GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 22, 2024

Violet Bettig
Guardian Angel Homes LLC
725 N. Dettman Rd.
Jackson, MI 49201

RE: License #: AS380389381
Investigation #: 2024A0007003
Saint Gabriel

Dear Violet Bettig:

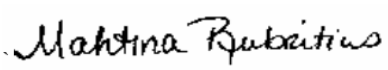
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (313) 456-0380.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604

Enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS380389381
Investigation #:	2024A0007003
Complaint Receipt Date:	11/13/2023
Investigation Initiation Date:	11/13/2023
Report Due Date:	01/12/2024
Licensee Name:	Guardian Angel Homes LLC
Licensee Address:	725 N. Dettman Rd. Jackson, MI 49201
Licensee Telephone #:	(517) 914-1039
Administrator:	Violet Bettig
Licensee Designee:	Violet Bettig
Name of Facility:	Saint Gabriel
Facility Address:	1038 Woodbridge Jackson, MI 49202
Facility Telephone #:	(517) 914-1039
Original Issuance Date:	02/23/2018
License Status:	REGULAR
Effective Date:	08/07/2022
Expiration Date:	08/06/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL TRAUMATICALLY BRAIN INJURED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A choked on chicken, due to his food not being ground up.	No
About a month ago, Resident A had $700 in his account. When Resident A moved out of the home on December 3, 2023, he only had $91.00 left.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/13/2023	Special Investigation Intake - 2024A0007003
11/13/2023	Special Investigation Initiated – Letter -Email to ORR - Referral made.
11/14/2023	Contact - Face to Face contact with APS Worker #1.
11/14/2023	Inspection Completed On-site - Unannounced - Face to face contact with Ray Patino, Home Manager #1 and Resident A.
11/15/2023	Contact - Telephone call received from ORR Officer #1. Case discussion.
12/01/2023	Contact - Telephone call made Guardian A, no answer.
12/04/2023	Contact - Telephone call made Guardian A, no answer. Message left. I requested a returned phone call.
12/08/2023	Contact - Telephone call made to Guardian A. Discussion.
12/08/2023	Contact - Telephone call made to Ray Patino. Resident funds documents requested. Case discussion.
12/11/2023	Contact - Telephone call made - Interview with Guardian A.
12/14/2023	Contact - Face to Face with APS Worker #1. Case discussion.
12/18/2023	APS Referral - Made.

12/20/2023	Contact - Telephone call made to Friend #1. The phone subscriber was not in service.
12/20/2023	Contact - Document Sent - Email to and from ORR Officer #1. Status update requested. The investigation is ongoing.
12/21/2023	Contact - Telephone call made- Violet Bettig, Licensee Designee. Mailbox is full, unable to leave a message.
12/21/2023	Contact - Telephone call made to Ray Patino. New phone number for Violet Bettig obtained. Additional information provided.
12/21/2023	Contact - Telephone call made to Violet Bettig, Licensee Designee, for follow -up and to conduct the exit conference. No answer.
01/02/2024	Contact - Telephone call made to Violet Bettig, Licensee Designee, for follow up and to conduct the exit conference. Message left. I requested a returned phone call.
01/02/2024	Contact - Telephone call made to Ray Patino; he will give Violet Bettig the message to return my phone call.
01/02/2024	Contact - Telephone call received -Since moving home with his mother, Resident A has been hospitalized. He spent approximately five days at U of M, due to have a hole in his esophagus. They are looking for placement.
01/02/2024	Contact - Telephone call made to APS Worker #1. He has closed his case, and the allegations were unsubstantiated. Resident A's account was current when he moved out of the home.
01/02/2024	Exit Conference - conducted with Violet Bettig, Licensee Designee. Follow-up questions and exit conference conducted.
01/03/2024	Contact - Document Received – AFC Payments for 2023
01/03/2024	Inspection Completed On-site – Unannounced - Face to face contact with Ray Patino, Home Manager #1, Resident B, Resident C, and a direct care staff.
01/03/2024	Contact - Telephone call made to Ray Patino. Follow-up and discussion regarding inconsistencies on documents provided.

01/03/2024	Contact - Telephone call made to Violet Bettig, Licensee Designee x 2. I requested a returned phone call.
01/04/2024	Inspection Completed On-site – Unannounced - Face to face contact with APS Worker #2, Ray Patino, Home Manager #1, and Resident B. While at the facility, I requested that a message be given to Violet Bettig, to give me a call.
01/04/2024	Contact - Telephone call made to Violet Bettig, Licensee Designee x2 to conduct the exit conference. There was no answer, and the voicemail box was full.
01/08/2023	Exit Conference conducted with Violet Bettig, Licensee Designee.

ALLEGATIONS:

Resident A choked on chicken, due to his food not being ground up.

INVESTIGATION:

As a part of this investigation, I reviewed the written complaint, and the following additional information was noted:

> Resident A aspirated while in their care and ended up in the hospital. They did not transition him into regular underwear after he was released from the hospital. When Ray Patino (Staff), was questioned about it, he said out loud, right in front of Resident A, "He shits all over himself." When Resident A was picked up for a sleep study, a staff person stated that Resident A had choked on chicken. This was because Ray Patino had given him chicken that was not ground up and moistened. Staff have been informed that Resident A's food must be ground up for him to eat the meal. It was requested that Ray Patino no longer be Resident A's 1:1 caregiver.

On November 14, 2023, I made face to face contact with APS Worker #1. He currently has a pending investigation regarding Resident A. It's alleged that his mother (Guardian A) drinks heavily, and there is a concern that she is not sending the full amount of money, to cover his cost of care to the AFC home. There is a concern that the home is not getting paid. APS Worker #1 made face to face contact with Resident A on November 2, 2023. During the visit, he observed the home to be clean and there were no concerns. He did not smell any odors or observe Resident A not to be cared for by the facility staff.

On November 14, 2023, I conducted an unannounced on-site investigation and made face to face contact with Ray Patino, Lead Staff, Home Manager #1, and Resident A. The other residents were on a community outing with staff.

I informed them about that a complaint had been received and inquired about the allegations. Ray Patino and Home Manager #1 stated that when Resident A was admitted into the home in November of 2021, he aspirated all the time; however, he did not choke on anything, causing him to be hospitalized. Ray Patino and Home Manager #1 explained how when Resident A was first admitted into the home, he was “shoveling” food into his mouth, which caused problems. They now utilize teaspoons to assist with feeding, so there are smaller portions of food at one time. Ray Patino showed me the food processor they utilized to grind up the food for Resident A. He also informed me that they have a battery-operated food processor that they take with them on outings, so his food can be ground in the community.

Regarding the adult briefs, Home Manager #1 and Ray Patino informed that Resident A wears regular underwear, not adult briefs, and the last time he wore them was when he returned home from the hospital after having pneumonia and lung surgery. They stated that this happened a while ago, as Resident A was in the hospital back in January of 2022.

According to HM #1, Resident A was in the hospital for two months, on a ventilator, and during that time he was wearing adult briefs. He continued to wear them for about two weeks after being released from the hospital. This was due to them having to work with him and reteach him how to use the restroom. They stated that this happened a while ago, as Resident A was in the hospital in January of 2022.

While at the facility, I observed Resident A's bedroom, closet, and clothing in his dresser. I did not see any evidence that adult briefs were being utilized.

I observed Resident A interact with Ray Patino and Home Manager #1 during the on-site investigation. Resident A patted his stomach, communicating to them that he wanted something to eat. The staff responded, telling him it was almost time for lunch and recommended a snack in the meantime. They provided small soft baked chocolate chip cookies and a drink. They interacted with Resident A in a calm and caring manner.

Resident A was not interviewed due to his cognitive development and diagnoses.

While at the facility, I asked Ray Patino if he made the comment that Resident A “shits himself” to Guardian A when she inquired about him wearing adult briefs and Ray Patino stated he did make the comment to her. He stated that it was not in front of any residents, it was during a conversation that he was having with only her, and that it happened over a year ago.

Ray Patino and Home Manager #1 provided a history of concerns they had regarding Guardian A. They voiced concerns regarding Guardian A being untruthful, and doctor shopping. Ray Patino recalled that there is one doctor who will not meet with Guardian A alone, as she has lied on them. They reported that if Guardian A does not like something or a medication that’s prescribed, she will take Resident A

to a different doctor. Ray Patino recalled that when Resident A was first admitted into the home, he was very aggressive. The doctors finally found the right medication for him, which keeps him calm and has reduced his behaviors. The plan was to eventually reduce the medication. Most recently, Guardian A decided that she did not want him on that medication. She picked Resident A up, telling staff they were going somewhere else. They (staff) later learned that Guardian A took Resident A to be re-evaluated with a different doctor, who then changed his medication. Medical staff told them that Guardian A insisted on having the changes made. Staff were not sure if there would be any side effects, as the medication change was very recent, and it will take a few weeks to see if there are any differences.

Regarding the payment for care, Ray Patino and Home Manager #1 stated that in the past, they have only accepted cash from Guardian A, as the checks were not written in a manner that the bank would accept them or there would be other issues. Regarding the current payments due, Guardian A paid the money owed this month. They're still waiting to hear back from APS Worker #1 regarding the conclusion of his investigation, to determine if a payee will be assigned.

On November 15, 2023, I spoke with ORR Officer #1. ORR Officer #1 mentioned that these allegations were old, as Resident A's lung was removed in 2021. I informed ORR Officer #1 that I learned the allegations were older when I conducted the on-site investigation. She will continue to conduct the investigation regarding the change to Resident A's medications.

On December 11, 2023, I spoke with Guardian A. She informed me that Resident A choked on a piece of chicken in June of 2022, but that was not the reason that he ended up in the hospital. Two years ago, he was hospitalized as he aspirated, had pneumonia, and the doctors had to remove his lung. According to Guardian A, after Resident A's hospitalization, he couldn't control his bladder and bowels. Resident A had also been prescribed a diuretic. Resident A had to be retrained to use the bathroom. Once he was taken of the diuretic, facility staff kept putting him in briefs. Guardian A stated that Resident A would go to the bathroom when prompted and he was not incontinent. According to Guardian A, a month later, after being off the medications, Ray Patino was still putting Resident A in briefs because he was "lazy."

Guardian A stated that Resident A was transitioned back into regular underwear; however, one day she went for a visit and questioned Ray Patino as to why Resident A was back in briefs. According to Guardian A, while in front of Resident A, Ray Patino looked at her and stated, "Because he shits all over himself." I asked if there was anyone else there who observed this incident and Guardian A stated there was not. She stated that she called Violet Bettig, who stated that he should apologize to Resident A. Guardian A stated that Ray Patino never admitted that he was wrong.

Guardian A stated that Ray Patino was on an “ego trip” and he wanted to control the situation. She stated that he would try to diagnose Resident A with conditions. Guardian A stated that she is a retired nurse.

Guardian A informed me that Resident A also has a new psychiatrist. She decided that she didn’t like how things were going, that Resident A appeared to be “drugged out,” so the medication levels were reduced. Guardian A reported that Resident A is doing fine with the new medications.

Guardian A stated that Resident A is supposed to be provided with food that is ground up and moist. She recalled that she went to the facility to pick Resident A up for a sleep study, and she requested that they feed him prior to the appointment. When she arrived, around 6:00 p.m. and 7:00 p.m., the staff first handed her chopped hotdog, which she returned, and stated it should be chopped and moist. According to Guardian A, the staff member stated, “Oh yeah, we don’t want the same thing to happen again; he choked on chicken.” Guardian A also stated that Resident A should not have hotdogs. The staff member then gave them one hotdog which was ground up with BBQ sauce. Guardian A informed that the meat needed to be mixed with potatoes. The staff member gave them pudding. Guardian A stated she could not recall the staff members’ name but that she was no longer employed there. In addition, that Guardian A’s friend was there with her and witnessed the staff person tell her the information.

On December 14, 2023, I spoke with APS Worker #1. He inquired if I had any concerns regarding Home Manager #1 smelling like marijuana and I informed him that I did not. He informed me that he had spoken to Guardian A, and he explained to her that Resident A’s monies cannot be intermingled with her personal money. He also stated that he planned to make a few more contacts and then close the case.

On December 20, 2023, I attempted to contact Friend #1; however, the number provided was not in service.

On December 21, 2023, I spoke with Ray Patino. He informed me that Violet Bettig had a different phone number and that she had surgery recently. On this same day, I attempted to contact Violet Bettig, without success.

On January 2, 2024, I spoke with Violet Bettig, licensee designee. I inquired if she had spoken to Guardian A regarding the comment that Ray Patino had made, and she informed me that the conversation never happened. She stated that she had spoken to Guardian A on other occasions but nothing regarding this statement. I provided technical assistance, and I encouraged her to speak with staff about how they interact with guardians and to remain professional. Violet Bettig concurred with this recommendation. During this phone conversation, I also conducted the exit conference and Violet Bettig did not object to the recommendations.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**

ANALYSIS:	Ray Patino and Home Manager #1 stated that when Resident A was admitted into the home in November of 2021, he aspirated all the time; however, he did not choke on anything, causing him to be hospitalized. Ray Patino and Home Manager #1 reported to utilize a food processor to provide grinded meals for Resident A. I observed the food processor during an on-site investigation. Resident A was not interviewed due to his cognitive development and diagnoses. I spoke with Guardian A. She informed me that Resident A choked on a piece of chicken in June of 2022, but that was not the reason that he ended up in the hospital. Two years ago, he was hospitalized as he aspirated, had pneumonia, and the doctors had to remove his lung. According to Guardian A, more recently, a staff member, who is no longer employed at the home reported that Resident A choked on chicken. This was also witnessed by Friend #1. I attempted to contact Friend #1; however, the number provided was not in service. Based on the information gathered during this investigation and provided above, it's concluded that there is not a preponderance of the evidence to support the allegations that the kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs were not available in the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

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:	Guardian A stated that Resident A was transitioned back into regular underwear; however, one day she went for a visit and questioned Ray Patino why Resident A was back in briefs. According to Guardian A, while in front of Resident A, Ray Patino looked at her and stated, “Because he shits all over himself.” Guardian A stated that she called Violet Bettig, licensee designee, who stated that Ray Patino should apologize to Resident A. Guardian A stated that Ray Patino never admitted that he was wrong. Ray Patino admitted that he made the comment that Resident A “shits himself” to Guardian A when she inquired about him wearing adult briefs. Ray Patino stated that it was not in front of any residents, it was during a conversation that he was having with only her, and that it happened over a year ago. Violet Bettig, licensee designee, informed me that the conversation never happened between she and Guardian A, as related to the comment that Ray Patino made. I provided technical assistance, and I encouraged her to speak with staff about how they interact with guardians and to remain professional. Violet Bettig concurred with this recommendation. Based on the information gathered during this investigation and provided above, it’s concluded that there is not a preponderance of the evidence to support the allegations that Resident A was not treated with dignity.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS:

About a month ago, Resident A had $700 in his account. When Resident A moved out of the home on December 3, 2023, he only had $91.00 left.

INVESTIGATION:

During the interview with Guardian A, she recalled that about a month ago, Resident A had $700 in his account and when she removed him from the home on December 3, 2023, he only had $91.00 left. Guardian A stated that she requested a ledger with the resident funds listed and she only received four documents.

On December 8, 2023, I spoke with Ray Patino. He stated that Resident A was moved out of the home on Sunday (12/3/2023), and that Guardian A thinks he does not spend money, but he does. He agreed to send me the *Resident Funds Part II* forms.

It should be noted that a Renewal Inspection was completed in August of 2022, and R 400.14315 (3) was cited during that investigation regarding Resident A's funds.

As a part of this investigation, I reviewed the *Resident Funds Part II* forms for Resident A's personal funds. The records covered the time periods of April 2022 to December 3, 2023. It was noted that on multiple occasions, the licensee accepted more than $200.00 for safe keeping. It was also documented that the ending balance was $91.00, which was returned to the Guardian at the time of discharge.

On December 21, 2023, I spoke to Ray Patino. I inquired if Guardian A had paid the cost of care for the month of December. He stated that the cost of care was prorated for the days Resident A was in the home, and a receipt was provided. He agreed to send me a copy of the records. Ray Patino submitted the documents; however, they could not be read, therefore they were requested again.

On January 2, 2024, I spoke to APS Worker #1. APS Worker#1 informed me that he had closed his case, and the allegations were unsubstantiated. Resident A's account was current when he moved out of the home.

On January 3, 2024, I conducted an unannounced on-site investigation and made face to face contact with Ray Patino, Home Manager #1, Resident B, Resident C, and a direct care staff.

Ray Patino, Home Manager #1, and I reviewed the forms submitted and I requested clarification, as the information was inconsistent. They both agreed that that the information was inconsistent.

Some of the following inconsistencies were noted:

On January 3, 2024, I received and reviewed the AFC Payments for 2023. A review of the AFC Payments and *Resident Funds Part II* forms reflected that there were multiple inconsistencies in the amount of money left over after AFC Payments were received and the personal funds.

In January of 2023, it was documented that the facility received a payment of $1,030.00, the cost of care was $954.50, and the remaining balance was $75.50. There was no documentation that the remaining balance ($75.50) had been forwarded to Resident A's personal funds on the *Resident Funds Part II* form.

In February of 2023, it was documented that the facility received a payment of $1,050.00, the cost of care was $954.50, and the remaining balance was $95.50. There was no documentation that the entire remaining balance ($95.50) had

been forwarded to Resident A's personal funds on the *Resident Funds Part II* form. On February 11, 2023, the *Resident Funds Part II* form reflected that $81 dollars was transferred to Resident A's personal funds for that month.

In March of 2023, it was documented that the facility received a payment of $1,020.00, the cost of care was $954.50, and the remaining balance was $65.50. On March 12, 2023, staff documented that $80.00 was deposited into Resident A's personal funds.

A review of the documents reflected multiple inaccuracies. The AFC Payments were not documented on the *Resident Funds Part II* form.

On January 2, 2024, I conducted the exit conference with Violet Bettig, licensee designee. On January 3, 2024, and January 4, 2023, attempts were made to contact Violet Bettig, licensee designee, to conduct another exit conference, as additional information had been received.

On January 8, 2024, I conducted an exit conference with Violet Bettig, Licensee Designee. I explained that a review of the AFC Payments and *Resident Funds Part II* forms reflected that there were multiple inconsistencies in the amount of money left over after AFC Payments were received and the personal funds. She informed me that Guardian A was inconsistent with the amounts of money she would send. Additionally, that they had problems with her checks, as either they were not signed, dated, or missing information, which caused the bank not to accept the checks. There were also issues with checks bouncing. Violet Bettig stated there were times when Resident A did not have money, and staff paid for outings out of their own pockets. I explained to Violet Bettig that there were multiple inconsistencies; and the file should be reviewed, and the inaccuracies should be corrected. She agreed to review the file and address the inaccurate information. I also explained that there should be receipts for all transactions, and those are to be maintained in the resident files. I informed Violet Bettig that I would be requesting a written corrective action plan to address the violation. She agreed to submit a written corrective action plan.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.

ANALYSIS:	According to Guardian A, Resident A had $700.00 in his account about a month ago and when Resident A was discharged, he only had $91.00. According to Ray Patino, Guardian A thinks Resident A does not spend money, but he does. He agreed to send me a copy of the *Resident Funds Part II* forms. I reviewed the *Resident Funds Part II* forms for Resident A's personal funds. The records covered the time periods of April 2022 to December 3, 2023. I reviewed the AFC Payments received and documents for 2023. A review of the AFC Payments and *Resident Funds Part II* forms reflected that there were multiple inconsistencies in the amount of money left over after AFC Payments were received and the personal funds. The AFC Payments were not documented on the *Resident Funds Part II* form. While The *Resident Funds Part II f*orm documented that $91.00 was returned to Guardian A at the time of discharge, it should be noted that there were multiple inaccuracies noted in the records provided. **This is a REPEAT VIOLATION**
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

As a part of this investigation, I reviewed the *Resident Funds Part II* forms for Resident A's personal funds. The records covered the time periods of April 2022 to December 3, 2023. It was also noted that on multiple occasions, the licensee accepted more than $200.00 for safe keeping.

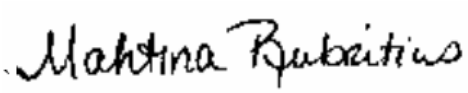
On January 2, 2024, I conducted the exit conference with Violet Bettig, licensee designee. She was informed of the conclusion of the investigation and my

recommendations. I informed her that I would be requesting a written corrective action plan to address the established violation.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(6) Except for bank accounts, a licensee shall not accept resident funds of more than $200.00 for any resident of the home after receiving payment of charges owed.
ANALYSIS:	A review of the *Resident Funds Part II* forms reflected that on multiple occasions, the licensee accepted more than $200.00 for safe keeping.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.



01/08/2024

_____

Mahtina Rubritius Date
Licensing Consultant

Approved By:

01/22/2024

_____

Ardra Hunter Date
Area Manager