GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 24, 2019

Denise Smith
Fresh Start Transitional Homes
PO Box 503
New Baltimore, MI 48047

RE: License #: AS820283747
Investigation #: 2019A0772025
Fresh Start Transitional Homes

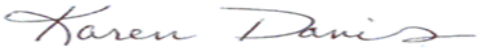
Dear Ms. Smith:

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.

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 (313) 456-0380.

Sincerely,



Karen Davis, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 296-5412

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820283747
Investigation #:	2019A0772025
Complaint Receipt Date:	08/21/2019
Investigation Initiation Date:	08/22/2019
Report Due Date:	10/20/2019
Licensee Name:	Fresh Start Transitional Homes
Licensee Address:	36674 Saint Clair Drive New Baltimore, MI 48047
Licensee Telephone #:	(313) 850-9220
Administrator:	Denise Smith
Licensee Designee:	Denise Smith
Name of Facility:	Fresh Start Transitional Homes
Facility Address:	95 Winona Highland Park, MI 48203
Facility Telephone #:	(313) 850-9220
Original Issuance Date:	10/02/2006
License **Status:**	REGULAR
Effective Date:	05/27/2019
Expiration Date:	05/26/2021
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
• **On 8/20/2019, Resident A was found to have elevated glucose levels on multiple dates with no follow-up with doctor. The protocol for glucose level from the PCP was not in the medication log or chart. Glucose strips were not ordered timely, causing multiple glucose levels not to be taken.**	**Yes**
• **The glucose log was not completed for three days 08/08/2019, 08/09/2019, and 08/10/2019.**	**Yes**

III. METHODOLOGY

08/21/2019	Special Investigation Intake 2019A0772025
08/21/2019	APS Referral
08/22/2019	Special Investigation Initiated - Letter Online complaints
08/28/2019	Contact - Telephone call made Megan Latimer at Central City- left voicemail message for a return call.
08/28/2019	Contact - Telephone call received Ms. Latimer returned call about Resident A.
10/03/2019	Contact - Telephone call made and Exit Conference with Denise Smith
10/07/2019	Inspection Completed On-site
10/09/2019	Contact - Telephone call made to staff Edna Wilson
10/17/2019	Contact - Telephone call made left message.
10/22/2019	Exit Conference - Denise Smith

ALLEGATION:

- **On 8/20/2019, Resident A was found to have elevated glucose levels on multiple dates with no follow-up with the doctor. The protocol for glucose level from the PCP was not in the medication log or chart. Glucose strips were not ordered timely, causing multiple glucose levels not to be taken.**
- **Glucose strips weren't ordered timely for Resident A therefore his glucose levels weren't taken on 08/08/2019, 08/09/2019, and 08/10/2019.**

INVESTIGATION:

On 08/28/2019, I talked with Resident A's caseworker Ms. Latimer from Central City, she stated that licensee designee, Denise Smith, is very good about ordering Resident A's glucose strips, but the glucose levels were not noted on the glucose sheet for 08/08/2019, 08/09/2019, and 08/10/2019. Also, the protocol was not followed when Resident A's glucose levels were over 300 on 8/15/2019 (415), 8/16/2019, (401), 8/19/2019 (390) and nothing was indicated if the protocol was followed in Resident A's case record.

On 10/07/2019, I conducted an on-site investigation at the facility. I interviewed Resident A and reviewed his facility file. Resident A stated that his glucose levels are taken daily. Resident A stated he tests his blood sugar levels while staff watch and record it in his chart. Resident A stated his sugar fluctuates because he does not adhere to his diet. He stated he sees the doctor regularly. Resident A stated that the licensee designee, Ms. Smith, makes sure he has his blood strips. Resident A stated they are kept locked up in the medication cabinet and extras are in the basement.

On 10/09/2019, staff Edna Wilson was interviewed via the telephone. She stated that the days of 08/08/2019, 08/09/2019, and 08/10/2019 she could not locate Resident A's glucose strips and she found them and watched him take his blood sugar levels but failed to write them on in the glucose level form in Resident A's case file. I observed the August 2019 glucose sheet did not have the glucose levels for the dates of 08/08/2019, 08/09/2019, and 08/10/2019. She stated that Resident A's blood sugar is high at times because he goes and buys soda pop and other sweets. She states they follow the doctor's protocol in the file on what to do when his blood sugar is over 300. She stated they encourage water and re-check Resident A's glucose level, if it remains high they call 911. Staff Wilson stated that Resident A will refuse to go to the hospital because he states he is a doctor and knows what to do. I observed that the file had a protocol on what to do if his glucose level is over 300.

On 10/03/19, I interviewed licensee designee, Denise Smith and we discussed the allegations. Ms. Smith stated that she purchases the glucose strips and there was

an adequate supply at the facility and staff Wilson was told to look in the office in the basement. Ms. Smith stated that staff Wilson stated she did take his glucose level for those three days but failed to record them. She stated that the protocol was followed, and incident reports were written. Ms. Smith stated that all the staff were in-serviced in regard to Resident A's glucose levels and the recording protocol in his case records.

On 10/22/2019, I conducted an exit conference via the telephone with licensee designee, Denise Smith. I went over the allegations, my findings, and recommendation.

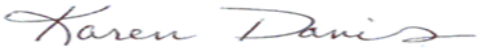
APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	The glucose level was not written in Resident A's case record. Staff Wilson stated she took the glucose levels but did not record them on 08/08/2019, 08/09/2019, and 08/10/2019 . Resident A stated he has not missed any days without taking his glucose levels due to the lack of glucose strips.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**

ANALYSIS:	I did not observe any documentation If the protocol was followed if Resident A's glucose level is over 300. Resident A's levels were documented as follows: 8/15/2019 (415), 8/16/2019, (401), 8/19/2019 (390). At the time of my on-site inspection I did review the case record and the protocol was in Resident A's file.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



10/22/2019

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Karen Davis Date
Licensing Consultant

Approved By:

10/24/2019

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Ardra Hunter Date
Area Manager