GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 3, 2020

Carol Gardiner
Pleasant View Manor Inc
6153 Brown Road
Parma, MI 49269

RE: License #: AL380007066
Investigation #: 2020A0007007
Pleasant View Manor Inc

Dear Mrs. Gardiner:

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 (313) 456-0380.

Sincerely,

Mahtina Rubritius

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
301 E. Louis Glick Hwy
Jackson, MI 49201
(517) 262-8604

Enclosures

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

I. IDENTIFYING INFORMATION

License #:	AL380007066
Investigation #:	2020A0007007
Complaint Receipt Date:	11/08/2019
Investigation Initiation Date:	11/12/2019
Report Due Date:	01/07/2020
Licensee Name:	Pleasant View Manor Inc
Licensee Address:	6153 Brown Road Parma, MI 49269
Licensee Telephone #:	(517) 531-4226
Administrator:	Carol Gardiner
Licensee Designee:	Carol Gardiner
Name of Facility:	Pleasant View Manor Inc
Facility Address:	6153 Brown Road Parma, MI 49269
Facility Telephone #:	(517) 531-4226
Original Issuance Date:	05/28/1985
License **Status:**	REGULAR
Effective Date:	08/08/2019
Expiration Date:	08/07/2021
Capacity:	16
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Allegations that Resident A's medications were not administered as prescribed.	Yes
Resident A showers and puts on dirty clothes.	No
Additional Findings	Yes

III. METHODOLOGY

11/08/2019	Special Investigation Intake - 2020A0007007
11/12/2019	Special Investigation Initiated - Letter APS Referral
11/12/2019	APS Referral made.
12/05/2019	Inspection Completed On-site- Unannounced - Face to Face contact with Mrs. Gardiner, Employee #1, Resident A, and other residents.
01/02/2020	Inspection Completed On-site- Unannounced - Face to face with Mrs. Gardiner, Employee #1, Resident A and other residents.
01/02/2020	Exit Conference with Mrs. Gardiner.

ALLEGATIONS:

Allegations that Resident A's medications were not administered as prescribed.

INVESTIGATION:

On November 8, 2019, I spoke with the Complainant. I was informed that Resident A did not receive her medications (Remeron and Seroquel) as prescribed. On November 8, 2019, it was discovered that Resident A's medications ran out approximately two weeks ago and the medications were not refilled. Carole Gardiner, Licensee, reported to Resident A's case manager (CM #1) that the medications did not work, and she wanted a different medication prescribed; so she (Mrs. Gardiner)

was going to address this issue with Resident A's doctor (Dr. #1) at the next appointment, which was scheduled for November 14, 2019.

According to the Complainant, CM #1 contacted Dr. #1's office on November 8, 2019, regarding the medications and a prescription was called in to Pharmacy #1.

On December 5, 2019, I conducted an unannounced on-site inspection and made face to face contact with Mrs. Gardiner, Employee #1, Resident A, and other residents. I interviewed Mrs. Gardiner and Employee #1. I inquired about Resident A running out of her medications, specifically, the Remeron and Seroquel. Mrs. Gardiner reported that Resident A did not run out of these medications and she didn't know why someone would make those allegations. According to Mrs. Gardiner, Resident A can't sit or sleep when taking the Remeron. I inquired if Mrs. Gardiner planned to discuss her concerns with Dr. #1 and if these matters were addressed during the visit on November 14, 2019. Mrs. Gardiner informed me that I needed to speak with Employee #1, as she assists with the doctor appointments.

I spoke with Employee #1 and she reported that she did not recall Resident A running out of the medications. According to Employee #1, when Resident A takes the medication, Remeron, she's restless. Resident A is in and out of the bathroom and other resident bedrooms. Resident A has also taken items from other residents and hid them in her room. Employee #1 reported that Resident A has also dementia. Employee #1 reported that she planned to speak to Dr. #1 regarding her concerns with the medications not working. I inquired if she attended the appointment on November 14, 2019, and Employee #1 informed me that she did not; they were unable to go to the appointment due to transportation issues. Employee #1 reported that her vehicle is now fixed. I inquired about the follow-up appointment and Employee #1 could not provide a date of the next appointment. While I was at the facility, Employee #1 called and scheduled the follow-up appointment with Dr. #1 for December 10, 2019.

While at the facility, I reviewed the prescribed medications for Resident A. It was noted that the medications Remeron and Seroquel were filled on November 8, 2019. I informed Mrs. Gardiner that the prescriptions were filled on the same day that it was alleged and discovered that the medications had run out. Mrs. Gardiner did not recall exactly who called the pharmacy to refill the prescription. It was also discovered that based on the date that the prescription was filled and the number of tablets that remained in the bubble packet; Resident A was not receiving her Remeron as prescribed. When this issue was brought to Mrs. Gardiner's attention, she admitted that she has been giving Resident A the Seroquel, but not the Remeron. I reminded Mrs. Gardiner that medications cannot be modified prior to approval from the doctor. Mrs. Gardiner stated she did speak with Resident A's case manager (CM #1) and told her that the Remeron "speeds her up and she can't sit still for two seconds."

On January 2, 2020, I conducted an unannounced on-site investigation and made face to face contact with Mrs. Gardiner, Employee #1, Resident A and other residents.

According to Employee #1, Resident A's medications (Remeron and Seroquel) were discontinued on December 12, 2019. I reviewed the medication logs and the medications were no longer listed. In addition, Employee #1 provided a copy of the hand-written note, which was on a notepad with letterhead, documenting that the medications were discontinued. Employee #1 also informed me that Dr. #2 was trying to prescribe a medication to help Resident A sleep, but in the meantime, she's to use Melatonin. This supplement was listed on the medication log.

While at the facility, I observed that several resident medications set up in advance. The medications were in cups and lined up on the countertop. I reminded Mrs. Gardiner that the medications could not be set up in advance. Mrs. Gardiner is aware of this rule.

On January 2, 2020, I conducted the exit conference with Mrs. Gardiner and informed her that these allegations would be substantiated.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Resident A did not receive her medications as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

Resident A showers and puts on dirty clothes.

INVESTIGATION:

According to the Complainant, Resident A has been wearing the same outfit for about two weeks. Resident A has Alcohol Induced Syndrome and she is confused. Resident A will take a shower and she's putting on dirty clothes. Per the Complainant, CM #1 spoke with Employee #1 regarding this matter. This issue was also discussed during a meeting with the Mrs. Gardiner, Licensee. According to the Complainant, Mrs. Gardiner thinks that Resident A is being stubborn.

On January 2, 2020, I spoke to Mrs. Gardiner and Employee #1. According to Mrs. Gardiner, Resident A gets up early and she showers on her own. In addition, that Resident A use to work at a donut shop, and she (Resident A) has a shirt from her previous place of employment. Mrs. Gardiner stated that it's Resident A's favorite shirt.

According to Employee #1, Resident A likes the shirt and they wash it at least twice a week. Per Employee #1, Resident A's daughter also purchased her some outfits. Both Employee #1 and Mrs. Gardiner report that Resident A dresses herself. Mrs. Gardiner stated there is a stain on Resident A's favorite shirt, but that she's not wearing dirty clothing. Employee #1 stated that Resident A's daughter will write out a list of reminders for Resident A, as to how her hygiene is to be addressed.

While at the facility, I reviewed the AFC Assessment Plan for Resident A. Regarding bathing and hygiene, it was documented that Resident A requires prompts.

I interviewed Resident A and she appeared to be neat, clean, and appropriately dressed. She had on a pink sweater, a zip up sweatshirt and jeans. She informed me that she dresses herself. Resident A confirmed that she previously worked in a donut shop, but she did not confirm that she had a favorite shirt from that establishment. I inquired if she has clean clothes to wear and Resident A replied "always." She didn't confirm the allegations of showering and putting dirty clothes on. I inquired if she had any concerns about the home, and she did not.

On January 2, 2020, I conducted the exit conference with Mrs. Gardiner and informed that these allegations were unfounded.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(4) A licensee shall afford a resident opportunities, and instruction when necessary, to dress as fashion, fit, cleanliness, and season warrant.

ANALYSIS:	Based on the information gathered during this investigation and provided above, it's concluded that there is not a preponderance of the evidence to support the allegations that Resident A showers and puts dirty clothes back on. According to Mrs. Gardiner, Resident A has a favorite shirt, which has a stain, that she wears often. Employee #1 reported to wash the shirt at least twice a week. Resident A reports to "always" have clean clothes available. During the interview, Resident A was observed to be neat, clean, and appropriately dressed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

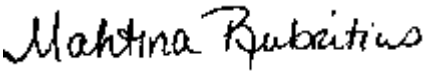
While at the facility, I observed that several resident medications set up in advance. The medications were in cups, lined up on the countertop. I reminded Mrs. Gardiner that the medications could not be set up in advance. Mrs. Gardiner is aware of this rule.

APPLICABLE RULE	
R 400.15312	**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 {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	On January 2, 2020, I observed several resident medications set up in advance. The medications were in cups, lined up on the countertop. THIS IS A REPEAT VIOLATION: SIR # 2018A0007034
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

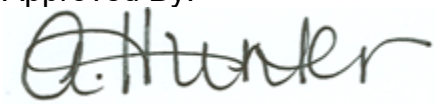
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



1/2/2020

Mahtina Rubritius — Date
Licensing Consultant

Approved By:



1/3/2020

Ardra Hunter — Date
Area Manager