, Isabelle Sanhou, acknowledged making telephone contacts to resident physicians and pharmacies relating to medications; however, there were no record of these contacts in resident records.

R 400.15318 Emergency preparedness; evacuation plan; emergency transportation.

(5) A licensee shall practice emergency and evacuation procedures during daytime, evening, and sleeping hours at least once per quarter. A record of the practices shall be maintained and be available for department review.

FINDING: There was no record of a sleeping hour fire drill for the 3rd quarter in 2023.

[REPEAT VIOLATION [SEE RENEWAL LICENSING STUDY REPORT, DATED 04/19/2023, CAP DATED 06/02/2023].

R 400.15401 Environmental health.

(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.

FINDING: Chemicals and cleaning products, including Concentrated Acid D-Lime, a floor and multi surface cleaner, detergent, crystal dri-rinse, Windex and sanitizer ES, were located under the facility's kitchen sink, which was accessible to residents.

R 400.15403 Maintenance of premises.

(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

FINDING: The cabinet under the facility's kitchen sink appeared to have water damage and was in disrepair.

The knobs on the facility's stove were missing. It was reported by direct care staff that residents had removed the knobs. The knobs could not be located during the inspection.

On 11/17/2023, I conducted the exit conference with the licensee designee, Connie Clauson, via telephone and informed her of my findings. She did not agree with the recommendation of not renewing the license as she was in the process of implementing changes at the facility. She indicated she planned to create an alert within the eMAR system to contact a designated person(s) who would then be aware of all medication errors. She stated this would eliminate medication errors or at least allow errors to be caught sooner. She also stated she would be appointing or designating a staffing director. Ms. Clauson stated she also planned to create a stronger management team to support the administrator.

IV. RECOMMENDATION

Based on the continual quality of care violations and repeated violations, refusal to renew the license is recommended.

11/20/2023

_____

Cathy Cushman — Date
Licensing Consultant

Approved:

11/28/2023

_____

Dawn Timm — Date
Area Manager