GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 16, 2022

Ira Combs, Jr.
Christ Centered Homes, Inc.
327 West Monroe Street
Jackson, MI 49202

RE: License #: AS130010444
Investigation #: 2022A0581043
Grace Home

Dear Mr. Combs, Jr.:

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) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS130010444
Investigation #:	2022A0581043
Complaint Receipt Date:	07/29/2022
Investigation Initiation Date:	07/29/2022
Report Due Date:	09/27/2022
Licensee Name:	Christ Centered Homes, Inc.
Licensee Address:	327 West Monroe Street Jackson, MI 49202
Licensee Telephone #:	(517) 499-6404
Administrator:	Ira Combs, Jr.
Licensee Designee:	Ira Combs, Jr.
Name of Facility:	Grace Home
Facility Address:	1215 Fitch Street Albion, MI 49224
Facility Telephone #:	(517) 629-6859
Original Issuance Date:	01/21/1992
License Status:	REGULAR
Effective Date:	05/17/2022
Expiration Date:	05/16/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Unexplainable bruises were discovered on Resident B indicating he was not being protected or supervised by facility staff.	No
Facility staff did not address Resident A becoming dehydrated.	No
Resident weight records have not been recorded since May 2022.	Yes
Resident records do not contain Incident Reports.	Yes
Expired milk is in the facility's refrigerator.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/29/2022	Special Investigation Intake 2022A0581043
07/29/2022	APS Referral Calhoun County APS received the allegations and are investigating; therefore, no referral is necessary.
07/29/2022	Special Investigation Initiated - Telephone Email correspondence with APS specialist, Rebecca Karrar
08/01/2022	Contact - Document Received Received additional allegations from intake # 189046
08/01/2022	Contact - Document Received Email correspondence with APS specialist, Rebecca Karrar. She'll be attending on-site inspection on 08/03/2022.
08/03/2022	Inspection Completed On-site Interviewed staff and observed residents.
08/04/2022	Contact - Telephone call received Voicemail from licensee designee.
08/08/2022	Contact - Document Received Email from facility's compliance officer.
08/15/2022	Contact - Document Received Email from APS, Anika Settler.
09/07/2022	Contact - Document Received Email from Mr. Thomas.

09/08/2022	Inspection Completed On-site Interviewed staff and observed residents.
09/08/2022	Contact – Telephone call made Interview with direct care staff, Steven McFall.
09/08/2022	Contact – Telephone call made Unable to leave voicemail for direct care staff, Debbie Price, due to voicemail box not being set up.
09/08/2022	Contact – Telephone call made Interview with Anquinetta Hogan.
09/09/2022	Inspection Completed-BCAL Sub. Compliance
09/12/2022	Referral – Recipient Rights Via email to Summit Pointe.
09/13/2022	Contact – Telephone call made Interview with Summit Pointe Recipient Rights Officer, Jaimie Fedor.
09/13/2022	Contact – Telephone call made Interview with direct care staff, Britney Lucio.
09/16/2022	Exit conference with the licensee designee, Ira Combs Jr.

ALLEGATION:

Unexplainable bruises were discovered on Resident B indicating he was not being protected or supervised by facility staff.

INVESTIGATION:

On 08/01/2022, I received a complaint through the Bureau of Community Health Systems (BCHS) online complaint system alleging bruises were discovered near Resident B's hips and direct care staff were unable to explain the origin of them despite Resident B being "bed bound and nonverbal." The complaint indicated Calhoun County Adult Protective Services (APS) had received the complaint and were investigating.

On 08/03/2022, I conducted an unannounced onsite inspection at the facility in conjunction with APS specialist, Anika Settler. Resident B was at the facility during

my inspection; however, I was unable to interview him due to him sleeping. I observed Resident B lying in his bed covered in blankets.

I interviewed direct care staff members Derek Caldwell and Anquinetta Hogan. Both Mr. Caldwell and Ms. Hogan indicated Resident B has limited mobility but is able to move from his bed into his wheelchair with minimal staff assistance and is able to walk around periodically. They indicated he also utilizes a wheelchair and once he is in a wheelchair, he can self-ambulate. Neither Mr. Caldwell nor Ms. Hogan knew how Resident B got the bruises on his side or leg.

I reviewed Resident B's *Assessment Plan for AFC Residents* (assessment plan), dated 09/16/2021, which indicated the only special equipment utilized by Resident B is a walker. His assessment plan did not indicate he required the use of a wheelchair. His assessment plan indicated he requires assistance from staff with toileting, bathing, and dressing, but it did not indicate or describe what kind of assistance was required.

On 08/15/2022, APS specialist, Ms. Settler, forwarded me three pictures of Resident B's bruises, which she indicated she had taken on 07/29/2022. The first picture appeared to be Resident B's right knee with an approximate quarter sized abrasion below the knee and a faint yellow nickel sized bruise approximately a few inches below the abrasion. The second bruise picture was Resident B's right shin and calf, which showed approximately five scrapes and abrasions on the left side of his shin ranging in size from a quarter to as long as a couple inches. An approximate five to seven inch section of the left side of Resident B's left shin was covered in a faint yellow/green bruise. The third bruise picture provided by Ms. Settler was of Resident B's right abdomen. On his abdomen, there were three yellow/green bruises. The lowest bruise, approximately the size of a quarter was several inches from the middle of his stomach. A larger bruise, approximately a couple of inches wide was located more towards his side or hip, while the third bruise, about an inch wide, was approximately an inch above and towards the middle of his stomach.

None of the bruises resembled handprints or could be attributed to certain objects. Based on the color of the bruises, they appeared to be approximately one week old.

On 09/06/2022, I Interviewed Resident B's guardian, Guardian B1, via telephone. She stated Resident B had resided at the facility "10-15 years" and his health "is steadily declining." Guardian B1 stated Resident B "has taken falls" and has a history of falls. She stated he recently broke his hip approximately May 2022. She stated she provided the facility with a bed and wheelchair alarm, which alerts direct care staff if Resident B is trying to get up. Guardian B1 stated she had only visited with Resident B "a couple times in July 2022." Guardian B1 did not indicate any concerns direct care staff had caused Resident B's bruises but had no knowledge of how he obtained the bruises.

On 09/08/2022, I completed a follow up onsite investigation at the facility, in conjunction with Adult Foster Care Consultant, Kevin Sellers. I again observed Resident B lying asleep in his hospital bed, which had two half bed rails on both sides. I observed the bed rails to be up and in position during the inspection. I interviewed home manager, Kim Hoag, regarding the bed rails. She stated Resident B has always had bed rails as they came with the hospital bed, which was provided by Guardian B1. The bed rail opposite Resident B's wall was not firmly or securely attached to the bed as it appeared loose and wobbly when I moved it. Additionally, the space between Resident B's mattress and the bed rails appeared more than at least two inches. Additionally, the space between the bed rails and the mattress was not filled with foam wedges. The space between the bed rail slats appeared in excess of several inches allowing Resident B's arms or legs to go through as I observed Resident B to be small in stature and size. Neither direct care staff, Derek Caldwell nor Ms. Hoag, stated there was a physician order for Resident B's bed rails. They also both stated Resident B was unable to move the bedrails up or down by himself. Mr. Caldwell stated the bedrails were utilized so Resident B could position himself up in bed but were primarily to prevent Resident B from falling out of bed. Mr. Caldwell indicated Resident B could have obtained the bruises on his body the end of July from the bedrails as he has been observed with his legs over the rails in an attempt to get over them. I informed Ms. Hoag during the onsite inspection the bedrails were not to be utilized unless there was a physician's order, they were indicated in his assessment plan, and they were not being utilized as a restraint. Ms. Hoag stated she understood.

I reviewed Resident B's assessment plan, which had no information about Resident B requiring the use of half bedrails.

On 09/08/2022, I interviewed direct care staff, Steven McFall, and re-interviewed direct care staff, Ms. Hogan, via telephone. Mr. McFall had no indication as to how Resident B obtained the bruising on his body the end of July/early August. He stated Resident B requires staff assistance with getting into his wheelchair or bed. He also stated Resident B has bed rails on his hospital bed "to keep him in bed" otherwise Resident "tries to get out bed and falls on the floor." Both Mr. McFall and Ms. Hogan stated Resident B was unable to put his bedrails up or down.

On 09/13/2022, I interviewed Brittany Lucio, via telephone. She stated she had covered shifts and assisted direct care staff at the facility towards the end of July. She stated she did not observe the bruises on Resident B but had been informed of them by Mr. Caldwell. She stated she did not know how the bruises came to be on Resident B but indicated they could have been caused by him bumping into furniture when he was self-ambulating in his wheelchair. Ms. Lucio had no concerns direct care staff could have caused the bruises. She stated Mr. Caldwell was the "primary male caretaker" and worked well with the male residents. Ms. Lucio was unable to recall if bed rails were on Resident B's bed at the time she worked in the facility.

On 09/13/2022, I reviewed Resident B's Daily Notes from the facility for the entire month of July, but there was no indication in the notes anything occurred with Resident B that could have caused the injuries on his leg and stomach areas.

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:	Based on my investigation, which included a review of Resident B's *Assessment Plan for AFC Residents*, dated 09/16/2021, his July and August Daily Progress notes written by direct care staff, and my interviews with direct care staff, I can establish Resident B had notable bruising to his leg and abdomen on or around the end of July 2022; however, no direct care staff could recall or had any idea how he obtained the bruising despite Resident B requiring staff's assistance with activities of daily living such as toileting, bathing and dressing. My interviews with direct care staff and Guardian B1 indicate Resident B has a history of falling, which resulted in a broken hip from a fall in May 2022 and the utilization of the half bedrails. Subsequently, given Resident B's history of falls and limited mobility, there is no evidence establishing facility staff were not providing Resident B with adequate protection, safety, and supervision on or around the end of July/early August that resulted in the notable bruising on his shin and abdomen.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
	"Assessment plan" means a written statement which is prepared in cooperation with a responsible agency or person and which identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical and behavioral needs and well-being and the methods of providing

	the care and services, taking into account the preferences and competency of the individual.
ANALYSIS:	Based on my review of Resident B's *Assessment Plan for AFC Residents*, dated 09/16/2021, it did not include Resident B's use of a wheelchair or half bedrails, despite direct care staff identifying these types of special equipment being utilized by Resident B as part of his care. A resident's assessment plan should be updated to reflect a resident's current assessment.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	Use of assistive devices. **(1) An assistive device shall only be used to promote the enhanced mobility, physical comfort, and well-being of a resident.** **(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.** **(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.**
ANALYSIS:	Resident B's hospital bed had half bedrails on both sides, which were being used when I conducted my unannounced onsite investigation on 09/08/2022. Multiple direct care staff indicated Resident B is unable to put his bed rails up or down by himself and stated the bed rails were to prevent him from falling out of bed. Additionally, the use of the bed rails was not indicated in Resident B's assessment plan and there was no physician's order available for review indicating they were authorized as a therapeutic support.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident weight records have not been recorded since May 2022.

INVESTIGATION:

The complaint alleged resident weights had not been recorded for Resident A since May 2022.

During my 08/03/2022 onsite inspection, I requested to review Resident A's weight records. According to my review of her weight records, no weight had been recorded for her since 05/20/2022. Mr. Caldwell and Ms. Hogan stated the facility home manager, Ms. Hoag, became sick in June 2022 and subsequently, residents were not weighed.

I also reviewed Resident B's and Resident D's weight records and established their weights had also not been recorded since May 2022.

During my 09/08/2022 inspection, Ms. Hoag indicated the facility's weight scale was not functioning.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	Monthly weights had not been recorded for residents since May 2022, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility staff did not address Resident A becoming dehydrated.

INVESTIGATION:

On 07/29/2022, I received this complaint through the Bureau of Community Health Systems (BCHS) on-line complaint system. The complaint alleged Resident B was severely hyponatremic (i.e. A condition where sodium levels in the blood are abnormally low. This causes nausea, vomiting, fatigue, headache or confusion). The complaint alleged that based on Resident A's lab work, she not had water for at least 3-4 days or possibly weeks. The complaint also alleged Resident A was severely malnourished and dehydrated indicating she has not been offered food or nutrition either.

During my unannounced onsite investigation, I interviewed Mr. Caldwell and Ms. Hogan, who both stated they had worked with Resident A the week prior to her being taken to the hospital. Mr. Caldwell stated on or around 07/24/2022, Resident A was having oatmeal for breakfast when she “vomited with a little phlegm in it.” He stated Emergency Medical Services (EMS) was contacted, she was sent to the hospital and had not returned to the facility. He stated Resident A did not require staff assistance to eat or drink, but staff would have to grind meat per her diet. He stated Resident A was “cheeking” her food the week prior to being hospitalized and stated at some meals she would eat all her food and some meals she would not. Mr. Caldwell indicated Resident A “missed” Ms. Hoag while she was on leave and believed this attributed to her decline.

I reviewed Resident A’s *Assessment Plan for AFC Residents* (assessment plan), dated 05/04/2022, which indicated Resident A had a “low sodium” diet and “meat needs to be soft/bite sized or ground and chopped.” Her assessment plan also indicated she “will sometimes aspirate, needs thickener in clear liquids”. It also indicated Resident A requires help with eating/feeding, but it did not indicate the type of help or assistance by staff other than indicating the type of diet Resident A required.

I reviewed Resident A’s Summit Pointe Treatment Plan (treatment plan), dated 05/04/2022, which indicated one of Resident A’s objectives to her treatment plan goals of “maintain her health, good spirit, and living conditions” was to be “provided with 8 oz of fluid ever two hours by staff to decrease risk of dehydration as evidence by staff report for the next twelve months”. Her treatment plan further indicated Resident A should be offered healthy foods at each meal and with appropriate portions of vegetables, protein, and low sugar carbs. I reviewed the corresponding documentation for Resident A’s treatment plan goals for July 2022, which indicated direct care staff provided Resident A with vegetables 1-2 times a day to meet her nutritional needs and offered her 8 oz of water every two hours the week prior to her being admitted to the hospital.

I reviewed the facility’s Incident/Accident Report (IR), which was identified as “Lifeways Incident Report”, dated 07/24/2022, rather than a Department Incident/Accident Report. What was written in the IR was consistent with what was reported by Mr. Caldwell. The IR indicated EMS was contacted and the action taken by staff was to “to keep watch or feed.” The action taken to prevent the incident from reoccurring was indicated as “she will have a different eating routine”; however, no additional information was provided.

I reviewed the facility’s Progress Notes for July 2022 relating to Resident A, which was dated 07/23/2022. According to this progress note, “[Resident A] ate small portion of food today she hardly wanted to eat she is weak in the left leg she is to be on watch for eating and strength and hydration watch [*sic*]. Dr. Appointment is set”.

I reviewed Resident A's *Health Care Appraisal*, dated 04/27/2022, which identified Resident A's diagnoses as "acquired hypothyroidism, hyperlipidemia, hypernatremia, gastro reflux disease, dysphagia, hypotension, hypokalemia."

On 09/06/2022, I interviewed Guardian A1, via telephone. Guardian A1 stated she last saw Resident A in June 2022 and "everything was good." She stated she had not heard anything about Resident A until she was notified Resident A was in the hospital. Guardian A1 had no information as to how Resident A had been doing the week prior to being admitted to the hospital. She stated no one contacted her to report any concerns.

On 09/06/2022, I interviewed Oaklawn hospital social worker, Donna Fausz. Ms. Fausz stated Resident A was not on a feeding tube when she was admitted to the hospital. She stated Resident A's lab were "off" indicating she was severely dehydrated upon admission. Ms. Fausz stated the doctor indicated Resident A would not have had water or food in several days to a week. She stated Resident A was "lethargic" and "not alert", but once she received fluids she became "more arousable" and "alert".

On 09/06/2022, I interviewed Relative A1. Relative A1 stated Resident A is able to feed and drink fluids herself and when he's visited with Resident A he's observed direct care staff providing her with food and water. He stated he had seen Resident A drink water on her own. Relative A1 stated he did not visit with Resident A the week prior to being admitted to the hospital; therefore, he had no information as to how she was doing.

On 09/08/2022, I conducted a follow up unannounced onsite investigation at the facility. I reinterviewed Mr. Caldwell, whose statement was consistent with his previous statement to me. The facility's home manager, Kim Hoag, was also present, but had not been working at the time Resident A was admitted to the hospital.

During my inspection, I interviewed Resident C. Resident C did not report any concerns pertaining to Resident A's or Resident B's care, how staff treated either resident or that they were not being provided with food and water.

I attempted to interview Resident D; however, she would not respond to my questions. Resident E was not present at the facility during my inspection and Resident F was in the hospital. Subsequently, the remaining residents were unable to be interviewed regarding the allegations.

Mr. McFall stated Resident A could feed herself and drink water on her own without staff assistance. He stated Resident A appeared to come down with a cold the week prior to her going to the hospital as she began to "cheek" food in her mouth, which was common for her to do when she was sick. He stated despite her cheeking her food, she did eat and drink the week prior to going to the hospital.

Ms. Lucio stated she had no information regarding Resident A prior to her entering the hospital as she was not working at the facility during that time.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on my investigation, which included a review of Resident A's assessment plan, treatment plan, treatment plan documentation completed by direct care staff, her Health Care Appraisal, and my interviews with direct care staff, there is no evidence establishing Resident A had a sudden adverse change in her physical condition like dehydration and the facility failed to obtain needed care immediately. Per the facility's documentation, Resident A's diagnosis of "Hypernatremia" and my interviews with direct care staff, Resident A was offered food and water the week prior to her getting admitted to the hospital. Then, on 7/24/2022 when Resident A vomited, direct care staff contacted emergency services to have her evaluated due to concerns of aspiration.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident records do not contain Incident Reports.

INVESTIGATION:

The complaint alleged recent incident reports (IR) were not in Resident B's resident record, specifically relating to Resident B's bruising discovered the end of July 2022.

During my 08/03/2022 onsite investigation, I requested Mr. Caldwell and Ms. Hogan provide IRs for Resident B for the last several months; however, they were unable to find any IRs pertaining to Resident B in the last year despite Resident B having gone to the hospital for emergency situations (e.g. broken hip in May 2022), which would have warranted an incident report.

Ms. Hogan stated she "thought" she completed an IR pertaining to Resident A going to the hospital in July 2022, but she was unable to locate it during my inspection.

On 08/03/2022, I requested from the licensee designee, Ira Combs Jr., any IRs for any residents within the last month.

On 08/06/2022, the facility's corporate compliance officer, Tony Thomas, sent via email a "Lifeways Incident Report", dated 07/24/2022, for Resident A rather than an *AFC Licensing Division Incident / Accident Report*. The IR indicated Resident A was taken by EMS due to choking. No additional IRs were provided.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(7) A copy of the written report that is required pursuant to subrules (1) and (6) of this rule shall be maintained in the home for a period of not less than 2 years. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Direct care staff documented Resident A being taken by EMS for choking on a "Lifeways Incident Report", dated 07/24/2022, rather than an *AFC Licensing Division Incident / Accident Report*, as required. A review of the facility file did not indicate a variance had been approved for the use of a substitute form.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, *and maintain in the home*, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(h) Incident reports and accident records.**

ANALYSIS:	At the time of my onsite investigation, the facility's direct care staff were unable to locate any *AFC Licensing Division Incident / Accident Reports* for 2022 relating to any of the residents despite known incidences occurring that would have warranted an Incident Report (e.g. Resident B broke his hip in May 2022 and Resident A was taken to the ER on 07/24/2022). Though the facility's Corporate Compliance officer, Tony Thomas, submitted an IR on 08/06/2022, it was not on the department's form and it was not in the facility at the time of my onsite investigation, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Expired milk is in the facility's refrigerator.

INVESTIGATION:

The complaint alleged on 07/27/2022 there had been milk in the facility refrigerator with an expiration date of 07/15/2022.

During my 08/03/2022 onsite inspection, I observed milk in the facility fridge, dated on the top "06/07", food in leftover containers that did not have dates on them (e.g. tuna salad and cooked potatoes) and there were two cooked cinnamon rolls on the inside of the refrigerator that were not in dated containers.

Direct care staff, Ms. Hogan, indicated staff were freezing gallons of milk to keep it longer. Ms. Hogan showed me frozen milk in their original gallon containers in the garage freezer. Neither she nor Mr. Caldwell were not able to provide any kind of documentation showing what the facility was doing to prevent spoilage (e.g. dates when the milk was purchased, when it was frozen and when it was placed in the refrigerator and opened for use).

On 08/06/2022, Mr. Thomas sent an email indicating the expired milk had been destroyed and replaced with fresh milk.

APPLICABLE RULE	
R 400.14402	**Food service.**
	(1) All food shall be from sources that are approved or considered satisfactory by the department and shall be safe for human consumption, clean, wholesome and free from spoilage, adulteration, and misbranding.

ANALYSIS:	Based on observations during my 08/03/2022 inspection, the facility had expired milk in the facility refrigerator, leftover food in undated containers and leftovers in the refrigerator that were neither in containers nor in dated containers. My observations established the licensee was not taking precautions to prevent the spoilage of food, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

During my 08/03/2022 onsite investigation, I observed Resident C's insulin, unlocked and accessible to residents and staff. Direct care staff stated there was not an additional refrigerator in the facility's medication room or a locked refrigerator where the insulin could be kept.

On 08/06/2022, Mr. Thomas indicated in his email a mini fridge would be purchased to hold the insulin in a secure room that would only be accessible by staff.

On 09/07/2022, I received an email from Mr. Thomas confirming a mini fridge had been purchased and was placed in the medication room. Mr. Thomas attached a picture of the new mini fridge.

On 09/08/2022, I completed a follow up onsite inspection at the facility and observed the mini fridge in the facility's locked medication room.

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:	Based on observations during my 08/03/2022 onsite investigation, facility staff were keeping Resident C's insulin unlocked in the facility refrigerator. Despite the licensee purchasing a mini fridge on or around 09/07/2022, which is kept in the facility's locked medication room, the violation had already been established on 08/03/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my 08/03/2022 onsite inspection, I observed a broken drawer in the facility laundry room, which did not present in an orderly appearance.

On 08/06/2022, I received an email from Mr. Thomas indicating a request has been sent to the facility's landlord maintenance concerning the replacement/repair of the drawer in the laundry room.

On 09/07/2022, Mr. Thomas sent via email a picture of a brand new cabinet in the laundry room, which replaced the broken drawer.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	During my 08/03/2022 onsite investigation, I observed a drawer in the facility laundry room broken and in disrepair. The licensee replaced this drawer with a new cabinet on 09/07/2022; however, this drawer did not present an orderly appearance at the time of my initial inspection, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/16/2022, I conducted the exit conference with the licensee designee, Ira Combs Jr., via telephone. Mr. Combs Jr. acknowledged the violations and indicated he would submit an acceptable plan of correction.

IV. RECOMMENDATION

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

09/14/2022

Cathy Cushman — Date
Licensing Consultant

Approved By:

09/16/2022

Dawn N. Timm — Date
Area Manager