GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 7, 2025

Joy Kane
P.O. Box 398
Schoolcraft, MI 49087

RE: License #: AF390003041
Investigation #: 2025A0578009
Kane Homestead

Dear Joy Kane:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 12/11/2024, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved 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) 284-9727.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF390003041
Investigation #:	2025A0578009
Complaint Receipt Date:	11/19/2024
Investigation Initiation Date:	11/19/2024
Report Due Date:	01/18/2025
Licensee Name:	Joy Kane
Licensee Address:	122 N Robinson Schoolcraft, MI 49087
Licensee Telephone #:	(269) 679-4856
Administrator:	N/A
Licensee Designee:	Joy Kane
Name of Facility:	Kane Homestead
Facility Address:	122 N. Robinson Schoolcraft, MI 49087
Facility Telephone #:	(269) 679-4856
Original Issuance Date:	08/20/1984
License **Status:**	REGULAR
Effective Date:	09/03/2023
Expiration Date:	09/02/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was improperly discharged from this facility.	Yes
Resident A was not provided with her medications for several days.	No

III. METHODOLOGY

11/19/2024	Special Investigation Intake 2025A0578009
11/19/2024	Special Investigation Initiated - Telephone
11/19/2024	APS Referral
11/19/2024	Contact-Telephone -Interview with Resident A.
12/11/2024	Special Investigation Completed On-site -Interview with licensee Joy Kane.
12/11/2024	Contact-Document Reviewed -*Medication Administration Records* for Resident A.
12/11/2024	Exit Conference -With licensee Joy Kane.
12/11/2024	Contact-Document Reviewed -Correction Action Plan Received.
12/11/2024	Contact-Document Reviewed -Correction Action Plan Approved.
01/03/2024	Contact-Telephone -Interview with Bridgeways case manager Alex Agular.

ALLEGATION: Resident A was improperly discharged from this facility.

INVESTIGATION:

On 11/19/2024, I received this complaint by telephone. Complainant reported Resident A was told she was “not welcome back” at this facility. Complainant alleged

Resident A was discharged from this facility without cause and without a written notice of discharge.

On 11/19/2024, I interviewed Resident A regarding the allegations. Resident A reported currently being at Bronson Hospital relating to a “manic episode” at this facility. Resident A reported she was yelling and singing at this facility, which is Resident A described as “normal” for her. Resident A reported these behaviors resulted in Resident A admitting herself to Bronson Hospital. Resident A reported that while at the Bronson Hospital, Resident A was informed that she would be transported to an inpatient facility in another county. Resident A reported that when she asked why she couldn’t return to this facility, Resident A was told she was “not welcome back” at this facility. Resident A reported confirming with her case managers and licensee Joy Kane that she was no longer welcome to return to this facility. Resident A denied receiving any type of written notice of discharge. Resident A denied knowing her expected discharge date and was informed she may be spending several weeks at an inpatient facility before being discharged from the hospital. Resident A reported feeling her discharge from this facility was unfair and discriminatory.

On 12/11/2024, I completed an unannounced investigation on-site at this facility and interviewed licensee Joy Kane regarding the allegations. Joy Kane reported Resident A had stopped taking her prescribed daily medications. Joy Kane reported Resident A became very “disruptive” and described that on one occasion, Resident A had run in and out of the facility to obtain a delivery when Resident A had run into Joy Kane, causing Joy Kane to fall. Joy Kane reported that she did not realize she was injured until the next morning when she experienced pain and bruising. Joy Kane reported Resident A is independent in the community and admitted herself to the hospital. Joy Kane reported several days later, she was called by someone at the hospital asking if Joy Kane was willing to take Resident A back and Joy Kane responded by saying “no.”

Joy Kane acknowledged not providing Resident A or her case manager with a written notice of discharge. Joy Kane reported she felt this was an emergency, and was unsure of what Resident A was capable.

On 12/11/2024, Joy Kane provided a corrective action plan related to the allegations.

On 01/03/2024, I interviewed Bridgeways case manager Alex Agular regarding the allegations. Alex Agular acknowledged that Resident A was discharged from this facility. Alex Agular reported Resident A had made verbal threats towards Joy Kane and other residents, in addition to causing Joy Kane physical harm. Alex Agular reported understanding Joy Kane’s intent to keep herself and other residents safe, and did not fault Joy Kane for discharging Resident A. Alex Agular confirmed not receiving a written notice of discharge for Resident A but reported speaking to Joy Kane on several occasions discussing the possible discharge of Resident A due to medication refusals.

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.**
	(13) A licensee may discharge a resident before the 30-day notice when it has been determined that any of the following exists: **(a) Substantial risk or an occurrence of self-destructive behavior.** **(b) Substantial risk or an occurrence of serious physical assault.** **(c) Substantial risk or an occurrence of destruction of property.** **(14) A licensee who discharges a resident pursuant to subrule (13) of this rule shall notify the resident's designated representative and responsible agency within 24 hours before discharge. Such notification shall be followed by a written notice to the resident's designated representative and responsible agency stating the reasons for discharge.**
ANALYSIS:	Based upon my investigation, which consisted of interviews with license Joy Kane, Resident A, and Bridgeways case manager Alex Agular, Resident A was not provided with a written notice of discharge that stated the reasons for Resident A's discharge.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A was not provided with her medications for several days.

INVESTIGATION:

On 11/19/2024, Complainant alleged Resident A was admitted to the hospital because of not receiving her medications for several days.

On 11/19/2024, I interviewed Resident A regarding the allegations. Resident A emphasized that she would never have been discharged or admitted to the hospital if she had not "missed" her medications. Resident A could not recall the medications she had missed and did not know why these medications were not passed. Resident

A could not recall the number of occurrences she had not received her medication, but suspected she may have missed her medications three days in a row.

On 12/11/2024, I interviewed licensee Joy Kane regarding the allegations. Joy Kane denied that any of Resident A's medications were not passed due to not being in the facility and clarified that Resident A had not been compliant with taking her daily medications. Joy Kane reported Resident A not being compliant with her medications may have resulted in the changes in Resident A's behavior prior to being discharged from this facility.

While at the facility, I identified Resident A's prescribed medications as Buspirone HCL 10MG, Lamotrigine 150MG TAB, Levothyroxine 75 MCG, Meloxicam 15MG, Magnesium Citrate 500MG, Desmopressin .1MG, Invega 3MG, and Montelukast Sodium 10MG.

While at the facility, I inspected the *Medication Administration Records* for Resident A and found them to be complete with no evidence or documentation of missing medications for Resident A.

On 01/03/2024, I interviewed Bridgeways case manager Alex Agular regarding the allegations. Alex Agular denied being informed that Resident A did not have her prescribed medications available at this facility for any reason. Alex Agular disclosed that Resident A has a history of not being compliant with her medications and did not express any concerns for medication procedures at this facility.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(2) Medication shall be given pursuant to label instructions.
ANALYSIS:	Based upon my investigation, which consisted of interviews with license Joy Kane, Resident A, and Bridgeways case manager Alex Agular, as well as a review of pertinent documentation relevant to this investigation, there was not enough evidence to substantiate the allegation that Resident A was not provided with her daily medications as prescribed by a physician.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend that the current license status continue.

01/07/2025

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Eli DeLeon Date
Licensing Consultant

Approved By:

01/07/2025

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Dawn N. Timm Date
Area Manager