GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 18, 2021

Patti Holland
801 W Geneva Dr.
Dewitt, MI 48820

RE: License #: AS330341802
Investigation #: 2021A0783047
Lansing Adult Foster Care

Dear Patti Holland:

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 (517) 284-9730.

Sincerely,

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330341802
Investigation #:	2021A0783047
Complaint Receipt Date:	08/18/2021
Investigation Initiation Date:	08/20/2021
Report Due Date:	10/17/2021
Licensee Name:	Patti Holland
Licensee Address:	801 W Geneva Dr. Dewitt, MI 48820
Licensee Telephone #:	(517) 669-8457
Administrator:	Patti Holland
Name of Facility:	Lansing Adult Foster Care
Facility Address:	3600 Simken Drive Lansing, MI 48910
Facility Telephone #:	(517) 203-5249
Original Issuance Date:	01/10/2014
License Status:	REGULAR
Effective Date:	07/08/2020
Expiration Date:	07/07/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A smokes cigarettes in his bedroom.	No
The designated smoking area is near where a resident's full oxygen tanks are stored.	Yes
There are cats living in the home that have worms and fleas.	No
Resident E was physically assaulted by direct care staff member Zatoria Martin.	No

III. METHODOLOGY

08/18/2021	Special Investigation Intake – 2021A0783047
08/20/2021	Special Investigation Initiated – Telephone call with Complainant
08/31/2021	Inspection Completed On-site
08/31/2021	Contact - Face to Face interviews with staff members Lori Robbins and Chastity Johnston and Residents A, B, C, and D
09/14/2021	Contact - Telephone call made to state fire marshal inspector with Bureau of Fire Services
10/04/2021	Contact - Telephone call made to staff member Zatoria Martin
10/04/2021	Contact - Telephone call made to licensee Patti Holland
10/04/2021	Exit Conference with Patti Holland

ALLEGATION:

Resident A smokes cigarettes in his bedroom.

INVESTIGATION:

On August 18, 2021, I received a complaint via centralized intake that stated Resident A smokes cigarettes in his bedroom.

On August 20, 2021, I spoke to Complainant wo confirmed the allegations in the Complaint and identified the other resident as Resident B.

On August 31, 2021, I completed an unannounced onsite investigation at the facility and inspected Resident A's bedroom. I did not note any indication such as odor, ashes, cigarettes, etc. that would indicate Resident B was smoking in his bedroom.

On August 31, 2021, I interviewed Resident A who said he smokes cigarettes outside of the facility in the designated smoking area. Resident B denied that he ever smoked in his bedroom at the facility.

On August 31, 2021, I interviewed Resident B, Resident C, and Resident D who denied that Resident A smokes in his bedroom at the facility.

On August 31, 2021, I interviewed direct care staff member Lori Robbins who denied that Resident A smokes in his bedroom. Ms. Robbins said she regularly cleans the room and has never seen any sign that Resident A was smoking in the room.

On October 4, 2021, I spoke to direct care staff member Zatoria Martin who denied that Resident A smokes in his bedroom.

On October 4, 2021, I spoke to licensee Patti Holland who said someone reported that Resident A was smoking in his bedroom so Ms. Holland inquired with staff members and other residents and inspected Resident A's bedroom and did not find any indication that Resident A smoked in his bedroom.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	Based on statements from Resident A, Resident B, Resident C, Resident D, Ms. Robbins, Ms. Martin, and Ms. Holland along with my own observations at the time of the onsite inspection there is lack of evidence to support the allegation that Resident A smoked in his bedroom at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The designated smoking area is near where a resident's full oxygen tanks are stored.

INVESTIGATION:

On August 18, 2021, I received a complaint via centralized intake that stated there are twenty oxygen tanks stored by the front door of the facility near the designated smoking area.

On August 20, 2021, I spoke to Complainant who confirmed the oxygen tanks stored on the front porch were full and that staff members and residents were observed smoking within six feet of the oxygen tanks.

On September 14, 2021, I spoke to Corey Irvin who is a state fire marshal inspector with Bureau of Fire Services. Mr. Irvin stated, "If the oxygen is stored outside, it needs to be in a secured area, 25 feet away from the building, with "No smoking allowed" signs within 25 feet. A provision shall be made for a rack or fastening to protect a cylinder from accidental damage or dislocation. This is from the 2012 BFS Adult Foster Care Facility rules."

On August 31, 2021, I completed an unannounced onsite inspection at the facility and observed approximately 25 full oxygen tanks stored openly within approximately ten feet of the designated smoking area. I observed staff members and residents smoking no more than ten feet from the oxygen tanks. I observed a sign hanging above the oxygen tanks that stated smoking within six feet of the oxygen tanks was prohibited.

On August 31, 2021, I interviewed direct care staff member Lori Robbins who said the oxygen tanks were placed outside because they are no longer needed and they will be picked up by the medical supply company soon. Ms. Robbins stated six feet is a safe distance within which to smoke near the oxygen tanks and that all staff members and residents who smoke have stayed at least six feet away from the oxygen tanks. On October 4, 2021, Ms. Robbins confirmed that the oxygen tanks were picked up and were no longer on the front porch at the facility.
On October 4, 2021, I spoke to direct care staff member Zatoria Martin who confirmed there were full oxygen tanks stored on the front porch within ten feet of

the designated smoking area. Ms. Martin said at the time of our conversation the oxygen tanks were no longer at the facility.

On October 4, 2021, I spoke to licensee Patti Holland who said she was not aware that there were full oxygen tanks stored on the front porch, near the designated smoking area. Ms. Holland stated there are no oxygen tanks currently stored on the porch.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based on statements from Complainant, Ms. Robbins, Ms. Martin, Mr. Irvin, and my observations at the unannounced onsite inspection it can be determined that full oxygen tanks were placed within 25 feet of the designated smoking area at the facility. According to the state fire marshal the designated smoking area should be at least 25 feet away from the oxygen to maintain the health and safety of the residents in the home and the investigation revealed the designated smoking area was closer than 25 feet from the oxygen tanks.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There are cats living in the home that have worms and fleas.

INVESTIGATION:

On August 18, 2021, I received a complaint via centralized intake that stated Resident A has a cat in the home and worms are crawling all over the cat.

On August 20, 2021, I spoke to Complainant who said she observed Resident A's cat with worms "all over his body." Complainant stated Resident D's cat has fleas "so bad you can see them jumping off" the cat. Complainant stated Resident A and Resident D are each responsible for caring for their own cats.

On August 31, 2021, I conducted an unannounced onsite investigation and observed Resident A's cat and Resident D's cat. Both cats appeared healthy, and I did not see any worms nor fleas on either cat.

On August 31, 2021, I spoke to direct care staff member Lori Robbins who denied that either cat living at the facility had worms nor fleas. Ms. Robbins stated if either cat needed treatment from a veterinarian for something such as worms or fleas the animal would be taken by a staff member to see a veterinarian.

On October 4, 2021, I spoke to direct care staff member Zatoria Martin who said there are two healthy cats living at the facility and denied observing worms nor fleas on either animals.

On October 4, 2021, I spoke to licensee designee Patti Holland who stated Residents A and D both have a cat for which the residents are responsible for daily care. Ms. Holland said if either cat needed treatment for worms or fleas the cat would be taken to the veterinarian by a staff member. Ms. Holland denied that she has seen worms nor fleas on either cat.

On August 31, 2021, I interviewed Resident A, Resident D, Resident C, and Resident D who all denied that either cat living at the facility has been observed with worms or fleas.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based on statements from Ms. Robbins, Ms. Martin, Ms. Holland, Resident A, Resident C, and Resident D along with my observations at the unannounced onsite investigation there is lack of evidence to support the allegation that the cats living at the facility are afflicted with fleas or worms nor that the home is not maintained to provide for the health, safety, and well – being of occupants.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident E was physically assaulted by direct care staff member Zatoria Martin.

INVESTIGATION:

On August 31, 2021, I interviewed Complainant who said direct care staff member Zatoria Martin physically assaulted Resident E when she knocked Resident E over

in her wheelchair and punched Resident E in the ear. Complainant stated Resident A and Resident D witnessed the physical assault which occurred inside the facility near Resident A's bedroom. Complainant said Resident E "blacked out" from the impact of Ms. Martin's punch. Complainant said Ms. Martin calls Resident A derogatory names and "elbows [Resident E] in the face" regularly.

On August 31, 2021, I interviewed Resident A who denied that he ever saw Ms. Martin physically assault Resident E nor that he ever heard her call Resident A derogatory names.

On August 31, 2021, I interviewed Resident B who described Ms. Martin as "good," and denied that he ever saw her physically assault Resident E nor that he ever heard her call Resident A derogatory names.

On August 31, 2021, I interviewed Resident C who described Ms. Martin as "perfect" and denied that she ever saw her physically assault Resident E. Resident C said Resident E regularly physically assaults Ms. Martin and calls her derogatory names but Ms. Martin "doesn't respond." Resident C said Ms. Martin never called Resident A derogatory names.

On August 31, 2021, I interviewed Resident D who denied that Ms. Martin has ever been "rude or mean," and denied that she ever saw Ms. Martin physically assault Resident E.

On October 4, 2021, spoke to direct care staff member Zatoria Martin who denied ever calling Resident E derogatory names, denied pushing Resident E's wheelchair, denied punching Resident E in the ear, and denied elbowing Resident E in the face. Ms. Martin said she has never "put her hands on" Resident E in an aggressive manner. Ms. Martin said Resident A regularly verbally assaults her and has tripped her and pulled her hair, but she has never responded aggressively in turn.

On August 31, 2021, I spoke to direct care staff member and home manager Chastity Johnston who said there have been several instances of Resident E verbally and/or physically attacking Ms. Martin and other staff members but Ms. Martin has never verbally or physically abused Resident E in any way. Ms. Johnston said after Resident E reported she was punched in the ear by Ms. Martin she was taken to the hospital per her request and the discharge summary documented Resident E's tendency to report things that are untrue. Ms. Johnston said Resident E was not injured during the alleged attack. Ms. Johnston stated she has no concerns regarding Ms. Martin and no other residents except for Resident E have voiced any concerns regarding Ms. Martin.

On August 31, 2021, I interviewed direct care staff member Lori Robbins who described Ms. Martin as "quiet" and mild mannered and Ms. Robbins denied having any concerns regarding Ms. Martin nor her interactions with Resident E. Ms. Robbins stated no other residents besides Resident E have "complained about" Ms.

Martin. Ms. Robbins added that Resident E regularly verbally and physically attacks Ms. Martin who always responds appropriately.

On October 4, 2021, I spoke to licensee designee Patti Holland who said Resident E have voiced “complaints” regarding Ms. Martin but when Ms. Holland has inquired with other residents and staff members the complaints appeared to be unfounded. Ms. Holland stated Ms. Martin has worked at the facility for “several months” and Ms. Holland has no concerns regarding Ms. Martin nor her interactions with Resident E.

On August 31, 2021, I reviewed Resident E’s resident record and observed a hospital discharge summary from Sparrow Hospital dated August 21, 2021. The discharge summary stated, “In the ED patient reported abuse at her AFC home multiple times to multiple staff members and APS report filed. LARA online complaints were reviewed and [the facility] has been found multiple times to be in compliance. Patient has a long history of similar allegations which have been investigated. Patient told hospital staff she only came to the hospital because she wants to be able to live in her own apartment. Guardian request and approve patient return to AFC.” There were no injuries documented on the written report.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on statements from Resident A, Resident B, Resident C, Resident D, Ms. Martin, Ms. Robbins, Ms. Johnston, and Ms. Holland as well as written documentation at the facility there is lack of evidence to indicate that Ms. Martin physically assaulted Resident E nor that Resident E’s safety and protection needs weren’t met at all times.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On August 18, 2021, I received a complaint via centralized intake that stated a direct care staff member “jumped on” Resident E while in her wheelchair causing Resident E to hit her head and sustain a brain bleed. See special investigation report 2021A0466022 dated April 19, 2021, wherein this allegation was investigated.

IV. RECOMMENDATION

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

10/07/21

Leslie Herrguth — Date
Licensing Consultant

Approved By:

10/18/2021

Dawn N. Timm — Date
Area Manager