GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 11, 2024

Jodie Nowak
Tranquility AFC Home LLC
11590 Lakeshore Drive
Lakeview, MI 48850

RE: License #: AM590407641
Investigation #: 2024A0622047
Tranquility AFC Home LLC

Dear Ms. Nowak:

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,

Amanda Blasius, 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 #:	AM590407641
Investigation #:	2024A0622047
Complaint Receipt Date:	08/26/2024
Investigation Initiation Date:	08/26/2024
Report Due Date:	10/25/2024
Licensee Name:	Tranquility AFC Home LLC
Licensee Address:	11590 Lakeshore Drive Lakeview, MI 48850
Licensee Telephone #:	(989) 304-4041
Administrator:	Jodie Nowak
Licensee Designee:	Jodie Nowak
Name of Facility:	Tranquility AFC Home LLC
Facility Address:	1380 East Main Street Edmore, MI 48829
Facility Telephone #:	(989) 560-9733
Original Issuance Date:	04/12/2023
License Status:	REGULAR
Effective Date:	10/12/2023
Expiration Date:	10/11/2025
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Others living in the AFC who are not residents.	No
Staff called police for resident not taking medications and eloping.	Yes
Residents caring for other residents.	No
No after life documentation on resident identification record.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/26/2024	Special Investigation Intake- 2024A0622047
08/26/2024	Special Investigation Initiated – Telephone call with adult protective services worker, Leslie Brugel. Current investigation is not open.
08/26/2024	Denied APS referral received.
08/27/2024	Inspection Completed-BCAL Sub. Compliance
08/29/2024	Contact - Telephone call made to Deputy Paulsen.
08/29/2024	Contact - Telephone call made licensee, Jodie Nowak.
09/09/2024	Contact- Interview with Resident C via phone.
09/10/2024	Exit Conference with Jodie Nowak

ALLEGATION: Others living in the AFC who are not residents.

INVESTIGATION:
On 08/26/2024, I received this complaint through the Bureau of Community and Health Systems online complaint system. According to the complaint, information was passed on from Deputy Paulsen who had recently been called out to Tranquility AFC. According to the complaint, it was reported that other individuals were living in the AFC who were not residents.

On 08/26/2024, I completed an unannounced onsite investigation to Tranquility AFC. During the onsite investigation, I viewed all nine resident bedrooms. On 08/26/2024, Tranquility AFC had three residents. During my inspection, I did not view any other belongings or evidence that others, besides the three residents, were living in Tranquility AFC.

On 08/29/2024, I interviewed Deputy Paulsen via phone. Deputy Paulsen reported that she had responded to Tranquility AFC due to staff calling regarding a resident

eloping the facility and trying to cross the highway. She stated that while she was at the facility, she viewed other individuals in the facility who were not residents and appeared to be living there. Deputy Paulsen stated that she did not look through the whole building at the time. It should be noted that fire doors are present between the facility and the licensee's personal home.

APPLICABLE RULE	
R 400.14105	**Licensed capacity.**
	(2) Any occupant of a home, other than the licensee or persons who are related to the licensee, live-in staff or the live-in staff's spouse and minor children, or a person related to a resident who is not in need of foster care, shall be considered a resident and be counted as a part of the licensed capacity.
ANALYSIS:	At the time of my unannounced onsite investigation, no additional individuals were living in Tranquility AFC. Three bedrooms were occupied by current residents and the other six bedroom were empty and available for future residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Staff called police for resident not taking medications and eloping.

INVESTIGATION:
On 08/26/2024, I received this complaint through the Bureau of Community and Health Systems online complaint system. According to the complaint, information was passed on from Deputy Paulsen who had recently been called out to Tranquility AFC. The complaint stated, Deputy Paulsen had been called out to Tranquility AFC multiple times due to Resident A eloping and refusing to take his medications. It was reported on the complaint that Deputy Paulsen had attempted to educate licensee designee, Jodie Nowak that this was not the role of law enforcement.

On 08/26/2024, I interviewed adult protective services worker, Leslie Brugel. She reported that she was concerned about the type of residents Tranquility AFC was accepting, as direct care staff have not been able to properly care for them. Ms. Brugel reported that she is concerned that some of the resident's placement at Tranquility AFC may be causing more harm than good, as the staff are unable to properly care for them. Ms. Brugel reported that she has had conversations with Deputy Paulsen regarding her concerns and currently she does not have an active adult protective services investigation open with Tranquility AFC.

On 08/29/2024, I interviewed Deputy Paulsen via phone. Deputy Paulsen reported that over the last month law enforcement has received many calls from Tranquility

AFC for concerns that Resident A was not taking his medications and has left the facility without staff approval. Deputy Paulsen reported that she had responded to Tranquility AFC after one of their calls. During her visit, Resident A tried to elope the facility several times and was able to leave the building out the back door and head over to the storage buildings behind Tranquility AFC. Deputy Paulsen stated that she was able to get Resident A back into the facility, but he did fall and skinned his knee. She reported that he was not taken to the hospital. Deputy Paulsen reported that during her visit to Tranquility AFC, she informed licensee designee Jodie Nowak, that responding to the calls that Resident A is not taking his medication or is leaving the facility is not their responsibility. She informed licensee designee, Jodie Nowak, that if Resident A has left the facility, she will need to call in additional staff to assist and will also need to exhaust all her efforts to find Resident A. If Resident A has been gone for several hours, she may then call law enforcement. Deputy Paulsen reported that six days later, law enforcement received another call from Tranquility AFC regarding Resident A leaving the facility and she informed licensee designee, Jodie Nowak that she would not be responding to the call. Deputy Paulsen, stated that before Resident A came to Tranquility AFC, he was in a facility with a fence, was able to go outside and watch the birds. Deputy Paulsen reported that she also reminded Ms. Nowak that Resident A is his own person, and he has the right to leave the facility. Deputy Paulsen stated that Tranquility AFC did not have enough staff available to care for Resident A.

On 08/27/2024, I completed an unannounced onsite investigation to Tranquility AFC. During the investigation, licensee designee Jodie Nowak was not at the facility, therefore, I interviewed Direct Care worker (DCW), Matt Crosby. DCW Crosby stated that Resident A was in the hospital before coming to Tranquility AFC and that licensee designee, Jodie Nowak visited him at the hospital and had the contacts with his guardian before accepting Resident A for placement. DCW Crosby stated that for the first week, Resident A seemed appropriate, but then started refusing his medications and walking out of the facility without informing staff. DCW Crosby reported that he did call law enforcement several times, as Resident A was crossing the main highway or walking right next to the road. DCW Crosby explained that he was unable to always follow Resident A, as he could not leave the other residents alone in the building.

On 08/29/2024, I interviewed licensee designee, Jodie Nowak via phone. Ms. Nowak reported that staff were attempting to follow Resident A when he was leaving the facility to prevent him from crossing the main highway. Ms. Nowak also reported that she added door alarms to the exits to alert staff of anyone leaving the facility. Ms. Nowak stated that she also attempted to keep Resident A’s guardian updated on safety concerns.

During the unannounced onsite investigation, I viewed Resident A’s resident record. According to his *AFC Resident Information and Identification Record*, Resident A moved into Tranquility AFC on 08/06/2024 and on 08/15/2024 licensee designee had written up an emergency discharge notice due to him being physically

aggressive with staff and attempting to escape the facility daily. It should be noted that the emergency discharge for Resident A was not discussed with this adult foster care licensing consultant, as Ms. Nowak reported that she thought she needed approval from adult protective services to issue an emergency discharge notice. According to the *Assessment Plan for AFC Residents* that was completed for Resident A, it reported that Resident A had community access and no safety concerns were documented on the plan. I viewed a *Health Care Appraisal* for Resident A and it reported that Resident A has paranoid schizophrenia.

APPLICABLE RULE	
R 400.14301	**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.** **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**
ANALYSIS:	Licensee designee, Jodie Nowak accepted Resident A into Tranquility AFC before determining if the direct care staff to resident ratio was enough to safely care for Resident A. Ms. Nowak did not take into consideration that Resident A was previously in a locked facility and moving him to a facility where he has community access would not provide the safest accommodations for Resident A. Based on interviews with DCW Crosby, Deputy Paulsen and Ms. Nowak, a full completed assessment was not completed appropriately to determine if Tranquility AFC could provide the appropriate personal care, supervision and protection needed for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents caring for other residents.

INVESTIGATION:
On 08/26/2024, I received this complaint through the Bureau of Community and Health Systems online complaint system. According to the complaint, information was passed on from Deputy Paulsen who had recently been called out to Tranquility AFC. The complaint stated that other residents are caring for current residents.

On 08/29/2024, I interviewed Deputy Paulsen via phone. Deputy Paulsen reported that during her visit to Tranquility AFC a resident report the following to her: “I try and keep an eye on [Resident A] and help Jodie out.” Deputy Paulsen stated that she was unsure of the resident’s name who stated this.

On 08/27/2024, I completed an unannounced onsite investigation to Tranquility AFC. During the onsite investigation, I interviewed direct care worker, Matt Crosby in person. He reported that residents are not helping to care for or supervise other residents, and he has been working more to assist with Resident A.

On 09/09/2024, I interviewed Resident C via phone. I asked Resident C if she was helping with other residents or had helped with Resident A. She reported that as a resident she is not allowed to help with other residents. Resident C also reported that Resident A scared her, therefore she tended to stay away from him. Resident D was the only other resident in the home during Deputy Paulsen’s visit to Tranquility AFC, but she struggles to respond to questions during interviews, therefore she was not interviewed.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Based on interviews with residents and direct care worker, Matt Crosby, there was no evidence of residents caring for other residents. Resident C is aware that she cannot assist with other residents, despite her willingness to want to help others.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: No after life documentation on resident identification record.

INVESTIGATION:
On 08/26/2024, I received this complaint through the Bureau of Community and Health Systems online complaint system. According to the complaint, information was passed on from Deputy Paulsen who had recently be called out to Tranquility AFC. The complaint stated that Resident B had recently passed away and the facility had no after life documentation on where to take Resident B's body.

On 08/29/2024, I interviewed Deputy Paulsen via phone. She reported that Resident B had passed away in the facility and when law enforcement arrived, there was no after life documentation available, and they needed to wait for licensee designee Jodie Nowak to call the guardian and try and track down to what funeral home they should take Resident B.

On 08/27/2024, I completed an unannounced onsite investigation to Tranquility AFC. During the unannounced onsite investigation, I viewed Resident A and B's *AFC Resident Information and Identification Records.* Resident A's identification record was missing the following information:

Social Security number
Veteran status
Home address
Date of birth
Placing agency
Address of placing agency
Name of physician, address and phone number
Address of the hospital preferred
Religion preference
Insurance information
Burial provisions

Resident B's *AFC Resident Information and Identification Record* was reviewed and was missing the following information:

Home address
Placing agency, phone number and address
Date of discharge
Name of physician, address and phone number
Address of preferred hospital
Religious preference
Insurance information
Burial provisions

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number, date of birth, case number, and marital status.** **(iii) Former address.** **(iv) Name, address, and telephone number of the next of kin or the designated representative.** **(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.** **(ix) Resident's religious preference information.**
ANALYSIS:	At the time of the unannounced onsite investigation, I viewed Resident A and B's *AFC Resident Information and Identification Record* and found that both of their forms were incomplete and missing important information that could assist direct care workers in providing proper care.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 08/29/2024, I interviewed licensee designee, Jodie Nowak via phone. During the interview, we discussed a new staff member and her status of employment. During the conversation, Ms. Nowak reported that this staff member, Tori Solmonson has been training alongside her part time, but since accepting Resident A she has been working full time and was working independently for some shifts, along with having to follow Resident A when he has left the facility without approval. Throughout the interview, Ms. Nowak brought up that direct care worker, Tori Solmonson has not completed her background check yet. During the interview, I reminded Ms. Nowak of a conversation that occurred during special investigation, 2024A0622044 and the

importance of completing the workforce background checks ASAP for all new employees. During the interview, I informed Ms. Nowak that Tori Solmonson could not work independently until the results from her workforce background check had been returned.

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:	Licensee Designee, Jodie Nowak admitted via a phone interview on 08/29/2024 that direct care worker, Tori Solmonson had not completed her workforce background check clearance, although she has been working independently.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 08/27/2024, I completed an unannounced, onsite investigation to Tranquility AFC. During the investigation, I viewed Resident A and B's resident records. Resident A's *Assessment Plan for AFC Residents* (assessment plan) was not fully completed. Page four of the assessment plan was blank; therefore, I was unable to determine who completed the assessment plan with Resident A and when the assessment plan was completed. The assessment plan information documented did not match the behaviors that were reported from direct care staff and licensee designee Jodie Nowak during Resident A's stay at Tranquility AFC.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	At the time of inspection, a fully completed *Assessment Plan for AFC Residents* was not available for Resident A. The last page, page four of the assessment plan was blank, therefore I am unable to determine who completed the assessment and verify that it was completed with the resident, resident's designated representative or a responsible agency.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 08/27/2024, I completed an unannounced onsite investigation to Tranquility AFC. The compliant received via the Bureau of Community and Health Systems online complaint system mentioned a resident had a black eye and she reported falling in the bathroom. During the unannounced onsite investigation, direct care worker (DCW), Matt Crosby confirmed that Resident C had fallen in the bathroom and that they called emergency medical services to check her out after her fall. DCW Crosby

stated that the fall happened about three weeks ago, and Resident C refused to be taken to the hospital for further medical treatment. DCW Crosby stated that EMS checked out Resident C within the facility and then left. DCW Crosby reported that he did not complete an incident report for the fall. After viewing the Resident C's file, an incident report was not available.

On 09/09/2024, I interviewed Resident C via phone, as she was not present during my unannounced onsite investigation. Resident C confirmed that she had fallen while grabbing a towel in the shower and hit her eye on the corner of the bathroom countertop. Resident C stated that the ambulance arrived, checked her out and she refused to seek any further medical treatment.

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(c) Physical hostility or self-inflicted harm or harm to others resulting in injury that requires outside medical attention or law enforcement involvement.**
ANALYSIS:	At the time of inspection, an incident report was not available for review, for the reported fall and medical treatment for Resident C.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains the same.

09/09/2024

Amanda Blasius Date
Licensing Consultant

Approved By:

09/11/2024

Dawn N. Timm Date
Area Manager