GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 27, 2022

Michael Fields
Advanced Teaching Concepts Inc
P.O. Box 158
South Lyon, MI 48178

RE: License #: AS630015591
Investigation #: 2022A0465024
South Lyon CLF Home

Dear Mr. Fields:

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,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
3026 W. Grand Blvd.
Detroit, MI 48202
Cell: 248-514-9391
Fax: 517-763-0204

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630015591
Investigation #:	2022A0465024
Complaint Receipt Date:	03/29/2022
Investigation Initiation Date:	03/29/2022
Report Due Date:	05/28/2022
Licensee Name:	Advanced Teaching Concepts Inc
Licensee Address:	60674 Russell Lane South Lyon, MI 48178
Licensee Telephone #:	(248) 486-5368
Administrator:	Michael Fields
Licensee Designee:	Michael Fields
Name of Facility:	South Lyon CLF Home
Facility Address:	60674 Russell Lane South Lyon, MI 48178-0158
Facility Telephone #:	(248) 486-0765
Original Issuance Date:	12/14/1993
License Status:	REGULAR
Effective Date:	04/28/2021
Expiration Date:	04/27/2023
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 3/29/2022, Resident A ate a dishwasher pod due to direct care staff failing to safeguard this caustic item.	Yes

III. METHODOLOGY

03/29/2022	Special Investigation Intake 2022A0465024
03/29/2022	Special Investigation Initiated - Letter Spoke to Complainant
04/26/2022	Inspection Completed On-site Reviewed Resident A's record, conducted a walkthrough of the facility and interviewed direct care staff, Melissa McNamara, and Hailee Chambers
04/29/2022	Contact - Telephone call made I left a voice mail for Guardian A1
05/20/2022	Contact - Telephone call made I left a voice mail for Guardian A1, requesting a return call
05/25/2022	Contact - Telephone call made Interviewed Guardian B1 and C1 via telephone
05/26/2022	Exit Conference Conducted an exit conference with licensee designee, Michael Fields, via telephone
05/26/2022	APS Referral I made an Adult Protective Services (APS) referral

ALLEGATION:

On 3/29/2022, Resident A ate a dishwasher pod due to direct care staff failing to safeguard caustic items.

INVESTIGATION:

On 3/29/2022, an *Incident/Accident Report* was received from the facility. The incident report stated that Resident A ate a dishwasher pod. The incident report indicated the following:

3/29/2022 at 8:00am; completed by Melissa McNamara and Hailee Chambers: Resident A came into the kitchen foaming at the mouth and gaging. A few minutes later we found a dish pod that had been bitten into. We sat Resident A down and gave him a bowl to throw up in and called Poison Control. Poison Control said if he vomits more than five times, to take him to the ER to make sure he doesn't get dehydrated, but he should be fine. We are uncertain how Resident A obtained this dishwasher pod, but we will be reviewing with all staff to closely monitor the dishwasher and make sure that Resident A is not left unsupervised while in the kitchen. Once a pod is placed in the dishwasher, the cycle is immediately started and monitored to ensure that no one opens and removes the pod from the dishwasher. This will be reviewed at our staff meeting scheduled for 3/30/2022. At this time, Resident A is not having any symptoms of illness or discomfort. His physician will be visiting the home today for a thorough checkup. Will continue to monitor.

On 4/26/2022, I conducted an onsite investigation at the facility. I reviewed Resident A's record, conducted a walkthrough of the facility, and interviewed direct care staff, Melissa McNamara, and Hailee Chambers.

Resident A's *Face Sheet* stated that he was admitted to the facility on 7/17/2017 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed his medical as diagnosis as Alzheimer's. The *Assessment Plan for AFC Residents* stated that Resident A requires supervision in the community, has verbal communication limitations, needs assistance with all personal care tasks and requires use of a walker and wheelchair for mobility assistance. Based on Resident A's medical diagnosis, he was unable to be interviewed for this investigation.

I conducted a walk-through of the facility, and I observed all caustic materials, including the dishwasher pods, secured and not accessible to residents.

During the onsite investigation, I interviewed direct care staff, Melissa McNamara. Ms. McNamara stated that she has worked at the facility for 10 years. Ms. McNamara stated, "I was working the day of the incident. When Resident A walked in the kitchen, I saw foam coming from his mouth and then he vomited a little bit. Then he spit out the pod. I didn't realize what it was until I went into the living room and found the remainder of the pod on the floor. I immediately called 911 and we monitored him through the day. I have no idea how Resident A got a hold of the dishwasher pod. What I think happened is that a staff left a dishwasher pod on the counter and maybe Resident A saw it and grabbed it. Or that maybe a staff put the pod in the dishwasher and forgot to start it, and Resident A opened the dishwasher and grabbed it because he thought it was candy.

Somehow, someone left the pod out for Resident A to grab because all of our cleaning supplies are locked and only staff have the key to access the cleaning supplies." Ms. McNamara acknowledged that this allegation is true.

I interviewed direct care staff, Hailee Chambers, during the onsite investigation. Ms. Chambers stated that she has worked at the facility for six months. Ms. Chambers stated that she was working the day of the incident. Ms. Chambers stated, "I was in the kitchen, getting everyone ready for breakfast. I went to get Resident A, and he was already walking towards the kitchen. His mouth was foaming, and I cleaned him up. We found a dishwasher pod in the living room. We don't know how he got it. It's possible it was accidently left on the counter by staff, and he grabbed it. All of our cleaning supplies, including dishwasher pods are always locked up so a staff must have left one out." Ms. Chambers acknowledged that this allegation is true.

On 4/29/2022 and 5/20/2022, I left voice messages for Guardian A1, requesting a return call. I have not received a return call as of the date of this report.

On 5/26/2022, I conducted an exit conference with licensee designee and administrator, Michael Fields, via telephone. Mr. Fields acknowledged that, on 3/29/2022, a direct care staff must have left the dishwasher pod unsecured in order for Resident A to have obtained access to it. Mr. Fields is in agreement with the findings of this report.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.
ANALYSIS:	According to the *Incident/Accident Report* and Ms. McNamara and Ms. Chambers and Mr. Fields, on 3/29/2022, a dishwasher pod was left unsecured and accessible to Resident A, which resulted in Resident A eating the pod. Based on the information above, on 3/29/2022, the facility did not ensure that all caustic materials were safeguarded and not accessible to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

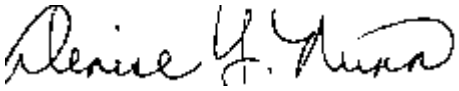
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

5/26/2022

Stephanie Gonzalez Date
Licensing Consultant

Approved By:



05/27/2022

Denise Y. Nunn Date
Area Manager