GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 28, 2025

Lisa Rice
Ebenezer Care Center
16013 Middlebelt Road
Livonia, MI 48170

RE: License #: AL330418806
Investigation #: 2025A0577031
Ebenezer Care Center

Dear Ms. Rice:

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 05/28/2025, 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) 335-5985.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, 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 #:	AL330418806
Investigation #:	2025A0577031
Complaint Receipt Date:	03/31/2025
Investigation Initiation Date:	03/31/2025
Report Due Date:	05/30/2025
Licensee Name:	Ebenezer Care Center
Licensee Address:	16013 Middlebelt Road Livonia, MI 48170
Licensee Telephone #:	(716) 704-9185
Licensee Designee:	Lisa Rice
Administrator:	Lisa Rice
Name of Facility:	Ebenezer Care Center
Facility Address:	2447 N. Williamston Road Williamston, MI 48895
Facility Telephone #:	(517) 230-6276
Original Issuance Date:	01/21/2025
License Status:	TEMPORARY
Effective Date:	01/21/2025
Expiration Date:	07/20/2025
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was administered medications that were not crushed as prescribed.	No
Resident A was served food that was not pureed as prescribed by a physician.	No
Resident medications were observed sitting in a box on the floor and the medication cart was unlocked.	Yes
Resident A was administered other residents' medications.	Yes
Residents are being served drinks that are scalding in temperature.	
Resident A had only been bathed once since being admitted.	No
The direct care staff were not properly equipped to handling an emergency evacuation.	No
Additional Findings	Yes

III. METHODOLOGY

03/31/2025	Special Investigation Intake 2025A0577031
03/31/2025	APS Referral- Complainant filed APS.
03/31/2025	Special Investigation Initiated – Telephone call made. Interview with Complainant.
04/01/2025	Contact - Document Received Intake# 204956 dismissed and added to current investigation.
04/03/2025	Contact - Telephone call made- Interview with Complainant.
04/11/2025	Contact - Face to Face- Interview with Resident A.
04/17/2025	Contact - Telephone call made- Interview with Relative A1 and A2.
04/24/2025	Contact - Telephone call made to Dobie Rd. Rehabilitation.
04/28/2025	Contact - Document Sent- Email to LD requesting information.
04/29/2025	Contact - Telephone call received from Lisa Rice, LD.

04/30/2025	Contact - Document Received- Email from Lisa Rice, LD with requested information attached.
05/01/2025	Contact - Telephone call made- Interviews with DCS.
05/02/2025	Contact - Document Received- Email correspondence with Lisa Rice, LD.
05/02/2025	Contact - Telephone call made- Interview with DCS.
05/02/2025	Contact - Telephone call made to Nicole Peters, Residential Home Care.
05/02/2025	Contact - Telephone call made- Nicole Peters, Case Manager with Residential Home Care.
05/02/2025	Contact - Document Received- Web search, Food Science and Technology at the University of Oregon.
05/05/2025	Contact - Telephone call made to Chief Michael Yanz with NIESA.
05/05/2025	Contact - Telephone call made- Interview with Doug Kinney, President.
05/05/2025	Contact - Telephone call made- Interview with DCS.
05/06/2025	Contact - Telephone call made- Interview with Michelle Hatfield.
05/07/2025	Contact - Telephone call made- Interview with DCS.
05/08/2025	Contact - Document Received- Shower log received. with DCS communication logs.
05/14/2025	Contact - Telephone call received-Charity Woods, Mid-Michigan District Health Department, Environmental Health Specialist.
05/28/2025	Inspection Completed On-site
05/28/2025	Exit Conference with licensee designee Lisa Rice.
05/28/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident A was administered medications that were not crushed as prescribed.

INVESTIGATION:

On March 31, 2025, the complaint received alleged the facility was not properly licensed to administer controlled narcotic medications and did not meet the requirements of reporting controlled narcotic medications to the MI Automated Prescription System (MAPS). Please note Adult Foster Care facilities are not licensed medical facilities and therefore there are no administrative rules requiring Adult Foster Care facility to be licensed to administer and/or report controlled narcotic medications.

On March 31, 2025, a complaint was filed alleging Resident A was administered Tylenol, without the tablet being crushed, causing Resident A to choke. The complaint reported Resident A's medications are to be crushed due to Resident A having issue with swallowing.

On March 31, 2025, I interviewed Complainant who reported on the day Resident A was admitted direct care staff (DCS) Tony Woods brought Resident A Tylenol. Complainant reported family was visiting and noticed the Tylenol was not crushed and told DCS Woods, "[Resident A's] medications are supposed to be crushed, due choking hazard." Complainant reported DSS Woods left the room and returned with Resident A's Tylenol crushed to administer.

On April 17, 2025, I interviewed Relative A1 and Relative A2 who reported on March 21, 2025, family was getting Resident A settled in when DCS Tony Woods came into Resident A's room to administer a Tylenol when family members noticed the Tylenol was not crushed. Relative A1 reported telling DCS Wood Resident A's medications need to be crushed as Resident A cannot swallow whole items due to swallowing/choking hazard. Relative A1 and Relative A2 reported DCS Woods stated, "I am sorry, I forgot about her medications needing to be crushed." Relative A1 and Relative A2 reported DCS Woods left the room, went and crushed Resident A's Tylenol and returned to administer the Tylenol.

DCS Tony Woods passed away prior to this investigation and could not be interviewed.

On May 01, 2025, I interviewed DCS Eva Fisher who reported she was not aware of a physician order to crush Resident A's medications. DCS Eva reported there is no order on Resident A's Medication Administration Record (MAR) ordering medications to be crushed. DCS Fisher reported she knows Resident A has swallow/chocking concerns because Resident A's food is pureed, but there are no crush orders for medications. DCS Fisher reported she did not crush Resident A's medications when they were administered.

On May 02, 2025, I contacted licensee designee Lisa Rice and requested a copy of the physician's order to crush Resident A's medications. Ms. Rice provided me with a copy of Resident A's *Health Care Appraisal* which documents under section

“Special Dietary Instructions and Recommended Calories” pureed diet is prescribed, but nothing is prescribed to crush Resident A’s medications. Resident A’s *Assessment Plan for AFC Residents* was provided by Ms. Rice. Under the section, “Health Care Assessment”, there were no directions to crush Resident A’s medication. Ms. Rice also provided a copy of Resident A MAR and upon review no order was observed for Resident A’s medications to be crushed.

On May 02, 2025, I interviewed DCS Teara Harris-Holbrook who reported she does not believe there was an order for Resident A’s medications to be crushed. DCS Harris-Holbrook reported she administered Resident A’s mediations with apple sauce or yogurt, so it was easier for Resident A to swallow and not choke due to Resident A’s dysphagia.

On May 05, 2025, I interviewed DCS Emily Groshong who reported there are no physician orders for Resident A to have her medications crushed. DCS Groshon reported Resident A is prescribed a pureed diet due to a diagnosis of chronic dysphagia with noted aspiration. DSC Groshon reported with the dysphagia diagnosis and prescribed pureed diet; it was assumed Resident A’s medications needed to be crushed. DCS Groshon reported Resident A’s family demanded Resident A’s medication be crushed. DCS Groshong reported she did not crush Resident A’s medications but administered Resident A’s medication in pudding to assist with swallowing and not choking due to the dysphasia.

On May 06, 2025, I interviewed DCS Michelle Hatfield, whose role is manager, who reported the family demanded Resident A’s medications be crushed upon administration. Ms. Hatfield reported there is no physician order for Resident A’s mediations to be crushed.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**
ANALYSIS:	Based on the information gathered during the investigation, there was no written physicians order prescribing Resident A’s medications to be crushed when administered. It has been determined Resident A’s medications were administered as prescribed by a physician.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A was served food that was not pureed as prescribed by a physician.

INVESTIGATION:

On March 31, 2025, a complaint was received with alleging Resident A was served apple slices with caramel sauce that were not pureed.

On March 31, 2025, Complainant reported Resident A has issues with swallowing then choking and has been prescribed a pureed diet. Complainant reported Resident A was given slice apples with caramel that were not pureed as required.

On April 17, 2025, I interviewed Relative A1 and Relative A2 who reported that on an unknown date, they were visiting Resident A when Resident A was provided with a plate of apple slices, with peeling still on them, and caramel dipping sauce by a direct care staff. Relative A1 and Relative A2 told the direct care staff Resident A is on a pureed diet and cannot have the apple slices and caramel sauce as served. Relative A1 and Relative A2 reported the direct care staff stated, “oh sorry, I forgot” and removed the apples from Resident A’s room.

On April 26, 2025, Brandy Eshelman, Director of Ingham County Medical Center-Dobie Road (Dobie Road) emailed me a copy of Resident A’s *Health Care Appraisal* completed on March 19, 2025. Resident A’s *Health Care Appraisal* document under Special Dietary Instructions that Resident A needs a pureed diet of thin consistency and liquids of the same consistency.

On May 01, 2025, I interviewed DCS Eva Fisher who reported she works third shift so food is not usually served during this shift. DCS Fisher reported she is aware of Resident A being on a pureed diet but cannot report if she is being served a pureed diet. DCS Fisher reported she understands Resident A being on a pureed diet and would serve Resident A her meals and snacks pureed.

On May 05, 2025, I interviewed DCS Emily Groshong who reported Resident A is prescribed a pureed diet. DCS Groshon reported she was not aware Resident A was served apple slices and caramel without being pureed. DCS Groshong reported she has not witnessed Resident A served food that is not pureed. DCS Groshong denied serving Resident A food that is not pureed.

On May 06, 2025, I interviewed DCS Michelle Hatfield who reported on March 21, 2025, after Resident A had moved into the facility DCS Tony Woods was going from room to room offering residents a snack of apples slices and peanut butter. Ms. Hatfield reported she was walking by Resident A’s bedroom when she heard a family member saying in an upset tone, “she cannot have that, her food needs to be pureed, why would you even bring that in here?” Ms. Hatfield stated, “I cannot say if Tony was just going into the room to see how things were going or if she was going into the room to offer [Resident A] apples with peanut butter.” Ms. Hatfield reported

DCS Woods came out of the bedroom upset with the plate of apple slices and peanut butter. DCS Tony Woods had passed away prior to this investigation and could not be interviewed.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(b) Special diets.**
ANALYSIS:	Based on the information gathered during the investigation, per Resident A's *Health Care Appraisal*, Resident A is prescribed a pureed diet. Per Relative A1 and Relative A2, Resident A was offered sliced apples and caramel that were not pureed, but reported Resident A did not have access to the snack. Per interviews with direct care staff, there was no evidence that Resident A was served food that was not pureed as prescribed by physician.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident medications were observed sitting in a box on the floor and the medication cart was unlocked.

INVESTIGATION:

On March 31, 2025, a complaint was received alleging resident medications were left sitting in boxes in the hallway of the facility and the medication cart was unlocked.

On March 31, 2025, I interviewed Complainant who reported they came into the facility on March 29, 2025, and observed a box of resident medications sitting on the floor in the hallway with no direct care staff around. Complainant stated, “I could have easily taken any of the medications I wanted.” Complainant reported the medication cart was also unlocked at this time. Complainant provided photos of the box of medications and the medication cart being unlocked with no direct care staff in the area. Per the photos provided, the photos documented a box of resident medications sitting next to a wall on the floor in a hallway. The photos were date and time stamped March 29, 2025, at 9:23pm. I observed the medication labels in the box had Resident B and Resident C’s names on the labels. The photos showed other medications in it, but the labels were not visible.

On May 01,2025, DCS Eva Fisher reported she has not witnessed any medications being left out or not locked up. DCS Fisher also denied ever observing the medication cart unlocked.

On May 02, 2025, I contacted licensee designee Lisa Rice and requested and received a copy of the staff schedule which documented DCS Amber Steinhaus-Swift worked from 6:00pm-6:00am on the date of the photo.

On May 02, 2025, I interviewed DCS Teara Harris-Holbrook who reported she has not witnessed the medication cart being unlocked nor has she observed medications being left out of the locked medication cart in the facility unsupervised.

On May 05, 2025, I interviewed DCS Emily Groshong who reported she has not seen medications sitting out unsupervised, but stated, “it could have happened, if it did happen it would have only been for 15-20 minutes.”

On May 07, 2025, I interviewed DCS Amber Steinhouse-Swift who reported she worked the evening of March 29, 2025, and did not see a box of medications sitting on the floor unsupervised. DCS Steinhouse-Swift stated, “if I had, I would have put them in the locked medication closet or in the medication cart.”

On May 06, 2025, I interviewed DCS Michelle Hatfield who reported resident cycle medications are delivered in a box from pharmacy. Ms. Hatfield reported she is not aware of this specific incident.

APPLICABLE RULE	
R 400.15312	**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 S333.1101 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:	On March 31, 2025, Complainant provided a photo date stamped March 29,2025, taken at 9:23pm with a box of resident medications sitting on the floor by the medication cart. The medications were not locked cabinet or drawer as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A was administered other residents' medications.

INVESTIGATION:

The complaint received on March 31, 2025, reported that on the morning of March 27, 2025, Resident A was administered medications not prescribed to Resident A.

On March 31, 2025, I interviewed Complainant who reported Resident A was administered two Norco tablets of 7.5-325mg a piece and three Gabapentin, 100 mg tablets. Complainant stated Resident A is not prescribed these medications.

On April 17, 2025, I interviewed Relative A1 and Relative A2 who reported on March 27, 2025, Resident A was administered the incorrect medication by DCS Eva Fisher. Relative A1 and Relative A2 reported that the nurse from Residential Health Care was completing an initial assessment on Resident A, became aware of the medication error and advised Resident A be sent to the hospital. Relative A1 and Relative A2 reported Resident A was administered the following medications incorrectly: Mannose one, tablet; 500mg, Gabapentin, three tablets, 100mg each; NP Thyroid, one tablet, 60mg; eye vitamin; Cetirizine, one table, 10mg; and Norco, two tablets, 7.5-325mg. Relative A1 and Relative A2 reported the medications Resident A was administered were not prescribed to Resident A. Relative A1 and Relative A1 stated confusion about how the medications were in Resident A's medication drawer.

On April 24, 2025, I interviewed Brandi Eschelman, Director at Dobie Road- Ingham County Care Facility who reported four residents were brought to their facility on March 30, 2025, as an emergency placement due to a tornado causing damage to Ebenezer Care Center. Ms. Eschelman reported being provided copies of Medication Administration Records (MAR) for two of the residents, but Ms. Eschelman could not specify which residents or if Dobie Road- Ingham County Care Facility still had copies of the MAR's. Ms. Eschelman reported a medication reconciliation was completed by comparing the MAR to the medications that were brought to Dobie Road- Ingham County Care Facility from Ebenezer Care Center. Ms. Eschelman stated any mediations that were not on the Ebenezer Care Center MAR and prescribed to a resident were disposed. Ms. Eschelman reported she cannot recall which medications were brought to Dolbie Road specifically for Resident A.

On April 29, 2025, licensee designee Lisa Rice provided me with a copy of an Oak Brook Incident Report (IR) dated March 27, 2025, documenting that at 6:30am, DCS Eva Fisher administered Resident C's morning medications to Resident A due to the medications for each resident being in the incorrect place in the medication cart. The IR documented per DCS Eva Fisher's response, "the new patients were mixed up and I take full responsibility." Ms. Rice also provided copies of Resident A's MAR for March 2025 documenting Resident A was prescribed the following medications to be administered in the morning: Acetaminophen 325mg; Amlodipine, 5mg; Aspirin,

81mg; Cal Antacid, 500mg; Furosemide, 40mg; Levothyroxine, 50mcg; Metformin 500mg; Methocarbamol, 500mg; Nitrofuran tin, 100mg; Benatoprazole, 40mg; Senna-Time, 8.6mg; Sertraline, 25mg; Vitamin C, 500mg;

On May 01, 2025, I interviewed Eva Fisher who acknowledged administering Resident C's medications to Resident A during the 6:00am medication pass. DCS Fisher reported this was her first shift administering medications. DCS Fisher reported she is not sure what happened at the 6:00am medication pass, other than she became confused on who each resident was due to no signage or photos of residents on the MAR or at the resident room. DCS Fisher reported she thought she was in Resident C's room, but she was in Resident A's room. DCS Fisher reported once the incorrect medications had been passed to Resident A, she called the on-call nurse for instructions. DCS Fisher stated she was directed to take Resident A's vitals, watch for unusual symptoms and notify oncoming direct care staff of Resident A needing to be monitored. DCS Fisher reported she was not advised at that time to send Resident A to the hospital.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	It has been determined reasonable precautions were not taken to ensure prescription medications are not used by a person other than the resident for whom the medications were prescribed. Based on the information gathered during the investigation, I determined that on March 27, 2025, Resident A was administered Resident C's medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents are being served drinks that are scalding in temperature.

INVESTIGATION:

On March 31, 2025, the complaint received reported Resident A was served hot cocoa that was scalding hot in temperature.

On March 31, 2025, I interviewed Complainant who reported that while Resident A was being assessed for Occupational Therapy a cup of hot cocoa was delivered to Resident A and the therapist noticed the hot cocoa was still boiling.

On April 02, 2025, I contacted the Mid-Michigan District Health Department and left a message with Environmental Specialist with no return phone call.

On April 17, 2025, I interviewed Relative A1 and Relative A2 and Relative A2 reported they entered Resident A's bedroom, date unknown, while Resident A was being assessed by Residential Occupational Therapy and was told by therapist that Resident A was served hot cocoa that was scalding hot but Resident A did not drink it. Relative A2 reported requesting which when delivered to Relative A2, the hot cocoa was still bubbling. Relative A2 stated she asked DCS Michelle Hatfield for some ice but was informed there was no ice. Relative A2 reported to Ms. Hatfield that the hot cocoa was scalding when served and Relative A2 stated and Ms. Hatfield replied, "well [Resident A] likes her coffee hot." Relative A1 and Relative A2 reported the water is heated in an electric hot pot.

On May 01, 2025, I interviewed DCS Eva Fisher who reported in the mornings, before her shift ends, she turns on the electric hot kettle in the kitchen. Ms. Fisher reported she has never poured any water from the pot so cannot answer if the water is boiling or scalding after being poured.

On May 02, 2025, I completed an internet search and per the University of Oregon, Food Science and Technology Department, documented, "hot beverages should be served at temperatures of 130 degrees to 160 degrees."

On May 02, 2025, interviewed DCS Teara Harris-Holbrook who reported she has used the electric tea kettle and when she has used it, the water has been hot, but the water was never boiling or warmed to temperature of being dangerous. DCS Harris-Holbrook reported when serving the residents, most residents like milk added to their tea or coffee and if the drink appears too hot still, ice cubes are added to cool the drink.

On May 02, 2025, I interviewed Nicole Peters, Nurse with Residential Home Care, who reported she is not aware of Resident A being served hot cocoa that was scalding in temperature. Ms. Peters reported she did not witness this while at the facility completing an assessment on Resident A.

On May 05, 2025, I interviewed DCS Emily Groshong who reported the water from the electric tea kettle is hot and does come out boiling sometimes. DCS Groshong stated the water temperature is dependent on how long the water was boiling prior to being turned off. DCS Groshong reported she is not aware of Resident A being served hot cocoa in her room at any time, stating, “usually hot beverages are served in the common area for safety reasons.” DCS Groshong reported there is an ice maker in the door of the refrigerator, so ice is available for all resident drinks.

On May 06, 2025, I interviewed DCS Michelle Hatfield who reported the facility does use an electric tea kettle as many resident’s drink tea. Ms. Hatfield reported the water is hot, but no residents or family members have reported the water being dangerously hot. Ms. Hatfield reported she cannot recall a conversation with a resident’s family requesting ice and Ms. Hatfield reported the facility does not have ice. Ms. Hatfield reported that the facility has an ice maker in the refrigerator and a countertop ice maker to which everyone has access.

May 15, 2025, I interviewed Charity Woods, Environmental Specialist with the Mid-Michigan District Health Department who reported the State of Michigan does not regulate the temperature of hot beverages. Ms. Woods reported the suggested temperature to serve hot beverages is between 130 degrees and 160 degrees.

On May 28, 2025, I completed an onsite investigation and observed residents drinking tea made from the electric tea kettle. I took a temperature of the water from the tea kettle, and it was 154 degrees.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	There was no evidence found that water used from the electric tea kettle was scalding hot, unsafe or not of proper temperature. The temperature of the water from the tea kettle was 145 degrees on May 28, 2025.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A had only been bathed once since being admitted.

INVESTIGATION:

The complaint received on March 31, 2025, alleged that since being admitted on March 21, 2025, Resident A has only been bathed once.

On March 31, 2025, Complainant reported Resident A was admitted into the facility on March 21, 2025, and had only been physically bathed one time since being admitted. Complainant reported they are not sure if bed baths have been provided.

On April 17, 2025, I interviewed Relative A1 and Relative A2 who reported since being admitted to the facility on March 21, 2025, Resident A had only been bathed one time, on March 29, 2025, by a direct care staff. Relative A1 and Relative A2 reported they were told by DCS Michelle Hatfield that all residents are on a schedule to shower or bathe twice a week. Relative A1 and Relative A2 reported Resident A has a sore on her buttocks and needed to be bathed daily to clean the sore. Relative A1 and Relative A2 reported they are not aware of Resident A being provided with a sponge bath on the other days, and if Resident A was bathed, it was provided by the family. Relative A1 and Relative A2 reported they bathed Resident A one time while Resident A was at the facility due to Resident A not being bathed in a timely manner. Relative A1 and Relative A2 reported Resident A would have liked to have been bathed more than twice a week but was told this is the bathing schedule.

On April 28, 2025, I received a copy of the *Resident Register* from Lisa Rice, Licensee Designee (LD) which documented Resident A was admitted to the facility on March 21, 2025, and discharged on March 30, 2025.

On May 01, 2025, I interviewed DCS Eva Fisher who reported baths/showers are normally not given during third shift, which is when she works, so she has no knowledge of Resident A's bath schedule. DCS Fisher reported there is an Activities of Daily Living (ADL) Binder in which direct care staff are supposed to document when the residents were bathed. DCS Fisher reported she was trained that residents are on a bathing/showering schedule which occurs twice per week.

On May 02, 2025, DCS Teara Harris-Holbrook reported residents are bathed/showered two times a week. DCS Harris-Holbrook reported that one day Resident A was sent out to the hospital and upon returning to the facility DCS Harris-Holbrook provided a bed bath to Resident A. DCS Teara Harris-Holbrook reported she cannot specify how many showers Resident A received in the time Resident A was at the facility. DCS Harris-Holbrook reported all residents are provided a sponge bath in the mornings prior to getting dressed and at times provided one at night prior to getting ready for bed.

I interviewed DCS Emily Groshong on May 05, 2025, and she reported that she provided Resident A with a shower one time during Resident A's admission at the

facility but could not remember the specific date. DCS Groshong reported all residents are provided with a sponge bath every morning prior to getting dressed on the days the resident is not showered.

On May 06, 2025, DCS Michelle Hatfield reported Resident A was on a schedule to receive showers twice a week and was supposed to be showered on March 27, 2025, but was at the hospital for the day. Ms. Hatfield reported upon Resident A's discharge and returned to the facility at 11:00pm Resident A was provided a full body sponge bath prior to getting ready for bed. Ms. Hatfield reported she is aware of Resident A's family provided Resident A with a shower and this shower was provided after Resident A had received a sponge bath. Ms. Hatfield reported Resident A's family did not request direct care staff to provide Resident A with a shower rather they administered the shower at their decision.

On May 08, 2025, I received a copy of Resident A's bath log and communication log from licensee designee Lisa Rice which documented Resident A was showered on March 22, 2025, and March 28, 2025. Resident A's bath log and communication log, Resident A was provided a sponge bath on March 23, 24, 25 and 27, 2025.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Resident A was admitted to the facility on March 21, 2025, and discharged on March 30, 2025. Per Resident A's bath and communication log, Resident A was provided a shower on March 22 and March 28, 2025, to include sponge baths on March 23, 24, 25, and 27. It has been determined Resident A was bathed at least weekly and more often as needed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: **The direct care staff were not properly equipped to handling an emergency evacuation.**

INVESTIGATION:

On April 01, 2025, a second complaint was received alleging that on March 30, 2025, the facility was hit by a tornado which caused immediate damage to the facility including shattered windows, broken door wall, and a downed powerline on the propane tank. The complaint reported due to the damage, residents were evacuated and relocated, but direct care staff working during the time of the tornado were not properly prepared to handle the emergency. The complaint reported that the facility

did not have portable oxygen tanks for residents to use while being evacuated, direct care staff did not know where to take the residents during the tornado watch, or how to properly prepare the residents for evacuation.

On April 01, 2025, I interviewed Complainant who reported they arrived at the facility around 7:15pm on March 30, 2025, and found residents and direct care staff in the storage area of the kitchen, excluding residents who were wheelchair users were in the kitchen. Complainant reported emergency responders arrived at the facility and identified a critical hazard due to a downed power line on top of the facility propane tank mandating an immediate evacuation of the facility. Complainant reported direct care staff evacuated the residents outside of the building, with some residents having a blanket for warmth and other residents not having anything but the clothes that were on them. Complainant reported there were residents who require oxygen, and the facility did not have portable oxygen tanks for each resident, so Resident A's extra portable oxygen tanks were used. Complainant reported residents were outside for about two hours until a relocation plan was developed. Complainant reported direct care staff were on the phone with facility director Douglas Kinney asking for guidance on what to do and how to evacuate. Complainant reported Mr. Kinney advised direct care staff that he will have someone come to the facility to board up the windows and door so residents could return to the facility. Complainant reported emergency services intervened and explained the facility is not habitable at this time due to the downed powerline and destruction of the property and that residents need to be relocated. Complainant reported direct care staff and Mr. Kinney, Director, did not know the procedures for the residents needing to be relocated, so the emergency services contacted Ingham County Medical Center-Dobie Road (ICMD-DR) to see if rooms were available for temporary displaced residents. Complainant reported the emergency services arranged for the residents at the facility to be transported by ambulance to ICMC-DR.

On May 01, 2025, I interviewed DCS Eva Fisher who reported she has worked at the facility since March 2025, but has worked at other facilities owned by the licensee prior to being transferred to this facility. DCS Fisher reported in the new hire training developed by Michigan Assisted Living Association (MALA) there was a fire prevention training which discussed tornado procedures also. DCS Fisher stated, "at the time of the tornado, we just did what we needed to do as things progressed, it went really smoothly."

On May 01, 2025, I spoke with licensee designee Lisa Rice who reported all direct care staff completed the MALA fire and emergency prevention training upon hire and are also trained on the facility's specific emergency preparedness and fire safety plan. Ms. Rice provided me with a copy of the facility's emergency preparedness and fire safety plan.

On May 02, 2025, I interviewed DCS Teara Harris-Holbrook who reported she was working on March 30, 2025, and arrived at the facility around 4:30pm. DCS Harris-Holbrook reported around 5:00pm Relative C1 came to direct care staff and reported

there was a tornado warning for the area. DCS Harris-Holbrook reported she started sending residents to the ‘safe zone’, the pantry behind the kitchen and residents in wheelchairs to the kitchen. DCS Harris-Holbrook reported she started working at this facility at the beginning of March 2025 after transferring from another licensed facility owned by the licensee. DCS Harris-Holbrook reported after the tornado came through, it broke some windows, and the dining room window door wall. DCS Harris-Holbrook reported she called call 911 and emergency responders arrived about 45 minutes later advising direct care staff to evacuate residents due to downed power lines and broken windows. DCS Harris-Holbrook reported some of the residents had jackets or blankets and were outside of the facility for about 30-45 minutes. DCS Harris-Holbrook reported Chief Yanz, with NIESA arrived, completed a walkthrough of the facility and advised direct care staff to move residents back into the front of the building and that residents needed to be relocated until the power line was removed and the structural items of the building were fixed. DCS Harris-Holbrook reported once Chief Yanz advised that residents needed to be relocated, he was able to transport residents as long as they were relocated in his jurisdiction. DCS Harris-Holbrook reported she contacted Doug Kinney who stated he would contact Dobie Road- Ingham County Medical Care to determine if any rooms were available for temporary relocation of residents. DCS Harris-Holbrook reported Ingham County Medical Center was able to take all the residents and Chief Yanz was able to transport all residents. DCS Harris-Holbrook reported Resident A, Resident B, and Resident C all require oxygen 24 hours a day. DCS Harris-Holbrook reported two of the three residents had portable oxygen tanks, but one resident did not, so direct care staff used an extra portable oxygen tank belonging to a different resident during this emergency. DCS Harris-Holbrook reported she read the emergency policy and procedures. DCS Harris-Holbrook stated, “since I have worked in the field for a long time, I have a general idea of how to handle a crisis and ensure the safety of everyone.”

On May 05, 2025, I interviewed Chief Michael Yanz with NIESA Emergency Services who reported upon arriving to the facility on March 30, 2025, all residents had been evacuated and were in the parking lot wrapped in blankets. Chief Yanz reported there were five residents and direct care staff were attentive to their needs. Chief Yanz reported due to the condition of the building and the downed powerlines; it was not safe for residents to return to the building. Chief Yanz reported he allowed residents and staff to return to the inside front living area of the building until a final plan could be put into place for relocating the residents. Chief Yanz reported direct care staff attempted to contact other facilities owned by the licensee but there were no available beds. Chief Yanz offered to transport the residents, but it needed to be within the county, and clarified that he could not transport residents outside of Ingham County. Chief Yanz reported direct care staff were able to contact the owner who advised direct care staff to call the Ingham Medical Center at Dobie Road to see if there were any beds available temporarily. Chief Yanz reported that Ingham Medical Center was able to take the four residents who needed placement and one resident went with family. Chief Yanz reported that the residents were outside for

about an hour and then brought into the facility once it was deemed safe. Chief Yanz reported that the direct care staff handled everything well.

On May 05, 2025, I interviewed director Doug Kinney who reported on March 30, 2025, a tornado hit the facility. Mr. Kinney reported he received a call from staff that went to voicemail. Mr. Kinney reported as he was calling the facility, he received a call from Relative B1 reporting the facility had been hit by a tornado and everyone was safe. Mr. Kinney reported he received a photo from DCS Teara Harris-Holbrook verifying everyone in the facility was in the pantry behind the kitchen. Mr. Kinney reported he received photos of the damage and was notified residents needed to relocate. Mr. Kinney reported he called Ingham Medical Center at Dobie Road to see if they had vacancies and would be willing to accept the residents on a temporary basis which they did. Mr. Kinney reported he believed everything went well, and direct care staff took all the safety measures needed.

On May 05, 2025, I interviewed DCS Emily Groshong who reported she was working on March 30, 2025, when the tornado occurred. DCS Groshong reported all residents, family members and direct care staff went into the pantry, until the tornado warning expired. DCS Groshong reported upon the expiration of the tornado warning, direct care staff did a walkthrough of the facility and found windows had been blown out and there was damage to the roof so 911 was called. DCS Groshong reported it was about 45 minutes after calling 911 that emergency services arrived at the facility and advised residents to be evacuated from the facility until a complete assessment of the damage could be done. DCS Groshong reported residents and family members were evacuated and provided blankets for warmth. DCS Groshong reported two residents required continual oxygen use. DCS Groshong reported there were three portable oxygen tanks at the facility for the residents to use and once the ambulance arrived, they provided oxygen to the residents who needed to save the portable oxygen tanks. DCS Groshong reported upon emergency services inspection, a downed powerline on the propane tank was observed requiring residents to be evacuated and relocated. DCS Groshong reported Chief Yanz advised direct care staff to take the residents to the front of the building just inside the door until the residents could be relocated. DCS Groshong reported Doug Kinney called Ingham Medical Center at Dobie Road and residents were able to relocate to that facility. DCS Groshong reported Chief Yanz arranged for ambulance transportation for residents being relocated to Ingham Medical Center at Dobie Road. DCS Groshong reported she has been trained in the facility emergency policy and procedures upon hire and also completed the MALA training for fire and weather emergencies. DCS Groshong reported there were no issues in handling the emergency, with evacuating, and relocating the residents.

On May 05, 2025, I left a message for Relative C1 with no return call.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**

	(2) Direct care staff shall possess all of the following qualifications: **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Based on the information gathered during the investigation, there was no evidence found that direct care staff were not capable of handling the emergency situation after a tornado hit the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On April 17, 2025, I interviewed Relative A1 and Relative A2 who reported the facility had a live-in direct care staff member named Tony Woods who has recently passed away. Relative A1 and Relative A2 reported DCS Woods resided in the basement of the facility.

On April 28, 2025, I interviewed licensee designee Lisa Rice who reported Tony Woods was a live-in direct care staff. Ms. Rice reported DCS Woods moved into the facility around December 2024 and was residing in the basement of the facility. Ms. Rice reported she was not aware of this needed to be reported to AFC licensing.

On April 28, 2025, I reviewed the Bureau of Information Tracking System (BITS), Affiliated Peoples Screen and Tony Woods was not added as a Live-In Staff.

APPLICABLE RULE	
R 400.15103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(5) An applicant or licensee shall give written notice to the department of any changes in information that was previously submitted in or with an application for a license, including any changes in the household and in personnel-related information, within 5 business days after the change occurs.

ANALYSIS:	Based on the information received during the investigation, DCS Tony Woods resided at the facility as a live-in staff and this was not reported to AFC licensing within 5 business days of DCS Woods moving into the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

On May 28, 2025, I completed an exit conference with Lisa Rice, Licensee Designee who agreed with the findings of the investigation.

IV. RECOMMENDATION

I recommend continuation of the current status of the license of this AFC adult large group home, capacity 20.

Bridget Vermeesch

05/28/2025

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm 05/28/2025

_____

Dawn N. Timm Date
Area Manager