GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 5, 2024

Stacey Griffin
2398 Pleasant Ridge
Howell, MI 48843

RE: License #: AF470288277
Investigation #: 2024A0466043
Just Like Home AFC

Dear Mrs. Griffin:

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.

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) 284-9727.

Sincerely,

Julie Elkins

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF470288277
Investigation #:	2024A0466043
Complaint Receipt Date:	06/10/2024
Investigation Initiation Date:	06/12/2024
Report Due Date:	08/09/2024
Licensee Name:	Stacey Griffin
Licensee Address:	2398 Pleasant Ridge Howell, MI 48843
Licensee Telephone #:	(734) 748-8012
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Just Like Home AFC
Facility Address:	2398 Pleasant Ridge Howell, MI 48843
Facility Telephone #:	(517) 545-3770
Original Issuance Date:	03/22/2007
License Status:	REGULAR
Effective Date:	10/25/2022
Expiration Date:	10/24/2024
Capacity:	6
Program Type:	ALZHEIMERS AGED

II. ALLEGATIONS:

	Violation Established?
Background checks are not being conducted on responsible people.	Yes
Proper discharge notice and procedure was not followed.	Yes
Direct care workers do not assist residents with toileting.	No
Resident medications are not being refilled timely.	No
Resident medications are being not locked up.	Yes
Residents are being charged more than agreed to on the resident care agreement.	No
Additional Findings	Yes

III. METHODOLOGY

06/10/2024	Special Investigation Intake 2024A0466043.
06/12/2024	Special Investigation Initiated – Telephone call, Complainant interviewed.
06/13/2024	Inspection Completed On-site.
07/15/2024	Contact- Document received from licensee Stacey Griffin, all residents moved out as of 6/15/2024.
07/22/2024	Contact-document sent to licensee Stacey Griffin.
07/29/2024	Contact-document sent to licensee Stacey Griffin.
07/29/2027	APS- referral, not required no residents living in facility.
07/30/2024	Contact- Telephone call made to Guardian A1, interviewed.
08/05/2024	Contact- Document sent to Katelyn Haskin regarding the Michigan Workforce Background Clearances.
08/05/2024	Contact- Document received from Katelyn Haskin regarding the Michigan Workforce Background Clearances.

08/05/2024	Exit Conference with licensee Stacey Griffin, email sent.

ALLEGATION: Background checks are not being conducted on responsible people.

INVESTIGATION:
On 06/10/2024, Complainant reported the licensee is not running background checks on the employees (responsible persons) working at the facility.

On 06/13/2024, I conducted an unannounced investigation and direct care worker (DCW) Shirley Hawkins was on duty. DCW Hawkins reported that licensee Stacey Griffin was not at the facility and she did not have access to any employee records. DCW Hawkins reported that employee records are stored in licensee Griffin's personal area of the house where residents and staff are not permitted. DCW Hawkins could not remember if she had been fingerprinted to work at this facility and reported that she did not have any knowledge if other direct care staff had been fingerprinted either. DCW Hawkins reported that the names of other direct care workers who work at the facility are Rebecca Dobbs, Casey Erickson and Naomie, last name unknown. DCW Hawkins reported she texted licensee Griffin when I arrived at the facility to inquire about obtaining the employee records and informed licensee Griffin that I was at the facility investigating. DCW Hawkins reported as I was leaving the facility that licensee Griffin did not respond to her text messages while I was at the facility.

I contacted licensee Griffing on 07/22/2024 and again on 07/29/2024 by text and email asking for her to contact me regarding this investigation and as of the writing of this report licensee Griffin has not responded.

On 08/05/2024, I contacted Katelyn Haskin who works at the Department of Licensing and Regulatory Affairs (LARA) and has access to the Michigan Workforce Background Clearances for adult foster care (AFC) facilities. Ms. Haskin reported that Just Like Home AFC had 22 names listed of individuals who have been fingerprinted and approved to work as responsible persons or direct care workers at the facility. Among the list of names of those approved to work at the facility were Rebecca Dobbs, Casey Erickson and Naomie Tucker. Shirley Hawkins, the direct care worker working alone at the time of the unannounced investigation, was not on the list of approved responsible person who had been fingerprinted. Therefore there was no documentation that DCW Hawkins had been fingerprinted as required prior to working independently with residents.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.

ANALYSIS:	On 08/05/2024, according to the documentation provided by LARA employee Katelyn Haskin, Shirley Hawkins, the direct care worker working along on 06/13/2024 at the time of the unannounced investigation, there was no documentation available to support that she had been fingerprinted and approved to provide care to those that live in an adult foster care home. Therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Proper discharge notice and procedure was not followed.

INVESTIGATION:
On 06/10/2024, Complainant reported that the facility is closing on 6/14/2024. Complainant reported that the owner/licensee Griffin has been telling residents to leave with less than a 30-day notice. Complainant reported that licensee Griffin gave residents a note on Saturday 6/8/2024 that she is closing the facility on Friday 6/14/2024 due to her own health reasons.

On 06/12/2024, Complainant was interviewed and reported that Resident A was hospitalized and did not return to the facility which is when licensee Griffin decided to close because only two residents remained, Resident B and Resident C. Complainant reported Resident B was provided with a discharge notice on 6/7/2024 and she moved out on 6/10/2024. Complainant reported that Resident A's guardian was informed of the facility closing in August.

On 06/13/2024, I conducted an unannounced investigation, DCW Hawkins reported that licensee Griffin was not at the facility and she did not have access to any resident records as those are stored in licensee Griffin's part of the house where residents and direct care workers are not permitted. DCW Hawkins reported that licensee Griffin never told her about the facility closing rather she heard about it from family members of the residents. DCW Hawkins reported that she has no knowledge if any written discharge notices were provided to the residents and their designated representative. DCW Hawkins reported that she heard residents must move out by Saturday 6/15/2024 by 5pm but again that was not information that she has received from licensee Griffin.

I interviewed Resident B and Resident C who both reported that they were moving as the facility was closing. Resident B and Resident C both reported that their designated representatives were finding alternative living arrangements for them. Resident B and Resident C both reported that they were not aware if they and their designated representative were provided discharge information about the facility closing in writing.

Prior to me leaving the facility on 06/13/2024, DCW Hawkins did find some files for me to review however none of the resident records contained any documentation of

a written discharge notice that was provided to the residents and their designated representative. DCW Hawkins reported that these were the only records to which she had access.

Licensee Griffin had contacted the department on 4/18/2024 via text message and reported that she would not be seeking renewal of her license which expired in October 2024 as she had only three residents and they would be discharged in the coming weeks. On 06/13/2024, licensee Griffin reported via text message that the two residents that were currently living at the facility would be moving out by the end of the week. On 06/15/2024, licensee Griffin reported via text message that the last resident left on 6/18/2024.

I contacted licensee Griffin on 07/22/2024 and again on 07/29/2024 by text message and email asking for her to contact me regarding this investigation and as of the writing of this report licensee Griffin has not responded.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physician's instructions; health care appraisal.**
	(12) A licensee shall provide a resident 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.
ANALYSIS:	At the time of the unannounced investigation, the resident records available were reviewed and there was no documentation that written discharge notices were provided to residents and their designated representative, despite residents and designated representatives being told to vacate the facility with only a seven-day notice. Based on this information and no confirmation of a written notice being issued, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care workers do not assist residents with toileting.

INVESTIGATION:
On 06/10/2024, Complainant reported that the facility has a direct care staff member who does not help residents go to the bathroom.

On 06/13/2024, I conducted an unannounced investigation, DCW Hawkins reported that licensee Stacey Griffin was not at the facility and she did not have access to any

resident records as they are stored in her personal area where direct care workers and residents are not permitted. DCW Hawkins reported that none of the residents that currently live in the facility require any toileting assistance. DCW Hawkins reported that if the residents required or requested toileting assistance, she would have helped them. DCW Hawkins reported that she texted licensee Griffin and licensee Griffin did not respond during the time that I was at the facility.

Resident B and Resident C were interviewed and reported that they both toilet themselves independently and reported that most residents living in the facility were independent. Resident B and Resident C both reported responsible persons help residents with activities of daily living, including toileting, as needed.

Prior to me leaving the facility on 06/13/2024, DCW Hawkins found some resident records for me to review however none of the resident records contain any written assessment plans. DCW Hawkins reported that these were the only records to which she had access.

I contacted licensee Griffin on 07/22/2024 and again on 07/29/2024 both by text and email asking for her to contact me regarding this investigation and as of the writing of this report licensee Griffin has not responded.

APPLICABLE RULE	
R 400.1407	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home**.
ANALYSIS:	At the time of the unannounced investigation no written assessment plans were available for review however, DCW Hawkins, Resident B and Resident C all reported that none of the residents currently living in the facility required any toileting assistance. DCW Hawkins, Resident B, and Resident C all reported that if residents required or requested toileting assistance that a direct care worker would have helped them.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident medications are not being refilled timely.

INVESTIGATION:
On 06/10/2024, Complainant reported resident medication administration records and signatures have been forged and medications often run out at the house because the medications are not refilled on timely. Complainant reported that licensee Griffin has medication from residents that have passed away and uses those medications for current residents as needed.

On 06/12/2024, Complainant reported that when resident medications ran out, licensee Griffin used deceased resident medications. Complaint reported that the facility gave Resident A, Resident F's medication after he passed away.

On 06/13/2024, I conducted an unannounced investigation, DCW Hawkins reported that licensee Griffin was not at the facility and she did not have access to any resident records including the medication administration records (MAR)s. DCW Hawkins denied that the facility ever administered any medication to a resident for whom it was not prescribed. DCW Hawkins denied that the facility used medications of deceased residents for current residents. DCW Hawkins reported that the pharmacy delivers resident medications timely. DCW Hawkins reported that licensee designee Griffin does have medications that are no longer being used in her cabinet in her part of the house that direct care workers and residents are not able to access. DCW Hawkins reported that she texted licensee Griffin and licensee Griffin did not respond during the time that I was at the facility.

I interviewed Resident B and Resident C who both reported that they are being administered their medications as prescribed.

I contacted licensee Griffin on 07/22/2024 and again on 07/29/2024 both by text and email asking for her to contact me regarding this investigation and as of the writing of this report licensee Griffin has not responded.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(2) Medication shall be given pursuant to label instructions. **(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions:** **(a) Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years.** **(b) Not adjust or modify a resident's prescription medication without agreement and instructions from a**

	physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record in writing any adjustments or modifications of a resident's prescription medication. **(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.**
ANALYSIS:	At the time of the unannounced investigation, resident records that were available were reviewed and there was no documentation that medication administration is being documented. Since medication administration records were not available for review, they could not be compared to residents medication and therefore it could not be determined if medications were being administered according to label instructions and/ or if reasonable precautions were being taken to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed**.**
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident medications are being not locked up.

INVESTIGATION:
On 06/10/2024, Complainant reported that none of the medications are locked up.

On 06/12/2024, Complainant reported that all resident medications are stored in the kitchen cabinet not secured.

On 06/13/2024, I conducted an unannounced investigation and observed the resident medications to be in an unlocked cabinet in the kitchen. DCW Hawkins reported that the cabinet did lock and showed me the key that was being stored in a kitchen drawer.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(5) Prescription medication shall be kept in the original pharmacy supplied and pharmacy-labeled container, stored in a locked cabinet or drawer, refrigerated if required, and labeled for the specific resident.

ANALYSIS:	At the time of the unannounced investigation resident medications were stored in an unlocked cabinet in the kitchen therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents are being charged more than agreed to on the resident care agreement.

INVESTIGATION:
On 06/10/2024, Complaint reported that licensee Griffin has been up charging certain residents, not telling them why and is stealing the extra money. Complainant reported that licensee Griffin has taken $5500 from a resident when she knew she was not taking the resident back the following month, taking a double payment from the resident without providing the resident with room and board.

On 06/12/2024, Complainant reported that Resident A and Resident D's family paid first and last month's rent upon admission and that licensee Griffin would increase the monthly rate without updating the resident care agreement. Complainant reported that Resident A and Resident D were both overpaid by two months when they were discharged and not provided the refund they were owed.

On 06/13/2024, I conducted an unannounced investigation, DCW Hawkins reported that licensee Griffin was not at the facility and she did not have access to any resident records including resident care agreements and funds and valuable transaction records. DCW Hawkins believed that licensee Griffin kept these records in her personal area of the facility where residents and staff were not permitted. DCW Hawkins reported that she was not involved at all with resident payments, nor did she discuss any financial payments with resident family members.

I contacted licensee Griffin on 07/22/2024 and again on 07/29/2024 both by text and email asking for her to contact me regarding this investigation and as of the writing of this report licensee Griffin has not responded.

On 07/30/2024, I interviewed Guardian A1 who reported that while Resident A was hospitalized, licensee Griffin asked for a check in the amount of $5500.00 for the upcoming month. Guardian A1 reported that he provided the check and the day it cleared licensee designee Griffin told him that Resident C could not return to the facility as she required more care that she could provide. Guardian A1 reported that licensee Griffin refused to provide a refund. Guardian A1 reported that Resident A's health continues to decline and she is under hospice care. Guardian A1 reported that because of Resident A's health he has not had the time or the energy to fight for his refund or to file a police report.

APPLICABLE RULE	
R 400.1421	**Handling of resident funds and valuables.**
	(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted in writing by the department. **(10) Charges against the resident's account shall not exceed the agreed price for the services rendered and goods furnished or made available by the home to the resident.**
ANALYSIS:	At the time of the unannounced investigation the resident's funds and valuables transaction forms were not available for review and therefore it could not be determined if the charges against the residents account exceeded the agreed upon price.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 06/13/2024, I conducted an unannounced investigation and DCW Hawkins reported that licensee Stacey Griffin was not at the facility and she did not have access to any resident records as they are stored in her personal area. Prior to me leaving the facility on 06/13/2024, DCW Hawkins found some resident records for me to review however none of the resident records contain any written *Assessment Plans for AFC Residents* (written assessment plans) or *Resident Care Agreements.* DCW Hawkins reported that she texted licensee Griffin and licensee Griffin did not respond during the time that I was at the facility.

I contacted licensee Griffin on 07/22/2024 and again on 07/29/2024 both by text and email asking for her to contact me regarding this investigation and as of the writing of this report licensee Griffin has not responded.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until a resident assessment plan is made and it is determined that the resident is suitable pursuant to the following provisions:

	(a) The amount of personal care, supervision, and protection required by the resident is available in the home. (5) At the time of a resident's admission, a licensee shall complete a written resident care agreement which shall be established between the resident or the resident's designated representative, the responsible agency, and the licensee. A department form shall be used unless prior authorization for a substitute form has been granted in writing by the department. A resident shall be provided the care and services as stated in the written resident care agreement.
ANALYSIS:	At the time of the unannounced investigation, resident records that were available were reviewed and there were no written assessment plans or resident care agreements available for review. There was no verification that the resident written assessment plans or the resident care agreements have been completed, updated and/or provided to the residents and their designated representative therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 06/13/2024, I conducted an unannounced investigation, DCW Hawkins reported that licensee Griffin was not at the facility and she did not have access to any resident records including MARs. DCW Hawkins reported that she texted licensee Griffin and licensee Griffin did not respond during the time that I was at the facility.

I contacted licensee Griffin on 07/22/2024 and again on 07/29/2024 both by text and email asking for her to contact me regarding this investigation and as of the writing of this report licensee Griffin has not responded or provided any MARs.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions: **(a) Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years.**

ANALYSIS:	At the time of the unannounced investigation the resident records that were available were reviewed and there was no documentation that medication administration is being documented therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

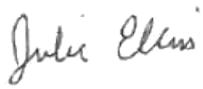
INVESTIGATION:
On 06/13/2024, I conducted an unannounced investigation, DCW Hawkins reported that licensee Griffin was not at the facility and she did not have access to any resident funds and valuable transaction records. DCW Hawkins believed that licensee Griffin kept these records in her personal area of the facility where residents and staff were not permitted.

I contacted licensee Griffin on 07/22/2024 and again on 07/29/2024 both by text and email asking for her to contact me regarding this investigation and as of the writing of this report licensee Griffin has not responded.

APPLICABLE RULE	
R 400.1421	**Handling of resident funds and valuables.**
	(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted in writing by the department.
ANALYSIS:	At the time of the unannounced investigation the resident's funds and valuables transaction forms were not available for review therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in license status.



08/05/2024

Julie Elkins Date
Licensing Consultant

Approved By:

08/05/2024

Dawn N. Timm Date
Area Manager