STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

January 10, 2022

Sonia McKeown
JARC
Suite 100
6735 Telegraph Rd
Bloomfield Hills, MI 48301

RE: License #: AS630095511
Investigation #: 2022A0611008
Pitt

Dear Ms. McKeown:

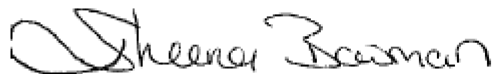
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630095511
Investigation #:	2022A0611008
Complaint Receipt Date:	12/17/2021
Investigation Initiation Date:	12/17/2021
Report Due Date:	02/15/2022
Licensee Name:	JARC
Licensee Address:	Suite 100 6735 Telegraph Rd Bloomfield Hills, MI 48301
Licensee Telephone #:	(248) 403-6013
Administrator:	Sonia McKeown
Licensee Designee:	Sonia McKeown
Name of Facility:	Pitt
Facility Address:	5920 Indianwood Tr Bloomfield Twp, MI 48301
Facility Telephone #:	(248) 865-7862
Original Issuance Date:	11/20/2001
License Status:	REGULAR
Effective Date:	11/15/2020
Expiration Date:	11/14/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 12/14/2021, staff left Resident J unattended at her dialysis appointment.	Yes

III. METHODOLOGY

12/17/2021	Special Investigation Intake 2022A0611008
12/17/2021	Special Investigation Initiated - Letter I emailed the recipient rights specialist, Kathleen Garcia regarding the specifics of the allegations.
12/29/2021	Inspection Completed On-site I completed an unannounced onsite. I interviewed Resident J, staff member Rochelle Grubbs, and the home manager, Kelly Johnson. I received a copy of Resident J's IPOS summary.
12/29/2021	Contact - Telephone call made I made a telephone call to the reporting source. The allegations were discussed.
01/05/2022	Contact - Telephone call made I made a telephone call to staff member, Dorothy Harris. The allegations were discussed.
01/05/2022	Contact-Document Sent I emailed the recipient rights specialist, Kathleen Garcia regarding the outcome of her investigation.
01/05/2022	Exit Conference I completed an exit conference with the licensee designee, Sonia Mckeown via telephone.

ALLEGATION:

On 12/14/2021, staff left Resident J unattended at her dialysis appointment.

INVESTIGATION:

On 12/17/21, I received an intake regarding the abovementioned allegations. On 12/17/21, I received an email response from the recipient rights specialist, Kathleen Garcia. Ms. Garcia stated she has not investigated any further than what was in the online complaint as of yet.

On 12/29/21, I made a telephone call to the reporting source. Regarding the allegations, the reporting source stated Resident J was left at the doctor's appointment by herself. The reporting source stated normally the staff would stay with Resident J during her doctor's appointment. Per Resident J's MORC support coordinator, Lydia Lamba, the staff are supposed to stay with Resident J at her doctor's appointments. The reporting source stated staff are allowed to sit in the lobby area at the doctor's office. The reporting source does not know if the staff at the doctor's office knew who dropped Resident J off at her appointment.

The reporting source provided the doctor's office with the number to the AFC group home. The reporting source attempted to contact the AFC group home however, the number was disconnected. The reporting source also attempted to contact two staff members however, they did not answer their phone. The reporting source spoke to a different staff member but that staff member was off work. The reporting source stated she tried to contact the doctor's appointment around 5:45 pm to follow up with Resident J's transportation however, the office was closed.

On 12/29/21, I completed an unannounced onsite. I interviewed Resident J, staff member Rochelle Grubbs, and the home manager, Kelly Johnson. I received a copy of Resident J's IPOS summary.

On 12/29/21, I interviewed Resident J. Regarding the allegations, Resident J stated she goes to her dialysis appointment three times a week. Resident J stated she has bad kidneys. Resident J stated there was two instances where staff left her at her doctor's appointment. Both incidents occurred in December 2021. Resident J was left at her doctor's appointment the first time because the staff had to pick up Resident J's roommate from the hospital. The staff returned to pick up Resident J at 7:00pm. Resident J stated her appointments start at 2:00 pm but the duration of the appointments vary as it depends on how long it takes for the dialysis machine to finish. Resident J stated she had to wait in the lobby for an hour after she was finished with her dialysis for staff to pick her up.

Resident J stated staff left her at her doctor's appointment the second time to get food. The staff returned after 5:00 pm. Resident J thinks she had to wait for two hours before staff returned. Resident J stated now staff wait in the van during her doctor's appointments. Resident J stated she feels safe at the AFC group home and the staff are nice to her.

On 12/29/21, I interviewed staff member Rochelle Grubbs. Regarding the allegations, Ms. Grubbs stated Resident J goes to her dialysis appointments three times a week. Resident J's appointments are scheduled from 2:00pm-6:00 pm however, the duration depends on how fast the machine runs. Ms. Grubbs stated different staff members transport Resident J to her dialysis appointments. The staff will wait for Resident J in the lobby area or they will sit in the van. Ms. Grubbs denied dropping Resident J's off to her appointments and leaving her. Ms. Grubbs stated she does not know if any staff members have left Resident J at her doctors' appointments. Ms. Grubbs stated she heard that the new home manager, Kelly Johnson may have left Resident J at her doctor's appointment but she does not know any details. Ms. Grubbs stated the protocol per the previous home manager, Sonia Wilson, staff had to wait for Resident J in the lobby or in the van. Ms. Grubbs stated this expectation has not changed since Ms. Johnson has become the new home manager.

On 12/29/21, I interviewed the home manager, Kelly Johnson. Regarding the allegations, Ms. Johnson stated she has transported Resident J to her dialysis appointment once or twice. Ms. Johnson stated the protocol is for staff to wait for Resident J in the lobby area. Two weeks ago, she transported Resident J to her doctor's appointment. Ms. Johnson admitted to leaving Resident J at her appointment to go to Dollar General which was down the street. Ms. Johnson stated she had the other five residents and staff member, Dorothy Harris in the van. Ms. Johnson stated they went to Dollar General because one resident had to use the bathroom and another resident wanted to buy something. They were gone for 15 minutes. Ms. Johnson stated they returned around 5:20 pm and Resident J was ready to go when they returned. Ms. Johnson stated prior to going to Dollar General, they waited in the parking lot for a couple of hours.

Ms. Johnson stated when they returned to the doctor's office, she was informed that the staff at the doctor's office was trying to call her. Ms. Johnson stated she did not receive any phone calls from them as they were calling the wrong number. Ms. Johnson provided the doctor's office on several different occasions with her personal cell number and the new AFC group home number. However, the doctor's office did not update their records pertaining to Resident J's contact information. Ms. Johnson received confirmation yesterday that the doctor's office updated Resident J's contact information.

On 12/29/21, I received a copy of Resident J's IPOS summary. According to the IPOS summary, caregivers need to be within eye contact of Resident J in the community. Staff should be monitoring her as she is a fall risk and uses a walker.

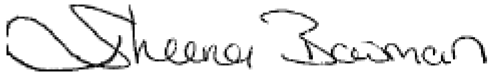
On 01/05/22, I made a telephone call to staff member, Dorothy Harris. Regarding the allegations, Ms. Harris stated that was the first time she assisted with taking Resident J to her dialysis appointment. Ms. Harris stated she accompanied Ms. Johnson because Ms. Johnson had not completed her trainings at the time. Ms. Harris stated they waited in the parking lot for about an hour and a half before Resident M had to use the bathroom. Ms. Harris asked the receptionist if Resident M could use the bathroom and she was told no. The receptionist stated Resident J will be done with her treatment in about an hour. Ms. Harris stated they went to Dollar Tree which was about 25 minutes away. They were gone for about an hour. Ms. Harris stated Resident J waited for them to return for about 10 minutes. Ms. Harris is now aware that Resident J cannot be left alone at her doctor's appointment.

On 01/05/22, I completed an exit conference with the licensee designee, Sonia Mckeown via telephone. Ms. McKeown was informed that the allegations will be substantiated and a corrective action plan will be required.

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:	Based on my investigation and findings, Ms. Johnson and Ms. Harris admitted to leaving Resident J at her doctor's appointment on or about 12/14/21. Resident J was left at her doctor's appointment for about an hour. Resident J had completed her dialysis treatment and was waiting for staff to return. According to Resident J's IPOS summary, caregivers need to be within eye contact of Resident J in the community. Staff should be monitoring her as she is a fall risk and uses a walker.
CONCLUSION:	**VIOLATION ESTABLISHED**

RECOMMENDATION

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



01/05/22

Sheena Bowman
Licensing Consultant

Date

Approved By:

01/10/2022

Denise Y. Nunn
Area Manager

Date