RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

May 16, 2018

Tamika Ruth
514 S. Ortman Street
Saginaw, MI 48601

RE: License #: AS730377214
Investigation #: 2018A0572025
Annie's Home Care

Dear Ms. Ruth:

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) 787-7031.

Sincerely,

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730377214
Investigation #:	2018A0572025
Complaint Receipt Date:	03/16/2018
Investigation Initiation Date:	03/19/2018
Report Due Date:	05/15/2018
Licensee Name:	Tamika Ruth
Licensee Address:	514 S. Ortman Street Saginaw, MI 48601
Licensee Telephone #:	(989) 714-1271
Administrator:	Tamika Ruth
Licensee Designee:	N/A
Name of Facility:	Annie's Home Care
Facility Address:	514 N. Warren Avenue Saginaw, MI 48607
Facility Telephone #:	(989) 401-7835
Original Issuance Date:	11/16/2015
License Status:	REGULAR
Effective Date:	05/16/2016
Expiration Date:	05/15/2018
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Concern regarding the lack of dignity and respect as managers make inappropriate comments to residents.	No
Report that Resident B did not receive her medication.	No
Resident A's belongings were left outside and damaged when water poured on them.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/16/2018	Special Investigation Intake 2018A0572025
03/19/2018	Special Investigation Initiated - Letter Complainant.
03/20/2018	APS Referral
04/10/2018	Contact - Telephone call made Complainant.
05/02/2018	Contact - Face to Face Licensee, Tamika Ruth and Resident B.
05/02/2018	Contact - Telephone call made Complainant.
05/10/2018	Contact - Face to Face Resident A
05/10/2018	Inspection Completed-BCAL Sub. Compliance
05/10/2018	Contact - Telephone call made Briana Mc Daniel
05/10/2018	Contact - Telephone call made Case Manager, Laura Long

05/10/2018	Exit Conference Licensee, Tamika Ruth.

ALLEGATION:

Concern regarding the lack of dignity and respect as managers make inappropriate comments to residents.

INVESTIGATION:

On 03/16/2018, a complaint was received at the local licensing office for investigation.

On 03/19/2018, an unannounced visit was made at Annie's Home Care, located in Saginaw County, MI. Interviewed were Licensee, Tamika Ruth and Resident B.

On 03/19/2018, an interview was conducted with Licensee, Tamika Ruth regarding allegations of lack of dignity and respect as managers make inappropriate comments to residents. Ms. Ruth informed that Resident A and Resident B have had issues and indicated that Resident A pulled a knife out on Resident B. Three petitions were filed this week for aggressive behavior, not taking his medications and verbal threats. Ms. Ruth denied that Staff, Keith Bulger has every threatened to snap Resident A's back. She informed that they have argued several times, but Resident A argues with everyone.

On 03/19/2018, an interview was conducted with Resident D regarding any issues with Resident A. She informed that she knows Resident A very well and he no longer lives in the home. She explained a recent encounter where Resident A came into her room and called her an expletive and stated, "Let's fight". Resident D informed Resident A that she did not want to fight him, but he grabbed her by her hair and hit her several times on her back and shoulders. Resident D informed that she was just reading a book at the time. She did not know why he wanted to fight her. Informed that Resident A picks with other residents and staff. She informed that Resident A and Staff, Keith Bulger had gotten into it because he broke Staff, Keith phone and then came after him. She is not aware of Staff, Keith saying that he will snap Resident A's back.

On 03/23/2018, an Licensee, Tamika Ruth was re-interviewed. She informed that Resident A wanted Resident B moved out of the home about a month ago and he would often threaten Resident B and Resident D. Resident A was upset that they did not move Resident B, so he started making inappropriate comments about his private parts and he also jumped on Resident D. Ms. Ruth informed that Resident A's Case Manager indicated that if anyone was messing with Resident A, he would have told her. Resident A had a knife and threatened residents with it and the police were called. Those issues led to him being moved out of the home. Ms. Ruth informed that Resident A keeps coming to the home, although he had been put out.

On 03/26/2018, an interview was conducted with Staff, Keith Bulger regarding allegations of lack of dignity and respect as managers make inappropriate comments to

residents. Mr. Bulger was asked specifically if he had ever stated to Resident A that he'll snap his back. Mr. Bulger denied saying this but informed that they do argue all the time because Resident A would try to run over the ladies in the home and was trying to control everything in the house, including the tv. Resident A moved out a couple days ago. His Case Manager told Resident A that if he felt like he was going to do something, then he needs to go to the Rescue Mission. Resident A had gone a few times. He had gotten into a fight at the Rescue Mission and may have been kicked out of there. Mr. Bulger informed that he heard Resident A came back to the home this morning.

On 03/26/2018, an interview was conducted with Resident B. She was asked if she ever had any issues with Resident A. She informed that Resident A has threatened her and beat up her friend, Resident D. She indicated that she is not Afraid of Resident A and he has never hurt her, but Resident D is afraid of him. She was asked if Resident A and Staff, Keith Bulger ever got into an argument and she informed that they have. When asked if Mr. Bulger ever threatened Resident A, she informed that she did not know.

On 03/26/2018, an Emergency Discharge was received from Ms. Tamika Ruth which indicates that Resident A violated several rules in his assault on Resident D. It is indicated that on 03/16/2018, Resident A tried to fight Resident D and Ms. Ruth got in between the two of them. The Police Dispatcher overheard Resident A threatening to cut Ms. Ruth, so several police cars were sent to Annie's Home Care. The officers informed her that she had to properly discharge him and can't just kick Resident A out of the home because that is a crime. Resident A checked himself into the Rescue Mission and recorded a sex tape on his phone with another resident at the Rescue Mission. Resident A was asked to leave the Rescue Mission because he was showing other residents at the Rescue Mission the sex tape. Resident A returned to Annie's Home Care on 03/18/2018 and continued his behaviors. On 03/22/2018, Resident A went into Resident D's bedroom and jumped on top of her and began pulling her hair and hitting her. Resident A told police that if she would have been quiet, he wouldn't have had to beat her up. Resident B went to the hospital with a pickup order and then went back to the Rescue Mission until his Case Manager can locate another placement.

On 04/10/2018, contact was made with the Complainant regarding their interaction with the home. The Complainant informed that the interaction has been pretty good. The Complainant informed that Adult Protective Services had informed Ms. Ruth to give Resident A a 30-Day Discharge Notice because he kept threatening the residents and he keeps coming back to the home. The Complainant did not have any other issues or concerns beyond the allegations.

On 05/09/2018, contact was made with Resident A regarding allegations of lack of dignity and respect as managers make inappropriate comments to residents. Resident A was asked specifically if Staff, Keith Bulger stated to him that he will snap his back. Resident A informed that this was true, but did not remember what brought this on. Resident A informed that it may have stemmed from an argument. Resident A was

asked if he had any issues with Resident B and he informed that they had several arguments, but nothing serious. He was asked about a knife that he has in his possession and he indicated that he does have a knife, but it is for religious purposes, not a weapon. Resident A informed that it's a Ritual Dagger which is used to practice his faith of Paganism to direct energy from the universe. Resident A admits that he has threatened Resident B verbally and informed that she has threatened him to. He has said things to her out of anger, but had no intentions on ever acting on his threats.

On 05/10/2018, an interview was conducted with Resident A's Case Manager, Laura Long regarding allegations of lack of dignity and respect as managers make inappropriate comments to residents. She informed that she had not heard anything about any staff threatening to snap his back, however; she has witness Resident A making threats towards staff and he has even began making threats at his new home. Ms. Long informed that Resident A told her that he was going to amp up his behavior in order to get the results that he wanted because he was not being moved out of the home quick enough. Ms. Long informed that she has witnessed Resident A threatening Ms. Ruth and he is currently threatening a pregnant staff at his new home.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.**
ANALYSIS:	There is no evidence that Staff, Keith Bulger has threated Resident A. There are several witnesses to Resident A being aggressive towards staff and residents of the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Report that Resident B did not receive her medication.

INVESTIGATION:

On 03/23/2018, Licensee, Tamika Ruth was interviewed regarding allegations that Resident B did not receive her medication on 03/16/2018. She informed that she did receive her medication and that Resident A does things to get out of work. Ms. Ruth pulled up the Electronic Med Sheet and it indicates that Resident B's morning

medication, Omeprazole Cap 20mg was passed by “TR” on 03/16/2018. Ms. Ruth indicated that she is the only worker who passes medication. Ms. Ruth informed that everyone took their medications at the table around breakfast time. Ms. Ruth informed that every time Resident B has to physically work, she will tell people that she either did not take her medications, she did not get fed or she is sick. Ms. Ruth presented a W2 for Resident B showing that she was employed for the entire year of 2017 and made a total of $170.34. Ms. Ruth was asked about Resident B’s memory and she informed that she wasn’t sure if she had any memory issues, but informed that Resident B does see things and said about two months ago that she was pregnant, but her tubes had been tied for 15 years.

On 03/26/2018, contact was made with Resident C regarding allegations that Resident B had not received her medications for the morning. When asked if he has a good memory, he informed that his memory is good. Resident C was asked if all residents had received their morning medications and he informed that they had not. When asked who did not receive their medications, Resident C informed that Resident B did not receive hers. He informed that Resident B left earlier than normal so she didn’t take her medication. Resident C was unsure where she went, but informed that she went towards the bus station.

On 03/26/2018, contact was made with Resident D. When asked who passes their medication, she informed that Ms. Ruth passes their medications. When asked where it is passed, she stated, “At the dining room table.” When asked if Ms. Ruth is ever late or ever forgets to pass any medications, she informed that Ms. Ruth is always on time passing them their medications.

On 03/26/2018, contact was made with Resident B regarding allegations that she did not receive her medication. She stated, “I didn’t take my medication that day but now they have to take a picture of me taking it.” Resident B takes the van and the bus to work, but does not remember how she got to work the day she did not take her medication. She informed that they take their medication at the dining room table. She has never taken them in the living room, or on the van. She has taking them in the bedroom before if she wasn’t feeling well, but mostly takes them in the dining room.

On 03/26/2018, contact was made with staff, Keith Bulger regarding allegations that Resident B did not receive her medication. Mr. Bulger informed that he does not know because he does not normally pass medication. Mr. Bulger indicated that Ms. Ruth passes the medication, unless she has to leave, then she’ll have someone else do it. Mr. Bulger informed that he will pass medication, but he does not give shots.

On 05/10/2018, an interview was conducted with Resident A’s Case Manager, Laura Long regarding medications. She informed that Resident A has never complained about not receiving his medications. The issue with him is refusing to take his medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	There is not enough evidence to say that Resident B did not take her medication. The MAR System indicates that it was taken and Resident B does have a history of saying things to get out of work.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's belongings were left outside and damaged with water poured on them.

INVESTIGATION:

On 04/10/2018, contact was made with the Complainant regarding allegations that Resident A's belongings were left outside and damaged with water poured on them. The Complainant informed that the interaction with the home has been pretty good, however; there was an incident where the staff from Resident A's new placement came to pick up his belongings from Annie's Home Care, the bags were torn and wet. The Complainant informed that the Case Manager had asked the home to keep the belongings until he gets settled into his placement and have the opportunity to get the remainder of his belongings.

On 05/02/2018, contact was made with Licensee, Tamika Ruth regarding allegations that Resident A's belongings were left outside and damaged with water poured on them. Ms. Ruth stated, "He did that." Ms. Ruth informed that his Case Manager picked him up because he had just assaulted Resident D and she took him to the Mission. Resident A packed all of his belongings himself. His Case manager was only able to take only so much of his belongings to the Rescue Mission and only so much of it was able to fit into her car. Resident A's mom said that she was going to pick his belongings up because of all the problems he had at the home, but after two days of waiting for her to pick them up, she never came. Ms. Ruth informed that Resident A wanted his belongings left outside because he didn't want to cause any confusion because of the incident he had with Resident D. Ms. Ruth informed that she brought his belongings back inside the house and took a picture of his bags in the entranceway of the home. She informed that she took pictures of the bags because Resident A was packing himself and he was slanging his bags and throwing them around and didn't want to be blamed regarding any damage it may cause.

On 05/02/2018, contact was made with Resident D regarding allegations that Resident A's belongings were left outside and damaged with water poured on them. She informed that his belongings were outside on the back porch, but does not know why.

Resident D did not recall the bags ever being brought back into the home after they were left outside. She informed that the bags were left outside for about 4 days.

On 05/08/2018, contact was made with Resident A regarding allegations that his belongings were left outside and damaged with water poured on them. Resident A informed that this was true as his clothes were left on the back porch with mop water left on it. Resident A was asked what porch the clothes were left on and he informed that they were left on the front porch, but they were found on the back porch. When asked how he know it was mop water on his clothes, he informed that a mop bucket was next to his belongings and that the mop water has a distinct smell. Resident A informed that Ms. Ruth would not leave his clothing in his old room until he was able to come and get them. Resident A was unable to take all his belongings the day he moved. Resident A informed that nothing was broken or torn, they were just wet.

On 05/10/2018, contact was made with staff, Briana McDaniels of Resident A's new facility. She informed that she transported Resident A to his Annie's Home Care to get the remainder of his belongings and they were located on the back-porch drench with rain or mop water. Ms. McDaniels was unsure if it was rain water or mop water as it had been a rain storm the day before and there was a mop bucket sitting next to Resident A's belongings.

On 05/10/2018, an interview was conducted with Resident A's Case Manager, Laura Long regarding allegations that his belongings were left outside and damaged with water poured on them. She informed that she heard about this incident from the new placement and was told that the new placement took pictures of his bags as they were torn and had some contents poured on them.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(16) Personal property and belongings that are left at the home after discharge shall be inventoried and stored by the licensee. The resident and designated representative shall be notified by the licensee, by registered mail, of the existence of property and belongings. Personal property and belongings that remain unclaimed, or for which arrangements have not been made, may be disposed of by the licensee after 30 days from the date that written notification is sent to the resident and the designated representative.

ANALYSIS:	Resident A's belongings were in a bag, which was left on the porch overnight. The bag(s) appeared to have moved from the front porch, to the back porch. The bag(s) were not stored properly and were drenched by mop water and possibly a rain storm. This was confirmed by an employee from another company.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 05/10/2018, in review of Annie's Home Care file, there was no Incident Reports regarding Resident A's aggressive behaviors. The licensee did not submit an incident report to the department for any of Resident A's aggressive behavior.

APPLICABLE RULE	
R 400. 14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction of property.**
ANALYSIS:	The Licensee failed to provide the responsible party and this department with an Incident Report for Resident A's aggressive behaviors.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable correction action plan, I recommend no change to the licensing status of this small Adult Foster Care group home.

05/16/2018

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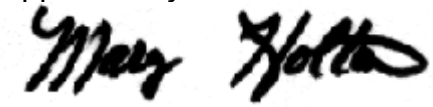
Anthony Humphrey Date
Licensing Consultant

Approved By:



05/16/2018

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Mary E Holton Date
Area Manager