



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 4, 2026

Patti Holland
801 W Geneva Dr.
Dewitt, MI 48820

RE: License #: AM330073582
Investigation #: 2026A1024022
Simken 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 was required. On April 1, 2026, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (616) 356-0183.

Sincerely,

A handwritten signature in cursive script that reads "Ondrea Johnson".

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM330073582
Investigation #:	2026A1024022
Complaint Receipt Date:	03/11/2026
Investigation Initiation Date:	03/11/2026
Report Due Date:	05/10/2026
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:	Simken Adult Foster Care
Facility Address:	3600 Simken Lansing, MI 48910
Facility Telephone #:	(517) 394-3058
Original Issuance Date:	03/12/1997
License Status:	REGULAR
Effective Date:	03/23/2026
Expiration Date:	03/22/2028
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS

	AGED
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II. ALLEGATION(S)

	Violation Established?
Staff failed to administer Resident A’s newly prescribed medication Clozaril for about a week after he was discharged from psychiatric hospitalization.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/11/2026	Special Investigation Intake 2026A1024022
03/11/2026	Special Investigation Initiated – Telephone with direct care staff members Deshia Lane and Autica Allen
03/11/2026	APS Referral not warranted
03/17/2026	Contact - Telephone call made with Resident A's case manager Sarah Landers
03/17/2026	Contact-Document Received- Resident A’s <i>Medication List at Discharge</i>
03/24/2026	Inspection Completed On-site with direct care staff member Alicia Baker
04/01/2026	Inspection Completed-BCAL Sub. Compliance
04/01/2026	Exit Conference with licensee designee Patti Holland
04/01/2026	Corrective Action Plan Requested and Due on 04/16/2026
04/01/2026	Corrective Action Plan Received
04/01/2026	Corrective Action Plan Approved

ALLEGATION: Staff failed to administer Resident A's newly prescribed medication Clozaril for about a week after he was discharged from psychiatric hospitalization.

INVESTIGATION:

On 3/11/2026, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged staff failed to administer Resident A's newly prescribed medication Clozaril for about a week after he was discharged from psychiatric hospitalization.

On 3/11/2026, I conducted an interview with direct care staff members Deshia Lane and Autica Allen. Deshia Lane stated that Resident A had issues with receiving his newly prescribed medication as instructed when he was discharged from the psychiatric hospital on 2/26/2026 because the staff person who received the medication from the pharmacy delivery staff person was new and did not follow their proper medication protocol. Deshia Lane stated this direct care staff member did not document the new medication on Resident A's *Medication Administration Record (MAR)* or immediately notifying the home manager of the new medication. Deshia Lane stated that she was first made aware of Resident A's new medication Clozaril when Resident A's case manager Sarah Landers contacted her on 3/3/26 to get an update on Resident A's condition in response to the new medication that was prescribed. Deshia Lane stated during this time she explained to Sarah Landers that she did not know anything about the medication and reported her conversation with Sarah Landers to the house manager Autica Allen who further investigated this matter. Deshia Lane stated that due to the breakdown in the communication by staff members, Resident A did not start taking his Clozaril medication until 3/7/2026 instead of the start date of 2/26/2026.

Autica Allen stated she is the home manager of the facility and on 3/3/2026 she learned that Resident A had a new medication, Clozaril, delivered to the facility on 2/26/2026 by the pharmacy however the new medication was not documented on Resident A's MAR nor was it reported to her that Resident A was supposed to start this new medication which is a standard protocol when new medications are prescribed to residents. Autica Allen stated there was confusion around this medication because when she learned about Resident A needing to take this medication, the nurse mentioned to her that he needed to wait to take the medication however another hospital staff member then stated that it was okay for him to take the medication. Due to contradictory instructions, Autica Allen stated she made several attempts to contact Resident A's doctor's office to ensure that Resident A was in fact supposed to take the Clozaril medication ordered at the time of his discharge. Autica Allen stated that nevertheless, the medication was not administered in a timely manner due to their medication protocol not being followed properly by the staff member who received the medication from the pharmacy and staff failing to review Resident A's medication list when he was discharged. Autica Allen stated that although Resident A was supposed to start taking this medication on 2/26/2026, he did not begin the medication until 3/7/2026.

On 3/17/2026, I conducted an interview with Resident A's case manager Sarah Landers who stated that while Resident A was in the psychiatric hospital, he began taking Clozaril 350mg and when he was discharged back to his adult foster care facility on 2/26/2026 staff members failed to administer this new medication for a week despite the medication being dropped off by the pharmacy and in staff's possession. Sarah Landers stated that verbal instructions were given to staff members at the time of Resident A's discharge by hospital staff to start administering this new medication and staff members also had Resident A's new medication list that clearly showed that Resident A was supposed to have this new medication administered to him.

On 3/17/2026, I reviewed Resident A's *Medication List at Discharge* which documented that as of 2/26/26 at 1:42pm Resident A should be given 7 tablets (350mg total) of Clozaril 50mg by mouth nightly.

On 3/24/2026, I conducted an onsite investigation at the facility with direct care staff member Alicia Baker who stated that it was reported to her that staff delayed giving Resident A his Clozaril medication for seven days due to staff failing to add this medication to Resident A's MAR once it was ordered and dropped off by the pharmacy. Alicia Baker stated that staff did not follow their medication procedures as they were supposed to contact the home manager when the new medication was dropped off to the facility, however this did not occur.

While at the facility, I reviewed Resident A's *Medication Administration Record (MAR)* for February and March of 2026 which documented that Resident A began taking Clozaril 50mg medication on 3/7/2026.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	Based on my investigation which included interviews with direct care staff members Deshia Lane, Autica Allen, Alicia Baker, Resident A's case manager Sarah Landers, review of Resident A's <i>Medication List at Discharge, Medication Administration Record (MAR)</i> there is evidence to support the allegation staff failed to administer Resident A's newly prescribed medication Clozaril for about a week after he was discharged from psychiatric hospitalization. According to Sarah Landers, staff was instructed by hospital staff to give the new medication Clozaril to Resident A, at the time of his discharge and was provided with a medication list which included this new medication and the medication start date. Autica Allen and Deshia Lane both stated that facility medication procedures were not followed at the time Resident A was returned from the psychiatric hospital which resulted in Resident A missing his medication for 10 days. I reviewed Resident A's <i>Medication List at Discharge</i> which documented that Resident A should begin taking Clozaril 50mg seven tablets a day with a start date of 2/26/2026 however Resident A' MAR shows that staff did not administer this medication until 3/7/2026. Therefore, Resident A was not administered his medication as prescribed.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION:

While at the facility, I reviewed Resident A's MAR which documented Resident A's medication Clozaril 50mg medication. There was no other information noted on this MAR as it pertains to dosage, label instructions for use and time to be administered for this medication.

APPLICABLE RULE	
R 400.675	Resident medications.
	<p>(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident:</p> <p>(b) Complete an individual medication log that contains all of the following:</p> <ul style="list-style-type: none"> (ii) Dosage. (iii) Label instructions for use. (iv) Time to be administered.

ANALYSIS:	While at the facility, I reviewed Resident A's MAR which only documented Resident A's medication Clozaril 50mg medication. There was no other information noted on this MAR as it pertains to dosage amount, label instructions for use and time to be administered for this medication.
CONCLUSION:	VIOLATION ESTABLISHED

On 4/1/2026, I conducted an exit conference with licensee designee Patti Holland. I informed Patti Holland of my findings and allowed her an opportunity to ask questions and make comments. On 4/1/2026 I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

I recommend the current license status remain unchanged.

Ondrea Johnson

Ondrea Johnson
Licensing Consultant

4/28/2026
Date

Approved By:

Dawn Timm

05/04/2026

Dawn N. Timm
Area Manager

Date