GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 1, 2025

Tamika Ruth
514 S. Ortman Street
Saginaw, MI 48601

RE: License #: AS730377214
Investigation #: 2025A0623034
Annie's Home Care

Dear Tamika Ruth:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violation, disciplinary action against your license is recommended. There is current disciplinary action for previous violations under investigation #2025A0572016, dated 02/04/2025.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

Cynthia Badour

Cynthia Badour, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(517) 648-8877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730377214
Investigation #:	2025A0623034
Complaint Receipt Date:	05/08/2025
Investigation Initiation Date:	05/09/2025
Report Due Date:	07/07/2025
Licensee Name:	Tamika Ruth
Licensee Address:	514 S. Ortman Street Saginaw, MI 48601
Licensee Telephone #:	(989) 714-1271
Administrator:	Tamika Ruth
Licensee Designee:	N/A
Name of Facility:	Annie's Home Care
Facility Address:	514 N. Warren Avenue Saginaw, MI 48607
Facility Telephone #:	(989) 401-7835
Original Issuance Date:	11/16/2015
License Status:	REGULAR
Effective Date:	05/16/2024
Expiration Date:	05/15/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident C was incontinent and wearing briefs, clothes were dirty and smelled bad.	No
Resident C left the AFC home and staff did not know their whereabouts.	No
Additional Findings	Yes

III. METHODOLOGY

05/08/2025	Special Investigation Intake 2025A0623034
05/09/2025	APS Referral
05/09/2025	Special Investigation Initiated - Telephone I contacted APS worker Jessire Ramos
05/21/2025	Contact - Telephone call made I contacted Hope Network case manager Kaitlyn Wangler
05/29/2025	Inspection Completed On-site Observation and interview
05/29/2025	Contact - Face to Face I met with Resident A. I interviewed staff Daisy Sherman.
06/13/2025	Contact - Document Received AFC documents
06/16/2025	Contact - Telephone call made I contacted Licensee Tamika Ruth
06/24/2025	Contact - Document Received AFC documents
06/26/2025	Inspection Completed On-site Observation and interviews
06/26/2025	Inspection Completed-BCAL Sub. Non-Compliance
06/27/2025	APS Referral An APS referral was made

06/27/2025	Contact - Telephone call made I contacted Resident F.
06/30/2025	Exit Conference I completed an Exit Conference with Licensee Tamika Ruth.
06/30/2025	Contact - Telephone call made I contacted Property Owner Keith Bulger.

ALLEGATION:

- **Resident C was incontinent and wearing briefs, clothes were dirty and smelled bad.**
- **Resident C left the AFC home and staff did not know their whereabouts.**

INVESTIGATION:

On 05/09/2025, I completed an Adult Protective Services (APS) referral. I shared this information with Adult Protective Services.

On 05/09/2025, I contacted Adult Protective Services (APS) worker Jessire Ramos. APS Ramos stated that Resident C is no longer living at Annie's Home Care, and they moved as of 05/01/2025. APS Ramos stated that Resident C can make their own decisions, can complete their own dressing, bathing and changing without assistance. APS Ramos stated that she substantiated for neglect because Resident A's clothes were dirty and they had walked away from the home and staff did not know where they were. APS Ramos stated that once Resident C moved, they closed their case. APS Ramos stated that Resident C does not need or use adult briefs at their new placement. APS Ramos stated that there is no current APS investigation in the home at this time.

On 05/21/2025, I contacted Hope Network case manager (CM) for Resident C, Kaitlyn Wangler. CM Wangler stated that Resident A is their own guardian and can decide for themselves where they want to live. CM Wangler stated that Resident C wanted to move from Annie's Home Care, so another AFC home placement was obtained. CM Wangler stated that Resident C moved 05/01/2025 and appears to be doing well at the new facility. CM Wangler stated that Resident C used to soil or urinate on themselves because they wanted to and it was unknown to her how many times a day Resident C would need to change clothes at their previous placement. CM Wangler stated that at the new placement, Resident C does not have this behavior and does not wear adult briefs. CM Wangler stated that Resident C would notify staff where they would be going and they would go there, however they would often change their mind and stop at other places. CM Wangler stated that Resident C did not have their own phone, however they knew phone numbers to call to get transportation. CM Wangler stated that they are leaving Hope Network and Resident C will be assigned a new case manager.

On 05/29/2025, I completed an unannounced on-site inspection at the facility. At the home was staff Roderick York. I interviewed Roderick York regarding the allegations. I discussed my allegations with Staff York. Staff York stated that Resident C moved out at the beginning of May 2025. Staff York stated that Resident C can make their own choices and chose to move. Staff York stated that Resident C would mess themselves even with an adult brief on just because they wanted to. Staff York stated that laundry was done as needed and Resident C had a lot of clothes that Resident C left when Resident C moved out. I entered the facility and noticed that the home appeared dusty and went to the 2nd floor of the home into what had been Resident C's bedroom. I observed 4 large black plastic garbage bags tied up against the windows. Staff York stated the bags were full of clothes that Resident C left behind when Resident C moved. I observed an unmade bed with stained linens in the room. Staff York stated that Resident C would tell him when they were leaving to go into the community, however, they would often change their mind and call if needed. Staff York denied allegations of neglect stating that because Resident C was able to make their own decisions, they can only go by what is told to them.

On 05/29/2025, I completed a face-to-face unannounced contact with Resident C at another licensed AFC facility. I observed the home was clean and organized. I interviewed Resident C in their bedroom. I observed the bedroom was clean and furnished. I observed Resident C was clean, neatly groomed and dressed. I observed Resident C was alert and oriented to person, place and time. When I asked about clothing at the previous placement Resident C stated that their clothes got washed and denied being dirty. When I inquired about Resident C needing to wear adult briefs, Resident C just shook their head and stated they didn't need to anymore. When I asked Resident C if they would notify staff when Resident C was leaving and where Resident C was going, Resident C said that Resident C did. Resident C stated that they would often change their mind and go do something else. Resident C stated that Resident C knows how to call to get a ride. Resident C denied being neglected at their previous home. Resident C stated that Resident C knows they left clothing at the other home, however, Resident C does not want them and obtained new clothes.

On 05/29/2025, I spoke with Staff Daisy Sherman at Resident C's new placement. Staff Sherman stated that Resident C did move into the home on 05/01/2025. Staff Sherman stated that Resident C did not have many clothes, what Resident C had was clean, and Resident C's case manager also brought Resident C new clothes. Staff Sherman stated that Resident C is cooperative and follows the rules. Staff Sherman stated that Resident C is getting a new case manager as their current one is leaving.

On 06/13/2025, I received AFC documents for Resident C from the new placement. I observed the AFC-Resident Information and Identification Record, Assessment Plan, AFC Care Agreement. The documents appeared to be completed and signed on 05/01/2025.

On 06/16/2025, I contacted Licensee Tamika Ruth. I discussed the allegations with Licensee Ruth. Licensee Ruth stated that Resident C would mess up their pants to get

attention. Licensee Ruth stated that she believed Resident C needed a guardian, however the Hope Network doctor said that they can make their own decisions. Licensee Ruth stated that Resident C would make decisions to mess up their pants and Resident C can dress and change themselves. Licensee Ruth stated that Resident C's laundry was cleaned and denied that Resident C was left dirty. Licensee Ruth stated that Resident C would tell staff when Resident C was leaving and where Resident C. Resident C would then change Resident C's mind. Licensee Ruth stated that Resident C does not have their own phone, however they know phone numbers to call to obtain a ride.

On 06/24/2025, I received AFC documents for Resident C from Licensee Tamika Ruth. I observed the AFC-Resident Information and Identification Record, Assessment Plan, AFC Care Agreement and Health Care Appraisal forms for Resident C. I observed the completed forms, including the Health Care Appraisal completed on 02/24/2025.

On 06/26/2025, I completed an unannounced on-site inspection at the facility. Staff Roderick York was at the home. Also present were Resident A and Resident B. Staff York greeted me outside on the front porch. Staff York stated that there are currently 3 residents, Resident C moved out at the beginning of May 2025, Resident E moved out at the end of May 2025 and Resident F just moved in the beginning of June 2025. Staff York stated that Resident F informed him that they were going to a friend's house and would be back later. Staff York stated that Residents A and B were currently home.

On 06/26/2025, I interviewed Resident A in a small open room with a TV on the 1st floor. I observed the floors appeared to be swept and free of debris. I asked Resident A how they liked living in the home and if they had any concerns. Resident A quickly became angry and stated that they did not want to talk to me and to leave them alone. Resident A began to pace back and forth in the room. I gently thanked Resident A for letting me know and explained I just wanted to make sure they were okay and had what they needed. Resident A then stated they are good. I observed Resident A was wearing clean clothes, hair was clean and neatly groomed.

On 06/26/2025, I interviewed Resident B in the dining room area of the home. Resident B appeared clean, neatly groomed and alert and oriented x3 for person, place and time. Resident B was just finishing lunch which consisted of a salami sandwich, a small bag of potato chips and a plastic cup of pop. I asked Resident B if they had any concerns about living in the home and they stated that they did not. Resident B stated if they need anything they just ask. Resident B stated when they want to leave the house, they just let staff know where they are going.

On 06/27/2025, I contacted the facility and spoke with Resident F. Resident F identified themselves and that they had moved into the facility at the beginning of the month. Resident F stated that they have lived at the facility before. Resident F stated that they had no concerns about the home or else they would not have moved in. Resident F stated that they can make their own decisions. Resident F stated they are going now and thank you for calling. Resident F ended the call.

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:	The allegations stated the following: Resident C was incontinent and wearing briefs, clothes were dirty and smelled bad. Resident C left the AFC home and staff did not know their whereabouts. During the investigation it was noted that Resident C had a habit of soiling themselves, requiring the use of adult briefs when Resident C resided at Annie's Home Care. Upon moving to a new placement this behavior stopped. Resident C no longer required adult briefs at their new placement. Resident C denied that their clothes were not cleaned and since they moved, they left most of their clothes at Annie's Home Care and their case manager provided new clothing. Staff and Licensee of Annie's Home Care denied that Resident C did not inform them of their whereabouts when Resident C left the facility. However Resident C often changes their plans while out in the community. I conclude there is insufficient findings to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/26/2025, I went upstairs at Annie's Home Care and as I walked through the house I observed the 2nd floor bathroom's neglected condition. I observed dirty water standing in the toilet and in the sink. I observed tiles sitting on the bathroom vanity, and exposed subfloor between the vanity and toilet. Both the toilet and sink appeared to be clogged. I questioned staff York regarding the bathroom, and he stated he tells the residents to use the 1st floor bathroom and not the 2nd floor because the sink and toilet do not work. I noted that the current residents' bedrooms are all on the 2nd floor.
I observed the 1st floor bathroom which appeared in working order, except the linoleum flooring on one side of the bathroom floor was ripped up.

Special Investigation Report SIR 2025A0580003, dated 12/13/2024 cited violation to R 400.14403(1) due to the upstairs toilet being broken and feces smeared on the toilet. The investigation recommended a provisional license contingent upon receipt of an acceptable corrective action plan. No corrective action has been received.

Special Investigation Report SIR 2025A0572016, dated 02/04/2025 cited violation to R 400.14403(1) due to the non-working toilet in the upstairs bathroom leaking, causing damage to the drywall below it. Several floor tiles are damaged in both bathrooms and need to be replaced. This investigation recommended revocation of the license due to willful and substantial rule violations.

On 06/27/2025, I completed an APS (Adult Protective Services) referral. The concerns of the physical condition of this home were shared with APS.

On 06/30/2025, I conducted an exit interview with Licensee Tamika Ruth. I informed her of my findings and conclusion regarding the condition of the 2nd floor bathroom. Licensee Ruth stated, “I thought they had fixed that”. When I inquired who “they” were, Licensee Ruth stated the property owner, Keith Bulger. I informed Licensee Ruth of the recommendation of revocation of the license. This facility has already been cited numerous times and continues to be willfully and substantially out of compliance.

On 06/30/2025, I contacted property owner Keith Bulger. I left a voice mail message.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	On 06/26/2025, I conducted an unannounced onsite inspection of this facility. I observed the 2nd floor bathroom’s neglected condition. I observed dirty water standing in the toilet and in the sink. I observed tiles sitting on the bathroom vanity, and exposed subfloor between the vanity and toilet. Both the toilet and sink appeared to be clogged. I noted that the current residents’ bedrooms are all on the 2nd floor. I conclude that there is sufficient evidence to substantiate a rule violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR 2024A0580003, dated 12/13/2024.** **SIR 2025A0572016, dated 02/04/2025.**

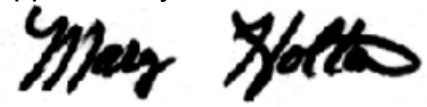
IV. RECOMMENDATION

I recommend revocation of this license.

07/01/2025

Cynthia Badour — Date
Licensing Consultant

Approved By:



07/01/2025

Mary E. Holton — Date
Area Manager