RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

December 28, 2017

Tamika Ruth
514 S. Ortman Street
Saginaw, MI 48601

RE: License #: AS730377214
Investigation #: 2018A0572009
Annie's Home Care

Dear Ms. Ruth:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (810) 787-7031.

Sincerely,

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730377214
Investigation #:	2018A0572009
Complaint Receipt Date:	12/12/2017
Investigation Initiation Date:	12/14/2017
Report Due Date:	02/10/2018
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:	05/16/2016
Expiration Date:	05/15/2018
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED

	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was dropped off 1/2 hour before an event, to wander around the parking lot unsupervised. Resident A was there for a total of 3 hrs. A call was made for someone to pick Resident A up, but instead - they dropped off 2 additional residents. Multiple calls were made to the home to pick up the residents. The residents were out in the cold waiting multiple times because they were told someone was on their way. Residents left unsupervised for an extended time.	No

III. METHODOLOGY

12/12/2017	Special Investigation Intake 2018A0572009
12/14/2017	Special Investigation Initiated - On Site Licensee, Tamika Ruth and Resident A.
12/14/2017	Contact - Telephone call received Resident A's Case Manager, Jamie Smith.
12/14/2017	Contact - Telephone call made Left message with Complainant.
12/14/2017	Contact - Telephone call received Complainant Left voicemail.
12/27/2017	Exit Conference Licensee, Tamika Ruth.
12/28/2017	APS Referral APS Referral made.

ALLEGATION:
Resident A was dropped off 1/2 hour before an event, to wander around the parking lot unsupervised. Resident A was there for a total of 3 hrs. A call was made for someone to pick Resident A up, but instead - they dropped off 2 additional residents. Multiple calls were made to the home to pick up the residents. The residents were out in the cold waiting multiple times because they were told someone was on their way. Residents left unsupervised for an extended time.

INVESTIGATION:
On 12/12/2017, the local licensing office received a complaint for investigation. On 12/14/2017, a voicemail was left with the Complainant.

On 12/14/2017, an unannounced onsite visit was conducted at Annie's Home Care, located in Saginaw County. The Licensee, Tamika Ruth and Resident A were both interviewed.

On 12/14/2017, Ms. Tamika Ruth was interviewed regarding Resident A being left unattended in the parking lot of an event. Ms. Ruth informed that there was a Christmas Party Gift Card Event at the Anderson Center that Resident A attended from 1pm to 4pm. Ms. Ruth indicated that because Resident A is her own guardian, she contacted Resident A's Case Manager, Jamie Smith to see was it okay if she attended the event by herself. According to Ms. Ruth, Ms. Smith indicated that since Resident A is able to go out into the community on her own and is able to feed herself, there is not a problem. Ms. Ruth informed that she does not know where this is coming from, other than the fact that she received a call on her cellphone from a lady at the event that they had been calling her to say that Resident A needed a ride back home. Ms. Ruth informed that she had never spoke with anyone regarding picking Resident A up from the program until then and that they must have called the house phone. Ms. Ruth indicated that when they called the house phone, one of the residents must have been on the phone at the time and didn't relay the message. Ms. Ruth indicated that the house phone is open to all of the residents. She informed that Resident A must have gave them her cellphone. When asked if she refused to pick Resident A up after the phone call, she informed that she immediately called her ride, but her ride was already pulling into the parking lot. Ms. Ruth estimated that the call on her cellphone was received at about 3:30pm and the residents were picked up no later than 3:45pm. Ms. Ruth explained that two of her Residents were invited to an event from 1pm to 4pm. Resident A was dropped off at the event at approximately 1pm and Resident B was taken to a scheduled 1:20pm appointment. After the appointment, Resident B was taken to the Christmas Party also. Ms. Ruth stated, "Whomever called, called the house phone first and must have spoken to a resident, then they called my cellphone and said that Resident A was ready to go. I called their ride and they were already pulling up into the driveway."

On 12/14/2017, I spoke with Resident A regarding the Christmas Party event at the Anderson Center. I asked Resident A did she attend a Christmas Party and she replied, “Yes.” When asked did she ever go inside the building, she stated, “Yes. They gave me a name tag at the door.” Resident A was asked how long she was there and she stated, “From 1pm – 4pm.” She was asked if she liked the event and she informed that it was good. When asked if she received any gift cards, she stated, “Yes. Two of them. The Dollar Tree and Meijers.” Resident A was asked if she was outside in the parking lot and she stated, “No. The only time we go outside in the parking lot is to get into people’s cars to leave.” Resident A was informed that when she did go to the parking lot, it was time to leave. Resident A was asked several other questions and it was found that Resident A utilizes the public bus system by herself and uses it to go to stores, program and to visit friends. Resident A also informed that she was not left by herself and when it was time to go, her ride came.

On 12/14/2017, Resident A’s Case Manager, Jamie Smith called the Licensee, Tamika Ruth. After a short conversation, Ms. Ruth informed her that licensing was there conducting an investigation and asked if she had a moment to speak with me. An interview was conducted with Ms. Smith, regarding allegations that Resident A was left outside in the parking lot unsupervised. Ms. Smith informed that she is the case manager for both Resident A and Resident B and they are both their own guardian and are able to go out into the community on their own. Ms. Smith informed that both residents are capable of using the bus system and they both have cellphones. Ms. Smith stated, “It’s strange, I never received a call from anyone that my people were left unattended.” Ms. Smith informed that Ms. Ruth called her to make sure that it was okay for the residents to attend on their own and that it was her fault if she steered Ms. Ruth the wrong way because maybe there was a policy that she was not aware of indicating that someone needed to be there with the residents. Ms. Smith indicated again that both residents are able to go out into the community on their own without supervision and they both have cellphones. Ms. Smith was informed that the allegations were in regards to Resident A because she was there the entire time, while Resident B was at a scheduled appointment and did not attend until the latter part of the event.

On 12/14/2017, I reviewed Resident A’s Assessment Plan. It indicates that Resident A is able to move independently within the community. The Assessment Plan was signed on 12/05/2017.

On 12/14/2017, I reviewed Resident A’s PCP and it states, “(Resident A) attends SVRC three days a week, outings with the AFC and attends church weekly. She likes to walk around the community and visit with friends and family.”

On 12/27/2017, an exit conference was held with Licensee, Tamika Ruth. She was informed that there was no rule violations found during the investigation. Ms. Ruth informed that the program had a meeting following this investigation. There was a

volunteer who was working the event and did not know that there would be residents there that are able to attend the event by themselves.

On 12/28/2017, an APS Referral was made. The referral reported the allegations received in this complaint.

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:	Resident A denies being left unattended in the parking lot. The Licensee and Resident A's Case Manager, informed that Resident A is her own guardian and able to go out into the community on her own.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

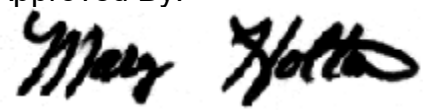
I recommend no change to the licensing status of this small adult foster care group home (Capacity 1-6).

12/28/2017

_____

Anthony Humphrey Date
Licensing Consultant

Approved By:



12/28/2017

_____

Mary E Holton Date
Area Manager