GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 18, 2023

Karon Lee
Michigan Community Services, Inc.
PO Box 317
Swartz Creek, MI 48473
N. Elms Road Afc

RE: License #: AS250072681
Investigation #: 2023A0779031

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) 643-7960.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250072681
Investigation #:	2023A0779031
Complaint Receipt Date:	03/20/2023
Investigation Initiation Date:	03/21/2023
Report Due Date:	05/19/2023
Licensee Name:	Michigan Community Services, Inc.
Licensee Address:	5239 Morrish Rd. Swartz Creek, MI 48473
Licensee Telephone #:	(810) 635-4407
Administrator:	Lena Crosson
Licensee Designee:	Karon Lee
Name of Facility:	N. Elms Road Afc
Facility Address:	11238 N Elms Clio, MI 48420
Facility Telephone #:	(810) 564-0232
Original Issuance Date:	08/03/1997
License **Status:**	REGULAR
Effective Date:	04/10/2022
Expiration Date:	04/09/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 3/15/23, Resident A was left sitting in her wheelchair in only a shirt and brief. Staff did not make attempts to cover her up.	Yes

III. METHODOLOGY

03/20/2023	Special Investigation Intake 2023A0779031
03/21/2023	Special Investigation Initiated - Telephone Interview conducted with home manager, Gayle Barylski.
03/21/2023	Contact - Telephone call made Spoke to administrator, Lena Crosson.
03/21/2023	Contact - Telephone call made Interview conducted with staff person, Tamara Richardson.
03/23/2023	Inspection Completed On-site
04/17/2023	Exit Conference Held with administrator, Lena Crosson.
04/18/2023	APS Referral Complaint was referred to APS centralized intake.

ALLEGATION:

On 3/15/23, Resident A was left sitting in her wheelchair in only a shirt and brief. Staff did not make attempts to cover her up.

INVESTIGATION:

On 3/21/23, a phone interview was conducted with home manager, Gayle Barylski, who stated that she witnessed Resident A to be seated in her wheelchair at a table located in the common area of the home. She stated that Resident A was only wearing an adult brief and a shirt. Ms. Barylski reported that staff person, Tamara Richardson, had cleaned Resident A up and then left her at the table in this condition and in sight of other residents. Ms. Barylski stated that Resident A requires full assistance from staff

and is not able to dress herself. She stated that as soon as she saw Resident A in this condition, Resident A was immediately taken and appropriately clothed.

On 3/21/23, a phone call was made to administrator, Lena Crosson, who confirmed that she was aware of this situation. She stated that she had spoken to Ms. Richardson and that Ms. Richardson did not seem to understand that leaving Resident A in the common area of the home in this condition was a dignity issue. Ms. Crosson stated that she has suspended Ms. Richardson for one day and will provide her with additional training.

On 3/21/23, a phone interview was conducted with staff person, Tamara Richardson. She admitted that she left Resident A sitting at a table in the common area of the home wearing only an adult brief and a shirt. She stated that one other male resident may have been in visual sight of Resident A during that time. Ms. Richardson reported that she thought that Resident A's shirt was long enough to cover the brief, but that Resident A's movement did expose the brief. Ms. Richardson stated that she did not understand at the time that this would violate Resident A's right to dignity, but that she understands that fact now.

On 3/23/23, an on-site inspection was conducted. Resident A was viewed to be clean and well groomed. Due to her cognitive deficiencies, Resident A was not able to be interviewed. The table where Resident A sat during the incident was viewed to be in the middle of the common area of the home. The table is in view of many other rooms of the home.

Resident A's *Assessment Plan For AFC Residents* was reviewed. It confirmed that Resident A utilizes a wheelchair and requires full assistance from staff to complete all her activities of daily living.

APPLICABLE RULE	
R 400.14304	**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: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**

ANALYSIS:	It was confirmed that on 3/15/23, Resident A was left sitting a table located in the common area of the home wearing only a shirt and an adult brief. Staff person, Tamara Richardson, had admitted that she left Resident A sitting at the table in this condition. On 3/23/23, the table that Resident A was sat at was viewed to be in the middle of the common area of the home and in view from many other rooms of the home. There was sufficient evidence found to support that Resident A's right to be treated with consideration and respect, with due recognition of personal dignity was violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/17/23, an exit conference was held with administrator, Lena Crosson. She was informed of the outcome of this investigation and that a corrective action plan is required to address the above licensing rule violation.

IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

Christopher A. Holvey

4/18/2023

_____

Christopher Holvey Date
Licensing Consultant

Approved By:

Mary E. Holton

4/18/2023

_____

Mary E. Holton Date
Area Manager