GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 13, 2023

Peggy Root
411 Silver Street
Reading, MI 49274

RE: License #: AM300008365
Investigation #: 2023A1032059
Heritage House AFC

Dear Peggy Root:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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
Unit 13, 7th Floor
350 Ottawa, N.W.
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 #:	2023A1032059
Complaint Receipt Date:	09/21/2023
Investigation Initiation Date:	09/21/2023
Report Due Date:	11/20/2023
Licensee Name:	Peggy Root
Licensee Address:	411 Silver Street Reading, MI 49274
Licensee Telephone #:	(517) 283-1478
Name of Facility:	Heritage House AFC
Facility Address:	121 West State Street 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 DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
A resident was driving other residents to appointments.	No
A staff member delivered Tylenol to a resident through other residents.	No
Additional Findings	No

III. METHODOLOGY

09/21/2023	Special Investigation Intake 2023A1032059
09/21/2023	Special Investigation Initiated - Telephone Interview with complainant
09/22/2023	Inspection Completed On-site
09/29/2023	Contact - Telephone call received
10/03/2023	Contact - Document Received Added info from intake # 197901 to this complaint
10/06/2023	Contact - Telephone call made
10/10/2023	Inspection Completed On-site
10/10/2023	Contact - Document Received
10/12/2023	Exit Conference

ALLEGATION:

A resident was driving other residents to appointments.

INVESTIGATION:

On 9/21/23, I interviewed the complainant. The complainant denied having firsthand knowledge about the incident but received the information from a trusted associate.

On 9/22/23, I interviewed Resident A. Resident A denied driving a van to pick up residents from any community programming.

I interviewed Resident B in the home. Resident B denied that Resident A has ever picked up residents from community programming or from doctor's appointments or shopping. Resident B stated that either staff members Allyson Baker or Alexis Oates do transportation.

I interviewed Resident C in the home. Resident C added that sometimes licensee Peg Root also does transportation. Resident C denied that Resident A has ever driven the van.

I interviewed licensee Peg Root in the home. Ms. Root denied that Resident A does transportation.

On 9/29/23, I interviewed staff member Allyson Baker via telephone. Ms. Baker stated that either she or Alexa drive the residents to community appointments.

On 10/10/23, I interviewed staff member Alexis Oates in the home. Ms. Oates denied that Resident A has been allowed to transport residents to and from community appointments.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(1) A resident shall be assured privacy and protection from moral, social, and financial exploitation.

ANALYSIS:	All residents and staff members who were interviewed, denied that Resident A was allowed to transport residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

A staff member delivered Tylenol to a resident through other residents.

INVESTIGATION:

On 10/3/23, I received a complaint that Resident B fell at a grocery store on 9/18/23, and that an employee had residents hand him Tylenol.

On 10/6/23, I interviewed licensee Peg Root via telephone. Ms. Root stated that it was doubtful that Allyson Baker had residents deliver Tylenol to Resident B while he was in the van, after falling at a grocery store. Ms. Root advised that Resident B was taken to the hospital after he fell. It should be noted that I saw resident B at the home after the incident date noted on the attached new complaint.

I interviewed staff member Allyson Baker via telephone. Ms. Baker stated that on 9/18/23, she took Resident B to Coldwater Hospital after he fell at a grocery store. Ms. Baker denied having residents pass Tylenol to Resident B while he was in the van. Ms. Baker stated that Resident B asked for Tylenol. She reported that she advised Resident B that it was not a good idea to give him any medication that might interfere with drugs supplied at the hospital.

On 10/10/23, I made an onsite inspection at the home. I witnessed Resident B leaving the home via ambulance and was unable to interview him regarding the new complaint.

I interviewed staff member Alexis Oates in the home. Ms. Oates stated that she was unaware of any staff member having residents give Resident B Tylenol after he fell at a grocery store. Ms. Oates stated that she has been working at the home since August 2023, and that Resident B has started falling within the past two weeks. Ms Oates denied that on 9/18/23, she drove the residents to a grocery store and had other residents give Resident B Tylenol.

I interviewed Resident A, who denied that other residents handed Resident B pain medication. Resident A advised that he was at the back of the van.

I interviewed Resident C, who advised that no residents were directed to give Resident B Tylenol.

I interviewed Resident D in the home. Resident D stated that staff member Alexis Oates had taken them to a grocery store, where Resident B fell, and was handed Tylenol by residents at the direction of Ms. Oates.

I reviewed an incident report (IR) written by Allyson Baker on 9/18/23, which is consistent with her report that Resident B was not given Tylenol and transported to Coldwater Hospital.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on interviews with staff members and residents, there is insufficient evidence that a staff member improperly supervised the administration of medication after a resident fell in the community.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 10/12/23, I conducted an exit conference with licensee Peggy Root. I shared my findings and Ms. Root agreed with the conclusions reached.

IV. RECOMMENDATION

I recommend no change to the status of this license.

10/13/23

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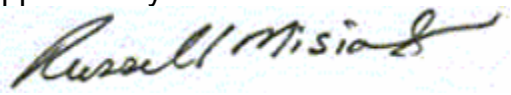
Dwight Forde Date
Licensing Consultant

Approved By:



11/1/23

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Russell B. Misiak Date
Area Manager