GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 11, 2023

Peggy Root
411 Silver Street
Reading, MI 49274

RE: License #: AM300008365
Investigation #: 2023A1032022
Heritage House AFC

Dear Ms. Root:

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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AM300008365 |
| | |
| **Investigation #:** | 2023A1032022 |
| | |
| **Complaint Receipt Date:** | 12/15/2022 |
| | |
| **Investigation Initiation Date:** | 12/16/2022 |
| | |
| **Report Due Date:** | 01/14/2023 |
| | |
| **Licensee Name:** | Peggy Root |
| | |
| **Licensee Address:** | 411 Silver Street<br>Reading, MI 49274 |
| | |
| **Licensee Telephone #:** | (517) 283-1478 |
| | |
| **Name of Facility:** | Heritage House AFC |
| | |
| **Facility Address:** | 121 West State Street<br>Reading, MI 49274 |
| | |
| **Facility Telephone #:** | (517) 283-3152 |
| | |
| **Original Issuance Date:** | 08/02/1993 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 04/23/2022 |
| | |
| **Expiration Date:** | 04/22/2024 |
| | |
| **Capacity:** | 12 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A was not adequately supervised while in the community and left at an outside location. | Yes |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 12/15/2022 | Special Investigation Intake<br>2023A1032022 |
| 12/16/2022 | Special Investigation Initiated – Telephone Interview with complainant. |
| 12/20/2022 | Inspection Completed On-site<br>Face to Face Interviews with licensee, Resident A and Resident B. |
| 12/20/2022 | Contact - Telephone call made Interview with Employee #1. |
| 01/06/2023 | Exit Conference with Licensee Peg Root |

**ALLEGATION:**

**Resident A was not adequately supervised while in the community and left at an outside location.**

**INVESTIGATION:**

On 12/16/22, I interviewed the complainant via telephone for the purpose of verifying the complaint information.

On 12/20/22, I interviewed licensee Peg Root in the home. Ms. Root stated that Employee #1 took all the residents to a doctor's office because one of the residents

had an appointment. Ms. Root stated that once the appointment ended, Employee #1 gathered all the residents and left the doctor's office. Ms. Root reported that, upon arrival at the home, Employee #1 called out for Resident A. When there was no response, Employee #1 determined that Resident A had been left at the doctor's office. Ms. Root stated that as far as she knew, Resident A was inside the doctor's office lobby, waiting for Employee #1 to return. Ms. Root identified Resident A as someone who has autism spectrum disorder and can be difficult to communicate with.

I interviewed Resident A at the home. Resident A stated that Resident B came back for him at the doctor's office.

I interviewed Resident B, who was identified as Resident A's roommate. Resident B stated that Resident A was left behind at the doctor's office, and that upon their return, Resident A was inside the building, in the lobby, waiting on their return.

I interviewed Employee #1 via telephone. Employee #1 stated that she took the residents to a doctor's office to accompany a resident who had an appointment there. She reported that the residents remained in the lobby while the resident with the appointment was attended to. Employee #1 posited that Resident A was in the rest room when the appointment ended but an assumption was made that all residents were accounted for when they left the doctor's office, identified as Three Meadows Medical Plaza. After leaving the doctor's office, Employee #1 stated that she drove to a pharmacy to fill a prescription, then returned to the home. She noticed then, while at the home, that Resident A was not there. Employee #1 stated that she gathered the residents and proceeded to the doctor's office. She found Resident A in the lobby, and noted that a gentleman had provided Resident A with a beverage and had waited with him in the lobby. Employee #1 acknowledged that she did not take a "head count" of the residents when they left the doctor's office initially, and stated that going forward, she plans to do so whenever they leave the home for appointments or activities in the community.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14303** | **Resident care; licensee responsibilities.** |
| | **(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.** |
| **ANALYSIS:** | Employee #1 acknowledged that when the van left the doctor's office, a resident count was not performed. Resident A was left at the doctor's office and was not properly supervised. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 1/6/23, I conducted an exit interview with licensee Peg Root. Ms. Root agreed with the findings shared and agreed to consistently apply a procedure of counting residents prior to leaving any location.

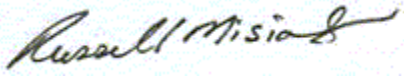
## IV. RECOMMENDATION

I recommend no change to the status of this license, contingent upon an acceptable corrective action plan.

1/11/23

Dwight Forde — Date
Licensing Consultant

Approved By:



2/9/23

Russell B. Misiak — Date
Area Manager