

GRETCHEN WHITMER GOVERNOR STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

July 13, 2023

Thomas Hart Independent Living Solutions, LLC 2786 Cecelia St. Saginaw, MI 48602

> RE: License #: AS730296476 Investigation #: 2023A0576042 Cardinal Care AFC

Dear Thomas Hart:

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.
- Be signed and dated.

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,

C. Barna

Christina Garza, Licensing Consultant Bureau of Community and Health Systems 611 W. Ottawa Street P.O. Box 30664 Lansing, MI 48909 (810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

Licopoo #	49720206476
License #:	AS730296476
	000040570040
Investigation #:	2023A0576042
Complaint Receipt Date:	05/17/2023
Investigation Initiation Date:	05/19/2023
Report Due Date:	07/16/2023
Licensee Name:	Independent Living Solutions, LLC
Licensee Address:	2786 Cecelia St., Saginaw, MI 48602
Licensee Telephone #:	(989) 752-6142
Administrator:	Thomas Hart
Administrator.	
	Thomas Hart
Licensee Designee:	
Name of Facility:	Cardinal Care AFC
Facility Address:	2700 Cecelia St., Saginaw, MI 48602
Facility Telephone #:	(989) 401-2802
Original Issuance Date:	09/18/2008
License Status:	REGULAR
Effective Date:	03/18/2023
Expiration Date:	03/17/2025
•	
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL,
	DEVELOPMENTALLY DISABLED, ALZHEIMERS,
	TRAUMATICALLY BRAIN INJURED, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is missing appointments. Appointments have been observed on the calendar at the home and several reminders are left. Resident A will miss the appointment and staff seem unaware of the appointments. Resident A missed scheduled injections on 3/1/2023, 3/27/2023 and a medication review on 5/9/2023.	Yes

III. METHODOLOGY

05/17/2023	Special Investigation Intake 2023A0576042
05/19/2023	Special Investigation Initiated - Telephone Left message for Complainant
05/30/2023	Contact - Telephone call made Interviewed Complainant
06/30/2023	Inspection Completed On-site Interviewed Staff, Aniya West
07/07/2023	Contact - Telephone call made Interviewed Case Manager, Danita Rider
07/11/2023	Contact - Telephone call made Interviewed Guardian A
07/11/2023	Contact - Telephone call made Interviewed Resident A
07/11/2023	Contact - Telephone call made Interviewed Brittany Burton, Resident A's Therapist
07/13/2023	Contact - Face to Face Interviewed Staff, Jason Tillman
07/13/2023	Contact - Face to Face Interviewed Home Manager, Jasmine Tillman
07/13/2023	Contact - Telephone call made Interviewed previous Home Manager, Steven Bell

07/13/2023	APS Referral Referral made to APS.
07/13/2023	Exit Conference Exit Conference conducted with Licensee Designee, Thomas Hart

ALLEGATION:

Resident A is missing appointments. Appointments have been observed on the calendar at the home and several reminders are left. Resident A will miss the appointment and staff seem unaware of the appointments. Resident A missed scheduled injections on 3/1/2023, 3/27/2023 and a medication review on 5/9/2023.

INVESTIGATION:

On May 19, 2023, I left a message for Complainant to return call. May 30, 2023, I interviewed Complainant who advised Resident A has missed several appointments including appointments for therapy and medication injections.

On June 30, 2023, I completed an unannounced on-site inspection at Cardinal Care and interviewed Staff, Aniya West who reported to working at the facility for 1 year. Staff West advised that Resident A is not home and left with family. Regarding the allegations, Staff West advised that Resident A will leave the home even though she has appointments. Resident A has community access and Resident A will sometimes not return in time for her medications. Staff West reported appointments are written on a calendar for staff to see and she is not sure if staff are forgetting about Resident A's appointments.

On July 7, 2023, I interviewed Danita Rider, Resident A's Case Manager who reported Resident A will be moving from the home soon in part to her missing appointments and concerns the guardian has. Regarding the allegations, Case Manager Rider provides the home with appointment cards, and she has witnessed staff write Resident A's appointments on the calendar at the home however appointments are still missed. Staff from the home have not advised Case Manager Rider that Resident A leaves the home when it was time for an appointment. Resident A missed a therapy appointment on May 31, 2023, due to staff bringing Resident A 30 minutes late to the appointment so it had to be rescheduled. Resident A missed 2 injection appointments in March 2023, and a medication review on May 9, 2023.

On July 11, 2023, I interviewed Resident A's guardian, Guardian A who reported there have been issues with Resident A missing appointments so much so Guardian A will take off work to take Resident A to appointments, so they are not missed. Guardian A reminds the home of upcoming appointments for Resident A however appointments are still missed. Guardian A explained that they made Resident A a dental appointment due

to a tooth ache. The home was notified, and Resident A was taken to the appointment by staff. A second dental appointment was made by staff after the initial appointment for an extraction and this 2nd appointment was missed by AFC staff. The dental office notified Guardian A and Guardian A contacted the home. Staff was advised of the missed appointment and reported Resident A would not get up for the appointment. Guardian A spoke with Resident A about the appointment, and she denied staff attempted to wake her for the appointment. Guardian A rescheduled this appointment and made the home aware. On the day of the 3rd appointment, Guardian A began calling the home at 7am to remind them of the morning appointment and no one answered the phone. At 8am Guardian A went to the home and knocked several times before staff answered the door. According to Guardian A, it did not appear staff were going to take Resident A to the appointment as Resident A was still asleep, and the staff did not appear to know Resident A had an appointment. Guardian A got Resident A up and told her to get ready and directed staff to take her to the appointment, which they did as she confirmed it with the dental office. While at this 3rd appointment a 4th appointment was scheduled by AFC staff because Resident A needed another extraction, and this appointment was missed by the home. The dental office called Guardian A to warn them about Resident A missing a 3rd appointment and if she did, she would be dropped as a patient. Guardian A rescheduled Resident A's 5th appointment and took her to the appointment so there would be no issues. Guardian A reported in addition to missed dental appointments, Resident A also missed therapy and injection appointments. After missing her therapy appointment, it took several weeks before Resident A could return and be seen by her therapist. Guardian A reported she talked with Home Manager, Steven Bell about her concerns with Resident A missing appointments and Manager Bell advised he would talk with staff. Guardian A denied she has been told by staff that Resident A is leaving the home when she has appointments scheduled or she refuses to get up for her appointments. Guardian A reported Resident A will get up for appointments when prompted by staff and does not refuse to attend appointments.

On July 11, 2023, I interviewed Resident A regarding the allegations and reported she has missed appointments however she is not sure which ones. Resident A reported she missed an appointment at a day program a few weeks ago and she is not sure why. Resident A receives injections every other month and missed an injection appointment however she went back the following week. Resident A was not sure why she missed the appointment.

On July 11, 2023, I left a message for Brittany Burton, Therapist from Saginaw County Community Mental Health Authority. On July 12, 2023, I interviewed Therapist Burton who reported Resident A missed a therapy appointment on May 31, 2023. Therapist Burton talked with Resident A about the missed appointment and Resident A explained there was a staffing issue and that is why she did not make her appointment.

On July 13, 2023, I reviewed Resident A's AFC Assessment Plan and Individual Plan of Service (IPOS). The plans reveal Resident A is 24 years old and moves independently in the community. Resident A is dependent on staff for attendance at medical

appointments and transportation although she can utilize public transportation. AFC Staff will provide transportation to medical/psychiatrist appointments and staff will attend appointments with the resident.

On July 13, 2023, I interviewed Staff, Jason Tillman who reported he has worked at the facility for 5 years. Staff Tillman reported Resident A has missed appointments due to her leaving the home at her appointment times. Resident A will be aware she has an appointment and if she gets upset, she will take off walking or get on the bus and will not come back for her appointment. Additionally, there are times that Resident A will not get up for her scheduled appointments. Staff Tillman reported there has been confusion on the part of staff regarding Resident A's appointments as staff are not sure where to take her or when. Resident A will keep the reminder cards in her pocket so staff will not be aware of appointments. Staff Tillman reported he believes the previous Home Manager, Steven Bell reported to the guardian and case manager that Resident A was not being compliant with attending her scheduled appointments.

On July 13, 2023, I interviewed the current Home Manager, Jasmine Tillman who reported Resident A missed her injections because she would not get out of bed. Resident A would leave the home or not get up causing her to miss appointments. Manager Tillman had no knowledge about Resident A missing dental appointments. Manager Tillman reported she tried contacting Resident A's case manager about Resident A refusing to attend appointments however the case manager did not return her call. A review of Resident A's records was viewed and there was no documentation indicating Resident A refused to attend appointments.

On July 13, 2013, I interviewed the previous Home Manager, Steven Bell regarding the allegations. Manager Bell reported he has not been employed at the facility for the last 2 months. Regarding the allegations, Manager Bell reported Resident A does not like to get up and staff cannot force her to do anything. Resident A would follow the directives of Manager Bell however did not often follow staff directives when they prompted her to awake for appointments. Manager Bell reported staff could have done more "or taken other routes" to try to get Resident A up for her appointments. Manager Bell reported there were times that staff did not look at the resident appointment calendar or staff called in and Resident A's appointment was missed.

APPLICABLE RULE	
R 400.14310	Resident health care.
	 (1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: (a) Medications. (b) Special diets.

	 (c) Susceptibility to hyperthermia and hypothermia and related limitations for physical activity, as appropriate. (d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.
ANALYSIS:	It was alleged that Resident A is missing several appointments. Upon conclusion of investigative interviews, there is a preponderance of evidence to conclude a rule violation. According to Resident A's IPOS, Resident A requires staff assistance with transportation and staff are to attend all appointments with Resident A. Resident A's Case Manager, Danita Rider reported Resident A missed appointments for therapy, medication injections, and a medication review. Guardian A was interviewed and reported Resident A missed dental appointments. Guardian A and the Case Manager Rider deny being made aware of Resident A being noncompliant with appointment attendance due to her not being home or not getting up for the appointment. Previous Home Manager, Steven Bell reported there were occasions Resident A missed appointment calendar or because staff did not come to work. There is a preponderance of evidence to conclude Resident A's health care needs (attendance to medical appointments) was not adhered to and any refusal of said health care needs was not recorded in the resident record.
CONCLUSION:	VIOLATION ESTABLISHED

On July 13, 2023, I conducted an Exit Conference with Licensee Designee, Thomas Hart. I advised Licensee Designee Hart I would be requesting a corrective action plan with regard to the cited rule violation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the license status.

C. Barna

7/13/2023

Christina Garza Licensing Consultant Date

Date

Approved By:

her Holto

7/13/2023

Mary E. Holton Area Manager