



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 29, 2026

Patti Holland
801 W Geneva Dr.
Dewitt, MI 48820

RE: License #: AM330073582
Investigation #: 2026A1024027
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 May 13, 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 #:	2026A1024027
Complaint Receipt Date:	04/16/2026
Investigation Initiation Date:	04/16/2026
Report Due Date:	06/15/2026
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 AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A missed a scheduled lab draw ordered by his medical provider due to staff issues.	Yes

III. METHODOLOGY

04/16/2026	Special Investigation Intake 2026A1024027
04/16/2026	Special Investigation Initiated – Telephone left voicemail for Resident A's case manager Sara Landers
04/16/2026	APS Referral not warranted
04/20/2026	Contact - Telephone call made with direct care staff member Autica Allen
04/27/2026	Contact - Telephone call made with Resident A's nurse Lisa Ross from Community Mental Health (CMH)
04/29/2026	Inspection Completed On-site with Resident A and direct care staff member Alcia Baker
05/13/2026	Exit Conference with licensee designee Patti Holland
05/13/2026	Inspection Completed-BCAL Sub. Compliance
05/13/2026	Corrective Action Plan Requested and Due on 5/28/2026
05/13/2026	Corrective Action Plan Received
05/13/2026	Corrective Action Plan Approved

ALLEGATION: Resident A missed a scheduled lab appointment ordered by his medical provider due to staff issues.

INVESTIGATION:

On 4/16/2026, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged Resident A missed a scheduled lab appointment ordered by his medical provider due to staff issues.

On 4/20/2026, I interviewed direct care staff member Autica Allen, who reported that she serves as the house manager. She stated that she was notified by telephone from

Resident A's CMH nurse that Resident A needed to have his blood drawn on 4/10/2026 due to a psychiatric medication he is taking. Autica Allen stated she followed facility procedures and documented the appointment on the facility calendar, where all resident appointments are recorded. She explained that the facility has three staff members assigned specifically to transport residents to medical appointments. However, on 4/10/2026, the staff member scheduled to transport Resident A called off due to illness and failed to notify any other staff that Resident A still needed transportation. As a result, Resident A missed his appointment. Ms. Allen stated that once she became aware of the missed appointment, she contacted her supervisor and arranged for Resident A to have his blood drawn approximately five days later. She also reported that, following this incident, staffing adjustments were made to increase the number of employees available for resident transportation, and she is now an assigned driver responsible for ensuring that Resident A attends all future medical appointments.

On 4/27/2026, I conducted an interview with Resident A's nurse Lisa Ross who stated that she contacted direct care staff member Autica Allen in March 2026 and provided clear instructions that Resident A needed to have his blood drawn every Friday for the next six months to monitor his blood levels due to a psychiatric medication, Clozapine 400mg, that he is prescribed to take daily. Lisa Ross stated that unfortunately, Resident A missed his third scheduled blood drawn appointment on 4/10/2026 and did not make up this appointment until five days later due to an oversight by staff. Lisa Ross stated that these lab medical appointments are very critical for Resident A to make due to potential complications that could occur from taking this medication. Lisa Ross stated she has provided consultation to staff members, so they are aware of the seriousness of the medical appointments.

On 4/29/2026, I conducted an onsite investigation at the facility with Resident A and direct staff member Alicia Baker. Resident A stated that he is ordered to have his blood drawn every week and staff members have been transporting him to his appointments regularly.

Alicia Baker stated that it was reported to her that one of the facility scheduled drivers called off work and failed to communicate to other staff members who transport residents that Resident A had a medical appointment on 4/10/2026 to have his blood drawn as ordered by his mental health provider. Consequently, Resident A missed this scheduled blood draw. Alicia Baker stated that additional staff members have been assigned as drivers to alleviate this issue in the future.

APPLICABLE RULE	
R 400.689	Resident health care.
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.

ANALYSIS:	<p>Based on my investigation which included interviews with direct care staff members Autica Allen, Alicia Baker, Resident A, and CMH nurse Lisa Ross there is evidence Resident A missed a scheduled lab appointment ordered by his medical provider due to staff issues.</p> <p>According to Autica Allen and Alicia Baker, the scheduled driver called off work and did not inform the other transportation staff that Resident A had a blood draw appointment on 4/10/2026, which had been ordered by his mental health provider. As a result, Resident A missed the appointment. Lisa Ross stated that she informed Autica Allen in March 2026 that Resident A needed weekly Friday blood draws for six months to monitor the effects of his prescribed psychiatric medication, Clozapine 400 mg. Despite these instructions, Resident A missed his third scheduled blood draw on 4/10/2026 and did not complete it until five days later due to staff oversight. Therefore, the licensee did not follow the instructions and recommendations of Resident A's health care professional.</p>
CONCLUSION:	VIOLATION ESTABLISHED

On 5/13/2026, 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 5/13/2026, I received and approved of an acceptable corrective action.

IV. RECOMMENDATION

An acceptable corrective action plan was received; therefore, I recommend the current license status remain unchanged.



Ondrea Johnson
Licensing Consultant

5/28/2026
Date

Approved By:



05/29/2026

Dawn N. Timm
Area Manager

Date