RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

May 23, 2018

Tamika Ruth
514 S. Ortman Street
Saginaw, MI 48601

RE: License #: AS730377214
Investigation #: 2018A0572028
Annie's Home Care

Dear Ms. Ruth:

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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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 #:	2018A0572028
Complaint Receipt Date:	04/10/2018
Investigation Initiation Date:	04/10/2018
Report Due Date:	06/09/2018
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?
On 04/10/2018, residents were observed to be unattended by staff. Licensing Consultant & APS Workers both stayed at the facility until the licensee returned to the home.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/10/2018	Special Investigation Intake 2018A0572028
04/10/2018	APS Referral APS made referral.
04/10/2018	Special Investigation Initiated - On Site
04/13/2018	Exit Conference Licensee, Tamika Ruth.
04/13/2018	Inspection Completed-BCAL Sub. Compliance
05/02/2018	Licensee, Tamika Ruth.
05/21/2018	Exit Conference Licensee, Tamika Ruth.

ALLEGATION:
On 04/10/2018, residents were observed to be unattended by staff. Licensing Consultant & APS Worker both stayed at the facility until the licensee returned to the home.

INVESTIGATION:
On 04/10/2018, a complaint was received from Adult Protective Services (APS) for investigation.

On 04/10/2018, APS Investigator, Katrice Humphrey contacted me regarding Annie's Home Care. Ms. Humphrey was dropping off paperwork for licensing and conducting a home visit to close out a previous investigation. Ms. Humphrey contacted me and asked if the facility was supposed to be staffed and she was informed that it does if there are residents in the home. Ms. Humphrey informed that there are residents in the home, but there are no staff. She indicated that a resident opened the door and he appeared to be staff, but she knew from previous encounters with the home and a previous licensing investigation with a different licensing worker, that the person she was speaking with was not staff.

On 04/10/2018, I met with APS Investigator, Katrice Humphrey at Annie's Home Care. We spoke with all of the residents in the home and they indicated that staff had been gone for about an hour. When speaking with Resident A, he informed that he was the only staff there. When asked who supervises the residents while the owner or staff is not home and he indicated that he helps out and supervise sometimes. Resident A was sitting at the Office Desk as if he was staff. When asked was there any other staff that were at the home, he indicated just him and that the Licensee, Tamika Ruth should be home any minute. Resident A called Keith Bulger, who owns the home and informed him that the State of Michigan were at the home.

On 04/10/2018, I interviewed Staff, Keith Bulger when he arrived at the home. Mr. Bulger is the owner of the home and fiancé of the Licensee, Tamika Ruth. He informed that he did not know that the residents were home alone. He indicated that he was only gone for about 30 minutes and that they had someone there with the residents. Mr. Bulger indicated that he was not aware that the residents were by themselves until Resident A called him.

On 04/10/2018, I interviewed Licensee, Tamika Ruth when she arrived at the home. She informed that her son was the staff in charge and did not know that he had left the facility. Ms. Ruth tried calling him, but he did not answer.

On 04/13/2018, I re-interviewed Licensee, Tamika Ruth. She informed that she terminated her son because he left the residents alone in the home and did not call her back when she tried calling him. She indicated that he just showed up to the home after we (Licensing and APS) left her home. She informed that her son, Cameron Mitchell said he left to go to Rally's because he needed a break. She

indicated that he was working sparingly because he had another job, but she had to give him some more hours because she was getting burned out. Ms. Ruth informed that on the day of the incident, she had left about 2:30pm and Keith Bulger had left later on that day when her son Cameron was cooking Hamburger Helper and Green Beans. She informed that Keith Bulger had indicated to her that he was only gone 30 minutes before he got a call from Resident A that Licensing and APS was at the home. Ms. Ruth indicated that Resident A believes that he is staff because he grew up in the home as it was originally his mother's home. Resident A believes that he has to maintain the home, keep it clean and he will even try to cut the grass. Ms. Ruth informed that she has tried talking to him to let him know that he is not staff, but it is not registering to him. Ms. Ruth was informed that several workers from various agencies believe that Resident A is staff. Ms. Ruth posted a picture of staff and volunteers in the office so visitors will know who staff is. She also put up a sign which reads, "No Resident Allowed in Office". Ms. Ruth was informed that since residents are allowed to use the phone, she needs to have a system in place because people who call the home believe that Resident A is staff when he answers the phone. Ms. Ruth informed that she will have to get a 2nd line or use her cellphone as the facility number. Ms. Ruth also informed that Resident A may have to move out because he's going to continue to think that he is a staff person and feels obligated to help her and Mr. Bulger out.

On 05/04/2018, APS Investigator, Katrice Humphrey shared her notes from her interview with staff, Cameron Mitchell. In Ms. Humphrey's notes, it indicates that Mr. Mitchell reported that he began working at the Annie's Home Care in February 2016, was a full-time worker and a floater that worked all shifts. He informed that he was working on 04/10/2018 but left because he couldn't handle it anymore and was having a mental breakdown. Mr. Cameron indicated that he no longer works in the facility. Mr. Cameron was unable to name any of the residents in the home since his employment began in February 2016.

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:	The residents in the home were observed being by themselves for at least 30 minutes by licensing and APS. Resident A indicated that he supervises the residents in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 05/02/2018, an unannounced visit was made to Annie's Home Care. Licensee, Tamika Ruth was asked to provide Employee Records. She informed that some of her records are at home and did not know that they had to be in the facility. I went over the records that should be in her Employee Files and she informed that she will get them to me in a couple days.

On 05/10/2018, I reviewed the Employee Records that Licensee, Tamika Ruth provided. The following were missing from the Employee Records:

- Verification of Education/Training
- Medical Information
- Annual Health Review
- Health Review of Volunteers
- TB Testing
- Required Personnel Policies
- Verification of Receipt of Personnel Policies and Job Description
- Good Moral Character
- Competencies in Reporting Requirements
- References
- Staff Schedule

On 05/21/2018, an unannounced visit was made with Licensee, Tamika Ruth. A discussion was made in regards to the missing documents within her Employee Records. She was informed to review pages 6-10 for required documents. She was also given copies of a checklist that indicates everything that needs to be in her Employee File. She was advised to maintain these records in an orderly fashion and to keep each Employee's Records in separate binders.

On 05/04/2018, APS Investigator, Katrice Humphrey shared her notes from her interview with staff, Cameron Mitchell. In Ms. Humphrey's notes, it indicates that Mr. Cameron reported that he did not receive any Community Mental Health Training as it pertains to the population that they are servicing.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before

	performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	At the time of the investigation, there was no evidence that staff working in the facility received training. Former Staff, Cameron Mitchell denies receiving any training as it relates to working with a vulnerable adult population.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.
ANALYSIS:	At the time of the investigation, there were no signed documentation from a licensed physician which indicated that any employees or volunteers are healthy and physically capable of completing the job duties required in an Adult Foster Care Home.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.
ANALYSIS:	At the time of the investigation, there was no evidence that the staff had been tested for TB.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(6) A licensee shall annually review the health status of the administrator, direct care staff, other employees, and members of the household. Verification of annual reviews shall be maintained by the home and shall be available for department review.
ANALYSIS:	At the time of the investigation, there was no evidence that a yearly review of employee's health status was completed.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(7) A licensee shall obtain certification from a volunteer that the volunteer is free from communicable disease and that the volunteers physical and mental health will not negatively affect either the health of the resident or the quality of the resident's care.

ANALYSIS:	At the time of the investigation, there was no evidence that the volunteer had been tested for TB.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14207	**Required personnel policies.**
	(1) A licensee shall have written policies and procedures that include all of the following: **(a) Mandatory reporting, including reporting that is required by law.** **(b) Resident care related prohibited practices.** **(c) Confidentiality requirements, including requirements specified in law.** **(d) Training requirements.** **(e) Resident rights.** **(f) The process for reviewing the licensing statute and administrative rules.**
ANALYSIS:	At the time of the investigation, there was no evidence that the licensee had all of the policies and procedures of the AFC Home in place for review.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14207	**Required personnel policies.**
	(2) The written policies and procedures identified in subrule (1) of this rule shall be given to employees and volunteers at the time of appointment. A verification of receipt of the policies and procedures shall be maintained in the personnel records.
ANALYSIS:	At the time of the investigation, there was no verification found that would indicate that staff members received any written policies and procedures of the AFC Home.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14207	**Required personnel policies.**
	(3) A licensee shall have a written job description for each position. The job description shall define the tasks, duties, and responsibilities of the position. Each employee and

	volunteer who is under the direction of the licensee shall receive a copy of his or her job description. Verification of receipt of a job description shall be maintained in the individuals personnel record.
ANALYSIS:	At the time of the investigation, there were no job description for the employees.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(e)Verification of experience, education, and training.**
ANALYSIS:	At the time of the investigation, some of the experience, education and/or training records were incomplete.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(f)Verification of reference checks.**
ANALYSIS:	At the time of the investigation, there is no evidence that there were any reference checks conducted for their employees.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(h)Medical information, as required.**
ANALYSIS:	At the time of the investigation, there is no evidence that there were any medical information provided to the AFC Home.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 04/10/2018, I met with APS Investigator, Katrice Humphrey at Annie's Home Care. We spoke with all of the residents in the home and they indicated that staff had been gone for about an hour. When speaking with Resident A, he informed that he was the only staff there. When asked who supervises the residents while the owner or staff is not home, and he indicated that he helps and supervises sometimes. Resident A was sitting at the Office Desk as if he was staff. When asked was there any other staff that were at the home, he indicated just him, and that Tamika Ruth should be home any minute. Resident A called Mr. Bulger, who owns the home and informed him that the State of Michigan were at the home.

On 04/13/2018, an interview was conducted with Licensee, Tamika Ruth. She informed that Keith Bulger had indicated to her that he was only gone 30 minutes before he got a call from Resident A that Licensing and APS was at the home. Ms. Ruth indicated that Resident A believes that he is staff because he grew up in the home as it was originally his mother's home. Resident A believes that he has to maintain the home, keep it clean and he will even try to cut the grass. Ms. Ruth informed that he has tried talking to him to let him know that he is not staff, but it is not registering to him. Ms. Ruth was informed that several workers from various agencies believe that Resident A is staff. Ms. Ruth posted a picture of staff and volunteers in the office so visitors will know who staff is. She also put up a sign which reads, "No Resident Allowed in Office". Ms. Ruth was informed that since residents are allowed to use the phone, she needs to have a system in place because people who call the home believe that Resident A is staff when he answers the phone. Ms. Ruth informed that she will have to get a 2nd line or use her cellphone as the facility number. Ms. Ruth also informed that Resident A may have to move out because he's going to continue to think that he is a staff person and feels obligated to help her and Mr. Bulger out.

On 05/10/2018, contact was made with Resident B regarding the residents be left alone in the home. Resident B informed that they were never left alone in the home. Resident B was asked if there were staff working at night. Resident B replied, "Yes, if you count (Resident A) as staff. But I don't know if you would consider him staff because he is a resident. If you don't consider him a employee, then we were left alone at night."

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**
	(1) An administrator and direct care staff shall be persons who are not residents.

ANALYSIS:	At the time of the investigation, there was evidence that the resident at Annie's Home Care were being supervised by Resident A. This is according to Resident A and Resident B and outside agencies.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 04/13/2018, an exit conference was conducted with Licensee, Tamika Ruth regarding the findings of this investigation.

On 05/21/2018, another exit conference was conducted with Licensee, Tamika Ruth regarding additional findings of this investigation.

IV. RECOMMENDATION

It is recommended that no changes be made to the licensing status of this small adult foster care group home, pending the receipt of an appropriate corrective action plan (Capacity 1-6).

05/22/2018

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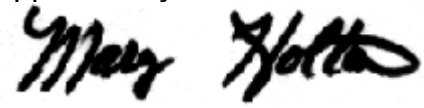
Anthony Humphrey Date
Licensing Consultant

Approved By:



05/23/2018

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Mary E Holton Date
Area Manager