



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

SHELLY EDGERTON  
DIRECTOR

March 1, 2018

Shaunteka Dawkins  
605 Oak Ave.  
Muskegon, MI 49442

RE: Application #:	AS610390844 Loving Orchards 922 Orchard Muskegon, MI 49442
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Dear Ms. Dawkins:

Attached is the Original Licensing Study Report for the above referenced facility. The study has determined substantial compliance with applicable licensing statutes and administrative rules. Therefore, a temporary license with a maximum capacity of 5 is issued.

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 (616) 356-0100.

Sincerely,

Elizabeth Elliott, Licensing Consultant  
Bureau of Community and Health Systems  
Unit 13, 7th Floor  
350 Ottawa, N.W.  
Grand Rapids, MI 49503  
(616) 901-0585

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
BUREAU OF COMMUNITY AND HEALTH SYSTEMS  
LICENSING STUDY REPORT**

**I. IDENTIFYING INFORMATION**

<b>License Application #:</b>	AS610390844
<b>Applicant Name:</b>	Shaunteka Dawkins
<b>Applicant Address:</b>	605 Oak Ave. Muskegon, MI 49442
<b>Applicant Telephone #:</b>	(231) 457-7758
<b>Administrator/Licensee:</b>	Shaunteka Dawkins
<b>Name of Facility:</b>	Loving Orchards
<b>Facility Address:</b>	922 Orchard Muskegon, MI 49442
<b>Facility Telephone #:</b>	(231) 457-7758
<b>Application Date:</b>	10/09/2017
<b>Capacity:</b>	5
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL PHYSICALLY HANDICAPPED AGED

## II. METHODOLOGY

10/09/2017	Enrollment
10/10/2017	Application Incomplete Letter Sent 1326/Fingerprint/RI 030 for Shaunteka Jones (Dawkins)
01/03/2018	Contact - Document Received 1326/Fingerprint/RI 030 for Shaunteka Dawkins and revised application forms.
01/04/2018	File Transferred To Field Office Grand Rapids
01/12/2018	Application Incomplete Letter Sent
01/22/2018	Contact - Telephone call received Applicant Shaunteka Dawson. Set date for initial inspection.
02/06/2018	Inspection Completed On-site
02/06/2018	Inspection Completed-BCAL Sub. Compliance
02/15/2018	Contact - Face to Face Corrections made.
02/16/2018	Contact - Telephone call made Applicant re: interconnected smoke detectors.
02/23/2018	Contact - Face to Face Interconnected smoke detection
02/23/2018	Inspection Completed-BCAL Full Compliance
03/01/2018	Recommend License Issuance

## III. DESCRIPTION OF FINDINGS & CONCLUSIONS

### **A. Physical Description of Facility**

This Cape Cod style home in the City of Muskegon has 2 resident bedrooms and a full bathroom for resident use on the main floor. Upon entrance through the front door, you pass through the living room then the kitchen and dining room in the back area of the house, all of these rooms are for resident use. The upper level of the home has 2 more resident bedrooms and a half bath for resident use. The home is not wheelchair accessible and cannot accommodate residents that require the use of a wheelchair.

There are 2 approved means of egress from the main floor of the home. The home utilizes public water and sewer.

The gas furnace and hot water heater are located in the basement with a 1-3/4 inch solid core door equipped with an automatic self-closing device and positive latching hardware located at top of stairs. The facility is equipped with interconnected, hardwire smoke detection system with battery backup and is fully operational.

Resident bedrooms were measured during the on-site inspection and have the following dimensions:

Bedroom #	Room Dimensions	Total Square Footage	Total Resident Beds
1	11.66 X 11.83	137.93	2
2	11.75 X 9.42	110.68	1
3	11.75 X 11.58	136	1
4	12 X 11.83 Minus-2.17 X 4.75	131.66	1

The living, dining, and sitting room areas measure a total of 572.87 square feet of living space. This exceeds the minimum of 35 square feet per occupant requirement.

Based on the above information, it is concluded that this facility can accommodate **five (5)** residents. It is the licensee's responsibility not to exceed the facility's licensed capacity.

## **B. Program Description**

Admission and discharge policies, program statement, refund policy, personnel policies, and standard procedures for the facility were reviewed and accepted as written. The applicant intends to provide 24-hour supervision, protection and personal care to **five (5)** male or female ambulatory adults whose diagnosis is developmentally disabled, physically handicapped, aged or mentally impaired, in the least restrictive environment possible. The program will include social interaction skills, personal hygiene, personal adjustment skills, and public safety skills. A personal behavior support plan will be designed and implemented for each resident's social and behavioral developmental needs. The applicant intends to accept residents from Muskegon County-DHHS, other area County CMH, or private pay individuals as a referral source.

If required, behavioral intervention and crisis intervention programs will be developed as identified in the assessment plan. These programs shall be implemented only by trained staff, and only with the prior approval of the resident, guardian, and the responsible agency.

The licensee will provide all transportation for program and medical needs. The facility will make provision for a variety of leisure and recreational equipment. It is the intent of

this facility to utilize local community resources including public schools and libraries, local museums, shopping centers, and local parks.

### **C. Applicant and Administrator Qualifications**

The applicant has reported sufficient financial resources to provide for the adequate care of the residents and a review of the applicant's credit report and the budget statement submitted to operate the adult foster care facility has been reviewed. The applicant also has cash in savings and income from the applicant's spouse who has outside employment income.

A licensing record clearance request was completed with no LEIN convictions recorded for the applicant and the administrator (same). The applicant and administrator (same) submitted a medical clearance request with statements from a physician documenting their good health and current TB-tine negative results.

The applicant and administrator (same) have provided documentation to satisfy the qualifications and training requirements identified in the administrative group home rules.

The staffing pattern for the original license of this 5 bed facility is adequate and includes a minimum of 1 staff –to- 5 residents per shift. The applicant acknowledges that the staff –to- resident ratio will change to reflect any increase in the level of supervision, protection, or personal care required by the residents. The applicant has indicated that direct care staff will be awake during sleeping hours.

The applicant acknowledged that at no time will this facility rely on “roaming” staff or other staff that are on duty and working at another facility to be considered part of this facility's staff -to- resident ratio or expected to assist in providing supervision, protection, or personal care to the resident population.

The applicant acknowledges an understanding of the qualifications, suitability, and training requirements for direct care staff prior to each person working in the facility in that capacity or being considered as part of the staff -to- resident ratio.

The applicant acknowledged an understanding of the responsibility to assess the good moral character of employees and contractors who have regular, ongoing, “direct access” to residents or the resident information or both. The licensing consultant provided technical assistance on the process for obtaining criminal record checks utilizing the Michigan Long Term Care Partnership website ([www.miltcpartnership.org](http://www.miltcpartnership.org)) and the related documents required to be maintained in each employee's record to demonstrate compliance.

The applicant acknowledges an understanding of the administrative rules regarding medication procedures and that only those direct care staff that have received medication training and have been determined competent by the licensee, can

administer medication to residents. In addition, the applicant has indicated that resident medication will be stored in a locked cabinet and that daily medication logs will be maintained on each resident receiving medication.

The applicant acknowledges their responsibility to obtain all required good moral character, medical, and training documentation and signatures that are to be completed prior to each direct care staff or volunteer working directly with residents. In addition, the applicant acknowledges their responsibility to maintain all required documentation in each employee's record for each licensee or licensee designee, administrator, and direct care staff or volunteer and follow the retention schedule for those documents contained within each employee's record.

The applicant acknowledges an understanding of the administrative rules regarding the admission criteria and procedural requirements for accepting a resident into the home for adult foster care.

The applicant acknowledges their responsibility to obtain the required written assessment, written assessment plan, resident care agreement, and health care appraisal forms and signatures that are to be completed prior to, or at the time of each resident's admission to the home as well as updating and completing those forms and obtaining new signatures for each resident on an annual basis.

The applicant acknowledges their responsibility to maintain a current resident record on file in the home for each resident and follow the retention schedule for all of the documents that are required to be maintained within each resident's file.

The applicant acknowledges an understanding of the administrative rules regarding the handling of resident funds and valuables and intends to comply. The applicant acknowledges that a separate *Resident Funds Part II BCAL-2319* form will be created for each resident in order to document the date and amount of the adult foster care service fee paid each month and all of the resident's personal money transactions that have been agreed to be managed by the applicant.

The applicant acknowledges an understanding of the administrative rules regarding informing each resident of their resident rights and providing them with a copy of those rights. The applicant indicated that it is their intent to achieve and maintain compliance with these requirements.

The applicant acknowledges an understanding of the administrative rules regarding the written and verbal reporting of incidents and accidents and the responsibility to conduct an immediate investigation of the cause. The applicant has indicated their intention to achieve and maintain compliance with the reporting and investigation of each incident and accident involving a resident, employee, and/or visitor.

The applicant acknowledges their responsibility to provide a written discharge notice to the appropriate parties when a 30-day or less than 30-day discharge is requested.

The applicant acknowledges that residents with mobility impairments may only reside on the main floor of the facility.

**D. Rule/Statutory Violations**

The applicant was in compliance with the licensing act and applicable administrative rules at the time of licensure.

**VI. RECOMMENDATION**

I recommend issuance of a six-month temporary license to this adult foster care small group home (capacity 5).



03/01/2018

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Elizabeth Elliott  
Licensing Consultant

Date

Approved By:



03/01/2018

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Jerry Hendrick  
Area Manager

Date