GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 1, 2024

Patti Holland
801 W Geneva Dr.
Dewitt, MI 48820

RE: License #: AM330008452
Investigation #: 2024A0578041
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,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM330008452
Investigation #:	2024A0578041
Complaint Receipt Date:	06/18/2024
Investigation Initiation Date:	06/20/2024
Report Due Date:	08/17/2024
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:	01/22/2024
Expiration Date:	01/21/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Medications are not being provided to residents on a routine basis.	Yes

III. METHODOLOGY

06/18/2024	Special Investigation Intake 2024A0578041
06/20/2024	Special Investigation Initiated - On Site
06/20/2024	APS Referral
06/20/2024	Special Investigation Completed On-site -Interview with direct care staff Taleah Etchison. Interview with Resident A and Resident C.
06/20/2024	Contact-Document Reviewed. *-Medication Administration Records, May 2024, June 2024, for Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, Resident H, Resident I, Resident J, and Resident K.*
06/26/2024	Contact-Document Reviewed. - Letter from Ascension RX, dated 05/22/2024.
07/31/2024	Exit Conference -With the licensee designee Patti Holland.

ALLEGATION:

Medications are not being provided to residents on a routine basis.

INVESTIGATION:

On 06/18/2024, I received this anonymous complaint through the BCHS On-line Complaint System. Complainant alleged residents are not being provided with their prescribed medications on a routine basis. No additional details or information was provided.

On 06/20/2024, I completed an unannounced investigation on-site at this facility and interviewed direct care staff Taleah Etchison regarding the allegation. Taleah Etchison acknowledged serving as the home manager for this facility. Taleah Etchison denied the allegation and reported Resident A and Resident B are the only residents that have not routinely received their medications. Taleah Etchison

clarified this was due to an issue with Ascension pharmacy being “hacked” and Ascension pharmacy not having access to critical information to provide medications on time. Taleah Etchison reported having to resend all the residents’ prescriptions for medications or having to obtain new prescriptions from the prescribing physician. Taleah Etchison reported Resident A missed his Divalproex 500MG for two days until Resident A’s Divalproex 500MG was delivered on Friday, 06/14/2024. Taleah Etchison reported Resident B missed her Atorvastatin 20MG as someone from the facility had gone to the pharmacy to pick up Resident B’s medication and it was unavailable. Taleah Etchison reported having documentation from Ascension pharmacy explaining the security breach that resulted in a delay of medications.

While at the facility, I interviewed Resident A regarding the allegations. Resident A reported living at this facility for five years. Resident A acknowledged receiving daily medications prepared by direct care staff at this facility.

While at the facility, I interviewed Resident C regarding the allegations. Resident C reported living at this facility for over three months. Resident C acknowledged receiving daily medications and reported these medications are prepared by direct care staff. Resident C denied missing any of his daily medications for any reason.

On 06/26/2024, I reviewed a letter from Ascension Rx provided by direct care staff Taleah Etchison. The letter from Ascension RX was dated 05/22/2024 and included the following:

> “On May 8th, Ascension detected unusual activity in our network systems, which we have determined is due to a ransomware attack. We continue to diligently investigate and address this ransomware incident, and we are working closely with external experts and federal law enforcement. While our restoration work continues in earnest, our primary focus is on restoring systems as safely as possible and, as such, we expect this process will take some time to complete. Our pharmacy will remain open and operational; however, Ascension Pharmacy is currently unable to receive any prescriptions electronically, all prescriptions will need to be faxed or called into the pharmacy until further notice. If you are expecting new prescriptions or changes and have not received them, please check WebConnect or call the pharmacy to verify the prescription has been received. We apologize for any inconvenience this may cause and appreciate your understanding. Please reach out to the pharmacy with any questions or concerns.”

While at the facility, I reviewed the *Medication Administration Records* for Resident A. The *Medication Administration Records* for Resident A did not document the initials of the direct care staff who administered the following medications for Resident A, entered at the time the medication was given, on the following dates:

Amiodarone 200 MG, QD, 06/01/2024, 06/05/2024, and 06/07/2024,
Atorvastatin 10 MG, QD, 06/03/2024, 06/05/2024, 06/08/2024 and 06/09/2024.

Buspirone 30 MG, QD, 06/07/2024.
Cephalexin 250 MG, QD, 06/07/2024.
Farxiga 10 MG, QD, 06/07/2024.
Furosemide 40 MG, QD, 06/09/2024.
Losartan 25 MG, QD, 06/07/2024.
Metroprolol 25 MG, QD, 06/07/2024.
Potassium 20 MG QD, 06/05/2024 and 06/09/2024.

On 06/26/2024, I reviewed the *Medication Administration Records* for Resident B. The *Medication Administration Records* for Resident B did not document the initials of the direct care staff who administered the following medications for Resident B, entered at the time the medication was given, on the following dates:

Atorvastatin 20MG, QD 05/23/2024, 05/27/2024.
Aptiom 800MG, QD 05/26/2024, 05/27/2024.
Famotidine 20MG, QD, 05/26/2024 and 05/27/2024.
Lacosamide 50MG, BID, 05/26/2024 and 05/27/2024.
Levetiracetam 1000MG, BID, 05/26/2024 and 05/27/2024.

On 06/26/2024, I reviewed the *Medication Administration Records* for Resident C. The *Medication Administration Records* for Resident C did not document the initials of the direct care staff who administered the following medications for Resident C, entered at the time the medication was given, on the following dates:

Clonidine HCL .2 MG, HS, 05/21/2024, 05/25/2024, 05/26/2024, 06/05/2024, 06/07/2024,06/09/2024, 06/15/2024, and 06/16/2024.
Divalproex ER 500 MG, HS, 05/21/2024, 05/25/2024, 05/26/2024, 06/05/2024, 06/07/2024,06/09/2024, 06/15/2024, and 06/16/2024.
Levothyroxine 25 MG, HS, 05/22/2024, 06/03/2024, 06/04/2024,06/07/2024, and 06/18/2024.
Vitamin D3 2000 MG, QD, 05/22/2024, 06/03/2024, 06/04/2024,06/07/2024, and 06/18/2024.
Benztropine 2 MG, BID, 05/22/2024, 05/25/2024, 05/26/2024, 06/03/2024, 06/04/2024,06/07/2024, 06/17/2024, and 06/18/2024.

On 06/26/2024, I reviewed the *Medication Administration Records* for Resident D. The *Medication Administration Records* for Resident D did not document the initials of the direct care staff who administered the following medications for Resident D, entered at the time the medication was given, on the following dates:

Famotidine 20 MG, QD, 06/07/2024.
Hydrochlorothiazide 25 MG, QD, 06/07/2024.
Levothyroxine 75 MG, QD, 06/07/2024.
Lisinopril 2.5 MG, QD, 06/07/2024.
Magnesium oxide 400 MG, QD, 06/07/2024.
Vitamin B12 1000 MG, QD, 06/07/2024.

On 06/26/2024, I reviewed the *Medication Administration Records* for Resident E. The *Medication Administration Records* for Resident E did not document the initials of the direct care staff who administered the following medications for Resident E, entered at the time the medication was given, on the following dates:

Cetirizine 10 MG, QD, 05/23/2024, 05/24/2024, 05/25/2024, 05/26/2024, 06/07/2024 and 06/08/2024.
Clozapine 100 MG, HS, 05/19/2024, 05/23/2024, 05/24/2024, 05/25/2024, 05/26/2024, 06/05/2024, 06/07/2024, 06/08/2024, and 06/09/2024.
Clozapine 200 MG, HS, 05/19/2024, 05/23/2024, 05/24/2024, 05/25/2024, 05/26/2024, 06/05/2024, 06/07/2024, 06/08/2024, and 06/09/2024.
Divalproex 500 MG, HS, 05/19/2024, 05/23/2024, 05/24/2024, 05/25/2024, 05/26/2024, 06/05/2024, 06/07/2024, 06/08/2024, and 06/09/2024.
Hydroxyzine 25 MG, QD, 05/23/2024, 05/24/2024, 05/25/2024, 05/26/2024, 06/07/2024 and 06/08/2024.
Pantoprazole 40 MG, QD, 05/23/2024, 05/24/2024, 05/25/2024, 05/26/2024, 06/07/2024 and 06/08/2024.
Trihexyphenidyl 2 MG, QD, 05/23/2024, 05/24/2024, 05/25/2024, 05/26/2024, 06/07/2024 and 06/08/2024.
Vitamin D3 2000 QD, 05/23/2024, 05/24/2024, 05/25/2024, 05/26/2024, 06/07/2024 and 06/08/2024.

On 06/26/2024, I reviewed the *Medication Administration Records* for Resident F. The *Medication Administration Records* for Resident F did not document the initials of the direct care staff who administered the following medications for Resident F, entered at the time the medication was given, on the following dates:

BD UF mini pen needle 5mm BID, 06/04/2024, 06/05/2024, 06/07/2024, 06/09/2024, 06/11/2024, and 06/18/2024.
Clonidine .2 milligrams HS, 05/23/2024, 05/25/2024, 05/26/2024, 06/05/2024, and 06/09/2024.
Fluoxetine 60 MG, QD, 06/07/2024.
Lantus solostar 100 units QD, 06/07/2024.
Insulin lispro 100 units BID, 05/20/2024, 05/21/2024, 05/26/2024, 06/04/2024, 06/07/2024, and 06/09/2024.
Risperidone 3 MG, QD, 06/05/2024, 06/07/2024, and 06/09/2024.
Accu check soft clicks Lancet HS, 05/20/2024, 05/21/2024, 05/26/2024, 06/04/2024, 06/07/2024, 06/09/2024, 06/18/2024, and 06/19/2024.
Alcohol 70% swabs QID, 05/20/2024, 05/21/2024, 05/26/2024, 06/04/2024, 06/07/2024, 06/09/2024, 06/18/2024, and 06/19/2024.

On 06/26/2024, I reviewed the *Medication Administration Records* for Resident G. The *Medication Administration Records* for Resident G did not include the initials of the direct care staff who administered the following medications for Resident G, entered at the time the medication was given, on the following dates:

Acetazolamide 500 MG, BID, 06/16/2024.
Lurasidone 120 MG, QD 06/15/2024, 06/16/2024.
Topiramate 100 MG, QD, 06/16/2024.

On 06/26/2024, I reviewed the *Medication Administration Records* for Resident H. The *Medication Administration Records* for Resident H did not include the initials of the direct care staff who administered the following medications for Resident H, entered at the time the medication was given, on the following dates:

Amitriptyline 25 MG, QD, 06/05/2024, 06/09/2024, and 06/17/2024.
Atorvastatin 20 MG, HS, 06/05/2024, 06/08/2024, and 06/09/2024.
Cetirizine 10 MG, QD, 06/07/2024, and 06/18/2024.
Furosemide 40 MG, QD, 06/07/2024, and 06/18/2024.
Hydroxychloroquine 200 MG, QD, 06/07/2024, and 06/18/2024.
Jardiance 25 MG, QD, 06/07/2024 and 06/18/2024.
Lisinopril 5 MG, QD, 06/07/2024, 06/09/2024, and 06/18/2024.
Olanzapine 10 MG, QD, 06/07/2024, and 06/18/2024.
Olanzapine 5 MG, HS, 06/05/2024, 06/09/2024, and 06/17/2024.

On 06/26/2024, I reviewed the *Medication Administration Records* for Resident I. The *Medication Administration Records* for Resident I did not include the initials of the direct care staff who administered the following medications for Resident I, entered at the time the medication was given, on the following dates:

Olanzapine 20 milligrams, HS, 06/05/2024, 06/08/2024, and 06/09/2024.
Paroxetine 10 MG, QD, 06/07/2024.
Quetiapine fumarate 400 MG, HS, 06/05/2024, 06/08/2024, and 06/09/2024.
Vitamin D3 2000 IU, 06/07/2024.
Buspirone 15 MG, BID, 06/05/2024, and 06/07/2024.

On 06/26/2024, I reviewed the *Medication Administration Records* for Resident J. The *Medication Administration Records* for Resident J did not include the initials of the direct care staff who administered the following medications for Resident J, entered at the time the medication was given, on the following dates:

Amlodipine besylate10 MG, QD, 06/07/2024.
Atorvastatin 20 MG, QD, 06/07/2024.
Clozapine 200 MG, HS, 06/05/2024, 06/09/2024, and 06/16/2024.
Cranberry 450 MG, HS, 06/07/2024.
Fish oil 1000 MG, QD, 06/07/2024.
Hydrochlorothiazide 12.5 MG, QD, 06/04/2024, 06/07/2024, 06/16/2024, and 06/17/2024.
Levothyroxine 25 MG, QD, 06/07/2024.

On 06/26/2024, I reviewed the *Medication Administration Records* for Resident K. The *Medication Administration Records* for Resident K did not include the initials of the direct care staff who administered the following medications for Resident K, entered at the time the medication was given, on the following dates:

Atorvastatin 10 MG, QD, 05/21/2024.
Potassium 20 MEQ, 05/21/2024, 05/22/2024, and 05/26/2024.
Tab a vite tablet, QD, 05/20/2024.
Vitamin D3 2000 IU, QD, 05/20/2024, and 05/22/2024.
Eliquis 2.5 MG, QD, 06/05/2024, 06/20/2024, 06/21/2024, and 06/22/2024.
Carbidopa-levodopa 25-100 TAB, TID, 06/01/2024, 06/05/2024, 06/09/2024, 06/20/2024, 06/21/2024, 06/22/2024, 06/25/2024, and 06/25/2024.
Losartan Potassium 25MG, QD, 06/20/2024, and 06/26/2024.

While at this facility, I reviewed the Medication Administration Records for several residents and my findings with direct care staff Taleah Etchison. Taleah Etchison reported she knew the direct care staff responsible for the missing documentation and would discuss the missing documentation with human resources.

According to SIR # 2023A0466046, dated 7/07/2023, the facility was in violation of rule 400.14312 when it was established that on 06/06/2023, 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.

The facilities approved Corrective Action Plan (CAP) dated 07/28/2023 stated that all resident medications were checked and corrected or fixed, and that direct care staff Alicia Baker was placed in charge of correct medication administration at all three of this licensee's facilities.

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: (a) Be trained in the proper handling and administration of medication. (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:	Based upon my investigation, which consisted of interviews with Resident A, Resident C, and direct care staff Taleah Etchison, as well as observations made during an unannounced investigation on-site and a review of pertinent documentation relevant to this investigation, direct care staff at this facility did not document the initials of the direct care staff administering medications to residents at the time medications were given, assuring residents received their medications as prescribed on a routine basis. While direct care staff Taleah Etchison identified a security breach with Ascension RX as the reason for a delay in medications, this facility was previously cited for not documenting whether medications were refused or administered and submitted an approved corrective action plan on 07/28/2024.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [Reference SIR #2023A0466046 dated 07/07/2023 and CAP dated 07/28/2023].**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

07/31/2024

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Eli DeLeon Date
Licensing Consultant

Approved By:

08/01/2024

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Dawn N. Timm Date
Area Manager