GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 14, 2024

John Morcom & Theresa Posey
7550 E. Allen
Fenton, MI 48430

RE: License #: AS470312591
Investigation #: 2025A0466001
Greener Acres

Dear John Morcom & Theresa Posey:

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,

Julie Elkins

Julie Elkins, 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 #:	AS470312591
Investigation #:	2025A0466001
Complaint Receipt Date:	09/30/2024
Investigation Initiation Date:	10/01/2024
Report Due Date:	11/29/2024
Licensee Name:	John Morcom & Theresa Posey
Licensee Address:	5491 Green Road Fenton, MI 48430
Licensee Telephone #:	(810) 210-8167
Administrator:	Nancy Posey
Name of Facility:	Greener Acres
Facility Address:	5491 Green Road Fenton, MI 48430
Facility Telephone #:	(810) 599-6707
Original Issuance Date:	03/13/2012
License Status:	REGULAR
Effective Date:	09/13/2024
Expiration Date:	09/12/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION:

	Violation Established?
Resident A struck Resident B with his cane.	No
Additional Findings	Yes

III. METHODOLOGY

09/30/2024	Special Investigation Intake 2025A0466001.
09/30/2024	APS Referral- James Lynch assigned.
10/01/2024	Special Investigation Initiated – Telephone call to APS James Lynch, interviewed.
10/01/2024	Contact - Telephone call received from administrator Nancy Posey.
10/03/2024	Inspection Completed On-site.
10/03/2024	Exit conference with administrator Nancy Posey as co-licensee Theresa Posey is out of town.
10/10/2024	Contact- Document received from APS Jame Lynch.
11/14/2024	Exit Conference with licensee Theresa Posey, message left.

ALLEGATION: Resident A struck Resident B with his cane.

INVESTIGATION:
On 09/30/2024, Complainant reported that Resident B is a 77-year-old male who resides at Greener Acres Adult Foster Care (AFC) home diagnosed with a traumatic brain injury (TBI), he is unsteady on his feet and uses a walker to ambulate. Complainant reported on 9/24/24 at approximately 1:30 AM, Resident B who is Resident A's roommate was in his bedroom and direct care worker (DCW) Jen Caryl was changing his adult brief when Resident A got up and struck Resident B with his cane. Complainant reported DCW Caryl took the cane from Resident A but Resident A grabbed another cane from the closet and attempted to hit Resident B again. Complainant reported Resident B had injuries to his arms and hands but did not require medical attention. Complainant reported 911 was called, Resident A was temporally removed from the facility but is now back. Complainant reported Resident A is no longer sharing a room with Resident B, but Resident B still fears Resident A.

On 10/01/2024, adult protective service (APS) worker James Lynch reported that he interviewed DCW Caryl who reported that Resident A has never struck anyone with his cane before and that she did all that she could do in the moment to protect Resident B. APS Lynch reported that DCW Caryl no longer works at the facility.

On 10/01/2024, administrator Nancy Posey contacted me and reported that Resident A hit Resident B several times with his cane in the middle of the night. Administrator Posey reported that the police were called, Resident A went to the hospital for assessment but he has since been discharged back to the facility. Administrator Posey reported that Resident A is very mobile, so she suggested to Resident A's designated representative that he needed a staff member to sit with him 24/7 as there was no reason for why Resident A hit Resident B with his cane. Ms. Posey stated Resident A has never exhibited any similar behavior previously. Administrator Posey reported Resident A is diagnosed with dementia. Administrator Posey reported that Resident A's designated representative took Resident A to the Veteran Affairs (VA) Hospital on 10/01/2024 where he was admitted for an in-service program. Ms. Posey stated this program is taking care of his housing so Resident A will not be returning to the facility.

On 10/03/2024, I conducted an unannounced investigation and I interviewed DCW Erin Isaacs who was on duty and reported that there were four residents living in the facility. DCW Isaacs reported that on 09/24/2024, there were five residents, but that Resident A moved out on 10/01/2024. DCW Isaacs reported that she has worked with Resident A and he had never been physical, violent or acted impulsively before. DCW Isaacs reported Resident A has never attempted or threated to hit anyone with his cane. DCW Isaacs reported Resident A would get into her and others personal space but that he hadn't lived here long, just about two months and he was still adjusting. DCW Isaacs reported that they had not seen any mood changes with Resident A since his admission on 08/03/2024 and she noted that he did not have a urinary tract infection. DCW Isaacs reported that Resident B was not currently at the facility as he was in the community with family therefore he could not be interviewed.

I reviewed an *AFC Licensing Division Accident/Incident Report* dated 9/24/2024 signed by DCW Caryl and administrator Posey. In the "explain what happened" section of the report it stated, "[Resident A] woke up confused. Hit [Resident B]. In the "action taken by staff" section of the report it stated, "Separated them called 911." In the "corrective measures taken to remedy and or prevent reoccurrence" it stated "moved."

I reviewed Resident A's record which documented that he was admitted to the facility on 08/03/2024. I reviewed Resident A's *Health Care Appraisal* that was dated 08/01/2024, documented Resident A is 79 years and diagnosed with "Afib, coronary artery disease (CAD), type 2 diabetes mellitus (T2DM), vascular dementia, high density lipoprotein (HLD) and stroke." In the mobility section of the report it stated," fully ambulatory."

I reviewed Resident A's *Physician Instructions and Contact Log* which documented on 9/24/2024, "sent out for change of mental status. Hit a resident multiple times with cane. Covid positive."

I reviewed Resident A's written *Assessment Plan for Adult Foster Care (AFC) Residents* that was dated 08/02/2024 and signed by Relative A1. The written assessment plan documented that Resident A, gets along with others, controls aggressive behaviors, he is mobile and that he uses a cane, "PRN-not necessary."

I reviewed Resident B's record which documented that he was admitted to the facility on 08/03/2024. I reviewed Resident B's *Health Care Appraisal* that was dated 06/21/2024, which documented Resident B is 77 years and diagnosed with "arthritis, ataxic cerebral palsy, benign hypertension and glaucoma." In the "mobility" section it documented that he uses a "walker and cane."

I reviewed Resident B's written *Assessment Plan for AFC Residents* that was dated 06/04/2024 and signed by Relative B1. The written assessment plan documented that Resident B, gets along with others and controls aggressive behavior. In the "special equipment" used it documented "walker and shower chair."

I reviewed an *AFC Licensing Division Accident/Incident Report* dated 9/24/2024 signed by DCW Caryl and administrator Posey. In the "explain what happened" section of the report it stated, "[Resident B] got hit with a cane by [Resident A]. In the "action taken by staff" section of the report it stated, "Separated them called 911." In the "corrective measures taken to remedy and or prevent reoccurrence" it stated, "physician ordered walker for [Resident A] d/c cane." In the "name of treating physician/health care/medical facility/hospital" it stated, "Trinity Health in Howell."

On 10/10/2024, APS Lynch reported that he did not have any findings/substations as DCW Caryl did the best she could to protect Resident B when Resident A hit him with his cane. APS Lynch reported that Resident A's violent behavior was exhibited for the first time on 09/24/2024, Resident A was moved into another bedroom and then discharged from the facility on 10/01/2024.

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.**

ANALYSIS:	Resident A and Resident B were both admitted to the facility on 08/03/2024 and resided as roommates without any issues until 9/24/2024, when Resident A struck Resident B with his cane. Administrator Posey, DCW Caryl and DCW Isaacs all reported that Resident A had never exhibited any behavioral concerns previously. At the time that Resident A hit Resident B with the cane, DCW Caryl was in the bedroom changing Resident B's incontinent brief therefore she was able to take the cane from Resident A to protect Resident B. Resident A and Resident B's written assessment plans did not contain any specific supervision instructions and therefore a violation has not been established as the amount of personal care, supervision, and protection that is required by both Resident A and Resident B was available in the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

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:	Administrator Posey, DCW Caryl and DCW Isaacs all reported that Resident A had never exhibited any behavioral concerns prior to 9/24/2024 when Resident A hit Resident B with his cane. DCW Caryl was in the bedroom changing Resident B's incontinent brief as Resident A hit Resident B therefore she was able to take the cane from Resident A to protect Resident B. Resident B was moved to another bedroom and then discharged from the facility on 10/03/2024 therefore a violation has not been established as the facility ensured protection and safety for both Resident A and Resident B.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
I reviewed the facilities *Resident Register* and Resident B's record which both documented that Resident B was admitted to the facility on 08/03/2024. I reviewed Resident B's entire record and the only written *Assessment Plan for AFC Residents* in the record was dated 06/04/2024 prior to his admission to this facility.

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 licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident B was admitted to the facility on 08/03/2024 and Resident B's record did not contain a written assessment plan that had been completed upon admission therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 10/03/2024, I conducted an unannounced investigation and I reviewed Resident A's *Health Care Appraisal* that was dated 08/01/2024. In the mobility section of the report it stated," fully ambulatory."

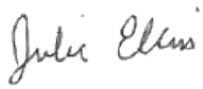
I reviewed Resident A's written *Assessment Plan for AFC Residents* that was dated 08/02/2024 and signed by Relative A1. The written assessment plan documented Resident A is ambulatory and that he uses a cane, "PRN-not necessary."

I reviewed Resident A's record in its entirety and there was no written authorization by a licensed physician for Resident A to use a cane.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	Resident A's record did not contain written physician authorization for the cane he was using therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in license status.



11/14/2024

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Julie Elkins Date
Licensing Consultant

Approved By:

11/14/2024

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Dawn N. Timm Date
Area Manager