GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 2, 2023

Tamika Ruth
514 S. Ortman Street
Saginaw, MI 48601

RE: License #: AS730377214
Investigation #: 2023A0582023
Annie's Home Care

Dear Ms. Ruth:

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. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

Derrick Britton, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-9721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730377214
Investigation #:	2023A0582023
Complaint Receipt Date:	01/13/2023
Investigation Initiation Date:	01/18/2023
Report Due Date:	03/14/2023
Licensee Name:	Tamika Ruth
Licensee Address:	514 S. Ortman Street Saginaw, MI 48601
Licensee Telephone #:	(989) 714-1271
Administrator:	Tamika Ruth
Licensee:	Tamika Ruth
Name of Facility:	Annie's Home Care
Facility Address:	514 N. Warren Avenue Saginaw, MI 48607
Facility Telephone #:	(989) 401-7835
Original Issuance Date:	11/16/2015
License Status:	REGULAR
Effective Date:	05/16/2022
Expiration Date:	05/15/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATIONS

	Violation Established?
On 01/16/2023, Resident A was found at the home in clothes that were not his and smelling of urine. He was found to have on two urine-soaked briefs. Resident A had new skin tears on his shins. Staff did not know when the last time Resident A had eaten or was given fluids.	Yes
On 01/16/2023, Resident A's bed had no sheets.	No
On 01/16/2023, staff could not provide a Medication Administration Record to Guardian A and did not know when the last time Resident A's medications were administered.	No
Additional Findings	Yes

III. METHODOLOGY

01/13/2023	Special Investigation Intake 2023A0582023
01/13/2023	APS Referral Denied APS Referral
01/18/2023	Special Investigation Initiated - On Site
01/18/2023	Contact - Face to Face With Resident A and Guardian A
01/19/2023	Contact - Document Received Assessment Plan and Discharge Summary for Resident A
02/16/2023	Contact - Telephone call made From Maria Blackman, Physical Therapist, first State Home Health
02/17/2023	Contact - Telephone call made From Cassandra Herweyer, Registered Nurse, First State Home Health
02/21/2023	Contact - Document Received Medication Log from Tamika Ruth, Licensee
02/28/2023	Contact - Telephone call received

	With Melissa Johnson, Social Worker, Covenant Medical Center
03/01/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

On 01/16/2023, Resident A was found at the home in clothes that were not his and smelling of urine. He was found to have on two urine-soaked briefs. Resident A had new skin tears on his shins. Staff did not know when the last time Resident A had eaten or was given fluids.

INVESTIGATION:

I received this denied Adult Protective Services referral on 01/13/2023. On 01/18/2023, I conducted an unannounced, onsite inspection at the facility. I interviewed Direct Care Worker Terry Bulger. Mr. Bulger stated that Resident A was removed from the home by Guardian A on Monday, 01/16/2023. Mr. Bulger stated that he did not know if Resident A was double briefed before he was removed from the home by Guardian A. Mr. Bulger stated that he was not aware if Resident A had skin tears on his shins. Mr. Bulger stated that Resident A required assistance with feeding. Mr. Bulger stated that he tried to feed Resident A while he was in the home, but he would not eat all the time. I checked the home and found that there was adequate food for meals.

On 01/18/2023, I interviewed Tamika Ruth, Licensee. Ms. Ruth stated that Resident A was admitted to the home on Friday, 01/13/2023 after being hospitalized at Saginaw Covenant Medical Center for 95 days. Ms. Ruth stated that Resident A was brought to the facility from the hospital with no clothes and no briefs. Ms. Ruth stated that she would send Resident A's *Assessment Plan*. Ms. Ruth denied that Resident A was double briefed.

On 01/18/2023, I visited Resident A at Covenant Medical Center, where he was in bed. He was not able to be understood when speaking. I interviewed Guardian A, who was sitting with Resident A at the time. Guardian A stated that Resident A has kidney failure and severe dementia. Guardian A stated that she removed Resident A from the home on 01/16/2023 due to the lack of care he was receiving. Guardian A stated that Resident A was soaked in urine, had on two pull-ups, had a strong smell of urine, and skin tears on his shins when she arrived at the home. Guardian A stated that Maria Blackman, Physical Therapist, arrived at the home at the same time she went on 01/16/2023, and could verify his condition. Guardian A stated that Direct Care Worker Terry Bulger was at the home when she removed Resident A, and he did not have answers to any questions she asked. Guardian A stated that Mr. Bulger did not know when the last time Resident A had eaten or drank fluids. Guardian A stated that it was the hospital's decision to place Resident A at the

home, and she did not sign any paperwork for him to be admitted to the home. Guardian A stated that she was granted guardianship on 01/10/2023 before Resident A's discharge from the hospital and acceptance at the AFC home. Guardian A provided court documentation to show that she was granted guardianship on 01/10/2023. Guardian A stated that when she found out where Resident A was being discharged to from the hospital, she asked a relative to drop off clothes for him. Guardian A stated that she does not know if the relative dropped off clothes for Resident A.

I reviewed a text that Guardian A received from Cassandra Herweyer, Registered Nurse, First State Home Health. The text documented that the home staff were not monitoring Resident A's blood sugar, and the owner did not know much about Resident A because he had "just got there." Ms. Herweyer's text documented that she would not have attempted to walk Resident A, as he "couldn't even sit in the chair without being tipsy" and would doze in and out and she would have to grab him.

On 01/19/2023, I received and reviewed Resident A's *Assessment Plan*, dated 01/14/2023 which documented that he has "severe dementia," "cannot talk well," "needs a standby assist" for mobility, "has to be fed-does not pick up silverware to feed self," needs assistance with dressing, and needs assistance for toileting since he "will go and have no understanding that he has gone on himself." Other information/special instructions documented that "[Resident A] is a 1-on-1 person, he has needs of help with everything." I received and reviewed the Discharge Summary for Resident A from Covenant Hospital, which documented that while hospitalized, Resident A was placed on "dysphagia advanced diet with one-to one supervision. Additionally, the Discharge Summary documented the following:

> Admit Date: 10/10/2022
> Discharge Date: 01/13/2023
> Discharge Diagnoses: Severe dementia, Acute kidney injury present on admission-resolved, Rhabdomyolysis present on admission-improved, atrial fibrillation with controlled ventricular rate-on Cardizem and Eliquis, Thrombosed left superior ophthalmic vein on anticoagulation, severe protein calorie malnutrition due to poor oral intake, sepsis present on admission-resolved, chronic normocytic normochromic anemia, Type 2 diabetes, elevated lipase due to Seroquel-improved with discontinuation of medication, lacks decision-making capacity.

On 02/16/2023, I interviewed Maria Blackman, Physical Therapist from First State Home Health. Ms. Blackman stated that she went to the home on 01/16/2023 to begin initial services for Resident A. Ms. Blackman stated that she arrived at the home at the same time as Guardian A. Ms. Blackman stated that they were greeted by Direct Care Worker Terry Bulger. Ms. Blackman stated that when they arrived, Resident A was sitting on the edge of the bed and almost toppling over. Ms. Blackman stated that Resident A had an electrical cord tangled around his feet,

which she had to unwrap. Ms. Blackman stated that Resident A had fresh new skin tears on legs, which were not there the day prior when he was seen by Cassandra Herweyer, Registered Nurse from First State Home Health. Ms. Blackman stated that she confirmed this with Nurse Herweyer. Ms. Blackman stated that Resident A's clothes were completely saturated in a pool of urine and was double briefed. Ms. Blackman stated that she got Resident A up to change him and was trying to find new briefs. Ms. Blackman stated that she looked in the night stand next to Resident A's bed and found dirty "disgusting" briefs that were saturated with urine. Ms. Blackman stated that the Licensee Designee, Tamika Ruth, commented to her afterwards that Resident A was up and walking while he was at the home, which she found difficult to believe. Ms. Blackman stated that Ms. Ruth told her that Resident A had not eaten or drank in the last few days, and when staff tried to feed him, Resident A refused to eat.

On 02/17/2023, I interviewed Cassandra Herweyer, Registered Nurse, First State Home Health. Ms. Herweyer stated that she began home care with Resident A on 01/15/2023. Ms. Herweyer stated that when she arrived at the home, Resident A was sitting in a chair, and she had to catch him three or four times from falling out of the chair. Ms. Herweyer stated that Resident A did not have any wounds on his legs when she initially visited him but learned that he had skin tears on his legs when he was removed from the home the next day. Ms. Herweyer theorized that Resident A possibly received wounds from falling and staff not watching him appropriately.

On 02/28/2023, I interviewed Melissa Johnson, Social Worker from Covenant Medical Center. Ms. Johnson stated that Resident A was a patient at the hospital for 70-90 days. Ms. Johnson stated that the decision to discharge Resident A from the hospital went beyond her, as there was a team of specialist who were involved in his hospital care and discharge decision. Ms. Johnson stated that she did not think Resident A was appropriate for going to an AFC home, but a supervisor made the decision in conjunction with the AFC homeowner. Ms. Johnson stated that Resident A needed a lot of care and guidance, and the AFC homeowner initially declined to accept him. Ms. Johnson stated that once her leadership became involved, they convinced the AFC homeowner that they could accommodate Resident A. Ms. Johnson stated that Guardian A was told that discharge to the AFC home was the only option. Ms. Johnson stated that Guardian A was agreeable to the discharge because she felt like she did not have another option. Ms. Johnson stated that neither she nor Guardian A felt comfortable with Resident A being discharge to an AFC home at that time.

On 03/01/2023, I interviewed Tamika Ruth, Licensee. Ms. Ruth denied that Resident A was double briefed. Ms. Ruth stated that during his short time at the home, Resident A, who had to be fed, did not eat often. Ms. Ruth stated that there was another resident in the room shared with Resident A who would put soiled briefs in the nightstand.

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:	Based on interviews and a review of documents, Resident A was admitted to the home on 01/13/2023 and removed from the home by Guardian A on 01/16/2023. According to his *Assessment Plan*, Resident A required assistance with feeding, toileting, mobility, dressing, and "is a 1-on-1 person." Resident A was dressed in clothing that was not his, as he came to the home from the hospital with none of his own clothes or briefs. Guardian A and Ms. Blackman confirmed that on 01/16/2023, Resident A was found to be double briefed. Additionally, he was found with an electrical cord tangled around his feet and skin tears on his shins. Appropriate supervision and personal care were not being provided to Resident A in accordance with his Assessment Plan, which called for 1-on-1 supervision and assistance with toileting.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 01/16/2023, Resident A's bed had no sheets.

INVESTIGATION:

I received this complaint on 01/13/2023. On 01/18/2023, I conducted an unannounced, onsite inspection at the facility. I interviewed Direct Care Worker Terry Bulger. Mr. Bulger stated that Resident A was removed from the home by Guardian A on Monday, 01/16/2023. I observed Resident A's bed, which was still at the facility and belonged to him, according to Mr. Bulger. There was a sheet on the bed at the time of the visit. I observed that there were bed sheets in the home.

On 01/18/2023, I visited Resident A at Covenant Medical Center, where he was in bed. He was not able to be understood when speaking. I interviewed Guardian A, who was sitting with Resident A at the time. Guardian A stated that there were no sheets on Resident A's bed when she removed him from the home on 01/16/2023. Guardian A stated that Maria Blackman, physical therapist, could confirm that Resident A's bed had no sheets at the time they went to the home on 01/16/2023. Guardian A provided a picture of the bed, which showed no sheets.

On 01/19/2023, I received and reviewed Resident A's *Assessment Plan*, dated 01/14/2023 which documented that he needs assistance for toileting since he "will go and have no understanding that he has gone on himself."

On 02/16/2023, I interviewed Maria Blackman, Physical Therapist from First State Home Health. Ms. Blackman stated that Resident A's bed had no sheets or blanket when she went to the home on 01/16/2023.

On 02/17/2023, I interviewed Cassandra Herweyer, Registered Nurse, First State Home Health. Ms. Herweyer stated that Resident A's bed did not have sheets on it when she visited the home on 01/15/2023.

APPLICABLE RULE	
R 400.14411	**Linens.**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillowcase, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.
ANALYSIS:	Based on interviews and personal observation, Resident A did not have a sheet on it when observed by Guardian A, Ms. Blackman, and Ms. Herweyer. While Resident A was removed from the home before my onsite inspection, the home did have adequate bedding present. Due to Resident A having toileting issues and wearing briefs, it is unknown if his sheets were being soiled and being washed during visits by Guardian A, Ms. Blackman, and Ms. Herweyer.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

On 01/16/2023, staff could not provide a Medication Administration Record to Guardian A and did not know when the last time Resident A's medications were administered.

INVESTIGATION:

I received this complaint on 01/13/2023. On 01/18/2023, I conducted an unannounced, onsite inspection at the facility. I interviewed Direct Care Worker Terry Bulger. Mr. Bulger stated that Resident A was removed from the home by Guardian A on Monday, 01/16/2023. I reviewed the "Medication Profile" for Resident

A from First State Home Health and Hospice Care, which documented three medications for Resident A. Mr. Bulger stated that Resident A’s *Medication Administration Record* was with Tamika Ruth, Licensee.

On 01/18/2023, I visited Resident A at Covenant Medical Center, where he was in bed. He was not able to be understood when speaking. I interviewed Guardian A, who was sitting with Resident A at the time. Guardian A stated that when she removed Resident A from the home, she was only given three out of four medications that he should have been taking. Guardian A stated that Resident A was missing a medication for A-fib.

On 01/19/2023, I received and reviewed Resident A’s *Assessment Plan*, which documented that Resident A had to take medications in food, and he does not follow directions for taking his medications. The *Assessment Plan* documented that Resident A was prescribed four medications: apixaban, diltiazem, mirtazapine, and olanzapine.

On 02/16/2023, I interviewed Maria Blackman, physical therapist from First State Home Health. Ms. Blackman stated that she went to the home on 01/16/2023 to begin initial services for Resident A. Ms. Ms. Blackman stated that she arrived at the home at the same time as Guardian A. Ms. Blackman stated that when staff was asked for medications, Direct Care Worker Terry Bulger provided them with a couple of bottles. Ms. Blackman stated that Guardian A had a list of medications that was sent with Resident A to the home, and he was missing one of the medications.

On 02/17/2023, I interviewed Cassandra Herweyer, Registered Nurse, First State Home Health. Ms. Herweyer stated that when she visited the home on 01/15/2023, she asked for a medication list. Ms. Herweyer stated that staff told her that Resident A was a “new patient,” he had no idea where his medications list was. Ms. Herweyer stated that there were only two medications that staff could find when she was at the facility. Ms. Herweyer stated that she spoke with Tamika Ruth, Licensee, who stated that she was “working on” getting his medications together, as he was not sent with a medication list. Ms. Herweyer stated that the list she had showed that Resident A should have four prescribed medications. Ms. Herweyer stated that Ms. Ruth informed her that Resident A was sent to them with nothing from the hospital.

On 02/21/2023, I received a medication log for Resident A from Tamika Ruth, Licensee Designee. The log documented that Resident A was prescribed and administered four different medications from 01/13/2023 through 01/16/2023. Medications were documented as administered at 7 AM and 7 PM and put in pudding.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(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 interviews and a review of the Medication Administration Record, there is no evidence to suggest that a medication log was not completed for Resident A while he was in the home. There seemed to be a discrepancy as to the number of medications Resident A was sent with from the hospital and when he was removed from the home. Additionally, the Medication Profile from First State Home Health listed three medications with one medication taken twice daily and two medications taken at bedtime.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 01/18/2023, I interviewed Guardian A. Guardian A stated that she did not sign any documents to have Resident A admitted to the home. Guardian A stated that she did not want Resident A to go the home because she did not have time to visit. Guardian A stated that the hospital staff made the decision to discharge Resident A and place him in the home. Guardian A provided court documents to verify that she was granted guardianship on 01/10/2023.

On 01/19/2023 and 01/20/2023, I received and reviewed the *Assessment Plan* and *AFC Resident Care Agreement* from Tamika Ruth, Licensee. Neither of these documents, dated 01/14/2023, had a signature for Resident A's Designated Representative.

APPLICABLE RULE	
R 400.14301	**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 400.14315.** **(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 a review of the document and interviews, Guardian A did not sign a *Resident Care Agreement* when Resident A was admitted on 01/13/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Based on a review of the document and interviews, Guardian A did not sign an *Assessment Plan* when Resident A was admitted on 01/13/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 02/21/2023, I asked Tamika Ruth, Licensee, to provide Resident A's Health Care Appraisal. Ms. Ruth stated that Resident A had not had a doctor in years, and she was only provided a Discharge Summary from the hospital upon his admittance to the home.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of

	an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Based on interviewing Ms. Ruth, a Health Care Appraisal was not completed for Resident A within the 90-day period before his admission to the home. Resident A's admission was not an emergency admission and did not have documented approval from Guardian A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/01/2023, I conducted an Exit Conference with Tamika Ruth, Licensee. Ms. Ruth stated that Covenant Hospital case management initially contacted her a month prior to Resident A's admission to the home. Ms. Ruth stated that she went to the hospital to observe Resident A and she initially did not think Resident A was a good fit for the home. Ms. Ruth stated that Resident A was in restraints in bed while at the hospital. Ms. Ruth stated that she later decided to admit Resident A but did not get the full story about him from the hospital. Ms. Ruth stated that she did not know that Resident A could not walk around. Ms. Ruth stated that she spoke with Guardian A before Resident A's admittance to the home, and she was agreeable to his placement but did not have time to come see the home. Ms. Ruth stated that she would provide a Corrective Action Plan for the violations discussed.

IV. RECOMMENDATION

Contingent upon an acceptable Corrective Action Plan, I recommend no change in the license status.

03/02/2023

Derrick Britton — Date
Licensing Consultant

Approved By:

03/02/2023

Mary E. Holton — Date
Area Manager