GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 10, 2022

Vicky Cates
3960 Sharp Rd.
Adrian, MI 49256

RE: License #: AM460095319
Investigation #: 2022A1032016
New Beginnings AFC

Dear Ms. Cates:

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
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503
(616)-240-3850

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AM460095319 |
| | |
| **Investigation #:** | 2022A1032016 |
| | |
| **Complaint Receipt Date:** | 08/17/2022 |
| | |
| **Investigation Initiation Date:** | 08/17/2022 |
| | |
| **Report Due Date:** | 09/16/2022 |
| | |
| **Licensee Name:** | Vicky Cates |
| | |
| **Licensee Address:** | 3960 Sharp Rd.<br>Adrian, MI 49256 |
| | |
| **Licensee Telephone #:** | (517) 902-3950 |
| | |
| **Name of Facility:** | New Beginnings AFC |
| | |
| **Facility Address:** | 211 E. Main Street<br>Morenci, MI 49256 |
| | |
| **Facility Telephone #:** | (517) 458-6926 |
| | |
| **Original Issuance Date:** | 05/24/2001 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 03/21/2022 |
| | |
| **Expiration Date:** | 03/20/2024 |
| | |
| **Capacity:** | 12 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>AGED |

ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Staff did not provide medications to Resident A | No |
| Staff did not provide meals to Resident A | No |
| Additional Findings | No |

## II. METHODOLOGY

| | |
|---|---|
| 08/17/2022 | Special Investigation Intake<br>2022A1032016 |
| 08/17/2022 | Special Investigation Initiated - Telephone |
| 08/25/2022 | Contact - Face to Face |
| 09/20/2022 | Exit Conference |
| 10/10/2022 | Contact - Telephone call received<br>With Guardian |

**ALLEGATION:**

**Staff did not provide Resident A with medications.**

**INVESTIGATION:**

On 8/17/22, I interviewed Rochelle Flores via telephone. She stated that she is the director of the Daylight Program that is an adjunct service of the Senior Center in Lenawee County. She stated that on August 15, Resident A came to the program complaining that she had not eaten breakfast and did not receive her morning medication. Ms. Flores stated that Resident A is transported to the program via Lenawee Transportation, and that the bus driver had to honk the horn several times before an employee at the home came to assist Resident A on to the bus. Resident

A reportedly did not receive her medication at the home, but the medication was later supplied at the program.

On 8/25/22, I interviewed live-in employee, Theresa Morey, at the home. Ms. Morey stated that last Monday, the bus may have come early for Resident A. Ms. Morey stated that Resident A is fairly new and that she goes to a program all day at a place called Daybreak on Mondays and Thursdays. She stated that another Resident also attends the same program on Thursdays along with Resident A. She reported that she was confused about which days Resident A went by herself. She stated that because the bus came early, she did not give Resident A her morning medication at the home. She stated that she sent Resident A's medications with another employee later that morning so that they would not be missed. She denied that this has happened since, or with other residents who may have to get up early for programming. She reported that she assists Resident A onto the bus that provides transport to the Daybreak program.

I interviewed Resident A. She stated that she heard the bus come and went outside before seeking assistance from the home employee. She reported that she felt anxious because she did not want to miss the bus to take her to the Daybreak program. She mentioned that when she got to the program, she advised the staff there that she had not eaten breakfast that morning nor had she received her medications. She advised that she was served breakfast at Daybreak and subsequently got her medications from a home employee who came to Daybreak for that purpose. She denied that this has happened since, and that the employees serve her breakfast and give her medications before she leaves for Daybreak. She stated that she attends Daybreak on Mondays and Thursdays. She expressed satisfaction with the routine at New Beginnings.

Resident A was observed ambulating freely, out of the shower. She did not require assistance as she navigated the home.

I interviewed Resident B. She stated that she has been at the home for approximately 10 years and that Ms. Morey has kept the place running very well, when compared to past employees. She stated that Ms. Morey dispenses medications without issue.

| **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:** | The home took steps to ensure that Resident A received her medication. Resident A advised that she did in fact receive her medication. Employees at Daybreak confirmed that a staff member from the home delivered the medications to Resident A at the program. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Staff did not provide meals to Resident A.**

**INVESTIGATION:**

Ms. Morey stated that on the day in question she did not serve breakfast to Resident A. She acknowledged that a mistake had been made given that she had not properly adjusted to Resident A's schedule.

Resident A stated that she was not served breakfast at the home that day, but since then, there have been no issues with missed meals. She stated that this incident was atypical of the operations at the home. She stated that she felt anxious about missing the bus and went outside unassisted when she realized it came early, rather than get the staff. She stated that she did receive a meal at Daybreak.

Resident B stated that Ms. Morey serves meals in a timely fashion.

On 10/10/22, I received a call from Guardian A1. Guardian A1 stated that she also discussed the incident with Resident A, and that there was a mix up with times, since Resident A was fairly new to the home. Guardian A stated that Resident A has been receiving good care in the home and likes her situation. She advised that a new assessment plan has been devised since Resident A left her previous home and is now at New Beginnings AFC.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14313** | **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:** | Resident A stated that she had woken up early and got on the bus. There appeared to be some confusion about her schedule, since she was a fairly new resident at the time. While she did not receive a meal at the home, she was served breakfast at Daybreak. This appears to be an isolated incident and not a chronic issue. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

On 9/20/22, I conducted an exit interview with licensee Vicki Cates. I shared the results of the investigation and she agreed with the findings.

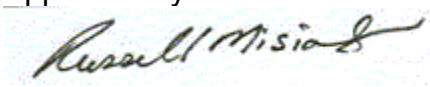
## III. RECOMMENDATION

I recommend no change to the status of this license.

10/10/22

Dwight Forde — Date
Licensing Consultant

Approved By:



11/4/22

Russell B. Misiak — Date
Area Manager