GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 18, 2024

Charles Baroi
3979 140th Ave.
Holland, MI 49424

RE: License #: AS700417921
Investigation #: 2024A0350022
Mayabe Care

Dear Charles Baroi:

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 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 (616) 356-0100.

Sincerely,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS700417921
Investigation #:	2024A0350022
Complaint Receipt Date:	03/13/2024
Investigation Initiation Date:	03/14/2024
Report Due Date:	04/12/2024
Licensee Name:	Charles Baroi
Licensee Address:	3979 140th Ave. Holland, MI 49424
Licensee Telephone #:	(616) 377-8187
Administrator:	Charles Baroi
Licensee Designee:	Charles Baroi
Name of Facility:	Mayabe Care
Facility Address:	3993 140th Ave Holland, MI 49424
Facility Telephone #:	(616) 377-8197
Original Issuance Date:	12/12/2023
License Status:	TEMPORARY
Effective Date:	12/12/2023
Expiration Date:	06/11/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED, ALZHEIMERS, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Residents are left unsupervised.	Yes
Residents are given their medications to take whenever they want and without staff supervision.	Yes

III. METHODOLOGY

03/13/2024	Special Investigation Intake 2024A0350022
03/14/2024	Special Investigation Initiated - On Site I made an onsite inspection and spoke with Resident A, Resident B, Resident C, Charles Baroi, Licensee, and James Baroi, DCW
03/18/2024	Exit conference – Held with Charles Baroi, Licensee Designee

ALLEGATION: Residents are left unsupervised.

INVESTIGATION: On 03/14/2024, I made an onsite inspection. No staff person answered the door after I rang the doorbell, which I heard, three times. Resident A finally answered the door and I introduced myself and asked if I could speak with him. He agreed, and I followed him to the lower level of the home where Resident B was. I then informed Resident A and Resident B who I was and what the allegations were. Resident A told me that Resident C was currently home but was in his room sleeping. I asked Resident A how long he had lived in this home, and he said about a month-and-a-half. I then asked Resident B the same question and he said about three weeks. I asked both of them if there was always a staff person at the home whenever they were present, and they both said no. When I inquired as to how often this happens and how long of a time would there be no staff member present, Resident A reported that it happens "now and then," and that there would be no staff member at the home for "about 15 to 20 minutes." Resident A told me that Charles Baroi, Licensee Designee, sleeps during the day in this home, but he wasn't sure whether Mr. Baroi was there at this time or not.

On 03/14/2024, I spoke with Resident C. I told him who I was and asked him about this allegation. He told me that he only moved in two days ago and was not sure if there had been occasions when no staff member was at the home since he has lived there.

On 03/14/2024, I knocked on a bedroom door on the upper level of this home, and Mr. Baroi answered the door and came out to speak with me. I informed him that Resident A and Resident B told me there were occasions when there was no staff member in the home for up to twenty minutes while they were present. Mr. Baroi did

not respond to this, and I reminded him that a staff member is required to be in the home whenever a resident is present. He nodded his head that he understood this requirement.

On 03/18/2024, I called and held an exit conference with Charles Baroi, Licensee Designee. I informed Mr. Baroi that I was citing a violation of this rule and that his Corrective Action Plan is due in 15 days. Mr. Baroi thanked me and had no further comment.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Resident A and Resident B stated that there have been occasions when they were home but no staff person was present. They reported that this happens "now and then," for up to 20 minutes. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents are given their medications to take whenever they want and without staff supervision.

INVESTIGATION: On 03/13/2024, I received the intake information regarding this complaint. It was stated in the report that upon visiting Resident A at this home, Alyssa Lang, his Community Mental Health Case Manager, noticed a full weekly dispenser with four times per day slots full of medications. She asked him why he had that in his room and he said staff help him fill it up but they don't give the medications to the residents and he is responsible to remember when to take them.

On 03/14/2024, I made an onsite inspection. I met and spoke with Resident A and Resident B. I informed them of who I was and what the allegations were. Both Resident A and Resident B told me that they have their medications in their rooms and they take them whenever they want without staff supervision. I asked them if they were ever given a doctor's note giving them permission to take their medications on their own, and they both said no. Resident A told me that Resident C was currently home but was in his room sleeping.

On 03/14/2024, I knocked on Resident C's bedroom door, and he invited me in. I told him who I was and asked him if he took medications and if so, were they administered by a staff member. He stated that he has only lived at this home for two days, and that he took insulin and another medication. Resident C said that the insulin is in his room, and he gives his injections himself. He reported that a staff member brings his other medication to him when it is time to take it. Resident C informed me that he does not have a doctor's note granting him permission to take his insulin on his own.

On 03/13/2024, I spoke with Charles Baroi, Licensee Designee while I was at the home. I informed him that all the residents told me they keep some or all of their medications in their rooms and take them whenever they want without staff supervision. I asked Mr. Baroi if any of the residents provided him with a doctor's note stating they can take their own medications without supervision, and he said no. I advised him to obtain all the resident medications that are currently in their rooms, lock them up in the medication cabinet, and make sure the giving and taking of their medications is supervised by staff. He agreed to do this.

On 03/18/2024, I called and held an exit conference with Charles Baroi, Licensee Designee. I informed Mr. Baroi that I was citing a violation of this rule and that his Corrective Action Plan is due in 15 days. Mr. Baroi thanked me and had no further comment.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	Resident A, Resident B, and Resident C all reported that they have their medications in their rooms and that they take them whenever they want without staff supervision. They also each denied that a doctor's permission has been obtained granting them permission to take their medications on their own. Charles Baroi, Licensee Designee, confirmed that none of the residents have provided him with a doctor's permission to take their medications on their own. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

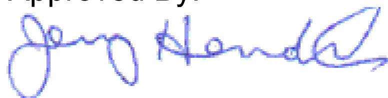
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remain unchanged, and that this special investigation be closed.

March 18, 2024

Ian Tschirhart　　　　Date
Licensing Consultant

Approved By:



March 18, 2024

Jerry Hendrick　　　　Date
Area Manager