GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 20, 2022

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

RE: License #: AM370085651
Investigation #: 2022A0783011
Country Place II

Dear Ms. Woodcock:

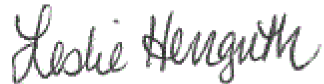
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AM370085651
Investigation #:	2022A0783011
Complaint Receipt Date:	11/22/2021
Investigation Initiation Date:	11/23/2021
Report Due Date:	01/21/2022
Licensee Name:	Community Health Care Management
Licensee Address:	2033 Westbrook Ionia, MI 48846
Licensee Telephone #:	(989) 773-6320
Administrator:	Jennia Woodcock
Licensee Designee:	Jennia Woodcock
Name of Facility:	Country Place II
Facility Address:	1807 E. Jordan Mount Pleasant, MI 48858
Facility Telephone #:	(989) 773-6320
Original Issuance Date:	07/02/2001
License Status:	REGULAR
Effective Date:	07/12/2020
Expiration Date:	07/11/2022
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was made to use her personal spending money to buy a new jar of peanut butter without written approval from Resident A nor her designated representative.	Yes
Staff members hide the peanut butter from Resident A.	No
A staff member “ripped” a peanut butter sandwich from Resident A’s hands and threw it in the trash.	No

III. METHODOLOGY

11/22/2021	Special Investigation Intake – 2022A0783011
11/23/2021	Special Investigation Initiated – Telephone call with Complainant
11/24/2021	Contact - Telephone call made to direct care staff member and former home manager Kimberly Waldron
11/24/2021	Contact - Telephone call made to direct care staff members Krista Newhouse, Katlynn Wiggins, and Lisa Bowers
01/12/2022	Contact - Face to Face interviews with licensee designee Jennia Woodcock, Resident A, Resident B, Resident C, and Resident D
01/12/2022	Inspection Completed On-site
01/12/2022	Contact - Document Received – Resident A's resident record
01/13/2022	Contact - Telephone call made to direct care staff member Sarah Schmittler
01/19/2022	Exit Conference with Jennia Woodcock

ALLEGATION:

Resident A was made to use her personal spending money to buy a new jar of peanut butter without written approval from Resident A nor her designated representative.

INVESTIGATION:

On November 22, 2021, I received a complaint via centralized intake that stated Resident A reported a direct care staff member accused her of taking a large jar of peanut butter and told Resident A she would need to purchase a new jar of peanut better. The written complaint stated Resident A said, "I made a sandwich. The jar [of peanut butter] was full to the top. I opened it, made a sandwich, and put it back. I didn't take the jar. They told me I had to buy a whole new jar." The written complaint stated Resident A was unsure which date this occurred and could not remember which staff was involved.

On November 23, 2021, I interviewed Complainant who said she spoke to direct care staff member Sarah Schmittler who said staff member Lisa Bowers told Resident A that she would have to replace the jars of peanut butter that she had "contaminated" by sticking her fingers into the jar but Resident A never actually purchased peanut better for the home to replace what she had "contaminated."

On January 13, 2022, I spoke to direct care staff member Sarah Schmittler who said it was direct care staff member and home manager Kimberly Waldron who told her that Resident A had to use her personal spending money to purchase "three to four" jars of peanut better for the facility because Resident A "contaminated" the peanut butter by sticking her fingers into the jar of peanut butter. Ms. Schmittler said Ms. Waldron advised the information needed to be communicated to all staff members that if Resident A "contaminated" any jars of peanut butter Ms. Waldron needed to be notified because Resident A would need to use her personal spending money to replace the "contaminated" peanut butter. Ms. Schmittler said she did not believe Resident A ever used her money to purchase peanut butter for the facility, but Resident A did use her personal spending money to purchase her own peanut butter. Ms. Schmittler said at that time Resident A's written assessment and treatment plans did not indicate that Resident A was required to use her personal spending money to purchase peanut butter if she "contaminated" the jar meant for all residents. Ms. Schmittler said that was the policy for every resident, regardless of what was written in the assessment and treatment plans.

On November 24, 2021, I spoke to direct care staff member and former home manager Kimberly Waldron who said she told Resident A that she would have to replace three jars of peanut butter that Resident A "contaminated" by putting her fingers into. Ms. Waldron said she told Resident A she would need to purchase peanut butter for the facility because Resident A ate a whole jar of peanut butter in two days and "there was not enough [peanut butter] for other [residents.]" Ms.

Waldron said Resident A also ruined several jars of peanut butter that had to be thrown away because Resident A put her fingers in the jars of peanut butter which were then “contaminated” and were thrown away. Ms. Waldron said she took Resident A to the grocery store and Resident A purchased one jar of peanut butter for all residents’ use to “replace” the peanut butter she had eaten and ruined. Ms. Waldron said she told Resident A to purchase the peanut butter because it is a “house rule,” and a “policy” and that it was the same concept as stealing food. Ms. Waldron said at that time Resident A’s written assessment and treatment plans did not require Resident A to use her personal spending money to purchase peanut butter if she “contaminated” the jar meant for all residents.

On November 24, 2021, I spoke to direct care staff member Krista Newhouse who said Resident A had a habit of putting her hands into the jars of peanut butter that were intended for all residents to use so the peanut butter had to be thrown away after Resident A put her hand in the peanut butter. Ms. Newhouse said Resident A was “greedy” with peanut butter and would put “four to five servings” of peanut butter on one piece of bread. Ms. Newhouse said direct care staff member and home manager Kimberly Waldron told her to tell Resident A that if she put her hands into the jar of peanut butter, she would have to purchase a jar to replace the “contaminated” peanut butter. Ms. Newhouse stated she did not know if Resident A used her personal spending money to purchase peanut butter for the facility.

On November 24, 2021, I spoke to former direct care staff member Katlynn Wiggins who said she only knew that residents were prohibited from “eating peanut butter from the jar” without a utensil, and Resident A had a habit of doing that.

On November 24, 2021, I spoke to direct care staff member Lisa Bowers who stated she typically works the overnight shift while Resident A is asleep. Ms. Bowers said Resident A “eats a lot of peanut butter,” but she was never told that Resident A was told to or directed to use her personal money to purchase peanut butter for the facility.

On January 12, 2021, I interviewed facility administrator and licensee designee Jennia Woodcock who stated she knew nothing about Resident A and any concerns with peanut butter until after she received a telephone call from someone at the office of recipient rights. Ms. Woodcock said after that telephone call she learned that staff members were purchasing up to six jars of peanut butter per week because Resident A “contaminated” the peanut butter by putting her hand into the jar of peanut butter. Ms. Woodcock said direct care staff member Kimberly Waldron allegedly told Resident A she needed to use personal funds to purchase peanut butter for the facility because she had “contaminated” several jars. Ms. Woodcock said Ms. Waldron never told her she said that to Resident A nor that Resident A was taken to the store by Ms. Waldron to purchase peanut butter. Ms. Woodcock said if Ms. Waldron said that to Resident A, she never intended it to be a threat, rather, Ms. Waldron likely thought that was appropriate because other residents have food replacement protocol in their written assessment and treatment plans. Ms.

Woodcock said Resident A did not have anything written in her assessment plan, treatment plan, nor Resident Care Agreement that would indicate Resident A should use personal funds to purchase peanut butter for the facility.

On January 12, 2021 and January 18, 2021 I reviewed Resident A's written resident record including her *Assessment Plan for AFC Residents, Resident Care Agreement,* and *Person Centered Plan* from Community Mental health and none of the documents authorized a resident funds transaction wherein Resident A would use her personal funds to purchase peanut butter for all residents' use at the facility.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(8) All resident fund transactions shall require the signature of the resident or the resident's designated representative and the licensee or prior written approval from the resident or the resident's designated representative.
ANALYSIS:	Based on statements from Complainant, Ms. Schmittler, Ms. Waldron, Ms. Newhouse, Ms. Wiggins, Ms. Bowers, and Ms. Woodcock along with written documentation in Resident A's written resident record it can be determined that Resident A nor her designated representative authorized nor provided prior written approval for Resident A's personal spending funds to be used to purchase peanut butter for all residents' use.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff members hide the peanut butter from Resident A.

INVESTIGATION:

On November 22, 2021, I received a complaint via centralized intake that stated staff members "hide the peanut butter" from Resident A.

On November 23, 2021, I spoke to Complainant who said staff members were instructed by direct care staff member and home manager Kimberly Waldron to "hide" the peanut butter in the medication cart so that Resident A could not continue to "contaminate" the peanut butter by sticking her hand in the jar.

On November 24, 2021, I spoke to direct care staff member and former home manager Kimberly Waldron who said she instructed staff members to lock some of the peanut butter in the medication cart so Resident A could not eat nor

“contaminate” all the peanut butter. Ms. Waldron denied that all the peanut butter was locked in the medication cart and said there was still peanut butter in the kitchen for Resident A and others to use.

On November 24, 2021, I spoke to direct care staff member Krista Newhouse who said she was directed by then home manager Kimberly Waldron to lock all but one jar of peanut butter in the medication cart so Resident A could not eat or “contaminate” all the peanut butter, as it was needed for other residents. Ms. Newhouse said one jar of peanut butter was always available for resident use. Ms. Newhouse said approximately two weeks prior to the interview staff members stopped locking peanut butter in the medication cart.

On January 13, 2022, I spoke to direct care staff member Sarah Schmittler who said she was directed by then home manager Kimberly Waldron to place all the peanut butter in the locked medication cart so that Resident A could not use nor “contaminate” all the peanut butter that was needed for each resident’s use. Ms. Schmittler said all the facility peanut butter was locked in the medication cart and if a resident wanted access to the peanut butter the/she had to ask a staff member to get it out of the medication cart.

On November 24, 2021, I spoke to direct care staff member Katlynn Wiggins who stated peanut butter was always available in the kitchen and she never saw any peanut butter locked in the medication cart.

On November 24, 2021, I spoke to direct care staff member Lisa Bowers who said she was never instructed to lock peanut butter in the medication cart and she never did that nor noticed that any other staff member put peanut butter in the locked medication cart.

On January 12, 2021, I interviewed facility administrator and licensee designee Jennia Woodcock who said she was not aware of any concerns regarding peanut butter being locked in the medication cart until she spoke to a representative from the community mental health office of recipient rights. Ms. Woodcock stated after she learned of the allegation she went to the kitchen and noted there were at least two jars of peanut butter in the kitchen cupboard. Ms. Woodcock stated she also looked inside the locked medication cart and found two partially used jars of peanut butter.

On January 12, 2022, I interviewed Resident A who denied that she was ever restricted from consuming peanut butter. On the same day I interviewed Residents B, C, and D who all said they regularly eat peanut butter and have never had restricted access to peanut butter.

On January 12, 2022, I completed an unannounced onsite inspection and saw multiple jars of peanut butter stored in multiple cupboards in the kitchen. At the onsite inspection I did not observe any peanut butter locked in the medication cart.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based on statements from Complainant, Ms. Waldron, Ms. Newhouse, Ms. Schmittler, Ms. Wiggins, Ms. Bowers, Ms. Woodcock, Resident A, Resident B, Resident C and Resident D as well as my observations at the unannounced onsite investigation I determined that while some peanut butter was locked in the medication cart at one time, there was at least one additional jar of peanut butter always left unlocked in the kitchen for resident use.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

A staff member “ripped” a peanut butter sandwich from Resident A’s hands and threw it in the trash.

INVESTIGATION:

On November 22, 2021, I received a complaint via centralized intake that stated Resident A reported that a staff member "ripped a sandwich from [Resident A’s] hands and threw it in the garbage."

On November 23, 2021, I spoke to Complainant who said staff member Sarah Schmittler said that staff member Katlynn Wiggins took a peanut butter sandwich from Resident A and threw it in the trash.

On November 24, 2021, I spoke to former direct care staff member Katlynn Wiggins who denied that she ever took nor “ripped” a peanut butter sandwich from Resident

A's hands and threw it in the trash. Ms. Wiggins stated she last worked at the facility on September 14, 2021.

On January 13, 2022, I spoke to direct care staff member Sarah Schmittler who said staff member Krista Newhouse told her that she saw staff member Katlynn Wiggins "rip" a peanut butter sandwich from Resident A and throw it in the trash. Ms. Schmittler denied that she ever saw Ms. Wiggins take a sandwich from Resident A and throw it in the trash.

On November 24, 2021, I spoke to direct care staff member Krista Newhouse who said she was working with direct care staff member Katlynn Wiggins when she saw Ms. Wiggins "rip" a peanut butter sandwich from Resident A's hands. Ms. Newhouse said this happened after Ms. Wiggins attempted to verbally redirect Resident A from making a snack using peanut butter. Ms. Newhouse stated Ms. Wiggins also "yelled at" Resident A for using peanut butter.

On January 12, 2022, I interviewed Resident A who said she was not familiar with direct care staff member Katlynn Wiggins but does not recall any staff member taking a peanut butter sandwich from her and throwing it in the trash. Resident A said every staff member allows her to have peanut butter any time she requests peanut butter.

On January 12, 2022, I interviewed Residents B, C, and D. None of the residents could recall staff member Katlynn Wiggins specifically, but none of them reported seeing a staff member take or "rip" a sandwich from Resident A's hands.

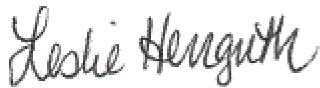
On November 24, 2021, I interviewed direct care staff members Lisa Bowers and Kimberly Waldron who stated they never saw nor heard anything about any staff member taking a sandwich away from a resident.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	Though Ms. Newhouse reported seeing direct care staff member Katlynn Wiggins “rip” a peanut butter sandwich away from Resident A, interviews with Resident A, Resident B, Resident C, Resident D, Ms. Schmittler, Ms. Bowers and Ms. Waldron did not corroborate Ms. Newhouse’s statement.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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



01/19/2022

Leslie Herrguth — Date
Licensing Consultant

Approved By:

01/20/2022

Dawn N. Timm — Date
Area Manager