STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

May 29, 2024

DeElla Johnson
Andrews & Johnson Inc
P.O. Box 457
Genesee, MI 48437

RE: License #: AS250345774
Investigation #: 2024A0576035
Andrews & Johnson #4

Dear DeElla Johnson:

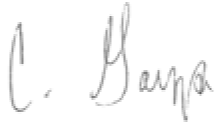
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Be signed and dated.

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,



Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250345774
Investigation #:	2024A0576035
Complaint Receipt Date:	05/02/2024
Investigation Initiation Date:	05/07/2024
Report Due Date:	07/01/2024
Licensee Name:	Andrews & Johnson Inc
Licensee Address:	P.O. Box 457, Genesee, MI 48437
Licensee Telephone #:	(810) 938-8177
Administrator:	DeElla Johnson
Licensee Designee:	DeElla Johnson
Name of Facility:	Andrews & Johnson #4
Facility Address:	7404 N Bray Road, Mt Morris, MI 48458
Facility Telephone #:	(810) 686-2198
Original Issuance Date:	08/29/2013
License Status:	REGULAR
Effective Date:	02/25/2024
Expiration Date:	02/24/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was unaccompanied by AFC staff as required in the ER (Emergency Room) of McLaren Hospital on February 4, 2024	Yes

III. METHODOLOGY

05/02/2024	Special Investigation Intake 2024A0576035
05/07/2024	Special Investigation Initiated - Letter Sent email to Patricia Shepard, Genesee County Office of Recipient Rights (ORR)
05/07/2024	Contact - Document Received Received email from Patricia Shepard
05/23/2024	Contact - Telephone call made Left message for Rachael Schatzberg, Nurse to return call
05/23/2024	Contact - Telephone call made Left message for Crisann Havens, Case Manager to return call
05/24/2024	Contact - Telephone call made Interviewed Rachael Schatzberg
05/24/2024	Contact - Telephone call made Interviewed Crisann Havens
05/24/2024	Inspection Completed On-site Interviewed Michelle Paige, Home Manager
05/28/2024	Contact - Telephone call made Interviewed Resident A
05/28/2024	Contact - Telephone call made Interviewed Licensee Designee, DeElla Johnson
05/28/2024	Exit Conference
05/29/2024	APS Referral

ALLEGATION:

Resident A was unaccompanied by AFC staff as required in the ER of McLaren Hospital on February 4, 2024.

INVESTIGATION:

On May 7, 2024, I sent an email to Patricia Shepard, Genesee County Office of Recipient Rights (ORR) Investigator. I requested contact information for Resident A's Nurse and Case Manager. Investigator Shepard provided the requested information.

On May 23, 2024, I left a message for Resident A's Nurse from Genesee Health System (GHS), Rachael Schatzberg to return call. On May 24, 2024, I interviewed Nurse Schatzberg regarding the allegations, and she reported she was reviewing Resident A's medical records from a hospital encounter in February 2024. Resident A went to the emergency room for vaginal bleeding and the hospital physician noted they were unable to obtain a medical history due to no one accompanying Resident A and Resident A's inability to provide her history due to developmental delay. Nurse Schatzberg advised that in Resident A's plan of service it is outlined that Resident A is to be accompanied by someone when sent to the hospital.

On May 23, 2024, I left a message for Resident A's Case Manager from GHS, Crisann Havens to return call. On May 24, 2024, I interviewed Case Manager Havens and she reported she was aware that Resident A was sent to the hospital in February 2024 for vaginal bleeding. According to Case Manager Havens, Resident A is unable to access the community alone and is verbal. Case Manager Havens was unaware of the allegations and advised she has no concerns regarding the home.

On May 24, 2024, I completed an unannounced on-site inspection at Andrews & Johnson #4 and interviewed Home Manager, Michelle Paige regarding the allegations. Manager Paige confirmed the allegations were true and Resident A went to the hospital on February 4, 2024, for vaginal bleeding. It was 2am and staff called her to report that Resident A had a lot of blood on her bed. Staff cleaned Resident A and Manager Paige called Licensee Designee, DeElla Johnson who advised Resident A needed to be sent to the hospital. Staff called 911 and Resident A was transported to the hospital. No one accompanied Resident A to the hospital and Home Manager Paige advised that she was unaware that someone needed to accompany Resident A. Resident A was not admitted to the hospital and returned home a few hours later.

On May 24, 2024, I reviewed an Incident / Accident Report (IR) dated for February 4, 2024, and authored by Andrea McReynolds. The IR documented that on February 4, 2024, Resident A went to use the bathroom and staff noticed she was bleeding very heavy. Staff assisted Resident A in the shower and putting on clean clothes. Staff also changed Resident A's bed linen. 911 was contacted and Resident A was sent to the hospital.

On May 24, 2024, I reviewed Resident A's Individual Plan of Service (IPOS). The IPOS indicates that when Resident A "attends medical appointments, physical tests, dental appointments, etc. and especially hospital/emergency room visits via ambulance, that a staff person who is knowledgeable about Resident A will be in attendance with her."

On May 28, 2024, I interviewed Resident A and she reported she was doing well. Resident A could not recall how long she has lived at her home. Resident A confirmed she went to the hospital in February 2024, and she could not remember if anyone went with her. Resident A denied any current concerns. The interview was concluded as Resident A unable to stay on topic.

On May 28, 2024, I interviewed Licensee Designee, DeElla Johnson regarding the allegations. Licensee Designee Johnson confirmed the allegations were true and that the Home Manager, Michelle Paige was unaware or forgot that staff needed to accompany Resident A to the hospital. Resident A was sent to the hospital due to vaginal bleeding and the hospital was unable to find the cause. Currently, Resident A is doing well, and her doctor continues to look for the cause of the bleeding.

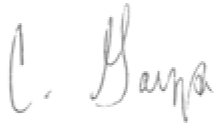
APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	It was alleged that on February 4, 2024, Resident A was sent to the hospital without staff present. Upon conclusion of investigative interviews and a review of documentation, there is a preponderance of evidence to conclude a rule violation. Resident A was sent to the hospital on February 4, 2024, due to vaginal bleeding. 911 was contacted and Resident A was transported to the emergency room at McLaren Hospital, and no one accompanied Resident A. Home Manager, Michelle Paige was contacted and advised the allegations were true and she was unaware that Resident A needed to be accompanied by staff. Licensee Designee was interviewed and confirmed the allegations were true. Resident A's IPOS indicated that staff are to accompany Resident A to hospital/emergency room visits.

	There is a preponderance of evidence to conclude Resident A was not provided supervision as specified in the resident's written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

On May 28, 2024, I conducted an Exit Conference with Licensee Designee, DeElla Johnson. I advised Licensee Designee Johnson I would be citing a rule violation and requesting a corrective action plan.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change in the license status is recommended.



5/29/2024

Christina Garza Date
Licensing Consultant

Approved By:

5/29/2024

Mary E. Holton Date
Area Manager