STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

October 1, 2021

Peggy Root
411 Silver Street
Reading, MI 49274

RE: License #: AM300008365
Investigation #: 2021A0007020
Heritage House AFC

Dear Ms. Root:

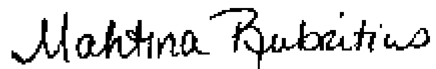
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604

Enclosures

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AM300008365
Investigation #:	2021A0007020
Complaint Receipt Date:	07/27/2021
Investigation Initiation Date:	07/30/2021
Report Due Date:	09/25/2021
Licensee Name:	Peggy Root
Licensee Address:	411 Silver Street Reading, MI 49274
Licensee Telephone #:	(517) 283-1478
Administrator:	Peggy Root
Licensee Designee:	Peggy Root
Name of Facility:	Heritage House AFC
Facility Address:	121 West State Street Reading, MI 49274
Facility Telephone #:	(517) 283-3152
Original Issuance Date:	08/02/1993
License Status:	REGULAR
Effective Date:	04/23/2020
Expiration Date:	04/22/2022
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was on the phone with a friend and the owner, Ms. Root, grabbed the phone from him and hung it up, for an unknown reason. Ms. Root screams at Resident A and is very verbally abusive towards him. Resident A lost his mother on April 13, 2021. Ms. Root threatened to not allow Resident A to go to his mother's memorial multiple times.	Yes
APS has been to the home multiple times, but no one tells them the truth due to threats from Ms. Root.	No
Allegations that Resident A does not get enough to eat.	No

III. METHODOLOGY

07/27/2021	Special Investigation Intake - 2021A0007020
07/27/2021	APS Referral Received.
07/30/2021	Special Investigation Initiated – Telephone - Interview with Family Member A.
07/30/2021	Contact - Telephone call received from Family Friend #1.
08/03/2021	Contact - Telephone call made to Family Friend #1. Message left.
08/05/2021	Contact - Telephone call received from Family Friend #1. Interview.
08/09/2021	Inspection Completed On-site
08/10/2021	Contact - Document Received - Email from Ms. Root.
08/11/2021	Contact - Telephone call received from Family Member #1. The guardian is on a "power trip."
08/11/2021	Contact - Telephone call received from Family Member #1.
08/12/2021	Contact - Telephone call made to Ms. Cossel, APS Supervisor. They already received and investigated the complaint.

08/18/2021	Contact - Telephone call received from Ms. Clark, APS Worker.
08/20/2021	Contact - Telephone call made to Ms. Clark, no answer. Follow-up email sent. I requested a returned phone call.
08/25/2021	Contact - Telephone call received from FF #1. Resident A is using the phone. Ms. Root called her. There is no voicemail set up at the home. Can't get through. The court returned the guardianship paperwork.
08/30/2021	Contact - Telephone call received from FF #1 Resident A still not allowed to use the phone. The guardian won't communicate with them. The facility is up for sale.
09/01/2021	Contact - Telephone call received from Ombudsman Worker #1.
09/02/2021	Contact - Telephone call received from Ms. Root.
09/03/2021	Contact - Telephone call received from FF #1.
09/22/2021	Contact - Telephone call made to Ms. Cossel, APS Supervisor.
09/23/2021	Contact - Document Received from APS.
09/23/2021	Contact - Telephone call received from Ms. Cossel, APS Supervisor.
09/23/2021	Contact - Telephone call made to facility. I spoke to Ms. Baker, Direct Care Staff, Resident E and Resident F.
09/23/2021	Contact - Telephone call made to Guardian A. Interview.
09/24/2021	Contact - Document Received - Email from Ms. Rodgers, APS Supervisor. There have been about nine complaints at this facility.
09/24/2021	Contact - Telephone call made to Ms. Root regarding the exit conference. No answer.
09/24/2021	Exit Conference (attempted) - Telephone call made to the facility. Ms. Baker informed me that Ms. Root was not at the facility. I requested a returned phone call regarding the exit conference. Ms. Baker informed that it would probably be on Monday, as Ms. Root is out of town.

09/28/2021	Contact - Telephone call made to Ms. Root regarding the exit conference. No answer.
09/30/2021	Contact – Document Sent – Email to Ms. Root. I requested that she give me a call that afternoon, so the exit conference could be completed.
09/30/2021	Contact – Document Received – Email from Ms. Root. She requested that I call her.
09/30/2021	Exit Conference conducted with Ms. Root.

ALLEGATIONS:

Resident A was on the phone with a friend and the owner, Ms. Root, grabbed the phone from him and hung it up, for an unknown reason. Ms. Root screams at Resident A and is very verbally abusive towards him. Resident A lost his mother on April 13, 2021. Ms. Root threatened to not allow Resident A to go to his mother's memorial multiple times.

INVESTIGATION:

Resident A is a 64-year-old male, who resides in Heritage House AFC Home.

On July 30, 2021, I interviewed Resident A's sister, Family Member #1 (FM #1). FM #1 informed me that she resides in another state and that she had difficulties reaching her brother, Resident A, who resides at the facility. Prior to being placed in group homes, Resident A resided with their mother. FM #1 explained that before her brother was removed from her mother's care, he (Resident A) experienced verbal abuse. Their mother suffered with a mental illness. In addition, that Resident A and his mother would scream and swear at each other. FM #1 informed me that now Resident A is placed in this home and Ms. Root is a "screamer." FM #1 stated that she knew Ms. Root was hard of hearing. She also talked about incidents that occurred and the challenges her family faced. Resident A is a registered sex offender. FM #1 stated that her brother has an anger issue.

FM #1 recalled that she and other family members were trying to get a hold of Resident A. Phone calls to the facility were unanswered. However, when Family Member #2 called from his phone, he was able to get through and speak with Resident A. While on the phone, Resident A was upset and stated that he wanted out of the home. After being calmed down over the phone, Resident A was able to tell FM #2 what happened, leading up to him being grounded. Resident A was on the

phone with a family friend (FF #1). Resident A and FF #1 were talking about a cat named Gracie, when Ms. Root grabbed the phone and hung up.

FM #1 informed me that their mother passed away in April. The memorial service for her mother was held on July 15, 2021. The location was about two hours away from the facility; therefore, FM #1 asked if Resident A could stay overnight in a hotel to reduce the drive times. This wasn't allowed. FM #1 stated that she didn't understand why. According to FM #1, staff harassed Resident A and told him that he didn't have to go to his mother's memorial.

FM #1 recalled another incident. FM #1 resides in Florida. When Resident A got upset, he said to Ms. Root that he was moving to Florida. Ms. Root asked FM #1 about this, and FM #1 told her that she told Resident A that she didn't think it was possible but that she would check into it. Then Ms. Root says to Resident A "I TOLD YOU! YOU WEREN'T MOVING!" This caused Resident A to become upset, escalating the situation. FM #1 told Ms. Root that the past counselors said going for a walk could help when he was having a meltdown. Ms. Root said walking is a privilege. Ms. Root and Resident A were arguing back and forth. FM #1 stated that Ms. Root knew how to push his buttons. Resident A was put in his room for time out.

FM #1 also informed me that law enforcement was contacted for a welfare check as they could not get a hold of Resident A. Officer Cooley called the home and they answered the phone. The police told them that his family was trying to get a hold of him. Staff told the police that Resident A was fine. FM #1 reported that Resident A is used to riding his bike around town, on his own. Her brother reported that he was grounded and could not leave the home. During the interview with FM #1, she stated that Ms. Root was not a nice person.

FM #1 informed me that an old shed was purchased for $400.00 for Resident A's belongings. There is a concern regarding the condition of the shed and the lock is broken.

On August 5, 2021, I spoke with Family Friend #1 (FF #1). She reported to know the family for a long time. She stated that Resident A loved his mother, even though she was abusive. Resident A was removed and placed in a group home. FF #1 expressed that there is family who wants to take care of Resident A. In the past, Resident A's siblings, (Family Member #1 and Family Member #3) were told by an APS Worker that the courts would not give them guardianship because they resided out of state. FF #1 reported that she has been a longtime family friend, she has an apartment, and she could care for Resident A. According to FF #1, FM #1 said that she (FF #1) needed to be Resident A's guardian. FF #1 reported that she has mailed the paperwork to apply for guardianship.

Regarding the phone call on July 24, 2021, FF #1 stated that FM #1 had given her the phone number to the staff phoneline, and she was able to speak with Resident A. FF #1 and Resident A talked about placement and FF #1 asked if he would like to

stay with her. She resided in the area that he was familiar with, extended family members lived close by, and he might be able to return to his employment at Kroger. FF #1 had switched subjects and were then talking about a pet cat. Prior to the lady (Ms. Root) picking up the phone, FF #1 had told Resident A that she would have to get permission from the judge first; before any changes could be made. FF #1 informed that she was trying to calm Resident A down. FF#1 stated that the lady got on the phone and started in on her. Ms. Root stated that Resident A was not going anywhere! Ms. Root reported to wear a hearing aid. Ms. Root told FF #1 that she had no idea what she had to put up with. FF #1 told Ms. Root that Resident A needed grief counseling to deal with his mother passing away. During the conversation, Ms. Root was "nasty", and FF #1 told Ms. Root that she did not know her, but she would do some research. There was a concern that Ms. Root could treat a stranger this way, going off, and she didn't even know FF #1. FF #1 told Ms. Root that she didn't deserve that treatment and to have a blessed day. After that phone call (on or about July 24, 2021), Resident A was grounded.
FF #1 further recalled that Family Member #3 (FM #3) and FF #1 called Resident A and spoke to him on a three-way phone call. Resident A told them that he got grounded and that he was too old to get grounded. FF #1 told Resident A that she was sorry.

According to FF #1, in another attempt to call the facility (specific date unknown), there was no one answering the facility phone. She even checked to make sure there was not a power outage in the area. Then FF #1 contacted the local police, speaking with Officer Cooley. He reported to know where the facility was located, as he had dealt with Ms. Root in the past. Officer Cooley made sure that the phone was working. Officer Cooley reached out to facility staff and let them know that the family would like to talk to Resident A. It appeared that the calls were being screened (as when certain family members called) the phone just rings and rings.

According to FF #1, there were five calls made to the home on July 30, 2021, and there was no answer.

FF #1 informed me that Resident A likes to ride his bike and go for walks; however, he's not allowed to go for walks. He can't use the phone and he is sent to his room. There are also concerns that he has not received any grief counseling. FF #1 also expressed concerns that Resident A was charged $400 for a shed to store his belongings outside. The lock on the shed is broken.

On August 9, 2021, I conducted an unannounced on-site investigation and made face-to-face contact with Ms. Root, Licensee, Resident A, Resident B, and Resident C. When I arrived, they were outside, unloading a vehicle. Ms. Root was on the phone but invited me into the home. As I stood in the dining room waiting for Ms. Root to end her conversation, the residents walked up and said hello. I made face-to-face contact with Resident A. I asked if I could speak with him outside and he agreed.

On August 9, 2021, I interviewed Resident A outside on the back porch of the facility. It was somewhat difficult to understand Resident A; however, he did confirm that he had been grounded. When asked why, he stated “I got mad.” Resident A informed me that he told Ms. Root that he was moving out and Ms. Root said, “you’re not.” Resident A confirmed that he wanted to move out of the home. Resident A told me that he can’t talk to his sister FM #1 or FF #1. While I was talking to Resident A, Ms. Root and two other residents (names unknown), entered the yard, placing plants next to the house. The interview was paused, and once they left, the interview was continued.

I inquired about the incident when he (Resident A) was on the phone with FF #1. Resident A told me that Ms. Root said to give her the phone. FF #1 heard Ms. Root talking to him. Ms. Root was yelling. Ms. Root hung up the phone on FF #1.

I asked if Resident A is allowed to go for a walk and he stated, “now I can, and I can ride my bike.” Resident A pointed out that he had a bench, a chair, and some other items that belonged to him. There was also a shed, which he kept some of his belongings including his bike and some other items. Resident A reported to not be concerned about the broken lock. The condition of the shed appeared to be okay.

On August 9, 2021, once back in the facility, I asked to review Resident A’s file. Resident A was admitted into the facility on October 5, 2017. While at the table, Ms. Root told me “You have no idea what these people are like.” Ms. Root explained that when Resident A’s mother passed, FM #1 took Resident A to FF #1’s house and asked if she would become the guardian. FF #1 has an apartment. Additionally, that Resident A could get a job at ACE Hardware. Ms. Root reported that Resident A’s guardian (Guardian A) has the paperwork, documenting that he can’t live alone. According to Ms. Root, since Resident A’s mother has passed, the family now wants to know the financials, as they thought his mom left him some money. I inquired about the shed, and Ms. Root informed me that the shed was purchased for Resident A (he’s not renting it), and when he leaves, the shed will go with him. While at the facility, I reviewed the checkbook which noted that the shed had been purchased for $400.15.

Ms. Root stated that Resident A is rageful. In addition, that he has stated that he doesn’t have to live there and that she does not care for him.

I reviewed Resident A’s file, which contained a letter from Guardian A. The letter was dated July 27, 2021. It was documented that the Guardian permitted the staff and licensee of the home to limit, as deemed necessary, and monitor Resident A’s phone calls from his sister (FM #1) and family friend (FF #1), due to recent incidents and behaviors from Resident A after phone conversations with them. A copy of the letter was retained for the licensing file.

During the conversation, Ms. Root appeared very agitated. As I was discussing information in the file and asking for clarification on a document, Ms. Root aggressively pushed the file towards me on the table, so I could see the document. I stated, “you’re throwing things?” Ms. Root then stated in a loud voice, “you’re making false accusations!” I apologized and said I misspoke. I said “you’re pushing things” towards me.

I asked to see the Resident Funds Part I & II forms and she reported that she did not have them. I asked to review Resident A’s weight chart and Ms. Root did not have that document either. It should be noted that Ms. Root faxed these documents to me the following day.

I asked if Resident A is grounded and Ms. Root replied when he is swearing and saying, “I don’t have to fucking stay here,” and “I ask him to please stop; we don’t talk that way to you.” I asked if she sent him to his room and Ms. Root stated “yes, I do because no one should have to listen to that.” Ms. Root followed up by stating that Resident A is asked to go to his room.

Regarding the phone calls, Ms. Root informed that she does have to monitor the phone calls. She stated that they (family) have not called in the last three or four weeks. Ms. Root informed me that Resident A can call them, but she has to be there to monitor the conversation; this is per the guardian’s directions. Per Ms. Root, before July 27, 2021, his calls were “never, ever” monitored. Per Ms. Root, Ms. Williams was the staff on duty when Officer Cooley called the facility regarding Resident A.

I inquired about the phone call with FF #1 and Ms. Root stated, “it wasn’t good.” Ms. Root described that FF #1 didn’t understand AFC, and Ms. Root suggested that she could ask some questions regarding the matter first. Ms. Root denied yelling but informed that if she raised her voice, it was in frustration. Ms. Root admitted that she was a little frustrated. During the conversation, FF #1 told Ms. Root that she was going to check into her, and Ms. Root provided her name and the website. Ms. Root stated she had nothing to hide.

As I was concluding my investigation, Ms. Root wanted to discuss another matter. It should be noted that I conducted a previous investigation and Ms. Root wanted to discuss those findings. I informed that I was not going to discuss that investigation at that time and informed her of protocols if she wanted to follow up. Ms. Root then forcefully closed her notebook. I brought this to her attention and stated that I was just going to leave. She stood up, stomping her foot, and asked if I knew if she did that all the time. I replied that I didn’t know. Ms. Root stated that she was sure this would be in my report.

On August 10, 2021, Ms. Root sent me an email and the relevant parts included the following:

Ms. Root informed me that Resident A's Funds Part II form was in his file in the locked drawer and that it would be faxed over.

In addition, that she (Ms. Root) was thinking about Resident A's eating and "it can only be because they didn't think he was getting enough food. they have never asked. I spoke w/ both AJ and SarAH AND THEY SAID NO THEY HADN'T . HE WILL OFTEN RFUSE 2ND SAYING HE IS FULL OR WHEN HE IS IN A MODD(USUALLY AFTER SPEAKING WITH THEM THAT HE WILL REFUSE TO EAT MY "CRAp yes i'M frustrated(as i have a right to be)When they keep this up. if they don't like him living here or his guardian they have the Right to go to court. which they don't do AND INSIST ON DOING THIS THESE TYPE OF THINGS [Resident A] HAS TOLD ME MORE THAN ONCE (AFYER HE SPOKE W/ THEM) THAT THEY WILL GET ME CLOSED , TAKING ME TO COURT TO DO IT…."

It was also documented in the email that "AS FAR AS "CLOSING MY NOTE BOOK, IT WAS IN I"'M SO GLAD THIS IS OVER". NOT ANGER ETC I AM LEARNING W/[Professional] I NEED TO REFRAME MY REACTION TO WHAT I PERCEIVE PPL ACTIONS MEAN (IT WASN'T TO YOU) TO REDUCE MY FRUSTRATION. . i DON'T UNDERSTAND THESE TYPE OF PPL. INSTEAD OF ASKING OR SPEAKING W/ HIS GUARDIAN THEY DO THIESE TYPES OF THINGS…"

On August 12, 2021, I received a call from FM #1. She informed me that Ms. Root said that this was all their fault, and that Guardian A wants Resident A's phone calls monitored. FM #1 stated that Guardian A will not tell them anything. FM #1's mother passed in April and the memorial service was in July. Resident A was told that they didn't have to allow him to go to the memorial service. FM #1 questioned this and wondered why he could not stay with her, overnight, to reduce the amount of driving.

FM #1 also informed of an incident in which her brother (Resident A) put his hand down Resident D's shirt. FM #1 asked him if Resident D was mad, and he (Resident A) said she (Resident D) liked it. FM #1 stated that she thinks her brother is acting out since their mother died. FM #1 questioned if Resident A should remain in this home.

On August 12, 2021, I contacted Ms. Cossel, APS Supervisor, and inquired about the allegations that Resident A had put his hands down Resident D's shirt. Ms. Cossel informed me that they had already received the complaint, it had been investigated by Ms. Clark, APS Worker and closed on August 4, 2021. The AFC home assured the safety of the residents, and there is a safety plan in place.

On August 20, 2021, I spoke with Ms. Clark, APS Worker. We discussed the case and she provided me with some family history regarding Resident A. The family is not happy with the new guardian. Before Resident A's mother passed and while they were looking for a guardian for Resident A, no one in the family wanted to take care

of him. Now that his mother has passed away, the sisters and cousins have been calling Resident A, discussing the possibility of him moving. Resident A has been acting out. The guardian (Guardian A) is concerned that he will jeopardize this placement.

On August 25, 2021, FF #1 provided a case update and informed me that Resident A is using the phone. In addition, that Ms. Root called her. There is no voicemail set up at the home and she can't get through. The court returned the guardianship paperwork.

On September 1, 2021, I received a call from Ombudsman Worker #1. She informed me that she was conducting an investigation, as there is a concern that Resident A is not using the phone and being denied visits with family. She has interviewed Resident A, who reported that he feels like he is in jail. She will be referring Resident A for some additional intervention and services. While the worker was at the home, Ms. Root questioned the legitimacy of the Ombudsman Program.

On September 2, 2021, I received a call from Ms. Root. She stated that Ms. Baker, Direct Care Staff, came in and Resident A was on the phone. She asked who he called and after that, Resident A went into cursing, saying "F-that." Ms. Root expressed concern as she is stuck in the middle as a provider. Ms. Root confirmed that she did speak with the worker from the Ombudsman's Office, and she questioned whose authority should she follow. The guardian is saying one thing and the Ombudsman is saying another. I explained that I didn't know exactly who's authority superseded; however, I encouraged Ms. Root to cooperate with the Ombudsman. I also informed that Resident A could call her (the Ombudsman) as needed. Ms. Root stated she was also going to seek counsel and get a lawyer as she was upset how the worker from the Ombudsman came into her home and disrupted things.

On September 3, 2021, FF #1 contacted me and informed that Guardian A went in front of the judge and requested that the family visits be blocked. I asked if she had a copy of the court order, and she did not, as she was not aware of the hearing. FF #1 also spoke with Attorney #1 from the Ombudsman's Office and told her about the possibility of Resident A residing in the apartment at her home.

On September 23, 2021, I spoke with Guardian A. She informed me that she has not been the guardian very long but believed that the family didn't start contacting Resident A until after his mother had passed away. She explained that there were many family dynamics, issues, and problems. She was told that an ex-husband of one of the sisters had raped Resident A.

After his mother passed, and the sister (FM #1) asked if he (Resident A) could leave overnight to attend the memorial service, and Guardian A had to check into the matter first. She was not aware of Resident A being discouraged or not being allowed to attend the memorial service. She allowed him to go to the service and the

sister kept in contact during the trip. While Resident A was at the memorial, someone gave him $50.00. When he returned to the facility, he went to Family Dollar and purchased $50.00 worth of snacks and borrowed $20.00 from the cashier. The $20.00 was returned. Guardian A was not sure if he was allowed to bring the snacks into the home, but she has dropped snacks off without a problem.

I inquired about the rules and guidelines regarding the phone calls, and Guardian A informed that Resident A would have behaviors, usually after the calls ended. This only occurs when he talks to certain family members and family friends. She stated that the calls are to be monitored and ended if Resident A becomes upset. Resident A has told her that he wants to move so he can be buried in the cemetery with his mother. Guardian A explained that he did not have to move to be buried by his mother. Guardian A stated that there are several people in the home and when she sometimes calls, there is not an answer. She did not know if they had call waiting.

Guardian A also stated she was aware that there were issues with Ms. Root talking loudly, but that she was hard of hearing.

At the conclusion of the interview Guardian A informed me that since the passing of Resident A's mother, she has been contacted by an attorney out of Brighton, representing the sisters, to open the estate, although this file is already opened in another county. She also stated that she is aware that FF #1 filed for guardianship of Resident A. She stated that the paperwork she has indicates that Resident A is in need of adult foster care. Guardian A explained that she cares about her residents and looks out for their best interest.

As a part of this investigation, I reviewed the AFC Assessment Plan for Resident A. It was noted that staff supervision is required when he is in the community.

On September 23, 2021, I interviewed Ms. Baker, Direct Care Staff. She informed me that she never saw or heard Ms. Root threaten that Resident A could not go to the memorial service. Regarding the allegations of yelling, Ms. Baker stated that she has known Ms. Root for 43 years, and she talks loudly, due to her hearing impairment.

I also interviewed Resident E and inquired if any residents were yelled at, and Resident A stated that Ms. Root had a hard time hearing, and she has to talk loudly; but he has never heard the kind of yelling like "bleep, bleep, bleep" (cursing).

On September 24, 2021, I called the facility to conduct the exit conference with Ms. Root. Ms. Baker informed me that Ms. Root was not at the facility. I requested a returned phone call regarding the exit conference. Ms. Baker informed that it would probably be on Monday, as Ms. Root is out of town.

On September 30, 2021, I conducted the exit conference with Ms. Root, Licensee. I explained my findings, and that there was a preponderance of the evidence to

support the allegations that she was not fully cooperative with Resident A's family. Ms. Root did not agree. Ms. Root stated that was not her call and Guardian A made the decisions. Ms. Root did not confirm that she threatened for Resident A to not attend his mother's memorial service. I inquired if Ms. Root had ever hung up on either FM #1 or FF #1. Ms. Root stated that one of the residents was looking for the phone; she (Ms. Root) found the phone in Resident A's room. The phone was laying on the bed between his left thigh and the wall. According to Ms. Root, Resident A was not using the phone. She told him she needed to get the phone. The phone was making a busy beeping noise, so she hung it up, by pushing the off button.

I followed up by specifically asking her about the phone conversation with FF #1, as she previously told me the conversation was not good. Ms. Root stated that FF #1 was being accusatory, and she said she didn't know about adult foster care. According to Ms. Root, FF #1 had concerns about men and women being in the same home. In addition, that she (FF #1) would be checking into things. Ms. Root stated that she then provided her (FF #1) with the state website and the name of the business. She stated, okay, fine. Ms. Root stated, "and I hung up, as there was no reason for me to continue listening."

Ms. Root explained that she should not "take a hit" for this one. She stated that everything was fine, and she recalled that there was a family visit that was cooperative. Ms. Root stated that she encourages family members to take the residents with them for visits. Ms. Root stated that she did not know why things went sour. Ms. Root recalled that FM #1 wanted Resident A's money to go on a road trip and Ms. Root informed that the guardian would have to give permission. Guardian A said no. After Resident A talks to some of the family members, he then responds with "F-this", and that FM #1 was going to be his guardian.

During this conversation, Ms. Root also recalled situations in which Resident A did not tell the truth. She has asked him why he says things that are not true. According to Ms. Root, some family members have put into Resident A's head that she does not care about him, which is not true. Ms. Root also described how she told Resident A that she did care about him, and Resident A responded, "fucking bullshit you do." Then he says sorry. Ms. Root stated that she is "pretty upfront" and if the family had called her to discuss the problem, she would have dealt with it.

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.**
	(11) A licensee, direct care staff, and an administrator shall be willing to cooperate fully with a resident, the resident's

	family, a designated representative of the resident and the responsible agency.
ANALYSIS:	Based on the information gathered during this investigation and provided above, it's concluded that while it's noted that Guardian A provided written permission for the phone contact to be limited with FM #1 and FF #1, that was on July 27, 2021. Prior to this, there is a preponderance of the evidence to support the allegations that the licensee, overall, did not fully cooperate with certain members of Resident A's family and friends.
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:	Family Member #1 and Family Friend #1 both describe incidents in which they observed Ms. Root contributing to a situation and causing Resident A to become upset. I inquired about the incident when he (Resident A) was on the phone with FF #1. Resident A told me that Ms. Root said to give her the phone. FF #1 heard Ms. Root talking to him. Ms. Root was yelling. Ms. Root hung up the phone on FF #1. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Resident A was not treated with dignity and his personal needs, including protection and safety, were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

APS has been to the home multiple times, but no one tells them the truth due to threats from Ms. Root.

INVESTIGATION:

During the interview with FM #1, she stated that Ms. Root was not a nice person. In addition, that Ms. Clark, APS Worker says the residents in the home are fine. According to FM #1, Resident A said mom (Ms. Root) says we'll get grounded if they tell the truth.

On September 22, 2021, I spoke with Ms. Cossel, APS Supervisor. She stated that they have been to the home several times. In addition, that she would review referral information, and follow-up with an approximate number of complaints at the home.

On September 23, 2021, Ms. Cossel informed me that between 2018-2021, there have been about 8 referrals regarding this home. A summary of the allegations included that Ms. Root raised the rent three times, she yells and screams at the residents, phone calls are monitored, phone is taken off the hook, Ms. Root has bullied the residents, and Ms. Root monitors and tries to control phone conversations. They also received the complaint involving Resident A and Resident D. It should be noted that some of the complaints were not assigned or substantiated.

On September 23, 2021, I interviewed Guardian A. She has other residents placed in the home. I inquired if they have disclosed or mentioned any concerns about being threatened by Ms. Root. Guardian A informed me that they had not. She stated that she recently moved one resident because he needed a smaller setting and he told her they argued all the time, but he did not provide any names or specific information.

On September 23, 2021, I interviewed Resident E and Resident F. During my interview with Resident E, I asked if he was threatened or afraid to tell the truth about what was occurring in the home, when questioned by case workers and he stated he was not. Resident E stated, "If I'm afraid, I'm supposed to let you know."

During the interview with Resident F, she too reported not to be afraid to tell the truth regarding what's going on in the home if asked.

On September 24, 2021, Ms. Rodgers, APS Supervisor, sent additional information, informing that there have been about 9 referrals regarding this home.

On September 24, 2021, I spoke with Ms. Baker, Direct Care Staff, I inquired if she had ever heard Ms. Root threaten the residents if they told the truth and she stated she had not. She informed me that Ms. Root tells the residents that things would be worse if they lie.

During the exit conference with Ms. Root, she stated that when APS does arrive at the house, she leaves the area, allowing them to talk to the residents. Ms. Root

informed that she has no idea when APS will stop by, but they are always welcomed. Ms. Root denied threatening the residents.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(f) The right to voice grievances and present recommendations pertaining to the policies, services, and house rules of the home without fear of retaliation.**
ANALYSIS:	While it's noted that APS has been out to the facility for complaints, it's not confirmed that the residents don't tell the truth due to threats from Ms. Root.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS:

Allegations that Resident A does not get enough to eat.

INVESTIGATION:

During my interview with FM #1 (July 30, 2021), she stated that her brother is very thin, and there is a concern that he is not getting enough to eat. She recalled that when she picked him up for the memorial service that he at a lot for breakfast that day. When asked about this, Resident A informed that he is only allowed one bowl of cereal for breakfast and seconds were not allowed. Resident A told her he was hungry. FM #1 later asked staff if she could buy snacks for him and she was told no because there is nowhere to store them; however, other residents have snacks.

During my Interview with Resident A (August 9, 2021), I asked about meals and Resident A informed me that if he requests seconds, he is told no. For breakfast everyone gets ½ cup of cereal. I asked what he had for breakfast that day and he said cereal and juice. There was toast available, but he did not want any. Resident A stated that he likes the food at the home but that "I still get hungry."

During the on-site inspection (August 9, 2021), I completed a walk-through of the home and observed plenty of food in the refrigerator, freezers, and pantries. Ms. Root informed me that the residents can have seconds if they would like.

On August 10, 2021, Ms. Root sent me an email and the relevant parts included following:

> In addition, that she (Ms. Root) was thinking about Resident A's eating and "it can only be because they didn't think he was getting enough food. they have never asked. I spoke w/ both AJ and SarAH AND THEY SAID NO THEY HADN'T . HE WILL OFTEN RFUSE 2ND SAYING HE IS FULL OR WHEN HE IS IN A MODD(USUALLY AFTER SPEAKING WITH THEM THAT HE WILL REFUSE TO EAT MY "CRAp yes i'M frustrated(as i have a right to be)When they keep this up….."

As a part of this investigation, I reviewed the weight records for Resident A. When he was admitted into the home in 2017, he was 146.2lbs. In January of 2021, Resident A was 168.0. His weight fluctuated over the next several months. In August of 2021, Resident A weighed 162.4.

During my interview with Guardian A (September 23, 2021), she did not have any concerns about the allegations related to the food. She reported to take snacks to the residents in the home as well. I informed her that I observed plenty of food in the home, but that Resident A reported that he was hungry.

During my interview with Ms. Baker, DCS, (September 23, 2021) she informed that the residents are allowed seconds. Some residents have their own snacks, and they are allowed to keep them in the home.

During the interview with Resident E, (September 23, 2021) he reported that the food was "really good." He reported to get enough to eat. I asked if he was allowed a second serving of food and he informed that he usually does not have to ask for more food, as the first serving is usually enough.

On September 23, 2021, Resident F also reported to get enough food but asked if was a state rule that soup had to be served once a week. I informed that it was not a rule but that the licensee could decide to serve soup, weekly, and that would be okay.

On September 30, 2021, during the exit conference, Ms. Root explained that Resident A has gained weight since being placed in her home. He drops weight when it's warm out, due to walking outside more during the summer months. Ms. Root stated that Resident A is provided with enough food to eat and that when refuses to eat, it's usually because he is angry or just had one of his swearing fits.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on the information gathered during this investigation and provided above, it’s concluded that there is not a preponderance of the evidence to support the allegations that Resident A is not offered 3 regular nutritious meals daily.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the exit conference with Ms. Root, I inquired if she had completed an incident report regarding Resident A putting his hands down Resident D’s shirt. Ms. Root informed me that she did not complete an incident report, as APS investigated and said it was closed. Ms. Root provided some background information about Resident A and stated that he had a history of stalking other women and being infatuated with them. Ms. Root described that she does have a plan in place and has talked to the female residents about what they should do if anyone tries to touch them inappropriately.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(2) An immediate investigation of the cause of an accident or incident that involves a resident, employee, or visitor shall be initiated by a group home licensee or administrator and an appropriate accident record or incident report shall be completed and maintained.
ANALYSIS:	Ms. Root did not complete an incident report, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon a very detailed written corrective action plan, I recommend no change to the status of the license.

10/01/2021

Mahtina Rubritius
Licensing Consultant

Date

Approved By:

10/01/2021

Mary Holton
Area Manager

Date