STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
ACTING DIRECTOR

March 11, 2024

Joyce Adams-McEaddy
724 Dorset
Ypsilanti, MI 48198

RE: License #: AF810287198
Investigation #: 2024A0122013
Adams AFCH

Dear Ms. Adams-McEaddy:

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:

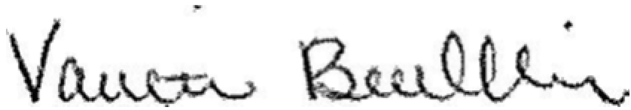
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance 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.

611 W. OTTAWA • P.O. BOX 30664 • LANSING, MICHIGAN 48909
www.michigan.gov/lara • 517-335-1980

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) 284-9720.

Sincerely,



Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF810287198
Investigation #:	2024A0122013
Complaint Receipt Date:	02/09/2024
Investigation Initiation Date:	02/09/2024
Report Due Date:	04/09/2024
Licensee Name:	Joyce Adams-McEaddy
Licensee Address:	724 Dorset Ypsilanti, MI 48198
Licensee Telephone #:	(734) 730-6733
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Adams AFCH
Facility Address:	724 Dorset Ypsilanti, MI 48198
Facility Telephone #:	(734) 217-0831
Original Issuance Date:	04/04/2007
License **Status:**	REGULAR
Effective Date:	07/26/2023
Expiration Date:	07/25/2025
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Residents are forced to stay in bed until 10:00 a.m.	No
Resident A is not properly fed.	No
ADDITIONAL FINDINGS	Yes

III. METHODOLOGY

02/09/2024	Special Investigation Intake 2024A0122013 APS Referral
02/09/2024	Special Investigation Initiated - Telephone Left voice message for Complainant 1, requesting return phone call.
02/23/2024	Contact – Telephone call made. Completed interview with Complainant 1.
02/23/2024	Inspection Completed On-site Completed interview with Joyce Adams, Licensee, and Resident A.
02/23/2024	Contact - Face to Face Completed interview with Resident B.
03/01/2024	Contact – Telephone call received. Completed interview with Complainant 1.
03/04/2024	Contact – Document received. Pictures of Resident A’s medication received via email.
03/04/2024	Inspection Completed On-site Completed interview with Joyce Adams, Licensee.
03/04/2024	Exit Conference Discussed findings with Joyce Adams, Licensee

ALLEGATION: Residents are forced to stay in bed until 10:00 a.m.

INVESTIGATION: On 02/23/2024, Complainant 1 reported that Joyce Adams, Licensee, stated that her residents must stay in bed until 10:00 a.m. Complainant 1 stated Ms. Adams reported this incident during a replacement meeting for Resident A. Complainant 1 stated Resident A never reported that he was confined to his bedroom but also stated his speech can be difficult to understand.

On 02/23/2024, I completed an interview with Resident B at his day program located in Ypsilanti, MI. Resident B denied that he is forced to stay in bed until 10:00 a.m. He reported the following schedule: Monday through Friday, he wakes up at approximately 8:00 a.m., given medication and breakfast, dresses, and is taken to his day program. On Saturday's he wakes up at his leisure, completes his activities of daily living at his leisure, and is given breakfast at 10:00 a.m. Resident B further reported that he has access to the home as he wishes. Resident B stated he has no problems and/or concerns with living at the Adams AFCH adult foster care family home.

On 02/23/2024, I completed an interview with Resident A. His speech was difficult to understand, and he was unable to give details. I asked Resident A if he was forced to stay in his room until 10:00 a.m. and he responded by saying, "No." I asked him additional questions about his schedule, but I was unable to understand his responses. Resident A was observed sitting in the living room watching television with Joyce Adams upon my arrival showing no signs of discomfort or distress.

On 02/23/2024, I completed an interview with Joyce Adams, Licensee. Ms. Adams denied forcing the residents to remain in their rooms until 10:00 a.m. Ms. Adams repeated the weekly schedule stated by Resident B, i.e. the residents attend day program during the week and sleep in on the weekend.

On 03/04/2024, I completed an exit conference with Joyce Adams, discussing my findings with her. Ms. Adamas stated she understood my findings.

APPLICABLE RULE	
R 400.1412	**Resident behavior management; prohibitions.**
	(2) A licensee, responsible person, or any person living in the home shall not use any of the following methods of handling a resident for discipline purposes: **(c) Confining a resident in an area such as a closet, locked room, box, or similar cubicle.**

ANALYSIS:	On 02/23/2024, Complainant 1 reported that Joyce Adams, Licensee, stated that her residents must stay in bed until 10:00 a.m. On 02/23/2024, both Residents A and B denied that they are forced to stay in their bedrooms until 10:00 a.m. Based upon my investigation I find no evidence to support the allegation that Joyce Adams, Licensee, confines residents to their bedrooms until 10:00 a.m.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS: Resident A is not properly fed.

INVESTIGATION: On 02/23/2024, I completed an interview with Complainant 1. Complainant 1 stated she had concerns about Resident A being fed properly as she observed that he was hungry during a replacement meeting. Complainant 1 stated Resident A was offered something to eat during this meeting and she observed him eating as if he were extremely hungry. Complainant 1 had not received reports from Resident A that he was not being fed properly or meals were being withheld from him.

On 02/23/2024, I completed interviews with both Residents A and B. Both reported they received 3 meals per day. Both reported they received enough food during meals.

On 02/23/2024, I completed an interview with Joyce Adams, Licensee. Ms. Adams reported that she prepares and serves at least 3 meals per day to the residents, including snacks. Ms. Adams stated she had not received reports that the residents are not fed properly.

On 02/23/2024, I observed the facility’s kitchen. I observed that the refrigerator was stocked with an appropriate amount of perishable foods and drinks. The adjacent pantry had enough food to cover 3 meals per day for each person in the home for approximately one month.

On 03/04/2024, I completed an exit conference with Joyce Adams, discussing my findings with her. Ms. Adamas stated she understood my findings.

APPLICABLE RULE	
R 400.1419	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	On 02/23/2024, Complainant 1 stated she had concerns about Resident A being fed properly as she observed that he was hungry during a replacement meeting. On 02/23/2024, both Residents A and B reported they received 3 meals per day. Both reported they received enough food during meals. On 02/23/2024, Ms. Adams reported that she prepares and serves at least 3 meals per day to the residents, including snacks. On 02/23/2024, I observed the facility had enough food in the pantry to cover 3 meals per day for each person in the home for approximately one month. Based upon my investigation I find that the licensee provides a minimum of 3 regular meals per day.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 03/01/2024, Complainant 1 reported that Resident A's medications were not administered as prescribed. Complainant 1 stated that Resident A's pharmacy containers/bubble packs, for the following were full of medication: Olanzapine, Linsopril, and Escitalopram.

On 03/04/2024, I received pictures of Resident A's medication held in pharmacy containers/bubble packs dated February 2024. The following was observed: Olanzapine odt 10mg dated 02/16/2024 had 30 pills in the bubble pack – Take one pill by mouth at bedtime for 30 days, Linsopril 5mg dated 02/07/2024 had 30 pills in the bubble pack – Take one tablet by mouth daily, Escitalopram 20 mg dated 02/16/2024 had 30 pills in the bubble pack – Take one tablet by mouth at bedtime.

Pictures of Resident A's bubble packs for January 2024 were submitted and reviewed as well. The following was observed: Olanzapine odt 10mg dated 01/10/2024 – 10 pills in the bubble pack, last pill given on 01/11/2024. Linsopril 5mg dated 01/10/2024 – 13 pills left in the bubble pack; last pill given on 01/14/2024. Escitalopram 20mg dated 01/10/2024 – 7 pills left in the bubble pack; last pill given on 01/11/2024.

On 03/04/2024, I completed an interview with Joyce Adams, Licensee. Ms. Adams stated that she administered Resident A's medication as prescribed. She stated that she received Resident A's medication a month in advance so that he doesn't run out. Ms. Adams could give no explanation as to why Resident A had medication in both his January 2024 and February 2024 bubble packs/pharmacy containers. I asked to review Resident A's medication administration sheets, but Ms. Adams stated she had sent them with Resident A at his new placement.

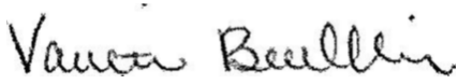
On 03/04/2024, I completed an exit conference with Joyce Adams, discussing my findings with her. Ms. Adamas stated she understood my findings and she would submit a corrective action plan to address the rule violation found.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(1) Prescription medication, including tranquilizers, sedatives, dietary supplements, or individual special medical procedures, shall be given or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy container which shall be labeled for the specific resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Complied Laws.

ANALYSIS:	On 03/01/2024, Complainant 1 reported that Resident A's medications were not administered as prescribed. On 03/04/2024, I observed pictures of Resident A's pharmacy containers/bubble packs for January and February 2024 for the following medications: Olanzapine, Linsopril, and Escitalopram. I observed that the bubble packs for January and February had medication in them. On 03/04/2024, Joyce Adams, Licensee could provide no explanation as to why there was medications left in Resident A's bubble packs for January and February 2024. Based upon my investigation I find that Resident A was not given medication, Olanzapine, Linsopril, and Escitalopram as prescribed by his licensed physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of a Corrective Action Plan I recommend no change in the status of the license.



Vanita C. Bouldin   Date: 03/05/2024
Licensing Consultant

Approved By:

Ardra Hunter   Date: 03/11/2024
Area Manager