GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 14, 2024

Jason and Jessica Taylor
3773 Hudson Road
Osseo, MI 49266

RE: License #: AM300276139
Investigation #: 2024A1032036
Somewhere in Time

Dear Jason and Jessica Taylor:

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 #:	AM300276139
Investigation #:	2024A1032036
Complaint Receipt Date:	05/13/2024
Investigation Initiation Date:	05/13/2024
Report Due Date:	07/12/2024
Licensee Name:	Jason and Jessica Taylor
Licensee Address:	3773 Hudson Road Osseo, MI 49266
Licensee Telephone #:	(517) 286-5407
Licensee Designee:	
Name of Facility:	Somewhere in Time
Facility Address:	3773 Hudson Rd. Osseo, MI 49266
Facility Telephone #:	(517) 523-2621
Original Issuance Date:	06/12/2006
License Status:	REGULAR
Effective Date:	01/25/2023
Expiration Date:	01/24/2025
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was not properly discharged.	No
Resident A was struck by an employee.	No
Resident A was improperly given medication.	No
Additional Findings	No

III. METHODOLOGY

05/13/2024	Special Investigation Intake 2024A1032036
05/13/2024	Special Investigation Initiated - Telephone Interview with Guardian A1
05/17/2024	Contact - Telephone call received Interview with APS Specialist Betsy Clark
05/28/2024	Inspection Completed On-site
05/30/2024	Contact - Document Received Interview with Lifeways Case Manager Jeanie Ashworth
06/10/2024	Contact - Document Received
06/14/2024	Contact - Telephone call made Attempted phone call to Employee Joann Post
06/14/2024	Exit Conference

ALLEGATION:

Resident A was not properly discharged.

INVESTIGATION:

On 5/3/24, I interviewed APS specialist Betsy Clark via telephone. Ms. Clark discussed Resident A's guardian receiving a text from licensee Jessica Taylor, stating that Resident A had leave in 30 days. I asked whether a reason for the discharge was given, or whether new placement had been found. Ms. Clark advised that to her knowledge, neither element of the discharge was met.

On 5/13/24, I interviewed Guardian A1 by telephone. Guardian A1 stated that she received a copy of Resident A's discharge notice over the weekend, on or about 5/11/24. Guardian A1 further stated that this action was likely taken after the licensee was told that the verbal notice given in April 2024 was insufficient. Guardian A1 stated that the reason given for the discharge was the home's inability to provide care going forward.

Guardian A1 stated that in February, she was advised that things were going well at the home and denied being told of any concerns. She reported that she only learned recently that Resident A struck another resident. Guardian A1 discussed Resident A having some medication challenges that were affecting her behavior but had hoped that given time, that finding the right prescription would end further behavioral dysregulation. She shared that one of the medications caused hallucinations.

On 5/28/24, I interviewed licensees Jason and Jessica Taylor in the home. I was advised that Resident A in recent months began displaying aggressive behaviors toward other residents, such as urinating on a roommate's stuffed animals and smearing feces on walls. They had hoped that Resident A's behaviors could be managed by medication but things had not changed much. They reported that the case manager was made aware that things were becoming more difficult but ultimately decided that discharge was the best course of action.

On 5/30/24, I interviewed Lifeways case manager Jeanie Ashworth by telephone. Ms. Ashworth stated that prior to Resident A having medication issues in 2024, she had no concerns with placing residents in the home. Ms. Ashworth advised that a few months ago, she asked Jessica Taylor about openings, and Mrs. Taylor had advised her that there would be one soon. She stated that she asked Mrs. Taylor if Resident A was going to be discharged and Mrs. Taylor advised her that this was correct.

On 6/10/24, I reviewed Resident A's assessment plan. The plan reflected that Resident A controls aggressive behavior, but sometimes yells randomly at other people.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy;**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	Resident A's representative was provided a written notice detailing the reason for discharge.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was struck by an employee.

INVESTIGATION:

On 5/3/24, Ms. Clark reported that an employee allegedly swatted Resident A on her buttocks after Resident A had a toileting accident.

On 5/13/24, Guardian A1 stated that around April 30, 2024, and employee allegedly struck Resident A on the buttocks in response to a toileting accident.

On 5/17/24, I spoke with APS specialist Betsy Clark via telephone. Ms. Clark provided an update, that she spoke with employee Joanne Post, regarding the allegation that she struck Resident A in the buttocks. Ms. Clark advised that Ms. Post had denied doing so. Ms. Clark acknowledged that there were no marks or bruises that had been reported.

On 5/28/24, The Taylors advised that they addressed the issue off their employee allegedly striking Resident A in the buttocks as a means of punishment. They denied

hearing any such reports from the other residents or Resident A and that Joann Post denied taking any such action. They provided a telephone number for Ms. Post, as she was not on shift during the onsite inspection.

The Taylors advised that Resident A seems to accuse others of assaulting her when she gets upset. They made reference to a recent conversation where Resident A accused Guardian A1 of striking her, supposedly after Guardian A1 did not get her something she wanted.

I interviewed Resident A in the home. Resident A reported that generally speaking, things were going well and that she was receiving her medication. I asked Resident A about any negative interactions with residents or staff, and she reported that an employee named Joanne hit her once.

I interviewed Resident B in the home. Resident B stated that she has been in the home for approximately 11 years and denied having any issues.

I interviewed Resident C in the home. Resident C reported that he enjoys living in the home. I observed Resident C assisting others in bringing in groceries.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	There is insufficient evidence to establish a violation that Resident A was struck by an employee. I gathered information that details Resident A having some difficulty orienting to reality. There was no physical evidence at the time that I received the complaint.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was improperly given medication.

INVESTIGATION:

On 5/28/24, The Taylors denied that physician's orders were ignored and that Resident A's medications were switched improperly.

I reviewed Resident A's Medication Administration Record. The MAR reflected that Resident A was weaned off of Keppra between December 2023 and March 2024, then replaced by Depakote, per physician's orders.

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.
ANALYSIS:	I reviewed Resident A's MAR and physician's instructions, which appeared to have been followed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 6/14/24, I conducted an exit conference with licensee Jason Taylor. I shared my findings and Mr. Taylor agreed with the conclusions reached.

IV. RECOMMENDATION

I recommend no change to the status of this license.

6/14/24

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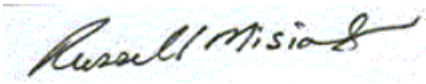
Dwight Forde — Date
Licensing Consultant

Approved By:



6/18/24

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Russell B. Misiak — Date
Area Manager