RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

October 3, 2018

Barry Bruns
HomeLife Inc
PMB #360
5420A Beckley Rd.
Battle Creek, MI 49015

RE: License #: AS390078924
Investigation #: **2018A0581058**
10713 South 12th Street AFC

Dear Mr. Bruns:

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.

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) 356-0183.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390078924
Investigation #:	2018A0581058
Complaint Receipt Date:	09/07/2018
Investigation Initiation Date:	09/10/2018
Report Due Date:	11/06/2018
Licensee Name:	HomeLife Inc
Licensee Address:	3 Heritage Oak Lane Battle Creek, MI 49015
Licensee Telephone #:	(269) 660-0854
Administrator:	Barry Bruns
Licensee Designee:	Barry Bruns
Name of Facility:	10713 South 12th Street AFC
Facility Address:	10713 South 12th St Portage, MI 49087
Facility Telephone #:	(269) 372-4820
Original Issuance Date:	11/06/1997
License Status:	REGULAR
Effective Date:	08/11/2018
Expiration Date:	08/10/2020
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A had $50 of his funds go missing from the facility.	Yes
On 09/06/2018, overnight staff left the facility leaving residents alone.	No

III. METHODOLOGY

09/07/2018	Special Investigation Intake 2018A0581058
09/07/2018	Referral - Recipient Rights Kalamazoo Community Mental Health
09/10/2018	Special Investigation Initiated - On Site Interviews with direct care staff with recipient rights officer (RRO), Lisa Smith
09/18/2018	Contact - Face to Face Interview with direct care staff, Dora Woodard, in conjunction with RRO, Lisa Smith.
09/19/2018	Contact - Document Received Email from home manager, Jessica Cummins
09/27/2018	Contact - Document Sent Email to home manager, Jessica Cummins.
09/27/2018	Exit conference with Barry Bruns.

ALLEGATION:

Resident A had $50 of his funds go missing from the facility.

INVESTIGATION:

On 09/07/2018, I received this complaint through the BCHS online complaint system. On this date, I also received an email from Kalamazoo's Recipient Right's Officer (RRO), Lisa Smith, reporting to me she had set up direct care staff interviews at the facility for 09/10/2018 to address the allegations I had received. Ms. Smith

reported she was also investigating the allegations and a referral to the Office of Recipient Rights was not needed.

On 09/10/2018, I conducted an unannounced onsite at the facility, as part of my investigation, as Ms. Smith did not report to staff that I would also be partaking in interviews. Ms. Smith and I interviewed several direct care staff including Taresha Perry, Shakira Bonds, Lilliann Kaye, Shannon Nuyen, and Bob DeRushia.

Ms. Smith and I interviewed direct care staff, Taresha Perry, first. Ms. Perry reported she's been working at the facility since May 2017. She reported she worked from 11 pm – 7 am on 09/06/2018. She reported she worked this shift with direct care staff, Shakira Bonds.

Ms. Perry reported the facility has a protocol for counting resident funds. She reported the resident funds book is either locked in the basement (but left on the table out in the open) or it is kept out on the table in the medication room on the main floor of the home. She reported when she came into work that evening she counted the resident funds in the medication room in front of direct care staff, Mr. DeRushia, Ms. Nuyen and Ms. Bonds. She reported when she was done counting resident funds, she left the binder in the medication room unattended. Ms. Perry reported she did not believe any of the residents are "capable of stealing funds." She reported there were instances throughout the night where she left the money binder completely unattended like when she went in the basement to clean the laundry area for "at least an hour." Ms. Perry denied taking Resident A's money from the money binder or seeing Ms. Bonds or anyone else take it.

Ms. Smith and I then interviewed direct care staff, Shakira Bonds. Ms. Bonds reported she has worked at the facility for over a year and typically works 1st and 3rd shifts. Ms. Bonds confirmed she worked at the facility on 09/06/2018 from 11 pm-7 am. She reported when she got into work that evening Ms. Perry was already counting resident funds in the medication room. Ms. Bonds reported the money binder contains both resident and emergency funds for the facility. She reported the first staff who gets to work is the staff who then counts the resident funds. She reported in a "perfect world" the money should be counted with another person, so the amounts can be verified. Ms. Bonds reported the money binder is "sometimes upstairs, sometimes downstairs." She reported if the money binder is downstairs in the basement then it is locked away (as the basement door is always locked). She reported if the money binder is upstairs then it is not locked up.

Ms. Bonds reported her shift on 09/06/2018 was an overall "normal shift". She denied taking Resident A's funds or seeing anyone take it from the money binder. Ms. Bonds reported when she left the facility around 7 am she didn't see anyone from 1st shift counting the resident funds to confirm how much money was there.

Ms. Bonds also reported she was informed on 09/07/2018 by the home manager, Jessica Cummins that $20 of Resident A's funds had also gone missing on

08/25/2018 and that she (Ms. Bonds) was being held accountable for these funds since the funds went missing during her work shift.

Ms. Smith and I also interviewed lead supervisor, Lilliann Kaye. Ms. Kaye reported Resident A has had his money taken twice from the facility; both times Ms. Bonds was working. She reported it had been discovered on 08/26/2018 from 1st shift staff that $20 had gone missing from Resident A's file in the money binder, which occurred during 3rd shift on 08/25/2018. She reported on 09/07/2018, 1st shift again discovered $50 of Resident A's funds missing. Ms. Kaye reported direct care staff reporting to their shift are supposed to count resident funds with the direct card staff leaving so the resident funds can be accounted for and eliminate issues with any missing funds. She also reported the money binder is supposed to be kept locked downstairs. Ms. Kaye reported that the staff working the shift when money goes missing is held accountable for the missing funds.

Ms. Smith and I then interviewed direct care staff, Shannon Nuyen. Ms. Nuyen reported she's worked at the facility for 4 months and primarily works 2nd shift, which is 3 pm–11 pm. Ms. Nuyen reported that a couple weeks ago she was counting funds with another direct care staff when they noticed $20 was missing from Resident A's funds. She reported she had believed a receipt was missing from the binder, which could have explained the missing $20; however, she was informed the following day by management that the $20 was actually missing and there was no corresponding receipt.

Ms. Nuyen reported that since the money went missing on 08/25/2018, a new policy had been implemented where staff at "shift change" are supposed to count resident funds together in the medication room and then take the money binder back downstairs afterwards so it's locked up.

Ms. Nuyen reported she had worked on 09/06/2018 until 11 pm; however, she left the facility before witnessing direct care staff, Ms. Perry, count the resident funds from the money binder.

Lastly, Ms. Smith and I interviewed direct care staff, Bob DeRushia. Mr. DeRushia reported he's worked at the facility for 15 years and works 2nd shift, Monday through Friday. Mr. DeRushia reported that resident funds and "house funds" are all kept in a money binder. Mr. DeRushia reported that several months ago, staff were instructed to "count funds with other shift staff." He reported on 09/06/2018, he remembered Ms. Perry counting the resident's funds in the medication room on the main level of the home right before he left the facility at the end of his shift. He noted she was the only staff counting the funds.

During the onsite, I obtained staff schedules from 08/12/2018 through 09/08/2018 confirming I had interviewed the correct direct care staff working when Resident A's money went missing on 08/25/2018 and 09/06/2018.

I also obtained copies of the facility's "Shift Change Money Check Offs" sheet from 08/26/2018 through 09/08/2018, which documented the funds kept in the money binder including "E-Funds" or emergency house funds, "Van Gas" and "Activities", as well as, resident funds for four out of six residents, including Resident A. The "Shift Change Money Check Offs" sheet could not be located by Ms. Kaye for the week prior to 08/26/2018, which would have showed Resident A's funds for 08/23/2018.

On 09/18/2018, Ms. Smith and I returned to the facility for an announced onsite to interview direct care staff, Dora Woodard. Ms. Woodard reported she's worked at the facility for four years. She reported there are procedures specifically for reviewing resident funds. She reported the "incoming shift should be counting money with the previous shift to make sure the money is all there." She reported this protocol has "always been true, but not always practiced." She reported staff should be "counting together to verify money is there." She reported this should be done with both resident and house funds.

Ms. Woodard reported on 09/06/2018, she worked 1st shift from 7 am-3 pm. She reported her coworker, Emilia Allard, did not count the resident or house funds from the money binder until around 10 am because when she and Ms. Allard came into work that day they took care of their morning obligations like feeding the residents and completing ADL's. She reported it is hard to count funds from the money binder at shift change as it's "chaotic" at the facility, but she reported "it's now happening." She reported when the money binder is counted, it occurs upstairs in the medication room where it was left unlocked or it was being left downstairs in the basement on the table. Ms. Woodard reported the binder is now being locked up when it's left upstairs.

Ms. Woodard reported when Ms. Allard found out about the missing money, she told Ms. Woodard and then Ms. Woodard told home manager, Ms. Cummins. Ms. Woodard reported there was a $100 missing in total; $50 of Resident A's funds and then $50 from the facility's house funds. She also reported there had been another time, recently, where $20 went missing from Resident A's funds. She reported this occurred during 3rd shift and had been discovered during 1st shift. Ms. Woodard reported she and Ms. Allard recounted all the funds to ensure it hadn't gotten mixed up with another resident's funds; however, they were unable to locate the missing funds. Ms. Woodard denied taking Resident A's funds, denied knowing who took it, and denied hearing anyone talking about taking the money.

When Ms. Smith and I were leaving the facility, we observed the money binder in a locked cabinet in the medication room. I also requested copies of Resident A's *Resident Funds I* and *Resident Funds II* records from Ms. Kaye, the senior lead supervisor; however, she reported these records were unavailable to any of the direct care staff working because only the home manager, Ms. Cummins, had the keys and she wasn't working at the facility.

On 09/19/2018, I received an email from home manager, Ms. Cummins, stating Resident A's missing $50 had been replaced by the facility.

On 09/27/2018, I sent an email to Ms. Cummins requesting *Resident Funds I* and *Resident Funds II* (for months July through September 2018) for Resident A, which she promptly faxed over. I reviewed Resident A's *Resident Funds II* form, which showed Resident A had $153.76 on 08/14/2018. On 08/23/2018, Resident A used $29.67 at Best Buy leaving him with a balance of $124.09. The next entry on the form was on 08/23/2018 with the entry of "missing funds" for $20 leaving Resident A with a total of $104.09. On 08/25/2018, there was an entry of "Transfer for missing funds" with a deposit of $20 bringing Resident A's total funds back to $124.09. On 09/06/2018, there was an entry for a $100 deposit into Resident A's funds giving Resident A a balance of $224.09; however, there was a follow-up entry on 09/06/2018 with the entry "missing funds" for $50 leaving Resident A with only $174.09. The final entry on the *Resident Funds II* form as for 09/07/2018 with the entry of "Transfer for missing funds" with a deposit of $50 making the final balance of Resident A's funds $224.09.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	Based on my interviews with multiple direct care staff, a review of Resident A's *Resident Funds II* form, along with the facility's own form, "Shift Change Money Check Offs", it is clear the facility's money binder, which contained Resident A's funds, was not safeguarded. As a result, someone within the facility accessed it and stole $50 of Resident A's funds.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 09/06/2018, overnight staff left the facility leaving residents alone.

INVESTIGATION:

On 09/10/2018, during my unannounced onsite at the facility, as part of my investigation, I interviewed direct care staff, Taresha Perry. Ms. Perry confirmed she worked 09/06/2018 from 11 pm – 7 am. She confirmed she also worked with direct

care staff, Shakira Bonds. Ms. Perry reported around 11:45 pm, Ms. Bonds left the facility in the facility van to get something to eat. She reported Ms. Bonds was gone from the facility for approximately “10-15 minutes”.

I also interviewed direct care staff, Shakira Bonds, who confirmed what Ms. Perry reported to me.

During the onsite, I also obtained the staff schedule for 09/06/2018, which also confirmed Ms. Perry and Ms. Bonds worked from 11 pm-7 am that night.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Based on my interviews with Ms. Perry and Ms. Bonds, both direct care staff confirmed they worked 11 pm -7 am on 09/06/2018. The facility’s staff schedule also confirmed both direct care staff were working. Even though Ms. Bonds left the facility around 11:45 pm to obtain food, it still left 1 direct care staff, Ms. Perry, to care for the 6 residents left at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

On 09/27/2018, Ms. Cummins faxed me a copy of Resident A’s *Resident Funds II* form, which showed Resident A had a balance of $224.09 on 09/07/2018.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(6) Except for bank accounts, a licensee shall not accept resident funds of more than $200.00 for any resident of the home after receiving payment of charges owed.

ANALYSIS:	According to Resident A's *Resident Funds II* form, the facility accepted more than $200.00 of Resident A's funds and was holding it at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/27/2018, I conducted my exit conference with licensee designee, Barry Bruns. I relayed my findings to Mr. Bruns and allowed him an opportunity to ask questions or provide input. He reported the staff who were working when the money went missing were disciplined appropriately. He also reported the facility supplemented the resident's missing funds by using facility funds. Mr. Bruns reported he would be working with the facility's home manager on creating stronger policy on reviewing resident funds. I provided consultation to Mr. Bruns by discussing how limiting the number of direct care staff with access to the funds is important when safekeeping resident's funds, as well as, having staff maintain consistency with following resident funds policy.

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective plan of action, I recommend the current license status continue.

09/28/2018

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Cathy Cushman Date
Licensing Consultant

Approved By:

10/03/2018

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Dawn N. Timm Date
Area Manager