GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 7, 2024

Teresa Wendt
HGA Non-Profit Homes Inc.
917 West Norton
Muskegon, MI 49441

RE: License #:	AS610067776
Investigation #:	2024A0356054
	Shaffer House AFC

Dear Ms. Wendt:

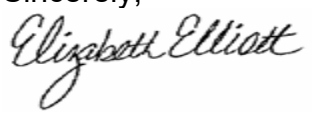
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610067776
Investigation #:	2024A0356054
Complaint Receipt Date:	08/12/2024
Investigation Initiation Date:	08/12/2024
Report Due Date:	10/11/2024
Licensee Name:	HGA Non-Profit Homes Inc.
Licensee Address:	917 West Norton Muskegon, MI 49441
Licensee Telephone #:	(231) 728-3501
Administrator:	Melanie Billings
Licensee Designee:	Teresa Wendt
Name of Facility:	Shaffer House AFC
Facility Address:	171 Dennis Street Fruitport, MI 49415-9755
Facility Telephone #:	(231) 865-3444
Original Issuance Date:	10/01/1995
License Status:	REGULAR
Effective Date:	04/01/2024
Expiration Date:	03/31/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident care needs are not being met by staff at the facility.	Yes
Residents are subjected to emotional and verbal abuse by staff at the facility.	No
There are “fire safety issues” in the facility and staff do not conduct fire drills.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/12/2024	Special Investigation Intake 2024A0356054
08/12/2024	APS Referral Morgan Dennison, APS, Muskegon County DHHS.
08/12/2024	Special Investigation Initiated - Telephone Morgan Dennison, APS.
08/22/2024	Inspection Completed On-site
08/22/2024	Contact - Face to Face DCW's Shamuka Boden, Latrice Kimble. Observed Resident's A, B, C, D, E, F.
08/22/2024	Contact-Documents received Reviewed facility documents.
08/28/2024	Contact - Face to Face Myra Dutton, CEO and Teresa Wendt, Licensee Designee.
09/10/2024	Contact - Telephone call received Jennifer Leon, APS, Oceana County.
09/11/2024	Contact - Face to Face Jennifer Leon, DCW Latrice Kimble, Falon Walcott, home manager, Pam Gentry DCW, Resident's A, B, C.
09/11/2024	Contact - Document Received Facility Documents reviewed.

10/01/2024	Contact-Document Received IR from ORR, Linda Wagner.
10/04/2024	Contact-Telephone call made. DCW Kaylie Fetterhoff, Resident F.
10/07/2024	Exit Conference-Teresa Wendt, Licensee Designee.

ALLEGATION: Resident care needs are not being met by staff at the facility.

INVESTIGATION: On 08/12/2024, I received a complaint from Adult Protective Services, Department of Health and Human Services. The complaint documented that staff at the facility leave residents in soiled briefs for long periods of time and last week, an unknown resident was left in a soiled brief so long that by the time someone finally changed him, he was “soaked up to his neck”. The complainant reported if a resident soils himself, staff ignore it and leave the resident to sit in feces until the next shift starts so someone else must deal with it. The complainant reported Resident D has a “bad foot” and approximately a month ago, he fell, and staff never made a report or sought care for Resident D, they just put him back to bed. Resident D sustained a significant bruise on the left side of his back from falling and staff still did not seek any medical care for Resident D. DHHS (Department of Health and Human Services) APS (Adult Protective Services) worker, Morgan Dennison has been assigned for investigation. A review of these allegations with Ms. Dennison was conducted on 08/12/2024.

On 08/22/2024, I conducted an unannounced inspection at the facility and interviewed DCW (direct care worker) Shamuka Boden. Ms. Boden stated the allegations about staff leaving residents in soiled briefs are true and (former) 3rd shift Direct Care Worker (DCW), Amarionna Tate is the person who left residents in soiled briefs, so 1st shift staff had to clean residents up once they began their shifts. Ms. Boden stated staff are supposed to check on residents throughout the night at 12:00 a.m., 3:00 a.m. and 6:00 a.m. and if they are soiled or wet, change their briefs and make sure they are clean and in dry clothing. Ms. Boden stated this occurred with Resident A most often. Ms. Boden stated she is not aware of a resident sustaining a significant bruise and staff not seeking medical attention. Ms. Boden stated she recalls an incident when Resident D had a seizure, fell and went to the hospital but not any time when anything happened to a resident and care was not sought. DCW Latrice Kimble was present during this interview but was cooking and unable to participate in the interview.

On 09/10/2024, Jennifer Leon, Oceana County DHHS, APS worker called and informed me that she is now the APS worker on this complaint. Ms. Leon reported she conducted an unannounced inspection at the facility on 09/10/2024 at 10:00a.m. and there were 3 staff present, 6 residents and the residents appeared clean and well cared for. Ms. Leon reported that she interviewed Falen Walcott, home manager

and Ms. Walcott acknowledged that Ms. Tate was in charge on 3rd shift and was the cause of issues related to a resident being wet to their neck because she did not change the resident during her shift. Ms. Leon stated Ms. Walcott reported that Ms. Tate no longer works in the facility and the issue has been resolved. Ms. Leon and I planned to meet at the facility on 09/11/2024 for another unannounced inspection.

On 09/11/2024, Ms. Leon and I conducted an unannounced inspection at the facility and interviewed Ms. Kimble. Ms. Kimble stated she has never experienced having to clean or change a resident that was wet up to their necks due to staff failing to check and change them during 3rd shift. Ms. Kimble stated they check on Resident A every 2 hours during the night because he is incontinent and needs assistance with toileting. Ms. Kimble stated the other residents are capable of toileting themselves. Ms. Kimble stated Resident C needs some supervision while toileting because he uses his hands to wipe and needs cleaning up after he uses the bathroom. Ms. Kimble stated Resident D does not have a bad foot and at the end of July 2024, Resident D fell in the bathroom, an IR (incident report) was completed, and he did not sustain an injury that required hospitalization. Ms. Kimble stated more recently, Resident A was visiting family and fell off a bed at his family's home sustaining a large bruise on his side and an IR was written. Ms. Kimble stated Resident A & B are nonverbal and unable to participate in an interview and Resident C, D, E & F are capable of being interviewed.

On 09/11/2024, Ms. Leon and I interviewed Ms. Walcott in her office. Ms. Walcott stated she found Resident A at 7:00a.m. one morning and he was soaked with urine. Ms. Walcott stated Ms. Tate was the 3rd shift staff and Resident A should not have been that wet if he had been checked and changed at 6:00a.m. as required. Ms. Walcott stated Ms. Tate was written up and subsequently terminated from her position at the facility. Ms. Walcott stated the only significant bruise Resident D has had was on his right upper arm and it happened while he was on an outing with his family. Ms. Walcott stated she spoke to Resident D's family member, Relative #1 and she confirmed that while on an overnight outing with his family, Resident D got up to use the bathroom during the night and fell. Ms. Walcott stated an IR was completed even though the incident did not occur while Resident A was in the facility. Ms. Walcott stated Resident D has some issues with ambulation but with the use of a walker, can ambulate independently.

On 09/11/2024, Resident A & B are not able to provide information pertinent to this investigation due to cognitive deficits.

On 09/11/2024, Ms. Leon and I interviewed Resident C in his room at the facility. Resident C stated he can use the bathroom on his own and does not need staff assistance. He stated he does not wear a brief, have accidents and is not left in wet or soiled clothing by staff at the facility.

On 09/11/2024, Ms. Leon and I interviewed Resident D at the facility. Resident D stated he can toilet himself without staff assistance. Resident D stated he is not left

in wet or soiled clothing by staff. Resident D acknowledged the faded bruise on his upper right bicep and stated he does not recall how it happened and that he did not fall when visiting his family. Resident D stated he does fall on occasion and did fall in the shower at the facility, staff were watching tv and they did not hear him fall. He thought staff wrote an IR on the incident and stated he does not remember who the staff was.

On 09/11/2024, Ms. Leon and I interviewed Resident E in his room at the facility. Resident E stated he can toilet himself and only needs staff to assist him with buttoning up his pants. Resident E stated if he needs to use the bathroom during the night, he is able to do that on his own and does not need staff assistance.

On 09/11/2024, Ms. Leon and I interviewed DCW Pam Gentry at the facility. Ms. Gentry stated she has worked at this facility since 1995 and works 2nd shift but works all shifts where needed. Ms. Gentry stated she has not seen any residents including Resident A left in wet briefs. Ms. Gentry stated the staff accused of leaving Resident A in soiled briefs no longer works at the facility. Ms. Gentry stated Resident D had a fall when he was with family and sustained a large bruise on his arm. Ms. Gentry stated she has heard that Resident D fell in the shower or in his room, but an IR should be written documenting any fall Resident D has had. Ms. Gentry stated whenever anything happens with Resident D, she (Ms. Gentry) documents the event by writing an IR and sending it to Health West.

On 09/11/2024, I reviewed an IR dated 07/25/2024, written by DCW Mackenzie Bishop, signed by Ms. Walcott, regarding the incident that occurred on a boat outing with family. The IR documented, *'When being dropped off back home from family outing, Mackenzie was told (Resident D) had fallen backward while family member was wheeling him up the ramp to get into boat, was seated on his walker. Family member provided Ibuprofen for any pain that may show up. Reported to supervisor, IR written, monitoring for any bruising that may show up and if he is in any pain.'* Ms. Walcott documented, *'(Resident D) was frequently monitored for any injury or pain.'*

On 09/11/2024, I reviewed an IR dated 07/31/2024, written by DCW Kaylie Fetterhoff, signed by Ms. Walcott regarding the incident that occurred in the shower. The IR documented, *'(Resident D) was in the shower, I went to go check on him and when I walked in the bathroom, he told me he fell, by that time he got up himself and was on the toilet. I asked if he was okay many times, and he said yes. I looked for bruises and at that time, there wasn't. I told my assistant and manager.'* Ms. Walcott documented, *'Spoke to staff and instructed them to be with (Resident A) while he is showering, no exceptions. Head protocol started as a precaution.'*

On 09/11/2024, I reviewed an IR dated 08/27/2024, written by Ms. Fetterhoff, and signed by Ms. Walcott. The IR documented, *'(Resident D) was watching tv and I happened to glance over and see a bruise by his arm. He states he has no clue how he got it. Asked if he was okay or needed anything.'* Ms. Walcott documented,

'Resident on overnight on 08/23/2024 when he has a fall using the bathroom at 2-3a.m. Requested that all accidents on family outings be reported to me directly.'

On 09/11/2024, I reviewed Resident A, B, C, D, E and F's assessment plans. The assessment plans documented that Residents A, B and D require staff assistance with toileting. Residents C, E, and F do not require staff assistance with toileting.

On 09/11/2024, I reviewed Resident D's assessment plan dated 04/24/2024. The assessment plan documented that Resident D requires staff assistance with bathing. The assessment plan documented, *'staff will prompt and guide resident with bathing.'*

On 10/07/2024, I conducted an exit conference with Licensee Designee, Teresa Wendt. Ms. Wendt stated she will review the report and submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	The complaint reported that staff at the facility leave residents in soiled briefs for long periods of time. The complainant also reported that Resident D fell, and staff never made a report or sought care for him. Based on investigative findings there is a preponderance of evidence to indicate that third shift staff failed to provide necessary personal care to Resident A and he was found soaked in urine by the home manager, Falen Walcott when she arrived at the facility for first shift. In addition, there is a preponderance of evidence to show that staff at the facility failed to protect Resident D when he fell unsupervised in the shower, when the assessment plan documented Resident D requires assistance while showering. A violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents are subjected to emotional and verbal abuse by staff at the facility.

INVESTIGATION: On 08/12/2024, I received a complaint from Adult Protective Services, Department of Health and Human Services. The complainant reported that staff emotionally abuse the residents who cannot ambulate or make it to the bathroom in time, and staff are disrespectful, cuss and yell at the residents. The complainant reported Resident A & B are targets for this because they are nonverbal, but Resident E & F are also regularly yelled at. The complainant reported that Resident E gets agitated when staff yell at him and he tries to hit staff. Ms. Dennison was assigned for investigation through APS. A review of these allegations with Ms. Dennison was conducted on 08/12/2024.

On 08/22/2024, I conducted an unannounced inspection at the facility and interviewed DCW (direct care worker) Shamuka Boden. Ms. Boden stated (former) DCW Deontae David began cussing, yelling and swearing at Resident C while in the bathroom at the facility. Ms. Boden stated she was present when the incident occurred. An IR was written and an ORR (Office of Recipient Rights) complaint through Health West was filed. Ms. Boden stated Mr. David no longer works at the facility.

On 09/11/2024, Ms. Leon and I conducted an unannounced inspection at the facility and interviewed Ms. Kimble. Ms. Kimble stated she never heard Mr. David yell or swear at the residents but stated Ms. Boden has been verbally aggressive with the residents. Ms. Kimble stated on 08/22/2024, after I had left the facility, Resident F urinated on the floor and Ms. Boden berated him by saying, “Why did you do that?” “Why did you pee?” Ms. Kimble stated she never witnessed any other DCW’s close the bedroom door on Resident A until she worked with Ms. Boden and Ms. Boden closed Resident A’s door knowing that he does not like his door closed. Ms. Kimble stated Ms. Boden no longer works at the facility.

On 09/11/2024, Ms. Leon and I interviewed Ms. Walcott in her office. Ms. Walcott stated she never witnessed or heard a single person in the facility speaking harshly or in an abusive manner to any of the residents living in the home. Ms. Walcott stated in her opinion, this accusation is “far from the truth” but staff, Ms. Tate, Ms. Boden and Mr. David are no longer working at the facility.

On 09/11/2024, Resident A & B are not able to provide information pertinent to this investigation due to cognitive deficits.

On 09/11/2024, Ms. Leon and I interviewed Resident C in his room at the facility. Resident C answered “yeah” when asked if staff are nice to him, if he likes staff and if he feels safe in the facility. Resident C stated staff treat him nice and they do not yell.

On 09/11/2024, Ms. Leon and I interviewed Resident D at the facility. Resident D stated things are going well for him, the staff are “good to me” and they do not yell or scream. Resident D stated he is not afraid or scared and that he likes living in the facility.

On 09/11/2024, Ms. Leon and I interviewed Resident E in his room at the facility. Resident E stated staff are “ok” and after that, Resident E was not able to provide any information pertinent to this investigation as he was unable to remain on subject due to cognitive deficits.

On 09/11/2024, Ms. Leon and I interviewed DCW Pam Gentry at the facility. Ms. Gentry stated she has never heard or witnessed any staff verbally abusing any of the residents by yelling or screaming at them.

On 10/01/2024, I reviewed an IR written by Ms. Bolden on 06/30/2024, signed by Ms. Walcott. The IR documented the following information, *‘I Shamuka Bolden was giving (Resident F) a shower, I told (Resident C) to use the other bathroom. I walked out to get (Resident F) some socks as I came back to the big bathroom to wash (Resident F) up, (Resident C) was in the bathroom with (Resident F). I asked (Resident C) to sit down on the toilet until I was done with (Resident F). That’s when Deonte David came yelling at (Resident C) and cussing, he told (Resident C), “what the fuck are you doing, Shamuka didn’t tell you to take off your shit with your dumb ass, you always doing some shit, you are hardheaded as hell.” Deonte kept on going with the yelling and cussing for about 10 minutes. I talked to Deonte and did an IR. Ms. Walcott documented on the IR that Mr. David was ‘suspended pending investigation.’*

On 10/04/2024, I interviewed Resident F via telephone. Resident F stated staff are “good and nice”, Resident F stated he does not remember staff yelling, swearing or speaking to him or any other residents in a negative, harsh manner or tone. Resident F stated he does not recall Mr. David yelling or cussing at Resident C in the bathroom at the facility as documented in the IR dated 06/30/2024.

On 10/04/2024, I interviewed Ms. Fetterhoff via telephone. Ms. Fetterhoff stated she has worked 1st shift at this facility since August and has had no issues and has never heard staff speaking negatively to the residents.

On 10/07/2024, I conducted an exit conference with Licensee Designee, Teresa Wendt. Ms. Wendt stated she agrees with the information, analysis, and conclusion of this applicable rule.

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:	The complainant reported that staff emotionally abuse residents, staff are disrespectful, cuss and yell at the residents. While there is an IR that correlates with the allegation dated 06/30/2024, there is not a preponderance of evidence to show that staff were verbally and emotionally abusive to residents at the facility. Therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: There are "fire safety issues" in the facility and staff do not conduct fire drills.

INVESTIGATION: On 08/12/2024, I received a complaint through Adult Protective Services, Department of Health and Human Services. The complainant reported the home's fire alarm does not work, and the staff have not performed a fire drill in a very long time.

On 08/22/2024, I conducted an unannounced inspection at the facility and interviewed DCW (direct care worker) Shamuka Boden. Ms. Boden showed me the fire panel and the pull station on the wall. Ms. Boden and I saw the pull station was not reset so the lever could not be pulled to sound the alarms. Ms. Boden retrieved the key and reset the pull station lever so when she pulled it down, the smoke detectors rang. Ms. Boden stated they do practice fire drills.

On 08/22/2024, I reviewed the fire drill records at the facility. The first quarter of 2024, January, February and March had documented fire drills for daytime, evening and sleeping hours. The second quarter of 2024, April, May and June had documented fire drills in May 2024 for sleeping hours only, there were no documented fire drills for daytime or evening.

On 09/11/2024, Ms. Leon and I conducted an unannounced inspection at the facility and interviewed Ms. Kimble. Ms. Kimble stated because of the home managers changing so often, fire drills were not conducted as often as they were supposed to be done. Ms. Kimble stated she thought drills were conducted in June, July and August 2024.

On 09/11/2024, Ms. Leon and I interviewed Ms. Walcott in her office. Ms. Walcott stated fire drills are being conducted by staff at the facility.

On 09/11/2024, I reviewed fire drill records at the facility for the third quarter of 2024, July, August and September. The records documented fire drills for evening and sleeping hours but there is no daytime fire drill documented.

On 09/11/2024, Ms. Leon and I interviewed Resident C in his room at the facility. Resident C stated “yes” staff conduct fire drills and that he “goes to the door” and the residents “meet out by the pole in the front yard.”

On 09/11/2024, Ms. Leon and I interviewed Resident D at the facility. Resident D stated they practice fire drills at the facility.

On 09/11/2024, Ms. Leon and I interviewed DCW Pam Gentry at the facility and Ms. Gentry stated staff conduct fire drills. Ms. Gentry stated staff conduct fire drills on every shift once a month to meet the daytime, evening and sleeping hour rule. Ms. Gentry stated staff and residents meet near the lamp post outside the facility.

On 10/07/2024, I conducted an exit conference with Licensee Designee, Teresa Wendt. Ms. Wendt stated the facility has experienced high turnover with home managers which can cause issues with fire drills being run and properly documented. Ms. Wendt stated she will review this report and submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14318	**Emergency preparedness; evacuation plan; emergency transportation.**
	(5) A licensee shall practice emergency and evacuation procedures during daytime, evening, and sleeping hours at least once per quarter. A record of the practices shall be maintained and be available for department review.
ANALYSIS:	The complainant reported the home’s fire alarm does not work, and the staff have not performed a fire drill in a very long time. Despite interviews with staff and residents who reported fire drills are being conducted, a review of the documented fire drills showed that fire drills are not being completed during daytime, evening and sleeping hours at least once per quarter per the applicable rule. Therefore, a violation of this rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

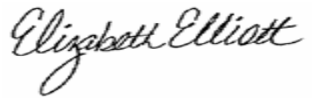
INVESTIGATION: On 09/11/2024, I reviewed Resident A, B, C, D, E and F's assessment plans. The assessment plan for Resident C has no signature for the Licensee, the responsible person or the responsible agency. The assessment plan for Resident D is dated 04/24/2024 with a signature of home manager, Ms. Walcott in the Licensee section and there are no other signatures on the document for the responsible person or the responsible agency. The assessment plan for Resident E is dated 05/2023 and the document must be completed annually.

On 10/07/2024, I conducted an exit conference with Licensee Designee, Teresa Wendt. Ms. Wendt stated the facility has experienced high turnover with home managers which can cause issues with facility paperwork being updated. Ms. Wendt stated she will review this report and submit an acceptable corrective action plan.

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:	Resident assessment plans are not completed and signed on an annual basis per this applicable rule. Therefore, a violation of this rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

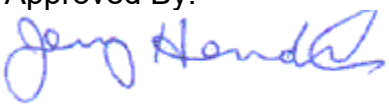
Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.



10/07/2024

Elizabeth Elliott Date
Licensing Consultant

Approved By:



10/07/2024

_____

Jerry Hendrick Date
Area Manager