GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 6, 2022

Virtrina Johnson
2 Five Oaks Drive
Saginaw, MI 48638

RE: License #: AS730383141
Investigation #: 2022A0576029
Kneaded Angels Adult Living Home II

Dear Ms. Johnson:

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.

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,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730383141
Investigation #:	2022A0576029
Complaint Receipt Date:	03/21/2022
Investigation Initiation Date:	03/25/2022
Report Due Date:	05/20/2022
Licensee Name:	Virtrina Johnson
Licensee Address:	2 Five Oaks Drive, Saginaw, MI 48638
Licensee Telephone #:	(989) 793-2935
Administrator:	Virtrina Johnson
Licensee Designee:	Virtrina Johnson
Name of Facility:	Kneaded Angels Adult Living Home II
Facility Address:	2 Five Oaks Drive, Saginaw, MI 48638
Facility Telephone #:	(989) 245-2089
Original Issuance Date:	07/13/2016
License Status:	REGULAR
Effective Date:	01/13/2021
Expiration Date:	01/12/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
On 3/20/2022, Resident A was found in neighbors' kitchen uninvited. Resident A found the door to be unlocked and let himself in. Staff were not aware he had left the property. This is not the first occurrence. This has been an ongoing issue for years and the residents wander unsupervised. There is concern for resident's safety.	Yes

III. METHODOLOGY

03/21/2022	Special Investigation Intake 2022A0576029
03/25/2022	Special Investigation Initiated - Telephone Interviewed Complainant
04/07/2022	Inspection Completed On-site Interviewed Staff, Ashley Allen, and Corey Fort
04/07/2022	Contact - Face to Face Resident A
04/07/2022	Contact - Document Received Reviewed Resident A's Individual Plan of Services (IPOS)
05/02/2022	Contact - Telephone call made Left message for Witness 1 to return call
05/03/2022	Contact - Telephone call received Interviewed Witness 1
05/06/2022	APS Referral Referral made to APS regarding this allegation.
05/06/2022	Exit Conference Exit Conference conducted with Licensee Designee, Virtrina Johnson

ALLEGATION:

On 3/20/2022, Resident A was found in neighbors' kitchen uninvited. Resident A found the door to be unlocked and let himself in. Staff were not aware he had left the property. This is not the first occurrence. This has been an ongoing issue for years and the residents wander unsupervised. There is concern for resident's safety.

INVESTIGATION:

On March 25, 2022, I spoke to the Complainant who reported they believe Resident A is being neglected. Complainant reported Resident A seems to be mentally challenged. He is in his early 20's, white male, tall, and no verbal skills. Complainant has seen Resident A swinging in the rain with no shoes or socks on. Resident A was found in the Complainant's home on more than one occasion. Complainant reported on March 20, 2022, Resident A was standing in her kitchen. Complainant opened the door and told him to go. Complainant watched Resident A go to his backyard and began swinging. Complainant did not see any staff and they do not think staff were aware he had left his home. Complainant stated 2 other witnesses have viewed Resident A not being supervised by staff and him making it to Complainant's home. Complainant advised there was an occasion where Resident A tried to enter her home however the door was locked. Another time Resident A made it inside her home and was going from room to room. Complainant advised they worry that someone will hurt Resident A if he walks into someone else's home.

On April 7, 2022, I completed an unannounced on-site inspection at Kneaded Angels Adult Living Home II and interviewed Staff, Ashley Allen, and Corey Fort. Ms. Allen reported she has worked at the home for 5 years and Resident A has lived at the home since 2018. Ms. Allen reported Resident A will try to wander off and leave out of the fence. Ms. Allen has heard of an occasion where Resident A tried to leave out of the front yard however staff brought him back. Ms. Allen denied any knowledge of Resident A getting inside of a neighbor's home. Ms. Allen denied being aware of a neighbor brining Resident A back to his home. Ms. Allen reported Resident A cannot be outside by himself. Resident A is nonverbal, autistic, fast, and smart. Resident A has a 1 on 1 staff.

On April 7, 2022, Resident A was viewed at his home. Resident A appeared happy as she was smiling and gave me a high five. Resident A appeared clean and was dressed in clean clothing.

On April 7, 2022, I interviewed Staff, Corey Fort. Mr. Fort denied any knowledge of the allegation. Mr. Fort denied knowledge of anyone bringing Resident A home. Mr. Fort reported Resident A cannot go into the community by himself. Resident A has a 1 on 1 staff person all day including while he sleeps.

On April 7, 2022, I viewed Resident A's Individual Plan of Service (IPOS). Resident A is a 29-year-old male and "essentially nonverbal". Resident A "does not go out into the

community alone" as he cannot relay personal information and does not understand traffic safety. According to the IPOS, Staff "need to be aware of him throughout the enhanced shift (in the home, in the community, in the yard). If he leaves the yard or starts to wander away in the community redirect back to the yard…"

On May 2, 2022, I left a message for Witness 1 to return call. On May 3, 2022, I interviewed Witness 1 who reported Resident A has entered a home in the neighborhood where the facility is located. Witness 1 reported this has occurred twice. One year ago, Resident A walked into a neighboring home and when Witness 1 realized he was there, Witness 1 walked him back to the AFC home. Witness 1 followed Resident A back to the AFC home and talked to staff about what occurred. The staff person apologized to Witness 1. Witness 1 corroborated the current allegations and reported they were told by the Complainant that Resident A had entered the home. According to Witness 1, the Complainant was visibly upset by what occurred and a discussion was had about making a complaint.

On May 6, 2022, I interviewed Licensee Designee, Virtrina Johnson regarding the allegations. Ms. Johnson advised she does not believe the allegations to be true. Ms. Johnson reported staff are aware they are to monitor Resident A while in the community.

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:	It was alleged that Resident A entered a neighboring home and there is concern for the safety of Resident A. Upon completion of investigative interviews, there is a preponderance of evidence to conclude a rule violation.

	Resident A is nonverbal and, per his IPOS, requires supervision while in the community for his safety. Complainant and Witness 1 reported Resident A entered a neighboring home without staff knowledge on 2 occasions. Complainant was concerned for Resident A and advised someone may try to harm Resident A if he enters the wrong home unaware that he presents no threat. There is a preponderance of evidence to conclude Resident A's protection and safety were not adhered to at all times given the statements by 2 different community members that Resident A accessed a neighboring home without staff being aware.
CONCLUSION:	**VIOLATION ESTABLISHED**

On May 6, 2022, I conducted an Exit Conference with Licensee Designee, Virtrina Johnson. Ms. Johnson was advised I would be requesting a corrective action plan with regards to the cited rule violation.

IV. RECOMMENDATION

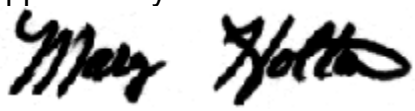
Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the license status.

5/6/2022

_____

Christina Garza Date
Licensing Consultant

Approved By:



5/6/2022

_____

Mary E. Holton Date
Area Manager