GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 10, 2024

Cindy Whaley
Liberty Living Inc.
P O Box 1273
Bay City, MI 48706

RE: License #:	AS090238876
Investigation #:	2024A0123043 Jefferson House

Dear Cindy Whaley:

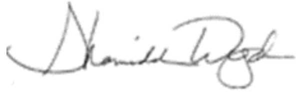
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate 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,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090238876
Investigation #:	2024A0123043
Complaint Receipt Date:	06/13/2024
Investigation Initiation Date:	06/14/2024
Report Due Date:	08/12/2024
Licensee Name:	Liberty Living Inc.
Licensee Address:	P O Box 1273 Bay City, MI 48706
Licensee Telephone #:	(989) 892-0247
Administrator:	Cindy Whaley
Licensee Designee:	Cindy Whaley
Name of Facility:	Jefferson House
Facility Address:	1700 S Jefferson Bay City, MI 48708
Facility Telephone #:	(989) 895-3809
Original Issuance Date:	12/01/2001
License Status:	REGULAR
Effective Date:	06/01/2024
Expiration Date:	05/31/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 06/11/2024 at 11:56 pm home manager Elizabeth Jajo received a call that staff were not at the facility. Staff Jajo responded to the home and staff were not there at 12:00 am.	Yes

III. METHODOLOGY

06/13/2024	Special Investigation Intake 2024A0123043
06/14/2024	Special Investigation Initiated - On Site I conducted an unannounced on-site at the facility with recipient rights investigator Melissa Prusi.
06/14/2024	Contact - Telephone call received I received a call from Kelly Richnak, administrative assistant.
06/17/2024	APS Referral APS referral completed.
06/21/2024	Contact- Telephone call made I left a voicemail requesting a return call from staff Guy Trimble.
06/21/2024	Contact- Telephone call made I interviewed staff Elizabeth Jajo via phone.
06/21/2024	Contact- Telephone call made I left a voicemail requesting a return call from staff Corrie Aldridge.
06/21/2024	Contact- Telephone call received I interviewed staff Corrie Aldridge.
06/26/2024	Contact- Telephone call made I made an attempted phone call to staff Guy Trimble.
07/09/2024	Exit Conference I spoke with licensee designee Cindy Whaley via phone.

ALLEGATION: On 06/11/2024 at 11:56 pm home manager Elizabeth Jajo received a call that staff were not at the facility. Staff Jajo responded to the home and staff were not there at 12:00 am.

INVESTIGATION: On 06/14/2024, I conducted an unannounced on-site inspection with recipient rights investigator Melissa Prusi. Home manager Lisa Yacks was interviewed. Staff Yacks stated that third shift is 11:00 pm to 7:00 am. Staff Yacks stated that on 06/11/2024, staff Corrie Aldridge was working third shift. Resident A and Resident B were still awake. The home manager at another facility across the street, staff Elizabeth Jajo came in to cover after getting a call that Staff Aldrige had left the premises. Resident A thought Staff Aldrige had gone outside to smoke a cigarette. Staff Yacks stated that on 06/03/2024, she received a call one morning from Staff Jajo that staff at the home across the street caught Staff Aldrige leaving the facility during his shift. Staff Yacks stated that they coordinated a plan to catch Staff Aldrige. Staff Yacks stated that they were expecting this to happen, but they could not prove that Staff Aldrige had left the home the first time. Staff Yacks stated that Staff Aldrige's car was missing from the home around 11:10 pm on 06/11/2024. She stated that per Staff Jajo, Resident A and Resident B were on the couch when Staff Jajo reported to the home. Staff Yacks stated that staff Chet Barthmeier relieved Staff Jajo. Staff Yacks stated that Staff Aldrige came back to the home that night around 2:00 am and walked into the facility with a fresh bag of food from McDonald's. Staff Yacks stated that there were five residents present in the home at the time Staff Aldrige left the residents alone.

Resident A was interviewed. Resident A stated that staff Corrie Aldridge is nice. Resident A stated that they remember Staff Jajo coming over, and Staff Jajo told Resident A that Staff Aldrige had taken off. Resident A stated that Staff Jajo was at the home for about 10-15 minutes, then Staff Barthmeier arrived at the home. Resident A stated that they did not see Staff Aldrige come back that night. Resident A stated they went to bed after Staff Barthmeier got to the home. Resident A stated that they do not remember Staff Aldrige leaving the premises before this and stated that they do not think that Staff Aldridge smokes.

Resident B and Resident C were observed during this on-site. They appeared clean and appropriately dressed. Resident B was observed lying in bed and was not interviewed as they were asleep.

During this on-site, staff Chet Barthmeier was interviewed via phone. Staff Barthmeier stated that he received a phone call that no staff were at the home on 06/11/2024. Staff Barthmeier stated he got to the home and relieved Staff Jajo. Staff Barthmeier stated that Staff Aldrige arrived at the home about 2:05 am with a bag of McDonald's. Staff Aldrige asked why Staff Barthmeier was there, and Staff Barthmeier stated he told Staff Aldrige it's because Staff Aldrige was not there. Staff Barthmeier stated that Staff Aldrige was gone for about two hours, and that he sent Staff Aldrige home. Staff Barthmeier stated that at 2:30 am, staff Jennifer Jones came in to relieve him. Resident A told staff that Staff Aldrige told Resident A he was

going to the car and would be right back. Staff Barthmeier stated that they had heard that Staff Aldrige had left during his shift before, but they did not have proof of it.

During this on-site, I obtained *Assessment Plan for AFC Residents* for Resident A, Resident B, Resident C, Resident D, and Resident E. Per Resident A's assessment plan dated 01/03/2024, they require verbal prompting for several personal care tasks, and requires staff assistance with medication administration. Resident B's assessment plan dated 04/04/2024 notes that Resident B needs assistance with toileting at night sometimes, full assistance with showering, some assistance with dressing, verbal prompts for personal hygiene, and assistance with medication administration. Resident C's assessment plan dated 01/18/2024 notes that Resident C needs 24-hour supervision (under *Moves Independently in Community*), occasional assistance with toileting, and staff assistance with medication administration. Resident D's assessment plan dated 04/24/2024 states that Resident D requires staff prompting for some personal care tasks and needs staff assistance with medication administration. Resident E's assessment plan dated 10/11/2023 notes that Resident E needs verbal prompting for several personal care tasks, staff assistance with stair climbing, and requires staff assistance with medication administration.

On 06/14/2024, I received a voicemail from Liberty Living Inc. administrative assistant Kelly Richnak. I returned her call. She stated that staff Guy Trimble called home manager Elizabeth Jajo and told Staff Jajo that he was pretty sure that Staff Aldrige had left the home. Staff Jajo arrived to the home, and Resident A and Resident B were awake. Staff Jajo stayed until Staff Barthmeier arrived. Staff Aldrige returned around 2:00 am with McDonald's. Staff Aldrige left the residents unattended for at least two hours. Staff Aldrige was immediately terminated.

On 06/21/2024, I interviewed home manager Elizabeth Jajo via phone. Staff Jajo stated that on 06/11/2024, she received a call at 11:56 pm from her third shift staff Guy Trimble stating that staff Corrie Aldrige's car was not at the facility. Staff Jajo stated that she got to Jefferson House at 11:58 pm as she was already out and about. Staff Jajo stated that there were two residents awake when she arrived. Resident A was on the couch, and Resident B was in the bathroom. She stated that she did a walk around the home. Resident A told her that Staff Aldridge had walked outside to grab something from his car. Staff Jajo stated that Staff Aldrige's car was not there. Staff Jajo stated she called manager Susan Barthmeier, who called Chet Barthmeier, and staff Chet Barthmaier arrived at the home to relieve her.

On 06/21/2024, I interviewed staff Corrie Aldridge via phone. Staff Aldridge stated that he reported to work about 11:30 pm on 06/11/2024. Staff Aldridge received a phone call from someone who needed Staff Aldridge to take them to the hospital. Staff Aldridge stated that he left the facility, then came back. Staff Aldridge stated that he does not know what time he got back to Jefferson House. Staff Aldridge denied leaving the facility while on shift before this incident. Staff Aldridge stated that he did not tell anyone he was leaving the facility. Staff Aldridge stated that staff Chet

Barthmaier was at the facility when he returned. Staff Barthmaier asked him to leave. Staff Aldridge stated that he believes Staff Barthmaier had another staff person who was going to come in to work the shift. Staff Aldridge stated that he was trained on providing proper supervision to residents.

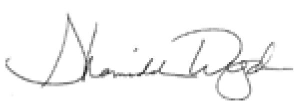
On 07/09/2024, I conducted an exit conference with licensee designee Cindy Whaley via phone. I informed her of the findings and conclusion. She stated that staff Corrie Aldridge's employment was terminated on 06/12/2024.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	On 06/14/2024, home manager Lisas Yack was interviewed and reported that staff Corrie Aldridge had left during third shift on 06/11/2024. She stated that Staff Aldrige had left the premises while on shift before, but there was no proof until now. Resident A was interviewed and stated that Staff Elizabeth Jajo came over one night and had told Resident A that Staff Aldrige had taken off. Resident A also recalled staff Chet Barthmeier arriving to the home as well. Staff Chet Barthmeier was interviewed and stated that he received a call that there was no staff at the home, and he reported to the facility to relives Staff Jajo. He stated that Staff Aldrige arrived back to the facility while he was there, and he sent Staff Aldrige home. On 06/21/2024, I interviewed home manager Elizabeth Jajo who stated that she reported to the facility after receiving a call that Staff Aldrige had left. She stated that there were two residents awake when she arrived, and no staff present. On 06/21/2024, I interviewed staff Corrie Aldridge who admitted to leaving the facility after receiving a call that someone needed a ride to the hospital. Staff Aldridge stated that he did not tell anyone that he had left the facility, and that Staff Barthmeier was there when he arrived back to work. There is a preponderance of evidence to substantiate a rule

	violation in regard to Staff Aldrige leaving the premises of the facility and leaving the residents unsupervised.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 3-6).



07/10/2024

Shamidah Wyden — Date
Licensing Consultant

Approved By:

07/10/2024

Mary E. Holton — Date
Area Manager