GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 28, 2022

Karrie Beilfuss
LifeSpan...A Community Service
PO Box 1978
524 North Jackson Street
Jackson, MI 49201-1978

RE: License #: AS380379307
Investigation #: 2022A0007018
Seymour Road Home

Dear Ms. Beilfuss:

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 (313) 456-0380.

Sincerely,

Mahtina Rubritius

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380379307
Investigation #:	2022A0007018
Complaint Receipt Date:	04/05/2022
Investigation Initiation Date:	04/06/2022
Report Due Date:	06/04/2022
Licensee Name:	LifeSpan...A Community Service
Licensee Address:	PO Box 1978 524 North Jackson Street Jackson, MI 49201-1978
Licensee Telephone #:	(517) 784-4426
Administrator:	Robert Dangler
Licensee Designee:	Karrie Beilfuss
Name of Facility:	Seymour Road Home
Facility Address:	4361 Seymour Road Jackson, MI 49201
Facility Telephone #:	(517) 395-4309
Original Issuance Date:	12/29/2015
License Status:	REGULAR
Effective Date:	06/29/2020
Expiration Date:	06/28/2022
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Residents do not have adequate food or water.	No
There is a staff at the home who leaves his emergency medication on the kitchen counter in the open, a resident could possibly grab this and be endangered.	Yes
Staffing ratios are not enforced; and at times, one staff will be left with all the residents.	No
Staff bring residents to their personal homes and leave them in cars. Residents are often not treated with respect or compassion.	No

III. METHODOLOGY

04/05/2022	Special Investigation Intake - 2022A0007018
04/06/2022	Special Investigation Initiated - On Site
04/14/2022	Contact - Document Received - Copy of Behavior Treatment Plans.
06/01/2022	Inspection Completed On-site - Unannounced - Face to face contact with Employee #2, Employee #3, Employee #5, Resident A, Resident B, and Resident C.
06/21/2022	Contact - Telephone call made to Home Manager #1. Follow-up questions. Follow-up interview with Employee #5.
06/21/2022	Contact - Document Received - Copy of time sheets.
06/21/2022	Contact - Telephone call made to Home Manager #1. Follow-up.
06/21/2022	Contact - Telephone call made to Jackson County Guardian A and Staff A.
06/21/2022	Exit Conference conducted with Ms. Beilfuss, Licensee Designee.
06/23/2022	Referral - Recipient Rights

ALLEGATIONS:

Residents do not have adequate food or water.

INVESTIGATION:

On April 6, 2022, I conducted an unannounced on-site investigation and made face to face contact with Employee #1, Resident A, and Resident B when I arrived. Employee #1 reported that Resident C was asleep and Resident D and Resident E were attending school.

Employee #1 reported that the residents had already eaten lunch. They were served chicken, green beans, and dressing for lunch.

I observed an adequate amount of food supply in the home at the time of the on-site inspection; I also observed 10 gallons of (full) filtered water containers.

Once Employee #2 walked into the kitchen, I interviewed him regarding the food supply. He reported that they never run low on food.

While at the facility, I interviewed Resident A. He reported to have breakfast sandwiches with sausage, bacon, and eggs for breakfast that day. He reported to be full after that meal. He reported to have stuffing, chicken, and green beans for lunch that day. Resident A informed me that they go to Meijer's to purchase food. I inquired if they ever run low on food and Resident A reported that sometimes they did. He reported to sometimes be a little hungry. He also informed me that he is served enough food on his plate. I inquired if he had any additional concerns and he reported not to have any.

During the on-site inspection, I attempted to interview Resident B. He did not provide any information to confirm or refute the allegations.

During the on-site inspection, Home Manager #1 arrived at the facility. He informed me that five residents have Bridge Cards to purchase food. He stated that due to the pandemic, stores limit what he can purchase to 4 items; therefore, they do not have as much stock. He assured me that the residents received adequate food and care.

On June 1, 2022, I conducted another unannounced on-site inspection and made face to face contact with Employee #2, Employee #3, Employee #5, Resident A, Resident B, and Resident C. Resident D and Resident E were attending school. Employee #3 was preparing lunch for the residents when I arrived. They were served fruit, beef, macaroni and cheese, macaroni salad and or potato salad. There

were 15 gallons of water observed in the home. I observed an adequate amount of food in the refrigerator, freezer, and cabinets.

According to Employee #3, they complete a big shop once a week but run to the store if they need milk or something during the week. He stated that the food levels get low sometimes but there is always enough food for the residents to eat, and the never run out of food.

According to Employee #2, they go to the water store about once a week and during the summer months, they may go twice a week as the residents drink more water during the warm months.

I interviewed Resident C. He reported to have eggs, sausage, and bacon for breakfast. He reported to get enough food to eat and that there was enough water in the home.

I reviewed the weight records for each of the residents. Resident A weighed 286lbs, Resident B (223lbs), Resident C (351lbs), Resident D (253lbs) and Resident E (154lbs). All the residents either maintained or gained weight during the timeframes reviewed.

On June 21, 2022, I interviewed Jackson County Guardian A and her staff, Staff A. They supervise Resident A, Resident B, and Resident E. According to Staff A, she often visits the home either at 8:00 a.m. or 4:00 p.m. as the residents are often out in the community. She has observed breakfast mealtimes and they receive a decent amount of food. For the most part, has observed too much food vs. not enough food in the home.

On June 21, 2022, I conducted the exit conference with Ms. Beilfuss, Licensee Designee. We discussed the investigation and my recommendations. She agreed with the conclusion of the investigation.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	During the course of this investigation, I conducted two unannounced on-site investigations. I observed an adequate amount of food and water in the home. Employee #3 reported they complete a big shop once a week; however, they do run low sometimes, but they never run out of food. Resident A reported to have breakfast sandwiches with sausage, bacon, and eggs for breakfast that day. He reported to be full after that meal. He reported to have stuffing, chicken, and green beans for lunch that day. Resident A reported to sometimes be a little hungry. He also informed me that he is served enough food on his plate. I inquired if he had any additional concerns and he reported not to have any. I interviewed Resident C. He reported to have eggs, sausage, and bacon for breakfast. He reported to get enough food to eat and that there was enough water in the home. Home Manager #1 reported that due to the pandemic, stores limit what he can purchase to 4 items; therefore, they do not have as much stock. He assured me that the residents received adequate food and care. According to Staff A, she has mainly observed too much food vs. not enough food in the home. Based on the information gathered during this investigation and provided above, it's concluded that there is not a preponderance of the evidence to support the allegations that there is an inadequate amount of food or water in the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS:

There is a staff at the home who leaves his emergency medication on the kitchen counter in the open, a resident could possibly grab this and be endangered.

INVESTIGATION:

On April 6, 2022, upon arrival to the home, I observed the kitchen and noted a diabetic testing kit on the kitchen counter. Employee #1 informed me that it was left

on the counter as a reminder, since the tests were completed twice a day. I expressed concern and informed that the bag needed to be kept in a locked cabinet. Employee #1 and Employee #2 reported that the other residents did not bother the testing kit. The staff placed the testing kit in the locked medication cabinet once the concern was brought to their attention. I did not observe any medication on the kitchen counter.

During my follow-up unannounced on-site investigation, I did not observe any emergency medications or diabetic testing kits on the kitchen counter.

Employee #3 stated he did not know if a staff member was leaving their emergency medication on the kitchen counter.

Employee #2, who is an assistant to Home Manager #1, stated that he had to remind Employee #6 several times not to keep his anti-seizure medication on the kitchen counter. Employee #2 stated that he (Employee #6) has been taken off the schedule as there were complaints and personnel issues.

I interviewed Employee #5. He stated that Employee #6 would leave his ibuprofen on the kitchen counter and this issue was brought to his attention.

According to Staff A, she has observed staff administering medications and she has not observed medications left unattended in the home.

During the exit conference with Ms. Beilfuss, Licensee Designee, she concurred with my findings and agreed to submit a written corrective action plan to address the established violation.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	On April 6, 2022, I observed the kitchen and noted a diabetic testing kit on the kitchen counter. The staff placed the testing kit into the locked medication cabinet, prior to the conclusion of the on-site inspection. During the unannounced on-site investigations, I did not observe any medications on the kitchen counters. While staff report there was an issue with Employee #6 leaving his medication on the counter, this matter was brought to his attention, and he had been removed from the schedule. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that the medical testing equipment was not safeguarded and maintained in a locked cabinet.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

Staffing ratios are not enforced; and at times, one staff will be left with all the residents.

INVESTIGATION:

On April 6, 2022, during the on-site investigation, Employee #1 informed me there were five residents admitted (Resident A, Resident B, Resident C, Resident D, and Resident E). I made face to face contact with Resident A and Resident B. Resident C was asleep, and Resident D and Resident E were attending school.

I inquired about the staffing ratios and supervision requirements. Employee #1 stated that Resident A is the only resident requiring 1:1 supervision. He informed that one staff could supervise three consumers. He also stated that Employee #2 was in the basement and that Home Manager #1 was on his way. After a few minutes, Employee #2 walked into the kitchen.

I discussed the staffing patterns with Employee #2. He stated that there were usually four staff on 1st shift, three staff on 2nd shift, and two staff on third shift.

During the interview with Home Manager #1, we discussed Resident B and his recent self-injurious behaviors. He reported that they are working to get him stabilized. I inquired about the supervision levels and staff ratios, and Home Manager #1 reported that Resident A was the only individual assigned 1:1

supervision. He has requested 1:1 supervision for Resident B but that has not occurred yet. I inquired about the staffing levels in the home. Home Manager #1 reported that there are three staff on 1st and 2nd shifts and two staff on 3rd shifts. Home Manager #1 informed me that he is also available and on-call. In addition, that he has worked remotely during spring break.

During the course of this investigation, I reviewed the staff schedule for the week of May 29, 2022 – June 4, 2022. It was noted that only one staff (Employee #7) was listed for third shift on Monday, May 30, 2022, and (Employee #8) on Tuesday, May 31, 2022. There were two staff scheduled on third shift each of the other days of that week.

As a part of this investigation, I reviewed the *AFC Assessment Plans* and the *Behavior Treatment Plans* for each of the residents. I was unable to find any information to support that Resident A or any of the residents required 1:1 supervision/dedicated staffing.

On June 21, 2022, I contacted Home Manager #1 as I had some follow-up questions. I asked that he send me the specific information in the plan that outlined the requirements for dedicated staffing. He informed me that it was confusing and that he had been working with Case Manager #1 to review the plans for Resident A and Resident B; however, the case manager changed. In addition, there was a funding change. Home Manager #1 stated this was confusing and that he would contact management to find out exactly what the plan was. Home Manager #1 stated that it was rare for there to only be one staff on duty, and they usually have two staff on duty.

I also inquired about the staff on duty on May 30, 2022, and May 31, 2022, as it appeared there was only one staff on duty (3rd shift). Home Manager #1 informed me there were two staff on duty. He also agreed to provide me with a copy of the time sheets. The information Home Manager #1 provided documented that there were two staff on 3rd shift for the days in question. Home Manager #1 also informed me that he contacted Ms. Wright, Administrative Staff, about the dedicated staff. Ms. Wright contacted Lifeways and they have no residents that have dedicated staffing (1:1).

According to Staff A, none of the residents (Resident A, Resident B, and Resident E) require 1:1 dedicated supervision in the home; however, they do require 1:1 supervision in the community. The home is often staffed with extra direct care staff in case a resident has a behavior, and oftentimes, there are enough staff to provide 1:1 supervision.

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:	Regarding staff ratios, Home Manager #1 reported that Resident A was the only individual assigned 1:1 supervision. He has requested 1:1 supervision for Resident B but that has not occurred yet. Home Manager #1 reported that there are three staff on 1st and 2nd shifts and two staff on 3rd shifts. Home Manager #1 informed me that he is also available and on-call. As a part of this investigation, I reviewed the *AFC Assessment Plans* and the *Behavior Treatment Plans* for each of the residents. I was unable to find any information to support that Resident A or any of the residents required 1:1 supervision/dedicated staffing. Home Manager #1 later informed me that he contacted Ms. Wright, Administrative Staff, about the dedicated staff. Ms. Wright contacted Lifeways and they have no residents that have dedicated staffing (1:1). Based on the information gathered during this investigation and provided above, it's concluded that there is not a preponderance of the evidence to support the allegations that there is inadequate staffing.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS:

Staff bring residents to their personal homes and leave them in cars.
Residents are often not treated with respect or compassion.

INVESTIGATION:

During the interview with Resident A, he did not report any concerns about how staff treated him.

I attempted to interview Resident B. He did not provide any information to confirm or refute the allegations.

During the on-site inspection, I also observed the staff interacting with the residents. The staff appeared to be respectful, kind, and attentive.

During my interview with Home Manager #1, he reported that in the past, they had an issue with staff taking the residents to their homes; however, this was investigated by ORR and the case was closed. Employee #4 was terminated. Home Manager #1 informed me that there were no recent issues regarding this matter.

During my interview with Employee #3, he stated he has not seen or heard of staff taking the residents to their personal homes or leaving them in the cars. He stated that some staff may be “gruffer” than others. When asked what he meant, he stated some staff are short or ask the residents “why did you do that?” He stated it does not happen often. In general, the residents are treated well, and he is impressed with most of the staff he works with. Employee #3 stated that everyone gets along for the most part.

Employee #2 stated that he has not observed the residents not being treated with respect or compassion. He stated that all the residents in the home are on the autism spectrum. In addition, that it is important that staff understand the difference between a prompt and a command. Regarding staff taking the residents to their homes, and leaving them in the cars, he stated that at one point that was happening. Prior to the pandemic, Resident A was left in a vehicle. It is not occurring anymore. He has not taken any residents to his home.

Resident C reported that staff treated him good. Resident C did not report any concerns.

Employee #5 stated that he had never observed a staff member take a resident to their home and leave them in the car, but he heard about it. This has not occurred since he has worked in the home. Employee #5 reported that he has heard rumors about how some staff treat the residents. He stated that Employee #6 gives commands instead of encouraging the residents or assisting them with household chores.

I interviewed Resident A. He reported that he has been left in the van. I inquired if this was in the past or recently. He stated it was recently. He stated that Employee #5 left him in the van. He ran into the store to grab something to drink. It was about 3-minutes.

On June 21, 2022, I conducted a follow- up interview with Employee #5. I informed him of the information I learned during the investigation and asked if he had ever left Resident A unattended in the car. He stated that he heard that information was reported to me, he was not sure why that was said, because it was not true.

Employee #5 stated that one resident likes to go to Burger King and the other likes to go to Walgreens; and that while on outings, he has never left any resident unattended in the van.

According to Staff A, Resident A was left in the car when he resided at a different home. They (Staff A and Jackson County Guardian A) have also heard that staff have left residents in the car at different homes. Staff A reported that she has observed the direct care staff and she has never observed them to be rude. According to Staff A, the staff in the home are caring.

During the exit conference with Ms. Beilfuss, Licensee Designee, she suggested that additional training may be provided to the staff to ensure that they are aware of the expectations as related to supervision when in the community.

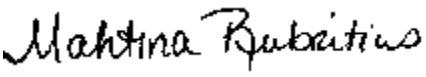
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	During the on-site inspection, I also observed the staff interacting with the residents. The staff appeared to be respectful, kind, and attentive. Home Manager #1, he reported that in the past, they had an issue with staff taking the residents to their homes; however, this was investigated by ORR and the case was closed. Employee #4 was terminated. Home Manager #1 informed me that there were no recent issues regarding this matter. According to Resident A, he has recently been left in the van. He stated that Employee #5 left him in the van. Employee #5 ran into the store to grab something to drink. It was about 3-minutes. As related to not being treated with respect and compassion, Resident A did not report any concerns about how staff treated him. Resident C reported that he was treated good by the staff. Resident C did not report any concerns. According to Employee #2, regarding staff taking the residents to their homes, and leaving them in the cars, he stated that at one point that was happening. Prior to the pandemic, Resident A was left in a vehicle. It is not occurring anymore. Employee #2 stated that he has not observed the residents not being treated with respect or compassion. During my interview with Employee #3, he stated he has not seen or heard of staff taking the residents to their personal homes or leaving them in the cars. According to Employee #3, in general, the residents are treated well, and he is impressed with most of the staff he works with. Employee #3 stated that everyone gets along for the most part. Employee #5 reported that he has never left residents unattended in the company van. Employee #5 reported that he has heard rumors about how some staff treat the residents. Staff A reported that she has observed the direct care staff and she has never observed them to be rude. According to Staff A, the staff in the home are caring. Based on the information gathered during this investigation and provided above, it's concluded that there is not a preponderance of the evidence to support the allegations that the residents are

	still being taken to the staff homes, left in the vehicles and not being treated with respect and compassion.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

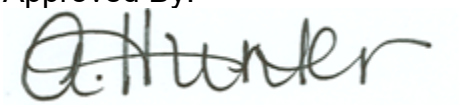


06/24/2022

_____

Mahtina Rubritius Date
Licensing Consultant

Approved By:



06/28/2022

_____

Ardra Hunter Date
Area Manager