GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 31, 2023

Karon Lee
Michigan Community Services, Inc.
PO Box 317
Swartz Creek, MI 48473

RE: License #: AS090295290
Investigation #: 2023A0871017
Beechwood

Dear Ms. Lee:

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) 643-7906.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090295290
Investigation #:	2023A0871017
Complaint Receipt Date:	01/25/2023
Investigation Initiation Date:	01/26/2023
Report Due Date:	03/26/2023
Licensee Name:	Michigan Community Services, Inc.
Licensee Address:	5239 Morrish Rd. Swartz Creek, MI 48473
Licensee Telephone #:	(810) 635-4407
Administrator:	Karon Keilia Lee
Licensee Designee:	Karon Keilia Lee
Name of Facility:	Beechwood
Facility Address:	3648 Bangor Road Bay City, MI 48706
Facility Telephone #:	(989) 667-3682
Original Issuance Date:	05/07/2008
License **Status:**	REGULAR
Effective Date:	11/12/2022
Expiration Date:	11/11/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff Jenny LaFave was sleeping while caring for the residents.	Yes

III. METHODOLOGY

01/25/2023	Special Investigation Intake 2023A0871017
01/25/2023	APS Referral Denied to Bay County MDHHS
01/26/2023	Special Investigation Initiated - On Site Along with Recipient Rights Officer Jeff Wells, interviewed Resident A, Staff Jennifer LaFave, and Home Manager Anita Willette
01/27/2023	Exit Conference Telephone exit conference with Executive Director Greg Kirkland
01/27/2023	Inspection Completed-BCAL Sub. Compliance
01/30/2023	Contact-Document Received Received policies manual regarding no sleeping from Mr. Kirkland.

ALLEGATION:

Staff Jenny LaFave was sleeping while caring for the residents.

INVESTIGATION:

On January 26, 2023, Recipient Rights Officer Jeff Wells and I conducted an onsite investigation and interviewed Resident A. Resident A stated she was "putting my daughter to bed" and saw the staff member sleeping. Resident A could not remember the staff's name that was sleeping. Resident A said she "had her eyes closed" but she was not snoring. Resident A indicated she had to go to the bathroom and when she came back, she wanted the staff to turn off the lights for her, but she was sleeping. Resident A said she tapped the foot stool to try to wake the staff member up. Resident A said she tried "three to four times to try to wake her up" but never woke up to turn off her light. Resident A said she called her name two times, and she did not wake up. Resident A said no other residents were up at that time and the staff member never did wake up. Resident A still could not remember her name and said she could not describe what she looked like.

Mr. Wells and I then interviewed Staff Jenny LaFave. Ms. LaFave indicated she has worked in the facility for about three months, and her shift is 10 pm to 6 am. Ms. LaFave was asked if she knew why she was there today and she replied, "because I fell asleep." Ms. LaFave stated she did fall asleep for a few minutes, at about midnight. Ms. LaFave indicated her doctor put her on several different medications to treat a medical condition and that made her sleepy. Ms. LaFave stated she was feeling better, so she came back to work. Ms. LaFave reported Resident A likes you to watch her dance before she goes to bed so "I sat in the recliner." Ms. LaFave said she only slept for "maybe five minutes" and thinks that it was the medications that made her so tired. Ms. LaFave indicated she is no longer on the medications and feels a lot better. Ms. LaFave said that was the only time that she has fallen asleep while working.

On January 26, 2023, Mr. Wells and I then interviewed Home Manager Anita Willette. Manager Willette said Resident A does have a hard time with her short-term memory, but she can remember what happened "three to four years ago." Manager Willette indicated there is only one staff per shift as there are four residents in the facility, and they are all pretty independent. Manager Willette said she has never heard of Ms. LaFave sleeping while on shift.

On January 27, 2023, I conducted a telephone exit conference with Executive Director Greg Kirkland, who is handling licensing issues in the absence of Keilia Karon. I advised Mr. Kirkland that this is a rule violation and he stated they will review Ms. LaFave's record to determine what action to take.

On January 30, 2023, Mr. Kirkland emailed me a copy of Michigan Community Services, Inc. Personnel Policies Manual that is provided to all staff. Indicated in Section 38 of the manual, it states "Sleeping on duty is strictly prohibited."

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:	Resident A said she saw Staff Jennifer LaFave sleeping and tried to wake her up. Ms. LaFave admitted to falling asleep for about five minutes while on shift. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

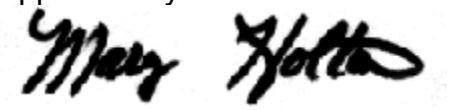
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care small group home remain unchanged (capacity 1-6).

01/30/2023

Kathryn A. Huber — Date
Licensing Consultant

Approved By:



01/31/2023

Mary E. Holton — Date
Area Manager