RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

October 22, 2018

Marcia Curtiss
Homestead Management
Suite 115
21800 Haggerty Rd.
Northville, MI 48167

RE: License #:	AL410305473
Investigation #:	2018A0356049
	Whispering Woods #5

Dear Mrs. Curtiss:

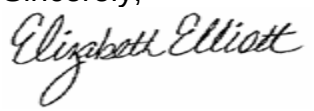
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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.

Please review the enclosed documentation for accuracy and contact me with any questions. If 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
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AL410305473
Investigation #:	2018A0356049
Complaint Receipt Date:	08/23/2018
Investigation Initiation Date:	08/23/2018
Report Due Date:	10/22/2018
Licensee Name:	Homestead Management
Licensee Address:	Suite 115 21800 Haggerty Rd. Northville, MI 48167
Licensee Telephone #:	(616) 949-9500
Administrator:	Marcia Curtiss
Licensee Designee:	Marcia Curtiss
Name of Facility:	Whispering Woods #5
Facility Address:	3964 Whispering Way Grand Rapids, MI 49546
Facility Telephone #:	(616) 949-9500
Original Issuance Date:	03/22/2011
License Status:	REGULAR
Effective Date:	10/07/2017
Expiration Date:	10/06/2019
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Direct Care Worker Janika Burton stole money from Resident A.	Yes
Direct Care Worker Janika Burton left Resident A alone in the shower.	Yes
Direct Care Worker's are not trained in the prevention and containment of communicable disease.	No

III. METHODOLOGY

08/23/2018	Special Investigation Intake 2018A0356049
08/23/2018	APS Referral
08/23/2018	Special Investigation Initiated - Telephone M. Curtiss, Licensee Designee.
08/28/2018	Inspection Completed On-site Jeannine Hayes and Kat Hartley, admin.
08/29/2018	Contact - Document Sent Complainant
10/01/2018	Contact - Telephone call made Relative #1
10/01/2018	Contact - Face to Face
10/02/2018	Contact - Document Received Facility/Resident A documents received.
10/03/2018	Contact - Telephone call made Marcia Curtiss, Licensee Designee.
10/09/2018	Contact - Document Sent Request for GRPD Police Report.
10/09/2018	Contact - Document Received GRPD reported received.

10/09/2018	Contact - Document Received Facility doc and Resident A docs received.
10/10/2018	Contact - Face to Face Audra Harmon, facility nurse and Kat Hartley, Admin.
10/22/2018	Exit Conference Marcia Curtiss, Licensee Designee.

ALLEGATION: Direct Care Worker (DCW) Janika Burton stole money from Resident A.

INVESTIGATION: On 08/23/2018, I received a BCHS (Bureau of Community and Health Systems) Online Complaint, the complainant reported that on 08/11/2018, Relative #1 observed a Direct Care Worker (DCW) stealing money from Resident A's room while Resident A was in the shower. The complainant reports the DCW offered to take Resident A to the shower room down the hall to assist her with a shower. The DCW, Janika (the complainant reported the last name of Williams, however, the DCW's last name is Burton) left Resident A in the shower room and returned to Resident A's room and stole money. The complainant reported Ms. Burton was observed a few times earlier the same day while Resident A was out of her room searching the room. The complainant reported this was caught on a "nest cam" that had been installed in Resident A's room by family after items turned up missing.

On 08/28/2018, I conducted an onsite inspection at the facility and met with regional nurse, Jeannine Hayes and Kat Hartley, administrator. Ms. Hartley and Ms. Hayes confirmed that Ms. Burton was suspended immediately and has since been fired from this facility for stealing money from Resident A's room. Ms. Hartley stated the police are involved and pursuing charges. Ms. Hartley stated the family placed a nest cam in Resident A's room unbeknownst to staff or management and observed Ms. Burton rummaging through Resident A's belongings to find money. Ms. Hartley and Ms. Hayes confirmed that all staff have their background checks completed and no one is hired that is not eligible to work in an AFC facility.

On 10/01/2018, I interviewed Relative #1 via telephone. Relative #1 stated she placed the nest cam in Resident A's room because of ongoing issues with items going missing from Resident A's room such as clothes, her walker and hygiene supplies since she was admitted in May 2018. Relative #1 stated she has experienced issues with communicating with management at this facility and has placed up to 30 calls to the facility to inform them of what was going on with no response. Relative #1 placed the nest cam in Resident A's room without informing anyone at the facility and on 08/11/2018 caught Ms. Burton stealing. Relative #1 stated she contacted the police on 08/12/2018 and filed a police report. Relative #1 stated she turned the videos over to the police on 08/13/2018 and on 08/17/2018, a warrant for Ms. Burton's arrest was issued. Relative #1 stated no one from the

facility including Ms. Curtiss filed a police report upon discovering staff was stealing, but Relative #1 stated Ms. Burton was suspended from work immediately and then fired once Ms. Curtiss found out.

10/01/2018, I interviewed Resident A in her room at the facility. Resident A stated Ms. Burton had stolen money from her room. Resident A stated Ms. Burton took her on more than one occasion to the shower room down the hall and left her there while she went back into Resident A's room and rummaged around looking for money. Resident A stated someone must have seen the DCW stealing from her room and caught her. During this interview, I noted the nest cam still in place on the shelving unit in Resident A's room.

On 10/03/2018, I interviewed Ms. Curtiss via telephone and she reiterated the information provided by Relative #1. Ms. Curtiss stated she did not know Relative #1 was having trouble with items going missing from Resident A's room and Ms. Curtiss stated she had no idea Relative #1 placed the nest cam in Resident A's room. Ms. Curtiss acknowledged at the time of this event and the time of Relative #1's calls to the facility the previous administrator had left without warning and the office was not staffed with anyone answering the phones so there was a period where communication with family members was poor. Ms. Curtiss stated Ms. Burton was suspended immediately upon being informed of the alleged theft of Resident A's funds and shortly thereafter Ms. Burton was fired. Ms. Curtiss stated Relative #1 filed the police report at the same time she reported the stealing incident to her (Ms. Curtiss). Ms. Curtiss stated Resident Funds are not held in the office for safekeeping and the facility does not have any involvement in the handling of resident's funds. Ms. Curtiss stated the resident's family members are encouraged to handle resident funds for safekeeping. Ms. Curtiss stated all staff are subject to background checks and Ms. Burton's yielded her ability to work in an AFC facility.

On 10/09/2018, I received and reviewed the Grand Rapids Police Report dated 08/12/2018, written by Officer Jacob Zuby. The report documents the following information: "*On 08/11/2018, (*Resident A) *reported to* (Relative #1) *she was missing 40 or 60 dollars from her bills fund.* (Relative #1) *reviewed the video and reviewed what happened. On 08/11/2018 at approximately 2030 hours* (8:30PM) (Resident A) *was taking a shower with the help of Janika Burton who is employed by the nursing home. As* (Resident A) *was taking a shower, Burton leaves her and enters her room alone. The camera shows Burton close the blinds on the window and then walk over to a shelving until All of (*Resident A's*) cash in on that shelving unit so she is able to pay her bills. She will place the correct or over the correct amount of cash in each envelope with the bill that is needed to be paid. The camera shows Burton checking three separate envelopes. She then leaves the room and returns to* (Resident A). *I spoke to* (Resident A) *and she stated she was missing at least 40 dollars. (*Resident A*) stated she was being bathed by Burton and Burton did leave her for a short period of time.*"

In addition to Officer Zuby's report, the following information was documented on 08/14/2018 by the Investigator assigned, Officer Eric Gizzi: "*I received three videos from (*Relative #1*). In the three videos, Janika Burton can be seen inside (*Resident A's*) room when she is not there. It also appears that Janika is searching through the room and at one point, she appears to place something in her pocket. She then exits the room. This is the area where (*Resident A*) keep money for bills that are to be paid. On 08/17/2018, Janika Burton came to the PD to speak with me. Janika first stated that (*Resident A*) had given her money to buy a skin loofa and a foot massage tub. She denied taking any money without permission. When confronted in more detail about this, Janika admitted she took (*Resident A's) *money without her permission. Janika stated she stole the money because she has bills and needed the money. On 08/17/2018 a felony larceny in a building warrant was authorized and on 08/20/2018 Ms. Burton turned herself into the KCCF on this warrant."*

On 10/09/2018, I received and reviewed Ms. Burton's Michigan Workforce Background Check dated 07/12/2018 that shows Ms. Burton is eligible for employment in an adult foster care facility.

On 10/22/2018, I conducted an Exit Conference with Licensee Designee, Marcia Curtiss via telephone. Ms. Curtiss stated she will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(1) A resident shall be assured privacy and protection from moral, social and financial exploitation.
ANALYSIS:	DCW, Janika Burton was captured on a "nest cam" installed in Resident A's room by Relative #1 stealing money out of envelopes of cash left in Resident A's room so Resident A can pay bills. Ms. Burton admitted to police she took money from envelopes in Resident A's room because she needed money. A felony larceny in a building warrant was authorized and Ms. Burton turned herself in. Ms. Burton was immediately suspended from her duties at the facility and then fired. Ms. Curtiss stated the facility does not handle any resident funds and they do not offer to hold resident funds for safekeeping. A background check on Ms. Burton was conducted and showed her eligibility to work in an AFC facility.

	Relative #1 reported she placed the nest cam in Resident A's room because of ongoing issues with items going missing from Resident A's room and her inability to address the issue with management at the facility. The facility did not protect Resident A from financial exploitation and therefore; a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct Care Worker Janika Burton left Resident A alone in the shower.

INVESTIGATION: On 08/23/2018, I received a BCHS (Bureau of Community and Health Systems) Online Complaint, the complainant reported that on 08/11/2018, Ms. Burton left Resident A in the shower room and returned to Resident A's room and stole money. The complainant reported Resident A should be supervised while showering.

On 10/01/2018, I interviewed Relative #1 via telephone. Relative #1 stated Resident A needs supervision while in the shower and on 08/11/2018, while Ms. Burton was looking for money in Resident A's room, Ms. Burton left Resident A alone in the shower room down the hall from Resident A's room. Relative #1 stated staff left Resident A alone in the shower even though she requies a "stand by assist."

10/01/2018, I interviewed Resident A in her room at the facility. Resident A stated Ms. Burton took her on more than one occasion to the shower room down the hall and left her alone in the shower room while she went back into Resident A's room and rummaged around looking for money. Resident A stated she requires assistance in adjusting the temperature of the water in the shower, assistance with getting soap on a washcloth and her hair shampooed and rinsed.

On 10/02/2018, I reviewed the Assessment Plan for AFC Residents dated 05/02/2018 and signed by Lucijana Tomic, the previous Administrator and Val Van Vianen, Resident A's Power of Attorney. The Assessment Plan documents that Resident A requires "remote supervision" with bathing and toileting.

On 10/03/2018, I interviewed Ms. Curtiss via telephone and asked what exactly "remote supervision" means. Ms. Curtiss stated she does not know what "remote" supervision means but Resident A requires supervision nonetheless.

On 10/22/2018, I conducted an Exit Conference with Licensee Designee, Marcia Curtiss via telephone. Ms. Curtiss stated she will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A's assessment plan documents that Resident A requires supervision with bathing and on 08/11/2018, DCW Janika Burton left Resident A in the shower room down the hall from Resident A's room alone and unsupervised while she returned to Resident A's room to look for money. A violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct Care Workers are not trained in the prevention and containment of communicable disease.

INVESTIGATION: On 08/23/2018, I received a BCHS (Bureau of Community and Health Systems) Online Complaint, the complainant reported it has been observed that staff enter Resident A's room to do blood sugar testing not wearing gloves nor do they wash their hands before or after leaving Resident A's room. The complainant reported the staff do not use universal precautions.

On 10/01/2018, I interviewed Relative #1 via telephone. Relative #1 stated she has witnessed staff not washing their hands, not using gloves or protective covering. Relative #1 stated the staff do not use universal precautions when handling Resident A or her medical treatments.

On 10/01/2018, I conducted an unannounced inspection at the facility and was in Resident A's room when staff came in to do a blood sugar test and staff Darnecia Morris and Shakira Adkinson-Warrens did have gloves on during their interactions with Resident A. Ms. Morris and Ms. Adkinson-Warrens stated they used gloves and wash their hands after each resident interaction. Ms. Morris and Ms. Adkinson-Warrens stated they have had training on the prevention and containment of communicable diseases.

On 10/10/2018, I met with Ms. Hartley, administrator and Audra Harmon, facility nurse at the facility and reviewed staff training records. I reviewed the Relias Web based Training records for all the staff in building #5 for the Blood borne pathogens and infection control. All the records are complete and to date showing all staff have been trained and tested as competent in blood borne pathogens and infection control.

On 10/22/2018, I conducted an Exit Conference with Licensee Designee, Marcia Curtiss via telephone. Ms. Curtiss agrees with the information, analysis and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.15204	**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: (g) Prevention and containment of communicable diseases.
ANALYSIS:	The complainant and Relative #1 report staff not do not use universal precaution when handling Resident A or her medical treatments. I reviewed the Relias Web based Training records for all the staff in building #5 for the Blood borne pathogens and infection control. All the records are complete and to date showing all staff have been trained and tested as competent in blood borne pathogens and infection control.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain the same.

Elizabeth Elliott

10/22/2018

Elizabeth Elliott Date
Licensing Consultant

Approved By:

Jerry Hendrick

10/22/2018

Jerry Hendrick Date
Area Manager