RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

October 11, 2017

Cindy Whaley
Liberty Living Inc.
P O Box 1273
Bay City, MI 48706

RE: License #:	AS090238876
Investigation #:	2017A0123051
	Jefferson House

Dear Mrs. Whaley:

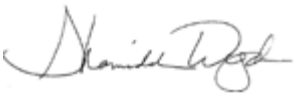
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (989) 787-7031.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090238876
Investigation #:	2017A0123051
Complaint Receipt Date:	08/23/2017
Investigation Initiation Date:	08/24/2017
Report Due Date:	10/22/2017
Licensee Name:	Liberty Living Inc.
Licensee Address:	P O Box 1273 Bay City, MI 48706
Licensee Telephone #:	(989) 892-0247
Administrator:	Cindy Whaley
Licensee Designee:	Cindy Whaley
Name of Facility:	Jefferson House
Facility Address:	1700 S Jefferson Bay City, MI 48708
Facility Telephone #:	(989) 895-3809
Original Issuance Date:	12/01/2001
License Status:	REGULAR
Effective Date:	06/01/2016
Expiration Date:	05/31/2018
Capacity:	6
Program Type:	MENTALLY ILL DEVELOPMENTALLY DISABLED PHYSICALLY HANDICAPPED

II. ALLEGATION(S)

	Violation Established?
On 8/15/17, staff Chanell Beckom left the residents unattended, as she left the facility prior to the arrival of the next shift's staff person. The residents were unattended for approximately 10 minutes.	Yes

III. METHODOLOGY

08/23/2017	Special Investigation Intake 2017A0123051
08/24/2017	Special Investigation Initiated - On Site I conducted an unannounced inspection to Jefferson House.
08/24/2017	APS Referral I received information regarding the APS referral via phone from APS worker Sarah LeBarge.
09/14/2017	Contact - Telephone call made I interviewed with staff Chanell Beckom via phone.
09/20/2017	Contact - Face to Face I interviewed Residents D, and Resident F and spoke to Staff Beilby at Jefferson House.
09/28/2017	Contact - Telephone call made I left a message for public guardian Bethany Weber asking for a return call.
09/28/2017	Contact- Telephone call made I attempted to contact Resident A's guardian. There was no answer. I left a message via voicemail.
09/29/2017	Contact - Telephone call received I spoke with public guardian Bethany Weber via phone.
10/05/2017	Contact - Telephone call made I attempted to contact Resident A's guardian. There was no answer. I left a message via voicemail.
10/11/2017	Contact- Telephone call made I spoke with Susan Barthmaier via phone.
10/11/2017	Exit Conference I conducted an exit conference with Cindy Whaley via phone.

ALLEGATION:
On 8/15/17, staff Chanell Beckom left the residents unattended, as she left the facility prior to the arrival of the next shift's staff person. The residents were unattended for approximately 10 minutes.

INVESTIGATION:
On 08/24/2017, I conducted an unannounced inspection to Jefferson House. I spoke with home manager Tracy Beilby. She stated that the incident occurred on Friday August 18th, at 3:00 pm. She found out about the incident the following Monday as she was out of town, and was not on call during the weekend. She stated that another staff person called Staff Beckom on the Jefferson House phone and told her that the second shift staff was stuck in traffic, and that staff Sue Barthmaier was going to come and relieve her. She stated that when Staff Barthmaier arrived to the home there was no staff present, and that Staff Beckom had clocked out at 2:59 pm. She stated that the med keys were left sitting on the counter by Staff Beckom. Staff Beilby stated that narcotics and sharps (knives) are stored in there (med cabinet). Staff Beilby stated that Staff Beckom was covering her shift for her that day. She stated that Staff Beckom left Jefferson House and went across the street to the Jefferson North foster care home to pick up her check. She stated that Staff Beckom left residents with challenging behaviors unattended, and that one resident has a history of attacking others. She stated that Staff Beckom sent her a text message asking what she did that was so bad that she has been taken off of the schedule.

On 08/24/2017, I interviewed Resident A at Jefferson House. Resident A stated that Staff Beckom said she had to go to another job and was going to be late. Resident A stated that she went out for a smoke break, and when she came back into the house, Staff Beckom was gone, and so was her bag. Resident A stated that she yelled downstairs for Staff Beckom but nobody was there. Resident A stated that she has a guardian.

Resident A's health care appraisal indicates that she is diagnosed with HTN, COPD, dyslipidemia, and schizophrenia. Resident A is fully ambulatory, but according to her assessment plan she is unable to move independently in the community as she needs staff supervision.

On 08/24/2017, I interviewed Resident B. Resident B stated that he saw Staff Beckom walk to the office area, and saw her clock out. Resident B stated that he gave a puzzled look to someone who was sitting at the table. He stated that he saw Staff Beckom grab her stuff and leave. He stated that he did not know what to do, he was lost. He stated that he does know how to call 911. He stated that he hopes Staff Beckom gets fired, as it was uncalled for. He stated that he saw Staff Beckom walk down the ramp and leave. He stated that he felt abandoned.

Resident B's health care appraisal indicates that he is diagnosed with DM II, a-fib, COPD, hv CNA, hv DVI's, chronic BLE, and cellulitis. Resident B uses a walker due

to impaired mobility. Resident B's assessment plan indicates that he is not able to move independently in the community. It states that he prefers to have staff with him for safety reasons.

On 08/24/2017, I observed Resident C at Jefferson House. He appeared clean and appropriately dressed. He appeared to have limit verbal skills and was not interviewed. Resident C's health care appraisal indicates he is diagnosed with HTN, DM type 2, and hyperlipidemia. Resident C is fully ambulatory. Per his assessment plan, Resident C is not able to move independently in the community, and needs staff supervision 24 hours a day as needed. His assessment plan also indicates under "communicates needs" that he may need staff to help interpret.

On 08/24/2017, I spoke with Adult Protective Services worker Sarah LeBarge via phone. She stated that she will be substantiating her investigation, and that she is going to contact Staff Beckom today. She stated that she is aware that Staff Beckom left the med keys on the counter.

On 09/14/2017, I interviewed staff Chanell Beckom via phone. Staff Beckom stated that she had just started working at Jefferson House, and it was her third day there. She stated that she is not familiar with the staff. She stated that 3:00 pm (on 08/18/2017), came a round, and she called the manager across the street (at Jefferson North). She stated that she was told that Sue (Barthmaier) was coming, because the other staff person was stuck in traffic. She stated that a staff person named Ariana Feltson arrived to the home, so she went across the street to Jefferson North. She stated that Staff Feltson was inside Jefferson House when Staff Beckom left the home. She stated that she did not know that Staff Feltson was only picking up her check. She stated that she thought that Staff Feltson was the staff person who was stuck in traffic and that she did not communicate with Staff Feltson when she left to go across the street. Staff Beckom stated that she punched out at 2:59 pm. She stated that she saw Staff Barthmaier pull into the driveway at Jefferson House while she was still across the street at Jefferson North. She stated that she saw the other lady (Staff Barthmaier) walk into Jefferson House, so she left and went to her other job. She stated that the next day she was told someone had picked up her shift. She stated that she is currently suspended right now. She stated that Staff Feltson was in her car leaving when Staff Barthmaier pulled up. Staff Beckom stated that she has met with recipient rights and adult protective services. She stated that she left the med keys on the medicine cabinet pushed in a corner. She stated that all of the residents were in their rooms when Staff Feltson came in. She stated that it was an honest mistake, and a misunderstanding.

On 09/20/2017, I interviewed Resident D at Jefferson House. Resident D stated that he was in his bedroom sleeping at the time of the incident. He stated that he did hear about it, but that's about it. He stated that he knows Staff Beckom, and that she is new. He stated that he did not know she was the staff person that left. He stated that he is his own guardian. He stated that he did not have any concerns regarding that day.

Resident D's health care appraisal indicates that he is diagnosed with bipolar affective disorder, DMT 2, COPD, and HTN. Resident D's assessment plan indicates that he is able to move independently in the community.

On 09/20/2017, I spoke with home manager Tracy Beilby. She stated that Ariana Feltson is a staff person. She stated that she recently did a no call no show all weekend long. She stated that the story about Staff Feltson coming to the home that day is one of the stories that she has heard about what happened. She stated that there have been a couple of different versions, as staff Beckom has changed her story a few times.

I observed Resident E on 09/20/2017 sitting at the dining room table on 09/20/2017. Resident E was not at the home on the day of this incident.

On 09/20/2017, I interviewed Resident F. Resident F was observed sitting in a wheelchair. He stated that he does not know a staff named Chanell Beckom. When asked if he felt safe in the home he stated, "I feel real good." When asked if there is always a staff person here, he stated "I like the staff." When I asked if he has ever been left alone in the home, Resident F stated "I prefer staying with somebody." Resident F did not appear to understand the questions I posed. He stated that he knows he has a guardian but does not know the guardian's name.

Resident F is diagnosed with schizoaffective disorder, impulse disorder, hyperlipidemia, mild mental retardation, bipolar affective disorder, glaucoma, macular degeneration, Gerd, and IBS. Resident F's assessment plan indicates that he is not able to move independently in the community, and that he needs staff with him at all times.

On 09/28/2017, and 10/05/2017, I made attempts to contact Resident A's guardian. There was no answer, and voicemails were left both times asking for the guardian to return the calls.

On 09/29/2017, I spoke with public guardian Bethany Weber from Catholic Family Services. She is the guardian for Resident C and Resident F. She stated that she was not aware of this matter, and assumes the home has taken corrective action. She stated that she has no concerns regarding the home.

On 10/11/2017, I spoke with consumer program director Susan Barthmaier via phone. She stated that when she arrived that day to Jefferson House, she walked into the house and did not see a staff person. She stated that she looked in the bathroom and outside. She stated that there were no vehicles at the home when she pulled up. She stated that she got the call that the home needed to be covered, and she arrived to the home within five minutes. Staff Barthmaier stated that the keys were left on the counter in plain sight. She stated that she did not see a staff person

leaving the home in a vehicle when she arrived (i.e. Staff Feltson). She stated “how can I relieve someone if there’s no one there?”

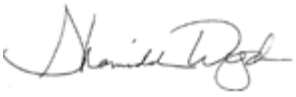
On 10/11/2017, I spoke with licensee designee Cindy Whaley via phone. An exit conference was conducted. The findings and conclusions were discussed. Ms. Whaley stated that because Jefferson House is a specialized home, staff have to complete their training before their start date. She stated that Staff Beckom would not have been working had she not completed training. She stated that Staff Beckom did not see anything wrong with what she did. Ms. Whaley stated that Staff Beckom was immediately put on suspension following the incident, and has since been terminated from employment. Ms. Whaley stated that recipient rights substantiated their investigation. She stated that to her knowledge Staff Beckom had never met Staff Feltson or Staff Barthmaier. She stated that Staff Feltson reported to recipient rights that she had come to the home on the day of the incident to pick up her last check. Staff Feltson reported to recipient rights that she and Staff Beckom crossed paths but did not speak with one another. I asked if staff are supposed to communicate between shift-change. Ms. Whaley stated yes, and that Staff Beckom should have handed the med keys off (to the next shift staff). Ms. Whaley stated that Staff Feltson reported to recipient rights that she was in the house maybe a minute to pick up her final check and leave, and that Staff Beckom never said anything to her. Staff Feltson was not on the schedule to work. Ms. Whaley stated that Staff Beckom reported to recipient rights that someone told her, but she did not know who they were that she could leave while the second shift staff was on their way. She stated that the on call manager had related to Staff Beckom that someone was on their way to relieve her. Ms. Whaley also reported that Staff Barthmaier stated that she did not see any staff at the home when she arrived to Jefferson Home.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	There is a preponderance of evidence to substantiate a rule violation. On 08/18/2017, Staff Beckom left Jefferson Home unattended and went across the street to Jefferson North to pick up her pay check. Five vulnerable adults were left in the home alone during this time. Staff Beilby stated that Staff Beckom left residents with challenging behaviors unattended, and that one resident has a history of attacking others. In addition, Staff Beckom left the keys to the medication cabinet (which also stores sharps) unattended on the counter, where residents had easy access to them.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	There is a preponderance of evidence to substantiate a rule violation. On 08/18/2017, Staff Beckom left Jefferson Home unattended and went across the street to Jefferson North to pick up her pay check. Five vulnerable adults were left in the home alone during this time. Staff Beilby stated that Staff Beckom left residents with challenging behaviors unattended, and that one resident has a history of attacking others. In addition, Staff Beckom left the keys to the medication cabinet (which also stores sharps) unattended on the counter, where residents had easy access to them. According to home manager Tracy Beilby and licensee designee Cindy Whaley, Staff Beckom did not seem to understand that she did anything wrong. Staff Beckom did not communicate with a second shift staff person prior to leaving the home, failing to ensure the home was properly staffed prior to her leaving the premises.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

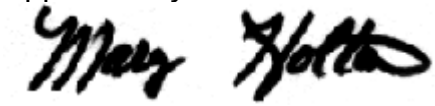
Upon receipt of an acceptable corrective action plan, I recommend continuation of the current status of the license of this AFC adult small group home (capacity 6 or less.)



10/11/2017

Shamidah Wyden Date
Licensing Consultant

Approved By:



10/11/2017

Mary E Holton Date
Area Manager