GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 15, 2021

Rose Martin
Choice Care IV Inc
12-14 Mary St
Battle Creek, MI 49014

RE: License #: AM130065342
Investigation #: 2021A0584024
Choice Care IV Inc

Dear Mrs. Martin:

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. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9727.

Sincerely,

Candace L. Pilarski

Candace Pilarski, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 243-7590

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM130065342
Investigation #:	2021A0584024
Complaint Receipt Date:	07/21/2021
Investigation Initiation Date:	07/23/2021
Report Due Date:	09/19/2021
Licensee Name:	Choice Care IV Inc
Licensee Address:	12-14 Mary St Battle Creek, MI 49014
Licensee Telephone #:	(269) 964-2801
Administrator:	Rose Martin
Licensee Designee:	Rose Martin
Name of Facility:	Choice Care IV Inc
Facility Address:	12-14 Mary Street Battle Creek, MI 49014
Facility Telephone #:	(269) 964-2801
Original Issuance Date:	04/17/1997
License Status:	REGULAR
Effective Date:	06/27/2020
Expiration Date:	06/26/2022
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A has left the home over a week ago and has not been reported missing.	No
Additional Findings	Yes

III. METHODOLOGY

07/21/2021	Special Investigation Intake 2021A0584024
07/23/2021	Special Investigation Initiated - Letter Email to Jennifer Stockford, Adult Protective Services, Calhoun County Department of Health and Human Services
07/28/2021	Contact - Telephone call received From Jennifer Stockford, Calhoun County Department of Health and Human Services Adult Protective Services
08/02/2021	Contact - Document Sent Email to Dawn Campbell, Licensing Consultant
08/03/2021	Contact - Face to Face With Deb Weaver, Direct care worker.
08/03/2021	Contact - Face to Face With Tiffany Haas, direct care worker
08/03/2021	Inspection Completed On-site Viewed five residents in the living area of the home.
08/10/2021	Contact - Telephone call made Zoom interview with Rose Martin Licensee Designee, and Andie Martin
08/10/2021	Exit Conference With Rose Martin via Zoom
08/13/2021	Contact - Document Sent Email to Rose Martin, Licensee Designee
08/24/2021	Contact - Document Sent

	Email to Rose Martin, Licensee Designee
09/03/2021	Contact - Telephone call received With Rose Martin, Licensee Designee

ALLEGATION:
Resident A has left the home over a week ago and has not been reported missing.

INVESTIGATION:

On 7/28/2021 I received a telephone call back from a message I had left for Jennifer Stockford, Adult Protective Services (APS) worker at the Calhoun County Department of Health and Human Services (MDHHS). I inquired if their department had an investigation regarding Resident A. Ms. Stockford stated that they did have an investigation, but closed it due to not being able to locate Resident A. Ms. Stockford stated the complaint was received by their department around July 9, 2021.

On 8/3/2021, I conducted an unannounced visit to the home at 12-14 Mary St, Battle Creek, MI and arrived approximately 11:30 am. I met Debra Walker, direct care staff worker and Tiffany Haas, who identified herself as a worker in training. Ms. Walker stated that Tiffany Haas is being trained to learn home management duties. I asked Ms. Walker to allow me to see the home resident records but she said she is not sure where they are located. Ms. Walker stated to me the owner has been painting the interior of the living room and the office the last couple of weeks and everything is out of place. Ms. Walker was asked to show me the Resident Register. Ms. Walker said she does not know where that can be located. Ms. Walker was asked if she is familiar with Resident A. Ms. Walker said she knows who that is, but he has not been at the facility since he left with his sister around July 5, 2021.

On 8/3/2021, I conducted a phone interview with licensee designee Rose Martin. I spoke with Ms. Martin and asked how I would view the resident records. Ms. Martin said that she is out of town about three hours away and everything is completely moved around in the office area due to recent remodeling. Ms. Martin asked if I could come back to the home at 3:00 pm that afternoon to meet with her and she would have the records for review. I informed Ms. Martin that I was not able to return later in the day and asked if the records are here at the home. Ms. Martin said the resident records are at the home currently however was sure Ms. Walker would not be able to locate them. Ms. Martin also stated that the Resident Register is also not easily located, but she would be glad to assist me another day with that information. Ms. Martin was asked about Resident A being gone from the facility. Ms. Martin stated that she notified several agencies Resident A is involved with that he left the home with a family member on July 5th. Ms. Martin stated Resident A is

his own guardian and has family that will take him out of the home for several days at a time. Ms. Martin said that Resident A usually returns after a few days, but when he was gone for four days, Ms. Martin stated she decided to notify his Payee, the Veterans Administration who monitors his health, and notified the Battle Creek Police Department.

On 8/13/21, I reviewed an *AFC Licensing Division-Incident/Accident Report – BCAL 4607* that was sent to the department on July 9, 2021. A note was added on that report from a follow-up contact call on July 19, 2021 to the licensee. The contact note documented that the licensee designee notified the payee and the Battle Creek police department Resident A left with a family member and has not returned.

On 8/13/2021, I reviewed copies of Resident A's *Resident Care Agreement BCAL-3266* and *Assessment Plan for AFC Residents BCAL-3265*. The Resident Care agreement and Resident Assessment forms show a signature by Resident A as his own representative. I reviewed the most recent dated *Assessment Plan for AFC Residents BCAL-3265* signed January 1, 2020 to determine if Resident A was able to have independent access to the community. Section I, *Social/Behavioral Assessment, Box A*, documented that Resident A Moves Independently in Community is checked as "YES" and no other information restricting Resident A from leaving the home was listed in that assessment.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A signed his own paperwork as his own representative when agreeing to reside at the facility. Resident A's written assessment plan had no restrictions regarding his moving independently in the community. Resident A, at the time of leaving the facility with his sister, was able to make that decision to do so.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 8/3/2021, I conducted an unannounced onsite visit at the home. I did not locate or view a posted copy of the license. I asked the direct care worker Debra Walker where the license is posted. Ms. Walker stated it was taken down when the walls were being painted and was not put back up afterwards.

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.**
	(4) The current license, whether regular, provisional, or temporary, shall be posted in the home and shall be available for public inspection.
ANALYSIS:	The license was not posted in the home for public inspection.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 8/3/2021, I conducted an unannounced visit to the home. At the time of the visit, resident records were not available when requested for department review. It was not certain the records were located at the home since Debra Walker, the direct care worker was not sure where the records were located or how to find them.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	Resident records. **(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information:** **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number, date of birth, case number, and marital status.** **(iii) Former address.** **(iv) Name, address, and telephone number of the next of kin or the designated representative.** **(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.** **(ix) Resident's religious preference information.**

	(b) Date of admission. **(c) Date of discharge and the place to which the resident was discharged.** **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.** **(e) Resident care agreement.** **(f) Assessment plan.** **(g) Weight record.** **(h) Incident reports and accident records.** **(i) Resident funds and valuables record and resident refund agreement.** **(j) Resident grievances and complaints.** **(2) Resident records shall be kept on file in the home for 2 years after the date of a resident's discharge from a home.**
ANALYSIS:	The department must have access to resident records when an onsite visit is conducted. The resident records were not available for department review while I was at the home and the staff on duty were not able to provide or access the records at that time.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 8/13/21, I reviewed Resident A's *Assessment Plan for AFC Residents BCAL-3265.* The most recent form provided for review was signed by Resident A January 21, 2020.

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 the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall

	maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	The written assessment plan provided to me by the licensee for review was signed by Resident A on January 21, 2020. The written assessment plan is to be updated at minimum annually. The assessment plan as of this date of the investigation is overdue by 7 months.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

When an acceptable corrective action plan is received, I recommend no change in the status of this license.

9/9/2021

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Candace Pilarski Date
Licensing Consultant

Approved By:

09/15/2021

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Dawn N. Timm Date
Area Manager