GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 21, 2023

Gregory Cheff
Harmony Manor LLC
PO Box 235
Atlas, MI 48411

RE: License #:	AL250281678
Investigation #:	2023A0123043
	Harmony Manor

Dear Mr. Cheff:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250281678
Investigation #:	2023A0123043
Complaint Receipt Date:	05/16/2023
Investigation Initiation Date:	05/17/2023
Report Due Date:	07/15/2023
Licensee Name:	Harmony Manor LLC
Licensee Address:	PO Box 235 Atlas, MI 48411
Licensee Telephone #:	(248) 568-1422
Administrator:	Gregory Cheff
Licensee Designee:	Gregory Cheff
Name of Facility:	Harmony Manor
Facility Address:	903 E Court Street Flint, MI 48503
Facility Telephone #:	(810) 762-0988
Original Issuance Date:	04/22/2008
License Status:	1ST PROVISIONAL
Effective Date:	03/24/2023
Expiration Date:	09/23/2023
Capacity:	15
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
In the last year Resident C has wandered off from the home twice and become lost. He was missing four days one of the times and he was also listed on the news. Resident C wandered off again on 05/05/23 but it is believed he returned back home. There is one staff person for 13 residents. It is believed he requires a higher level of supervision that they are not able to provide. It is believed the residents are able to enter and leave as they please at the AFC home.	Yes

III. METHODOLOGY

05/16/2023	Special Investigation Intake 2023A0123043
05/16/2023	APS Referral Information received regarding APS referral.
05/17/2023	Special Investigation Initiated - Telephone I spoke with adult protective services investigator Cynthia Badour via phone.
05/17/2023	Inspection Completed On-site I conducted an unannounced on-site at the facility with APS investigator Ms. Badour.
05/25/2023	Contact- Document Received Requested documentation received via fax from the facility.
06/07/2023	Contact - Telephone call made I spoke with Complainant 1 via phone.
06/07/2023	Contact - Telephone call made I spoke with Guardian 1 via phone.
06/12/2023	Contact- Telephone call made I spoke with Resident C's case manager via phone.
06/12/2023	Contact- Document Received A copy of Resident C's Individual Plan of Service was received via email.
06/21/2023	Exit Conference I spoke with licensee designee Gregg Cheff via phone.

ALLEGATION: In the last year Resident C has wandered off from the home twice and become lost. He was missing four days one of the times and he was also listed on the news. Resident C wandered off again on 05/05/23 but it is believed he returned back home. There is one staff person for 13 residents. It is believed he requires a higher level of supervision that they are not able to provide. It is believed the residents are able to enter and leave as they please at the AFC home.

INVESTIGATION: On 05/17/2023, I spoke with adult protective services worker Cynthia Badour via phone. Ms. Badour stated that she spoke with Guardian 1 who is working with Resident A's case manager to find him a new home because Resident C wanders. Ms. Badour stated that per Guardian 1, Resident C did not qualify for the PACE program due to his behavior (i.e., wandering).

On 05/17/2023, I conducted an unannounced on-site visit with adult protective services worker Cynthia Badour. We interviewed Resident C. Resident C stated that he goes to the store by himself and comes back to the facility. He denied going anywhere else in the community. He stated that he has left before and gotten lost, and that this has happened about three to four times. He stated that he is on top of it now because he pays attention to and from wherever he goes. He stated that one time, the police found him when he was lost, and another time he caught a ride home with strangers. Resident C denied knowing the address of the facility. He stated that he knows the building across the street and knows that he lives on Court Street. He stated that he can describe it well enough to get dropped back off here. Resident C stated that it has been a while since he left and got lost. He stated that lately he leaves and comes back. He stated that he does not recall going anywhere 12 days ago, and that he does not go to the store a lot. He stated that he goes about one to three times per week. Resident C stated that he does not notify staff when he leaves and that he "just takes off and walks." Resident C stated that he goes to the store for other people. He denied that he signs in and out when coming and going. He stated that he does not have a phone but knows his sister's phone number. He stated that he likes living in the facility and that it is peaceful.

On 05/17/2023, I interviewed staff Sherry Joy at the facility. She stated that the last time that Resident C got lost was last year when he was on the news (as a missing person). She stated that residents are supposed to let her know when they come and go, but they don't. She stated that residents including Resident C will just leave. She stated that there are only three residents who will tell her they are leaving the premises. She stated that some residents leave out at nighttime. She stated that Resident C does not listen to staff or his guardian.

On 05/25/2023, I received requested documentation via fax from the facility. Resident C's *Assessment Plan for AFC Residents* dated 03/11/2023 has "yes" checked for *Moves Independently in Community*. The assessment notes that Resident C "loves to walk." The assessment also has "yes" checked for *Communicates Needs*, *Understands Verbal Communication*, and *Alert to*

Surroundings. For personal care, the assessment notes that Resident C needs prompting for bathing, grooming, dressing, and personal hygiene. Toileting is checked “yes” for needs help, and it is noted that he “*wairs diapers*.” Per the assessment plan, staff are responsible for passing medication to Resident C. For *Recreation* and *Physical Exercise* it notes that he “*likes to be outside*” and “*likes to walk*.” The assessment plan is signed and dated on 03/11/2023 by Resident C, licensee designee Gregory Cheff, and Guardian 1. Resident C’s *Health Care Appraisal* dated for 07/15/2022 has *Bipolar* and *Tobacco Use* noted for his diagnoses, and it also notes that he is fully ambulatory. The appraisal was completed by Tara Evans NP-C.

On 06/07/2023, I spoke with Complainant 1 via phone. Complainant 1 Resident C has a history of wandering off and did so last spring and in the fall of last year. Resident C was observed on 05/05/2023 taking off down the road. He did not inform staff that he was leaving the facility and was not observed to have signed out. Staff at the facility did not come outside to check on him. Resident C was a missing person for about four days the last time he went missing, and there was police involvement. Resident C does not speak very much, so there was concern that he would not be able to communicate effectively with anyone to make it back to the facility. Complainant 1 stated that during the last incident where he was missing, he had been out panhandling with another resident who left him, and he ended up being lost for four days.

On 06/07/2023, I conducted an internet search for news articles regarding Resident C. In September 2022, there was a news article indicating that Resident C last seen on 09/08/2022, that he suffers from dementia and other mental health issues, and that investigators at the time were not sure about what he was wearing when he was last seen.

On 06/07/2023, I spoke with Resident C’s Guardian 1 via phone. Guardian 1 stated that she was informed that the facility cannot stop Resident C from going out, and that staff Sherry Joy told her that they are only responsible for feeding, bedding, and keeping the residents clean. She stated that on Sunday (06/04/2023) she saw Resident C at the corner by the highway (I-475; which is about three blocks west of where the facility is situated) asleep. She stated that Resident C was with another resident at the corner. Guardian 1 stated that she pulled over, got out of the car, woke up Resident C, and told him to go home.

On 06/12/2023, I spoke with Resident C’s Genesee Health System’s case manager Tanisha Parham via phone. Ms. Parham stated that she spoke with Guardian 1 today regarding moving Resident C to a new placement. She stated that Resident C wandered off in the past, and to her knowledge it happened once last year. She stated that law enforcement was involved in the incident last year. She stated that per her case notes, she received a call from licensee designee Greg Cheff on 09/01/2022 notifying her that Resident C was missing. She stated that in that incident from September 2022, Resident C was with another resident who left him,

and as a result Resident C got lost. She stated that Resident C told her that he was on the street staying in a bunch of houses that nobody lived in (during the time he went missing). She stated that Resident C needs to be placed in a more secure setting. Ms. Parham stated that staff Sherry Joy is the staff that is in the home most of the time, but she does not know what the staffing ratio is of the facility. She stated that Resident C does need a higher level of supervision.

On 06/12/2023, I received a copy of Resident C's *Genesee Health System IPOS Meeting* (Individual Plan of Service) documentation dated for 05/22/2023. His *Goal #2* is noted as community inclusion and stated that he will "*take a daily walk during the weather appropriate days for the next year. [Resident C] will engage with the other residence in his AFC Home at least 2 times out of the week for the next year*."

APPLICABLE RULE	
MCL 400.707	**Definitions; R to T.**
	(7) "Supervision" means guidance of a resident in the activities of daily living, including 1 or more of the following: **(d) Being aware of a resident's general whereabouts even though the resident may travel independently about the community.**
ANALYSIS:	Resident C reported that he comes and goes from the home without notifying staff. He reported that he has left the home on more than one occasion and has gotten lost. Staff Sherry Joy stated that residents are supposed to let her know when they come and go, but some do not. She stated that Resident C does not inform her when he is leaving the premises. Staff Joy also reported that Resident C had gotten lost last year and was on the news as a missing person. Resident C's *Assessment Plan for AFC Residents* and Genesee Health System's *IPOS* does not note any restrictions on Resident A having community access rights. Complainant 1 stated that Resident C was observed on 05/05/2023, leaving the premises of the home without informing staff or signing out. Guardian 1 stated that she was informed by the facility that they cannot stop Resident C from going out. Resident C's case manager Tanisha Parham confirmed that Resident C was lost for a few days in September 2022. She reported that Resident C needs a more secure setting to be

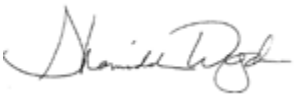
	placed in and needs a higher level of supervision. There is a preponderance of evidence to substantiate a rule violation in regard to staff not being aware of the general whereabouts of Resident C while he is out in the community.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/21/2023, I conducted an exit conference with licensee designee Gregory Cheff via phone. I informed him of the findings and conclusion.

On 06/21/2023, I completed SIR #2023A0123039 at this facility and substantiated quality of care and physical plant violations, as well as repeat violations. Since this facility was on a provisional license status at the time, I recommended revocation of the license.

IV. RECOMMENDATION

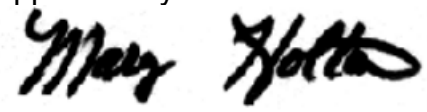
I recommend revocation of this license.



06/21/2023

Shamidah Wyden Date
Licensing Consultant

Approved By:



06/21/2023

Mary E. Holton Date
Area Manager