GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 13, 2021

Wendy Davidson
Carter Country Homes Inc.
1536 Essay Lane
Holly, MI 48442

RE: License #: AS630386668
Investigation #: 2021A0993032
Carter Country Homes

Dear Ms. Davidson:

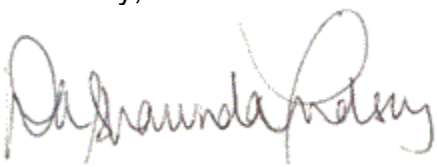
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630386668
Investigation #:	2021A0993032
Complaint Receipt Date:	08/13/2021
Investigation Initiation Date:	08/16/2021
Report Due Date:	10/12/2021
Licensee Name:	Carter Country Homes Inc.
Licensee Address:	1536 Essay Lane Holly, MI 48442
Licensee Telephone #:	(248) 887-3176
Administrator:	Brittni Eagle
Licensee Designee:	Wendy Davidson
Name of Facility:	Carter Country Homes
Facility Address:	1536 Essay Lane Holly, MI 48442
Facility Telephone #:	(248) 240-7828
Original Issuance Date:	04/28/2021
License Status:	TEMPORARY
Effective Date:	04/28/2021
Expiration Date:	10/27/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The maintenance worker lived in the basement of the facility.	No
• There is concern for the residents of the home. • There is no supervision in the evenings. • About eight months ago, the maintenance worker was dispensing medications to the residents.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/13/2021	Special Investigation Intake 2021A0993032
08/13/2021	APS Referral Received the allegations from adult protective services (APS). The intake was denied.
08/16/2021	Special Investigation Initiated - Telephone Telephone call made to the reporting source. Left a message.
08/17/2021	Inspection Completed On-site Conducted an unannounced onsite inspection
08/25/2021	Inspection Completed On-site Conducted an announced onsite investigation
08/25/2021	Contact - Telephone call made Telephone call made to the reporting source
10/11/2021	Exit Conference Held with licensee designee Wendy Davidson

ALLEGATION:

The maintenance worker lived in the basement of the facility.

INVESTIGATION:

On 08/13/2021, I received the allegations from adult protective services (APS). The intake was denied.

On 08/17/2021, I conducted an unannounced onsite investigation. I interviewed licensee designee Wendy Davidson and staff Palma Young. Ms. Davidson confirmed staff James Malloy completed maintenance tasks in the facility, in addition to providing care to the residents. She also confirmed Mr. Malloy resided in the basement of the facility. Ms. Davidson stated Mr. Malloy died a couple of weeks ago.

Ms. Young confirmed Mr. Malloy lived in the facility. She also confirmed Mr. Malloy died a couple of weeks ago.

On 08/25/2021, I conducted an announced onsite investigation. I interviewed Resident A, Resident B, Resident C, Resident D, and Resident E. Resident A, Resident B, Resident C, and Resident D confirmed that Mr. Malloy used to live in the facility.

I conducted a follow up interview with Ms. Davidson. Ms. Davidson stated Mr. Malloy died on the edge of the pond outside of the facility. She stated she believe he had a heart attack.

On 08/25/2021, I conducted a telephone interview with the reporting source. The reporting source confirmed Mr. Malloy use to live in the facility; however, Mr. Malloy died on 08/03/2021 outside of the facility. The reporting source confirmed Mr. Malloy died while cutting grass outside of the facility. He was cutting grass and his hat blew off. While attempting to retrieve his hat, he fell into the pond.

On 10/11/2021, I reviewed documents submitted by licensee designee Wendy Davidson via email during the licensure process. On 12/04/2020, Ms. Davidson submitted a copy of Ms. Young's and Mr. Malloy's medical clearance, verification of a negative TB as well as a BCHS_AFC_100 form (the form used to complete a background check) to the department.

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:	I confirmed Mr. Malloy was a household member. Ms. Davidson notified the department that Mr. Malloy was a household member on 12/04/2020.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **There is concern for the residents of the home.**
- **There is no supervision in the evenings.**
- **About eight months ago the maintenance worker was dispensing medications to the residents.**

INVESTIGATION:

On 08/17/2021, I conducted an unannounced onsite investigation. I interviewed licensee designee Wendy Davidson and staff Palma Young.

Ms. Davidson denied there is a concern for the safety and well-being of the residents. Ms. Davidson stated there is at least one staff person always present in the facility. Per Ms. Davidson, she works from 8am to 5pm, and staff Palma Young works from 5pm to 8am (the next morning). Ms. Davidson stated Ms. Young is also a household member. There are times when Ms. Davidson and Ms. Young are present in the facility at the same time. Ms. Davidson denied that staff James Malloy (who is referred to as the maintenance worker in the allegations) administered medications to the residents. Ms. Davidson stated only Ms. Young and herself administer medications to the residents.

Ms. Young confirmed she currently lives in the facility. She denied there is a concern for the safety and well-being of the residents. She denied that there is a lack of supervision in the facility. Per Ms. Young, there is at least one staff always present in the facility. The staff are Ms. Davidson and Ms. Young. Ms. Young denied that Mr. Malloy administered medications to the residents. She stated only Ms. Davidson and Ms. Young administer medications.

During the onsite investigation, I reviewed Ms. Young's and Mr. Malloy's staff file. I verified Ms. Young completed medication administrator training. There was no verification that Mr. Malloy completed medication administration training. Ms. Davidson stated Mr. Malloy did not administer medications so he did not complete the medication administration training.

On 08/25/2021, I conducted an announced onsite investigation. I interviewed Resident A, Resident B, Resident C, Resident D, and Resident E.

Resident A stated there is always staff present in the facility. The staff are Ms. Davidson, who owns the facility, and Ms. Young. Ms. Davidson and Ms. Young prepare meals and administer medications. Resident A denied the need for assistance with personal care needs (i.e., dressing, grooming, bathing/showing, mobility, etc.). Resident A verified Mr. Malloy used to work in the facility. Per Resident A, Mr. Malloy never administered medications, prepared meals, or supervised the residents. Resident A stated Mr. Malloy completed maintenance work.

Resident B stated there is always staff present in the facility. The staff are Ms. Davidson, who owns the facility, and Ms. Young. Ms. Young prepare meals. Both Ms. Davidson and Ms. Young and administer medications. Resident A denied the need for assistance with personal care needs (i.e., dressing, grooming, bathing/showing, mobility, etc.). Resident B verified Mr. Malloy used to work in the facility. Per Resident B, Mr. Malloy never administered medications. He did not complete any work inside of the facility.

Resident C stated there is always staff present in the facility. The staff are Ms. Davidson, who owns the facility, and Ms. Young. Ms. Young prepare meals. Both Ms. Davidson and Ms. Young and administer medications. Resident C denied the need for assistance with personal care needs (i.e., dressing, grooming, bathing/showing, mobility, etc.). Resident C verified Mr. Malloy used to work in the facility. Per Resident C, Mr. Malloy used to prepare meals, administer medications, and do everything else that staff do.

Resident D stated there is always staff present in the facility. The staff are Ms. Davidson, who owns the facility, and Ms. Young. Ms. Young and Ms. Davidson prepare meals. Only Ms. Young and administer medications. Resident A denied the need for assistance with personal care needs (i.e., dressing, grooming, bathing/showing, mobility, etc.). Resident D verified Mr. Malloy used to work in the facility. Per Resident D, Mr. Malloy never administered medications or prepared meals. Mr. Malloy used to clean up around the facility.

Resident E stated there is always staff present in the facility. The staff are Ms. Davidson, who owns the facility, and Ms. Young. Both Ms. Davidson and Ms. Young prepare meals and administer medications. Resident A denied the need for assistance with personal care needs (i.e., dressing, grooming, bathing/showing, mobility, etc.). However, Ms. Davidson will assist her with a shower, if needed. Resident E verified Mr. Malloy used to work in the facility. Per Resident E, Mr. Malloy never administered medications. Mr. Malloy completed maintenance tasks outside the facility.

I also conducted a follow up interview with Ms. Davidson. Ms. Davidson stressed that Ms. Young is in the facility 24-hours per day. Ms. Davidson stated that she comes to the facility very often as well. She stated there is not a written staff schedule, but there is a staff always present in the facility with the residents. Per Ms. Davidson, Mr. Malloy mainly cut the grass and took out the trash. He did not administer medications or prepare meals. She stated Mr. Malloy may have talked to the residents or cleaned around the facility, but he did not provide direct care to the residents.

During the announced onsite investigation, I reviewed the residents' medication administration records (MARs) from April 2021 to August 2021. I observed that the letter "J" appeared to have been changed to the letter "P" on many of the MARs. I also observed three signatures at the bottom of most of the MARs. Two of the signatures were Ms. Davidson's and Ms. Young's. The other signature had been whited out and

replaced with Ms. Davidson's signature. It is plausible that the signature belonged to Mr. Malloy.

On 08/25/2021, I conducted a telephone interview with the reporting source. The reporting source stated Mr. Malloy died on the property and the family had trouble with retrieving his belongings. Therefore, she is a concern for the safety and well-being of the residents. The reporting source denied ever witnessing abuse or neglect of the residents. She stated Mr. Malloy told her in the past that there was no supervision of the residents in the evenings. Regarding whether Mr. Malloy administered medications, the reporting source stated, "it was hearsay from [Mr. Malloy] that he was administering medications". Per the reporting source, Mr. Malloy never said how often it occurred and/or when it occurred. The reporting source denied ever observing Mr. Malloy administer medications to the residents. The reporting confirmed Mr. Malloy worked in the facility, but she did not know what his duties included.

On 10/11/2021, I reviewed documents submitted by licensee designee Wendy Davidson via email during the licensure process. On 12/19/2019, I verified Ms. Davidson completed medication administrator training.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Ms. Davidson, Ms. Young as well as Resident A, Resident B, Resident C, Resident D, and Resident E stated there is always at least one staff always present in the facility with the residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Date of schedule.** **(e) Any scheduling changes.**

ANALYSIS:	Ms. Davidson stated there was no written staff schedule. However, Ms. Davidson stated she works from 8am to 5pm, and staff Palma Young works from 5pm to 8am (the next morning).
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Based on the observation of the MARs, Mr. Malloy administered medications. There was no verification that Mr. Malloy completed medication administration training. I observed that the letter "J" appeared to have been changed to the letter "P" on many of the MARs. I also observed three signatures at the bottom of most of the MARs. Two of the signatures were Ms. Davidson's and Ms. Young's. The other signature had been whited out and replaced with Ms. Davidson's signature. It is plausible that the signature belonged to Mr. Malloy. I reviewed verification that Ms. Davidson and Ms. Young completed medication administration training. There was no verification that Mr. Malloy completed medication administration training.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 08/17/2021, I reviewed staff James Malloy's staff file. There was no verification that a background check was completed for Mr. Malloy through the workforce background as required for staff.

On 10/11/2021, I reviewed the BCHS_AFC_100 (background check form) submitted for Mr. Malloy and staff Palma Young. The form was not signed by Mr. Malloy or Ms. Young.

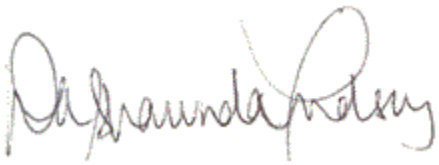
On 10/11/2021, I conducted an exit conference with licensee designee Wendy Davidson. I informed her of the findings.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.

ANALYSIS:	There was no verification that a background check was completed for Mr. Malloy through workforce background. In addition, the BCHS_AFC_100 was not signed by Mr. Malloy or Ms. Young.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of a corrective action plan, I recommend no change in the license status.



10/12/2021

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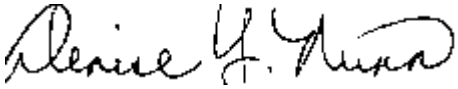
DaShawnda Lindsey Date
Licensing Consultant

Approved By:



10/12/2021

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Denise Y. Nunn Date
Area Manager