GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 20, 2021

Reconna Marshall
A Caring Touch LLC
11854 Kennebec
Detroit, MI 48205

RE: License #: AS820398784
Investigation #: 2021A0101023
A Caring Touch

Dear Mrs. Marshall:

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 (313) 456-0380.

Sincerely,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820398784
Investigation #:	2021A0101023
Complaint Receipt Date:	06/24/2021
Investigation Initiation Date:	06/25/2021
Report Due Date:	08/23/2021
Licensee Name:	A Caring Touch LLC
Licensee Address:	11854 Kennebec Detroit, MI 48205
Licensee Telephone #:	(313) 492-9371
Administrator:	Reconna Marshall
Licensee Designee:	Reconna Marshall
Name of Facility:	A Caring Touch
Facility Address:	11866 Kennebec St Detroit, MI 48205
Facility Telephone #:	(313) 371-7011
Original Issuance Date:	02/18/2020
License **Status:**	REGULAR
Effective Date:	08/18/2020
Expiration Date:	08/17/2022
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
On 06/02/2021 Resident A's daughter arrived at the group home and she observed the only direct care staff (DCS) on duty exiting a car where marijuana was being smoked. Resident A and two other residents were left alone inside of the home. Resident A has dementia and should not be left alone.	Yes
After this incident occurred the licensee changed the visitation policy to appointments only.	Yes

III. METHODOLOGY

06/24/2021	Special Investigation Intake 2021A0101023
06/25/2021	Special Investigation Initiated - Telephone LD
06/25/2021	Contact – Telephone call made. Resident A's daughter
06/25/2021	Contact - Document Received
06/27/2021	Contact - Document Received
07/14/2021	Contact - Document Received
08/10/2021	Inspection Completed On-site
08/10/2021	Inspection Completed-BCAL Sub. Compliance
08/11/2021	Contact – Telephone call made. Resident A's daughter
08/11/2021	Contact - Document Received

08/11/2021	APS Referral
08/11/2021	Contact – Telephone call made Direct Care Staff (DCS)
08/11/2021	Exit Conference
08/11/2021	Corrective Action Plan Requested and Due on 09/01/2021

ALLEGATION: On 06/02/2021 Resident A's daughter arrived at the group home and she observed the only direct care staff (DCS) on duty exiting a car where marijuana was being smoked. Resident A and two other residents were left alone inside of the home. Resident A has dementia and should not be left alone.

INVESTIGATION: On 06/25/2021 I interviewed Resident A's daughter. Resident A's daughter stated on 06/02/2021 she arrived at the group home at approximately 6:00 pm to visit her mother. Upon arrival she observed the only direct care staff (DCS) on duty exiting a car where marijuana was being smoked. She further stated her mother who has dementia, and two other residents were left alone inside of the home. Resident A's daughter stated she did not know the name of the staff who was on duty.

I interviewed the Licensee Designee Reconna Marshall on 06/25/2021. Ms. Marshall stated the staff person on duty was Kebra Ramsey. Ms. Marshall stated when Resident A's daughter called her on 06/02/2021 and apprised her of the situation, she immediately sent DCS Alayja Dean to the home. Ms. Marshall stated Ms. Ramsey denied smoking marijuana. According to Ms. Marshall, Ms. Ramsey told her it was her boyfriend who was smoking marijuana in the car. Ms. Marshall further stated Ms. Ramsey was immediately taken off the schedule and was sent to Concentra for drug testing. When I was at the home on 08/10/2021 Ms. Marshall informed me, Ms. Ramsey never gave her the drug test result and therefore was subsequently terminated. Ms. Ramsey also stated her security footage, which is now erased, showed Ms. Ramsey was outside of the home. Ms. Marshall stated the security footage did not show if Ms. Ramsey was smoking marijuana.

Ms. Alayja Dean was interviewed on 08/11/2021. Ms. Dean stated on 06/02/2021 she went to the home to relieve Ms. Ramsey. She further stated Ms. Ramsey went to the car to get snacks from her friend.

On 08/10/2021 and 08/11/2021 I reviewed the resident records. Resident A is a fall risk, cannot walk independently and has dementia. Resident B's, and C's

assessment plans did not indicate a need to be within staff eyesight at all times unlike Resident A. Resident B and C both move independently in the community, communicate needs, understands communication, manage money and alert to their surroundings.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**
	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.
ANALYSIS:	Direct care staff Kebra Ramsey was not suitable to assure the welfare of the residents. While on duty Ms. Ramsey left Resident A unattended and out of sight while deciding to sit in a car where marijuana was smoked.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	DCS Kebra Ramsey left three residents alone in the home. Resident A is a fall risk, cannot walk independently and has dementia. Therefore, it is concluded the licensee failed to provide protection and safety to Resident A at all times. Leaving Resident A alone put her at substantial risk of harm.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: After this incident occurred the licensee changed the visitation policy to appointments only.

INVESTIGATION: On 06/25/2021 I interviewed Resident A's daughter. Resident

A's daughter stated after she reported observing the only staff person on duty exiting a car where marijuana was being used to Ms. Marshall, Ms. Marshall told her she needed to make an appointment when she plans to visit her mother.

I interviewed Ms. Marshall on 06/25/2021, she stated she changed the visitation policy to appointments only, due to the pandemic and to ensure sufficient staffing is available.

APPLICABLE RULE	
R 400.14304	**Resident rights.**
	(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule. **and safeguard the resident's rights specified in subrule (1) of this rule.**
For Reference:	**1(k) The right to have contact with relatives and friends and receive visitors in the home at a reasonable time. Exceptions shall be covered in the resident's assessment plan. Special consideration shall be given to visitors coming from out of town or whose hours of employment warrant deviation from usual visiting hours.**
ANALYSIS:	Ms. Marshall changed the visitation policy to appointments only, after Resident A's daughter observed the DCS on duty exiting a car where marijuana was being smoked. The licensee failed to respect and safeguard Resident A's right to have contact with relatives and friends and receive visitors in the home at a reasonable time. Appointments are required to cover exceptions in the resident's assessment plan and visitors coming from out of town or whose hours of employment warrant deviation from usual visiting hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 08/10/2021 I reviewed the residents' records. Ms. Marshall is providing care to a resident with Dementia. Ms. Marshall is not licensed to provide care to this population and do not meet the qualifications to provide care to individuals with Alzheimer's Disease or related conditions.

On 08/10/2021 I interviewed Ms. Marshall. Ms. Marshall stated she accepted a resident with dementia because her program type includes the aged and Resident A

was in the home during her last renewal inspection.

On 08/11/2021 I interviewed Resident A's daughter. Resident A's daughter stated she did not receive a written description of the services provided by the home or facility to patients or residents with Alzheimer's Disease or related conditions. Resident A's daughter further stated at the time of placement Ms. Marshall was aware that her mother has Dementia as indicated in Resident A's assessment plan. Resident A's assessment plan was completed by Ms. Marshall when Resident A was admitted into the home.

APPLICABLE RULE	
MCL 400.726b	**Adult foster care; description of services to patients or residents with Alzheimer's disease; contents; "represents to the public" defined.**
	(1) Beginning not more than 90 days after the effective date of the amendatory act that added this section, an adult foster care large group home, an adult foster care small group home, or an adult foster care congregate facility that represents to the public that it provides inpatient or residential care or services, or both, to persons with Alzheimer's disease or related conditions shall provide to each prospective patient, resident, or surrogate decision maker a written description of the services provided by the home or facility to patients or residents with Alzheimer's disease or related conditions. A written description shall include, but not be limited to, all of the following: **(a) The overall philosophy and mission reflecting the needs of residents with Alzheimer's disease or related conditions.** **(b) The process and criteria for placement in or transfer or discharge from a program for residents with alzheimer's disease or related conditions.** **(c) The process used for assessment and establishment of a plan of care and its implementation.** **(d) Staff training and continuing education practices.** **(e) The physical environment and design features appropriate to support the function of residents with Alzheimer's disease or related conditions.** **(f) The frequency and types of activities for residents with Alzheimer's disease or related conditions.** **(g) Identification of supplemental fees for services provided to patients or residents with Alzheimer's disease or related conditions.**

ANALYSIS:	Ms. Marshall is not licensed to provide care to this population and do not meet the qualifications to provide care to individuals with Alzheimer's Disease or related conditions.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 08/10/2021 I reviewed DCS Kebra Ramsey employee record. Ms. Ramsey employee record did not contain verification of training in the following areas:

Reporting requirements
Personal care, supervision, and protection

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Ms. Ramsey employee record did not contain verification of training in the following areas: • Reporting requirements • Personal care, supervision, and protection
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 08/10/2021 I reviewed Ms. Marshall's personnel policies. The personnel policies did not contain the following required content:

Mandatory reporting

Act 218 (AFC)
Act 519 (APS)

Resident care related prohibited practices:
Rule 307(4) – Intervention not for punishment, discipline, convenience
Rule 308 – Behavior intervention prohibitions
Rule 309(8) – Crisis intervention not used without training
Rule 315(9) – No ownership interest
Rule 315(10) – No accepting, borrowing or taking funds/valuables

Confidentiality requirements including those specified in law:
Act 218 Sec.12(3) – safeguarding resident records
Rule 304(1)(q) – Resident right to confidentiality of records

Training requirements
Resident Rights (SEE RULE 304).
Process for having staff review the licensing statute (ACT 218) and the administrative rules (GROUP HOME RULES).

APPLICABLE RULE	
R 400.14207	**Required personnel policies.**
	(1) A licensee shall have written policies and procedures that include all of the following: **(a) Mandatory reporting, including reporting that is required by law.** **(b) Resident care related prohibited practices.** **(c) Confidentiality requirements, including requirements specified in law.** **(d) Training requirements.** **(e) Resident rights.** **(f) The process for reviewing the licensing statute and administrative rules.**
ANALYSIS:	The personnel file of Ms. Marshall did not contain the following: Mandatory reporting Act 218 (AFC) Act 519 (APS) Resident care related prohibited practices: Rule 307(4) – Intervention not for punishment, discipline, convenience Rule 308 – Behavior intervention prohibitions Rule 309(8) – Crisis intervention not used without training Rule 315(9) – No ownership interest

	Rule 315(10) – No accepting, borrowing, or taking funds/valuables Confidentiality requirements including those specified in law: Act 218 Sec.12(3) – safeguarding resident records Rule 304(1)(q) – Resident right to confidentiality of records Training requirements Resident Rights (SEE RULE 304). Process for having staff review the licensing statute (ACT 218) and the administrative rules (GROUP HOME RULES).
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 08/10/2021 I reviewed DCS Kebra Ramsey employee file. Ms. Ramsey employee file did not contain verification of receipt of the policies and procedures.

APPLICABLE RULE	
R 400.14207	**Required personnel policies.**
	(2) The written policies and procedures identified in subrule (1) of this rule shall be given to employees and volunteers at the time of appointment. A verification of receipt of the policies and procedures shall be maintained in the personnel records.
ANALYSIS:	Ms. Ramsey employee file did not contain verification of receipt of the policies and procedures.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 08/10/2021 I reviewed Resident A's resident records. A department health care appraisal form was not being used.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	The licensee did not use the department health care appraisal form for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

RECOMMENDATION

Upon submission of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

Edith Richardson
Licensing Consultant

08/12/2021
Date

Approved By:

8/20/21

Ardra Hunter
Area Manager

Date