GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 22, 2022

Julie Brooks
Pleasant View Manor, Inc.
16000 Pine Lake Ave.
Sand Lake, MI 49343

RE: License #: AM410377803
Investigation #: 2022A0357017
Pleasant View Manor

Dear Ms. Brooks:

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 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 (616) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM410377803
Investigation #:	2022A0357017
Complaint Receipt Date:	04/15/2022
Investigation Initiation Date:	04/15/2022
Report Due Date:	06/14/2022
Licensee Name:	Pleasant View Manor, Inc.
Licensee Address:	16000 Pine Lake Ave. Sand Lake, MI 49343
Licensee Telephone #:	(616) 696-2400
Administrator:	Julie Brooks
Licensee Designee:	Julie Brooks
Name of Facility:	Pleasant View Manor
Facility Address:	16000 Pine Lake Ave. Sand Lake, MI 49343
Facility Telephone #:	(616) 696-2400
Original Issuance Date:	11/17/2015
License Status:	REGULAR
Effective Date:	05/17/2020
Expiration Date:	05/16/2022
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's physician had changed her Prozac on 03/29/2022 to take effect on 03/30/2022. By 04/13/2022 Resident A was still not receiving the new dosage of Prozac.	Yes

III. METHODOLOGY

04/15/2022	Special Investigation Intake 2022A0357017
04/15/2022	APS Referral/declined
04/15/2022	Special Investigation Initiated - Telephone Telephone to Recipient Rights.
04/15/2022	Contact - Telephone call made to Recipient Rights.
04/18/2022	Contact - Telephone call made Montcalm Community Mental Heath.
05/10/2022	Contact - Telephone call made Montcalm Community Mental Health.
06/14/2022	Contact - Telephone call made Montcalm Community Mental Health,
06/15/2022	Inspection Completed On-site Unannounced inspection
06/15/2022	Contact - Face to Face Face-to-face with Licensee Julia and direct care staff, Steva DeJong
06/15/2022	Contact - Document Received Reviewed and Received Resident A's documents, prescription, and MAR's,
06/21/2022	Contact – Telephone call made To Guardian Pharmacy of Michigan and I conducted an interview with Harley Adrianse, Pharmacy Aid.

06/22/2022	Conducted telephone exit conference with Licensee Designee, Julie Brooks.

ALLEGATION: Resident A's physician had changed her Prozac on 03/29/2022 to take effect on 03/30/2022. By 04/13/2022 Resident A was still not receiving the new dosage of Prozac.

INVESTIGATION: On 06/15/2022, I made an unannounced inspection of the facility. I met with the Licensee Designee Julie Brooks and her staff Steva DeJong. They explained that on 03/29/2022 they had a teleconference with Resident A's physician, Dr. Sansait. He changed/increased Resident A's Prozac medication. A faxed copy from the pharmacy was dated 03/29/2022 at 12:35 AM. The new order read: "*PROzac 20 MG Capsule Take 2 by mouth Daily every morning and one capsule at hs. Effective 03/29/2022. * Note: This Rx is a change. Please discontinue previous PROzac 20 MG Capsule from 03/04/2022."* On this same sheet was handwritten the following: "Per Pharmacy Insurance would not pay for the additional 30 capsules."

06/15/2022, Ms. Brooks stated that she could not give Resident A the new added dose because she did not have enough of them. She explained that she would run out before the new cycle medications were delivered. Ms. Brooks showed me the printed Medication Administration Records (MARs) before the change which read, *"PROzac (Fluoxetine) 20MG*, was written, *take one 20 MG capsule by mouth twice a day 7:00 AM and 8:00 PM."* She also explained that she did not receive the new script from the doctor at Montcalm Community Mental Health which has always come by fax, but they had changed their system to something new. She said she was waiting for the prescription from the physician, but it never came.

On 06/15/2022, Ms. Brooks and I reviewed the Incident/Accident Report that Montcalm Community Mental Health had told her she had to complete. It was dated 4/13/22 at 2:30 PM. It read as follows: "*Medication Error: Psch increased Prozac to 2 tabs in morning (See attached Script.) Did not receive new med. On 04/13/22 we questioned the office. It appears that insurance would not pay for it at this time. According to the Pharmacy we should be giving her 2 out of the AM pack and contact them when we were short. Normally we would get communication but really didn't."* The corrective measures read as follows: "*Contact sooner or Dr. office. Should follow up as usual to Pharmacy and Dr, Office."*

On 06/15/2022, Ms. Brooks stated that they did not have specific orders to take the two pills out of the original pack. She stated this was all very confusing. She said it would have helped if they had had a script that said to discontinue the original order, and then the new order written with the new amounts and times. She stated that is how she is used to doing it. The New Prescription Summary did note that Rx was a change and to please discontinue previous PROzac 20 MG Capsule from 03/04/2022. The directions on the New Prescription Summary read in part: "*Take 2 by mouth Daily every morning and one capsule at hs."* Ms. Brooks stated that since

she did not know when the insurance would be paying for the new dosages, she was afraid she would run out and not have any to administer to Resident A. She also reported that what is on the screen when they pull up Resident A's medications is not the same if she prints the MARs. She stated that she administered the two pills for the new prescription at first. I asked her if she recorded it as two pills and she said no.

On 06/17/2022, I received a returned call from Milessa Scott, Medical Assistant from Dr. Sansait, Montcalm Community Mental Health. She stated Dr. Sansait had changed Resident A's medication after they had a Tele-Conference. He changed the PROzac 20MG to, two in the AM instead of one and kept the nighttime the same, which was one. She stated they sent the prescription to the pharmacy on 03/29/2022, expecting that Resident A would be starting the additional medication right away. She reported that she contacted Harley Adrianse, Pharmacy Aid at Guardian Pharmacy of Michigan, on 03/30/2022 to confirm the changed order for the PROzac. She reported that Ms. Adrianse stated that she had sent the copy of the new prescription to Ms. Brooks on 03/29/2022. Ms. Scott stated that Ms. Brooks did not let anyone know about needing more medication until 04/13/2022, when she notified the pharmacy that she still had not received the new medication. Ms. Scott stated that they sent the new prescription to Ms. Brooks by encrypted email, but she learned later that Ms. Brooks did not know how to open the encrypted email. She reported they are working with their IT department to help Ms. Brooks either learn how to open the email or if they can still use the fax to send important information to Ms. Brooks. She stated that she had learned from the pharmacy that Resident A had not been receiving the correct dose of PROzac so she asked Ms. Brooks to complete an Incident/Accident report. She also stated that Ms. Brooks should have called her and the pharmacy sooner about the need for more medication.

On 06/21/2022, I conducted a telephone interview with Ms. Adrianse, Pharmacy Aid from Guardian Pharmacy of Michigan. She stated that on 04/27/2022, they sent 81 capsules of 20 MG, for PROzac to the AFC home which was for the new dosage. She confirmed that the insurance would not pay for the additional 30 capsules at first, but they were able to have the insurance pay for the new prescription eventually. She explained that the home had the Blister Packs for the PROzac medication, and they were expecting Ms. Brooks to use two from the current Blister Pack in the AM, instead of one in the AM. She reported they could not take back the already used Blister Pack of PROzac, for Resident A. She stated it made sense to have Ms. Brooks use up the medication in the current Blister Pack then she should call them to explain what she had done and to report she was almost out the medication. I explained that our rule on administration of resident medications requires that they administer the resident's medication as it appears on the label instructions. She stated they have a sticker change with the new medication or change in the medication to put on the Blister Pack, but she was not aware if Ms. Brooks received one or not. She stated that Ms. Brooks should have called them when they were running low on medications. She referenced the "*New Prescription Summary*," dated 03/29/2022 that had the new amount of *"PROzac with 30 supply take 2 by mouth Daily every morning then one capsule at hs." The note on this document stated "This Rx is a change. Please discontinue previous*

PROzac 20 MG from 03/03/2022." Therefore, according to Ms. Adrianse, Ms. Brooks was notified to discontinue the old prescription and to start with the new prescription.

On 06/15/2022, I requested and reviewed Resident A's MARs, from April and May 2022. I reviewed them again on 06/21/2022. Resident A's April MAR read: *"D/C – 4/19/2022, 12:53 PM."* This was followed by "*Fluoxetine Cap 20MG 3/29/2022, Prozac take two capsules by mouth every morning."* At 7:00 AM staff's initials were recorded 04/01 through 19/2022 with the new prescription of two caps at 7:00 AM. On 04/20/2022 the medication was noted as "D/C" (discontinued). There were no staff initials from 04/20 through 30/2022, which is a total of 11 days when there were no staff initials indicating the medication was administered at two caps of Prozac at 7:00 AM.

The same April MAR for Resident A had the following: "*D/C – 4/19/2022, 12:53 PM."* This was followed by *"Fluoxetine Cap 20MG 3/29/2022, Prozac take one capsule by mouth at bedtime."* At 8:00 PM. staff's initials were recorded from 04/01 through 19/2022. On 04/19/2022, the medication was noted as "D/C" (discontinued), but on the same April MAR for Resident A the following was recorded: "*Fluoxetine Cap 20MG 04/27/2022 Prozac take one capsule by mouth at bedtime."* At 8:00 PM the staff's initials were recorded for 04/27 though 30/2022. Therefore, the one prescribed 20MG of Prozac at 8:00 PM was missed for eight days, 04/19 through 26/2022. According to Ms. Adrinase she confirmed that on 04/27/2022, they sent 81 capsules of 20 MG, for PROzac to the AFC home which was for the new dosage.

On 06/15 and 21/2022, I reviewed Resident A's, May MAR which had the following*: "D/C-3/29/2022 11: 41 AM," "Fluoxetine Cap 20MG 3/07/2022 Prozac, take one capsule by mouth twice daily, times 7:00 AM and 8:00 PM." (*This was the old prescription). The next medication on the same MAR was recorded as: "*D/C-3/7/2022 11:42 AM, Fluoxetine Cap 20MG 1/25/2022, Prozac, take one capsule by mouth twice daily, 7:00 AM and 8:00 PM."* Again, the old prescription Staff's initials were recorded for administration from 05/01 through 29/2022, for the 7:00 AM, for one dose of Prozac. On the MAR for May the following was recorded*: "Fluoxetine Cap 20MG 3/29/2022, Prozac take two capsules by mouth every morning, 7:00 AM.*

There were staff's initials for 05/30 and 31/2022 for the two doses of Prozac on these dates. Therefore, Resident A only received one dose of Prozac at 20MG from 05/01 through 29/2022. Resident A did receive the two doses of Prozac on 05/30 and 31/2022. Resident A did not receive the correct dosage of two 20MG of Prozac for 28 days of May 2022. I continued to look at the 8:00 PM dosage of administration of one cap of Prozac. and staff's initials were recorded from 05/01 through 28/2022. The medication of one Prozac for the 8:00 PM dose on 05/29/2022, read "D/C" (discontinued). There were no staff's initials recorded for the 8:00 PM dose of Prozac on 05/30 and 31/2022. Therefore, two doses of the 8:00 PM Prozac were not recorded as administered.

On 06/22/2022, I conducted a telephone exit conference with the Licensee Designee, Julie Brooks she agreed with my findings. She said if she had administered the new dose at two a day from her blister pack, she would not have any left to administer to Resident A.

APPLICABLE RULE	
R 400, 14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A's physician had changed her Prozac on 03/29/2022 to take effect on 03/30/2022. By 04/13/2022, Resident A was still not receiving the new dosage of Prozac. The Licensee Designee, Julie Brooks acknowledged that she was confused about Resident A's medications and only administered two pills for a time at 7:00 AM. She also acknowledged that she did not document it correctly on the MAR. The New Prescription Summary contained a note that the prescription had changed and provided instructions to discontinue previous PROzac 20MG from 03/04/2022. The same document stated the new prescription was for two 20MG's tablets to be administered every morning and then one 20MG capsule at hs. Milessa Scott, Medical Assistant for Dr. Sansait stated that Ms. Brooks and Ms. DeJong were both present with Resident A at Resident A's medication review with Dr. Sansait on 03/29/2022 by Tele-Conference, when the Prozac prescription was changed from one 20MG at 7:00 AM to two 20MG at 7:00 AM and the 8:00PM dose of 20MG remained the same. She stated that Ms. Brooks did not follow-up with the doctor's office or pharmacy until 04/13/2022, when she needed more medications. She stated that Resident A was not receiving the correct dosage of the Prozac that was to start on 03/30/2022. Resident A's MARs did not include staff's initials from 04/20/2022 through 04/30/2022, indicating the medication was not administered at two caps of Prozac at 7:00 AM. There were no staff's initials for the one prescribed 20MG of Prozac at 8:00 PM from 04/19/2022 through 04/26/2022. Resident A's MARs for May 2022, contained the old prescription of one Prozac of 20MG at 7:00 AM and according to the staff's

	initials Resident A only received the one dose of Prozac from 05/01/2022 through 05/29/2022, indicating Resident A did not receive the correct dosage of two 20MG of Prozac for 28 days of May 2022. There were no staff's initials recorded for the 8:00 PM dose of Prozac on 05/30/2022 and 05/31/2022. Therefore, two doses of 20MG for the 8:00 PM Prozac were not recorded as administered. There was evidence that Resident A did not receive her prescribed medication of Prozac of 20MG two capsules consistently either at the 7:00 AM dose or the one 20MG at the 8:00 PM dose. Therefore, there is a violation established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend that the Licensee Designee provide an acceptable plan of correction and the license remain unchanged.

Arlene B. Smith 06/22/2022

Arlene B. Smith, MSW Date
Licensing Consultant

Approved By:

Jerry Hendrick 06/22/2022

Jerry Hendrick Date
Area Manager