ADULT FOSTER CARE FACILITY INQUIRY RECORD

Michigan Department of Social Services

Log Number	2. Date of Inquiry
	8/12/91

3. Inquiry Taken By: Vernon

DISTRIBUTION: PART 1 - Inquiry Log
PART 2 - Licensing Consultant

INQUIRY/FACILITY INFORMATION:

4. Name of Inquirer (Last, First, Middle): L.A.P.D.

5. Phone No. of Inquirer: 313 625-3570

6. Address of Inquirer (No., Street and City): P.O. Box 672 Rochester, Michigan Zip Code 48308 ~~48446~~

7. Type of Facility Proposed:
- ☐ Family Home
- ☒ Small Group 12 or less
- ☐ Large Group
- ☐ Congregate
- ☐ Adult Camp

8. Name of Proposed Facility (if any)

9. Address (No., Street and City): corner Summit & Pleasant Waterford, Michigan Zip Code

10. Programming Interest:
- ☐ Physically Handicapped
- ☐ Developmentally Disabled
- ☐ Social Emotional Problems
- ☐ Aged
- ☐ Other (Explain):

11. Assigned To:

12. Date Assigned

13. Referred To:

14. Date Referred:

15. Date Returned:

FOLLOW-UP AND DISPOSITION:

16. Follow-up(s) Needed
- ☒ Licensing Requirements and Informational Brochure Provided . . . . . (Date) 08/13/91 ~~RKO~~
- ☐ Information Only, and Cleared . . . . . (Date)
- ☒ Application Packet Provided . . . . . (Date) 08/13/91 ~~RKO~~
- ☐ Application not returned in 30 days:
  - ☐ Application Closure Sent (Complete No. 17) . . . . . (Date)
  - ☐ Inquiry Cleared (Complete No. 18) . . . . . (Date)

17. Reason(s) Application not Returned

18. Reason(s) Inquiry Cleared

19.	20. Registration Number	21. Date of Registration
☐ APPLICATION RETURNED		

DSS-3429 (Rev. 11-79) Previous editions obsolete.

LICENSE APPLICATION
ADULT FOSTER CARE FACILITY
Michigan Department of Social Services

FOR DSS USE ONLY Temp 294

Consultant Number	Receipt Date	License Number
Versaw		
Application type: XX Original ☐ Renew		Was Fee Received? ☐ Yes ☐ No

FACILITY/HOME INFORMATION

1. Facility/Home Name: SUMMIT HOME
2. Facility/Home Type: ☐ Family Home (1-6) ☐ Sm. Group Home (1-12) XX (six or less) ☐ Lg. Group Home (13-20) ☐ Congregate Facility (21 or more)
3. Applicant Name: L.A.D.D. INC.
4. Proposed Capac.: 6
5. Facility/Home Street Address: LOTS 364 SILVER TERRACE ADDITION #1
6. Area Code, Facility Phone Number:
7. City/Village: WATERVLIET
8. Township:
9. County: BERRIEN
10. State: MI
11. Zip Code:
12. Zoning Authority: ☐ Township ☒ City/Village Named Above

PARENT ORGANIZATION INFORMATION (person, partnership, corporation, or association, if applicable)

13. Name (if same as above, indicate "same"): SAME
14. Area Code, Telephone Number: 313-625-3870
15. Street Address: P.O. BOX 672
16. City/Village: ROCHESTER
17. State: MI
18. Zip Code: 48308

SPONSOR INFORMATION (if applicable)

19. Name (if same as above, indicate "same"): SMCLS
20. Area Code, Telephone Number: 616-777-5342
21. Supplemental Information:
22. Street Address: 1903 MARQUETTE AVE
23. City/Village: MUSKEGON
24. State:
25. Zip Code: 49442

26.

I have read Act No. 218, P.A. 1979 and the Administrative Rules regulating the operation of the Adult Foster Care Facility indicated above, and if granted a license, will endeavor to comply with the Act and these rules.

In order to permit a proper determination of conformity with the rules, I give permission to the Department of Social Services to make a necessary and reasonable investigation of my activities and proposed standards of care and to make an on-site evaluation of the proposed facility. The investigation may include the securing of statements from references I submit, as well as from others who may make judgments as to my ability to comply with the rules.

I am aware of the legal provision that to operate an adult foster care facility without a license constitutes a misdemeanor as stated in Section 13 and Section 31 of Act 218, Public Act of 1979.

I hereby certify that if I or any member of the staff having direct contact with adults have been convicted of an offense for other than a minor traffic violation, such information shall be shared with the Department.

I also certify that any information I give in respect to the investigation will be, to the best of my ability, true and correct.

27. Applicant Name (please print or type)	28. Applicant Signature	29. Date
LADD INC	[signature]	9-24-91
30. Spouse Name (if joint application)	**31. Spouse Signature**	**32. Date**
N/A	N/A	
33. Applicant's Home Telephone Number	**34. Witness Signature**	**35. Date**
313-625-3870	[signature]	9-24-91

36. Applicant's Home Address: P.O. BOX 672 ROCHESTER MI 48308

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Mich. Dept. of Social Services

37. A non-refundable license fee, payable by check or money order ONLY to: State of Michigan, Department of Social Services, must ACCOMPANY this application. (See enclosed fee instructions.) The fee's are:

Family Home — $15.00
Small Group Home — $25.00
Large Group Home — $50.00
Congregate Facility — $75.00

The Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, or political beliefs.

AUTHORITY: PA 218 of 1979.
COMPLETION: Is required if this is a license renewal.
NON-COMPLETION: Will result in a refusal to renew the license.

DSS-569 (Rev. 2-86) Previous edition may be used.

SUPPLEMENTAL INFORMATION
ADULT FOSTER CARE FACILITY
Michigan Department of Social Services

INSTRUCTIONS: Attach additional sheets, if necessary. Licensing Consultant - Complete last item before providing form to applicant.

FOR DSS USE ONLY		
Consultant Number: Versaw	Receipt Date:	License Number:
Application Type: ☒ Original ☐ Renewal ☐ Governmental ☐ Non-Governmental		Was Fee Received? ☐ Yes ☐ No

1. Applicant Name (last, first, middle, former or maiden) List both if joint.
   A. L.A.D.D. INC.
   B. (If joint) N/A

2. Social Security Number: N/A
3. Driver's License Number: N/A
4. Birth Date: N/A
5. Marital Status: ☐ Single N/A ☐ Married ☐ Separated

6. Employment	Place of Employment	Job Held (Shift)	Hours Worked (Shift)	Annual Income(s)
A. Applicant(s)				
B. Administrative Personnel (Facility Staff)	GLORIA S. MITZELFELD	ADMINISTRATOR	40	52,000-
	DAVID C. MANSELL	DIRECTOR	40	52000

7. Does Non-Applicant-Spouse live in Facility? ☒ No ☐ Yes (must sign the following statement)

I hereby certify that I am not an applicant for an adult foster care facility license. I acknowledge awarness of the filing of applications for adult foster care. I have no objection to the provision of foster care in the home. This acknowledgment does not bar future disclosure of testimony of facts of activities in the facility. My actions will not prohibit compliance with the statute or rules.

Spouse Signature: _____ Date: _____

8. Does applicant intend to reside in the facility and be the facility administrator? ☐ Yes ☒ No (explain arrangements)

HOME WILL BE STAFFED ON A TWENTY-FOUR ROTATING STAFF BASIS

9. The following information must be submitted to the Department:

A. Description of any health problems, mental problems or emotional problems of the family members, staff members or other non-resident members of the household.

NONE ARE KNOWN

B. Description of any convictions of the applicant or responsible persons for other than a minor traffic violation.

NONE

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Mich. Dept. of Social Services

C. Description of applicant's financial difficulties (bankruptcy, credit problems, evictions, repossessions)

NONE

10. Do you now or have you ever cared for persons other than your family or operated a foster care facility (permit home, licensed residential care facility, community placement facility, any equivalent type facility, licensed/certified foster care for children) or ever made an application to operate a foster care facility to any agency?
☐ No ☒ Yes (complete the following) License Number SEE ATTACHED

a. Date	b. Name of Agency	c. Type of Care
1978 -	SAME	AFC

11. Enter the number, name and address of Adult Foster Care facilities you now operate. Use additional sheet if necessary. DO NOT include licensed nursing homes or homes for the aged.

Number of Facilities: 11

Name	Address	City	Zip
	SEE ATTACHED		

L.A.D.D. / Living Alternatives for the Developmentally Disabled, Inc.

Post Office Box 672, Rochester, MI 48308-0672, 625-3870

1. **DAVISBURG HOME** - SG630019

   11914 Davisburg Rd.
   Davisburg, MI 48350

2. **DUNLEAVY HOME** - SG630038

   2906 Dunleavy Dr.
   Highland, MI 48356

3. **ADAMS HOME** - SG630012

   2840 N. Adams
   Troy, MI 48084

4. **GROVELAND HOME** - SG6300139

   9921 Walnut Hill Dr.
   Davisburg, MI 48350

5. **LAKE BRAEMAR HOME** - SG630008

   1255 E. Davisburg Rd.
   Holly, MI 48442

6. **COUNTY LINE HOME** - SG630049

   12202 County Line Rd.
   Ortonville, MI 48462

7. **SUNNINGDALE HOME** - SG630011

   6488 Sunningdale Dr.
   Birmingham, MI 48010

8. **HOLCOMB HOME** - SG630086

   8415 Holcomb Rd.
   Clarkston, MI 48348

9. **WILDWOOD HOME** - SG6300160

   2985 Wildwood
   Holly, MI 48442

10. **FAIRVIEW HOME** - SG1400010

    703 Fairview
    Dowagiac, MI 49047

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L.A.D.D. / Living Alternatives for the Developmentally Disabled, Inc.

Post Office Box 672, Rochester, MI 48308-0672, 625-3870

11. LUCINDA HOME

157 Lucinda
Watervliet, MI 49098

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Mich. Dept. of Social Services

MICHIGAN DEPARTMENT OF STATE POLICE

FAX

TRANSMITTAL SHEET

40A NCR (6/88)
DEPARTMENT OF STATE POLICE
FIRE MARSHAL DIVISION

FIRE SAFETY INSPECTION/CERTIFICATION REPORT

4-00-0306-92

FACILITY NAME: Summit Drive AIS/MR	DATE OF INSPECTION: 6/25/92	COUNTY: Berrien	FM NO. ☐ OPEN ☐ CLOSED
ADDRESS: Summit Drive	FACILITY TYPE: AIS/MR	[illegible]: UCFA	[illegible] FAC. NO.
CITY: Watervliet · STATE: MI · ZIP: 49098	FACILITY REP.: Paul McClary		INSPECTION TYPE: Final

RULE NO.	DESCRIPTION OF NON-COMPLIANCE
	New Construction ([illegible] type home)
7-2	Provide combustion air and [illegible] heat [illegible] for the heat plant [illegible] compliance with [illegible] 54 [illegible] gas appliances. [illegible] through [illegible] and [illegible] the [illegible] prior to inclimate weather.
	[illegible] approval must be submitted [illegible] matters [illegible] sanitation, food handling and water supply are involved.

DATE [illegible] · [illegible] · [illegible] [illegible] 30 days [illegible]

WHITE [illegible] · CAN. [illegible] · PINK [illegible] · GOLDENROD [illegible]

[illegible] · ADDRESS: 706 W. Michigan Ave · TELEPHONE: (616) 657-5571

CITY: Paw Paw · ZIP: 49079

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S.M

ENVIRONMENTAL HEALTH INSPECTION REPORT (PART A)
WATER SUPPLY AND SEWAGE DISPOSAL
Michigan Department of Social Services

1. Name of Facility: Summit Home	3. License Number:
2. Address of Facility (Number and Street): 551 Summit	4. Type of Facility: Small Group
City: Waterville; State: MI; Zip Code: 49098	5. Have there been any major changes to buildings and grounds since the last inspection? ☑ NO ☐ YES ▶ If yes, describe in 5a.
5a. Describe major changes to buildings and grounds since last inspection. NEW	

SECTION 1 - WATER SUPPLY SYSTEM

6. Is a municipal water supply system available? ☑ YES ☐ NO	8. Explain:
7. If yes, is it utilized? ☑ YES ☐ NO	
9. Bacteriological Analysis ☐ SAFE ☐ UNSAFE; 10. Date Sampled:	11. Is the private well construction, location and maintenance satisfactory? ☐ YES ☐ UNABLE TO DETERMINE ☐ NO (Explain)

12. CHEMICAL ANALYSIS (Where necessary)

CHEMICAL TYPE	DATE SAMPLED	CONCENTRATION	RECOMMENDED LIMITS
Nitrates (No_3)		PPM	PPM
		PPM	PPM

13. PRIORITY STATUS (If any water supply system is unsatisfactory, indicate your priority recommendation and explain)

Priority (Back of Form): ☐ I ☐ II ☐ III ☐ IV

Reason for Priority:

14. If water supply system is not satisfactory, cite DSS rule number, violation and means of correction:

SECTION 2 - SEWAGE DISPOSAL SYSTEM

15. Is a municipal sewage disposal system available? ☑ YES ☐ NO	17. Explain:
16. If yes, is it utilized? ☑ YES ☐ NO	

18. If the sewage disposal system is not satisfactory, cite DSS rule number, violation and means of correction:

Use Additional Sheets When Necessary and Refer to Item Numbers

RECOMMENDATION

A. ☑ This facility has been determined to be in substantial compliance with applicable rules.
B. ☐ Because of the above listed deficiencies, temporary approval is recommended until the next annual inspection or report.
C. ☐ Because of the above listed deficiencies, temporary approval is recommended until (date) _____.
D. ☐ This facility has been determined to be in substantial non-compliance with applicable rules. Approval is not recommended.

If you have any questions concerning this report, please contact the inspecting health agency named below.

19. Name of Inspecting Health Agency: mich Dept Public Health		20. Agency Telephone Number: 517-334-8462	
21. Agency Address (Number, Street): 3423 N Logan PO Box 30195	22. City: LANSING	23. Zip Code: 48909	24. Time Spent (Minutes): 60
25. Interviewee Signature	26. Signature of Sanitarian: [signature] RS		27. Inspection Date: 4-28-92

DSS-1788 (Rev. 12-88) Previous edition obsolete.

LICENSING CONSULTANT

S.M. L.S.

ENVIRONMENTAL HEALTH INSPECTION REPORT (PART - B)
GENERAL SANITATION AND SAFETY
Michigan Department of Social Services

24. Facility Name	25. License Number	26. Facility Type
Summit Home		Small Group

27. Facility Address (Street Number and Name)	City	State	Zip Code
551 Summit	Waterville	MI	49098

SECTION 3 Insect and Rodent Control Effective. Garbage, Rubbish, and Solid Waste Properly Collected, Stored and Removed. Proper Screening of Doors and Windows.

Comments: OK

SECTION 3 Lighting, Ventilation, and Heating Satisfactory.

Comments: OK

SECTION 5 Site and Structures Acceptable, Properly Located and Maintained (General Housekeeping). Plumbing Properly Installed and Maintained.

Comments: OK

SECTION 6 Swimming Pool and/or Beach Constructed and Maintained, in Safe and Sanitary Condition.

Comments: N A

SECTION 7 Accident Prevention: Hazardous Materials, Hot Water At Resident Handwashing and Bathing Facilities, Electrical Safety, Recreational Equipment, Fencing; Buildings, Equipment and General Premises.

Comments: OK

SECTION 8 Toilet, Handwashing and Bathing Facilities Adequate and Maintained.

Comments: OK

SECTION 9 Foods, Beverages and Ice are From Approved Sources and are Properly Protected Through: Personal Health and Hygiene; Effective Temperature Control; Correct Construction of Utensils, Equipment and Buildings; Cleaning and Sanitizing of Utensils, Equipment, Proper Storage, Handling, Preparation, Display, Service and Transportation. (See reverse side for Food Service Sanitation Criteria.)

Comments: OK

28. If Any Items Listed Above are not Satisfactory, Cite DSS Rule Number, Cite Violation and Means of Correction:

Home 60%-65% complete at the time of the inspection visit

29. Interviewee Signature	30. Sanitarian's Signature	31. Time Spent (in minutes)	32. Date of Inspection
	C Neal RS	60	4-28-92

AUTHORITY: PA 218 of 1979, as amended.
COMPLETION: Mandatory
PENALTY: License issuance or renewal may be denied.

The Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap or political beliefs.

DSS-1789 (Rev. 9-90) Previous edition obsolete.

LICENSING CONSULTANT / WORKER

CERTIFICATION STATEMENT
APPLICABILITY OF FEDERAL FAIR HOUSING AMENDMENTS ACT
Michigan Department of Social Services

▼ FOR DSS USE ONLY ▼

Applicant's Name: LADD INC	License Number:
Facility/Home Name: SUMMIT HOME	
Facility/Home Address (Street Number and Name): LOT 3+4	
City: WATERVLIET / State: MI / Zip Code:	
County: BERRIEN / Township:	
Applicant's Phone Number: A/C (313) 625-3870	

Facility/Home Type

- ☐ Child Caring Institution (for five or six)
- ☐ Child Foster Family Group Home
- ☐ Adult Foster Care Small Group Home (for one to six)
- ☐ Adult Foster Care Family Home

- The federal Fair Housing Amendments Act of 1988 protects individuals with disabilities and also children from discriminatory housing practices. The Michigan Zoning Enabling Acts apply only to those license applicants that are exempt from the provisions of the Fair Housing Amendments Act.
- Your answers to the questions on this checklist will enable us to determine which statute, the federal or the state, will apply to your license application.
- Please respond to each of the following questions to the best of your knowledge. For the purpose of these questions, "dwelling" is considered to be the physical living structure to be licensed.

	Yes	No
1. Was a real estate broker, sales person, or any person in the business of selling or renting dwellings involved in the **last** sale or rental of this dwelling?	☒	☐
2. Was there an advertisement, mailing, written notice, or other public posting in any newspaper, magazine, publication, or location offering this dwelling for sale or rent?	☒	☐
3. Has the owner sold similar dwellings that the owner did not live in within any 24-month period?	☐	☒
4. Does the owner of this dwelling own more than 3 similar dwellings at this time?	☐	☒
5. Has the owner of this dwelling had any interest in the proceeds of the sale or rental of more than 3 single family dwellings at any one time?	☐	☒
6. Is the dwelling owned or operated by the Federal Government or one of its departments or agencies?	☐	☒
7. Was the dwelling, or any improvement to the dwelling, financed in whole or part with the aid of loans, grants, contributions, or advances from the Federal Government?	☐	☒
8. Was this dwelling financed with a loan or mortgage insured, guaranteed, or otherwise secured by the Federal Government or one of its departments or agencies?	☐	☒
9. a. Was this dwelling obtained through a State or local public agency involved in slum clearance or urban renewal?	☐	☒
b. Did the State or local public agency referenced above receive federal funding?	☐	☒
10. Is this dwelling part of an apartment building or complex or other multiple-unit dwelling that has more than 4 separate apartments or other separate living quarters?	☐	☒

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Mich. Dept. of Social Services

I certify that the information that I have provided on this form is true and accurate to the best of my knowledge.

Applicant's Signature: [signature] Date: 9-23-91

The Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap or political beliefs.

AUTHORITY: P.A. 218 of 1979 as amended. P.A. 116 of 1973, as amended. Federal 100-430 CFR of 1988.
COMPLETION: Mandatory. PENALTY: License may not be issued.

DISTRIBUTION: Return white and canary copies to your licensing consultant with your license application, and retain pink copy for your records.

DSS-4602 (10-89)

ADULT FOSTER CARE FACILITY COMPLIANCE
DETERMINATION REPORT
Michigan Department of Social Services

License Number:
SG[redacted]0073

Reason for Determination:
2 ORIGINAL

License Effective Date:
07/07/92

Date of Original Application:
10/02/91

I. FACILITY/LICENSEE INFORMATION:

Facility Name:			Licensee Name(s):		
SUMMIT HOME			LADD INC		
No. and Street:			No. and Street:		
444 SUMMIT ST			8054 ORTONVILLE RD		
City:	State:	Zip:	City:	State:	Zip:
WATERVLIET	MI	49098	CLARKSTON	MI	48347

II. SCOPE OF EVALUATION:	Completed Yes	Completed No
A. Determination of Compliance with Act 218, P.A. 1979 as amended	X	
B. Determination of Compliance with Licensing Rules	X	
1. Quality of Care Rules	X	
2. Physical Plant Rules	X	
3. Fire Safety Rules	X	
C. Variances Granted		X

III. LICENSING RECOMMENDATION:

1 TEMPORARY

IV. ATTACHMENTS:

A. Adult Foster Care Group Home Compliance Record.

1. Quality of Care Rules
2. Physical Plant Rules
3. Fire Safety Rules
4. Environmental Report

B. Other

Licensing Consultant Signature — Date

Wally Versaw — 7/1/92

ADULT FOSTER CARE GROUP HOME COMPLIANCE RECORD
QUALITY OF CARE RULES
R 400.2111 - R 400.2113; R 400.2116 - R 400.2122;
R 400.2302 - R 400.2324; R 400.2351 - R 400.2375

License Number:
SG1100073

Date of Onsite Visit
06/25/92

Michigan Department of Social Services

	IN COMPLIANCE		SEE ADDENDUM
	YES	NO	
R400.2111 Licensing applications and renewals.	X		Y
R400.2112 Inspections and investigations.	X		Y
R400.2113 License limitation of numbers of residents and beds; posting of license; change of information provided in license application.	X		Y
R400.2116 Reports.	X		Y
R400.2119 Grievance procedures.	X		Y
R400.2122 Staff training programs.	X		Y
R400.2302 Licensees and administrators.	X		Y
R400.2303 Admission and discharge.	X		Y
R400.2304 Illnesses and accidents.	X		Y
R400.2305 Deaths of residents.	X		Y
R400.2306 Personnel policies and health supervision.	X		Y
R400.2307 Staffing.	X		Y
R400.2311 Services for residents.	X		Y
R400.2312 Care of residents.	X		Y
R400.2313 Residents, personal care.	X		Y
R400.2314 Complaints.	X		Y
R400.2315 Health care of residents.	X		Y
R400.2316 Prohibited practices.	X		Y
R400.2317 Assessment plan.	X		Y
R400.2318 Resident activities.	X		Y
R400.2321 Residents funds, access, safekeeping.	X		Y
R400.2322 Accounting of residents funds.	X		Y
R400.2323 Charges against residents funds.	X		Y

License Number:
SG1100073

QUALITY OF CARE RULES - Continued	IN COMPLIANCE		SEE ADDENDUM
	YES	NO	
R400.2324 Transactions prohibited; review.	X		Y
R400.2351 Records generally.	X		Y
R400.2352 Resident records.	X		Y
R400.2353 Resident register.	X		Y
R400.2354 Accident records and incident reports.	X		Y
R400.2355 Employee records and schedules.	X		Y
R400.2356 Residents grievances and complaints record.	X		Y
R400.2357 Resident funds and valuables.	X		Y
R400.2371 Quality of meals.	X		Y
R400.2372 Food service.	X		Y
R400.2373 Equipment.	X		Y
R400.2374 Meal planning.	X		Y
R400.2375 Staff.	X		Y

ADULT FOSTER CARE GROUP HOME COMPLIANCE RECORD
PHYSICAL PLANT RULES
R 400.2331 - R 400.2348

License Number:
SG1100073

Date of Onsite Visit
06/25/92

Michigan Department of Social Services

	IN COMPLIANCE		SEE ADDENDUM
	YES	NO	
R400.2331 Home environment.	X		N
R400.2332 Living areas.	X		N
R400.2333 Bedrooms.	X		N
R400.2334 Bedding and linen.	X		N
R400.2347 Safety, generally.	X		N
R400.2348 Water and sanitation.	X		N

ADULT FOSTER CARE GROUP HOME COMPLIANCE RECORD
FIRE SAFETY RULES FOR HOMES ORIGINALLY LICENSED
OR PROPOSED AFTER MARCH 27, 1980
R 400.1602 - R 400.1613

License Number:
SG1100073

Date of Onsite Visit
06/25/92

Michigan Department of Social Services

	IN COMPLIANCE		SEE ADDENDUM
	YES	NO	
R400.1602 Interior finishes and materials.	X		N
R400.1603 Interior finish of walls and ceilings; prohibited materials.	X		N
R400.1604 Smoke detection equipment.	X		N
R400.1605 Fire extinguishers.	X		N
R400.1606 Means of egress generally.	X		N
R400.1607 Means of egress; sleeping areas.	X		N
R400.1608 Means of egress; wheelchairs.	X		N
R400.1609 Heating equipment generally.	X		N
R400.1610 Flame-producing equipment; enclosures.	X		N
R400.1611 Electrical service.	X		N
R400.1612 Emergency preparedness; evacuation plan; emergency transportation.	X		N
R400.1613 Exemption from rules.	X		N

This home has been determined to be in substantial compliance with applicable rules.

I verify that the findings reported above for this organization are true to the best of my knowledge.

Consultant Date

Wally Verocai 7/1/92

The Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, or political beliefs.

ADDENDUM TO COMPLIANCE RECORD

Michigan Department of Social Services
Bureau of Regulatory Services

Date:
07/01/92

Facility/Home Name:
SUMMIT HOME

License Number:
SG1100073

OBSERVATIONS/COMMENTS

==========

COMPLIANCE WITH THE RESIDENT QUALITY OF CARE RULES WILL BE DETERMINED AT THE TIME THAT THE TEMPORARY LICENSE IS RENEWED.

This home has been determined to be in substantial compliance with applicable rules.

I verify that the findings reported above for this organization are true to the best of my knowledge.

Consultant Date

Wally Vercauv 7/1/92

The Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, or political beliefs.

ADULT FOSTER CARE LICENSING TRANSACTION
Michigan Department of Social Services

2. Lic. Action: 1
3. Lic. No.: 294
4. Cons. No.: 046
7. Fac. Name: SUMMIT HOME
8. St. Addr.: SILVER TERR 1 LOT 3&4
9. City: WATERVLIET
10. St.: MI
11. Zip.: 49098
12. Tel. No.:
13. Co.: 11
14. Orig. App. Date: 100291
15. Zoning Auth.: 0227
16. Mail Code: 2
17. Lic. Eff. Dt.:
19. Fac. Type: SG
20. Rule Viol.:
21. Act Viol.: NO

a. Fire 0
b. Envir. 0
c. Qual. 0
d. Admin. 0
e. TOTAL 0

22. AIS/MR: 1
23. CLF/DD: 2
24. CLF/MI: 2
25. Lic. Type: 0
27. Cont. Agencies: A. 00 B. 00 C. 00
28. Capacity: 006
30. Prev. Lic. No.:
32. Appeal Type: 0
33. Appeal Date:
34. Close Reason: 00
35. Close Cause: 00
36. Close Date:

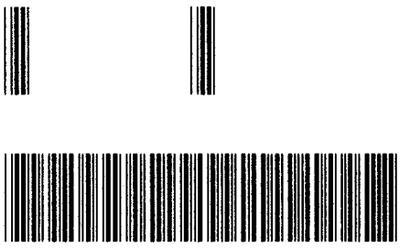
37. Oper. Name: LADD INC
38. St. Addr.: 8054 ORTONVILLE RD
39. City: CLARKSTON
40. St.: MI
41. Zip.: 48016
42. Tel. No.: 3136253870
43. Auspices: 1
44. Corp. Status: 2

45. Dev. Agn. Name: SOUTHWEST MI COMM LIVING SERV
46. St. Address: 10 THIRD STREET
47. City: COLDWATER
48. St.: MI
49. Zip.: 49036
50. Tel. No.: 0000000000
51. Contact Person:

DSS-3193 (facsimile) Date: 10/04/91

L I C E N S I N G T R A N S A C T I O N R E C O R D

LICENSE NO.: * *



TRANSACTION NO.: *AFA1089L65610*

Action Date: 10/04/91

Facility Name: SUMMIT HOME

Licensing Action: 1 Enrollment

Assigned Consultant: 046

STATE OF MICHIGAN

JOHN ENGLER, Governor

DEPARTMENT OF SOCIAL SERVICES

GERALD H. MILLER, Director

KALAMAZOO COUNTY
DEPARTMENT OF SOCIAL SERVICES
322 Stockbridge
Kalamazoo, Michigan 49001

TRANSMITTAL LETTER

June 22, 1992

Gloria Mitzelfeld, Administrator
Living Alternatives for the Developmentally Disabled, Inc.
P.O. Box 965
Clarkston, MI 48374

RE: Summit Home
License #SG1100073

Dear Ms. Mitzelfeld:

Attached is the Licensing Study Report for Summit AIS/MR.

Based upon compliance with the Administrative Rules and the Adult Foster Care Licensing Act, a Temporary License will be issued. The terms of your License will enable you to provide a General Program for 006 adults. The effective dates of the License are 07/07/92 through 01/06/93.

Please review all of the documents carefully.

As required by Act 218 (1979), Section 9(2), the Department provides Technical Assistance to assist Homes and Facilities in meeting the requirements of the Licensing Act and the Administrative Rules. The Department also provides consultation, upon written request, to assist Homes and Facilities to improve services to adults.

If you have further questions, please feel free to contact me at: **322 Stockbridge Avenue, Kalamazoo, Michigan 49001** or by phone at **(616) 388-6483.**

Sincerely,

Wally Versaw

Wally Versaw, AFC Licensing Consultant
KALAMAZOO COUNTY DEPARTMENT OF SOCIAL SERVICES

WV:nf-w

Attachment

cc: Central Office File
Berrien County D.S.S.
Berrien County C.M.H.
Michigan Dept. of Public Health, Annette Haas
Case File

RECYCLED PAPER

LICENSING STUDY REPORT

I. LICENSING DATA

Facility Name:	Summit Home
Facility Address:	444 Summit Street Watervliet, MI 49098
Facility Telephone:	(616) 463-3096
Facility License Number:	SG1100073
Licensee Name:	Living Alternatives for the Developmentally Disabled, Inc.
Licensee Address:	P.O. Box 965 Clarkston, MI 48347
Licensee Telephone:	(313) 625-3870
Program Designation:	Developmentally Disabled (AIS/MR)
Population Served:	Developmentally Disabled
Responsible Agencies:	SMCLS Riverwood CMH - effective 08/01/92
Zoning Authority:	Watervliet
Zoning Approval Date:	FFHAA
Environmental Certification:	04/28/92
Fire Safety Certification:	06/26/92
Original License Date:	07/07/92
Directory Information:	Capacity - 006 Age Range - 18 and over Gender - Males & Females Barrier Free - Yes Smokers - Not admitted
Purpose of Study:	Application dated 10/02/91
Date of On-site Inspection:	06/25/92

Directions to Facility: I-94 to M-140 exit - toward Watervliet to Lucinda Lane - left to Pleasant Street - left to Summit - on corner.

II. SUMMARY OF FINDINGS

The Study is based upon Act No. 218 of the Public Acts of 1979, as amended, and the Administrative Rules governing operation of Adult Foster Care Facilities. Included in the inspection was a review of policies and practices regarding resident care, resident programming, and Administrative Management as well as Fire and Environmental Safety. The findings of the on-site inspection are as follows:

A. Administrative Structure:

L.A.D.D., Inc. is the Licensee. The Michigan Department of Mental Health is the renters of the Facility. The primary caregivers is Teresa Shave, Program Manager and Thomas Hutchinson, Home Manager. Other designated responsible persons include: Shift leaders as designated.

A review of the application and support documents such as the Financial Statement and Medical Information Form indicate substantial compliance with the applicable Rules regarding Administrative Structure and capability of the Licensee.

B. Admission Criteria:

L.A.D.D., Inc. has filed an Admission Policy with the Department. The provider prefers to care for both men and women who are developmentally disabled. Residents must be ambulatory and ages 18 and over. Smokers are not accepted. Residents using wheelchairs can be accommodated. Residents are accepted in accordance with AIS/MR contract criteria.

C. Facility Program:

L.A.D.D., Inc. will provide an AIS/MR Program which includes basic self-care, habilitation training and transportation. In addition to providing supervision and personal care, the following programs/activities are provided: Adult activity center or appropriate education programs. Also, resident social/recreational activities will be provided.

D. Physical Plant:

1. Physical Description of Facility

This facility was constructed to replace the Lucinda Home (SG1100066) which is located a few blocks away and, in general, will be receiving by transfer the same residents, staff, files, furniture, etc.

Unlike the Lucinda Home, this facility was designed and constructed to meet the currently defined needs and regulatory standards of the client population. All accommodations are on the first floor and laid out to facilitate the delivery of services in a home-like setting.

2. Fire Safety

On 06/26/92, a Fire Safety Report was completed. The Report indicated this Facility is in substantial compliance with Rules pertaining to Fire Safety.

3. Environmental Report

On 04/28/92, an Environmental Report was completed. The Report indicated this Facility is in substantial compliance with Rules pertaining to Environmental Safety.

4. Emergency Procedures

In accordance with Rule 361 a written procedure in case of fire or other emergency is available. Emergency telephone numbers are posted near the telephone. Fire Drills are being held quarterly. Fire drills are recorded on a regular basis.

E. Items of Non-Compliance with the Administrative Rules:

Quality of Care

Compliance with the Rules pertaining to the quality of resident care in this new facility will be determined at the time that the temporary license is renewed.

Physical Plant

None

III. **RECOMMENDATIONS**

Based upon the Licensing Evaluation, I recommend that a Temporary License be issued for six (6) months.

The terms of the License will enable the Licensee to provide a General Program which consists of basic self-care, habilitation training, and transportation for 006 residents.

7/1/92
Date

Wally Versaw
Wally Versaw, AFC Licensing Consultant

WV:nf-w

STATE OF MICHIGAN

JOHN ENGLER, GOVERNOR

DEPARTMENT OF SOCIAL SERVICES

235 South Grand Avenue, P.O. Box 30037, Lansing, MI 48909

Gerald H. Miller, Director

10/04/91

GLORIA MITZELFELD
SUMMIT HOME
8054 ORTONVILLE RD
CLARKSTON MI, 48016

Re: SUMMIT HOME
SILVER TERR 1
WATERVLIET MI, 49098

Dear GLORIA MITZELFELD,

This letter is to notify you that your application for a license to operate a SMALL GROUP HOME with a capacity of 6 has been received.

I am the licensing consultant who has been assigned to your application. If you have any questions, please contact me.

Sincerely,

Wally Versaw
Licensing Consultant
Division of AFC Licensing
322 Stockbridge

Kalamazoo MI, 49001

(616) 388-6483

ADULT FOSTER CARE LICENSING TRANSACTION

Michigan Department of Social Services

1. Transaction Number	2. Lic. Action	3. License Number
	ENROLL	SG1100873

4. Consultant Number	5. Consultant Name	6. Supv. Number
045	VERSAW MALLY	04

FACILITY/HOME IDENTIFICATION (Do not write in shaded area)

7. Facility/Home Known As: SUMMIT HOME

8. Street Address: SILVER TERR 1 LOT 364

9. City/Village: WATERVLIET | 10. St: MI | 11. Zip Code: 49098 | 12. Telephone Number | 13. Co.: BERRIEN 11

14. Application Date	15. Zoning Authority	16. Mail Code	17. Lic. Effective Date	18. Lic. Exp. Date	19. Facility Type
10/02/91	0227	OPER			SML GRP HMC(1-6)

20. Rule Violations		21. Act Violations	22. AIS/MR	23. CLF/DD	24. CLF/MI	25. License Type
Fire Safety	00	NO	YES	NO	NO	
b. Environmental	00					
c. Quality of Care	00					
d. Admin. Mgmt.	00					
e. TOTAL	00					

26. Program Certification		27. Contract Agency(ies)	
a. Physically Handicapped	NO	a.	NONE
b. Developmentally Disabled	NO	b.	
c. Mentally Ill	NO	c.	
d. Aged Persons	NO		

28. Capacity: 006

29. Interim Visit: N/R

30. Previous License Number:

31. Previous Transaction Number: F9141121

32. Appeal Type	33. Appeal Date	34. Close Reason	35. Close Cause	36. Close Date
NONE				

OPERATOR/PARENT ORGANIZATION IDENTIFICATION

37. Name: LADD INC

38. Street Address: 8054 ORTONVILLE RD

39. City/Village: CLARKSTON | 40. St: MI | 41. Zip Code: 48016

42. Telephone Number: 313/625-3870 | 43. Auspices: NON GOVT | 44. Corporate Status: NONE

DEVELOPING AGENCY IDENTIFICATION

45. Name: SOUTHWEST MI COMM LIVING SERV

46. Address: 10 THIRD STREET

47. City/Village: COLDWATER | 48. St: MI | 49. Zip Code: 49036

50. Telephone Number | 51. Contact Person

CENTRAL OFFICE

52. Consultant Signature	53. Date	54. Supervisor Signature	55. Date

DSS-[redacted] (Rev. 10-84) Previous edition may be used.

STATE OF MICHIGAN

JOHN ENGLER, Governor

DEPARTMENT OF SOCIAL SERVICES

GERALD H. MILLER, Director

KALAMAZOO COUNTY
DEPARTMENT OF SOCIAL SERVICES
322 Stockbridge
Kalamazoo, Michigan 49001

August 9, 1991

Cindy Muth
340 N. Summitt Drive
Watervliet, MI 49098

Dear Mrs. Muth:

Thank you for speaking with me on the telephone and your willingness to accept this response to the 08/02/91 letter from citizens concerned about the establishment of an Adult Foster Care facility in Watervliet.

I have informed you and others who have telephoned their concerns that the Adult Foster Care Licensing Division has not received an application for licensing the proposed facility at this time and has not participated in the planning of the proposed facility.

If the facility is actually developed, we can assume that application will be made to operate it under Act No. 218 of the Public Acts of 1979, as amended, (The Adult Foster Care Facility Licensing Act), and the Licensing Rules. I am sending copies of these documents in a separate envelope for the group's information.

As far as I know, all persons expressing similar concerns to this office have been referred to Mr. Jerry Pieh, Southwest Michigan Community Living Services, 620 Marshall Road, Coldwater, Michigan 49036 who we believe would be the appropriate source of information at this time.

I am taking the liberty of forwarding the letter sent to me by the concerned citizens and a copy of this response to Mr. James Quigley, Director, Adult Foster Care Licensing Division, 235 South Grand Avenue, P.O. Box 30037, Lansing, Michigan 48909 for his information and review.

Although the response contained in this letter may not equal the requests that your group would like to make of Adult Foster Care Licensing, please remember that I have no authority to enter the matter without an application for a license.

RECYCLED PAPER

August 2, 1991

RECEIVED
AUG - 8 1991
AFC LICENSING DIV.
Mich. Dept. of Social Services

Mr. W. Versaw
Michigan Department of Social Services
322 Stockbridge
Kalamazoo, Michigan 49001

Dear Mr. W. Versaw:

It has come to my attention that the Michigan Department of Mental Health, with the approval of the Berrien County Department of Mental Health, is contemplating the relocation of an adult foster care facility from St. Joseph's Catholic Church property to the two vacant lots (Lots 3 and 4, Silver Terrace Addition Number 1) at the northeast corner of Summit Drive and South Pleasant Street in the City of Watervliet. Since the property in question is zoned R-1 (Single family), I feel this proposal is not in the best interests of the Sub-division or the residents of the area.

It would seem that our current economic woes would prompt some prudent fiscal thinking before spending many thousands of dollars to relocate the client two blocks from an Adult Foster Care facility that has been adequate for several years. As a representative of the people, I strongly urge you to recommend that this project be halted immediately, if for no other reason than that of questionable fiscal soundness. It would be more practical to upgrade the existing facility to a barrier free status than to erect a new facility.

There are many question and concerns about this proposal and no one seems to have the information or is willing to discuss it with the residents of the area. I do not feel that the people in charge of the project, for whatever reasons, are able, or willing to discuss the matter with me and my neighbors.

Traffic, drainage, noise, property values, zoning, deed restrictions, and safety are just a few of my concerns. Since we, the people, essentially, are the government, why are we not given some consideration in this matter? Rumors and guesses are running rampant at this time and we, as residents, feel we need some open and honest dialogue. We have been given generalities, half-truths and generally been stonewalled. I find it reprehensible that state employees connot give me an honest straightforward answer.

Please bring your influence to bear to remedy this situation.

Sincerely,

David & Cindy Muth
Suzi Anthony Sagliardo
Shirley & Richard Callendar
Meldred & Kay Hutchens
Christine A. Vonderheid
Joseph P. Vonderheid
Timothy & Joyce Brad Dlouhy
Andrea Steffens
Anna D. Hauch

cc: Governor John Engler
Senator Harry Gast, Jr.
Representive Robert L. Brackenridge
Commissioner Kenneth L. Wendzel
Bishop Paul V. Donovan
Mayor Robert E. Flaherty
Mr. Jeremy Peih
Mr. W. Versaw

Albert R Steffens

12. Number of Adults I would prefer to accommo	13. I would prefer	14. Ages
6	☐ Males ☐ Females ☒ Males and Females	18 AND OLDER

15. Type of resident population to be accommodated (A separate program statement must be submitted for each type of resident population checked)

- ☒ 1. Developmentally Disabled
- ☐ 2. Social Emotional Problems
- ☐ 3. Physically Handicapped
- ☐ 4. Aged
- ☐ 5. Other _____

16. Names of three persons to whom the Department may provide "Reference Questionnaires" for completion. (You may use your physician if you like.)

Name of Reference	Address	Occupation
RICHARD DOBBECK	57 CHURCH ST. MT CLEMENS, MI	DIRECTOR MACOMB FAMILY SERVICES
E.J. DEHUT	P.O. BOX 846 ROCH, MI 48308	DIRECTOR PROGRESSIVE RESIDENTIAL
JON GARRETT	BUHL BLDG DETROIT, MI	ATTORNEY

17. Directions for reaching facility from DSS office.

18. Current Zoning Status or Classification	19. Date Started as AFC Facility at this Location	20. Ownership of Facility to be Licensed
RESIDENTIAL	NEW CONSTRUCTION	☐ Own ☒ Rent ☐ Buying

21. If Renting, Please Complete the following.

Name of Owner (last, first, middle)	Phone	Street Address	City	Zip
TO BE SUBMITTED				

22. In addition to the above information, the following material will also be required as part of the Adult Foster Care Licensing Application:

(If this application is for renewal of your license, submit only those items circled.)

1. Program Statements
2. Completed Medical Release and Request for Information Form(s) for the Applicant and Employees
3. Spouse's Concurrence Statement If Living in the Facility and Not a Joint Application. (Complete Item 12 on this Form.)
4. Names and Employment Positions, Qualifications and Job Descriptions for all Staff (employees) Working in the Facility.
5. A Copy of any Existing Foster Care Agreement and Contract between the Facility and a Sponsoring Agency.
6. Admission Policy Statement Including Specification of Facility Rates and Charges.
7. Part 2 of the Application Fee Transmittal Form (DSS-2066)

23. List all persons with ownership interest in the facility. (Either property or business) Use additional sheets if necessary.

Name	Address	City	Zip

24. If the Applicant is a Corporation, attach the following information. ☐ Profit ☒ Non-Profit

1. Articles of Incorporation
2. List of Board of Directors (including name, title, address and phone number)
3. Description of Administrative Structure

Complete Items 25 - 29 only if you are applying for a group home or congregate facility; all others go to Item 28.

25. Floor plan with measurements (small group, large group and congregate facilities only)
26. Financial statement and proposed annual operating budget (group and congregate facilities only)
27. Approval from zoning authority for special or conditional use permit if you are applying for a capacity of 7 or more residents.

28. Applicant Signature	29. Date	30. Joint Signature	31. Date
[signature]	9-23-91		

32. Return Application To:

ATTN: Adult Foster Care Licensing Consultant

RECEIVED
OCT - 2 1991
AFC LICENSING DIV.
Mich. Dept. of Social Services

DSS-3[illegible] (Rev. 4-86) (Back)

AUTHORITY: Act 218, PA of 1979.
COMPLETION: Is required.
CONSEQUENCE OF NONCOMPLIANCE: Applicant cannot be licensed.

The Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, or political beliefs.

Please feel free to telephone me at (616) 388-6483 if there are further questions about Adult Foster Care Licensing concerns.

Sincerely,

Wally D. Versaw

Wally D. Versaw, AFC Licensing Consultant
KALAMAZOO COUNTY DEPARTMENT OF SOCIAL SERVICES

WDV:nf-w

cc: James B. Quigley, Director AFC Licensing
Joseph Nied, Supervisor
AFC Licensing