RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

February 6, 2018

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

RE: License #: AS090238876
Investigation #: 2018A0871009
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.
- 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 (989) 732-8062.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090238876
Investigation #:	2018A0871009
Complaint Receipt Date:	12/26/2017
Investigation Initiation Date:	12/27/2017
Report Due Date:	02/24/2018
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:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
• Resident A alleges that staff at the facility do not take him to therapy appointments. His therapy was subsequently cancelled due to him missing his appointments.	Yes
• On December 20, 2017, Resident A alleged that he fell and the facility did not fill out an incident report.	No

III. METHODOLOGY

12/26/2017	Special Investigation Intake 2018A0871009
12/27/2017	Special Investigation Initiated - Telephone Telephone contact with Recipient Rights Officer Melissa Prusi
12/27/2017	APS Referral Through Central Intake to Bay County MDHHS
12/28/2017	Inspection Completed On-site Along with Recipient Rights Officer Melissa Prusi, Interviewed Marc Brodie and Resident A
01/02/2018	Inspection Completed On-site Along with Adult Protective Services Worker Christy Llamas, interviewed Marc Brodie
01/05/2018	Contact - Document Received Received information from Recipient Rights Officer Melissa Prusi regarding appointments
01/31/2018	Exit Conference Telephone contact with Licensee Cindy Whaley
02/02/2018	Inspection Completed On-site

ALLEGATION:
Resident A alleges that staff at the facility do not take him to therapy appointments. His therapy was subsequently cancelled due to him missing his appointments.

INVESTIGATION:
On December 28, 2017, Recipient Rights Officer Melissa Prusi and I conducted an onsite investigation and interviewed Manager Mark Brodie. Manager Brodie said physical therapy was set up and Resident A was supposed to go three times the first week and two times for the following five weeks, for a total of 13 therapy appointments. Manager Brodie indicated there was transportation for Resident A but he would refuse to go to therapy. Resident A would tell him "I'm too tired" and not go to therapy. One day, Resident A stayed in bed and refused to go. Manager Brodie indicated Resident A "decided not to go to therapy." Manager Brodie said he thinks it was three times that he refused to go. Manager Brodie said the manager at the facility that is kitty-corner (Jefferson North, 1611 S. Jefferson, Bay City, MI) and he arranged transportation for Resident A to go to his therapy appointments.

Manager Brodie also said that he sometimes advises Resident A ahead of time of his appointments and agrees to go. When it is time to go to the appointments, Resident A will say "I'm not feeling like going" or "I'm having trouble sleeping." Mr. Brodie said at least on two occasions, Resident A told him he was not going. Mr. Brodie said he lets Paramount Therapy know that Resident A is not coming and there may have been one appointment that was a no show. Mr. Brodie said he prompts and reminds Resident A about his appointments.

Manager Brodie provide me with documentation of appointments missed by Resident A. On November 9, 2017 it is indicated 'refused therapy,' on November 13, 2017 'stated too tired to go,' November 14, 2017 'cancelled don't feel well, tired' and November 20, 2017 'stated I'm not going.'

Resident A was then interviewed and said he was prescribed physical therapy because "my knee keeps popping out" and his right leg is giving him problems. Resident A said he cancelled physical therapy one time because "I was in a mood and have a mood disorder." Resident A said more appointments were cancelled because "no transportation." Resident A said his Paramount Rehab cut him off because he missed two appointments. Resident A said one of his appointments was rescheduled but he did not go and was told there was no transportation available.

On January 2, 2018, I conducted an unannounced onsite investigation with Adult Protective Service Worker Christy Llamas and interviewed Manager Brodie. Manager Brodie indicated Resident A has a "has a history of agreeing" but does not go when it is time. Mr. Brodie said Resident A does not get dressed or says he is not in the mood. Resident A tends to not want to participate.

Resident A was also interviewed and said he likes living there. Resident A did not provide any further information about not going to therapy or it being cancelled.

On January 5, 2018, Recipient Rights Officer Melissa Prusi faxed information she received from Paramount Rehab. Ms. Prusi spoke with Deanna Snable at

Paramount Rehab regarding Resident A. She informed Ms. Prusi about scheduled appointments and they were as follows:

Resident A was scheduled for his initial evaluation on October 12, 2017, which he was a no show. He was then rescheduled for another initial evaluation on November 7, 2017 which he attended. Deanna also provided the following information:

November 9, 2017 – appointment cancelled
November 13, 2017 – no show
November 14, 2017 – appointment cancelled
November 16, 2017 – appointment attended
November 21, 2017 – appointment cancelled
November 24, 2017 – appointment cancelled
November 28, 2017 – no show.

According to Deanna, when the office would call to reschedule an appointment, AFC staff would inform her they were short staffed and had no one to transport Resident A to appointments. She indicated staff at the home were non-compliant which resulted in Resident A being discharged from services.

On January 31, 2018, I conducted a telephone exit conference with Licensee Cindy Whaley.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Resident A told Recipient Rights Officer Melissa Prusi and me that there was no transportation to take him to his therapy appointments. Deanna Snable from Paramount Rehab provided information that Resident A was discharged from services due to staff not being available to transport him. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
On December 20, 2017, Resident A alleged that he fell and the facility did not fill out an incident report.

INVESTIGATION:
On February 2, 2018, I conducted an unannounced onsite investigation and interviewed Manager Marc Brodie. Manager Brodie indicated he did not know anything about Resident A falling on December 20, 2017. Manager Brodie looked through staff progress notes and all the *AFC Licensing Division Incident/Accident Reports* in regards to Resident A and could not find documentation that Resident A fell on December 20, 2017. Manager Brodie indicated that when Resident A went to the hospital on December 22, 2017 his blood pressure was low. Manager Brodie said Resident A is going to be tested for orthostatic hypotension, a condition in which your blood pressure drops when you stand up. Manager Brodie indicated Resident A does not have a history of falling but there is concern when he stands up and feels dizzy.

I also interviewed Resident A and he could not provide any information about a fall on December 20, 2017. Resident A said he was with a peer support and "I misplaced my foot in the car and fell." Resident A indicated staff are "doing what they are supposed to" and has no complaints about the facility.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information: (a) The name of the person who was involved in the accident or incident. (b) The date, hour, place, and cause of the accident or incident. (c) The effect of the accident or incident on the person who was involved and the care given. (d) The name of the individuals who were notified and the time of notification. (e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved. (f) The corrective measures that were taken to prevent the accident or incident from happening again.

ANALYSIS:	Manager Marc Brodie could not provide any documentation about a fall on December 20, 2017 and said he was unaware of any falls on that day. Resident A could not provide any information about falling on December 20, 2017. There is no evidence to confirm violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

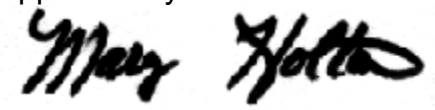
IV. RECOMMENDATION

Upon receipt of an acceptable correction plan, I recommend the status of this adult foster care small group home remain unchanged (capacity 1-6).

02/06/2018

Kathryn A. Huber — Date
Licensing Consultant

Approved By:



02/06/2018

Mary E Holton — Date
Area Manager