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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 20, 2021

Paula Ott
Central State Community Services, Inc.
Suite 201
2603 W Wackerly Rd
Midland, MI 48640

RE: License #: AS250010981
Investigation #: 2021A0779042
Parkside FAIS

Dear Ms. Ott:

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 (906) 226-4171.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010981
Investigation #:	2021A0779042
Complaint Receipt Date:	09/07/2021
Investigation Initiation Date:	09/07/2021
Report Due Date:	11/06/2021
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Allison Gould
Licensee Designee:	Paula Ott
Name of Facility:	Parkside FAIS
Facility Address:	8358 Neff Rd Mt Morris, MI 48458
Facility Telephone #:	(810) 687-7751
Original Issuance Date:	03/04/1993
License **Status:**	1ST PROVISIONAL
Effective Date:	06/23/2021
Expiration Date:	12/22/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 9/5/21, staff left the home and the residents were left unsupervised.	Yes

III. METHODOLOGY

09/07/2021	Special Investigation Intake 2021A0779042
09/07/2021	APS Referral Complaint was referred to AFC licensing by APS.
09/07/2021	Special Investigation Initiated - Telephone Spoke to recipient rights associate, Pat Shepard.
09/07/2021	Contact - Telephone call made Interview conducted with administrator, Debra McGuire.
09/08/2021	Contact - Telephone call made Interview conducted with home manager, Robin Prince.
09/09/2021	Contact - Face to Face Interview conducted with Resident A.
09/10/2021	Contact – Documents received Received resident assessment plans via fax.
09/15/2021	Contact - Telephone call made Interview conducted with staff person, Artavia Robins.
09/17/2021	Contact - Telephone call made Interview conducted with staff person, Shaqunda Williams.
09/17/2021	Contact - Telephone call made Spoke to GHS case manager, Sara Kipfmiller.
09/21/2021	Contact - Telephone call made Spoke to GHS case manager, Carla Webb.
09/21/2021	Inspection Completed On-site Viewed to 2 residents.
10/19/2021	Exit Conference Conducted with licensee designee, Paula Ott.

ALLEGATION:

On 9/5/21, staff left the home and the residents were left unsupervised.

INVESTIGATION:

On 9/7/21, a phone conversation took place with recipient rights associate, Pat Shepard, who confirmed that she is investigating the same allegations. Ms. Shepard stated that she already had spoken to home manager, Robin Prince and staff person, Shaqunda Williams. She stated that Ms. Prince told her that when she arrived to work there were no 3rd shift staff at the home, the door was locked and she had to wake up a resident to let her into the home. Ms. Shepard reported that Ms. Williams, who was the 3rd shift staff in question, told her that she was in her car in the driveway smoking for 10-15 minutes and that when she saw Ms. Prince pull into the driveway, she left.

On 9/7/21, a phone interview was conducted with program coordinator, Debra McGuire. Ms. McGuire stated that Ms. Prince called on the morning of 9/5/21 to say that there were no other staff cars in the driveway and that she was locked out of the home. Ms. McGuire reported that she told Ms. Prince to knock on Resident A's window and have him let her in. She stated that Ms. Prince told her that there was no 3rd shift staff in the home and sent her a picture of the emergency door being closed, with the couch blocking the door. Ms. McGuire reported that both 3rd shift staff that were working that night have been suspended pending further investigation. She stated that this is a first incident of this nature.

On 9/8/21, a phone interview was conducted with home manager, Robin Prince, who admitted that she was late to work on the morning of 9/5/21. She stated that when she arrived to work at approximately 6:08 am, the door to the home was locked, the home was dark and there was no answer at the door. She stated that she went to Resident A's bedroom window, knocked to wake him up and that Resident A had to let her into the home. Ms. Prince reported that there were no staff in the home and all the residents were in bed asleep. Ms. Prince stated that the 3rd shift staff had closed the emergency fire door to the resident's bedroom hallway and pushed a couch up against the door. She stated that neither 3rd shift staff called her before leaving and that she was not sure what time they actually left the home or how long the residents were left unsupervised.

On 9/9/21, face-to-face contact was made with Resident A, at the new AFC home that he had just moved too. Due to his cognitive deficiencies, Resident A was only able to answer specific questions with one-word answers. Resident A appeared to be able to acknowledge that he knew who Robin (Ms. Prince) was. When asked if he remembers a time when Robin had knocked on his bedroom window, Resident A chuckled and said "Yeah". When asked if he had to let Robin into the home, he said "Yeah". When asked if there were any other staff at the home besides Robin, Resident A said "No".

There were four residents present at the time of this incident on 9/5/21. All four resident's written assessment plans were reviewed. The assessment plans confirmed

the need for all four residents to require AFC services. They all require some level of staff intervention in order to complete all of their activities of daily living.

On 9/15/21, a phone interview was conducted with staff person, Artavia Robins, who confirmed that she worked 3rd shift on 9/5/21, along with staff person, Shaqunda Williams. Ms. Robins stated that Ms. Prince was late coming in to start 1st shift, but that they did not try to contact her. She reported that it was Ms. Williams responsibility that day to stay after if necessary, so she left at her scheduled time of 5:30am. Ms. Robins stated that Ms. Williams said she would stay until Ms. Prince got there and that Ms. Williams was still there when she left. She stated that all the residents were asleep in their beds when she left at 5:30am, the fire emergency door was open and the couches were in their normal spots in the living room.

On 9/17/21, a phone interview was conducted with staff person, Shaqunda Williams, who confirmed that she was aware of the allegations and immediately stated that the allegations are a lie. She stated that Ms. Prince was late coming in for 1st shift and that she told Ms. Robins that she would stay and wait, so Ms. Robins left at 5:30am. Ms. Williams reported that at approximately 5:35-5:40am, she unlocked the front door of the home and went out to her car to smoke. She stated that Ms. Prince pulled into the driveway around 5:45am and that is when she drove off. Ms. Williams claims that Ms. Prince had to have seen her in the driveway. Ms. Williams stated that all the residents were in their beds sleeping when she went out to her car to smoke.

On 9/17/21, a phone conversation took place with GHS case manager, Sara Kipfmiller. She confirmed that she was the case manager for Resident A, Resident B and Resident C. Ms. Kipfmiller stated that Resident A is the only verbal resident at this home, who may be able to say what happened the morning of 9/5/21. She reported that she is not aware of this type of situation ever happening in the past and that there has always been staff at this home when she has visited. Ms. Kipfmiller stated that she has no concerns or complaints regarding the care these three residents receive at this home.

On 9/21/21, a phone conversation took place with GHS case manager, Carla Webb, who is the case manager for Resident D. Ms. Webb stated that she is not aware of supervision ever being an issue before this incident. Ms. Webb reported that Resident D seems to receive good care here and that she has no complaints about this home.

On 9/21/21, an unannounced on-site inspection was conducted. Resident C and Resident D were the only residents present at the home, due to the other two residents moving out of the home. Resident C and Resident D were both viewed to be clean, well groomed and appeared to be doing fine. Due to their cognitive deficiencies, neither of them were able to be interviewed.

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:	First shift staff and home manager, Robin Prince, claims that when she arrived to work at 6:08am on 9/5/21, the door to the home was locked, the home was dark and there were no staff present inside the home. Ms. Prince claims that she had to knock on Resident A's bedroom window to get him to let her into the home. Resident A confirmed that Ms. Prince had done this and that no other staff, besides Ms. Prince, were present at the home at that time. Staff person, Shaqunda Williams, claims that she was outside in her car smoking from approximately 5:35-5:45, when she saw Ms. Prince arrive to work. Ms. Williams stated that she drove away from the home once she saw Ms. Prince park in the driveway. Regardless of whether Ms. Williams left the property or not, there was at least 5-10 minutes or more where there were no staff inside the home, leaving the residents unsupervised. There was sufficient evidence found to prove that all four residents of this home were left unsupervised and not provided the supervision and/or protection as specified in the resident's resident care agreement and assessment plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/19/21, an exit conference was conducted with licensee designee, Paula Ott. She was informed that a corrective action plan will be required to address the above licensing rule violation.

IV. RECOMMENDATION

This home is currently on a six-month provisional license. It is recommended that the status of this home's license remain unchanged contingent upon receipt of an acceptable plan of correction.

10/19/2021

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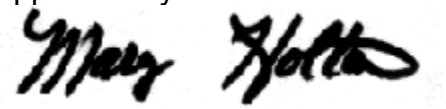
Christopher Holvey Date
Licensing Consultant

Approved By:



10/20/2021

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Mary E Holton Date
Area Manager