GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 9, 2024

Thomas Roy and Gita Roy
9330 S. Wind Dr.
Zeeland, MI 49464

RE: License #: AF700391966
Investigation #: 2024A0579036
Glory Care

Dear Ms. Runyon:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (616) 356-0183.

Sincerely,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF700391966
Investigation #:	2024A0579036
Complaint Receipt Date:	08/13/2024
Investigation Initiation Date:	08/14/2024
Report Due Date:	10/12/2024
Licensee Name:	Thomas Roy and Gita Roy
Licensee Address:	9330 Southwind Dr., Zeeland, MI 49464
Licensee Telephone #:	(646) 462-5232
Name of Facility:	Glory Care
Facility Address:	9330 Southwind Dr., Zeeland, MI 49464
Facility Telephone #:	(646) 462-5232
Original Issuance Date:	09/10/2018
License Status:	REGULAR
Effective Date:	03/10/2023
Expiration Date:	03/09/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED/MENTALLY ILL/ DEVELOPMENTALLY DISABLED/AGED

II. ALLEGATION(S)

	Violation Established?
Mr. Roy and Ms. Roy cannot effectively communicate with residents and their designated representatives.	Yes
Resident A did not receive appropriate supervision.	Yes
Resident A shared a room with two other residents.	No
Additional Finding	Yes

III. METHODOLOGY

08/13/2024	Special Investigation Intake 2024A0579036
08/14/2024	Special Investigation Initiated - Letter Complainant
09/05/2024	Contact- Face to Face Resident C, Gita Roy (Licensee), Thomas Roy (Licensee)
09/25/2024	Contact- Face to Face Resident F, Gita Roy (Licensee), Thomas Roy (Licensee)
09/30/2024	Contact- Documentation Sent Briana Fowler, Ottawa County Office of Recipient Rights
09/30/2024	Contact- Telephone Call Made Djohariah Stevens, Caseworker
09/30/2024	Contact- Telephone Call Made Raquel Solis, Caseworker
09/30/2024	Contact- Documentation Sent Delia Osga, APS Worker
09/30/2024	Contact- Telephone Call Made Relative B
09/30/2024	Contact- Telephone Call Made Relative F1
09/30/2024	Contact- Telephone Call Made Relative F2
09/30/2024	Contact- Telephone Call Made

	Relative D1
09/30/2024	Contact- Telephone Call Made Relative D2
09/30/2024	Contact- Documentation Sent Elizabeth Elliott, Licensing Consultant
10/01/2024	Contact- Telephone Call Received Leah Osterhaven, Ottawa County CMH
10/08/2024	Exit Conference Thomas Roy, Licensee

ALLEGATION: Mr. Roy and Ms. Roy cannot effectively communicate with residents and their designated representatives.

INVESTIGATION: On 8/13/24, I received this referral which alleged there is a "language and understanding barrier". More specifically, it was alleged that Ms. Roy and Mr. Roy, are unable to effectively communicate with the residents and the complainant.

On 8/14/24, I exchanged emails with the complainant who confirmed there are challenges communicating with Ms. Roy and Mr. Roy when he, Resident A, and other residents speak to them due to a language barrier.

On 9/5/24, I completed an unannounced on-site investigation. Interviews were completed with Resident C, Gita Roy (Licensee), and Thomas Roy (Licensee).

Ms. Roy stated she does not speak English and could not speak to me. She requested I ask questions regarding the allegations to Resident C instead. Mr. Roy was not at the home at this time and arrived later during my on-site visit.

Resident C was the primary person to speak to me during this on-site visit. Ms. Roy would at times briefly make a statement as she was present for part of the time I spoke to him. Resident C advised there were no other residents at the home at this time. He denied that he or his relatives have challenges communicating with Ms. Roy and Mr. Roy. He stated he or his relatives schedule his necessary appointments. He stated his relatives provide his transportation. He stated he does not mind speaking for Ms. Roy to me, other individuals who come to the home, or for other residents. He informed me that he is very independent.

Mr. Roy appeared to not understand me as he did not respond to the questions I asked. I had to show him a photo when requesting Resident A's Assessment Plan in order to obtain the right documentation. I provided consultation regarding beds in

resident bedrooms, and he did not appear to understand what I was explaining. He would repeat the phrase “three beds” although I was discussing how the home was licensed for two beds per bedroom, and he could not discuss this further.

On 9/25/24, I completed an unannounced on-site investigation with Resident F, Ms. Roy, and Mr. Roy. Mr. Roy arrived at the home toward the end of my on-site investigation.

Resident F stated neither he nor his relatives struggle with communicating with Ms. Roy or Mr. Roy. He stated he schedules his own appointments, and his relatives transport him to the appointments. He denied that Ms. Roy and Mr. Roy’s communication negatively impacts his care.

Ms. Roy agreed to speak with me today. She stated she does not speak English well, but she tries her best. I inquired why she said she could not speak English and referred me to speak to Resident C the last time I was at the home, but she could not provide an explanation. I inquired if she often had residents speak to individuals who come to the home on her behalf, and she said “sometimes.” When asked, she stated that she and Mr. Roy do not schedule appointments, provide transportation, talk to resident’s physicians, and they do not contact law enforcement. I inquired who Ms. Roy would contact if there was a medical emergency for a resident and Ms. Roy reported residents can use the telephone. I inquired if she and Mr. Roy communicate with caseworkers and she said, “Case managers say we do great.” Ms. Roy reported Resident A and Resident F’s caseworker is “Jo” (determined to be Djohariah Stevens), Resident B and Resident E’s caseworker is “Selena (last name unknown) but was formerly “Raquel”, determined to be Raquel Solis, Resident C’s caseworker is” Dolly (last name unknown) and Resident D’s caseworker is reportedly unknown. She reported she could not provide their contact information and does not know where the resident files are kept, so she called Mr. Roy to come to the home to assist me.

Mr. Roy returned to the home and provided resident files for my review. He reported he speaks with resident guardians and caseworkers and provided typed incident reports that he reported he sent to caseworkers. He denied having contact information for the caseworker “Selena” and I was unable to obtain the contact information for “Dolly” while on-site either. I inquired how he would contact the caseworkers to communicate about the residents’ care if he did not have their contact information. He could not provide an explanation regarding how he would communicate with them if needed. He denied that he is unable to appropriately communicate with residents, guardians, or caseworkers. Mr. Roy reported he will be leaving the country for several months at the end of October and Ms. Roy will be managing the home in his absence. He reported he needs to be present when on-site inspections occur and requested they be scheduled prior to his absence.

While reviewing resident files, I was able to obtain contact information for relatives and/or guardians for Resident B, Resident D, and Resident F. Ms. Roy and Mr. Roy

denied having contact information for relatives of Resident C, even though it was reported he has a relative who is his guardian. Ms. Roy and Mr. Roy denied having contact information for relatives of Resident E, who they reported is his own guardian.

I reviewed incident reports for Resident A. It was noted after Resident A assaulted Resident B on 8/9/24, it was Resident C who contacted law enforcement for assistance.

On 9/30/24, I exchanged emails with Briana Fowler from Ottawa County CMH Office of Recipient Rights. She responded Leah Osterhaven would be a better contact person to discuss this allegation.

On 9/30/24, I attempted a telephone interview with Djohariah Stevens, caseworker for two of the residents in the home. A voicemail message was left requesting a return phone call. A return phone call was not received at the time of report disposition.

On 9/30/24, I attempted a telephone interview with Raquel Solis, who was reported to be a former caseworker for a resident in the home. A voicemail was left requesting a return phone call. A return phone call was not received at the time of report disposition.

On 9/30/24, I exchanged emails with Delia Osga, Adult Protective Services (APS) Worker, inquiring about her interactions in the home. She denied providing case management to residents in the home currently but reported she has been in this home before. She stated Mr. Roy does not communicate with her, he just hands her documents and Ms. Roy “would not do anything unless Mr. Roy was home.”

On 9/30/24, I completed a telephone interview with Relative B. She reported she appreciates Ms. Roy and Mr. Roy, and she knows that they care about the residents, but she has had ongoing concerns about whether “they fully understand the requirements” of being a licensed AFC home. She stated she has previously had to explain to them that Resident B cannot be responsible for his own medications, they must manage his medications, including Tylenol. She stated she believes this issue was resolved but she had to correct them on this. She stated she does not believe, due to their limited English, that they fully understand Resident B or that Resident B fully understands them. She stated she has struggled with what to expect regarding care and communication in this home, because Resident B previously resided at another licensed home, and it was run with much more communication and licensing compliance than this home. She stated Resident B is expected to communicate information to them, Ms. Roy and Mr. Roy do not. She stated Resident B made her aware of an altercation between him and Resident A. She stated she was upset that Ms. Roy and Mr. Roy did not address this with her or the follow-up after Resident B had contact with a Victim Right’s Advocate, which she feels she should have been notified of and had to consent to since she is Resident B’s guardian. She stated prior

to that, it was Ms. Solis, who informed her that residents in the home were reporting that Resident A was targeting Resident B with bullying behavior and Ms. Solis spoke to Ms. Roy and Mr. Roy to address this as well.

On 9/30/24, I attempted a telephone interview with Relative F1 who is noted as Resident F's Power of Attorney. An automated message played stating the number "is not available, try again later." There was no option to leave a voicemail message.

On 9/30/24, I completed a telephone interview with Relative F2 who Resident F requested I speak to. Relative F2 reported aside from Ms. Roy and Mr. Roy giving Resident F "more freedom than we're comfortable with", he did not have concerns. He explained he does not feel that Resident F gets enough supervision in the home. He reported he does not communicate with Ms. Roy and Mr. Roy often but when he does, he feels he can understand them because he often communicates with individuals who have English as a second language. He stated he does sometimes wonder if Ms. Roy and Mr. Roy understand him or Resident F but it has not caused any concerns regarding Resident F's care thus far.

On 9/30/24, I attempted a telephone interview with Relative D1 who is noted as Resident D's guardian. An automated message played stating the number is no longer in service.

On 9/30/24, I completed a telephone interview with Relative D2 who reported he and Relative D1 are involved in Resident D's care. He denied any concerns regarding the care Resident D receives. He reported he has communicated with Ms. Roy and Mr. Roy "on occasion" and reported "it is a little bit of a chore" to ensure they are understanding him, but he does not feel that the language barrier has impacted the care Resident D receives thus far.

On 9/30/24, I exchanged emails with the home's former licensing consultant, Elizabeth Elliott. She reported she was aware Ms. Roy appeared more comfortable with Mr. Roy or her son present and reported that Ms. Roy does speak English, so she is not certain why Ms. Roy would initially claim she does not.

On 10/1/24, I completed a telephone interview with Leah Osterhaven from Ottawa County Community Mental Health. She stated Ms. Roy and Mr. Roy "mean very well" but in the years she has worked with them, they have needed a lot of guidance to complete licensing requirements. She stated she spends a lot of time thoroughly explaining licensing documents or requirements. They will come into compliance for a few weeks, and then they "totally forget" again. She agreed with the allegation that there is a language and understanding barrier, but that Ms. Roy does speak English so she is not certain why Ms. Roy would say she does not. She stated Mr. Roy leaves the country for approximately four months every year and she has concern that Ms. Roy cannot manage the home appropriately in Mr. Roy's absence. She stated she believes Ms. Roy relies on her son, Mark Roy, to assist her with operating the home while Mr. Roy is out of the country.

On 10/3/24, I completed an unannounced on-site investigation. An interview was completed with Mr. Mark Roy who reported he assists Ms. Roy and Mr. Roy with translating in order to run the home.

APPLICABLE RULE	
R 400.1404	**Licensee, responsible person, and member of the household; qualifications.**
	(3) A licensee or responsible person shall possess all of the following qualifications: **(b) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.**

ANALYSIS:	On 9/5/24, Ms. Roy reported she does not speak English and requested I speak to Resident C instead of her while I was on-site. I primarily spoke to Resident C during my first on-site investigation. He denied challenges communicating with Ms. and Mr. Roy. Mr. Roy did not appear to understand me when I was discussing licensing rules at the first on-site contact. I had to show him a photo in order to obtain Resident A's Assessment Plan and repeat the phrase "three beds" when I attempted to discuss the licensed number of beds in the home. The complainant and Relative B expressed concern that due to Ms. Roy and Mr. Roy's limited English they do not understand residents or their relatives/guardians. Relative F2 stated he questions if Ms. Roy and Mr. Roy understand Resident F. Relative D2 stated communicating with Ms. Roy and Mr. Roy is "a little bit of a chore." Ms. Osterhaven reported there is a language barrier with Ms. Roy and Mr. Roy and they need a lot of guidance to meet licensing requirements which they are able to sustain briefly before returning to not complying and needing more guidance. Mr. Mark Roy reported he provides translation assistance for Ms. Roy. Based on the interviews completed, there is sufficient evidence that due to a language barrier, Mr. Roy and Ms. Roy are not suitable to meet the physical, emotional, social, and intellectual needs of each resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A did not receive appropriate supervision.

INVESTIGATION: On 8/13/24, I reviewed this referral which alleged that on 8/9/24, Resident A assaulted Resident B. Resident A was arrested, and Resident B was sent to the hospital. Resident A's guardian was notified of the incident by Mr. Roy and informed that Resident A may not return to the home. The complainant did not feel Resident A received adequate supervision in the home.

On 9/5/24, Resident C reported Resident A was regularly agitated and Ms. Roy and Mr. Roy tried to make Resident A happy, such as allowing him to choose which

room he wanted to live in. He stated Resident A had a “really sweet side, a nasty side, and a bad temper.” He stated Resident A engaged in verbal arguments and liked to make fun of all the other residents. He stated Resident A recently got into a physical altercation with Resident B. He stated on three or four prior occasions, Resident A got into physical altercations with Resident B or Resident F. He reported he did not always feel safe when Resident A was in the home due to Resident A’s behavior but now, he does.

Ms. Roy confirmed Resident A was often agitated when she overheard Resident A as he was speaking to me. She did not provide further information, reportedly due to her not speaking English.

Mr. Roy confirmed Resident A was often agitated, got into an altercation with Resident B, and had to be discharged from this home. He could not provide further information regarding the allegations when I discussed them with him.

I observed Resident A’s assessment plan. It was noted Resident A moves independently in the community. On his assessment plan, it was noted Resident A needs assistance with eating, toileting, bathing, grooming, dressing, personal hygiene, walking/mobility, and stair climbing. An explanation of how these needs will be met was left blank on the form. There was no signature page indicating who this form was completed with or when it was completed. It was observed that Resident A had to ambulate a flight of stairs to get to the resident living area although it was noted he needs assistance with stair climbing.

On 9/26/24, Resident F stated he was involved with a physical altercation with Resident A where he had to call law enforcement to the home. He stated Resident A threw a phone at him and tried to bite him. He denied knowing when this occurred. He stated recently, Resident A “cracked [Resident B] over the head with a glass cup.” He stated Resident B also called law enforcement and Resident A was “kicked out” of the home. He stated Resident A would “talk trash”, “boss everyone around”, and “yelled at everyone a lot.” He stated he did not feel safe with Resident A in the home. He stated he had told his guardian, Ms. Roy, and Mr. Roy that he did not feel safe with Resident A in the home so Resident A was moved to a different bedroom.

Ms. Roy reported Resident A “was so sweet.” She stated he did not get along with other residents, but she did not want him to leave because she liked him. She stated she is not certain how long Resident A lived in this home, but he often did not get along with Resident B. She stated law enforcement came to the home one time when Resident A was shouting, and Resident B said Resident A hurt him. She stated she is not certain why law enforcement came to the home because she and Mr. Roy “never call police.” I inquired about the time Resident F reported he called law enforcement. She confirmed this occurred and reported Resident A and Resident F had a fight over a phone charging cord and Resident F called law enforcement. She stated Resident D also reported he did not like Resident A and did not feel safe with Resident A in the home. She stated Resident A would apologize

for his behavior and she spoke with the residents who expressed concern about Resident A and told them “every home has problems” and that anyone who was not happy at this home could go to a new home. She stated she and Mr. Roy never asked Resident A to leave because she liked him.

I asked Ms. Roy if Resident A required assistance with bathing, stair climbing, and the other tasks noted in his assessment plan. She stated he did not and that his assessment plan was completed incorrectly.

Mr. Roy reported Resident B called law enforcement after he said Resident A assaulted him. He stated he did an incident report for this incident. He stated Resident A was “rough and tough sometimes in the beginning” and did not get along with other residents. He stated they did not want to “dismiss” which he clarified was discharge Resident A even though he did not get along with other residents. He denied that they were going to discharge Resident A after he assaulted Resident B and reported it was Resident A’s caseworker and guardian who decided Resident A would not be returning to the home. He denied having a written discharge notice for Resident A.

I reviewed typed notes completed by Mr. Roy regarding Resident A.

On 7/12/24, it was noted Resident D reported he “can’t tolerate [Resident A’s] bad behavior and was very upset.” Resident D reportedly called his guardian and left the home for several days.

On 7/13/24, it was noted Resident A and Resident B got into an argument and Resident A threw a television remote at Resident B striking him in the head. Resident B contacted law enforcement who spoke to both residents and reportedly resolved the matter with Resident A apologizing.

On 7/20/24, it was noted Resident A and Resident F “had a fight with each other.” Resident F broke Resident A’s television and contacted law enforcement. Law enforcement could not determine who was at fault and Mr. Roy was advised to separate the residents “for sometimes.” Mr. Roy reported residents were separated for a day and then they were “okay with each other.”

On 8/9/24, it was noted Resident A assaulted Resident B with a glass. Resident B was yelling and there was a bump on his head. Resident C called law enforcement. Law enforcement and an ambulance arrived. Resident A was arrested, and his guardian was contacted. Mr. Roy asked “residents about [Resident A’s] coming back and everybody was unwilling to take him back.”

On 9/30/24, Relative B stated Resident B made her aware of an altercation with him and Resident A. She stated prior to that, it was Ms. Solis, who informed her that residents in the home were reporting that Resident A was targeting Resident B with bullying behavior and Ms. Solis spoke to Ms. Roy and Mr. Roy to address this as well.

On 9/30/24, Relative F2 reported Ms. Roy and Mr. Roy give Resident F “more freedom than we’re comfortable with” and explained he does not feel that Resident F gets enough supervision in the home.

On 10/1/24, Ms. Osterhaven stated Ms. Roy and Mr. Roy provide “bare minimum” supervision and support. She stated Ms. Roy truly loves and cares for residents. She stated Ms. Roy will make special meals for them. However, Ms. Roy and Mr. Roy do not go into the resident living area in the basement. She stated they also do not interact with residents regularly. She stated she has had to discuss with Ms. Roy and Mr. Roy that they must supervise and engage with residents and not just leave them unattended in the basement. She stated after these conversations, supervision and engagement with residents will “go well for a minute” but then “goes back to nothing.”

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.** **(c) The resident appears to be compatible with other residents and members of the household.**
ANALYSIS:	Resident C and Resident F reported they did not feel safe while Resident A resided in the home because Resident A was often agitated and engaged in violence on multiple occasions. Ms.

	Roy and Mr. Roy confirmed this. Typed notes completed by Mr. Roy noted concerns for Resident A's behavior were brought up by residents on 7/12/24 and law enforcement came to the home on 7/13/24, 7/20/24, and 8/9/24 for altercations involving Resident A. Resident A's assessment plan noted he needed assistance with eating, toileting, bathing, grooming, dressing, personal hygiene, walking/mobility, and stair climbing. An explanation of how these needs will be met was left blank on the form. There was no signature page noting when this was completed and who it was completed with. It was observed Resident A had to ambulate a flight of stairs to get to his living area. Ms. Roy acknowledged this form was completed incorrectly. Relative F2 expressed he does not feel Resident F receives enough supervision in the home. Ms. Osterhaven reported Ms. Roy and Mr. Roy provide "bare minimum supervision" and she has addressed that they must supervise and engage with residents, they cannot always leave residents unattended in the basement of the home. Based on the interviews completed and documentation observed, there is sufficient evidence that Resident A was accepted into the home without it being determined he was suitable due to the amount of personal care, supervision, and protection available in the home. It was also not determined that he was compatible with other members of the household due to his assessment plan being completed incorrectly and residents reporting they did not feel safe in the home due to Resident A's behaviors.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A shared a room with two other residents.

INVESTIGATION: On 8/13/24, I reviewed the referral which alleged Resident A shared a three-person bedroom with Resident D and Resident E.

On 8/13/24, I reviewed the file which noted the home was licensed for two beds in each of the three bedrooms in the lower level of the home.

On 9/5/24, I observed three beds in the room that Resident A reportedly resided in.

Resident C reported Resident A shared a bedroom with Resident D and Resident E. He stated Resident A had lived in each room in this home at one point. He stated Resident A was given the choice of which bedroom he wanted to sleep in to make him happy. He stated Resident A chose to room with Resident D and Resident E and requested his bed be moved into that room after previously residing in the other two bedrooms in the home.

Ms. Roy confirmed Resident A shared a room with Resident D and Resident E. She confirmed Resident A requested to be in that bedroom after previously residing in both other rooms in the home.

Mr. Roy confirmed Resident A shared a room with Resident D and Resident E. I attempted to explain that the room was initially licensed for two beds. I inquired why a third bed was moved into the bedroom. Mr. Roy could not explain why this occurred or confirm that the room was large enough for three residents.

On 9/25/24, I reviewed the Original Licensing Study. It was confirmed the room that Resident A resided in is 252 square feet.

APPLICABLE RULE	
R 400.1432	**Bedroom space; "usable floor space" defined.**
	(2) A bedroom shall have not less than 65 square feet of usable floor space per bed.
ANALYSIS:	Resident C, Ms. Roy, and Mr. Roy reported Resident A chose to room with Resident D and Resident E. It was noted the room Resident A, Resident D, and Resident E resided in was initially licensed for two beds but measures 252 square feet. Based on the interviews completed, observations made, and documentation reviewed, there is insufficient evidence that the bedroom Resident A resided in had less than 65 square feet per resident.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

On 9/5/24, while reviewing Resident A's *Assessment Plan for AFC Residents* form, I observed the fourth page of the document, that requires signatures, was replaced with a MDHHS form. That form had the signature of Mr. Roy, Resident A, and Ms. Osga but did not include the signature of Resident A's guardian.

I reviewed Resident A's assessment plan which noted Resident A needs assistance with eating, toileting, bathing, grooming, dressing, personal hygiene, walking/mobility, and stair climbing. An explanation of how these needs will be met was left blank on the form. It was observed that Resident A had to ambulate a flight of stairs to get to the resident living area although it was noted he needs assistance with stair climbing.

On 9/26/24, Ms. Roy reported Resident A was independent in eating, toileting, bathing, grooming, dressing, personal hygiene, mobility, and stair climbing. She reported his assessment plan was completed incorrectly.

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.**
	(3) In situations where a resident is referred for admission, the resident assessment plan shall be conducted in conjunction with the resident or the resident's designated representative, the responsible agency, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	The signature page for Resident A's assessment plan was replaced with another document and did not include Resident A's guardian's signature so it is unknown who the form was completed with. Resident A's assessment plan also noted he had significant needs in activities of daily living. Ms. Roy reported he did not have those needs and the form was completed incorrectly. Based on the documentation reviewed, there is sufficient evidence that Resident A's assessment plan was not conducted in conjunction with the resident's designated representative, responsible agency, and the licensee.

CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/26/24, while reviewing resident files to obtain guardian, relative, and caseworker information, I found that Resident B's *Resident Care Agreement* (RCA) signature page was blank, Resident C's RCA was only signed by Relative C, Resident D and Resident's E RCA was signed only by Mr. Roy, and Resident F's RCA was signed only by his caseworker. In addition, Resident C's RCA had a signature dated 4/25/23 and Resident D and Resident E's RCA had a signature dated 1/1/23.

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.**
	(6) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency at least annually or more often if necessary.
ANALYSIS:	Signatures were missing from each resident's *Resident Care Agreement*. Resident C, D, and E's *Resident Care Agreement* had not been appropriately updated in 2024. Based on the documentation reviewed, there is sufficient evidence that the licensee did not review the written care agreement with the resident's designated representative and responsible agency at least annually, as verified through dated signatures on the *Resident Care Agreement* form.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/26/24, while reviewing resident files to obtain guardian, relative, and caseworker information, I found that Resident E and Resident F had a blank, incomplete *Resident Funds Record Part I* form in their files.

APPLICABLE RULE	
R 400.1421	**Handling of resident funds and valuables.**
	(9) A licensee shall obtain prior written approval from a resident and his or her designated representative before charges are made to a resident's account.

ANALYSIS:	*Resident Funds Part I* forms were blank and incomplete in the file of Resident E and Resident F. Based on the documentation reviewed, there is sufficient evidence that prior written approval was obtained from the resident or their designated representative before charges were made to a resident's account.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/26/24, while reviewing resident files to obtain guardian, relative, and caseworker information, I found that Resident E and Resident F had a blank, incomplete *Resident Funds Record Part II* form in their files.

I asked Mr. Roy how payments were made for resident care. He denied recording payments and reported they were made via direct deposit to his bank account.

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:	*Resident Funds Part II* forms were blank and incomplete in the file of Resident E and Resident F. Based on the documentation reviewed, there is sufficient evidence that a resident funds and valuables transaction department form was not on file for Resident E and Resident F.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/26/24, while reviewing incident reports for Resident A, I found that Mr. Roy was typing paragraphs in a Word document to use as incident reports for Resident A. These paragraphs noted serious hostility and acts of harm to others on 7/13/24, 7/20/24, and 8/9/24. A department form was not being used. It was not documented who the report was sent to and when. Mr. Roy reported sending these documents to Resident A's caseworker after the incidents occurred.

APPLICABLE RULE	
R 400.1416	**Resident health care.**
	(4) A licensee shall make a reasonable attempt to contact the resident's next of kin, designated representative, and responsible agency by telephone, followed by a written report to the resident's designated representative and responsible agency within 48 hours of any of the following: **(c) Incidents involving displays of serious hostility, hospitalization, attempts at self-inflicted harm or harm to others, and instances of destruction to property.** **(5) A copy of the written report required in subrule (4) of this rule shall be maintained in the home for a period of not less than 2 years. A department form shall be used unless prior authorization for a substitute form has been granted in writing by the department.**
ANALYSIS:	Incidents of seriously hostility and harm to others regarding Resident A were noted in a Word document and not on a department form Based on the documentation reviewed there is sufficient evidence that incidents of serious hostility and harm to others were not maintained in the home on a department form.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/8/24, I completed an exit conference with Mr. Roy who stated he does not understand my findings or recommendations. I suggested it may be clearer when he reads the report and contact me at that time with any questions.

IV. RECOMMENDATION

Due to the above cited quality of care violations, I recommend issuance of a provisional license.

Cassandra Duursma 10/08/2024

Cassandra Duursma, Licensing Consultant — Date

Approved By:

10/09/2024

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Jerry Hendrick Date
Area Manager