GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 8, 2023

Jennia Woodcock
Community Health Care Management
1805 E Jordan
Mt. Pleasant, MI 48858

RE: License #: AM370085651
Investigation #: 2023A1033061
Country Place II

Dear Ms. Woodcock:

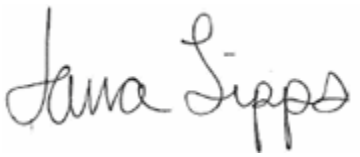
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9730.

Sincerely,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM370085651
Investigation #:	2023A1033061
Complaint Receipt Date:	08/16/2023
Investigation Initiation Date:	08/17/2023
Report Due Date:	10/15/2023
Licensee Name:	Community Health Care Management
Licensee Address:	2033 Westbrook Ionia, MI 48846
Licensee Telephone #:	(989) 773-6320
Administrator:	Jennia Woodcock
Licensee Designee:	Jennia Woodcock
Name of Facility:	Country Place II
Facility Address:	1807 E. Jordan Mount Pleasant, MI 48858
Facility Telephone #:	(989) 773-6320
Original Issuance Date:	07/02/2001
License **Status:**	REGULAR
Effective Date:	07/13/2022
Expiration Date:	07/12/2024
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff, Eileen Rucinski, gave Resident A the keys to her truck and her debit card and sent him to the liquor store to buy her alcohol.	Yes

III. METHODOLOGY

08/16/2023	Special Investigation Intake 2023A1033061
08/17/2023	Special Investigation Initiated – Letter- Email correspondence sent to CMH ORR, Jane Gilmore.
08/30/2023	Inspection Completed On-site- Interview with direct care staff/Assistant Administrator, Jamie Blizzard and Resident A. Review of employee file for former direct care staff, Elaine Rucinski. Review of Resident A resident record.
08/31/2023	Contact - Document Sent- Email correspondence with licensee designee, Jennia Woodcock.
09/07/2023	Contact - Telephone call made- Interview with direct care staff, Makenzie Bruner, via telephone.
09/07/2023	Contact - Telephone call made- Interview with direct care staff, Eileen Rucinski, via telephone.
09/07/2023	Inspection Completed-BCAL Sub. Compliance
09/08/2023	Exit Conference Conducted via telephone. Voicemail message left for licensee designee, Jennia Woodcock.

ALLEGATION: Direct care staff, Eileen Rucinski, gave Resident A the keys to her truck and her debit card and sent him to the liquor store to buy her alcohol.

INVESTIGATION:

On 8/16/23 I received an online complaint regarding the Country Place II adult foster care facility (the facility). The complaint alleged that on 8/9/23, direct care staff, Eileen Rucinski, gave Resident A the keys to her truck and sent him to the local liquor store to purchase alcohol for her. On 8/17/23 I sent an email correspondence to Jane Gilmore, Recipient Rights Officer with Community Mental Health of Central Michigan (CMHCM). Ms. Gilmore replied to this message on 8/18/23 reporting that she had made an on-site visit to the facility on 8/10/23 and interviewed Resident A and direct care staff members. She further reported Resident A had showed her a text message on his cell phone from Ms. Rucinski regarding the allegation.

On 8/21/23 I received an email correspondence from Ms. Gilmore reporting Ms. Rucinski has been substantiated for resident abuse two times at a different facility, which led to her ultimate termination at this previous facility.

On 8/30/23 I completed an on-site investigation at the facility. I interviewed direct care staff/Assistant Administrator, Jamie Blizzard. Ms. Blizzard reported that she was aware of the allegations, but she was not present on the date the incident occurred and only knows what was relayed to her from direct care staff, Makenzie Bruner. Ms. Blizzard reported that Ms. Rucinski had been working the midnight shift (12am – 8pm) the night of 8/10/23. She reported that after Ms. Rucinski's shift the following afternoon, Resident A had gone to the adjoining facility and spoken with Ms. Bruner. Ms. Blizzard reported Resident A disclosed to Ms. Bruner that Ms. Rucinski had pressured him into driving her car to the local liquor store to purchase alcohol for her while she was working. Ms. Blizzard reported she has not spoken with Resident A about this allegation. She reported Resident A is currently on probation and does not have an active driver's license. Ms. Blizzard reported Ms. Rucinski was taken off the facility schedule and has not responded to phone calls or text messages from other direct care staff members.

On 8/30/23, during on-site investigation, I interviewed Resident A. Resident A reported that on 8/10/23 at 12:37am (he found the exact time by looking through his phone history for text messages) he took Ms. Rucinski's truck to buy her Jack Daniels at the Liquor Well. Resident A stated that Ms. Rucinski had asked him to take her keys and drive into town to purchase the alcohol. He reported he felt pressured by Ms. Rucinski as she had made statements that if he did not do her this favor then she was going to have to leave the residents unattended and do it herself. Resident A reported this made him feel uncomfortable as he knows the other residents require supervision at all times. Resident A reported he agreed to drive Ms. Rucinski's truck to the store and that he did, but he ended up driving to the wrong store. Resident A reported "I was so scared!" and noted he had only driven a car a couple of times before this event. He reported that he does not have a driver's license. Resident A reported Ms. Rucinski had been texting him that evening and sent him a text he had gone to the wrong store. Resident A reported he became frightened and returned to the facility without the alcohol. Resident A reported Ms.

Rucinski had asked him on a previous occasion to drive into town and purchase her alcohol, but he thought she was joking. Resident A reported Ms. Rucinski has previously brought alcohol to work and offered him a drink. He reported he had refused this offer.

On 9/7/23 I interviewed Ms. Bruner, via telephone. Ms. Bruner reported she had been working in the neighboring facility on 8/10/23. She reported Resident A stopped by the facility in the afternoon and told her about Ms. Rucinski pressuring him to drive her truck to the store to obtain alcohol for her the night before. Ms. Bruner reported Resident A stated he did drive Ms. Rucinski's truck, but he went to the wrong liquor store and he was not successful in obtaining the alcohol and then returned to the facility. Ms. Bruner reported she had viewed a text message conversation on Resident A's cell phone between Resident A and Ms. Rucinski and Ms. Rucinski appeared mad that Resident A had gone to the wrong liquor store. She reported she took pictures of this text message exchange. Ms. Bruner reported she has never been aware of Ms. Rucinski bringing alcohol to work or asking residents to drive her vehicle for any reason. Ms. Bruner reported that after Resident A confided this information in her that she then reported this information to the licensee designee, Jennia Woodcock.

On 9/7/23 I interviewed Ms. Rucinski, via telephone. Ms. Rucinski reported she remembers the evening of 8/10/23 and she recalled that Resident A was awake late on that evening. She reported she had asked Resident A to move her truck closer to the dumpster, but she denied asking Resident A to drive her truck into town. She reported that Resident A did not drive her truck into town and instead he took a walk. Ms. Rucinski reported she never asked Resident A to purchase alcohol for her. When asked about the text message in question Ms. Rucinski reported that she has never had any of the residents' phone numbers as this is against company policy. She reported she has never sent text messages to Resident A and that her phone must have been "hacked".

On 9/7/23 I verified that the text message on Resident A's phone from 8/10/23 at 1:17am did come from Ms. Rucinski's telephone number. The telephone number listed on the text message matches the phone number that I contacted Ms. Rucinski on for the interview she provided on 9/7/23. The text message reads, "[Resident A] you went to the wrong store, you need to go to the liquor well its right before taco bell."

On 10/10/22 SIR # 2022A1033026 cited a rule violation for Rule 400.14305(3), the resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act. The analysis section of this report identified that a resident's established safety plan was not being followed. The corrective action plan dated 10/24/22 noted that the direct care staff would be provided a training/review of the resident Person Centered Plan (PCP) documents at the next staff meeting and new resident PCPs will be reviewed with direct care staff when received.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based upon interviews with Ms. Gilmore, Resident A, Ms. Blizzard, Ms. Bruner, & Ms. Rucinski, as well as review of Resident A's resident record and the text message exchange between Resident A and Ms. Rucinski on 8/10/23, it can be determined that Ms. Rucinski did not attend to the protection and safety of Resident A, by asking him to drive a motor vehicle when he does not possess a driver's license and to obtain alcohol for her personal use while working as a direct care staff.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR #2022A1033026 & CAP DATED 10/24/22]**

IV. RECOMMENDATION

Contingent upon the receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

09/07/23

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Jana Lipps Date
Licensing Consultant

Approved By:

09/08/2023

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Dawn N. Timm Date
Area Manager