GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 7, 2023

Patti Holland
801 W Geneva Dr.
Dewitt, MI 48820

RE: License #: AM330008452
Investigation #: 2023A0466046
Pleasant View AFC

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 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) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM330008452
Investigation #:	2023A0466046
Complaint Receipt Date:	05/17/2023
Investigation Initiation Date:	05/17/2023
Report Due Date:	07/16/2023
Licensee Name:	Patti Holland
Licensee Address:	801 W Geneva Dr. Dewitt, MI 48820
Licensee Telephone #:	(517) 669-8457
Administrator:	Patti Holland
Licensee Designee:	N/A
Name of Facility:	Pleasant View AFC
Facility Address:	3016 Risdale Lansing, MI 48911
Facility Telephone #:	(517) 394-6748
Original Issuance Date:	12/12/1992
License Status:	REGULAR
Effective Date:	01/22/2022
Expiration Date:	01/21/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED ALZHEIMERS

II. ALLEGATION:

	Violation Established?
Resident medications are not being administered as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/17/2023	Special Investigation Intake 2023A0466046.
05/17/2023	Special Investigation Initiated – Telephone call, Complainant interviewed.
05/17/2023	Contact- Telephone call made to Eileen Laryea, RD, Registered Dietitian/CSDD with Community Mental Health Authority of Clinton, Eaton, Ingham Counties, interviewed.
05/17/2023	Contact- Document received from Eileen Laryea.
06/07/2023	Inspection Completed On-site with licensing consultant Jana Lipps.
07/06/2023	Contact- Telephone call made to MacKenzie Meadows, pharmacy technician at Ascension Pharmacy interviewed.
07/06/2023	Exit conference with licensee Patti Holland.
07/07/2023	APS Referral.

ALLEGATION: Resident medications are not being administered as prescribed.

INVESTIGATION:
On 05/17/2023, Complainant reported the overall concern being errors with medications for all residents in the home. Complainant reported she discovered on 05/15/2023 that one of Resident A's medications, that was last filled by the pharmacy in January 2023 as a 30-day supply with no refills, remained listed on the current medication administration record (MAR) as being administered daily as of 05/15/2023 even though there should be no more medication available to administer. Complaint reported she then spot-checked other residents' medications and found that on 05/15/2023 several medications were being administered despite a documented pharmacy fill date of March 2023 and April 2023. Complainant reported that upon further review, there were medication packages of pills from February 2023 and even December 2022 still in administration rotation. Complainant

stated not being able to determine how medication packages this old were still available given the medications were prescribed as daily medications.

On 05/17/2023, I interviewed Eileen Laryea, Registered Dietitian (RD) with Community Mental Health (CMH) Authority of Clinton, Eaton, Ingham Counties who reported that on 05/15/2023 she reviewed Resident A's pharmacy packaged medications at the facility and compared the medication to Resident A's MAR. RD Laryea stated Resident A was being administered Vitamin B12 even though it should have been discontinued. RD Laryea reported the last time Resident A's Vitamin B12 was delivered/filled by the pharmacy was January 2023 as a 30-day supply with no refills. Consequently, RD Laryea stated there should not be any pills left yet the MAR documented the medication as being administered. RD Laryea reported that she talked to the home manager and direct care worker (DCW) Chastidy Johnson who did not know anything about Resident A's Vitamin B12 prescription.

On 05/17/2023 RD Laryea provided a copy of Resident A's May 2023 MAR which I reviewed. Resident A's May 2023 MAR documented that Resident A was administered Vitamin B12, 1000 MCG, take 1 tablet by mouth every morning between May 1, 2023 and May 15, 2023 except on May 9, 2023 as there were no initials verifying medication administration. RD Laryea did not provide a picture of the pharmacy packaged medication.

On 06/06/2023, I conducted an unannounced investigation with AFC licensing consultant Jana Lipps. At the time of the unannounced investigation DCW Alexiona Embry and DCW Taleah Etchison were on duty. I interviewed DCW Embry privately who reported she was not trained in medication administration and that she has been working at the facility for two weeks. DCW Embry reported either DCW Johnson or DCW Etchison order resident medications. DCW Embry reported she has not heard anything about there being any problems with any resident medications.

I interviewed DCW Etchsion who reported she is trained in medication administration and regularly administers medications to residents. DCW Etchsion reported all direct care staff trained in medication administration are responsible to contact the pharmacy and/or the prescribing physician if medications are needed/if prescriptions require refill. DCW Etchsion reported she was aware of the concerns that were raised on 5/15/2023 regarding Residents A by RD Laryea. DCW Etchsion confirmed Resident A's medications that were being administered were not from the current month. DCW Etchsion reported that they do not always administer the medications from the medication packet filled by pharmacy for that current month but medications are administered prior to the date of expiration. DCW Etchsion reported that if a medication is discontinued the pharmacy sends a letter in the mail or sends a MAR with a discontinued note on it. DCW Etchsion reported she was not aware that Resident A's Vitamin B12 was discontinued. DCW Etchsion reported on 5/15/2023, while Resident A's dietitian, RD Laryea was in the facility reviewing medications when she verbalized concern about Resident A's medications being administered from packages that were not in the current month. DCW Etchsion reported the

facility had medication overflow so she and DCW Johnson went through all the extra resident medications and destroyed all expired medications in coffee grounds. DCW Etchsion reported there were buckets full of medications. DCW Etchsion reported that they destroyed medication for numerous residents not just Resident A. DCW Etchsion reported she and DCW Johnson destroyed about 15 cards of resident medication because they deemed them as expired. DCW Etchsion reported that some of the medication cards were full and others were not. DCW Etchsion reported there were no narcotics that were destroyed.

DCW Embry and DCW Etchison both reported that Resident A was in rehabilitation and therefore not at the facility at the time of the unannounced investigation.

I reviewed Resident A's resident record and MAR which documented that Resident A was being administered "Vitamin B12, 1000 MCG, take 1 tablet by mouth every morning," The MAR document that this medication was administered to Resident A every day in May 2023.

Licensing consultant Jana Lipps and I reviewed the pharmacy packaged medications and compared them to the MARs for Residents A through Resident L and had the following findings:

- Resident B: Vitamin D3 was not available for administration.
  On 06/06/2023, DCW Etchison reported that this medication needs a new physician order and they need to contact the physician.
- Resident C: Ear Drops not available to administer.
  On 06/06/2023, DCW Etchison reported this medication needs to called in for the doctor to reorder.
- Resident E
  - Cephalexin 500mg: found in bin but was not listed on MAR. Ordered to be administered 4 times daily for 10 days on 5/9/23, pills remaining in the bottle. Directions required the medication to be taken until empty.
  - Vitamin D3: Not available to administer
  - Omeprazole: Not available to administer
  - Aviane: Not available to administer.

  On 06/06/2023, DCW Etchison reported Vitamin D3, Omeprazole, and Aviane need to be reordered by the physician.
- Resident G
  - Calcium 600 not available for administration

  On 06/06/2023, DCW Etchison reported Resident G is in rehabilitation and they will not refill her medications until she returns.
- Resident H
  - Lurasidone 40mg: not available for administration.

  On 06/06/2023, DCW Etchison reported this needs a new physician order.
- Resident J
  - Baclofen 20mg not available to administer.

On 06/06/2023, DCW Etchison reported this medication was no longer being administered. Discontinue order not available for review.

On 07/06/2023, I interviewed MacKenzie Meadows, pharmacy technician at Ascension Pharmacy who confirmed this pharmacy does fill medications for Pleasant View AFC. Pharmacy technician Meadows reported that pharmacy delivery drivers have reported concerns to her about Pleasant View AFC having a lot of over stock of medications for residents which was not typical because prescriptions are filled once a month on a 30-day cycle. Pharmacy technician Meadows reported that unless direct care staff members were not notifying the pharmacy when a resident was hospitalized or in rehabilitation there was no reason for the over stock medications on any resident. Pharmacy technician Meadows reported direct care staff members should be administering medication from either the previous month or current month medication packages only. Pharmacy technician Meadows reported Pleasant View AFC has a history of having missing medications which requires mid-month refills. Pharmacy technician Meadows reported resident refusals could impact some overstock but they still should not be administering medications from medication packages filled several months ago because of how stringently the medications are dispensed. Pharmacy technician Meadows reported that the pharmacy does not have an active prescription for Resident A to be administered Vitamin B-12, 1000 MCG, take 1 tablet by mouth every morning. Pharmacy technician Meadows reported that the last time that prescription was filled was on January 17, 2023, as a 30 day supply with no refills. Pharmacy technician Meadows reported that since then the pharmacy has not received a new prescription from Resident A's physician, they are not authorized to provide Vitamin B-12. Pharmacy technician Meadows reported Vitamin B-12 was removed from Resident A's June 2023 MAR. Pharmacy technician Meadows had no explanation how Resident A's Vitamin B-12 was administered to Resident A since March 2023 since because the medication should have run out. Pharmacy technician Meadows reported Vitamin B-12 is sold over the counter however Resident A does not have a doctor's order to have that medication administered to her.

APPLICABLE RULE	
R 400.14312	**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. **(2) Medication shall be given, taken, or applied pursuant to label instructions.** **(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:** **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**
ANALYSIS:	Pharmacy technician Meadows reported the pharmacy does not have an active prescription for Resident A to be administered Vitamin B-12 and that the last prescription that was dispensed by the pharmacy was dated January 17, 2023, as a 30-day supply without refills so the medication should have run out prior to May 15, 2023. A violation has been established as according to Resident A's May 2023 MAR, Resident A's Vitamin B12 was administered through May 31, 2023 therefore this medication was administered without a physician's order. AFC licensing consultant Lipps and I compared the pharmacy packaged medication to each residents' medication administration record and found multiple medications were listed on the medication administration records but were not available for administration. This occurred for Resident B, Resident C, Resident E, Resident G, Resident H and Resident J. Additionally, DCW Etchison reported a new prescription needed to be obtained from each resident's physician prior to being able to refill the prescriptions for those residents. This was not done timely by direct care staff members leaving residents without prescribed medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 06/06/2023, licensing consultant Lipps and I conducted an unannounced investigation and Resident I's Desenex Powder was observed unsecured in the bathroom. DCW Etchison reported that they keep the medication in the bathroom, unlocked, so Resident I can use it after her shower.

APPLICABLE RULE	
R 400.14312	**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 06/06/2023, Resident I's Desenex Powder was observed in the bathroom unsecured. DCW Etchison reported that Resident I's Desenex Powder is left in the bathroom unsecured so that she can use it after her shower therefore a violation has been established as all medications are required to be stored in a locked cabinet or drawer.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 06/06/2023, licensing consultant Lipps and I conducted an unannounced investigation and we reviewed the residents' medications in the pharmacy packaged containers and compared them to the MARs for Residents A-Resident L and had the following findings:

Resident C:

- Fluticasone Propionate medication found in medication closet labeled to Resident C but not listed on MAR.
  On 06/06/2023, DCW Etchison reported Guardian C1 brought this medication for Resident C this was over the counter and not prescribed by a physician.
- Ondansetron 4mg medication found in medication closet labeled for Resident C but not listed on MAR.
  On 06/06/2023, DCW Etchison reported this was a pro re nata (PRN) and is no longer needed. No discontinue order found in record.

Resident E

- Ibuprofen 600mg: found in medication closet labeled for Resident E but not listed on MAR.
- Ondansetron 4mg: found in medication closet labeled for Resident E but not on MAR.
- Trazadone 150mg: found in medication closet labeled for Resident E but not on MAR.

- Midol Complete found in medication closet labeled for Resident E but not on MAR.
- No discontinue orders were found in Resident E's record for any of the above medications.

Resident D

- Magnesium Oxide found in medication closet labeled for Resident E but not on MAR.
  On 06/06/2023, DCW Etchison reported the hospital prescribed this medication at Resident D's last hospital visit but it has not been added to the MAR yet. At least four pills were punched from the pack indicating that the medication had been administered at least four times however this was not documented on any MAR.

Resident F

- Ibuprofen 800mg, take one tablet by mouth twice daily. Found in medication closet labeled for Resident F but not listed on MAR.

Resident I

- Ondansetron: found in medication closet labeled for Resident I but not documented on MAR. On 06/06/2023, DCW Etchison reported this medication is no longer being used by resident but a discontinue order was not available for review.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**

ANALYSIS:	Licensing consultant Lipps and I compared the pharmacy packaged medication to residents' medication administration records. Medication administration records for Resident C, Resident E, Resident D, Resident F, and Resident I did not contain all prescribed medications, the dosage, label instructions for use, time to be administered and the initials of the person who administers the medication as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/06/2023

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Julie Elkins Date
Licensing Consultant

Approved By:

07/07/2023

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Dawn N. Timm Date
Area Manager