GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 6, 2024

Patti Holland
801 W Geneva Dr.
Dewitt, MI 48820

RE: License #: AM330008452
Investigation #: 2024A0578048
Pleasant View AFC

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. 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 #:	AM330008452
Investigation #:	2024A0578048
Complaint Receipt Date:	07/19/2024
Investigation Initiation Date:	07/19/2024
Report Due Date:	09/17/2024
Licensee Name:	Patti Holland
Licensee Address:	801 W Geneva Dr. Dewitt, MI 48820
Licensee Telephone #:	(517) 669-8457
Administrator:	Patti Holland
Licensee Designee:	Patti Holland
Name of Facility:	Pleasant View AFC
Facility Address:	3016 Risdale Lansing, MI 48911
Facility Telephone #:	(517) 394-6748
Original Issuance Date:	12/12/1992
License **Status:**	REGULAR
Effective Date:	01/22/2024
Expiration Date:	01/21/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Several Residents are out of their medications.	Yes
Resident A missed his court ordered injection.	No

III. METHODOLOGY

07/19/2024	Special Investigation Intake 2024A0578048
07/19/2024	Special Investigation Initiated - Telephone
07/19/2024	APS Referral
07/22/2024	Special Investigation Completed On-site -Interview with direct care staff Alisha Baker.
07/22/2024	Contact-Document Reviewed -*Medication Administration Records* for Resident A, Resident D, Resident E, Resident F, Resident H, and Resident G.
07/22/2024	Contact-Telephone -Interview with licensee designee Patti Holland.
07/25/2024	Contact-Document Reviewed -*Second Order for Mental Health Treatment* for Resident A, dated 06/12/2023.
07/25/2024	Contact-Telephone -Interview with CEI Community Mental Health case manager Abigail Ruonavaara.
07/25/2024	Contact-Document Reviewed -*Email Correspondence*, CEI Community Mental Health case manager Abigail Ruonavaara.and Psychiatric Services Clinic Supervisor Shannon Ranshaw, RN.
09/06/2024	Exit Conference -With licensee designee, Patti Holland.

ALLEGATION: Several Residents are out of their medications.

INVESTIGATION:

On 07/19/2024, I received this complaint through the BCHS On-line Complaint System. Complainant alleged that on 07/18/2024, direct care staff reported several residents were out of their medications and “kinda freaking out.” Complainant alleged Resident A had only received two of his three morning medications on 07/18/2024. Complainant alleged Resident A has been out of his Depakote for a month and has been out of his clonidine since 07/18/2024. Complainant reported Depakote and Clonidine are prescribed for Resident A’s psychiatric diagnoses. Complainant added that Resident A has not yet experienced any serious behavior changes. Complainant reported it is unknown why these medications have not been refilled. Complainant reported there had recently been a change in the manager at this facility, which may have contributed to refills being missed.

On 07/19/2024, I reviewed the details of the allegations with Complainant. Complainant clarified the home manager, and two other staff were fired from this facility on 07/12/2024. Complainant clarified the home manager and the human resources person, Alicia Baker, were the only two staff who had been trained on the managerial responsibilities of all the residents in the facility. Complainant suspected this was why Resident A missed his medical appointment for his medication injection. Complainant reported this injection was court ordered and could not be missed. Complainant reported Alicia Baker returned from vacation around 07/16/2024.

On 07/22/2024, I completed an unannounced investigation on-site at this facility and interviewed direct care staff Alisha Baker regarding the allegations. Alisha Baker reported recently being on vacation when the previous home manager was fired along with another direct care staff. Alisha Baker reported while she was on vacation, a home manager from another facility had worked several days at this facility to help. Alisha Baker acknowledged some resident medication administrations may have been missed due to this home manager being unfamiliar with the residents and their medications. Alisha Baker acknowledged this may have resulted in medications not being ordered from the pharmacy timely. Alisha Baker reported direct care staff did not make any kind of verbal or written report regarding missing medications.

Alicia Baker disclosed that when Resident A was brought for his monthly injections to the pharmacy at CEI Community Mental Health, the transporting direct care staff was supposed to pick up Resident A’s medications. Alicia Baker reported this direct care staff forgot to obtain Resident A’s medications, which resulted in Resident A being out of his psychotropic medications. Alicia Baker reported they were able to obtain an emergency supply of three days of medications before the 30-day supply of medications could be obtained again. Alicia Baker was unsure why the 30-day supply of medications was not immediately available instead of the three-day

emergency supply, but explained this pharmacy was located at CEI Community Mental Health and this was the solution they offered.

On 07/22/2024, I reviewed the *Medication Administration Records* for Resident A. The *Medication Administration Records* for Resident A did not document the initials of the direct care staff who administered the following medications for Resident A, entered at the time the medication was given, on the following dates:

- Clonidine HCL .2 MG, HS, 07/04/2024, 07/17/2024, 07/19/2024, 07/20/2024, 07/21/2024.
- Divalproex ER 500 MG, HS, 07/04/2024, 07/17/2024, 07/19/2024, 07/20/2024, 07/21/2024.
- Levothyroxine 25 MG, HS, 07/04/2024, 07/08/2024, 07/14/2024, 07/15/2024.
- Vitamin D3 2000 MG, QD, 07/08/2024, 07/14/2024, 7/15/2024, 7/20/2024.
- Benztropine 2 MG, BID, 07/07/2024, 07/14/2024, 07/15/2024, 07/16/2024, 07/17/2024, 07/19/2024, 07/20/2024, 07/21/2024.

Medication Administration Records for Resident A documented Resident A was not provided with the following medications on the following dates:

- Clonidine HCL .2 MG, 07/16/2024, 07/18/202.

On 07/22/2024, I reviewed the *Medication Administration Records* for Resident B. *Medication Administration Records* for Resident B documented Resident B was not provided with the following medications on the following dates:

- Vitamin B-12 1000 MCG, 07/18/2024, 07/19/2024, 07/20/2024, 07/21/2024.

On 07/22/2024, I reviewed the *Medication Administration Records* for Resident C. The *Medication Administration Records* for Resident C did not document the initials of the direct care staff who administered the following medications for Resident C, entered at the time the medication was given, on the following dates:

- Cetirizine 10 MG, QD, 07/21/2024.
- Clozapine 100 MG, HS, 07/01/2024, 07/08/2024, 07/20/2024, 07/21/2024,
- Clozapine 200 MG, HS, 07/01/2024, 07/04/2024, 07/08/2024, 07/20/2024, 07/21/2024.
- Divalproex 500 MG, HS, 07/01/2024, 07/04/2024, 07/08/2024, 07/20/2024, 07/21/2024.
- Hydroxyzine 25 MG, QD, 07/21/2024
- Pantoprazole 40 MG, QD, 07/05/2024, 07/21/2024.
- Trihexyphenidyl 2 MG, QD, 07/21/2024.
- Vitamin D3 2000 QD, 07/05/2024, 07/21/2024.

On 07/22/2024, I reviewed the *Medication Administration Records* for Resident D. The *Medication Administration Records* for Resident D did not document the initials

of the direct care staff who administered the following medications for Resident D, entered at the time the medication was given, on the following dates:

- BD UF mini pen needle 5mm BID, 07/04/2024, 07/17/2024, 07/20/2024, 07/21/2024, 07/22/2024.
- Clonidine .2 milligrams HS, 07/03/2024, 07/04/2024, 07/06/2024, 07/21/2024.
- Lantus solostar 100 units QD, 07/05/2024, 07/20/2024, 07/21/2024.
- Insulin lispro 100 units BID, 07/21/2024, 07/22/2024.
- Risperidone 3 MG, QD, 07/21/2024.
- Accu check soft clicks Lancet HS, 07/22/2024.
- Alcohol 70% swabs QID, 07/22/2024.

On 07/22/2024, I reviewed the *Medication Administration Records* for Resident E. The *Medication Administration Records* for Resident E did not document the initials of the direct care staff who administered the following medications for Resident E, entered at the time the medication was given, on the following dates:

- Aspirin 81 MG, 07/19/2024.
- Famotidine 20 MG, QD, 07/04/2024, 07/06/2024, 07/17/2024.
- Earwax removal kit 6.5 5 drops twice daily in each ear HS, 07/01/2024-07/22/2024.
- Acetaminophen 325 MG, 07/03/2024, 07/04/2024, 07/06/2024, 07/08/2024, 07/09/2024, 07/10/2024, 07/11/2024, 07/16/2024, 07/17/2024, 07/18/2024, 07/19/2024, 07/22/2024.

Medication Administration Records for Resident E documented Resident E was not provided with the following medications on the following dates:

- Levothyroxine 75 MCG, 07/18/2024, 07/19/2024.
- Olopatadine HCL 0.2%, 07/18/2024, 07/19/2024.
- Omeprazole DR 40 MG, 07/18/2024, 07/19/2024.
- Vitamin D 3 07/18/2024, 07/19/2024.

On 07/22/2024, I reviewed the *Medication Administration Records* for Resident F. The *Medication Administration Records* for Resident F did not include the initials of the direct care staff who administered the following medications for Resident F, entered at the time the medication was given, on the following dates:

- Atorvastatin 20 MG, HS, 07/22/2024.
- Basglar 100UNIT 07/21/2024.
- Cetirizine 10 MG, QD, 07/23/2024, 07/24/2024, 07/25/2024.
- Jardiance 25 MG, QD, 07/23/2024.

Medication Administration Records for Resident F documented Resident F was not provided with the following medications on the following dates:

- Cetirizine HCL 10MG 7/18/2024, 7/19/2024, 7/20/2024, 7/21/2024, 7/22/2024.
- Jardiance 25MG 7/18/2024, 7/19/2024, 7/20/2024, 7/21/2024, 7/22/2024.
- Omeprazole DR 40MG 7/18/2024, 7/19/2024, 7/20/2024, 7/21/2024, 7/22/2024.
- Nabumetone 750MG 7/16/2024, 7/17/2024, 7/18/2024.
- Dicyclomine 10MG 07/18/2024, 07/19/2024.
- Metoprolol Tartrate 25MG 07/18/2024, 07/19/2024.
- Lavetiracetan 1000mg 07/18/2024, 07/19/2024.
- Memantine HCL 5MG 07/18/2024, 07/19/2024.
- Metformin HCL 1000MG 07/18/2024, 07/19/2024.
- Pregabalin 150MG 07/18/2024, 07/19/2024.
- Tamsulosin HCL 0.4MG 07/18/2024, 07/19/2024, 07/20/2024, 07/21/2024.

On 07/22/2024, I interviewed the licensee designee, Patti Holland regarding the allegations. Patti Holland reported she was aware of the allegations and that direct care staff Alicia Baker was going through all the *Medication Administration Records* to document what medications were actually missed, as Patti Holland reported she was only aware of one prescribed medication being missed. Patti Holland commented she believed the blank entries on the *Medication Administration Records* were transcription errors by direct care staff. Patti Holland denied that direct care staff or the home manager did not know how to order medications but clarified having performance issues with the previous manager which led to the current home manager being hired. Patti Holland reported this new home manager was receiving additional oversight and training from Alicia Baker. Patti Holland reported direct care staff have previously been informed of the need to use the appropriate code to document when a resident is out of the facility or refuses a medication and clarified that Alicia Baker and the new manager have recently reviewed this expectation with all staff.

According to SIR # 2023A0466046, dated 7/07/2023, the facility was in violation of rule 400.14312 when it was established that on 06/06/2023, Medication administration records for Resident C, Resident E, Resident D, Resident F, and Resident I did not contain all prescribed medications, the dosage, label instructions for use, time to be administered and the initials of the person who administers the medication as required.

According to SIR # 2024A0466041, dated 8/01/2024, the facility was in violation of rule 400.14312 when it was established that on 06/18/2024, medications were not provided to residents on a routine basis.

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 S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required. **(2) Medication shall be given, taken, or applied pursuant to label instructions.**
ANALYSIS:	Based upon my investigation, which consisted of interviews with direct care staff Alicia Baker, licensee designee Patti Holland, and CEI Community Mental Health case manager Abigail Ruonavaara. As wells as a review of pertinent documentation relevant to this investigation, Resident A, Resident B, Resident E and Resident F were not provided with multiple medications as documented on their *Medication Administration Record.* While Alicia Baker and Patti Holland identified a change in home manager at this facility as the reason for a delay in medications, this facility was previously cited for not providing residents with their prescribed medications and submitted an approved corrective action plan on 07/28/2023.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[Reference SIR #2023A0466046 dated 07/07/2023 and CAP dated 07/28/2023].**

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: **(a) Be trained in the proper handling and administration** **of medication.** **(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 upon my investigation, which consisted of interviews with direct care staff Alicia Baker, licensee designee Patti Holland, and CEI Community Mental Health case manager Abigail Ruonavaara. As wells as a review of pertinent documentation relevant to this investigation, direct care staff at this facility did not document the initials of the direct care staff administering medications to residents at the time medications were given, assuring residents received their medications as prescribed on a routine basis. While Alicia Baker and Patti Holland identified a change in home manager at this facility as the reason for a delay in medications, this facility was previously cited for not documenting whether medications were refused or administered and submitted approved corrective action plans on 07/28/2023 and 08/06/2024.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[Reference SIR #2023A0466046 dated 07/07/2023 and CAP dated 07/28/2023].** **[Reference SIR #2024A0578041 dated 08/01/2024 and CAP dated 08/06/2024].**

ALLEGATION:

Resident A missed his court ordered injection.

INVESTIGATION:

On 07/19/2024, Complainant reported being informed by Resident A that his court ordered Abilify Maintena 300 MG injection was due on 07/16/2024. Complainant added that Resident A was informed by direct care staff that his appointment would not be completed on 07/16/2024, but instead on 07/18/2024 with a few other residents as other residents had appointments that day as well. When Complainant asked if it was okay for Resident A to have a couple days overlap with his Abilify Maintena 300 MG injection, Complainant was informed by direct care staff that it

“should be fine.” Complainant alleged Resident A was two days late for his court ordered injection.

On 07/22/2024, Alicia Baker acknowledged that Resident A was taken on 07/18/2024 instead of 07/16/2024 as Resident A is allowed to go to Community Mental Health within 48 hours of his injection due date to be in compliance with his court order and maintain his psychiatric needs. Alicia Baker was unaware of any specific physician or court order that approved this practice.

On 07/25/2024, I reviewed the *Second Order for Mental Health Treatment* for Resident A provided by the State of Michigan Probate Court of Ingham County on 06/12/2023. The *Second Order for Mental Health Treatment* for Resident A documented that Resident A is ordered to comply with the following assisted outpatient services: Case management, individual and group therapy, supervised living, and medication including injectables.

On 07/22/2024, Patti Holland confirmed that Resident A ordinarily receives his prescribed injection at CEI Community Mental Health. Patti Holland clarified since this medication is not administered by any direct care staff in this facility, Resident A’s injections are not recorded with a *Medication Administration Record* or medical appointment record. Patti Holland also believed Resident A could be provided with his Abilify Maintena 300 MG injection after the scheduled date for up to 48 hours.

On 07/25/2024, I reviewed the details of the allegations with CEI Community Mental Health case manager Abigail Ruonavaara. Abigail Ruonavaara reported that even though Resident A did not go to CEI Community Mental Health on 07/16/2024, he was still compliant with his court order relating to his prescribed Abilify Maintena 300 MG injection.

On 07/25/2024, I reviewed an email correspondence between CEI Community Mental Health case manager Abigail Ruonavaara.and Psychiatric Services Clinic Supervisor Shannon Ranshaw, RN. Shannon Ranshaw documented on 07/24/2024 that Resident A is on Abilify Maintena 300 MG every four weeks. Shannon Ranshaw documented Resident A can receive this medication up to two weeks late without needing additional medication to get “restarted” with this court ordered medication.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based upon my investigation, which consisted of interviews with direct care staff Alicia Baker, licensee designee Patti Holland, and CEI Community Mental Health case manager Abigail Ruonavaara. As wells as a review of pertinent documentation relevant to this investigation, there was not enough evidence to substantiate the allegation that Resident A was not provided with the level of supervision, protection, and personal care to be in compliance with his court ordered Abilify Maintena 300 MG injection.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

09/06/2024

Eli DeLeon Date
Licensing Consultant

Approved By:

09/06/2024

Dawn N. Timm Date
Area Manager