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GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

October 7, 2021

Jennia Woodcock Community Health Care Management 1805 E Jordan Mt. Pleasant, MI 48858

> RE: License #: AM370085651 Investigation #: 2021A1029024

Country Place II

Dear Ms. Woodcock:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (231) 922-5309.

Sincerely,

Gennifer Browning

Jennifer Browning, Licensing Consultant Bureau of Community and Health Systems Browningj1@michigan.gov (989) 444-9614

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM370085651
Investigation #:	2021A1029024
Complaint Descint Date:	00/40/2024
Complaint Receipt Date:	08/12/2021
Investigation Initiation Date:	08/12/2021
	001111111111111111111111111111111111111
Report Due Date:	10/11/2021
Licensee Name:	Community Health Care Management
Licensee Address:	2033 Westbrook
2.00.1000 / (4.41.000)	Ionia, MI 48846
Licensee Telephone #:	(989) 773-6320
Administrator:	Jennia Woodcock
Administrator:	Jennia Woodcock
Licensee Designee:	Jennia Woodcock
Name of Facility:	Country Place II
Facility Address:	1807 E. Jordan
Facility Address.	Mount Pleasant, MI 48858
	mount reason, m reese
Facility Telephone #:	(989) 773-6320
	07/00/0004
Original Issuance Date:	07/02/2001
License Status:	REGULAR
Effective Date:	07/12/2020
	07/44/0000
Expiration Date:	07/11/2022
Capacity:	10
Japaoity.	10

Program Type:	PHYSICALLY HANDICAPPED
	DEVELOPMENTALLY DISABLED
	MENTALLY ILL
	ALZHEIMERS
	AGED

ALLEGATION(S)

Violation Established?

Direct care staff members at Country Place II restricted Resident	No
A's access to Relative A1.	

II. METHODOLOGY

08/12/2021	Special Investigation Intake 2021A1029024		
08/12/2021	Contact - Document Sent - Emailed Angela Wend, Recipient Rights		
08/12/2021	Special Investigation Initiated – Telephone to Julie Elkins AFC licensing consultant		
08/23/2021	Contact - Document Received - Email from Angela Wend		
08/26/2021	Contact - Face to Face with Kaitlynn Wiggins at Country Place II. Resident A was out in the community.		
09/21/2021	Contact - Telephone call made to Jennia Woodcock, Licensee designee		
09/23/2021	Contact - Telephone call made to direct care staff member Gage Lynch, no voice mail set up for him		
09/23/2021	Contact - Telephone call made to Guardian A1		
09/23/2021	Contact - Telephone call made to Relative A1 Left him a message		
09/23/2021	Contact - Telephone call made to Nicole Seeman, left a message		
09/23/2021	Contact - Document Sent - Email to Nicole Seeman CMH		
09/23/2021	Contact - Document Sent - Email to Angela Wend		

09/23/2021	Contact - Telephone call made to Kim Waldron, home manager
09/23/2021	Contact - Telephone call made to Tina Brownridge, on call manager during the incident.
09/23/2021	Contact - Telephone call made to Jamie Blizzard
09/23/2021	Contact - Document Received - Email from Nicole Seeman
09/29/2021	Contact – Telephone call to Gage Lynch. No voice mail.
09/29/2021	Contact - Telephone call made to Relative A1 (JAY) and Resident A. Voicemail was left.
09292021	Exit Conference with licensee designee, Jennia Woodcock.

ALLEGATION:

Direct care staff members at Country Place II restricted Resident A's access to Relative A1.

INVESTIGATION:

On August 11, 2021, a complaint was received via the BCAL online complaint system alleging that a direct care staff member restricted Resident A's access to Relative A1 the week prior and there was no reason to do this. Nicole Seeman, case manager from Community Mental Health had spoken to the direct care staff members at Country Place II in the past regarding not restricting access to Relative A1.

On August 12, 2021, I emailed Complainant requesting additional information and phone numbers for the direct care staff member involved in the incident. I received a response on August 23, 2021 with the phone numbers and clarifying information that the direct care staff member involved was Gage Lynch who typically works third shift and may have been confused about whether or not to allow visits since that is typically not something he handles during his regular shift. During that weekend, Tina Brownridge was the manager on call for Country Place II according to Complainant.

On August 26, 2021 I interviewed direct care staff member Katlynn Wiggins at Country Place II. She stated that she had worked with Resident A since January 2021 and she would consider him to be independent. Resident A was not home during the onsite investigation. She stated he is typically home for meals and his medication but leaves in the morning. Most days he comes back to Country Place II around 8:00p.m. or 9:00 p.m. When he is out in the community he most often goes to the library.

Ms. Wiggins stated the residents can use the phone all day at Country Place II. On average, Ms. Wiggins stated Resident A called Relative A1 every day. Ms. Wiggins stated Resident A also has a guardian that he will call. Ms. Wiggins stated there are times she will mediate when Relative A1 and Resident A disagree with each other.

I reviewed Resident A's resident record. Resident A's *Assessment Plan for AFC Residents (BCAL-3265)* indicated that he could move independently in the community and there was nothing stating he could not have phone calls with family.

I reviewed Resident A's *Person Centered Plan* completed by his case manager, Nicole Seeman on March 22, 2021. Resident A had several goals in his person centered plan.

- 1. "I want to be mentally healthy."
 - a. [Resident A] will take all prescribed medications.
- 2. "I will not treat others the way others treat me; I will treat them better."
 - a. [Resident A] was becoming more defiant towards AFC staff. He agreed to not call the AFC staff names when he was feeling frustrated and use the natural supports to discuss frustrations.
- 3. "I want to go to the library."
 - This was the only community engagement activity that he enjoyed doing.
 He uses Iride or AFC staff for transportation and follow all rules once in the library.
- 4. "Get out of AFC home"
 - a. There was documentation that he could not move out of the AFC until [Relative A1's] home was clean and free of bed bugs. [Resident A] was communicating at least once a month with [Relative A1] regarding the home conditions and if it was a safe place so he could coordinate with [Guardian A1] about when a good time to move back would be.

In his resident record, there was also a log of daily activities for him for each day in August from August 5-August 25, 2021. Each day there was a notation that he went to the library or town. On August 11, 2021, there was documentation he went to the library and Relative A1's home.

I interviewed direct care staff member and home manager, Kim Waldron. She stated Resident A moved into Country Place II as an emergency placement from adult protective services. The residents at Country Place can place phone calls whenever needed. Ms. Waldron stated there was one incident he was denied when he wanted to call because there was a power outage on August 11, 2021 and the home phone did not work. She did not feel comfortable allowing Resident A to use her personal cell phone and there was no house phone to use until the power came back on. The outing log for that day has documentation that Resident A went to the library and Relative A1's home after leaving Country Place II at 10:00 a.m. so he did have contact with Relative A1 that day.

On September 21, 2021, I spoke with licensee designee, Jennia Woodcock. She stated that Resident A moved out of Country Place II on September 1, 2021. She believes he

moved back in with Relative A1. Ms. Woodcock stated Resident A was placed at the AFC by adult protective services due to the poor living conditions and bed bugs while he was residing with Relative A1. To her knowledge, it was unsafe for him to go on visits with Relative A1 due to the home conditions.

Ms. Woodcock stated Relative A1 has now moved into an apartment and the living conditions are better. Ms. Woodcock stated the goal for Resident A was always to reside short term at Country Place so the living arrangement could be resolved but then when coronavirus started in March 2020 this plan was delayed. The only time Ms. Woodcock stated she was aware there was an issue with him not being able to use the phone was when there was a power outage and he was not allowed to use a direct care staff member's personal cell phone. They have had a problem in the past with residents destroying the house phones and they did not want to risk something happening to the cell phone. Ms. Woodcock stated there was not an emergency at that time, but Resident A just wanted to speak with Relative A1.

On September 23, 2021, I called Guardian A1 who advised that Resident A moved out of Country Place II and moved in with Relative A1 on September 1, 2021. She does not know if there was a time that he was unable to use the phone. They have a lot of problems with power outages. There was never a time that she knows that he wanted to contact either herself or Relative A1 and was not able to do so. Guardian A1 reported there were times Resident A wanted to visit with Relative A1 but direct care staff members did not allow the visitation to occur. Initially, Relative A1 had bed bugs and they did not want him to go because they did not want the risk of bringing them back to the facility.

Ms. Seeman from Community Mental Health advised the staff at Country Place II that they needed to let him go with Relative A1. She was told by an unknown direct care staff member that the manager at that time told them he could not go. She was not sure who the manager was at that time. She does not know the exact date but believes this was around the beginning of August. Guardian A1 stated Resident A moving to Country Place was an emergency placement but due to COVID the plan was delayed and he stayed longer than intended. The plan was to always transition him to living back with Relative A1.

On September 23, 2021, I interviewed the direct care staff member and home manager at Country Place II, Kim Waldron. Ms. Waldron was not aware that he was told that he could not go visit his family on August 6, 2021. As far as she was aware, Relative A1 did not pick him up but he would take the bus to the library and he would walk to Relative A1's home. Then he would go back to the library and then take the bus back. He could have walked to Relative A1's home at any time when he would go out into the community.

Ms. Waldron stated she was never given a confirmation that the bed bugs and living conditions had been resolved and it was safe to allow visitation again. The direct care staff members were concerned that the bed bugs would have been brought to the

facility because he brought them when he first moved in. Ms. Waldron stated she was not aware that the bed bugs situation had been resolved. One of the reasons he was placed there to begin with was because of APS involvement because of the housing conditions. In April or May, Resident A was calling Relative A1 to see if the problem had been resolved and he could come visit. Relative A1 would not confirm whether or not the exterminator was even there and Resident A was upset with him. They did not have Relative A1's information because he was not the payee or guardian.

She does not recall a conversation with Ms. Seeman advising not to restrict access to his Dad's home. The last conversation was that she was going to confirm with Guardian A1 around mid-July 2021 that the conditions were resolved with the bed bugs. She was going to speak with Guardian A1 and then let her know if they could resume weekend visitation. She never heard back from her with an answer. As far as Ms. Waldron believed the conditions were not appropriate for visitation still because she was never told otherwise. On August 6, 2021, the on call manager would have been Tina Brownridge. Direct care staff member, Gage Lynch was also working that evening 4-12:00 a.m.

On September 23, 2021, I interviewed Tina Brownridge who was the on call manager the week of August 6, 2021. One of the staff, Gage Lynch, reached out to her and asked if he could go to Relative A1's home. She knew in the past, adult protective services stipulated that was not a safe environment for him to visit but since she did not work with Resident A regularly, she also reached out to their assistant administrator, Jamie Blizzard. Ms. Blizzard told her she believed it was still not a safe environment. She did not hear that Isabella County APS have lifted that ban of him going there. She denied that she has talked to Nicole Seeman about whether or not he can have contact with his family. After this incident occurred, it was changed back that he could have visits there but she did not know the date this changed.

On September 23, 2021, I interviewed Jamie Blizzard, the assistant administrator for County Place II. When Resident A moved in, it was a result of an adult protective services emergency placement due to Relative A1's housing conditions. When the last person centered plan with Community Mental Health was done in March 2021, there was documentation that it was not safe to go to his Relative A1's home. This is the information they were following at the beginning of August. When he moved out, this information was still in the person centered plan that it was unsafe to be there. He would tell them he was going to the library but she did not know he was going to Relative A1's house too during that time. Their procedure is to allow the residents go on visits with their family and encourage as much involvement with they can as long as it is not documented they should not for safety reasons. She was not aware if there was any contact with Nicole Seeman asking them to allow contact with Relative A1.

On September 23, 2021, I received an email from Nicole Seeman who is the case manager for Resident A through Community Mental Health for Central Michigan. To her knowledge this is the only time that direct care staff members withheld a visitation with the father and it occurred the weekend of August 6, 2021. Ms. Seeman was able to

send a copy of the Person Centered Plan that was completed on March 22, 2021 that was in place at the time of this incident. She confirmed that she did speak with the home manager, Kim Waldron but it was after this incident occurred because she was notified from Guardian A1 on the following Monday (August 9, 2021) that visits could occur.

On September 29, 2021, I completed the exit conference with licensee designee, Jennia Woodcock. Ms. Woodcock was told by Ms. Seeman that he was able to visit family when he signed out of the facility to spend time at the library as long as he signed in and out from the facility, he was being safe, and not causing trouble in the community. She stated again the staff members at Country Place II did not want to keep Resident A away from his family.

APPLICABLE RI	ULE		
R 400.14303	Resident care; licensee responsibilities.		
	(4) A licensee shall provide all of the following: (b) An opportunity for the resident to have contact with relatives and friends.		
ANALYSIS:	Resident A moved into Country Place II as a result of adult protective services intervention while he was living with Relative A1. The home conditions made the home unsafe for him to continue to live there and the plan was for him to return home with Relative A1.		
	Based on the onsite investigation and interviews with Ms. Wiggins, Ms. Waldron, Ms. Woodcock and his case manager, Ms. Seeman from Community Mental Health, it appears that the direct care staff members restricted visitation with Relative A1 as a result of the home conditions and Ms. Waldron confirmed that she did not have information that the bed bugs were no longer an issue. Resident A had the ability to take the bus to the library and was able to walk to Relative A1's home from the library.		
	There was one incident on August 11, 2021 that Resident A was not allowed to call on the phone but that was due to a power outage in the facility and there was no phone available to use. Typically, Resident A was able to call Relative A1 and Guardian A1 daily. Resident A also had a tablet that was used to connect with his family.		
CONCLUSION:	VIOLATION NOT ESTABLISHED		

III. RECOMMENDATION

I recommend no change in the license status.

Gennifer Browni	~g	_10/1/2021	
Jennifer Browning Licensing Consultant		Date	
Approved By:	10/07/2021		
Dawn N. Timm Area Manager		Date	