GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 9, 2024

Karen Laseck
Pathway Home of Elsie, LLC
133 W. Main Street
Elsie, MI 48831

RE: License #: AM190394424
Investigation #: 2024A0577003
Pathway Home Of Elsie

Dear Ms. Laseck:

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. 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,

Bridget Vermeesch

Bridget Vermeesch, 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 #:	AM190394424
Investigation #:	2024A0577003
Complaint Receipt Date:	07/24/2024
Investigation Initiation Date:	07/25/2024
Report Due Date:	09/22/2024
Licensee Name:	Pathway Home of Elsie, LLC
Licensee Address:	133 W. Main Street Elsie, MI 48831
Licensee Telephone #:	(517) 281-2729
Licensee Designee:	Karen Laseck
Administrator:	Karen Laseck
Name of Facility:	Pathway Home Of Elsie
Facility Address:	133 W Main Street Elsie, MI 48831
Facility Telephone #:	(517) 281-2729
Original Issuance Date:	10/31/2018
License Status:	REGULAR
Effective Date:	04/30/2023
Expiration Date:	04/29/2025
Capacity:	11
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident were left unsupervised on the front porch, with the entrance door locked while licensee designee/direct care staff, Karen Laseck was sleeping inside the facility.	No

III. METHODOLOGY

07/24/2024	Special Investigation Intake 2024A0577003
07/25/2024	Special Investigation Initiated – Telephone call made- Interview with complainant.
07/25/2024	APS Referral
08/01/2024	Inspection Completed On-site- Interviewed staff and residents.
08/01/2024	Exit Conference with licensee designee Karen Laseck.

ALLEGATION: Resident were left unsupervised on the front porch, with the entrance door locked while licensee designee/direct care staff, Karen Laseck was sleeping inside the facility.

INVESTIGATION:

On 07/25/2024 a complaint was received with allegations of residents being left unsupervised outside of the facility while licensee designee/staff member Karen Laseck was inside sleeping.

On 07/25/2024 I interviewed Complainant who refused to provide additional information. Complainant reported arriving at the facility and found the side door was locked. Complainant stated they rang the doorbell and pounded on the door a few times with no answer. Complainant reported residents were outside on the porch sitting. Complainant reported being told by residents they cannot use the front door. Complainant reported opening the front door, which was unlocked, and yelled with no answer. Complainant reported they went into the home and found licensee designee (LD), Karen Laseck sleeping in the recliner. Complainant reported Ms. Laseck stated, “Oh I must have dozed off for a minute.”

On August 01, 2024, I completed an unannounced onsite investigation and interviewed Resident A, Resident B, Resident C, and Resident D who all denied staff sleeping during the first shift, denied being left outside on the porch unsupervised, and denied not having access into the facility. All residents interviewed reported they have not seen direct care staff sleep during their shifts and denied ever seeing LD Karen Laseck sleeping.

On August 01, 2024, I interviewed Lisa Whisman, Home Manager who reported she was not aware of any direct care staff or LD Karen Laseck sleeping during their shifts. Ms. Whisman reported none of the residents or family members have reported to her that direct care staff or LD Karen Laseck were sleeping while providing care to residents.

On August 01, 2024, I interviewed LD Karen Laseck who denied sleeping while providing care to residents at any time. Ms. Laseck reported she was not aware nor has she received complaints of day shift direct care staff sleeping while on duty.

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:	Based on the information gathered during the investigation, there was insufficient evidence found that licensee designee Karen Laseck or any direct care staff were sleeping during their shift and not providing supervision and protection to the residents in care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend continuation of the current status of the license of this AFC adult medium group home.

Bridget Vermeesch

8/9/2024

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

08/09/2024

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Dawn N. Timm Date
Area Manager