GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 4, 2024

Veronica Iacoban
28529 Cumberland
Farmington Hills, MI 48334

RE: License #: AF630400208
Investigation #: 2024A0991014
Pleasant Valley Family Care

Dear Veronica Iacoban:

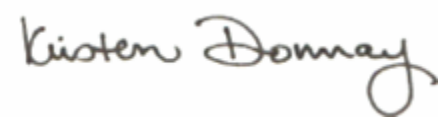
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF630400208
Investigation #:	2024A0991014
Complaint Receipt Date:	03/05/2024
Investigation Initiation Date:	03/05/2024
Report Due Date:	05/04/2024
Licensee Name:	Veronica Iacoban
Licensee Address:	28529 Cumberland Farmington Hills, MI 48334
Licensee Telephone #:	(734) 626-3257
Name of Facility:	Pleasant Valley Family Care
Facility Address:	28529 Cumberland Farmington Hills, MI 48334
Facility Telephone #:	(734) 626-3257
Original Issuance Date:	02/14/2020
License Status:	REGULAR
Effective Date:	08/14/2022
Expiration Date:	08/13/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
• Resident A had a suspected blood clot in her leg and the doctor advised her to stay in bed with her leg elevated, but staff placed her in a Geri chair all day. They ignored her request to return to her bed and she was sitting in feces for hours. • Resident A was constipated, so the caregivers used a tool to scrape the feces out of her rectum.	No
• The caregiver, Tshara, is rude and short with the residents. She scolded a resident for not eating and forced food into her mouth. • The licensee's husband, Bernard, threatened Resident A that she better not leave a bad review because he has ties to the community, and it would ruin his business and reputation.	No
Resident A's Fentanyl patch was not being changed on the required days and instructions were not being followed regarding the movement and placement of the patch.	No
Additional Findings	Yes

III. METHODOLOGY

03/05/2024	Special Investigation Intake 2024A0991014
03/05/2024	Special Investigation Initiated – Telephone Call to complainant
03/05/2024	APS Referral Referred to Adult Protective Services (APS) centralized intake
03/05/2024	Contact - Document Received Emails and pictures from complainant
03/12/2024	Inspection Completed On-site Unannounced onsite inspection
03/12/2024	Contact - Document Received Medication administration record, medical progress notes
04/17/2024	Contact - Telephone call made Interviewed hospice nurse, Ioana Dana Funelas, RN

04/17/2024	Contact - Telephone call made Interviewed Resident B's relative
04/17/2024	Contact - Telephone call made Interviewed Resident C's relatives
04/17/2024	Contact - Telephone call made Left message for Resident D's relative
04/17/2024	Contact - Telephone call received Message from Resident D's relative
04/18/2024	Exit Conference Via telephone with licensee, Veronica Iacoban

ALLEGATION:

- **Resident A had a suspected blood clot in her leg and the doctor advised her to stay in bed with her leg elevated, but staff placed her in a Geri chair all day. They ignored her request to return to her bed and she was sitting in feces for hours.**
- **Resident A was constipated, so the caregivers used a tool to scrape the feces out of her rectum.**

INVESTIGATION:

On 03/05/24, I received a complaint with concerns about the care and treatment that Resident A received while residing at Pleasant Valley Family Care. I initiated my investigation on 03/05/24 by contacting the complainant. A referral was also made to Adult Protective Services (APS) Centralized Intake.

On 03/05/24, I interviewed the complainant via telephone and reviewed her written complaint. The complainant stated that Resident A moved into Pleasant Valley Family Care in January 2024 following a stay in the intensive care unit at Providence Hospital. She stated that the owner, Veronica Iacoban, told her how wonderful her hospice nurse was and advised her that most of the residents in the home use Serenity Hospice, so she switched to Serenity Hospice. After some time, the complainant had concerns about the close relationship between the hospice nurse, Dana, and the owners of the facility. She stated that it was not clear if the hospice nurse was representing Resident A or protecting the business.

The complainant stated that on 01/24/24, she visited Resident A at the home and found her left leg and foot were swollen. She sent a picture to the hospice nurse, and the nurse stated that she would have Ms. Iacoban elevate Resident A’s leg on a pillow. After a few more days, Resident A’s leg got worse. It was more swollen and red. She

sent another picture to the hospice nurse, who consulted the hospice doctor, Dr. Ducu. The complainant spoke to Dr. Ducu and told her that Resident A's leg was swollen, hot, and red. Dr. Ducu concluded that it was likely a deep vein thrombosis (DVT), which is a blood clot in her leg. She stated that Resident A should remain in bed with the leg elevated. A few days later, the complainant visited Resident A in the home. Resident A told her that she had just returned to bed around 2:45pm from being in her Geri chair all day. Resident A stated that she had been in the chair since breakfast and asked to go back to her bed several times, but she was ignored. She had a bowel movement and was sitting in it all that time. The complainant stated that she emailed Ms. Iacoban about this, and Ms. Iacoban responded that Resident A might have asked another resident to be put back in bed, because the staff person, Tsahara does not remember being asked. The complainant stated that Resident A knows the difference between another resident and her aide. The complainant also asked Ms. Iacoban why Resident A was in the chair in the first place when she had a DVT. Ms. Iacoban stated that nobody told her she needed to remain in bed and that exercise is good for a DVT.

The complainant also stated that while Resident A was living in the home, she became constipated and was in excruciating pain. The complainant asked the caregiver, Tsahara what they gave Resident A to relieve her constipation. She replied in an annoyed tone that they had given her camphor oil and that Resident A just needed to push it out. The next morning, Resident A told the complainant that the caregivers, Tsahara and Bernard, came into her room, gave her a handful of pills, rolled her onto her side, and used a tool to scrape the feces out of her rectum. Resident A stated that it was very painful. The complainant stated that it was not a suppository or an enema, but they were scraping inside Resident A's rectum with something. The nurse was not present during this extraction and the complainant has since learned that you can put someone into cardiac arrest and kill them by doing this. The complainant stated that Resident A had a urinary tract infection (UTI) when she first moved into the home and was very confused, but after the UTI cleared up, she became much more lucid, so she believes the story to be true. The complainant stated that she decided to move Resident A from the home after this incident.

On 03/12/24, I conducted an unannounced onsite inspection at Pleasant Valley Family Care. I interviewed the licensee, Veronica Iacoban. Ms. Iacoban stated that they suspected Resident A had a blood clot because her leg was swollen. It was never officially diagnosed, because that would require her going to the hospital and she was on hospice. They started elevating her leg and the doctor prescribed Eliquis, because she had been prescribed this medication and tolerated it well before. Ms. Iacoban stated that they tried to elevate Resident A's leg, but Resident A would move it to the bed or put the pillow on top of it. They never received an order from the doctor that Resident A needed to stay in bed. Resident A wanted to be out of bed, and she would cry that she wanted to get out of her room. Resident A had a Hoyer lift and a Geri chair, so they transferred her to the chair when she asked. Ms. Iacoban stated that Resident A's daughter expressed concerns about her being up and stated that she wanted her to stay in bed, so they kept her in bed. This was the family's request and not a specific

order given by the doctor. Ms. Iacoban was not aware of Resident A asking staff to go back to her bed and being ignored. She was not aware of Resident A ever sitting in feces for an extended period of time. She stated that Resident A wore briefs and was changed regularly. She never observed any smells in the home and Resident A never had any wounds or bed sores. Resident A never complained to her about not being changed.

Ms. Iacoban stated that Resident A did have some issues with constipation. She was newly prescribed pain medications, which caused constipation. She stated that Resident A had suppositories in her comfort pack, which was provided by hospice. They put Resident A on her side and gave her a suppository. This was a one time occurrence. She was not aware of Tsahara or Bernard ever using a tool to extract feces from Resident A's rectum.

On 03/12/24, I interviewed the caregiver, Tsahara Patterson. Ms. Patterson stated that she has worked in the home for two months. She assists with cooking, cleaning, and personal care of the residents including changing and feeding them. Ms. Patterson stated that they only took Resident A out of bed when advised to do so by Ms. Iacoban, otherwise Resident A stayed in bed. She stated that they tried to keep her leg elevated when it was swollen. She denied ever ignoring Resident A when she asked to go back to her bedroom. She stated that Resident A did not talk much and never asked her to do anything. She would have to ask Resident A if she was okay or if she needed anything. Ms. Patterson stated that there was never a time when Resident A was soiled and was not changed in a timely manner. All of the residents are changed regularly. Ms. Patterson stated that she never inserted anything into Resident A's rectum when she was constipated. She stated that she believed Ms. Iacoban gave Resident A a suppository, but she was not present at the time. She never went into Resident A's room to help her with her constipation. She did not give her any laxatives and she does not administer medications. Ms. Patterson stated that Ms. Iacoban always communicates with the doctor or nurse and then advises her on what to do. She did not have any concerns about the care of the residents in the home. She stated that the owners are amazing people and she would recommend the home to anyone.

On 03/12/24, I interviewed Bernard Iacoban. Mr. Iacoban stated that he does not get involved in providing personal care to female residents in the home. He stated that he did not have any involvement when Resident A was constipated. He never put anything in her rectum to remove stool. He stated that he was not sure if she received a suppository, as this would have been administered by Ms. Iacoban. Mr. Iacoban stated that he was not aware of a time when Resident A was left sitting in feces or was ignored by Tsahara. He stated that they live in the home and he has never observed any smells. None of the residents have any sores or rashes from not being changed. They expect all of their caregivers to ensure that the residents are changed and clean for their own dignity and health.

During the onsite inspection, I observed Resident B, Resident C, and Resident D in the home. All of the residents appeared to be well cared for and clean. Resident B and Resident D were in the living room watching television. They were unable to participate in an interview due to limited cognitive abilities. Resident C was in his bedroom. He stated that he did not have any concerns about the home and they take good care of him.

During the onsite inspection, I reviewed a copy of Resident A's file and medical progress notes. On 01/13/24, the progress notes indicate that Resident A did not have a bowel movement and was given Senna. On 01/14/24, the progress notes stated that Resident A has stool she is not able to pass. She received Senna and a suppository the previous day. Resident A was asked if she would like to lay on her side instead of her back to try to pass it. Resident A ended up passing hard stool in the evening/late night. On 01/16/24, the notes state that Resident A is having normal bowel movements and is receiving Senna each day to keep her regular. On 01/24/24, the notes indicate that Resident A's leg was swollen for the first time. The nurse and doctor were notified. Resident A does not keep her leg elevated for very long. She moves, so they are trying to keep it elevated and reminding her to elevate it for the swelling. On 01/25/24, the notes state that Resident A will not keep her foot elevated. She moves her foot under the pillow constantly. On 01/27/24, the notes state that Dr. Ducu suspects DVT due to the swelling not getting better. The nurse spoke to Resident A's relative who stated Resident A was on Eliquis in the past. They will be restarting the medication and discontinuing the aspirin that was previously ordered. On 01/30/24, the notes state that Resident A's relative is concerned that Resident A should no longer be out of bed due to the possible DVT. Ms. Iacoban told her no problem and that they would keep her comfortable in bed. Resident A was crying to get out of bed. Ms. Iacoban told Resident A's relative and the nurse. They are continuing to try to elevate the leg as long as Resident A will keep it up.

On 04/17/24, I interviewed the hospice nurse from Serenity Hospice, Ioana Dana Funelas. Ms. Funelas stated that she is familiar with Pleasant Valley Family Care and has been visiting the home for the last four or five years to see hospice patients. She stated that for the last two years, she has been going to the home on more regular basis. She does not typically make an appointment and just shows up at the home. She does not have any concerns about the caregivers in the home or the care the residents are receiving. Ms. Funelas stated that she was the hospice nurse for Resident A. They suspected that Resident A had a blood clot in her leg, because her left extremity was very swollen. There was no redness or tenderness that is typical of a DVT. She sent a picture to the doctor, who ordered a blood thinner. Ms. Funelas stated that there was no specific order for Resident A to stay in bed. She stated that Resident A was not exercising or moving her leg when she was transferred to the Geri chair, so it was unlikely to cause her any harm or dislodge the blood clot. Ms. Funelas stated that after Resident A was on Eliquis, the swelling in her leg went down and it was normal by the time she moved out of the home. Ms. Funelas stated that Resident A's health improved a lot while she was residing at Pleasant Valley Family Care.

Ms. Funelas stated that the residents in the home are always clean and appear to be well cared for. She never observed anyone sitting in feces.

Ms. Funelas stated that constipation was an issue for Resident A, as she was on Fentanyl, which can cause constipation, and she was not moving around, which makes transit slower. She stated that Resident A had suppositories in her comfort pack from hospice and was aware that Ms. Iacoban had administered a suppository. Ms. Funelas stated that she was not aware of any caregivers using a tool to extract feces or manually disimpacting her. She was only aware of them using a suppository.

On 04/17/24, I interviewed Resident B's relative. She stated that Resident B has lived in the home for a year. She does not have any concerns about the home. She stated that the home is always clean and Resident B is well cared for. She never noticed any residents who had not been changed and were sitting in feces. She stated that the owners are very communicative and always keep her informed about what is going on with Resident B. She feels Resident B is receiving great care in the home.

On 04/17/24, I interviewed Resident C's relatives. They stated that Resident C has lived in the home for two years and they did not have any concerns about the home. They feel it is a fantastic place and Resident C is receiving amazing care. They stated that they do not follow the visitation policy to call in advance of visiting the home and they always show up unannounced. The home and the residents are always clean. Resident C is very comfortable in the home. They have never observed any residents sitting in feces or not being changed and cared for in a timely manner. They stated that Veronica Iacoban keeps detailed records and always keeps them informed. Resident C has never raised any concerns about the care he is receiving in the home.

APPLICABLE RULE	
R 400.1412	**Resident behavior management; prohibitions.**
	(1) A licensee shall not mistreat or permit the mistreatment of a resident by responsible persons or other occupants of the home. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk of physical or emotional harm.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that Resident A was mistreated in the home. The caregivers in the home denied ignoring Resident A's request to return to her room and denied that she was ever left sitting in feces for hours. Resident A told the complainant that the caregivers used a tool to extract stool from her rectum, but the caregivers denied that this happened. The licensee, Veronica Iacoban, stated that Resident A was given a suppository for her constipation. This information is reflected in Resident A's progress notes. The hospice nurse and

	the relatives of the other residents in the home did not express any concerns about mistreatment. They all felt that the residents were well cared for and all of their needs were being met by the caregivers. The residents appeared to be clean and well cared for during my unannounced onsite inspection.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.1416	**Resident healthcare.**
	(1) A licensee, in conjunction with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician regarding medications, special diets, and other resident healthcare needs that can be provided in the home.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that the physician's instructions were not followed when Resident A had a suspected blood clot (DVT) in her leg and was placed in her Geri chair. Resident A's progress notes do not indicate that the doctor ordered her to stay in bed and elevate her leg. The hospice nurse stated that this was not ordered by the doctor and that being transferred to a Geri chair would not likely cause any harm to Resident A. The caregivers and progress notes stated that they tried to elevate Resident A's leg, but she would often move her leg and would not keep it elevated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **The caregiver, Tshara, is rude and short with the residents. She scolded a resident for not eating and forced food into her mouth.**
- **The licensee's husband, Bernard, threatened Resident A that she better not leave a bad review because he has ties to the community, and it would ruin his business and reputation.**

INVESTIGATION:

The complaint also alleged that the caregiver, Tsahara, is rude to the residents, scolded a resident for not eating, and forced food into her mouth. The licensee's husband threatened Resident A about leaving a bad review. On 03/05/24, I interviewed the complainant via telephone and reviewed her written complaint. The complainant stated that Resident A complained about being scared in the home. She stated that the

caregiver, Tsahara, was short with her and snapped at her. The complainant stated that one time while visiting Resident A, she noticed that the skin on her legs and skin was flaking. She thought Resident A might be having an allergic reaction to the lotion they were using, so she told Resident A to have them use the lotion she brought her from home. The next day, Resident A asked Tsahara not to use the lotion because she thought she might be allergic to it. According to Resident A, Tsahara yelled and said, “Why didn’t she take it home?!” Tsahara yelled so loud that Resident A shook from being startled by her voice. Resident A also told the complainant that she heard Tsahara scolding another resident for not eating. The complainant also witnessed Tsahara scolding this resident while she was visiting the home. The resident was sitting at the dinner table with a plate of spaghetti. Tsahara said in a very firm and intimidating voice, “Stop playing with your food. Open your mouth. Open your mouth.” Resident A also reported that she saw Tsahara push food through the resident’s pursed lips telling her to eat.

The complainant also stated that after she decided to move Resident A from the home, the owner’s husband, Bernard Iacoban, went into Resident A’s bedroom and shut the door. He told her in an intimidating way that he knew people in the community and that they could lose their business if she left a negative review. Resident A felt threatened and afraid by this conversation.

On 03/12/24, I conducted an unannounced onsite inspection at Pleasant Valley Family Care. I interviewed the licensee, Veronica Iacoban. Ms. Iacoban stated that Tsahara Patterson is a live-in caregiver. She typically works five days a week during the day shift. She stated that Resident A’s family told her that Ms. Patterson has a nasty attitude, but they did not provide any specific details. She stated that she does not have any concerns about Ms. Patterson and has never received any complaints from any other family members or guardians. Everyone says good things about Ms. Patterson. Ms. Iacoban stated that Resident B has a hard time eating. You have to tell her to open her mouth while feeding her. She stated that she never observed any caregiver yelling at Resident B to open her mouth and never saw anyone forcing her to eat.

On 03/12/24, I interviewed Tsahara Patterson. Ms. Patterson denied the allegations about being rude to the residents and forcing a resident to eat. She stated that Resident B has difficulty hearing, so you have to talk louder to get her attention. She stated that she will tell Resident B to open her mouth and tells her that it is food and she has to eat. She stated that she has never forced anyone to eat and has not forced food in anyone’s mouth. Ms. Patterson stated that when Resident A told her that she might be allergic to the lotion, she stopped putting it on her. She was not rude and did not raise her voice at her.

On 03/12/24, I interviewed Bernard Iacoban. Mr. Iacoban stated that he has never observed Tsahara Patterson having an attitude or being rude to the residents. He stated that she is always bubbly and in a good mood. She is never sharp with anybody. She gives verbal cues to prompt the residents to eat, but he has never observed her forcing anyone to eat. He stated that she uses the same cues that he and Ms. Iacoban use to get Resident B's attention when feeding her. Resident B is hard of hearing and requires verbal prompts to eat. Mr. Iacoban stated that nobody else has expressed any concerns about Tsahara Patterson, but for some reason Resident A's family did not like her and they felt everything she did was wrong. They wanted Ms. Patterson fired. Mr. Iacoban stated that it was a very confusing situation. Mr. Iacoban denied threatening Resident A. He stated that he never told her not to leave a bad review or file a complaint.

On 04/17/24, I interviewed the hospice nurse from Serenity Hospice, Ioana Dana Funelas. Ms. Funelas stated that she has observed Tsahara Patterson in the home. She stated that she is pleasant and always talks nicely with the residents. She never had any concerns about any of the caregivers in the home and their interactions with the residents. She stated that on one occasion, Resident A stated that someone in the house doesn't like her. She asked her who and Resident A said never mind and it does not matter. Ms. Funelas stated that she felt Resident A did not like Ms. Patterson because she did not always sit and chat with her because she was taking care of other residents. Ms. Funelas stated that she has another resident in the home who is receiving hospice services. The caregivers have to repeat, "Open your mouth," when feeding the resident, as she requires encouragement and verbal prompts. She stated that she has never observed the caregivers force feeding anyone.

On 04/17/24, I interviewed Resident B and Resident C's relatives. I also received a voicemail message from Resident D's relative. None of the relatives had any concerns about the care being provided in the home. Resident B's relative stated that she visits with Resident B at the home briefly a few times a month. She met Tsahara Patterson on a couple of occasions. She never observed any concerning behavior. Resident C's relatives stated that they never saw Ms. Patterson being rude or raising her voice. They stated that they pop in at all times of the day. They did not have any concerns about the caregivers in the home. Resident D's relative stated that she did not have any concerns about the home and felt Resident D was being very well cared for at Pleasant Valley.

APPLICABLE RULE	
R 400.1412	**Resident behavior management; prohibitions.**
	(2) A licensee, responsible person, or any person living in the home shall not use any of the following methods of handling a resident for discipline purposes: **(e) Mental or emotional cruelty, including subjecting a resident to verbal abuse, making derogatory remarks**

	about the resident or members of his or her family or making malicious threats.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that Resident A or the other residents in the home were subjected to verbal abuse or threats. The caregivers denied being verbally aggressive towards any of the residents in the home. Tsahara Patterson denied being aggressive when trying to get Resident B to eat. The caregivers all stated that Resident B is hard of hearing and requires encouragement to open her mouth and verbal prompts to eat. Bernard Iacoban denied making a threat to Resident A about her leaving a bad review or making a complaint. The hospice nurse and the relatives of the other residents in the home never observed the caregivers being verbally abusive or rude towards the residents in the home. They did not have any concerns about the caregivers in the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A's Fentanyl patch was not being changed on the required days and instructions were not being followed regarding the movement and placement of the patch.

INVESTIGATION:

The complaint also alleged that Resident A's Fentanyl patch was not being changed and placed as required. On 03/05/24, I interviewed the complainant via telephone and reviewed her written complaint. The complainant stated that when she cared for Resident A, she was instructed to move the Fentanyl patch to a different part of her back or chest every three days when the patch was changed. She wrote the date on the patch to make sure it was changed on time. At Pleasant Valley Family Care, they put the new patch in the exact same spot of Resident A's upper back every time and there was never a date on it. The complainant stated that she mentioned this to the hospice nurse and questioned her about the patch being changed. She questioned Ms. Iacoban who replied that she had changed the patch the day before, which would have been 01/11/24. The complainant stated that Resident A's patch should have been changed on 01/03/24, 01/06/24, 01/09/24, and 01/12/24. She did not address this with them, but she hoped that the nurse's reminder would be enough to resolve the issue.

On 03/12/24, I interviewed the licensee, Veronica Iacoban. Ms. Iacoban stated that Resident A was prescribed a Fentanyl patch, which was changed every three days. She stated that there were no instructions from the doctor on where to apply the patch, but she always moved it from side to side to prevent the skin from breaking down. She

stated that she changed the patch every three days and alternated it from the left side to the right side. She stated that she documented the patch in Resident A's medication administration record, but she did not document which side it was placed on. She stated that she never put it on the same side. Resident A's family members never expressed concern to her about the placement of the Fentanyl patch.

On 03/12/24, I interviewed Bernard Iacoban. He stated that the Fentanyl patch was always moved from side to side when it was changed. The patch was replaced every three days.

On 04/17/24, I interviewed the hospice nurse from Serenity Hospice, Ioana Dana Funelas. Ms. Funelas stated that Resident A always had her Fentanyl patch on. She stated that the caregivers rotated it from side to side. She did not have any concerns about how it was being applied. She stated that they were in the process of tapering down the Fentanyl, as she felt the Fentanyl was contributing to Resident A's confusion and hallucinations. She did not have any concerns about how medications were administered in the home. She stated that Ms. Iacoban was very thorough in documenting the medications administered and would contact her if there were any issues with the medication administration records.

On 04/17/24, I interviewed Resident B and Resident C's relatives. I also received a voicemail message from Resident D's relative. None of the relatives had any concerns about the care being provided in the home. Resident C's relatives stated that Ms. Iacoban keeps thorough records for medications. She always gives them an updated medication administration record if Resident C is going to the doctor or needs to go to the hospital. It is always up to date. They did not have any concerns about how medications are administered in the home.

I reviewed a copy of Resident A's January 2024 medication administration record (MAR). It notes Resident A was prescribed Fentanyl 50mcg/1 hr TR patch with instructions to apply two patches every 72 hours as directed. The MAR notes Resident A's admission date was 01/04/24. The MAR was initialed indicating that the patches were applied on 01/07/24, 01/10/24, 01/13/24, 01/16/24, 01/19/24, 01/22/24, 01/25/24, 01/28/24, and 01/31/24.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(2) Medication shall be given pursuant to label instructions.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that Resident A's Fentanyl was not administered pursuant to label instructions. Resident A was prescribed Fentanyl 50mcg/1 hr TR patch with instructions to apply two patches every 72 hours as directed.

	The medication administration record (MAR) notes Resident A's admission date was 01/04/24. The MAR was initialed indicating that the patches were applied on 01/07/24, 01/10/24, 01/13/24, 01/16/24, 01/19/24, 01/22/24, 01/25/24, 01/28/24, and 01/31/24. The licensee, Veronica Iacoban, stated that the patch was moved from side to side each time it was changed to prevent skin breakdowns. The hospice nurse did not have any concerns regarding the administration and placement of the Fentanyl patches.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During my interview with the complainant, she stated that the caregiver, Tsahara Patterson, was living in the home. I reviewed the Bureau Information Tracking System (BITS) and noted that Tsahara Patterson was not listed as a member of the household and a criminal history check (ICHAT) had not been completed. During my onsite inspection on 03/12/24, the licensee, Veronica Iacoban, stated that Tsahara Patterson was living in the home. Ms. Patterson works as a caregiver five days a week. Ms. Iacoban stated that Ms. Patterson was not fingerprinted, and she did not have verification on file that fingerprints were obtained through the Michigan Workforce Background Check System.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt

	under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	Tsahara Patterson is a member of the household and a responsible person as a caregiver for the residents at Pleasant Valley Family Care. During my onsite inspection on 03/12/24, there was no documentation on file that Tsahara Patterson was fingerprinted through the Michigan Workforce Background Check System. She was not listed as a member of the household and did not have an ICHAT criminal history check completed.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my interview with the complainant, she stated that the caregiver, Tsahara Patterson, was living in the home. During my onsite inspection, on 03/12/24, the licensee Veronica Iacoban stated that she did not have a physical on file for Tsahara Patterson.

APPLICABLE RULE	
R 400.1405	**Health of a licensee, responsible person, and member of the household.**
	(2) A licensee shall have on file with the department a statement signed by a licensed physician or his or her designee with regard to his or her knowledge of the physical health of the licensee and each responsible person. The statement shall be

	signed within 6 months before the issuance of a license and at any other time requested by the department.
ANALYSIS:	Responsible person/member of the household, Tshara Patterson, did not have a physical on file during the onsite inspection on 03/12/24.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

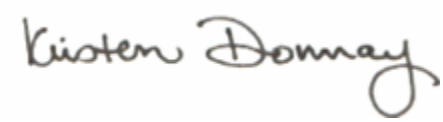
During my interview with the complainant, she stated that the caregiver, Tsahara Patterson, was living in the home. During my onsite inspection, on 03/12/24, the licensee Veronica Iacoban stated that she did not have verification of TB testing on file for Tsahara Patterson.

On 04/18/24, I conducted an exit conference via telephone with the licensee designee, Veronica Iacoban. She stated that Tsahara Patterson completed her physical and would be having her TB test read on 04/19/24. She stated that they scheduled an appointment for fingerprinting to be completed. Ms. Iacoban stated that she would submit a corrective action plan to address the violations.

APPLICABLE RULE	
R 400.1405	**Health of a licensee, responsible person, and member of the household.**
	(3) A licensee shall provide the department with written evidence that he or she and each responsible person in the home is free from communicable tuberculosis. Verification shall be within the 3-year period before employment and verification shall occur every 3 years thereafter.
ANALYSIS:	Responsible person/member of the household, Tshara Patterson, did not have a physical on file during the onsite inspection on 03/12/24.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

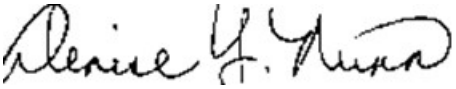
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



04/18/2024

Kristen Donnay Date
Licensing Consultant

Approved By:



06/04/2024

Denise Y. Nunn Date
Area Manager