GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 24, 2025

Dennis Strode
Strudwick & Strode AFC Inc
3726 Delta River Dr.
Lansing, MI 48906

RE: License #: AS230244372
Investigation #: 2025A1033036
Strudwick AFC Inc #2

Dear Mr. Strode:

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:

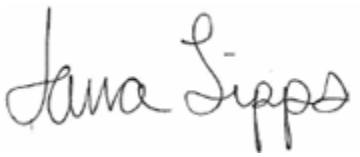
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once 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.

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.

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,



Jana Lipps, 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 #:	AS230244372
Investigation #:	2025A1033036
Complaint Receipt Date:	05/19/2025
Investigation Initiation Date:	05/21/2025
Report Due Date:	07/18/2025
Licensee Name:	Strudwick & Strode AFC Inc
Licensee Address:	3726 Delta River Dr. Lansing, MI 48906
Licensee Telephone #:	(151) 797-7124
Administrator:	Dennis Strode
Licensee Designee:	Dennis Strode
Name of Facility:	Strudwick AFC Inc #2
Facility Address:	1425 Elmwood Lansing, MI 48917
Facility Telephone #:	(517) 886-3898
Original Issuance Date:	10/10/2002
License Status:	REGULAR
Effective Date:	01/14/2024
Expiration Date:	01/13/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
An unidentified resident is assaulting the other residents and direct care staff members.	No
Medications are not being administered correctly to residents.	Yes
Direct care staff are not properly trained to administer medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/19/2025	Special Investigation Intake 2025A1033036
05/21/2025	Special Investigation Initiated – On Site Interviews conducted with direct care staff, DCS 1, DCS 3, DCS 4, Resident, B, C, D, & E, and licensee designee, Dennis Strode. Review of resident records and resident medications completed on-site.
05/21/2025	APS Referral- Referral made per protocol.
05/21/2025	Contact – Document sent Email correspondence sent to licensee designee, Dennis Strode, requesting documentation of completed medication administration training Michigan Workforce Background Checks for current direct care staff. Awaiting response.
05/27/2025	Inspection Completed On-site Follow-Up on-site investigation completed. The facility was observed without a direct care staff member present.
05/27/2025	Contact - Telephone call made Telephone conversation with licensee designee, Dennis Strode. Mr. Strode was informed that the facility was observed without a direct care staff member present. Mr. Strode reported that he would handle the situation promptly. It was discussed that a six-month provisional license status is being recommended due to no direct care staff on-site for resident care.
05/28/2025	Contact – Document Received

	Email correspondence received from Citizen 1 with verification of medication administration training and Michigan Workforce Background Checks for DSC 1 and DSC 3.
06/03/2025	Contact – Document Received Email correspondence received from Citizen 1 with completed medication administration and Michigan Workforce Background Check for DCS 2.
06/04/2025	Contact – Document Received Email correspondence received from Citizen 1 with information regarding DCS 5 employment record.
06/11/2025	Contact – Telephone call made Attempt to interview Wycliffe Okenye, case manager with CEI-CMH. Voicemail message left, awaiting response.
06/11/2025	Contact – Telephone call made Attempt to interview DCS 2, via telephone. Voicemail message left and awaiting response.
06/11/2025	Contact – Telephone call made Attempt to interview DCS 5 via telephone. Voicemail message left, awaiting response.
06/12/2025	Contact – Telephone call made Interview conducted with DCS 2, via telephone.
06/13/2025	Contact – Telephone call made Interview conducted with CEI-CMH case manager, Jenna Lottes, via telephone.
06/16/2025	Exit Conference Conducted via telephone, voicemail message left, and email correspondence, with licensee designee, Dennis Strode.

ALLEGATION: An unidentified resident is assaulting the other residents and direct care staff members.

INVESTIGATION:

On 5/19/25 I received an online complaint regarding the Strudwick AFC Inc. #2, adult foster care facility (the facility). The complaint alleged that there was an unnamed resident at the facility who was attacking other residents and the direct care staff. This complaint was received by an anonymous source.

On 5/21/25 I conducted an unannounced, on-site investigation at the facility. I interviewed licensee designee, Dennis Strode, via telephone, while I was at the facility. Mr. Strode reported that Resident A is a resident who receives services through Clinton-Eaton-Ingham Community Mental Health (CEI-CMH). Mr. Strode reported that CEI-CMH case managers have stated that Resident A is allowed to have independent access to the community and does not require supervision in the community. Mr. Strode reported that when Resident A goes out into the community it is believed he uses illegal drugs and then returns to the facility, intoxicated. Mr. Strode reported that Resident A assaulted Resident B, while Resident B was sleeping in his own bed, on an unidentified date. Mr. Strode reported that this was a recent occurrence within the past week and he thinks the assault occurred on 5/16/25 or 5/17/25. Mr. Strode reported that Resident A hit Resident B in the head, while Resident B was sleeping in his bed. Mr. Strode reported that he spoke with Resident A's case manager with CEI-CMH, Wycliffe Okenye, regarding the incident and stated that he wanted to discharge Resident A due to this incident and the other stated occurrences where Resident A has returned to the facility, presumably under the influence of illegal drugs. Mr. Strode reported that Resident A was taken to the local hospital and tested for illegal drugs. He reported that Resident A's drug test was positive, but he did not disclose which illegal substances Resident A tested positive for having in his system. Mr. Strode reported that Mr. Okenye obtained a court order for substance abuse treatment for Resident A and that he would be admitted to a drug treatment facility. Mr. Strode reported that Resident B is not the first resident to be assaulted by Resident A. He reported that there was another incident (date unknown) when Resident A threw water in the face of Resident C. Mr. Strode reported that he has not yet issued a discharge notice for Resident A.

On 5/21/25, during the on-site investigation, I interviewed Direct Care Staff 1 (DCS 1). DCS 1 reported that the alleged incident, by which Resident A hit Resident B in the head while he was sleeping happened when Direct Care Staff 2 (DCS 2) was working. DCS 1 reported that they heard about this incident from DCS 2 and Resident B. DCS 1 reported that Resident A will leave the facility for days at a time and it is believed that he uses illegal drugs and returns to the facility intoxicated. DCS 1 reported that Resident A has been confrontational with direct care staff members and will get in the face of direct care staff and shout and make verbal threats.

On 5/21/25, during the on-site investigation, I interviewed Direct Care Staff 3 (DCS 3) regarding the allegation. DCS 3 reported that they heard that Resident A stated he hit Resident B in the head because he had a dream about someone hitting him

and woke up from this dream and sought out Resident B and hit him in the head. DCS 3 reported that Resident A and Resident B do not share a bedroom and Resident A had to get up and leave his bedroom and go to the next bedroom and hit Resident B in the head. DCS 3 reported that DCS 2 was working at the time of the incident. DCS 3 reported that Resident A has thrown water at Resident C and has verbally assaulted direct care staff members. DCS 3 reported that Resident A has never physically assaulted a resident or direct care staff prior to this incident except for throwing water in the face of Resident C.

On 5/21/25, during the on-site investigation, I spoke with Citizen 1. Citizen 1 is a direct care staff member for another licensed adult foster care facility, operated by Mr. Strode. Citizen 1 reported that Mr. Strode had provided information regarding the incident between Resident A and Resident B as Citizen 1 provides additional staffing support to the facility in terms of managing paperwork for direct care staff and residents. She reported that she had little information regarding the incident. Citizen 1 reported that DCS 2 is a new direct care staff member and was recently hired to provide care at the facility.

On 5/21/25, during the on-site investigation, I interviewed Resident B. Resident B reported, “[Resident A] hit me upside the head”. He reported that he had been in his bed, sleeping, and Resident A came into the room, hit him in the head and then ran away. Resident B stated, “I was scared”. Resident B reported that when Resident A is in the facility he does not feel safe. He reported that Resident A will verbally assault other resident and the direct care staff members. He further reported that about a month prior Resident A threw water in the face of Resident C when he became frustrated with Resident C. Resident B stated that when Resident A hit him in the head, Resident B decided to contact the police. Resident B reported that he has expressed concerns to the direct care staff and his CEI-CMH case manager, Jenna Lottes, regarding the fact that he does not feel safe with Resident A residing at the facility.

On 5/21/25, during the on-site investigation, I interviewed Resident D regarding the allegation. Resident D reported that he has lived at the facility for about one month. He reported that he shares a bedroom with Resident A. Resident D reported that he did not witness Resident A hitting Resident B as he was sleeping when this occurred. Resident D stated that Resident A makes fun of the other residents and “picks on people”. He reported that Resident A tends to stay awake most of the night, making noises. Resident D reported that about a month ago, Resident A was putting his hands on one of the direct care staff and would not stop. He reported that Mr. Strode had to call the police on this occasion. Resident D reported that Resident A’s behaviors can be “annoying”, but he does not feel unsafe living with Resident A.

During the on-site investigation on 5/21/25 I interviewed Resident C. Resident C reported that he did not recall the exact date, but there was a recent event when Resident A threw water in his face. He reported that Resident A brags about using drugs, but Resident C has never seen Resident A bring drugs into the facility.

Resident C did not observe Resident A punch Resident B in the head. Resident C reported that he is uncomfortable with Resident A's behaviors as he will become verbally aggressive with other residents and direct care staff members and this makes him uncomfortable.

During the on-site investigation on 5/21/25, I interviewed Resident E. Resident E reported that Resident A brags about his drug use and has stated that he uses, "meth, cocaine, and weed". Resident E reported that Resident A always seems to want to pick a fight with someone at the facility. He reported, "We don't feel safe with [Resident A] in the house."

During the on-site investigation on 5/21/25 I reviewed the following documents:

- I requested to review the direct care staff schedule for the facility and was provided a large calendar for May 2025 which had direct care staff names and times listed for the dates 5/5/25 – 5/25/25. The facility is in a building that is zoned as a duplex, and the adjacent duplex is also a licensed adult foster care facility that is operated by Mr. Strode. I inquired whether this direct care staff schedule was for one of the facilities or both facilities in this duplex. DCS 1 reported that this schedule was for both licensed facilities. Direct Care Staff 4 (DCS 4) also reported that this schedule encompasses staffing for both licensed adult foster care facilities on this property. I observed that on most days there is only one direct care staff scheduled to work at both licensed adult foster care facilities on this property. There were six days between the hours of 10am to 2pm where there were two direct care staff scheduled to work at the same time. On 5/16/25 and 5/17/25 DCS 2 was scheduled from 11pm to 8am.
- *Medication Administration Record* (MAR) for Resident A for the month of May 2025. This document identified that the last documented dose of medications given to Resident A was 8pm on 5/16/25. This document indicates Resident A absent from the facility on 5/17/25 – 5/21/25.
- *PCP/IPOS In-Service Sign in Sheet* for Resident A. This document was signed by DCS 1, DCS 3, and DCS 4. Missing signatures for DCS 2 and Direct Care Staff 5 (DCS 5).
- CEI-CMH *Treatment Plan Annual/Initial*, for Resident A, dated 1/29/25. On page one, under section, *Areas of Need*, it reads, "The clinician has recommended the following areas be addressed in the treatment plan: Current health issues, abuse/trauma, substance history, family substance use history, suicidality, homicidality, physical aggression and/or other risk factors." On page one, under section, *Desired Outcomes (Hopes and Dreams)*, it reads, "To get a job, To move out of AFC and find affordable housing, I want to lose weight, Cut down on substance use and abuse." On page two, under section, *Objectives for Goal 1*, subsection, *1.04*, it reads, "The client agrees not to use drugs in the AFC home or even outside the home".
- *Health Care Appraisal* for Resident A, dated 4/30/25. Under section, *7. Diagnoses*, it reads, "Schizophrenia, tobacco use disorder, Cannabis use disorder".

- The direct care staff keep a daily logbook where they report on activities during the day. On 4/15/25 an entry was made by DCS 3 reporting an incident with Resident A screaming at Resident B and Resident C and threatening to hit them in the face. This entry dictated an escalation in Resident A's verbal threats to hit direct care staff, residents, and Mr. Strode. The police were called to deescalate the situation on this date per this note.
- *Assessment Plan for AFC Residents* document for Resident A, dated 4/30/25. On page one under section, *I. Social/Behavioral Assessment*, subsection, *A. Moves Independently in Community*, this area is marked "yes", with no written details. Under subsection, *I. Controls Aggressive Behaviors* & *K. Gets Along with Others*, the document is not marked with a "yes" or "no" and instead has a written statement that reads, "Sometimes". Under subsection, *O. Appropriately Uses Alcohol/Drugs*, the document is not marked with a "yes" or "no", but has a written narrative which reads, "He can get aggressive when he is high."

On 6/12/25 I interviewed DCS 2 regarding the allegation. DCS 2 reported that he has been employed at the facility for about one to two months. He could not give an exact date. DCS 2 reported that they were working at the facility the evening of the alleged assault from Resident A toward Resident B. DCS 2 reported that he did not witness the alleged assault and did not hear any commotion. He reported that Resident B came to him to report the assault and stated that he had been sleeping in his bed when Resident A entered his bedroom and punched him in the head and then left. DCS 2 reported that he did not visually see any injury to Resident B, but he did speak with Resident A about the allegation. DCS 2 reported that Resident A admitted to hitting Resident B in the head and stated that he thought someone had come into his bedroom and hit him and he assumed it had been Resident B. DCS 2 reported that the police were not called on his shift and he worked until 8am the next morning. DCS 2 reported that the incident occurred just after the residents had gone to sleep for the evening. He did not have the exact time. When asked where DCS 2 was at the time Resident B came to him to report the incident, DCS 2 reported that he had been standing in Resident B's bedroom doorway because he had been conducting safety checks on the residents. He reported that Resident B saw him in the doorway and then made the complaint. DCS 2 reported that he has never observed Resident A attempt to hit someone at the facility before and that Resident A can become verbally confrontational with others, but he has never resorted to physical violence to his knowledge. DCS 2 reported that he usually works the overnight shift at the facility, and he is awake for his entire shift. He reported that he supervises up to six residents during his shifts. This facility is adjacent to another licensed adult foster care facility, which shares a doorway between them as this building is a duplex. I inquired about who was working at the other licensed adult foster care facility at the time of the alleged incident between Resident A and Resident B. DCS 2 reported that he did not remember who was working at the other facility on this occasion.

On 6/13/25 I interviewed CEI-CMH, case manager, Jenna Lottes, via telephone regarding the allegation. Ms. Lottes reported that she has been the case manager for Resident B for about three years. She reported that she was first informed about the alleged assault from Resident A toward Resident B, during an on-site visit with Resident B at the facility on 5/28/25. She reported that she had not been informed by the direct care staff or licensee designee at the facility regarding the assault. Ms. Lottes reported that Resident B stated the police were contacted, but she also reported that Resident B is not notoriously a great historian, and she is unsure if this information is accurate. Ms. Lottes reported that she made an on-site visit to Resident B at the facility on 6/12/25 and discussed a safety plan with him as she was aware that Resident A has since returned to the facility and Resident B was uncomfortable with his return.

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:	Based upon the interviews conducted with multiple direct care staff, residents, and the licensee designee, as well as documentation reviewed, it can be determined that there is not substantial evidence to suggest that Resident A's alleged assault on Resident B was due to the direct care staff neglecting to supervise the residents and provide for their protection and safety. No person witnessed the alleged assault, and Resident A was not available for interview regarding the allegation. Therefore, due to a lack of evidence a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Medications are not being administered correctly to residents.**
- **Direct care staff are not properly trained to administer medications.**

INVESTIGATION:

On 5/19/25 I received an online complaint regarding the facility. The complaint was anonymous and alleged that resident medications are not being administered correctly and that direct care staff members have not been properly trained to administer medications. On 5/21/25 I conducted an unannounced, on-site

investigation at the facility. I reviewed the medications for all the current residents and reconciled the medications available to the resident MARs for the month of May 2025. I made the following observations:

- All medications were accounted for in the locked medication cabinet.
- Medications were signed for on the MARs with initials from DCS 1, DCS 3, and DCS 4.
- All resident MARs were missing signatures for completed medication administration for the dates 5/17/25 through 5/20/25 except for the 5pm doses.
- In Resident A's medication box I found a clear zippered sandwich bag with 8 loose medications inside the bag. The bag was labeled with a marker and stated, "Morning #Day 4". I asked DCS 4 about these medications and he reported that Resident A had been on a leave of absence with his family and was given his daily medications in these clear, plastic sandwich bags for his family to administer his medications. DCS 4 reported that the medications were taken out of the pharmacy supplied containers and placed into these bags and the direct care staff wrote on the bags which dates and times the medications were to be administered to Resident A during his leave of absence.
- In Resident A's medication box I found a small white pill ramekin, that contained three loose pills. DCS 4 reported that these were medications designated for Resident A but Resident A was on a leave of absence from the facility and these medications were not administered. DCS 4 reported that these medications were removed from the pharmacy supplied container and prepared for administration but not administered to Resident A due to his leave of absence. DCS 4 did not know which date these medications were intended to be administered.
- I observed a box of medications for Citizen 2. I inquired whether Citizen 2 was a resident of the facility. DCS 4 reported that Citizen 2 was a previous resident but has since been discharged from the facility. He reported that he was not sure of the exact discharge date. DCS 4 reviewed the *Resident Register* which still had Citizen 2 listed as a current resident, without a discharge date. DCS 4 reviewed Citizen 2's previous medication administration records and identified that the last date Citizen 2 was administered medications at the facility was 8/7/24.
- I observed that Resident E was prescribed two medications, Vitamin B12 (take 2 & ½ tablets under the tongue daily) and Probiotic Formula Cap (Take 1 capsule by mouth daily) on 5/15/25, that were not listed on the MAR and were being administered to Resident E. DCS 4 reported that these medications were just ordered for Resident E and had not yet been added to the MAR.
- I observed that as needed medications have been ordered for four of the residents.
- I reviewed the initials on the resident MARs next to the direct care staff schedule. DCS 4 signed for the medications administered on the MARs from 5/1/25 through 5/16/25 for evening and morning dosages except for the dates

5/3/25 & 5/4/25, and the 1pm and 5pm scheduled administrations. DCS 4 was not scheduled to work at the facility on 5/17/25 through 5/19/25.

During the on-site investigation on 5/21/25 I interviewed Residents B, C, D, & E, regarding medication administration. All residents interviewed reported that they receive their scheduled medications and have no concerns about medication administration at this time.

During the on-site investigation on 5/21/25 I interviewed Mr. Strode regarding Citizen 2's medications. Mr. Strode reported that Citizen 2 left the facility in August 2024 and they were unable to locate Citizen 2. Mr. Strode reported that the police were informed of Citizen 2's disappearance and reported him as a missing person. He reported that the CEI-CMH team were made aware of his disappearance. Mr. Strode reported that he continued to receive Citizen 2's medications and held them if he returned to the facility. Mr. Strode reported that he filled Citizen 2's bed at the facility with a new resident because he thought Citizen 2 had died. He reported that he received a telephone call about 1.5 months ago from the police stating they located Citizen 2 and wanted to bring him back to the facility. Mr. Strode reported that he advised the police that there was no longer a bed available for Citizen 2 at the facility.

During the on-site investigation on 5/21/25. I requested to review the direct care staff schedule for the facility and was provided a large calendar for May 2025 which had direct care staff names and times listed for the dates 5/5/25 – 5/25/25. The facility is in a building that is zoned as a duplex, and the adjacent duplex is also a licensed adult foster care facility that is operated by Mr. Strode. I inquired whether this direct care staff schedule was for one of the facilities or both of the facilities in this duplex. DCS 1 reported that this schedule was for both licensed facilities. Direct Care Staff 4 (DCS 4) also reported that this schedule encompasses staffing for both licensed adult foster care facilities on this property. I observed that on most days there is only one direct care staff scheduled to work at both licensed adult foster care facilities on this property. There were six days between the hours of 10am to 2pm where there were two direct care staff scheduled to work at the same time. DCS 2 was always scheduled as the only direct care staff on duty during their assigned shifts.

On 5/21/25 I sent email correspondence to Mr. Strode requesting documentation of completed medication administration training for DCS 1, DCS 2, DCS3, & DCS 5. On 5/28/25 I received confirmation of two of these requested trainings, from Citizen 1, which were completed on 5/17/24 and 9/17/23. On 6/3/25 I received confirmation of completed training for DCS 2, via email from Citizen 1, that was completed on 6/3/25. On 6/3/25 I received email correspondence from Citizen 1 reporting that DCS 5 no longer works at the facility and there is no documented medication administration training for DCS 5.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon the interviews conducted, medications reviewed, and medication administration records reviewed it can be determined that the MARs for the month of May 2025 were not initialed for scheduled doses of medications for all current residents from 5/17/25 through 5/20/25. There is no record confirming medications were administered to the residents on these dates as the direct care staff did not record these administrations on the resident MARs.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Based upon observations made in reviewing documentation provided regarding medication administration training, it can be observed that DCS 2 was scheduled to work independent shifts on the direct care staff calendar for the month of May 2025 and did not complete his medication administration training until 6/3/25. Additionally, at least four of the current residents have been ordered as needed medications that require random administration based upon resident needs/symptoms. As a result, a direct care staff member trained in medication administration must be available at the facility 24 hours per day seven days per week. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 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:	Based upon observations made during review of the resident medications and interview conducted with DCS 4, it can be determined that Resident A's medication box contained loose medications that were not kept in the pharmacy supplied container with a proper label from the pharmacy. As a result, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Based upon the observations made during the on-site investigation and the interviews conducted with DCS 4 and Mr. Strode, it can be determined that Citizen 2 left the facility in August 2024 and did not return. Citizen 2's medications continued to be delivered to the facility for a period after his disappearance. Mr. Strode received report from the police that Citizen 2 was located about 1.5 months ago and did not return or destroy the medications delivered to the facility for Citizen 2 after he received this report. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site investigation on 5/21/25. I requested to review the direct care staff schedule for the facility and was provided a large calendar for May 2025 which had direct care staff names and times listed for the dates 5/5/25 – 5/25/25. The facility is in a building that is zoned as a duplex, and the adjacent duplex is also a licensed adult foster care facility that is operated by Mr. Strode. I inquired whether this direct

care staff schedule was for one of the facilities or both facilities in this duplex. DCS 1 reported that this schedule was for both licensed facilities. DCS 4 also reported that this schedule encompasses staffing for both licensed adult foster care facilities on this property. I observed that on most days there is only one direct care staff scheduled to work at both licensed adult foster care facilities on this property. There were six days between the hours of 10am to 2pm where there were two direct care staff scheduled to work at the same time.

On 5/27/25 I conducted an unannounced on-site investigation at the facility. When I arrived there was not a direct care staff member at the facility. I went to the adjacent licensed adult foster care facility on this property and spoke with DCS 1 who reported that she was currently the only direct care staff member on the property covering direct care for both licensed adult foster care facilities. DCS 1 provided me with the direct care staff schedule for the property, which DCS 1 reported to encompass both licensed adult foster care facilities on this property. The schedule was reviewed and identified one direct care staff schedule per shift for the entire property for the dates 5/21/25 through 5/25/25. The dates 5/26/25 and 5/27/25 had no direct care staff scheduled for either of the adult foster care facilities on this property. DCS 1 reported that currently there are four residents at each of the licensed adult foster care facilities on this property, which is eight residents in total that she is providing direct care to on this date.

During the on-site investigation on 5/27/25 I interviewed Resident C. Resident C reported that there are dates and times when there is only one direct care staff member assigned to cover the direct care for all residents between both licensed adult foster care facilities on this property.

During the on-site investigation on 5/27/25 I made a telephone call to Mr. Strode. I explained to Mr. Strode that there was not a direct care staff member at the facility and that DCS 1 was providing care to all the residents at both licensed adult foster care facilities on this property. Mr. Strode advised that another direct care staff member was schedule to be at the facility and must not have arrived for their scheduled shift. I reported to Mr. Strode that the current direct care staff schedule only lists DCS 1 as being scheduled to provide direct care at this time. Mr. Strode reported that he would correct the issue and have another direct care staff come to the facility to provide care. Mr. Strode was made aware that not having a direct care staff present at the facility results in the recommendation for a six-month provisional license.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and

	shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Based upon observations made in reviewing the direct care staff schedule provided, as well as interviews with DCS 1 and Resident C during the unannounced on-site investigation, it can be determined that the facility was not staffed with a direct care staff member at the time of the on-site investigation and therefore not in ratio per the rule requirement. There were four residents at the facility at the time of this on-site inspection. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based upon observations made in reviewing the direct care staff schedule provided, as well as interviews with DCS 1 and Resident C during the unannounced on-site investigation, it can be determined that the facility was not staffed with a direct care staff member at the time of the on-site investigation. There were four residents at the facility at the time of this on-site inspection. Further review of the direct care staff schedule documented one direct care staff scheduled per shift for the entire property for the dates 5/21/25 through 5/25/25 to provide direct care, supervision, and protection to two licensed AFC facilities which is not sufficient staffing. The dates 5/26/25 and 5/27/25 had no direct care staff scheduled for either of the adult foster care facilities on this property. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the on-site investigation on 5/21/25. I requested to review the direct care staff schedule for the facility and was provided a large calendar for May 2025 which had direct care staff names and times listed for the dates 5/5/25 – 5/25/25. The facility is in a building that is zoned as a duplex, and the adjacent duplex is also a licensed adult foster care facility that is operated by Mr. Strode. I inquired whether this direct

care staff schedule was for one of the facilities or both facilities in this duplex. DCS 1 reported that this schedule was for both licensed facilities. DCS 4 also reported that this schedule encompasses staffing for both licensed adult foster care facilities on this property. I observed that on most days there is only one direct care staff scheduled to work at both licensed adult foster care facilities on this property. There were six days between the hours of 10am to 2pm where there were two direct care staff scheduled to work at the same time.

During the on-site investigation on 5/27/25 DCS 1 provided me the direct care staff schedule for the property, which was reported to encompass both licensed adult foster care facilities on this property. The schedule was reviewed and identified one direct care staff scheduled per shift for the entire property for the dates 5/21/25 through 5/25/25. The dates 5/26/25 and 5/27/25 had no direct care staff scheduled for either of the adult foster care facilities on this property.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	Based upon review of the direct care staff schedule provided during both on-site investigations on 5/21/25 & 5/27/25, it can be determined that the schedule does not clearly identify which direct care staff member is assigned to work at the two licensed adult foster care facilities on this property. There were also dates on the schedule that had passed when there was not a direct care staff member assigned to provide direct care. The current scheduling format being used is not adequate to identify the direct care staff scheduled for this individual facility, therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 5/21/25 I conducted an unannounced, on-site inspection at the facility. During this inspection I reviewed the *Resident Register* document. I observed the name for Citizen 2. I inquired whether Citizen 2 was a resident of the facility. DCS 4 reported that Citizen 2 was a previous resident but has since been discharged from the facility. He reported that he was not sure of the exact discharge date. The Resident Register listed Citizen 2 with an admission date of 12/15/23, but there was no discharge date and no information as to where Citizen 2 was discharged. DCS 4 reviewed Citizen 2's previous medication administration records and identified that the last date Citizen 2 was administered medications at the facility was 8/7/24. He reported that this former resident went missing in August of 2024 and the police have been involved due to Citizen 2 being identified as a missing person. DCS 4 asked if he should write the discharge date on the Resident Register as the last date medications were administered. Then DCS 4 updated the Resident Register with a discharge date of 8/7/24 for Citizen 2. Prior to DCS 4 updated this document the Resident Register listed seven active residents this six bed facility.

During the on-site investigation on 5/21/25 I interviewed Mr. Strode regarding Citizen 2. Mr. Strode reported that Citizen 2 left the facility in August 2024 and they were unable to locate Citizen 2. Mr. Strode reported that the police were informed of Citizen 2's disappearance and reported him as a missing person. He reported that the CEI-CMH team were made aware of his disappearance. Mr. Strode reported that he filled Citizen 2's bed at the facility with a new resident because he thought Citizen 2 had died. He reported that he received a telephone call about 1.5 months ago from the police stating they located Citizen 2 and wanted to bring him back to the facility. Mr. Strode reported that he advised the police that there was no longer a bed available for Citizen 2 at the facility.

APPLICABLE RULE	
R 400.14210	**Resident register.**
	Rule 210. A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident: **(a) Date of admission.** **(b) Date of discharge.** **(c) Place and address to which the resident moved, if known.**

	Based upon interviews conducted with DCS 4 and Mr. Strode, as well as review of the Resident Register, it can be determined that Citizen 2 was a previous resident at the facility and had not been living at the facility since August 2024, yet his name still appeared on the Resident Register as an active/current resident, even though his bed had been filled by a new resident. The Resident Register listed seven residents for this six-bed facility. Therefore, a violation has been established as the Resident Register was not updated with a proper discharge date for Citizen 2.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, a six-month provisional license is being recommended at this time due to quality of care violations cited.

6/16/25

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Jana Lipps Date
Licensing Consultant

Approved By:

06/18/2025

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Dawn N. Timm Date
Area Manager