GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 26, 2022

Michael Craft
Craft Care Homes Inc.
1800 N. Cedar
Holt, MI 48842

RE: License #: AL330093679
Investigation #: 2022A0466014
Crafts Care Homes

Dear Mr. Craft:

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) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL330093679 |
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| **Investigation #:** | 2022A0466014 |
| | |
| **Complaint Receipt Date:** | 12/07/2021 |
| | |
| **Investigation Initiation Date:** | 12/07/2021 |
| | |
| **Report Due Date:** | 02/05/2022 |
| | |
| **Licensee Name:** | Craft Care Homes Inc. |
| | |
| **Licensee Address:** | 1800 N. Cedar<br>Holt, MI 48842 |
| | |
| **Licensee Telephone #:** | (517) 204-0750 |
| | |
| **Administrator:** | Susan Craft |
| | |
| **Licensee Designee:** | Michael Craft |
| | |
| **Name of Facility:** | Crafts Care Homes |
| | |
| **Facility Address:** | 1800 N. Cedar Street<br>Holt, MI 48842 |
| | |
| **Facility Telephone #:** | (517) 694-3873 |
| | |
| **Original Issuance Date:** | 09/21/2000 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 09/26/2021 |
| | |
| **Expiration Date:** | 09/25/2023 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATIONS:

| | **Violation Established**? |
|---|---|
| Resident A was administered medications on 12/05/2021, from a direct care workers (DCW)s bare hand, as the medications were not in a cup. | Yes |
| The facility is not well-kept. | No |

## III. METHODOLOGY

| | |
|---|---|
| 12/07/2021 | Special Investigation Intake-2022A0466014. |
| 12/07/2021 | Special Investigation Initiated – Letter assigned licensing consultant Nile Khabeiry. |
| 12/07/2021 | Contact - Telephone call made to Complainant, voicemail was full and the number would not accept a text message. |
| 12/13/2021 | Inspection Completed On-site. |
| 01/25/2022 | Exit Conference with licensee designee Michael Craft, he was not available so the exit was conducted with admin Susan Craft. |

**ALLEGATION: Resident A was administered medications on 12/05/2021, from a direct care workers (DCW)s bare hand, as the medications were not in a cup.**

**INVESTIGATION:**
On 12/07/2022, Complainant reported visiting Resident A on 12/5/2021. Complainant reported a direct care worker (DCW) brought in a glass of water and Resident A's medication was in her hand. Complainant reported the DCW on shift did not have Resident A's medication in a cup when she gave it to her. Complainant voiced concerned about how unsanitary it was especially now with COVID and other diseases/viruses. Complainant reported Resident A does have dementia.

On 12/07/2021, I called Complainant but Complainant did not answer the phone. I was unable to leave a message as the voicemail box was full. I texted Complainant but the phone number would not accept a text message.

On 12/13/2021, AFC licensing consultant Rodney Gill and I conducted an unannounced investigation. Mr. Gill and I interviewed Resident A who reported she did not remember a time when a DCW administered her medication with their bare

hands. Resident A could not report if she was administered medications today rather, she stated she could not remember.

On 12/13/2021, Mr. Gill and I interviewed Resident B who was sitting in Resident A's room with her. Resident B reported that he and Resident A are friends and that they watch television and visit with each other during the day. Resident B reported he is typically with Resident A when medications are administered. Resident B reported all medications are administered from a cup. Resident B reported all of the resident medication is stored in a disposable container that requires the DCW to pull the top off the medication. Resident B reported that once the top is off the medication it acts like a cup for the residents to be able to put the medications either in their mouth or in their own hand. Resident B reported he has never witnessed any DCW administering medication to Resident A or himself with the medication in their bare hand.

On 12/13/2021, I reviewed the *Staff Schedule* which documented that DCW Brandy Emard worked on 12/05/2021 from 8am -8pm.

On 12/13/2021, Mr. Gill and I interviewed DCW Sara Belknap who reported all resident medications are in bubble packs and separated by morning, noon, and evening medications. DCW Belknap reported DCWs are trained not to touch medications with their bare hands. DCW Belknap reported all resident medications are in bubble packs and once the top is taken off the medications are in a cup like disposable container, so the medications do not have to be touched by the DCW who is administering them.

On 12/13/2021. Mr. Gill and I observed Resident A's medications which were all in individually labeled bubble packs.

On 01/24/2022, I interviewed DCW Brandy Emard who reported that she did touch Resident A's medications when administering them on 12/05/2021. DCW Emard reported that she had washed her hands and then poked the medications out. DCW Emard reported she then transferred them to her bare hand. DCW Emard reported she does not know why she did that as she typically does not touch residents' medications with her bare hand. DCW Emard reported she has been trained not to touch residents' medication. DCW Emard reported Relative A1 and Resident B were in the room when she administered the medications to Resident A from her bare hand. DCW Emard reported that she was not sick at the time nor has Resident A been sick since 12/05/2021.

| APPLICABLE RULE | |
|---|---|
| **R 400.15312** | **Direct care staff; qualifications and training.** |
| | **(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:**<br>**(a) Be trained in the proper handling and administration of medication.** |
| **ANALYSIS:** | Complainant and DCW Emard reported that DCW Emard touched Resident A's medications with her bare hands on 12/05/2021 when she administered her medication. DCW Emard reported that touching medications with bare hands is not proper handling procedure. By touching a resident's medication with bare skin this can contaminate the medication so it is not a proper method of handling and/or administering medication. DCW Emard reported she was trained not to touch resident medications with her hands therefore a violation has been established. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION: The facility is not well-kept.**

**INVESTIGATION:**
On 12/07/2022, Complainant reported the facility was not well-kept for the amount of money the residents pay to live there.

On 12/07/2021, I called Complainant but Complainant did not answer the phone. I was unable to leave a message as the voicemail was full. I texted Complainant and the phone number would not accept a text message.

On 12/13/2021, Mr. Gill and I conducted an unannounced investigation and observed the facility to be clean, orderly and odor free. Mr. Gill and I observed the common areas of the facility and Resident A's resident room.

| APPLICABLE RULE | |
|---|---|
| **R 400.15403** | **Maintenance of premises.** |
| | **(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.** |

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|---|---|
| **ANALYSIS:** | During an unannounced onsite investigation, Mr. Gill and I observed the facility to be clean, orderly and odor free therefore there was no evidence to establish a violation. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

## IV. RECOMMENDATION

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

01/25/2022

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Julie Elkins Date
Licensing Consultant

Approved By:

01/26/2022

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Dawn N. Timm Date
Area Manager