GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 12, 2024

Patti Holland
801 W Geneva Dr.
Dewitt, MI 48820

RE: License #: AM330008452
Investigation #: 2024A1029013
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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AM330008452
Investigation #:	2024A1029013
Complaint Receipt Date:	11/15/2023
Investigation Initiation Date:	11/16/2023
Report Due Date:	01/14/2024
Licensee Name:	Patti Holland
Licensee Address:	801 W Geneva Dr., Dewitt, MI 48820
Licensee Telephone #:	(517) 669-8457
Administrator:	Patti Holland
Licensee Designee:	Patti Holland
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 AGED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS

ALLEGATION(S)

	Violation Established?
On November 13, 2023 direct care staff member Ms. Etchison yelled at Resident A, threatened to hit him, and said inappropriate rude comments.	Yes
Resident A was not administered his Divalproex Sodium 500 mg as prescribed from November 12-November 16, 2023.	Yes

II. METHODOLOGY

11/15/2023	Special Investigation Intake 2024A1029013
11/16/2023	Special Investigation Initiated – Letter to Guardian A1
11/16/2023	APS Referral made to Centralized Intake
11/30/2023	Contact - Telephone call made to Chastidy Johnston
11/30/2023	Contact - Telephone call made Taleah Etchison
12/07/2023	Inspection Completed On-site - Face to Face with direct care staff members Ms. Etchison, Alexis Gilliam, Samaria Wilson and Resident B, Resident C
12/07/2023	Contact - Telephone call made to Chastidy Johnston (left message)
12/07/2023	Contact - Document Sent email to Chastidy Johnston and Patti Holland regarding phone numbers.
12/26/2023	Inspection Completed On-site – face to face interview Resident A
12/27/2023	Referral - Recipient Rights – Sent referral to Ashlee Bailey and Greg Fox at ORR CEI-CMH
12/27/2023	Contact - Telephone call made to direct care staff member Chastidy Johnston and Patti Holland; mailbox full.
01/02/2024	Contact – Telephone call to Ms. Holland (mailbox full), sent email to Ms. Holland, email to Guardian A1, CMH case manager, Megan Hazzard.
01/03/2024	Contact – Telephone call from licensee designee Ms. Holland

01/04/2024	Contact – Telephone call to Alicia Baker and email from Guardian A1
01/04/2024	Exit conference with licensee designee Patti Holland

ALLEGATION: On November 13, 2023, direct care staff member Ms. Etchison yelled at Resident A, threatened to hit him, and said inappropriate rude comments.

INVESTIGATION:

On November 15, 2023 a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns Resident A was yelled at and threatened by a direct care staff member nicknamed “T” which is Taleah Etchison. During this argument, Resident A was on the phone with Guardian A1 who overheard the whole conversation. According to the allegations, Guardian A1 contacted Ms. Johnston who also heard some of the argument including comments Ms. Etchison made to Resident A such as “no one wants you here,” “shut your lips before I swing” with the argument going on for about 13 minutes.

On November 16, 2023, I received an email from Guardian A1. Guardian A1 stated she was on the phone with Resident A when this argument was occurring. Guardian A1 stated she heard Ms. Etchison yelling in the background making statements such as, "Nobody wants you, that's why your here." Guardian A1 stated she did not remember her exact words but heard her state she would start “swinging.” Guardian A1 stated the argument went on for more than 13 minutes with Ms. Etchison stating, “that’s why your wife doesn’t want you,” and telling Resident A he was “useless, a bitch and to shut the fuck up.” Guardian A1 stated during the call, she tried to call Ms. Holland so she could hear the argument but when she could not reach her, she called direct care staff member Ms. Johnston who heard the end of the argument. Guardian A1 stated she told Resident A he was on speaker phone and he stated Ms. Etchison was the one who was talking to him like that. Guardian A1 stated during this conversation, Ms. Etchison did not believe Resident A was really on the phone with his guardian during the incident.

On November 30, 2023, I interviewed direct care staff member Ms. Etchison. Ms. Etchison stated she does not know who Resident A was arguing with on November 13, 2023 but she is the direct care staff member whom they refer to with the nickname “T” but denied she was arguing with him. Ms. Etchison stated Resident A starts arguments at least twice per week and in the past, he was more peaceful but since he has personal issues going on lately, he is angrier. Ms. Etchison denied she ever swore at Resident A or other residents and denied there was an argument that Guardian A1 heard over the phone. Ms. Etchison stated she would not threaten any of the residents. Ms. Etchison stated Resident A is very independent and he does not like the fact that she is the new house manager. Ms. Etchison stated she has never told Resident A he was “useless, a

bitch and to shut the fuck up." Ms. Etchison stated sometimes his stories are contradicting and he does not tell the truth.

On December 7, 2023, I completed an unannounced on-site investigation and met with direct care staff member Taleah Etchison. Resident A was at school at the time of this on-site. Ms. Etchison again stated she did not swear at Resident A or have any verbal or physical altercation with Resident A.

On December 7, 2023, I interviewed direct care staff member Alexis Gilliam who stated Resident A was "going through some stuff" lately which causes him to be upset with direct care staff members and he starts arguments and does not get along with direct care staff members. Ms. Gilliam stated she has never observed an altercation with Resident A and Ms. Etchison and she believed their relationship was "okay but he will lay into her" at times.

On December 7, 2023, I interviewed Resident B who stated Resident A and Ms. Etchison do not get along with each other. Resident B stated Ms. Etchison and Resident A were in an argument with each other because Resident A likes to start arguments with direct care staff members. Resident B stated she does not know the specifics of the argument or what was said but stated Resident A has problems with everyone in the house. Resident B stated she has never heard Ms. Etchison swear at Resident A or other residents but she can tell by her tone with him that she does not like Resident A.

On December 7, 2023, I interviewed Resident C who stated Ms. Etchison is not very nice to her and she does not like the way she does not save her dinner for her. Resident C stated Ms. Etchison has never yelled rather it is more "how she says it." Resident C stated she was unaware of any concerns between Resident A and Ms. Etchison.

On December 7, 2023, I interviewed direct care staff member Samaria Wilson. Ms. Wilson stated she has worked several shifts where she witnessed Resident A mad at other direct care staff members or residents. Ms. Wilson stated Resident A is going through a lot in his personal life and seems to take his aggression out on direct care staff members and other residents. Ms. Wilson stated when Resident A first arrived, he was not like this but over time, he is getting angrier. Ms. Wilson stated Ms. Etchison and Resident A "get along fine" and she is doing well in her new role. Ms. Wilson stated she has worked with Ms. Etchison a lot because she was trained by her and she has never heard Ms. Etchison swear at a resident or be disrespectful. Ms. Wilson stated, "You need to be on your toes with [Resident A] because you do not know what you will get."

On December 26, 2023 I interviewed Resident A at the facility. Resident A stated he did have an argument with Ms. Etchison because he has a lot of anger, he has no family and it makes him upset. Resident A stated he was on the phone with Guardian A1 and she overheard a heated discussion between he and Ms. Etchison. Resident A stated he could not recall what they were arguing about, what started the incident, or what she

said to him during this incident. Resident A stated he could not recall if she threatened him during this incident but Resident A stated he remembers feeling bad afterward for how she talked to him and was upset because he thought they got along really well in the past. Resident A stated he will sometimes hear direct care staff members tell one of the female residents (unknown name) to “shut up” when she is talking and they get mad at her but he has not heard swearing or any threats.

On December 27, 2023, I interviewed direct care staff member Chastidy Johnston. Ms. Johnston stated Guardian A1 called her during their argument on November 13, 2023 and put her on speaker phone so Ms. Etchison could not hear her but she could clearly hear Ms. Etchison yelling at Resident A while she was on the phone. Ms. Johnston stated she heard Ms. Etchison state “I don’t give a fuck what you are saying.” Ms. Johnston stated Ms. Etchison also has issues with her tone when talking to Resident C because she argues with her instead of making efforts to speak to Resident C in a respectful manner. Ms. Johnston stated Ms. Etchison “definitely has some things to work on” as far as her demeanor toward the residents. Ms. Johnston stated she has not been spoken to about this because they want “her to be caught by doing this” so it can be addressed. Ms. Johnston stated that Ms. Holland did not hear the conversation but Ms. Holland did get a phone call from Guardian A1 shortly after regarding the incident. Ms. Johnston stated it depends on the mood of the residents and Ms. Etchison however there is typically an outburst from her toward the residents around 2-3 times per week. Ms. Johnston stated this has been going on for at least two- three months. Ms. Johnston stated there are specific rules regarding direct care staff members not fighting or arguing with the residents and this is why Resident C starts breaking stuff and has to go to CMH and the emergency department because she feels Ms. Etchison is “egging her on.”

On January 3, 2024, I interviewed licensee designee Patti Holland. Ms. Holland stated she has had ongoing concerns about Ms. Etchison’s attitude toward the residents and this was not the first incident. Ms. Holland stated she did not hear this argument but that she knew Ms. Johnston heard it on the phone when Guardian A1 called her. Ms. Holland stated Ms. Etchison has not said any of these statements in front of her but she has heard reports from other direct care staff members and Ms. Baker that Ms. Etchison has called Resident C “no good” and Ms. Holland agreed this could be why Resident C’s behaviors increased.

On January 4, 2024, I interviewed direct care staff member Alicia Baker. Ms. Baker stated her current role involves handing administrative issues, training, and Recipient Rights concerns. Ms. Baker stated she was there during the argument with Ms. Etchison while Ms. Etchison was packing up to leave her shift when Resident A upset her. Ms. Baker stated she did swear at him during the incident and they were both very loud. Ms. Baker stated she was in the middle of Resident A and Ms. Etchison to try and calm down during the incident. Ms. Etchison was yelling at Resident A but she does not remember what she specifically stated but it was loud, there was an exchange between them. Resident A was also talking to his case manager on the phone during the time. Ms. Baker stated she did call Ms. Holland and talked to her about this. Ms. Baker stated

Ms. Holland told her she did not need to report the concerns because she already reported the incident. Ms. Baker stated there were two other direct care staff members working during that time. Ms. Baker stated this is the first time she has observed this between Resident A and Ms. Etchison. Ms. Baker stated she is not aware of concerns regarding Ms. Etchison and Resident B however she had concerns with Ms. Etchison's tone in the past. Ms. Baker stated she has the same negative tone with all the residents. Ms. Baker stated Resident A was sad and sulky after the incident and she stayed at the home for about 4 hours after the incident to make sure he was okay after the verbal altercation. Ms. Baker stated Resident A and Ms. Etchison were together the next day during her shift and they were able to get along fine. Ms. Baker stated there were other residents around during the time and they all seemed shocked and quiet that Ms. Etchison would talk to Resident A in that manner, however, no one said anything about the incident.

Ms. Baker submitted a copy of the *AFC Incident / Accident Report* which summarized the above incident and included the following statement:

> *"Ms. Baker spoke with Ms. Etchison about the incident and she expressed her feelings were hurt because she felt attacked. She showed remorse that she raised her voice and understood it was wrong. We talked about how we can all work on compassion, letting things go, and remembering proper behavior at work. She seemed optimistic about the future of her attitude on the job and ensuring that we set an example for other staff. She will be in the next Working with People training and also redoing the De-escalation PowerPoint and test."*

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	Ms. Etchison did not treat Resident A with respect and dignity during an incident on November 13, 2023, when she engaged in an argument with him in front of other residents and Ms. Walker. This argument was witnessed by Ms. Walker and overheard during a phone call with Guardian A1. Ms. Johnston stated she has also heard Ms. Etchison speak to Resident A and Resident C in a disrespectful manner. Licensee designee Ms. Holland stated she has also head concerns regarding Ms. Etchison's treatment toward Resident A and Resident C and stated this was not an isolated incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A was not administered his Divalproex Sodium 500 mg as prescribed November 12-November 16, 2023.

INVESTIGATION:

On November 15, 2023 a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns Resident A was out of his medications for two days. There was no information in the complaint regarding what dates he was out of his medications or what medications this included.

On November 16, 2023, Guardian A1 forwarded me an email that she sent to licensee designee Ms. Holland on November 14, 2023 inquiring why Resident A missed medication. Ms. Etchison responded back to her on November 15, 2023 stating Resident A did miss two days of medications, not two weeks and that she called the pharmacy on November 14, 2023, regarding the medication refill.

On November 30, 2023, I interviewed direct care staff member Ms. Etchison. Ms. Etchison stated that Resident A did not have any of his Divalproex medication at the facility for two days in November but she did not recall what days the medication was not administered to Resident A. Ms. Etchison stated sometimes Resident A refuses to take some of his medication. Ms. Etchison stated she did call the pharmacy to have the medication delivered however she did not recall what day she called. Ms. Etchison stated there was a delay because the medication cannot be delivered on Fridays. Ms. Etchison stated they use Accension Pharmacy through CMH.

On December 7, 2023, I completed an unannounced on-site investigation at Pleasant View and interviewed Ms. Etchison. Ms. Etchison stated she could not remember if there was an issue with the script or the pharmacy but since they did not have the medication, she did not administer the Divalproex Sodium DR 500 mg to Resident A.

I reviewed Resident A's Medication Administration Record (MAR) for November 2023 and confirmed he did not receive his Divalproex Sodium DR 500 mg (1 tablet every night at bedtime) as prescribed from November 12-November 16, 2023. There was no

notation for November 12 and the other dates just had “D” marked which according to the code on the back of the MAR indicates the drug was not given. There were no notes on the back of the MAR to indicate why he did not receive it for four days or if the pharmacy was contacted to have the medication refilled.

On December 27, 2023, I interviewed direct care staff member Ms. Johnston. Ms. Johnston stated “D” means Drug not given and they are supposed to indicate the reason on medication notes however, for Resident A there was no notation explaining why it was not given or if they attempted to contact Ascension pharmacy. Ms. Johnston stated she does not know if the pharmacy was contacted or what was going on with the medication because Ms. Etchison and Ms. Baker are the ones who handle all medication orders now.

On January 4, 2024, I interviewed direct care staff member Ms. Baker. Ms. Baker stated she was not aware Resident A was not administered his Divalproex Sod. Dr. 500 mg medication as prescribed. Ms. Baker stated Community Mental Health has been working with Ms. Etchison to complete the medications properly and improve documentation through training for the direct care staff members because this is not an isolated incident. Ms. Baker stated she has spoken to the direct care staff members regarding not writing “D” in the book without an explanation because there is no way of knowing why he was not administered his medication on November 12-16, 2023 or if the pharmacy was called to rectify the issue.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	I reviewed Resident A’s Medication Administration Record (MAR) for November 2023 and confirmed he did not receive his Divalproex Sodium Dr. 500 mg (1 tablet every night at bedtime) as prescribed from November 12-November 16, 2023. There was no notation for November 12 and the other dates had “D” marked which according to the code on the back of the MAR indicates the drug was not given. There were no notes on the back of the MAR to indicate why he did not receive it for four days or if the pharmacy was contacted to have the medication refilled. Regardless, Resident A did not receive this medication as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

_____01/04/2023_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

01/12/2024

_____

Dawn N. Timm
Area Manager

Date