GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 18, 2022

Patti Holland
801 W Geneva Dr.
Dewitt, MI 48820

RE: License #: AM330073582
Investigation #: 2022A0466059
Simken Adult Foster Care

Dear Patti Holland:

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) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM330073582
Investigation #:	2022A0466059
Complaint Receipt Date:	08/22/2022
Investigation Initiation Date:	08/22/2022
Report Due Date:	10/21/2022
Licensee Name:	Patti Holland
Licensee Address:	801 W Geneva Dr. Dewitt, MI 48820
Licensee Telephone #:	(517) 669-8457
Administrator:	Patti Holland
Licensee Designee:	N/A
Name of Facility:	Simken Adult Foster Care
Facility Address:	3600 Simken Lansing, MI 48910
Facility Telephone #:	(517) 394-3058
Original Issuance Date:	03/12/1997
License Status:	REGULAR
Effective Date:	03/23/2022
Expiration Date:	03/22/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION:

	Violation Established?
Resident A requires supervision in the community and Resident A was sent to the hospital on 08/09/2022 via emergency medical service without a direct care worker to provide her supervision.	No
Resident A was hospitalized on 08/09/2022 and Guardian A1 was not notified.	Yes
Additional Finding	Yes

III. METHODOLOGY

08/22/2022	Special Investigation Intake-2022A0466059.
08/22/2022	Special Investigation Initiated – Telephone call, Complainant interviewed.
08/22/2022	Contact - Telephone call made to licensing consultant, Rodney Gill, interviewed.
08/31/2022	Inspection Completed On-site.
10/17/2022	Contact – Document sent to licensing consultant, Rodney Gill.
10/17/2022	Contact - Telephone call made to DCW Crystal Martinez, message left.
10/17/2022	Contact - Telephone call made to DCW Ebany Simms, phone number not accepting calls.
10/17/2022	Exit Conference with licensee Patti Holland.

ALLEGATION: Resident A requires supervision in the community and Resident A was sent to the hospital on 08/09/2022 via emergency medical services without a direct care worker to provide her supervision.

INVESTIGATION:
On 08/22/2022, Complainant reported Resident A was hospitalized on 08/09/2022 but was sent to the hospital without supervision despite requiring supervision from direct care staff while out in the community.

On 08/22/2022, I interviewed Guardian A1 who reported Resident A was hospitalized on 08/09/2022. Guardian A1 reported Resident A requires supervision

in the community but she was sent to hospital alone without a direct care worker (DCW).

On 08/31/2022, I conducted an unannounced investigation and I interviewed DCW Sara Dzik who reported that she is the house manager. DCW Dzik reported that on 08/09/2022 around 4am, Resident A was complaining of chest pain and/or having a panic attack. DCW Dzik reported DCW Ebany Simms was on duty and sent Resident A to Sparrow Hospital via emergency medical service (EMS). DCW Dzik reported DCW Simms was the only DCW on duty at the time, so she could not go to the hospital with Resident A as she had to stay at the facility with the other residents. DCW Dzik reported DCW Crystal Martinez was called in and sent to Sparrow Hospital to be with Resident A. DCW Dzik reported a DCW got to the hospital as quickly as they could since this was an unplanned medical intervention during the early morning hours. DCW Dzik reported the hospital did not admit Resident A nor did they keep her very long for observation. DCW Dzik reported Resident A was home by 9:30am that same day (08/09/2022).

I interviewed Resident A who reported that on 08/09/2022, she was having chest pains so she called EMS. Resident A could not recall what time this occurred. Resident A reported that there was only one DCW on duty at the time since it was during sleeping hours; therefore, she went into the ambulance to the hospital by herself. Resident A reported she was not at the hospital long as DCW Martinez picked her up around 7am after she was discharged. Resident A reported she had her cellphone with her and that she called Guardian A1 at 7am to let her know that she was at the emergency room. Resident A reported that the cause of her chest pains was unknown, that the hospital said that she was fine, and that she could take Tylenol as needed. Resident A reported she had doctors and nurses at the hospital assisting/supervising her while she was there.

I reviewed Resident A's record which contained an *After Visit Summary* dated 08/09/2022 from Sparrow Hospital. This document stated in the "reason for visit" section of the report, "chest pain." In the "diagnosis" section of the report it stated, "atypical chest pain." The report documented that Resident A was prescribed ibuprofen. This document did not state what time Resident A arrived or was discharged from Sparrow Hospital.

I reviewed Resident A's written *Assessment Plan for Adult Foster Care (AFC) Residents* which was dated 06/25/2021 and signed by licensee designee Patti Holland and Resident A's case manager Lissel Reinke. Resident A's *Assessment Plan for AFC Residents* documented in the "moves independently in the community" section, "no, [Resident A] needs assistance with navigation and transportation."

I reviewed the *Staff Communication Log* which documented on 08/09/2022, "Gone upon my arrival at 7am. She text [sic] me at 2:20am and said she was going to the ER came in and said she was sent by ambulance that she called by herself. Returned home 9:30am and very quiet."

I reviewed Resident A's entire record and I did not locate any written *Incident Report* about Resident A's ER visit on 08/09/2022.

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.
ANALYSIS:	Complainant reported that Resident A requires supervision in the community and that Resident A was sent to the hospital alone on 08/09/2022. Resident A's written *Assessment Plan for Adult Foster Care (AFC) Residents* documented Resident A requires supervision in the community because she requires assistance with navigation and transportation. On 08/09/2022, Resident A was transported to the hospital via emergency medical services therefore her need for assistance with navigation and transportation were met. Additionally, Resident A was sent to the hospital unexpectedly and there was not an additional direct care worker available to go with her. The facility did call in a direct care worker that went to the hospital as soon as possible and transported Resident A home after discharge, therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A was hospitalized on 08/09/2022 and Guardian A1 was not notified.

INVESTIGATION:
On 08/22/2022, Complainant reported Resident A was hospitalized on 08/09/2022. Complainant reported Guardian A1 was never notified of the hospitalization. Complainant reported Sparrow Hospital contacted Guardian A1 about a billing issue for hospital services on 08/09/2022 for Resident A and that is how Guardian A1 was informed of the hospitalization.

On 08/22/2022, I interviewed Guardian A1 who reported that she was never notified of Resident A being hospitalized on 08/09/2022 by the facility. Guardian A1 reported Sparrow Hospital contacted her about a billing issue for hospital services on 08/09/2022 and that was when she learned of the hospitalization. Guardian A1 reported facility direct care staff members never called her, nor did they provide her with any written documentation including an *Incident Report* of Resident A's ER visit on 08/09/2022.

On 08/31/2022, I conducted an unannounced investigation and I interviewed DCW Dzik who reported that Resident A was sent to Sparrow Hospital via ambulance on 08/09/2022 very early in the morning. DCW Dzik reported DCW Martinez went to the hospital to be with Resident A and brought her home since she was discharged a couple of hours later. DCW Dzik reported that she is not sure if an *Incident Report* was completed as she did not complete one. DCW Dzik reported that DCW Chastidy Johnston completes all of the facilities *Incident Reports*. DCW Dzik reported that she did not contact Guardian A1 as she was not on duty. DCW Dzik reported that she is not aware if anyone else contacted Guardian A1 about Resident A's hospitalization since she was not admitted, just cared for the in ER.

I reviewed Resident A's entire record and I did not locate a written *Incident Report*. I did not locate any documentation in Resident A's record or in the facilities *Communication Log* that anyone communicated with Guardian A1 about Resident A's ER visit on 08/09/2022.

On 10/17/2022, I interviewed assigned licensing consultant Rodney Gill who reported he did not receive an *Incident Report* regarding Resident A's ER visit on 08/09/2022.

APPLICABLE RULE	
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: **(b) Any accident or illness that requires hospitalization.**
ANALYSIS:	Complainant and Guardian A1 both reported that the facility never called nor provided Guardian A1 with a written report about Resident A's emergency room intervention on 08/09/2022. Additionally, assigned licensing consultant did not receive a written report regarding Resident A's emergency room visit on 08/09/2022, therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING

INVESTIGATION:
On 08/31/2022, I reviewed Resident A's written *Assessment Plan for AFC Residents* which was dated 06/25/2021 and signed by licensee designee Patti Holland and case manager Reinke. This was the only copy of Resident A's *Assessment Plan for AFC Residents* in the file.

On 08/31/2022, DCW Dzik reported Resident A's updated written *Assessment Plan for AFC Residents* still needed to be reviewed and approved by Guardian A1 and case manager Lissel Reinke.

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 08/31/2022, Resident A's record contained a written *Assessment Plan for AFC Residents* which was dated 06/25/2021. Resident A's record did not contain a written assessment plan that had been updated annually or completed with Guardian A1; therefore, there is a violation established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/17/2022

Julie Elkins Date
Licensing Consultant

Approved By:

10/18/2022

Dawn N. Timm Date
Area Manager