GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 06, 2021

Dinah Owiti
Radiant Star LLC
203 Pepperidge Lane
Battle Creek, MI 49015

RE: License #: AS130393042
Investigation #: 2021A0466029
Radiant Star LLC

Dear Ms. Owiti:

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 (517) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS130393042
Investigation #:	2021A0466029
Complaint Receipt Date:	05/13/2021
Investigation Initiation Date:	05/13/2021
Report Due Date:	07/12/2021
Licensee Name:	Radiant Star LLC
Licensee Address:	203 Pepperidge Lane Battle Creek, MI 49015
Licensee Telephone #:	(269) 830-7252
Administrator:	Jasper Mukwada
Licensee Designee:	Dinah Owiti
Name of Facility:	Radiant Star LLC
Facility Address:	203 Pepperidge Lane Battle Creek, MI 49015
Facility Telephone #:	(269) 830-7252
Original Issuance Date:	10/16/2018
License Status:	REGULAR
Effective Date:	04/16/2021
Expiration Date:	04/15/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATIONS:

	Violation Established?
Resident A went to the hospital on 5/12/2021 and the facility could not be reached when Resident A was ready for discharge, so Resident A had to contact family for a ride.	No
Resident A had a physical altercation with a DCW.	Yes
The DCW on duty falls asleep, putting residents at risk of harm.	No
Additional Findings	Yes

III. METHODOLOGY

05/13/2021	Special Investigation Intake-2021A0466029.
05/13/2021	Special Investigation Initiated - Telephone APS Worker Jennifer Stockford interviewed.
05/18/2021	Contact - Document Received-Incident Report.
06/04/2021	Inspection Completed On-site.
06/22/2021	Contact - Document Sent- email to LD Dinah Owiti about documents that were requested on 06/04/2021.
06/22/2021	Contact - Document Received-email from Jasper Mukwada, no documents received.
06/23/2021	Contact - Document Sent- email to LD Dinah Owiti/admin Jasper Mukwada about documents that were requested on 06/04/2021 and have still not been recevied.
06/23/2021	Contact - Document Received from Jasper Mukwada,
07/06/2021	Exit Conference with licensee designee Dinah Owiti.

ALLEGATION: Resident A went to the hospital on 5/12/2021 and the facility could not be reached when Resident A was ready for discharge, so Resident A had to contact family for a ride.

INVESTIGATION:
On 05/13/2021, Complainant reported Resident A went to the hospital on 05/12/2021 and when Resident A was ready for discharge, no one at the adult foster care (AFC) facility could be reached so Resident A had no way to get back home. Complainant reported that Resident A ultimately was able to get a ride from a relative back to the AFC facility.

On 05/13/2021, Adult Protective Services (APS) worker, Jennifer Stockford reported Resident A was not waiting at the hospital a long time for a ride. APS Stockford reported administrator Jasper Mukwada stated that the hospital called but left a voicemail so by the time the facility called back, Resident A had been picked up by relatives and brought back to the facility. Administrator Mukwada reported that the facility was willing to provide Resident A transportation from the hospital however Resident A secured a ride home with his relatives before the facility direct care staff members were even aware of his discharge.

On 06/04/2021, I conducted an unannounced investigation and interviewed direct care worker (DCW) Seth Nshimiyimana who reported he was not aware of the details around this situation as it was handled by administrator Mukwada.

On 06/04/2021, I interviewed Resident A who reported that when he was ready for discharge at the hospital, he called his relative for a ride back home because the hospital could not get a hold of anyone at the adult foster care facility (AFC). Resident A reported that he was not waiting long at the hospital for a ride.

On 06/04/2021, I interviewed licensee designee Dinah Owiti who reported she did receive a voicemail from the hospital about Resident A being ready for discharge. Licensee designee Owiti reported that when she called the hospital back about twenty minutes after the hospital called her, she was told by the hospital that Resident A's family members would bring him back to the facility. Licensee designee Owiti stated that she was willing to provide Resident A transportation from the hospital however Resident A's family picked him up and brought him back. Licensee designee Owiti reported that Resident A was not at the hospital long as he was gone about an hour.

On 06/24/2021, I reviewed Resident A's *Resident Care Agreement* which was dated 07/02/2020 and documented that "the basic fee include the following transportation services." The space under this checked box was left blank.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care

	agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.**
ANALYSIS:	Resident A's *Resident Care Agreement* documented that the basic fee include transportation. Licensee Owiti and administrator Mukwada both reported that they were willing to provide transportation to Resident A from the hospital to the AFC facility, however Resident A called his family to secure a ride first therefore there is not enough evidence to establish a violation before AFC facility staff members were even aware Resident A had been discharged.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A had a physical altercation with a DCW.

INVESTIGATION:
On 05/13/2021, Complainant reported that in 03/2021 Resident A and an unknown DCW had a physical altercation. Complainant reported Resident A fell to the ground during this altercation and injured his leg. Complainant reported Resident A had a bruise on his right lower leg after this event which has turned into a scar in that area from the injury.

On 05/13/2021, APS Stockford reported that administrator Mukwada did not have an Incident Report (IR) from an altercation that took place between DCW Nshimiyimana and Resident A in 03/2021. APS Stockford reported that Resident A told her that DCW Nshimiyimana grabbed him from behind in 03/2021 trying to get the television remote control from him which resulted in Resident A falling and bruising his right lower leg.

On 06/04/2021, I interviewed Resident A who reported that in 03/2021, DCW Nshimiyimana grabbed him from behind in 03/2021 trying to get the television remote control from him which resulted in him falling and bruising his right lower leg which has now turned into a scar. Resident A reported that this altercation was due to not everyone wanting to watch the same television program. Resident A reported DCW Nshimiyimana never completed an IR about this incident. Resident A reported that another Resident did witnesses to this altercation between he and DCW Nshimiyimana however that resident has since moved out of the AFC facility.

On 06/04/2021, I interviewed DCW Nshimiyimana who reported that when the facility was having their floors redone in 03/2021, they stayed at another location for two

nights. DCW Nshimiyimana reported Resident A is the only resident that likes to watch cartoons and Resident A did not allow other residents to watch other types of television shows so other residents were getting upset with Resident A. DCW Nshimiyimana reported by the end of the second evening, residents were fighting over the television because they had watched a lot of cartoons. DCW Nshimiyimana reported Resident A brought out his homemade sword to threaten others, so that he could keep control of the television. DCW Nshimiyimana reported Resident A would not give up the remote control or the plastic sword for the television, so he went to "hold "Resident A because he was holding the sword up in a threatening manner. DCW Nshimiyimana reported that he "held" Resident A down because he was holding the sword in a threatening manor towards other residents. DCW Nshimiyimana reported that he "grabbed" Resident A and put him on the couch because the resident that Resident A was threatening was not able to run away from Resident A and DCW Nshimiyimana reported that he did not have any other option. DCW Nshimiyimana reported he held Resident A for two minutes and then Resident A went to bed. DCW Nshimiyimana denied that Resident A hit is leg or that he had any mark or bruise on his leg.

On 06/23/2021, I recevied an incident report (IR) authored by administrator Mukwada which documented that on 4/21/21 at 20:29 PM, in the "explain what happened "section of the report it stated "[Resident A] threaten staff and another resident with a fake sword because he did not want anyone to use the television. Resident was redirected and encouraged to calm down. "In the "action taken by staff" section of the report it stated "encourage him to calm down, offered him to use personal cell phone but he declined." "Resident was sent to his room." In the "corrective measures" section of the report it stated "encourage resident to respect of TV time. Sign up for programs that others can use the TV."

On 06/24/2021, I reviewed Resident A's *Resident Care Agreement* which was dated 07/02/2020 and documented under "controls aggressive behavior" that Resident A "needs redirection and firm limit setting when aggressive." Additionally, Resident A's *Resident Care Agreement* documented that Resident A "gets along with others."

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:	DCW Nshimiyimana reported that in 03/2021 he "held" Resident A down because he was holding a sword in a threatening manor towards other residents. DCW Nshimiyimana reported that he also "grabbed" Resident A and put him on the couch because the resident that Resident A was threatening was not able to run from him. A violation has been established because DCW Nshimiyimana did not treat Resident A with dignity including protection and safety, in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The DCW on duty falls asleep, putting residents at risk of harm.

INVESTIGATION:
On 05/13/2021, Complainant reported DCWs fall asleep while on duty. Complainant reported residents are at risk of harm when this happens because they have mental health issues and wander away from the home.

On 05/13/2021, APS Stockford reported that Resident A reported DCW Nshimiyimana fell asleep while on shift, but that Resident A could not report when DCW Nshimiyimana fell asleep.

On 06/04/2021, I interviewed DCW Nshimiyimana who reported that there is always an awake DCW on duty during the day and at night. DCW Nshimiyimana denied ever being asleep while on shift.

On 06/04/2021, I interviewed Resident A who reported that DCW Nshimiyimana has fallen asleep while on shift, but he could not recall when that occurred. Resident A did report that although DCW Nshimiyimana fell asleep, no resident eloped nor was any resident harmed.

On 06/04/2021, I interviewed licensee Owiti who reported that there is always an awake staff on duty during the day and at night. Licensee Owiti denied ever being asleep while on shift.

On 06/24/2021, I interviewed administrator Mukwada who reported that there is always an awake staff on duty during the day and at night. Administrator Mukwada denied ever being asleep while on shift.

On 07/02/2021, administrator Mukwada provided a staff schedule for May 2021 which documented that the facility has a DCW on shift 24 hours a day seven days a week including a DCW at night.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Although Resident A reported that DCW Nshimiyimana has fallen asleep while on shift, Resident A could not recall when that occurred. Additionally, Resident A did report that although DCW Nshimiyimana fell asleep, no resident eloped nor was any resident harmed. Additionally, licensee Owiti and administrator Mukwada reported that there is always an awake staff on duty during the day and at night. Administrator Mukwada, licensee Owiti and DCW Nshimiyimana denied ever being asleep while on shift therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 05/13/2021, APS worker Stockford reported that while she was at the facility on 05/13/2021, DCW Nshimiyimana did not have access to the resident records nor did administrator Jasper Mukwada.

On 06/04/2021, I conducted an unannounced investigation and DCW Nshimiyimana was on duty. DCW Nshimiyimana reported that he was the live-in staff however he did not have access to the resident records so he could not provide me with Resident A's written assessment plan or Resident A's resident care agreement.

During the time I was at the facility for the investigation on 06/04/2021, licensee designee Owiti came to the facility. Licensee designee Owiti reported that she did not have keys to the office that contained the resident records so she could not provide me with Resident A's written assessment plan or Resident A's resident care agreement either.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with licensee.

	A licensee shall maintain a copy of the resident's written assessment plan on file in the home. **(8) A copy of the signed resident care agreement shall be provided to the resident or the resident's designated representative. A copy of the resident care agreement shall be maintained in the resident's record.**
ANALYSIS:	On 06/04/2021, I conducted an unannounced investigation and DCW Nshimiyimana nor licensee designee Owiti had access to the staff office where the resident records were kept. Due to the fact that Resident A's written assessment plan and Resident A's resident care agreement were not available for review at the time the inspection was conducted a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 06/04/2021, I conducted an announced investigation and the window in the kitchen was open and being used for ventilation without a mesh screen. I observed flies in the home from the window not having a mesh screen on it.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(7) Each habitable room shall have direct outside ventilation by means of windows, louvers, air-conditioning, or mechanical ventilation. During fly season, from April to November, each door, openable window, or other opening to the outside that is used for ventilation purposes shall be supplied with a standard screen of not less than 16 mesh.
ANALYSIS:	On 06/04/2021, the kitchen window was open and being used for ventilation however it did not have a mesh screen on it therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 06/04/2021, I conducted an unannounced investigation and DCW Nshimiyimana, Resident A and licensee designee Owiti all reported that DCW Nshimiyimana was a live-in-staff. DCW Nshimiyimana reported that he has been the live-in-staff at the facility for the past 15 months.

As of the writing of this report, licensee designee Owiti did not provide the department with written notice of changes in the household.

APPLICABLE RULE	
R 400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(5) An applicant or licensee shall give written notice to the department of any changes in information that was previously submitted in or with an application for a license, including any changes in the household and in personnel-related information, within 5 business days after the change occurs.
ANALYSIS:	On 06/24/2021, DCW Nshimiyimana, Resident A and licensee designee Owiti all reported that DCW Nshimiyimana is live-in-staff. Licensee designee Owiti did not provide the department with written notice of changes in the household therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend no change in the license status.

07/06/2021

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Julie Elkins Date
Licensing Consultant

Approved By:

07/06/2021

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Dawn N. Timm Date
Area Manager