GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 9, 2022

Tamikya Lewis
G.R.A.C.E. Family Services
1904 Miller Rd.
Flint, MI 48503

RE: License #: AS250349772
Investigation #: 2022A0871027
Beautiful Blades II

Dear Mrs. Lewis:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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 (989) 732-8062.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250349772
Investigation #:	2022A0871027
Complaint Receipt Date:	03/18/2022
Investigation Initiation Date:	03/23/2022
Report Due Date:	05/17/2022
Licensee Name:	G.R.A.C.E. Family Services
Licensee Address:	1904 Miller Rd. Flint, MI 48503
Licensee Telephone #:	(810) 237-4105
Administrator:	Todd Lewis
Licensee Designee:	Tamikya Lewis
Name of Facility:	Beautiful Blades II
Facility Address:	210 Seventh Flint, MI 48503
Facility Telephone #:	(810) 237-4105
Original Issuance Date:	01/15/2014
License **Status:**	REGULAR
Effective Date:	07/04/2020
Expiration Date:	07/03/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

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II. ALLEGATION(S)

	Violation Established?
Resident A was found on the street on the night of 03/17/2022 around 9 pm. EMS picked him up and took him to Hurley Hospital to be assessed. Resident A was baseline delusional at that time. At the time of discharge about one hour later, the hospital telephoned the facility several times with no answer. A deputy was sent to the facility, knocked several times, and no one answered the door. No one picked up Resident A when he was discharged about an hour later and had to stay at the hospital util approximately noon on 03/18/2022. EMS returned Resident A to the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/18/2022	Special Investigation Intake 2022A0871027
03/23/2022	Special Investigation Initiated - On Site Interviewed Staff Todd Lewis and Resident A.
04/19/2022	Inspection Completed On-site Interviewed Staff Todd Lewis and Resident A.
04/27/2022	Inspection Completed On-site Observed Resident A.
04/29/2022	APS Referral Through Central Intake to Genesee County MDHHS.
04/29/2022	Inspection Completed-BCAL Sub. Compliance
04/29/2022	Contact - Telephone call made Telephone all to Licensee Tamikya Lewis
04/29/2022	Contact – Telephone call made Telephone exit conference with Licensee Tamikya Lewis
05/02/2022	Inspection Completed On-Site Interviewed Staff Todd Lewis

05/03/2022	Exit Conference- Telephone Exit Conference with Licensee Tamikya Lewis

ALLEGATION:

Resident A was found on the street on the night of 03/17/2022 around 9 pm. EMS picked him up and took him to Hurley Hospital to be assessed. Resident A was baseline delusional at that time. At the time of discharge about one hour later, the hospital telephoned the facility several times with no answer. A deputy was sent to the facility, knocked several times, and no one answered the door. No one picked up Resident A when he was discharged about an hour later and had to stay at the hospital util approximately noon on 03/18/2022. EMS returned Resident A to the facility.

INVESTIGATION:

On March 23, 2022, I conducted an unannounced onsite investigation and interviewed Staff Todd Lewis. Mr. Lewis said the hospital called Licensee Tamikya Lewis the night of March 17, 2022, and she did go to the hospital. Mr. Lewis indicated she went to the hospital about 1:00 am and Resident A was in a room. Mr. Lewis said the hospital called the following morning and indicated Resident A was being discharged. Mr. Lewis said the hospital ran tests on Resident A and an ambulance brought him back to the facility in the morning. Mr. Lewis reported that only female staff were working that night and that the only other female staff works from 2pm until 8 pm. This staff member would not have been working at the time of this incident and there were no other staff member to interview.

On March 23, 2022, I interviewed Resident A at the onsite investigation. Resident A stated he was taken to the hospital in the evening, and it was not dark outside. Resident A said the hospital did not keep him, just overnight. Resident A said the hospital gave him a ride home and it was daylight.

On March 23, 2022, and on April 19, 2022, Mr. Lewis could not provide me with a copy of Resident A's *Assessment Plan for AFC Residents.*

A staff schedule could not be provided for the evening of March 17, 2022.

On May 5, 2022, I emailed Case Manager 1 and she indicated Resident A "relies heavily for assistance from the home." Case Manager 1 stated the home provides transportation for him to all of his GHS appointments. Case Manager 1 reported Resident A "does go for walks independently for walks in the neighborhood." Case Manager 1 stated Resident A "could have returned to the facility in a taxi by himself, however, the concern of the hospital was that the AFC Home was not responding to attempted contacts to know if they could bring him back to the facility."

On April 29, 2022, I telephoned Complainant 1. Complainant 1 indicates she received a phone call from the hospital on March 18, 2022. Complainant 1 was told that Resident A called for an ambulance on March 17, 2022, and was taken to the hospital. An assessment was completed on Resident A at the hospital, and it was determined that he did not need any further care. Complainant 1 stated the hospital telephoned the facility several times and no one answered. A deputy that is stationed at the hospital went to the home, knocked on the door, and no one ever answered. Complainant 1 said Resident A arrived at the hospital about 9 pm and was assessed by 10 pm and was found to be psychiatric at baseline. That is when the hospital started contacting the home because Resident A was being discharged.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Complainant 1 said the hospital telephoned the facility several times to pick up Resident A. A deputy was sent to the facility and no one answered the door. Resident A was discharged approximately one hour after arriving on March 17, 2022 @ 9pm. Resident A was returned to the facility by an ambulance at approximately noon on March 18, 2022. No one was available to pick up Resident A from the hospital and the hospital could not contact anyone at the facility. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On March 23, 2022, I asked Staff Todd Lewis for Resident A's *Assessment Plan for AFC Residents.* Mr. Lewis did not provide a copy for me. On April 19, 2022, I conducted another onsite investigation and again asked Mr. Lewis for a copy of Resident A's *Assessment Plan for AFC Residents.* Mr. Lewis said Resident A's case manager is off work on sick leave and it has not been completed.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	On March 23 and April 19, 2022, at onsite investigations, Staff Todd Lewis could not provide me with a copy of Resident A's *Assessment Plan for AFC Residents.* I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On March 23, 2022, I observed approximately ten residents in the facility. I did not inquire about why there were so many residents in the facility at that time.

On April 19, 2022, I conducted an onsite investigation and observed a resident sitting on the porch. I asked the resident if she lived there, and she replied 'no.' The resident told me she lives at the other home but comes to this facility every day and that she likes it.

On April 19, 2022, I interviewed Resident A. Resident A said there are five residents living in this facility and that "other residents come every day." Resident A reported that they are all girls. I then counted the residents that were there, and it was 11.

This adult foster care (afc) home is licensed for a maximum capacity of 6 residents.

APPLICABLE RULE	
R 400.14105	**Licensed capacity.**
	(1) The number of residents cared for in a home and the number of resident beds shall not be more than the capacity that is authorized by the license.

ANALYSIS:	On April 19, 2022, Resident A said the residents from the other facility come there every day and they are all girls. The resident sitting on the porch reported she lives at the other home and comes to this facility every day. I counted 11 residents in the facility. This adult foster care home is licensed to provide adult foster care to a maximum of 6 residents. This afc home is licensed to provide adult foster care to a maximum of 6 residents. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On March 23, 2022, at the onsite investigation, Resident A told me that the sink upstairs was clogged. I went upstairs and observed water sitting in the sink. Staff Todd Lewis said that there was something clogging the drain. At the onsite investigation on April 19, 2022, I again observed water sitting in the sink in the upstairs bathroom.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(6) All plumbing fixtures and water and waste pipes shall be properly installed and maintained in good working condition. Each water heater shall be equipped with a thermostatic temperature control and a pressure relief valve, both of which shall be in good working condition.
ANALYSIS:	On March 23, 2022, Resident A told me the bathroom sink upstairs was clogged, and I observed it to be clogged. On April 19, 2022, I again observed the sink upstairs to have water sitting in it. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On April 19, 2022, I observed two trash barrels located on the side of the house with trash in them. I observed a trash can that had trash in it on its side. There were bags of trash laying on the grass.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(13) A yard area shall be kept reasonably free from all hazards, nuisances, refuse, and litter.
ANALYSIS:	There were two trash barrels on the side of the house with trash in them. A trash barrel was on its side with trash coming out of it. There is a broke children's slide set in the backyard. I confirm violation of this rule
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On March 23 and April 19, 2022, there was an odor in the upstairs that smelled of urine. The handrail on the stairway was sticky.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	There was an odor noted in the upstairs that smelled of urine. The handrail to the upstairs was sticky. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On March 23 and April 19, 2022, I observed the screen door to the front door was dented and screen was ripped.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(4) A roof, exterior walls, doors, skylights, and windows shall be weathertight and watertight and shall be kept in sound condition and good repair.

ANALYSIS:	On March 23 and April 19, 2022, I observed the screen door that had been dented and the screen torn out of part of it. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On March 23, 2022, and April 19, 2022, I observed the stairway handrail to be broken off. The broken handrail is locked on the landing where the stairs turn to go further up the steps.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(8) Stairways shall have sturdy and securely fastened handrails. The handrails shall be not less than 30, nor more than 34, inches above the upper surface of the tread. All exterior and interior stairways and ramps shall have handrails on the open sides. All porches and decks that are 8 inches or more above grade shall also have handrails on the open sides.
ANALYSIS:	On March 23, and April 19, 2022, I observed a broken handrail that is located by the landing where the stairs turn. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On May 2, 2022, I reviewed the file for Beautiful Blades I and there was not an *AFC Licensing Division – Incident/Accident Report* forwarded to the department regarding Resident A going to the hospital on March 17, 2022.

R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following:

	(a) The death of a resident. (b) Any accident or illness that requires hospitalization. (c) Incidents that involve any of the following: (i) Displays of serious hostility. (ii) Hospitalization. (iii) Attempts at self-inflicted harm or harm to others. (iv) Instances of destruction to property. (d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.
ANALYSIS:	I reviewed the Beautiful Blades II file and an *AFC Licensing Division – Incident/Accident Report* was not provided to the foster care licensing division for the hospitalization of Resident A. I confirm violation of this rule.
CONCLUSION	**VIOLATION ESTALBISHED**

INVESTIGATION:

On May 2, 2022, I conducted an unannounced onsite investigation and again interviewed Staff Todd Lewis. I asked Mr. Lewis for a copy of the staff schedule and he could not provide one. Mr. Lewis stated a female staff works Monday through Friday, 2pm through 8 pm. He stated that he is the staff for rest of the time.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: (a) Names of all staff on duty and those volunteers who are under the direction of the licensee. (b) Job titles. (c) Hours or shifts worked. (d) Date of schedule. (e) Any scheduling changes.
ANALYSIS:	On May 2, 2022, Staff Todd Lewis could not provide me with a copy of a staff schedule. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On May 3, 2022, I conducted a telephone exit conference with Licensee Tamikya Lewis. I advised Licensee Lewis if she could not obtain staff for Beautiful Blades I, she must give the residents a 30-day discharge notice as they cannot go to Beautiful Blades II every day. Ms. Lewis agreed to a provisional license and I also advised her that she needs to put it in writing.

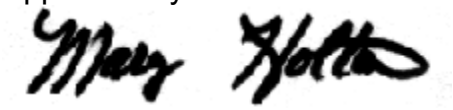
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend issuance of a six-month provisional license with enhanced supervision (capacity 1-6).

05/09/2022

Kathryn A. Huber Date
Licensing Consultant

Approved By:



05/09/2022

Mary E Holton Date
Area Manager