GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 20, 2021

Alicia Sain
Pal's Place, LLC
5336 E Court St S
Burton, MI 48509

RE: License #: AS250385628
Investigation #: 2021A0580041
Pal's Place

Dear Ms. Sain:

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,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250385628
Investigation #:	2021A0580041
Complaint Receipt Date:	08/23/2021
Investigation Initiation Date:	08/24/2021
Report Due Date:	10/22/2021
Licensee Name:	Pal's Place, LLC
Licensee Address:	5336 E Court St S Burton, MI 48509
Licensee Telephone #:	(810) 938-0018
Administrator:	Alicia Sain
Licensee Designee:	Alicia Sain
Name of Facility:	Pal's Place
Facility Address:	5336 E Court St S Burton, MI 48509
Facility Telephone #:	(810) 938-0018
Original Issuance Date:	07/06/2018
License Status:	REGULAR
Effective Date:	01/06/2021
Expiration Date:	01/05/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 09/29/2021, at 1:54 AM, both staff in the facility were found sleeping. Resident C requires 24-hour supervision.	Yes
Resident A is not allowed to go into the refrigerator when he feels hungry.	No
Owner did not reimburse Resident B's guardian after he left the facility.	No

III. METHODOLOGY

08/23/2021	Special Investigation Intake 2021A0580041
08/24/2021	Special Investigation Initiated - Telephone A call was made to the licensee.
08/31/2021	APS Referral A call was received from Dan Spalthoff, assigned APS Investigator.
08/31/2021	Inspection Completed On-site An onsite inspection was conducted at Pal's Place with APS.
08/31/2021	Contact – Face-to-Face An interview was conducted with direct staff, Ms. Kristen Croak.
08/31/2021	Contact – Face-to-Face An interview was conducted with direct staff, Ms. Arien Johnson.
08/31/2021	Contact - Face to Face An observation was made of Resident A.
08/31/2021	Contact - Document Received Email of documents requested received via email.
08/31/2021	Contact - Face to Face An interview was conducted with direct staff, Ms. Sara French.
10/14/2021	Contact - Telephone call made A call was made to Ms. Alicia San regarding the allegations received on 10/04/2021.
10/14/2021	Contact - Document Received

	An email with documents requested was received.
10/15/2021	Contact - Telephone call made A call was made to Ms. Sara Kipfmiller, assigned case manager for Resident C.
10/15/2021	Contact - Telephone call made I spoke with Mr. Ash Christenson-Resident A and Resident B.
10/15/2021	Contact - Telephone call made A call was made to Ms. Destiny Triplett, Staff.
10/15/2021	Contact - Telephone call made A call was made to Mr. John Croak, Staff.
10/15/2021	Contact - Telephone call made A call was made to Guardian B.
10/20/2021	Contact - Telephone call made A call was made to Mr. Todd Hopper, staff.
10/20/2021	Contact - Telephone call made A call was made to Mr. Dan Spalthoff, APS.
10/20/2021	Exit Conference – An exit conference was held with the licensee.

ALLEGATION:

On 09/29/2021 at 1:54 AM, both staff in the facility were found sleeping. Resident C requires 24-hour supervision.

INVESTIGATION:

On 10/04/2021, I received an additional complaint, intake #182381, alleging that the only 2 staff on 3rd shift duty were found sleeping on 09/29/2021. Resident C requires 24-hour care and supervision.

On 10/14/2021, I spoke with Ms. Alicia Sain regarding the allegations received on 10/04/2021. Ms. Sain shared that she and Mr. Hopper were working late in the office, located in the basement of the AFC on the evening in question. She recalls that she departed the home at approximately 1am. Staff, Ms. Destiny Tripplet was sitting on the couch when she left. At approximately 1:56pm, she received a call from Mr. Hopper

indicating that he'd found staff, Mr. John Croak sleeping in the sensory room, while staff, Ms. Tripplet could not be located. Ms. Sain returned to the facility and upon her arrival she found Ms. Tripplet fast asleep in her car, complete with a pillow and a blanket. Both staff were fired. Resident C is the only resident that requires 24-hour care and supervision.

On 10/14/2021, I received a copy of the AFC Assessment plan and IPOS for Resident C. The IPOS, completed by Genesee Health Systems (GHS), effective 08/18/2021, indicates that during sleeping hours, staff are to make 15-minute visual checks throughout the night. In the event that Resident C sleeps/naps during the day, staff may leave his room but are to make visual checks every 10 minutes.

On 10/15/2021, I spoke with Ms. Destiny Triplett, staff. She admitted that she was in her car when Ms. Sain found her. She denied that she was asleep. She verified that is no longer employed at Pals Place LLC.

On 10/15/2021, I spoke with Mr. John Croak, staff. He admitted that he fell asleep for what he estimates was about 15 minutes. He shared that he sat down due to his back hurting and must have fallen asleep. He indicated that it was a one-time occurrence. He verified that he is no longer employed at Pals Place LLC.

On 10/15/2021, I spoke with Ms. Sara Kipfmiller, assigned GHS case manager for Resident C. Ms. Kipfmiller had been made aware of the incident where the staff had fallen asleep. She shared that Resident C does require 24 care and supervision, including 15-minute bed checks while sleeping. She shared that it is an unfortunate event. Staff at the home typically do well with Resident C. She believes that they do a good job running the home and has no immediate concerns.

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:	It was alleged that only 2 staff on 3rd shift duty were found sleeping on 09/29/2021. Resident C requires 24-hour care and supervision. Ms. Alicia Sain, licensee indicated that both staff were discovered sleeping on 09/29/2021 during 3rd shift. Resident C requires 24-hour care and supervision. Both staff were fired.

	The IPOS for Resident C indicates that during sleeping hours, staff are to make 15-minute visual checks throughout the night. In the event that Resident C sleeps/naps during the day, staff may leave his room but are to make visual checks every 10 minutes. Ms. Destiny Triplett, staff, admitted that she was in her car when Ms. Sain found her. She denied that she was asleep. Mr. John Croak, staff, admitted that he fell asleep for what he estimates was about 15 minutes. Ms. Sara Kipfmiller, assigned GHS case manager for Resident C indicated that staff at the home typically do well with Resident C. She believes that they do a good job running the home and has no immediate concerns. Based on the information gathered throughout the course of this investigation, there is sufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A is not allowed to go into the refrigerator when he feels hungry.

INVESTIGATION:

On 08/23/2021, I received a complaint via BCAL Online complaints. This complaint was denied by APS for investigation.

On 08/24/2021, I made a call to the licensee, Ms. Alicia Sain. She currently has 4 residents. She denied that any of the residents are denied food. Residents a fed 3 regular meals a day, plus snacks. Ms. Sain indicates that there are no locks on the cabinets or the fridge doors. She indicated that the Resident A would eat non-stop if allowed to. Resident A has a food obsession and does require monitoring of his food intake. Ms. Sain shared that if Resident A is not watched, he will eat raw foods or from the trash, even after he has eaten a meal.

While onsite I was able to observe the contents of the fridge, freezer and pantry located in home. The food supply was adequate to meet the nutritional needs of the number of residents currently residing in the home.

A copy of the AFC Assessment Plan, Individual Plan of Service (IPOS), Food Intake chart, and weight record for Resident A were requested. Menus for the months of July and August were also requested.

On 08/31/2021, I spoke with direct staff, Ms. Kristen Croak while at Pals Place LLC. Ms. Croak indicated that Resident A can go in the kitchen when he likes, however, he is an obsessive eater and will often throw up after overeating. She adds that staff try and redirect Resident A when he is displaying food obsession.

On 08/31/2021, I spoke with direct staff, Ms. Sara French while at Pals Place LLC. Ms. French stated that Resident A is allowed in the kitchen to obtain his own snacks, however he is very food aggressive and will often snatch food from the stove, trash or eat it raw if not monitored and redirected.

On 08/31/2021, I made in-person contact with Resident A. Resident A was observed in the living room watching television with his 1 on 1 staff during the onsite visit. Resident A was appropriately dressed. Resident A appeared to be receiving adequate care. Resident A in non-verbal.

On 08/31/2021, I received an email from Mr. Todd Hopper with documents requested. A copy of the AFC Assessment Plan, IPOS, Food Intake chart, and weight record for Resident A was received. Menus for the months of July and August were also obtained.

The assessment plan indicates that Resident A requires assistance with eating by reminding him to eat slow, chew and cut food into bite sizes. The IPOS for Resident A, completed by Saginaw County Community Mental Health (CMH) effective 07/27/2021. It indicates that Resident A is able to eat food on his own but he does eat quickly and will take food from others if he finishes before them. He will also take uneaten food out of the trash. Staff are to verbally prompt Resident A to take his time when eating to prevent choking. To prevent him from stealing food from others, staff should redirect Resident A to a choice of activity when he has finished eating so he does not remain at the table. Staff should also make sure Resident A does not see food in the trash by keeping the lid of the trash closed or disposing food in a trash can that is not inside the house. The Food Intake chart for Resident A indicate that Resident A is receiving a minimum of 3 regular nutritious meals a day, including snacks between meals. Mealtimes indicate that there is less than 14 hours between the morning and evening meal. Resident A's beginning weight when entering the facility in January 2021 was 200 lbs. Resident A's weight as of August 2021 is 220 lbs. Menus for July and August reflect meals that meet the nutritional daily allowance recommended, by the Michigan Department of Public Health.

On 10/15/2021, I spoke with Mr. Ash Christenson, assigned Saginaw County CMH case manager for Residents A. Mr. Christians shared that Resident A is diagnosed as having Moderate Intellectual Disability, Autism Disorder, Obsessive Compulsive Disorder and Developmental Delays in Speech and Language. Resident A is non-verbal. He shared that Resident A does have a food obsession which requires monitoring. He added that

they are currently working on a Behavioral Treatment Plan to address his food aggressive behaviors such as head butting. He adds that the home does well in informing him when Resident A has food aggression incidents. Resident A has no weight loss concerns. He stated that he has no concerns that Resident A is not being provided with adequate food.

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:	It was alleged that Resident A is not allowed to go into the refrigerator when he feels hungry. Licensee, Ms. Alicia Sain, denied that any of the residents are denied food. Resident A has a food obsession and does require monitoring of his food intake. Direct staff, Ms. Kristen Croak, indicated that Resident A can go in the kitchen when he likes, however, he is an obsessive eater and will often throw up after overeating. Staff try and redirect Resident A when he is displaying food obsession. Direct staff, Ms. Sara French, stated that Resident A is allowed in the kitchen to obtain his own snacks, however he is very food aggressive and will often snatch food from the stove, trash or eat it raw if not monitored and redirected. Resident A was observed in the living room watching television with his 1 on 1 staff during the onsite visit. Resident A was appropriately dressed. Resident A appeared to be receiving adequate care. Resident A in non-verbal. The IPOS for Resident A, completed by Saginaw County Community Mental Health (CMH) effective 07/27/2021. It indicates that Resident A is able to eat food on his own but he does eat quickly and will take food from others if he finishes before them. He will also take uneaten food out of the trash. Staff are to verbally prompt Resident A to take his time when eating to prevent choking. To prevent him from stealing food

	from others, staff should redirect Resident A to a choice of activity when he has finished eating so he does not remain at the table. Staff should also make sure Resident A does not see food in the trash by keeping the lid of the trash closed or disposing food in a trash can that is not inside the house. Resident A's beginning weight when entering the facility in January 2021 was 200 lbs. Resident A's weight as of August 2021 is 220 lbs. Based on the information gathered throughout the course of this investigation, there is insufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Owner did not reimburse Resident B's guardian after he left the facility.

INVESTIGATION:

On 08/31/2021, I received an additional complaint, intake 181727, alleging that the licensee did not provide Resident B with a refund when he moved from the home.

On 08/31/2021, I spoke with Mr. Dan Spalthoff, APS Investigator, Genesee County. We agreed to do a joint visit to the AFC.

On 08/31/2021, I conducted an onsite inspection at Pals Place AFC. Contact was made with both the licensee and administrator, Mr. Todd Hopper and Ms. Alicia Sain. Ms. Sain denied the allegations that Resident B was not provided with a refund when moved from the facility if one was due. They would have to check their records.

On 08/31/2021, I received an email from Mr. Todd Hopper with documents requested. Documents for Resident B requested include a copy of the refund policy, the AFC care agreement, the discharge summary, and the Resident Funds II sheet.

The Refund Policy at Place LLC indicates that Refunds of the monthly charge that is paid to pals Place LLC shall be returned only when one of the following conditions occur: 1. An emergency discharge occurs as referred to in the discharge policy, 2. When a resident has been determined to be at risk pursuant to Sections 11 and 11 (a) or 11(f) of Act 280 of PA 1939, as amended (The Social Welfare Act); 3. When a resident has been determined to be at risk due to substantial noncompliance with licensing rules which result in the Department taking action to revoke or summarily

suspend or refuse to renew a license at the resident's location. The amount of the monthly charge to be returned to the resident shall be based upon the resident's location. The amount of monthly charge to be returned to the resident shall be based upon the resident's current rate as documented in the resident care agreement and /or agreement with resident's responsible agency or insurance company and shall be prorated based on the number of days that the resident lived in the home during that month and after consideration of balances due. This agreement was signed by Guardian B on 04/30/2019.

Resident B's Resident Care Agreement indicates that his monthly rate of pay is $951.50, with $44 dollars used towards personal funds.

Pal's Place Discharge Summary indicates that Resident B was discharged from the facility on 06/25/2021.

Resident Funds II sheet indicates that the pro-rated amount of the refund for the dates of 06/25/2021-06/30/2021 equals $151.25. This amount went towards Resident A's owed balance of $155.21 from the previous month, leaving the amount owed to Pals as $3.96.

On 10/15/2021, I spoke with Guardian B. She indicated that she has never received a refund from Pal's Place AFC.

On 10/15/2021, I spoke with Mr. Ash Christenson, assigned Saginaw County CMH case manager for Residents B. Mr. Christians has no knowledge of a refund that was not provided to Guardian B.

On 10/20/2021, I conducted a follow-up call to Mr. Todd Hooper. He clarified that no refund was due to the resident. Resident B left with a balance owed of $3.96.

On 10/20/2021, I spoke with Mr. Dan Spalthoff, of APS in Genesee County. He stated that his complaint yielded no abuse or neglect findings.

On 10/20/2021, I conducted an exit conference with the licensee, Ms. Alicia Sain. Ms. Sain was informed of the rule in which a licensing rule violation was established. A corrective action plan was requested within 15 days.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(14) A licensee shall have a written refund agreement with the resident or his or her designated representative. The agreement shall state under what conditions a refund or the unused portion of the monthly charge that is paid to the home shall be returned to the resident or his or her designated representative. The refund agreement shall

	provide for, at a minimum, refunds under any of the following conditions: **(a) When an emergency discharge from the home occurs as described in R 400.14302.** **(b) When a resident has been determined to be at risk pursuant to the provisions of sections 11 and 11a to 11f of Act No. 280 of the Public Acts of 1939, as amended, being {400.11 and 400.11a to 400.11 of the Michigan Compiled Laws.** **(c) When a resident has been determined to be at risk due to substantial noncompliance with these licensing rules which results in the department taking action to issue a provisional license or to revoke or summarily suspend, or refuse to renew, a license and the resident relocates. The amount of the monthly charge that is returned to the resident shall be based upon the written refund agreement and shall be prorated based on the number of days that the resident lived in the home during that month.**
ANALYSIS:	It was alleged that the owner did not reimburse Resident B's guardian after he left the facility. The Refund Policy at Place LLC indicates that Refunds of the monthly charge that is paid to pals Place LLC shall be returned only when one of the following conditions occur: 3. The amount of the monthly charge to be returned to the resident shall be based upon the resident's location. The amount of monthly charge to be returned to the resident shall be based upon the resident's current rate as documented in the resident care agreement and /or agreement with resident's responsible agency or insurance company and shall be prorated based on the number of days that the resident lived in the home during that month and after consideration of balances due.

	Resident B's Resident Care Agreement indicates that his monthly rate of pay is $951.50, with $44 dollars used towards personal funds. Mr. Todd Hooper, staff, indicated that no refund was due to the resident upon discharge. Resident B left with a balance owed of $3.96. Resident Funds II sheet indicates that the pro-rated amount of the refund for the dates of 06/25/2021-06/30/2021 equals $151.25. This amount went towards Resident A's owed balance of $155.21 from the previous month, leaving the amount owed to Pals as $3.96. Guardian B indicated that she has never received a refund from Pal's Place AFC. Based on the information gathered throughout the course of this investigation, there is insufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no changes to the status of the license is recommended.

Sabrina McGowan October 20, 2021

Sabrina McGowan Date
Licensing Consultant

Approved By:

Mary E Holton October 20, 2021

Mary E Holton Date
Area Manager