GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 16, 2024

Alan Perkins
2704 Corunna Rd
Flint, MI 48503

RE: License #: AS250010662
Investigation #: 2024A0779026
Perkins AFC Home

Dear Alan Perkins:

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) 643-7960

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010662
Investigation #:	2024A0779026
Complaint Receipt Date:	03/13/2024
Investigation Initiation Date:	03/14/2024
Report Due Date:	05/12/2024
Licensee Name:	Alan Perkins
Licensee Address:	2704 Corunna Rd Flint, MI 48503
Licensee Telephone #:	(810) 233-0399
Administrator:	Alan Perkins
Licensee Designee:	N/A
Name of Facility:	Perkins AFC Home
Facility Address:	1027 W Second St, Flint, MI 48503
Facility Telephone #:	(810) 239-4543
Original Issuance Date:	08/21/1976
License **Status:**	REGULAR
Effective Date:	12/04/2022
Expiration Date:	12/03/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was made to sit in the same chair for hours and cannot get out of the chair unless he has to use the bathroom.	No
Resident A has black rotting teeth and was never taken to the dentist.	No
All of Resident A's pant legs are dirty and crusty at the bottom.	No
There is feces and black mold in the bathroom of this home.	Yes
Resident A uses a walker and is made to sleep on the 2nd floor of the home.	No
Additional Findings	Yes

III. METHODOLOGY

03/13/2024	Special Investigation Intake 2024A0779026
03/13/2024	APS Referral Complaint was received from APS centralized intake.
03/14/2024	Special Investigation Initiated - Telephone Interview conducted with Resident A.
03/14/2024	Contact - Telephone call made. Spoke to Resident A's family member.
03/25/2024	Inspection Completed On-site
03/26/2024	Contact - Telephone call received. Spoke to licensee, Alan Perkins.
04/04/2024	Contact - Telephone call made. Spoke to Resident A's guardian.
04/04/2024	Contact - Telephone call made. Spoke to Witness1.
04/04/2024	Exit Conference Held with licensee, Al Perkins.

ALLEGATION:

Resident A was made to sit in the same chair for hours and cannot get out of the chair unless he has to use the bathroom.

INVESTIGATION:

On 3/14/24, a phone interview was conducted with Resident A, who stated that he was made to sit in the same chair all the time and was not allowed to move. Resident A stated that the home staff made him do this because he is a fall risk.

On 3/14/24, a phone conversation took place with Resident A's family member (FM1), who stated that he has just recently reentered Resident A's life from being absent for many years. FM1 stated that he has taken Resident A out of this home in January 2024 for a visit and Resident A was afraid to go back, so Resident A has been living with him since. FM1 stated that Resident A was made to sit in the same chair all day at this home unless he had to use the bathroom. FM1 reported that Resident A has alcohol induced dementia and has significant memory issues.

On 3/25/24, an on-site inspection was conducted and licensee, Alan Perkins, was interviewed. Licensee Perkins denied that Resident A was ever made to sit in a chair all day or for hours at a time. Licensee Perkins stated that all the residents of this home are free to go any where in the home they want. Licensee Perkins reported that Resident A liked to hang out in the dining room and chose to sit in the same spot every day but was never told or made not to move.

On 3/25/24, an interview was conducted with live-in staff person, Christine Adamson. Staff Adamson confirmed that Resident A liked to sit in the same chair in the dining room but was never told that he had to stay there. Staff Adamson reported that Resident A was free to go anywhere in the home and would frequently go out to the back porch to smoke.

On 3/25/24, interviews were conducted with Resident B, Resident C, Resident D and Resident E. All four residents denied that Resident A was made or ever told he had to sit in a chair for hours without moving. They all confirmed that Resident A liked to sit in the same place in the dining room all the time and frequently went outside to smoke throughout the day.

On 4/4/24, a phone conversation took place with Resident A's legal guardian, who stated that Resident A chose to sit in a chair all day. Guardian stated that Resident A did not like to socialize much and liked to be by himself. Guardian reported that Resident A never told her that he was made to stay in the same chair for hours.

On 4/4/24, a phone conversation took place with Witness1, who stated that she works for Guardian and completes the visits to this home for Guardian. Witness1 stated that Resident A chose to stay idle and had no desire to move around the home. Witness1

reported that Resident A seemed content to sit in one place and do “word search” books for hours.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.**
ANALYSIS:	It was confirmed that Resident A was the one who chose to sit in the same spot in the home every day. Licensee, Alan Perkins, and live-in staff person, Christine Adamson, denied that Resident A was ever told he had to stay in the same chair for hours. Four separate residents stated that Resident A was never made to stay in the same chair for hours and that Resident A would frequently go outside to smoke throughout the day. Resident A’s guardian stated that Resident A has never told her that he was made to stay in the same chair for hours at a time. There was insufficient evidence found to prove that any staff at this home has confined Resident A to a chair for any extended length of time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A has black rotting teeth and was never taken to the dentist.

INVESTIGATION:

On 3/14/24, Resident A and Witness1 confirmed that Resident A has black rotting teeth. They claim that Resident A has complained about his teeth hurting but the home has never made any dental appointments for him to go have his teeth looked at.

On 3/25/24, licensee Perkins stated that he has made a few dental appointments for Resident A, but Resident A had always refused to go to them. Licensee Perkins stated that he tried getting Resident A to go to the dentist throughout his 2-year stay at this home but Resident A would not go. Licensee Perkins reported that Resident A did not like to leave the home and that he had to have Resident A prescribed a PRN medication

for anxiety just to get Resident A to go doctor appointments and that did not always work.

On 4/4/24, Guardian confirmed that it was difficult to get Resident A to leave the home. Guardian stated that licensee Perkins had set up several dental appointments for Resident A over the years, but that Resident A always refused to go.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(11) A licensee shall contact a resident's physician for instructions as to the care of the resident if the resident requires the care of a physician while living in the home. A licensee shall record, in the resident's record, any instructions for the care of the resident.
ANALYSIS:	Licensee, Alan Perkins, stated that Resident A did not like to leave the home and that he had set up a few dental appointments for Resident A, but Resident A would always refuse to go. Resident A's guardian confirmed that fact to be true. There was insufficient evidence found to prove that this home denied Resident A of needed dental care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

All of Resident A's pant legs are dirty and crusty at the bottom.

INVESTIGATION:

On 3/14/24, Resident A and FM1 stated that all Resident A's clothing were dirty and the bottom of his pant legs were crusty. Resident A confirmed that the home washed his clothing for him but could not say how often.

On 3/25/24, licensee Perkins and Staff Adamson, stated that Resident A's clothing were washed at least once, if not twice, a week. Licensee Perkins stated that Resident A never left the home to get the bottom of his pant legs dirty and/or crusty. They both stated that Resident A would not even go off the back porch went he went outside to smoke. Licensee Perkins provided a good portion of Resident A's clothing that he still had in bags from after Resident A moved out of the home in January 2024. All the clothing in the bags were viewed to be appropriately clean.

On 3/25/24, four separate residents confirmed that their clothes get washed at least once a week. They all stated that they have never witnessed Resident A wearing dirty and/or crusty clothing and confirmed that Resident A would never even leave the back porch to smoke.

On 4/4/24, Witness1 stated that she had visited Resident A at this home approximately every two months. Witness1 stated that Resident A was never observed to be wearing dirty clothing.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(5) A licensee shall afford a resident with opportunities, and instructions when necessary, to routinely launder clothing. Clean clothing shall be available at all times.
ANALYSIS:	Licensee Alan Perkins and staff person, Christine Perkins, stated that Resident A's clothing was washed at least once weekly and denied that Resident A was ever made to wear dirty and crusty clothing. Four separate residents of this home confirmed that their clothes get washed at least once a week and that they have never witnessed Resident A wearing dirty and/or crusty clothing. Witness1 stated that she had visited Resident A at this home every two months and had never seen Resident A wearing dirty clothing. On 3/25/24, a bag full of Resident A's clothing that were still at this home were viewed to be appropriately clean. There was no evidence found to prove that Resident A's clothing was not being appropriately washed during his time at this home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There is feces and black mold in the bathroom of this home.

INVESTIGATION:

During the unannounced on-site inspection on 3/25/24, the bathroom of this home was inspected. The toilet was observed to be quite visibly dirty. There was what appeared to be black mold observed on the floor, all the way around the base of the toilet.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	During the unannounced on-site inspection on 3/25/24, the bathroom of this home was inspected. The toilet was observed to be quite visibly dirty. There was what appeared to be black mold observed on the floor, all the way around the base of the toilet. There was sufficient evidence found to prove that in this circumstance, licensee, Alan Perkins, has failed to provide adequately for the health, safety, and well-being of the residents of this home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A uses a walker and is made to sleep on the 2nd floor of the home.

INVESTIGATION:

On 3/14/24, FM1 stated that Resident A has to use a walker and is made to sleep on the second story of this home. FM1 stated that Resident A cannot safely do the stairs on his own. FM1 stated that when he took Resident A to his home in January for a visit, Resident A was afraid to go back to this home, so he has not returned him. FM1 reported that he has filed a motion for change of guardianship for Resident A and was given temporary permission from a judge to keep Resident A until the guardianship issue is resolved.

On 3/14/24, Resident A confirmed that he uses a walker, but could not say if he was actually prescribed a walker by a physician. Resident A stated that he has a walker to use on the first floor and another walker left him to use in the upstairs portion of the home. Resident A stated that it is hard for him to get up and down the stairs, but that he can do it using the handrails. Resident A claimed that he has fallen at this home a few times but has not had any real injuries or hospital visits as a result of a fall. Resident A could not say how many falls he has had or when the last fall had taken place.

On 3/25/24, Staff Adamson stated that Resident A chose to use a walker sometimes that the home had but stated that Resident A get around the home just fine without it. Staff Adamson stated that Resident A has never used a walker in the upstairs of the home.

On 3/25/24, licensee Perkins stated that Resident A is seen at this home almost on a monthly basis by visiting physicians and has never been prescribed a walker and did not have a walker when he moved into this home. Licensee Perkins admitted that Resident A would occasionally use a walker that the home had, but that Resident A could physically walk fine and never used a walker upstairs. Licensee Perkins reported that Resident A had dementia and would have good and bad days but has not had any known or reported falls in this home. Licensee Perkins stated that on the bad days, Resident A would even choose to crawl on the floor at times. Licensee Perkins stated that Resident A would be crawling on the floor one minute and then get up and walk just fine. Licensee Perkins reported that Resident A has had appointments with a neurologist, who could not figure out why Resident A would choose to crawl and blamed it on his dementia. The neurologist could not find a physical or medical reason for the crawling. Licensee Perkins stated that he never had any problems with Resident A and that Resident A never said anything about the stairs being an issue until FM1 came back into his life. Licensee Perkins stated that FM1 got upset when Guardian did not like Resident A going to FM1's home for visits and did not want him to provide FM1 with Resident A's belongings after FM1 refused to bring Resident A back to the home in January 2024.

The *Assessment Plan For AFC Residents* was reviewed for Resident A. The plan that was reviewed was from when Resident A initially entered the home in 2022 and stated that Resident A is quite independent and able to complete all his activities of daily living on his own, with only prompting from staff. The plan does not mention Resident A having a walker or other assistive devices. The home did not have a current assessment plan available for review for 2023. The home provided a copy of a separate/additional assessment the home uses upon admission and that assessment has a written statement from Resident A that said, "I can walk, just paranoid".

Resident A's health care appraisal was also reviewed. It did not mention anything about Resident A requiring the use of a walker or having mobility issues.

On 3/25/24, Resident B was interviewed, who confirmed that he was Resident A's roommate at this home. Resident B stated that Resident A would be walking just fine and then start crawling on the floor. Resident B reported that Resident A has never used a walker in the upstairs of the home and that he has never known of Resident A to ever have any falls. Resident B stated that Resident A would use the handrail and go up and down the stairs 2-3 daily with no major issues.

On 3/25/24, Resident C, Resident D and Resident E stated that they have observed Resident A use a walker downstairs sometimes, walk just fine and then crawl on the floor sometimes. None of them have ever witnessed Resident A to have a fall. Resident E stated that Resident A could walk when he wanted too and that he has observed Resident A go up and down the stairs with no problem.

On 4/4/24, Guardian stated that she is not aware of Resident A ever being prescribed a walker by a physician. Guardian stated that Resident A was very independent

regarding physically completing all his activities of daily living on his own and that Resident A could walk when he wanted too.

On 4/4/24, Witness1 stated that she has never seen Resident A use a walker. Witness1 stated that Resident A would walk just fine to do the majority of their visits outside.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(9) A resident who has impaired mobility shall not sleep in or be assigned a bedroom that is located above the street floor of the home.
ANALYSIS:	Multiple sources have confirmed that Resident A could not only walk on his own when he wanted too but could do stairs without any significant issues. Resident A was never prescribed the use and/or need of a walker from a physician. There was insufficient evidence found to cite this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site inspection on 3/25/24, licensee Alan Perkins stated that an *Assessment Plan For AFC Residents* form was completed for Resident A in 2023, but he was unable to locate it. On 3/26/24, a phone call was received from Licensee Perkins confirming that the home does not have a current/updated assessment plan for Resident A available for review.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.

ANALYSIS:	Licensee Alan Perkins was unable to provide a current and/or updated assessment plan for 2023 regarding Resident A. Resident A entered this home in January 2022; therefore, a required annual updated version of the assessment plan should have been completed in January 2023. Although Licensee Perkins stated that one was done and signed in 2023, there was not one for 2023 available in the home for review.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/4/24, an exit conference was held with licensee Alan Perkins. Licensee Perkins was informed of the outcome of this investigation and that a written corrective action plan is required.

IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

Christopher A. Holvey

4/15/2024

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Christopher Holvey Date
Licensing Consultant

Approved By:

Mary E. Holton

4/16/2024

_____

Mary E. Holton Date
Area Manager