GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 27, 2023

Connie Clauson
Pleasant Homes I L.L.C.
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL390007089
Park Place Living Centre #A
4214 S Westnedge
Kalamazoo, MI 49008

Dear Connie Clauson:

Attached is the Renewal Licensing Study Report for the facility referenced above. The study has determined substantial violations of applicable licensing statutes and administrative rules. Therefore, refusal to renew the license is recommended. You will be notified in writing of the Department's intention and your options for resolution of this matter.

Please contact me with any questions. In the event that I am not available and you need to speak to someone immediately, you may contact the local office at (517) 284-9730.

Sincerely,

Cathy Cushman

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

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AL390007089
Licensee Name:	Pleasant Homes I L.L.C.
Licensee Address:	Suite 203 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Licensee Designee:	Connie Clauson
Administrator:	Janet White
Name of Facility:	Park Place Living Centre #A
Facility Address:	4214 S Westnedge Kalamazoo, MI 49008
Facility Telephone #:	(269) 388-7303
Original Issuance Date:	01/01/1989
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. METHODS OF INSPECTION

Date of On-site Inspections: 11/06/2023 and 10/13/2023 (interim inspection)

Date of Bureau of Fire Services Inspection if applicable: 05/01/2023

Date of Health Authority Inspection if applicable: N/A

No. of staff interviewed and/or observed 2
No. of residents interviewed and/or observed 13
No. of others interviewed 1 Role: Administrator

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.
- Medication(s) and medication record(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☒ No ☐ If no, explain.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.
- Fire drills reviewed? Yes ☒ No ☐ If no, explain.
- Fire safety equipment and practices observed? Yes ☒ No ☐ If no, explain.
- E-scores reviewed? (Special Certification Only) Yes ☐ No ☐ N/A ☒ If no, explain.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.
- Incident report follow-up? Yes ☒ No ☐ If no, explain.
- Corrective action plan compliance verified? Yes ☒ CAP date/s and rule/s: SIR 2023A0581020, CAP dated 04/19/2023. R. 308(2)(b), R.204(3), R 411(3), R.403(2), R.312(7) N/A ☐
- Number of excluded employees followed-up? 2 N/A ☐
- Variances? Yes ☒ (please explain) No ☐ N/A ☐
  The licensee was granted a variance to R 400.15315(3) on 06/15/2023 to use their own electronic system to track Adult Foster Care payments rather than the Department's Resident Funds II form.

  A variance was granted on 08/02/2010 for R 400.15304(1)(b)(2) allowing the facility to have a secured fence. Residents or their designated responsbile person are required to sign a form consenting to their placement in a secured facility.

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following rules:

****To maintain the coding consistency of residents across past investigations and the current renewal, the residents in this renewal licensing report are not identified in sequential order.*

R 400.15205 **Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**

(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the physician's knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.

FINDING: Direct care staff, Earlinia Moore, was hired on 09/18/2023; however, there was no statement signed by a licensed physician attesting to the physician's knowledge of Ms. Moore's physical health within 30 days of Ms. Moore's employment or assumption of duties.

R 400.15205 **Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**

(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.

FINDING: Upon review of direct care staff, Herve Kampu Lumpanadio's, staff file it was determined he tested positive for tuberculosis (TB) on 08/25/2023; however, there was no written documentation from Mr. Lumpanadio's physician or the local health authority verifying treatment was being implemented or completed and that the residents in the home were not at risk. There was also no documentation verifying a chest x-ray had been completed showing Mr. Lumpanadio was negative for TB.

R 400.15306 Use of assistive devices.

(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.

FINDING: Upon review of resident records, there were multiple residents who required the use of therapeutic supports; however, the physician's order for these supports either did not state the reason for the support and/or the term of the authorization, as required.

The physician's order for Resident B's therapeutic support (e.g. walker) did not identify the reason for the walker or the term of the authorization.

The physician's order for Resident C's therapeutic supports (e.g. walker, bed rails, floor mat, and sit to stand lift) did not identify the term of these authorizations.

The physician's order for Resident G's therapeutic support (e.g. wheelchair) did not identify the reason for the wheelchair or the term of the authorization.

The physician's order for Resident J's therapeutic support (e.g. bed rails and wheelchair) did not state the reason for the bed rails and wheelchair or identify the terms of the authorizations.

R 400.15312 Resident medications.

(2) Medication shall be given, taken, or applied pursuant to label instructions.

FINDING: Upon review of multiple resident's October electronic Medication Administration Records (eMARs), residents were not receiving their medications, as required, because medications were not in the facility, as required.

According to documentation on Resident F's generated October eMAR, she was prescribed the following medication, but the eMAR notations of "waiting on a new script", "waiting on a script", "out has been reordered", "on order" and "out" indicated the medication was not administered:

- Divalproex 500 Mg DR tablet, to be administered by taking 2 tablets by mouth at bedtime. This medication was not administered to Resident F on 10/02, 10/03, 10/04, 10/05, 10/06, 10/07, 10/08, 10/09, 10/10, 10/11, 10/12, 10/13, 10/14, 10/15, or 10/16.
- Melatonin 3 Mg tabs, to be administered by taking 1 tablet by mouth at bedtime as needed (sleep). This medication was not administered to Resident F on 10/02, 10/28, 10/29, 10/30 or 10/31.

According to documentation on Resident G's generated October eMAR, she was prescribed the following medication, but the eMAR notations of "out of medication", "out has been reordered", and "on order" indicated the medication was not administered:

- Atorvastatin 40 Mg tablet, to be administered by taking 1 tablet by mouth every evening. This medication was not administered to Resident G on 10/01, 10/02, 10/03, 10/05, 10/06, 10/07, 10/08, 10/10, 10/28, or 10/29.

According to documentation on Resident H's generated October eMAR, she was prescribed the following medication, but the eMAR notations of "out has been reordered", "on order", "empty", "out of meds" indicated the medications was not administered:

- Levothryroxine 75 Mcg tablet, to be administered by taking 1 tablet oral every morning at 0600 before food or other medications. This medication was not administered to Resident H on 10/01 or 10/02.
- Atorvastatin 40 Mg tablet, to be administered by taking 1 tablet by mouth at bedtime. This medication was not administered to Resident H on 10/21, 10/22, 10/23, 10/24, 10/25, or 10/26.

According to documentation on Resident M's generated October eMAR, she was prescribed the following medication, but the eMAR notations of "waiting on a new script", "waiting on delivery", "out has been reordered", "empty" and "on order" indicated the medication was not administered:

- Chonazepam 0.5mg tablet, to be administered by taking 1 tablet by mouth twice daily. This medication was not administered to Resident M at 8 pm on 10/02, 8 am on 10/03 or 8 pm on 10/03.

- Melatonin 5 mg tablet, to be administered by taking 1 tablet by mouth at bedtime. This medication was not administered to Resident M on 10/08, 10/09, 10/10, 10/11, or 10/20.
- Donepezil Hcl 10 Mg tablet, to be administered by taking 1 tablet by mouth at bedtime. This medication was not administered to Resident M 10/20, 10/22, 10/23, or 10/25.

Resident O, who was admitted on 09/02/2023, was shown to have three medications on her eMAR including Digoxin 0.125 MG tablet, Diltiazem 24H ER(LA) 180 MG TB and Xarelto 15 MG tablet; however, none of these medications were in the medication cart.

According to documentation on Resident O's generated October eMAR, she was prescribed the following medication, but the eMAR notations of "issues with billing will follow up", "waiting on cardiologist to send hometown new scripts, ive called twice" and "on order" indicated the medication was not administered:

- Digoxin 0.125 Mg tablet, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident O on 10/24, 10/25, 10/26, 10/27, 10/28, 10/29, 10/30, and 10/31.
- Xarelto 15 Mg tablet, to be administered by giving 1 tablet by mouth at bedtime. This medication was not administered to Resident O on 10/31.

Direct care staff, Brianna White, stated in order to get a refill on Resident O's medications she needed an appointment with her cardiologist. Ms. White stated she had attempted to contact the cardiologist's office to no avail. During the inspection, the Administrator, Janet White, contacted Resident O's guardian and/or relative to request their assistance in contacting the cardiologist to obtain an appointment.

REPEAT VIOLATION [SEE SIR 2023A0581020, DATED 04/05/2023, CAP DATED 04/19/2023]

R 400.15312 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: (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.

FINDING: While reviewing resident medications with direct care staff and the facility's identified Resident Care Manager, Brianna White, she stated Resident O's medications had been crushed when they were administered to her; however, Ms. White stated there was no physician's order providing this instruction.

R 400.15401 Environmental health.

(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.

FINDING: Chemicals and cleaning products were being stored in cabinets in the bathroom adjacent to the living and dining rooms; however, during the inspection the cabinets were observed open and unlocked making them accessible to residents.

R 400.15403 Maintenance of premises.

(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

FINDING: Bedroom 13 had an entire wall covered in wrapping paper, which the Administrator, Janet White, stated was placed on the wall by the resident's family. The wrapping paper on the wall is a fire hazard.

R 400.15403 Maintenance of premises.

(3) All living, sleeping, hallway, storage, bathroom, and kitchen areas shall be well lighted and ventilated.

FINDING: Multiple lights in the facility's living room ceiling were without covers and were not emitting light. Additionally, multiple overhead lights in the hallway did not appear to be functioning properly; therefore, making the hallway dimly lit.

R 400.15403 Maintenance of premises.

(6) All plumbing fixtures and water and waste pipes shall be properly installed and maintained in good working condition. Each water heater shall be equipped with a thermostatic temperature control and a pressure relief valve, both of which shall be in good working condition.

FINDING: Bedroom 2's bathroom toilet was leaking water from the water supply valve, which was connected to the wall. The facility's Administrator, Janet White, stated the resident residing in the room pulled the toilet away from the wall on 11/04/2023 and neither she, nor staff, nor the maintenance director were able to shut the water off at the valve due to its location. Ms. White stated a company was contacted to come and address the leaking valve and they were expected to visit the facility the day of the inspection. I also observed the toilet's tank lid broke, which Ms. White stated was caused by the resident. While there was a container under the water valve near the wall, and there were towels to soak up the water, water still covered the bathroom floor.

Bedroom 1's bathroom toilet wasn't flushing. The toilet tank lid was off the toilet and the toilet lift chain was not connected and functioning properly.

R 400.15408 Bedrooms generally.

(4) Interior doorways of bedrooms that are occupied by residents shall be equipped with a side-hinged, permanently mounted door that is equipped with positive-latching, nonlocking-against-egress hardware.

FINDING: Bedrooms #7 and #17 both had locking against egress hardware on the bedroom doors.

On 11/17/2023, I conducted the exit conference with the licensee designee, Connie Clauson, via telephone and informed her of my findings. She did not agree with the recommendation of not renewing the license as she was in the process of implementing changes at the facility. She indicated she planned to create an alert within the eMAR system to contact a designated person(s) who would then be aware of all medication errors. She stated this would eliminate medication errors or at least allow errors to be caught sooner. She also stated she would be appointing or designating a staffing director. Ms. Clauson stated she also planned to create a stronger management team to support the administrator.

IV. RECOMMENDATION

Based on the continual quality of care violations and repeated violations, refusal to renew the license is recommended.

11/13/2023

_____

Cathy Cushman Date
Licensing Consultant

Approved:

11/20/2023

_____

Dawn Timm Date
Area Manager