GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 25, 2022

Vashu Patel
Hudson's Country Manor, Inc.
9842 Oakland Dr.
Portage, MI 49024

RE: License #: AL390292582
Investigation #: 2022A0581047
Hudson's Country Manor, Inc.

Dear Ms. Patel:

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 #:	AL390292582
Investigation #:	2022A0581047
Complaint Receipt Date:	08/31/2022
Investigation Initiation Date:	09/01/2022
Report Due Date:	10/30/2022
Licensee Name:	Hudson's Country Manor, Inc.
Licensee Address:	9842 Oakland Dr. Portage, MI 49024
Licensee Telephone #:	(269) 323-9752
Administrator:	Brittney Walker
Licensee Designee:	Vashu Patel
Name of Facility:	Hudson's Country Manor, Inc.
Facility Address:	9842 Oakland Dr. Portage, MI 49024
Facility Telephone #:	(269) 323-9752
Original Issuance Date:	08/29/2008
License Status:	REGULAR
Effective Date:	12/01/2021
Expiration Date:	11/30/2023
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The facility is insufficiently staffed.	No
Staff are not taking residents to medical appointments.	Yes
Staff are taking confidential resident documentation out of the facility.	Yes
A direct care staff is bringing a gun to work.	No
Direct care staff who administer medications aren't initialing or signing for medications when they're given.	Yes
There's not enough food in the facility to make meals.	No
Additional Findings	Yes

III. METHODOLOGY

08/31/2022	Special Investigation Intake 2022A0581047
08/31/2022	Referral - Recipient Rights ISK received allegations and is investigating
08/31/2022	Contact - Document Received Email from Lisa Smith, ISK RRO
09/01/2022	Special Investigation Initiated - On Site Interview with staff, licensee designee, and residents. Obtained documentation.
09/01/2022	Contact - Document Received Email from licensee designee.
09/02/2022	Contact - Document Received Email from ISK containing Portage police report #
09/09/2022	Contact - Telephone call made Interviews via MiTeams with direct care staff.
09/19/2022	Contact - Document Received Email from ISK RRO, Katlyn Johns.
09/22/2022	Contact - Document Sent Requested Portage Police report # 22-25376

09/22/2022	Contact - Document Sent Email to facility.
09/23/2022	Contact - Document Received Portage police report # 22-25376
09/27/2022	Contact - Document Received Email from licensee designee
10/13/2022	Inspection Completed-BCAL Sub. Compliance
10/18/2022	APS Referral Made via email.
10/20/2022	Contact – Document Sent Email correspondence with the licensee designee, Ms. Patel.
10/21/2022	Contact – Telephone call made Interview with assistant home manager, Ch'loe Whitley.
10/21/2022	Exit conference with licensee designee, Vashu Patel, via telephone.

ALLEGATION:

The facility is insufficiently staffed.

INVESTIGATION:

On 08/31/2022, I opened this complaint due to a referral from Integrated Services of Kalamazoo (ISK). ISK Recipient Rights Officer (RRO), Lisa Smith, stated ISK had received a Recipient Rights complaint that alleged there were 15 residents to one staff in the facility and the owners wanted to move five more residents in. The complaint alleged one staff had to cook, administer medications, collect vitals and watch the residents; which was too much for one staff to do. The complaint did not indicate any examples for how the resident's needs weren't being addressed at the facility.

On 09/01/2022, I conducted an unannounced onsite inspection, in conjunction with ISK Recipient Rights Officers (RRO), Lisa Smith and Katlyn Johns. Ms. Smith stated all 15 residents at the facility were ISK recipients, but one was in the hospital.

At the time of the inspection, there were two direct care staff working, Cierra Churchwell and Allyson Wilds. Both staff confirmed there were 14 residents at the

facility because one resident was hospitalized. Ms. Churchwell stated she was only at the facility to administer medications and provide transportation to residents for appointments. She stated she was not indicated as working on the facility's staff schedule. Ms. Churchwell did not indicate any concerns there were insufficient staff at the facility.

The facility's licensee designee, Vashu Patel, arrived shortly after the onsite investigation. Ms. Patel stated she took over as the facility's licensee designee in approximately June 2022; however, the facility's Administrator and home manager, Brittany Walker, was overseeing the day-to-day operations until only recently. Ms. Patel did not indicate any concerns or issues with the current staffing pattern, which was a minimum of one staff to 15 residents, per shift. She indicated once more staff were hired and trained or more residents were admitted then it was her intention to put an additional staff on first and second shifts. She stated currently first shift was 6:30 am until 2:30 pm, second shift was 2:30 pm until 10:30 pm and third shift was 10:30 pm until 6:30 am. Ms. Patel stated direct care staff, Ms. Churchwell, comes to the facility during the day or evening to administer medications, if new staff haven't completed their medication training, and to take residents to appointments, if needed.

Direct care staff, Allisyn Stintson, was also interviewed during the investigation. She stated none of the residents required two person assists or the assistance of a Hoyer Lift. She stated one direct care staff was sufficient for the needs of the residents.

I reviewed the September 2022 staff schedule during the inspection, which indicated one staff was working during each shift at the facility.

Resident A, C, D, E, F, G, H, I and J were all interviewed during the onsite investigation. None of the residents indicated issues with staffing or not having their care needs met because staff were not available. Additionally, all the residents interviewed stated they liked the facility. Resident B was unable to be interviewed due to tangential and delusional thoughts.

On 09/01/2022, Ms. Patel sent via email what resident records she could locate at the facility for the residents. According to my review of these records, which included reviewing each residents' assessment plans completed through Integrated Services of Kalamazoo, their Individual Plans of Service, and their *Health Care Appraisals*, there were 15 residents at the facility at the time of my onsite investigation and none of them required additional monitoring or supervision and not more than one direct care staff was needed for ambulation or with the assistance of personal care needs.

On 09/09/2022, I interviewed direct care staff, Sophia Lawrence, Margaret Clark, Irene Rugano, Latoriya "Tori" Moore, and Alexis Gordon, via MiTeams along with ISK RRO, Ms. Johns. All the staff indicated at least one staff works each shift and none of them had concerns regarding the number of staff working during each shift.

Additionally, none of the staff indicated any of the residents required increased supervision from staff or required the assistance of two staff with ambulation.

On 10/20/2022, I interviewed Ms. Patel via telephone. Ms. Patel's statement to me concerning the needs of the residents was consistent with the other staff's statements to me. Ms. Patel stated at the time of the onsite investigation, they did experience staffing issues and had only a "skeleton crew". She stated she is in the process of hiring additional staff and again it is the expectation to have two staff on for first and second shifts.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	Based on my investigation, which included reviewing facility staff schedules and interviews with direct care staff, there is one direct care staff to the minimum of 15 residents during waking hours at the facility and at least one direct care staff to 15 residents during sleeping hours indicating the facility has the appropriate ratio of direct care staff to residents, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff are not taking residents to medical appointments.

INVESTIGATION:

The complaint alleged direct care staff are supposed to be taking residents to appointments but have not been.

Direct care staff, Ms. Churchwell, stated she assists residents with all their medical appointments and direct care staff, Ms. Stintson, stated she's driven residents to their appointments as well. Ms. Stintson also stated other direct care staff specifically come to the facility to transport residents to their appointments.

Ms. Lawrence and Ms. Rugano stated they had no knowledge of residents not going to appointments because they only work third shift when appointments are not scheduled.

Ms. Clark stated she had been working at the facility when resident's case managers came to the facility inquiring about why residents had not attended medical appointments; however, she was unable to recall whose case managers came to the facility.

Ms. Moore stated none of the residents indicated to her they weren't attending appointments. She stated most appointments are made during first shift when there are two direct care staff working with the one direct care staff transporting for the resident's appointments.

Ms. Gordon stated residents missed multiple medical appointments during the last several months due to the facility previous managers "not doing their job." She could not recall the specific resident(s) but indicated missed appointments included a pulmonary and cardiologist appointment. She stated she knew appointments were being missed because she would text message the previous management to confirm the resident's appointments, but then the residents would never be picked for the appointment.

Of the residents interviewed, only Resident C could recall missing an appointment; however, he was unable to recall what appointment was missed and when it was supposed to occur.

Ms. Patel stated Ms. Walker had reported to her she was taking residents to appointments, but she later discovered this was not occurring as direct care staff reported to Ms. Patel residents were not going to their scheduled appointments. Ms. Patel stated Ms. Churchwell since took over scheduling resident appointments. She stated Ms. Churchwell was able to get residents caught up on their appointments and provides transportation.

At the time of the onsite investigation, Ms. Patel was unable to locate any documentation pertaining to resident's attending medical appointments. Additionally, there were no available *Resident Care Agreements* available for review for any of the residents during the onsite investigation. Ms. Patel stated Ms. Walker took resident documentation to her personal home and had not returned it.

On 10/21/2022, Ms. Patel provided documentation from resident medical appointments for September and October confirming residents were taken to medical and psychiatric appointments.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.** **(b) A description of services to be provided and the fee for the service.** **(c) A description of additional costs in addition to the basic fee that is charged.** **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.** **(e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission.** **(f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule.** **(g) An agreement by the resident to follow the house rules that are provided to him or her.** **(h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident.** **(i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures.** **(j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.15315.** **(k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met.** **(l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.**

ANALYSIS:	Based on the licensee designee, Vashu Patel's, own acknowledgement, as well as, direct care staff, Alexis Gordon's statement, residents were not transported to medical appointments for an undetermined length of time, prior to September 2022, while the facility's former home manager, Brittany Walker, was working. Additionally, there were no *Resident Care Agreements* available for review for any of the residents in the facility, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff are taking confidential resident documentation out of the facility.

INVESTIGATION:

The complaint alleged direct care staff were keeping their notes on residents at their personal homes. The complaint provided no additional information regarding confidential resident documentation.

Ms. Patel stated that due to the Covid-19 pandemic, the facility's Administrator and home manager, Brittany Walker, was allowed to work from home using the facility laptop. Ms. Patel stated Ms. Walker went off work for an extended period of time in August 2022 and when she did not return, Ms. Patel stated she attempted to contact Ms. Walker to terminate her employment, but Ms. Walker was unresponsive.

Ms. Patel stated she has attempted to contact Ms. Walker requesting she return the facility laptop and resident records; however, despite Ms. Patel's attempts to contact her Ms. Walker refused to return the items. Subsequently, Ms. Patel stated the facility's resident paper records were disorganized and missing pertinent information.

Ms. Patel stated she was filing a police report to obtain the laptop and records from Ms. Walker's home and on 09/07/2022, Ms. Patel stated she was able to recover the laptop from Ms. Walker. I reviewed Portage Police report # 22-25376; however, there was no additional information in the report relating to the resident records being held at Ms. Walker's personal residence.

Direct care staff, Sophia Lawrence, stated Ms. Walker and the facility's assistance home manager, Rachel Armentrout, would occasionally come to the facility on 3rd shift and would take crates and bags of folders and paperwork home with them. She stated she did not know what they were doing.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(q) The right to confidentiality of records as stated in section 12(3) of the act.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based on my investigation, which included interviews with facility staff, the licensee designee, Vashu Patel, and my review of Portage police report # 22-25376, the facility's former Administrator and home manager, Brittney Walker, took the facility's laptop home with her, which allowed unrestricted access to resident records. Additionally, Ms. Walker took resident paper records to her personal residence for an unknown length of time. The computer and some of the documents were later returned to the licensee designee, Ms. Patel, with the assistance of the Portage police department. Consequently, the licensee did not adequately safeguard resident documentation to keep the records confidential, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

A direct care staff is bringing a gun to work.

INVESTIGATION:

The complaint alleged firearms are not allowed in the home, but direct care staff, Sophia Lawrence, is bringing a handgun to the facility and keeping it in her handbag. The complaint provided no additional information.

Ms. Patel denied being aware of Ms. Lawrence bringing a gun to the facility and storing it in her handbag. She stated nothing like the allegations had been brought to her attention.

Direct care staff, Allyson Stintson, denied having any knowledge of Ms. Lawrence bringing a gun to work or having any concerns of Ms. Lawrence having a gun.

Integrated Services of Kalamazoo RRO, Ms. Johns, interviewed nine residents, Resident A, C, D, E, F, G, H, I, and J during the onsite investigation; however, none of the residents indicated any kind of concerns for their safety while residing in the facility. Additionally, none of the residents indicated concerns any direct care staff members were bringing guns or weapons to the facility.

On 09/09/2022, in conjunction with ISK RRO, Ms. Johns, we interviewed five direct care staff via MiTeams. These staff included Sophia Lawrence, Margaret Clark, Irene Rugano, Latoriya "Tori" Moore, and Alexis Gordon. Ms. Lawrence denied ever bringing a gun to work. Both Ms. Moore and Ms. Gordon denied having concerns with any staff, including Ms. Lawrence, bringing a gun to work. They both denied any safety issues with staff.

Neither Ms. Clark nor Ms. Rugano had any direct knowledge about Ms. Lawrence bringing a gun to the facility. Both stated they had never seen a gun in the facility. Ms. Clark indicated she heard from a former staff that Ms. Lawrence was bringing a gun to the facility and Ms. Rugano stated she heard from Ms. Clark about Ms. Lawrence bringing a gun to work but neither had ever seen a gun at work.

APPLICABLE RULE	
R 400.15305	**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, there is no evidence establishing direct care staff, Sophia Lawrence, brought or is bringing a gun or other weapon to the facility while she works 3rd shift. Nine residents were interviewed and none of them expressed any concerns with Ms. Lawrence having a gun. Additionally, my interviews with staff indicated none of them had seen Ms. Lawrence with a gun and had only heard about it through rumors.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Direct care staff who administer medications are not initialing or signing for medications when given.

INVESTIGATION:

The complaint alleged direct care staff, Sophia Lawrence, asks first shift staff to sign for medications she administers during third shift. The complaint further alleged it was unknown if medications were even being passed during third shift because residents are asleep and direct care staff complain it's too difficult to wake residents up to pass their medications.

Ms. Churchwell confirmed she administers medications to residents if staff are not trained on administering medication.

Ms. Stintson stated medications are administered to residents, as prescribed. She stated she had no concerns regarding resident medications and denied knowing if staff were asking other staff to initial medications for them.

Ms. Lawrence, who only works third shift, stated Resident O is the only resident who requires a medication during third shift, which is at 6 am. She stated Resident O is difficult to awaken at 6 am; therefore, Ms. Lawrence has asked first shift staff to administer Resident O's Levothryoxine sodium 150 mg, at 6:30 am when they arrive. She stated Resident O receives her Leveothryoxine sodium, but sometimes it does not occur until 6:30 am. Ms. Lawrence stated Resident O can be difficult to wake up at 6 am, which is why 1st shift staff may have to administer it to her. Ms. Lawrence denied passing any resident's medication, not initialing that it was passed, and then asking a first shift staff to initial it was passed by her. She stated she only initials for the medications she passes.

Both Ms. Clark and Ms. Rugano's statements to me were consistent with the allegations. They both stated Resident P requires medication at 6 am during third shift. Additionally, Ms. Rugano indicated Ms. Lawrence has asked Ms. Churchwell to initial for Ms. Lawrence administering Resident P's medications because Ms. Lawrence has stated she's "too busy cleaning to sign for meds."

Neither Ms. Moore nor Ms. Gordon had any concerns relating to resident medication. They both stated residents receive their medications, as prescribed. Additionally, they both denied any concerns staff were initialing for other staff administering medication.

Upon review of the facility's electronic Medication Administration Records (eMARs), I determined Resident O was the only resident who receives a medication during third shift at 6 am every day, which is Levothyroxine Sodium 150 mcg. The medication was initialed by direct care staff each day indicating the medication was administered to her, as ordered.

I reviewed the facility's August 2022 staff schedule and determined either the third or first shift direct care staff person always administered Resident O's Levothyroxine sodium medication, except for the following days:

- On 08/09/2022, direct care staff, Cierra Churchwell, administered Resident O's Levothyroxine Sodium 150 mcg; however, she was not indicated as working on the staff schedule.

- On 08/16/2022, direct care staff, Margaret Clark, administered Resident O's medication; however, she was not indicated as working on the staff schedule.

- On 08/18/2022, direct care staff Cierra Churchwell, administered Resident O's medication; however, she was not indicated as working on the staff schedule.

- On 08/29/2022, direct care staff, Cierra Churchwell, administered Resident O's medication; however, she was not indicated as working on the staff schedule.

On 10/21/2022, I interviewed assistant home manager, Ch'loe Whitley. She stated Resident O's Levothyroxine sodium could be administered an hour before or an hour after it's scheduled time of 6 am. She stated due to Resident O being a heavy sleeper first shift staff may pass her medication if third shift staff had a difficult time waking her up.

On 10/24/2022, I received email correspondence from ISK RRO, Ms. Johns, stating ISK's training department, who provides medication training to the facility, provided her with the following direction regarding the timeframe in which medications can be administered:

> Non-time critical scheduled medications are those for which a longer or shorter interval of time since the prior dose does not significantly change the medication's therapeutic effect or otherwise cause harm. For such medications greater flexibility in the timing of their administration is permissible. Specifically:
>
> - Medications prescribed for daily, weekly or monthly administration may be within 2 hours before or after the scheduled dosing time, for a total window that does not exceed 4 hours.
> - Medications prescribed more frequently than daily but no more frequently than every 4 hours may be administered within 1 hour before or after the scheduled dosing time, for a total window that does not exceed 2 hours

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4)(b) Complete an individual medication log that contains all of the following information: **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Based on my investigation, I cannot establish if staff who are administering Resident O's Levothyroxine sodium mcg medication, which is to be administered once daily at 6 am, are not initialing when the medication is given to her. Based on my investigation, the facility's staff schedule is not updated to reflect the actual staff who are working and/or coming into the facility to specifically administer medication; therefore, staff initials on the eMAR do not match with the first or third shift staff working on four separate occasions in August. Additionally, my interviews with direct care staff are consistent with my findings as well with staff indicating Resident O often sleeps through 6 am, but her medication can still be administered within at least an hour before or after 6 am. This medication procedure was confirmed with Integrated Services of Kalamazoo, which is the agency that provides medication training to the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There is not enough food in the facility to make meals.

INVESTIGATION:

The complaint alleged there was not food in the facility to cook for residents. The complaint alleged residents eat sandwiches because there's not enough food for the facility's planned menu. Additionally, the complaint alleged residents will sometimes go to the gas station to buy noodles to make themselves.

During my unannounced onsite inspection, I observed an abundance of food in the facility refrigerator, freezer, and cupboards. I saw a variety of items including meats, vegetables, and fruit.

Resident A, D, F, G, H, I, and J indicated they receive three meals per day and did not indicate any concerns or issues with the food. Resident C stated he did not like the food and wanted other types of food; however, he was unable to clarify what food he did not like and what food he wanted.

Direct care staff, Ms. Churchwell, Ms. Stintson, Ms. Lawrence, and Ms. Moore indicated there was food available to residents and 3 meals were provided daily. Ms. Stintson and Ms. Lawrence indicated while food was available in the facility it did not always coincide with the facility's weekly menu. They indicated if they put a meal together that was not on the menu then the menu was not updated to reflect this change. All the staff interviewed indicated if residents did not like what was served then a sandwich was available to eat, but a sandwich was not the primary item served to residents.

APPLICABLE RULE	
R 400.15313	**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:	Based on my investigation, there is no evidence the facility does not have sufficient food available to residents or that 3 regular nutritious meals aren't being served daily. I observed food during my inspection and multiple direct care staff all stated there was food available to the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.

ANALYSIS:	Facility staff are not updating the facility's menu to reflect changes or substitutions that are being made.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

Ms. Patel indicated during the onsite inspection that the facility's Administrator, Brittany Walker, had hired direct care staff in the last two months; however, Ms. Patel had not seen any staff documentation due to Ms. Walker being disorganized and keeping documentation at her personal residence.

Ms. Patel provided me with the facility's Workforce Background Check (WBC) application report confirming which staff had fingerprints completed as of 09/01/2022. Direct care staff members, Irene Rugano, Latoriya "Tori" Moore, and Alexis Gordon, all whom stated they were direct care staff at the facility; however, were not listed on the WBC application report indicating they did not have fingerprints completed through the WBC prior to assuming direct care staff duties at the facility.

APPLICABLE RULE	
Act 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall

	provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	The licensee designee, Vashu Patel, provided Michigan's Workforce Background Check application report, which was generated on 09/01/2022; however, multiple direct care staff members, including Irene Rugano, Latoriya "Tori" Moore, and Alexis Gordon, were not listed on the report indicating they did not have fingerprints completed through the WBC prior to assuming direct care staff duties at the facility, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(a) Name, address, telephone number, and social security number.** **(b) The professional or vocational license, certification, or registration number, if applicable.** **(c) A copy of the employee's driver license if a direct care staff member or employee provides transportation to residents.** **(d) Verification of the age requirement.** **(e) Verification of experience, education, and training.**

	(f) Verification of reference checks. **(g) Beginning and ending dates of employment.** **(h) Medical information, as required.** **(i) Required verification of the receipt of personnel policies and job descriptions.**
ANALYSIS:	The licensee designee, Vashu Patel, was unable to locate staff files for any current staff hired within the last two months.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

In my review of the facility's September staff schedule, interviews with direct care staff, and the licensee designee, direct care staff, Ciera Churchwell, comes into the facility specifically to administer medications to residents and transport residents for appointments; however, the schedules does not reflect these work assignments. Further, Ms. Churchwell stated the direct care staff member working during the times she comes in to administer medications is not trained in medication administration.

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	Direct care staff, Cierra Churchwell, comes into the facility specifically to administer resident medication and transport residents to appointments; however, these work assignments aren't reflected on the staff schedule, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15206	**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:	Direct care staff, Cierra Churchwell, comes into the facility specifically to administer resident medication as the direct care staff member working is not training in medication administration and thus cannot meet this resident personal care need.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my investigation, I requested to review the facility's *Resident Register;* however, Ms. Patel was unable to locate one.

APPLICABLE RULE	
R 400.15209	**Home records generally.**
	(1) A licensee shall keep, maintain, and make available for department review, all the following home records: **(e) A resident register.**
ANALYSIS:	There was no resident register available for review during my onsite inspection on 09/01/2022, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my onsite inspection, I requested Ms. Patel provide me with all the resident records for my review; however, Ms. Patel stated she was still attempting to organize resident files as Administrator and home manager, Brittany Walker, had taken resident documentation to her personal residence and the remaining resident records in the facility were scattered in different places with many items missing. Ms. Patel stated she had updated community mental health paperwork for residents, some assessments and *Health Care Appraisals*, but was unable to locate all the required AFC paperwork.

APPLICABLE RULE	
R 400.15316	**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: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number, date of birth, case number, and marital status.** **(iii) Former address.** **(iv) Name, address, and telephone number of the next of kin or the designated representative.** **(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.** **(ix) Resident's religious preference information.** **(b) Date of admission.** **(c) Date of discharge and the place to which the resident was discharged.** **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.** **(e) Resident care agreement.** **(f) Assessment plan.** **(g) Weight record.** **(h) Incident reports and accident records.** **(i) Resident funds and valuables record and resident refund agreement.** **(j) Resident grievances and complaints.**

ANALYSIS:	Resident records, in all their entirety, were not available for review during my 09/01/2022 onsite investigation as required. The licensee designee, Vashu Patel, indicated the facility's previous home manager and Administrator, Brittany Walker, hadn't been keeping up to date on resident records.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/21/2022, I conducted the exit conference with the licensee designee, Vashu Patel, via telephone. Ms. Patel acknowledged my findings. She indicated she immediately corrected the issues that were brought to her attention during the 09/01/2022 onsite inspection. She stated resident files were put together, menus are being updated to reflect substitutions/changes, and staff have been fingerprinted.

IV. RECOMMENDATION

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

Cathy Cushman

10/24/2022

Cathy Cushman — Date
Licensing Consultant

Approved By:

Dawn Timm

10/25/2022

Dawn N. Timm — Date
Area Manager