GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 13, 2024

Tamika Ruth
514 S. Ortman Street
Saginaw, MI 48601

RE: License #: AS730377214
Investigation #: 2025A0580003
Annie's Home Care

Dear Tamika Ruth:

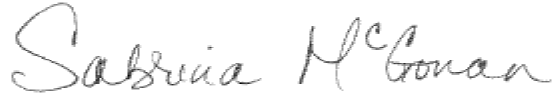
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 643-7960.

Sincerely,



Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730377214
Investigation #:	2025A0580003
Complaint Receipt Date:	10/18/2024
Investigation Initiation Date:	10/21/2024
Report Due Date:	12/17/2024
Licensee Name:	Tamika Ruth
Licensee Address:	514 S. Ortman Street Saginaw, MI 48601
Licensee Telephone #:	(989) 714-1271
Administrator:	Tamika Ruth
Licensee Designee:	N/A
Name of Facility:	Annie's Home Care
Facility Address:	514 N. Warren Avenue Saginaw, MI 48607
Facility Telephone #:	(989) 401-7835
Original Issuance Date:	11/16/2015
License Status:	REGULAR
Effective Date:	05/16/2024
Expiration Date:	05/15/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
Home does not have menus available for residents.	Yes
Home was visited, upon entering the home staff was laying on the floor wrapped in blankets sleeping.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/18/2024	Special Investigation Intake 2025A0580003
10/21/2024	APS Referral Referred to APS.
10/21/2024	Special Investigation Initiated - Letter Made an APS referral sharing the allegations.
10/30/2024	Inspection Completed On-site Unannounced onsite.
10/30/2024	Contact - Face to Face Interview with Residents A-C.
12/06/2024	Contact - Telephone call made Call to Licensee, Tamika Ruth.
12/10/2024	Contact - Telephone call received Call from Licensee Ruth.
12/10/2024	Exit Conference Exit Conference with Licensee Ruth.
12/11/2024	Inspection Completed-BCAL Sub. Non-Compliance
12/11/2024	Recommend Modify to Provisional

ALLEGATION:

Home does not have menus available for residents.

INVESTIGATION:

On 10/18/2024, I received a complaint LARA-BCHS-Complaints.

On 10/21/2024, I made a referral to Adult Protective Services (APS) sharing the allegations.

On 10/30/2024 I conducted an unannounced onsite inspection at Annie's Home Care. Contact was made with Roderick York, identified as staff in the home. No menu was observed visibly posted in the home. Staff York stated that there are no menus in the home, past or present. Staff York stated that he usually handles the residents' breakfast and lunch while his mother and licensee, Tamika Ruth, usually brings or cooks the dinner for the residents.

On 10/30/2024, Residents A-C were interviewed regarding the allegations. All 3 residents stated that there are no menus in the home. Cereal is served for breakfast daily, with no cooked foods being served for breakfast. Daily lunch consists of bologna sandwiches. Residents A-C all stated that they do not get enough food to eat, with Resident C adding that he goes to the local soup kitchen for additional food.

On 12/10/2024, I conducted an exit conference with the licensee, Tamika Ruth. License Ruth stated they have been cooking the food for the residents at a different location due to a recent extermination and she took the menu with her. Licensee Ruth stated that she did not realize that the menu needs to be visibly posted.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	It was alleged that the home does not have menus available for residents. No menu was observed visibly posted in the home. Staff York stated that there are no menus in the home, past or present.

	Residents A-C all stated that there are no menus in the home. Based on the interviews conducted and the observation of no menu visibly posted in the home, there is sufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Home was visited, upon entering the home staff was laying on the floor wrapped in blankets sleeping.

INVESTIGATION:

On 10/30/2024, while onsite, Staff York confirmed that he is live-in staff who resides in the home, however, he denied sleeping in the living room and identified a corner area near the entry foyer, which contains a desk and chair, as his area where he typically sleeps. While onsite, I observed in the living room area that there was a cot, with a pillow and a blanket, toolboxes and other miscellaneous items in the floor. There is no furniture in the home. Photos of both areas were taken.

On 10/30/2024, Residents A-C were interviewed regarding the allegations. Resident B stated that staff York sleeps on the floor, while the other 2 residents did not answer.

I did not obtain the staff schedule. I did review the previous SIR (SIR#2024A0572053, completed by A. Humphrey on 8/16/2024) where it appears as if the staff schedule is made up of 12-hour shifts between Licensee Designee, Tamika Ruth, her son, Roderick York and the owner of the home, Keith Bulger.

On 12/10/2024, I conducted an exit conference with Licensee Ruth. Licensee Ruth denied that Staff York sleeps in the living room area on the cot seen in the floor, indicating that a contractor left it behind and never returned for it. Licensee Ruth was informed that the area that live-in Staff York identified as his sleeping area is not approved for sleeping purposes, by anyone, per the rule.

On 04/19/2024, I concluded in Special Investigation Report (SIR) #2023A0580024. R400.14408(2) had been violated due to my observation of the bed in the dining room and staff, Mr. Bulger’s admission that he sleeps on the bed in the dining room. The corrective action dated 06/14/2023 and signed by Licensee Ruth, stated that bed was removed from the dining room on 05/15/2023.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(2) A living room, dining room, hallway, or other room that is not ordinarily used for sleeping or a room that contains a required means of egress shall not be used for sleeping purposes by anyone.
ANALYSIS:	It was alleged that staff was observed lying on the floor, wrapped in blankets, sleeping during shift. Staff York confirmed that he is live-in staff who resides in the home, however, he denied sleeping in the living room and identified a corner area near the entry foyer, which contains a desk and chair, as his area where he typically sleeps. While onsite, I observed in the living room area that there was a cot, with a pillow and a blanket. Resident B stated that staff York sleeps on the floor Based on the interview conducted and observation of cot, with a pillow and a blanket in the living room floor, there is sufficient evidence to support this rule violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR 2023A0580024, dated 04/19/2023.**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/30/2024, while onsite, resident medication was observed in the Frigidaire, which is unlocked. A photo was taken.

On 12/10/2024, an exit conference was conducted with Licensee Ruth. Licensee Ruth stated that there are 4 residents currently in the home. The medicine, which required refrigeration, belonged to Resident D, who passed away in June of 2024. I reminded Licensee Ruth that refrigerated medication should be kept in a locked box, inaccessible to residents.

On 04/19/2024, I concluded in Special Investigation Report (SIR) #2023A0580024. R400.14312(1) had been violated due to medication in the home having been observed unlocked. The corrective action dated 06/14/2023 and signed by Licensee Ruth stated that the licensee changed pharmacies in order to pick up and get rid of old medication daily.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	I observed resident medication in the Frigidaire, which is unlocked.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED SIR2023A0580024, dated 04/19/2023.**

INVESTIGATION:

On 10/30/2024, while onsite, resident medication was observed in the Frigidaire belonging to Resident D.

On 12/10/2024, Licensee Ruth stated that Resident D passed away in June 2024. I reminded Licensee Ruth that prescription medication that is no longer required by a resident shall be properly disposed.

On 04/19/2024, I concluded in Special Investigation Report (SIR) #2023A0580024. R400.14312(7) had been violated due to medication in the home having been observed unlocked. The corrective action dated 06/14/2023 and signed by Licensee Ruth stated that the licensee changed pharmacies in order to pick up and get rid of old medication daily.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	While onsite, I observed resident medication in the Frigidaire belonging to Resident D. Licensee Ruth stated that Resident D passed away in June 2024.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED SIR2023A0580024, dated 04/19/2023.**

INVESTIGATION:

On 10/30/2024, while onsite, I observed that the burners on the gas stove in the kitchen, were observed with caked grease and grime. The stove knobs were dirty, containing visible fingerprints from multiple uses without being washed. A photo was taken.

On 10/31/2024, I conducted an exit conference with Tamika Ruthe. I spoke with Tamika Ruth regarding the conditions of the stove, she stated, “ok”.

On 04/19/2024, I concluded in Special Investigation Report (SIR) #2023A0580024, that R400.14402(4) had been violated due to Witness 1 observing the stove in the kitchen with a lot of dirt, grime, and caked grease and Consultant, Mr. Humphrey, observing the kitchen stove with burnt food, grease and crud on top of the stove and around the burners. The corrective action dated 06/14/2023 and signed by Licensee Ruth stated that the licensee established a cleaning list, for each shift to maintain complete cleaning of the entire house, checking the list daily, effective 05/15/2023.

APPLICABLE RULE	
R 400.14402	**Food service.**
	(4) All food service equipment and utensils shall be constructed of material that is nontoxic, easily cleaned, and maintained in good repair. All food services equipment and eating and drinking utensils shall be thoroughly cleaned after each use.
ANALYSIS:	I observed that the burners on the gas stove in the kitchen, were observed with caked grease and grime. The stove knobs were dirty, containing visible fingerprints from multiple uses without being washed.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED SIR2023A0580024, dated 04/19/2023.**

INVESTIGATION:

On 10/30/2024, I conducted an unannounced onsite inspection at Annie’s Home Care. Upon arriving to the home, the porch was littered with trash items, consisting of brown paper bags, empty pop cans and cigarette packs, strewn about the porch. Photos were taken.

While onsite I observed the kitchen area of the home. Upon walking in the kitchen, I observed that the facing to the kitchen sink cabinets was missing, exposing the bottom of the kitchen sink. Along with the cabinet facing, a kitchen drawer is missing as well, seen on the kitchen floor. Upon opening the Frigidaire, I observed the top shelf of the fridge door contained several dead bugs. There were condiments throughout the remaining shelves in the fridge door. Dead bugs were also seen on bottom shelf.

Contents of the fridge included milk, eggs and tied up plastic bags, contents unknown. The fridge is not clean and contains dead bugs. The freezer contained 1 bag of frozen shrimp and additional 4 additional plastic bags, which were tied up. No packages of meat were observed. The freezer is not clean, and also contains dead bugs.

On 12/10/2024, Licensee Ruth stated that the bugs were in the home due to the home being recently exterminated, where she was instructed not to clean anything afterwards.

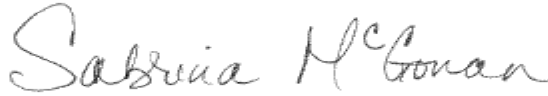
I conducted an exit conference with Licensee, Tamika Ruth. Licensee Ruth was informed of the findings of this investigation. A provisional license is recommended. Ms. Ruth stated, “ok” and hung up the phone.

On 04/19/2024, I concluded in Special Investigation Report (SIR) #2023A0580024, that R400.14403(1) had been violated due to the observation of old furniture and trash at the rear exit of the home, discarded cigarette butts on a residents’ bedroom floor. The corrective action dated 06/14/2023 and signed by Licensee Ruth stated that the licensee cleaned the area effective 05/15/2023.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based on my observation of the debris on the front porch, missing cabinet facing in the kitchen, and dead bugs throughout the fridge and freezer in the home, there is enough evidence to support the rule violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED SIR2023A0580024, dated 04/19/2023.**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend a modification of the license to provisional status due to willful and substantial quality of care and physical plant rule violations.


December 12, 2024

Sabrina McGowan
Licensing Consultant

Date

Approved By:

December 13, 2024

Mary E. Holton
Area Manager

Date