GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 18, 2022

Autumn Taylor
Pleasant Pines LLC
55871 Frank Jones Road
Mendon, MI 49072

RE: License #: AS750395484
Investigation #: 2022A0581015
Pleasant Pines

Dear Ms. Taylor:

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) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS750395484
Investigation #:	2022A0581015
Complaint Receipt Date:	01/11/2022
Investigation Initiation Date:	01/13/2022
Report Due Date:	03/12/2022
Licensee Name:	Pleasant Pines LLC
Licensee Address:	55871 Frank Jones Road Mendon, MI 49072
Licensee Telephone #:	(269) 496-9667
Administrator:	Kimberly Shapley
Licensee Designee:	Autumn Taylor
Name of Facility:	Pleasant Pines
Facility Address:	55871 Frank Jones Road Mendon, MI 49072
Facility Telephone #:	(269) 496-9667
Original Issuance Date:	10/09/2018
License **Status:**	REGULAR
Effective Date:	04/08/2021
Expiration Date:	04/07/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's evening medications were discovered missing from the evening blister packs on 01/11/2021.	Yes

III. METHODOLOGY

01/11/2022	Special Investigation Intake 2022A0581015
01/13/2022	Special Investigation Initiated - Telephone Email correspondence with licensee, Autumn Taylor.
01/13/2022	Referral - Law Enforcement St. Joe County sheriff's dept received referral regarding missing medication. Complaint # 235-22
01/19/2022	Contact - Telephone call received Interview with licensee designee, Ms. Taylor
01/19/2022	Contact - Document Received Email from Ms. Taylor.
01/20/2022	Contact - Document Received Received staff statements via email.
01/21/2022	Inspection Completed On-site Interviewed Resident A and staff. Observed resident medication.
01/21/2022	Inspection Completed-BCAL Sub. Compliance
01/26/2022	Exit conference with licensee designee, Autumn Taylor, via telephone.

ALLEGATION:

Resident A's evening medications were discovered missing from the evening blister packs on 01/11/2021.

INVESTIGATION:

On 01/11/2021, the facility's licensee designee, Autumn Taylor, contacted Adult Foster Care Consultant, Eli Deleon, to report facility staff discovered Resident A's evening medications were missing for an entire week. Ms. Taylor explained to Mr. Deleon Resident A receives his medication in weekly blister packs, so for one day all his morning medications are in one blister, all his noon medications are in one blister pack, and all his bedtime medications are in one blister pack. Ms. Taylor reported to Mr. Deleon she was unsure when the medications went missing as they had been delivered to the facility several weeks ago.

On 01/13/2022, I requested Ms. Taylor send via email a picture of the blister pack that was missing Resident A's bedtime medications for the week in question. Ms. Taylor emailed me pictures of the 7 day blister pack for the week of 01/10/2022 through 01/16/2022. The blister pack contained two cards of medications with the first card only containing one medication, Levothyroxine sodium, 25 mcg, that was to be administered to Resident A on an empty stomach and without his other medications. The remaining noon, evening, and bedtime blister packs on this card were empty. The second medication card contained the remaining morning medications prescribed to Resident A, his noon medications, and empty blister packs for his evening medications; however, the inside cover of the blister packs indicated Resident A does not receive evening medications; only morning, noon, and bedtime. I did not observe any bedtime blister packs on this card indicating the entire weeks' worth of Resident A's bedtime medications were missing from the 7 day blister card. The medications that were supposed to be in Resident A's evening blister packs were the following:

- Divaproex Sodium ER 500 mg
- Midodrine Hydrochloride 5 mg
- Olanzapine 20 mg
- Oxybutynin Chloride 5 mg
- Clonzapam 1 mg
- Quetiapine Fumarate ER 400 mg

On 01/19/2022, I interviewed Ms. Taylor via telephone. Ms. Taylor stated Resident A hadn't missed any of his bedtime medications; despite them being missing, because staff utilized Resident A's fourth weekly blister pack to administer the medications while the pharmacy worked with Resident A's insurance company to get duplicate bedtime medications for the missing week. Ms. Taylor stated she had all the staff take drug tests to determine if any of the staff had used Resident A's bedtime medications; however, all their urine screens were clear for the medications

indicating none of the staff ingested any of Resident A's bedtime medications. Ms. Taylor also indicated the facility's home manager, Darla Smith-McNett, would be sure to count all the medications and open the blister packs with multiple cards to ensure none of the morning, noon, evening, or bedtime medications are missing. Ms. Taylor indicated it's possible the blister pack came to the facility missing the bedtime medications by error from the pharmacy; however, there was no way to tell since Ms. Smith-McNett did not catch the error until weeks after receiving the 7 day blister packs.

Ms. Taylor also sent me via email copies of staff's written statements pertaining to the missing medications. I received written statements from Dean Kline (3rd shift staff), Victoria Schwartz (1st shift staff), Jaclyn Gesell (3rd shift staff), Darla Smith-McNett (1st shift staff/home manager), and Linda Oastendorp (1st shift staff). All five direct care staff denied taking Resident A's bedtime medications from his 7 day blister pack. They also denied knowing how these medications went missing.

On 01/21/2022, I conducted an announced on-site inspection at the facility. I interviewed Ms. Smith-McNett. Her statement to me was consistent with her written statement. Ms. Smith-McNett showed me the medication room, which is located within a locked closet within a locked staff room. Ms. Smith-McNett stated pantry type items are also kept in the locked closet so all staff would be able to access the area, including the medications. She stated since the incident, it was the facility's intention to implement an additional measure to prevent medications from being taken. She indicated the facility would obtain a locked cabinet for safekeeping resident medications and the locked cabinet would be kept within the locked closet.

I observed Resident A's 7 day blister with the missing bedtime medications. My observation of the blister pack was consistent with what was explained to me by Ms. Taylor and my observations from the pictures she sent me.

I interviewed Resident A while at the facility. Resident A was able to report the times of day he receives medications, which was morning, noon, and bedtime. He stated he receives his medications, as required, and had no complaints pertaining to the facility.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on my investigation, Resident A's bedtime medication from 01/10/2022 through 01/16/2022 went missing from the facility indicating they were taken by someone who had access to them. Subsequently, the licensee did not ensure Resident A's bedtime medications were safeguarded to prevent them from being used by a person other than Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/26/2022, I conducted an exit conference with the licensee designee, Autumn Taylor, via telephone. Ms. Taylor acknowledged my findings. She stated having staff review the medications more thoroughly upon receiving them from the pharmacy would catch any errors, if made by the pharmacy. She also stated she installed cameras in the medication room on 01/25/2022 as an extra precaution.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

Cathy Cushman

01/26/2022

_____

Cathy Cushman Date
Licensing Consultant

Approved By:

Dawn Timm

02/18/2022

_____

Dawn N. Timm Date
Area Manager