GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 12, 2020

Winifred Heighton
118 E. Westwood Drive
Kalamazoo, MI 49006

RE: License #: AF390297391
Investigation #: 2020A0581032
Comforts of Home

Dear Ms. Heighton:

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan. 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 (616) 356-0183.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF390297391
Investigation #:	2020A0581032
Complaint Receipt Date:	04/21/2020
Investigation Initiation Date:	04/22/2020
Report Due Date:	06/20/2020
Licensee Name:	Winifred Heighton
Licensee Address:	118 E. Westwood Drive Kalamazoo, MI 49006
Licensee Telephone #:	(269) 388-8863
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Comforts of Home
Facility Address:	118 E. Westwood Drive Kalamazoo, MI 49006
Facility Telephone #:	(269) 388-8863
Original Issuance Date:	01/30/2009
License Status:	REGULAR
Effective Date:	04/08/2018
Expiration Date:	04/07/2020
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The licensee is unable to care for Resident A.	Yes
Resident A is not receiving her medications on a regular and consistent basis because a medication administration record is not being kept in the facility.	No
The licensee is not providing Resident A with three nutritious meals per day.	No
Additional Findings	Yes

III. METHODOLOGY

04/21/2020	Special Investigation Intake 2020A0581032
04/22/2020	Special Investigation Initiated - Telephone Interview with Complainant.
04/22/2020	Contact – Telephone call made Interview with Guardian A1.
06/03/2020	Contact - Telephone call made Interview with licensee
06/03/2020	APS Referral
06/05/2020	Inspection completed on-site
06/09/2020	APS Referral
06/11/2020	Exit conference with licensee, Winifred Heighton.

ALLEGATION:

The licensee is unable to care for Resident A.

INVESTIGATION:

On 04/21/2020, I received this complaint through the Bureau of Community Health Systems (BCHS') on-line complaint system. The complaint alleged the licensee, Winifred Heighton, "is too old to run the home" and is not able to handle taking care of the residents anymore.

On 04/22/2020, I interviewed Complainant via telephone. Complainant stated Resident A has been residing at the facility since January or February 2020. Complainant stated Ms. Heighton constantly complains about taking care of Resident A. Complainant stated Resident A is incontinent and requires assistance with being lifted and had concerns Ms. Heighton was unable to provide this type of care to Resident A.

On 04/22/2020, I also interviewed Resident A's power of attorney, Guardian A1, via telephone. Guardian A1's statement was consistent with Complainant's statement. Guardian A1 stated Resident A was not assessed by Ms. Heighton when she was first admitted into the facility. Guardian A1 stated she also never signed a document or contract indicating how much adult foster care (AFC) payment was owed to Ms. Heighton every month for the care of Resident A.

On 06/03/2020, I interviewed the licensee, Ms. Heighton, via telephone. Ms. Heighton acknowledged Resident A requires "quite a bit" of personal care in her facility. She stated Resident A requires her assistance with bathing and incontinence, which Ms. Heighton stated she helps by having Resident A "hang onto [her]" and cleaning up after Resident A when she experiences "loose stools." Ms. Heighton stated she can care for Resident A; despite the level of personal care required by Resident A.

Ms. Heighton stated Guardian A1 is not paying her the full AFC payment of $1,650 a month that she and Guardian A1 agreed upon. She stated she did not have a signed *Resident Care Agreement* (RCA) for Resident A and that she and Guardian A1 had a "verbal agreement" for how much she was charging to care for Resident A. Ms. Heighton stated she had Guardian A1 sign "two or three different papers" related to AFC paperwork. She stated it was "[her] mistake" for moving Resident A into her facility without signing an RCA.

On 06/05/2020, I conducted an unannounced on-site investigation at the facility. Ms. Heighton stated she had just gotten home from the store and was glad I showed up when I did. She stated she had her neighbor watch the residents for approximately 30 minutes while she was gone and upon further questioning, Ms. Heighton acknowledged her neighbor was neither a responsible person for her facility nor was

the neighbor approved through the State of Michigan Work Force Background Check system to work with vulnerable adults including adult foster care residents. Ms. Heighton stated she had responsible persons for her facility in the past but currently does not have a responsible person named for the facility. Ms. Heighton stated she was unable to find a responsible person because she cannot afford to pay anyone $15 an hour.

I reviewed both Resident A's and Resident B's resident records. After confirming with Ms. Heighton, I determined there had been no RCA's completed or signed for either Resident A or Resident B. Ms. Heighton stated she told Guardian A1 that she charged $3000 per month; however. Ms. Heighton said she "took a big cut" by taking Resident A into her facility for the lesser amount of $1,650, but "wanted to help out."

I reviewed Resident A's *Assessment Plan for AFC Residents* (assessment plan). There was no specific date identifying when the assessment was completed other than 02/2020. According to the assessment plan, Resident A requires assistance with bathing and walking. The assessment plan stated Ms. Heighton assists Resident A with washing her back and Resident A requires the use of a cane or walker while walking.

I was unable to review Resident A's *Health Care Appraisal* due to Ms. Heighton not having one available. She stated one was not completed at the time of Resident A's admission into the facility. She also did not have one available for my review for Resident B.

Ms. Heighton stated Resident A can change her own incontinence briefs, but she needs to assist Resident A with cleaning up, especially if she experiences loose stools. Ms. Heighton stated Resident A has recently been "unsteady" in the facility and there have been several times she has fallen on the floor and Ms. Heighton was unable to lift her up. Ms. Heighton stated she had to contact her grandson to come assist her and most recently, 911, so that they could help lift Resident A off the floor. Ms. Heighton stated Resident A was "fine" and did not require hospitalization. Ms. Heighton stated she is able to help Resident A up if Resident A can also assist, but if not, then Ms. Heighton stated she's unable to lift Resident A by herself. Ms. Heighton stated her grandson is not a responsible person for the facility and has not been approved to work or volunteer in an Adult Foster Care facility. Ms. Heighton stated she had not issued Resident A a 30-day discharge notice due to the current Covid-19 pandemic.

I was unable to interview Resident A as she was sleeping at the time of the on-site investigation.

I discussed with Ms. Heighton that not having RCA's completed was a repeat rule violation. She acknowledged she "messed up" by not having RCA's signed at admission.

This is a repeat violation of administrative licensing rule 400.1407(5) based on Special Investigation Report (SIR) # 2018A0578031. According to SIR 2018A0578031, dated 06/28/2018, the licensee, Ms. Heighton was required to complete a written resident care agreement for another resident, at the time of her admission, outlining the personal care and services needed by that resident. On 5/21/2018, Ms. Heighton acknowledged she had not yet completed a written *Resident Care Agreement* for that particular resident outlining the specific personal care and services that resident required; therefore Ms. Heighton was unable to provide the care and services required by that resident as written in the completed resident care agreement. According to Ms. Heighton's corrective action plan (CAP), dated 07/13/2018, she stated she would ensure she completes and signs *Resident Care Agreements*. She stated in her CAP she had copies of all state forms, which she would be using.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physicians' instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until a resident assessment plan is made and it is determined that the resident is suitable pursuant to the following provisions: **(a) The amount of personal care, supervision, and protection required by the resident is available in the home.** **(b) The kinds of services and skills required of the home to meet the resident's needs are available in the home.**
ANALYSIS:	Based on my investigation, Ms. Heighton self-reported she was unable to provide the level of care, supervision, protection, skills and services required by Resident A as she was unable to lift her when Resident A began to fall and required assistance with getting up. Licensee Heighton had to rely on EMT assistance and/or her untrained and unapproved relative to assist with Resident A's care. Further, licensee Heighton knowingly left Resident A and Resident B in the care of an individual that had not been approved to work in an Adult Foster Care setting. Ms. Heighton retained Resident A in her facility despite not being able to provide the level of care Resident A required.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physicians' instructions; health care appraisal.**
	(5) At the time of a resident's admission, a licensee shall complete a written resident care agreement which shall be established between the resident or the resident's designated representative, the responsible agency, and the licensee. A department form shall be used unless prior authorization for a substitute form has been granted in writing by the department. A resident shall be provided the care and services as stated in the written resident care agreement.
ANALYSIS:	Ms. Heighton failed to complete or sign a Resident Care Agreement for Resident A or Resident B upon their admissions into the facility. Ms. Heighton stated she had a "verbal agreement" with Guardian A1 on what she would accept as Adult Foster Care payment. Ms. Heighton knowingly accepted and retained Resident A and Resident B into her facility without completing *Resident Care Agreements* outlining the specific personal care and services Resident A and Resident B as required. Ms. Heighton retained Resident A in her facility when she is unable to provide the personal care, supervision and protection required by Resident A. Ms. Heighton described several instances where Resident A had fallen and required assistance from either EMT responders or the licensee's relative with getting up; which Ms. Heighton was unable to provide. This required licensee Heighton to call 911 for assistance and/or an untrained, unapproved relative to lift Resident A from the floor. Therefore, Ms. Heighton is unable to provide the care and services indicated in the Resident Care Agreement, as required.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[SEE SIR # 2018A0578031 dated 06/28/2018 and CAP dated 07/13/2018].**

APPLICABLE RULE	
R 400.1410	**Resident protection.**
	A licensee or responsible person shall always be on the premises when a resident is in the home.
ANALYSIS:	Ms. Heighton indicated during my on-site investigation at the facility on 06/05/2020, she left the residents in the care of her neighbor who had not been approved to work at an Adult Foster Care facility. Ms. Heighton acknowledged not having a responsible person identified for her facility in the event of an emergency, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A is not receiving her medications on a regular and consistent basis because a medication administration record is not being kept in the facility.

INVESTIGATION:

The complaint alleged it was unknown if Resident A was receiving her medications on a regular and consistent basis.

I interviewed Complainant who stated never there were never any documents at the facility that could verify Resident A was receiving her medications. Complainant stated licensee Ms. Heighton, “seemed confused” about how to administer Resident A’s medications and had no routine relating to medications.

Guardian A1’s statement was consistent with Complainant’s statement.

I interviewed Ms. Heighton, via telephone who stated Resident A’s medications are delivered from the pharmacy to her home. She stated she administers Resident A’s medications in the morning, afternoon and evening. She stated she also keeps a log documenting when medications are administered. Ms. Heighton denied not administering Resident A’s medications to her on a regular and consistent basis.

During my on-site at the facility, I reviewed Resident A’s medications and her Medication Administration Record (MAR) for February, March, April, May and June 2020. There was no indication on Resident A’s MAR’s she was not receiving her medications on a regular and consistent basis. The MARs were completed in their entirety and were consistent with instruction on the medication bottles from the pharmacy.

I interviewed Resident B who stated Ms. Heighton administers her medication to her on a regular and consistent basis.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions: **(a) Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years.**
ANALYSIS:	There is no evidence the licensee, Ms. Heighton, is not maintaining a Medication Administration Record for Resident A. I reviewed Resident A's Medication Administration Records for February, March, April, May and June 2020, which indicated Ms. Heighton had administered all of Resident A's medication to her, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The licensee is not providing Resident A with three nutritious meals per day.

INVESTIGATION:

The complaint alleged the licensee is not providing Resident A with three meals a day and was only serving sandwiches and pizza.

I contacted Complainant who provided the same information as was alleged in the complaint. Complainant did not provide any additional information.

Guardian A1's statement was consistent with Complainant's statement.

I interviewed Ms. Heighton who stated she feeds her residents three meals a day. She stated Resident A "doesn't like meat" so she makes her grilled cheese sandwiches and salads. She acknowledged ordering pizza occasionally for dinner stating she "ordered pizza last night." Ms. Heighton stated she tries to get the residents to "eat healthy", but it can be difficult as Resident A likes to drink "a lot of Pepsi" and eat "sweets."

During my on-site at the facility, I observed ample food in Ms. Heighton's facility. Ms. Heighton showed me her food pantry, refrigerator, and freezer; all of which had an abundance of food in them. The food I observed in Ms. Heighton's facility also included fresh fruit and vegetables.

I reviewed Resident A's monthly weight charts, which indicated Resident A weighed 165.2 pounds upon admission in February 2020. The weight chart indicated she was weighed monthly thereafter with no major increase or decrease in weight. As of June 2020, Resident A weighed 163 pounds.

Resident B stated she eats three meals a day in the facility. She stated the food was "good" and stated Ms. Heighton was a good cook.

APPLICABLE RULE	
R 400.1419	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular nutritious meals daily. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on my investigation, there is no indication the licensee, Ms. Heighton, is not providing three nutritious meals per day. My observations of the facility's pantry, refrigerator, and freezer showed there was ample food in the facility, which included fresh fruits and vegetables. In addition, I reviewed Resident A's monthly weight charts which did not indicate Resident A had lost a significant amount of weight since residing at the facility since February 2020.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

During my on-site at the facility, I requested to review Resident A's *Health Care Appraisal* (HCA) form; however, Ms. Heighton stated she did not have one for Resident A. Ms. Heighton stated she ran out of HCA forms and therefore, was unable to complete them. I reviewed Resident B's resident file as well for an HCA form and one was not available for her either.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physicians' instructions; health care appraisal.**
	(9) If a resident is not under the care of a physician at the time of the resident's admission to the home, the licensee shall require that the resident or the resident's designated representative provide a written health care appraisal completed with the 90-day period before the resident's admission to the home. If a written health care appraisal is not available, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department form shall be used unless prior authorization for a substitute form has been granted in writing by the department.
ANALYSIS:	Ms. Heighton acknowledged she did not have *Health Care Appraisals* completed for either Resident A or Resident B, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 06/03/2020, Ms. Heighton stated to me during my telephone interview Resident A sleeps in a recliner in her bedroom. I asked Ms. Heighton if she had a doctor's note or order stating Resident A required the use of a recliner to sleep in and she stated she did not. Ms. Heighton stated Guardian A1 told her Resident A needed to sleep in a recliner.

When I conducted the unannounced on-site investigation at the facility I confirmed through observation, Resident A sleeping in a recliner in her bedroom. I did not observe a bed in Resident A's bedroom. Ms. Heighton stated again that she had a bed for Resident A; however, it had been taken out when she moved in because a recliner was what Resident A preferred. I discussed with Ms. Heighton a bed was required for all residents and if they required something other than a bed then she would need to request a variance, which was an exception to the adult foster care licensing rules.

I also reviewed Resident A's *Assessment Plan for AFC Residents* and there was nothing noted in Resident A's assessment plan indicating she required the use of a recliner to sleep in rather than a bed.

APPLICABLE RULE	
R 400.1433	**Bedroom furnishings.**
	(3) A licensee shall provide a resident with a bed that is not less than 36 inches wide and 72 inches long, with comfortable springs in good condition, a clean protected mattress which is not less than 5 inches thick or 4 inches thick if of synthetic construction, and with a pillow.
ANALYSIS:	Ms. Heighton stated Resident A did not have a bed to sleep in because she preferred a recliner. I also observed no bed in Resident A's bedroom during my on-site at the facility on 06/05/2020 and observed Resident A sleeping in a recliner. Resident A was not provided with a bed, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/11/2020, I conducted an exit conference with licensee, Winifred Heighton, via telephone. Ms. Heighton acknowledged my findings. She requested copies of all adult foster care forms, which I stated I would include with a copy of the special investigation. Consultation was also provided to Ms. Heighton regarding licensure.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend the license be modified to a provisional license.

06/12/2020

Cathy Cushman Date
Licensing Consultant

Approved By:

06/12/2020

Dawn N. Timm Date
Area Manager