GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 26, 2019

Barbara Mitchell
4021 Brian Paul Place
Bridgeport, MI 48722

RE: License #: AS730382916
Investigation #: 2020A0871001
Golden Hearts Adult Foster Care

Dear Ms. Mitchell:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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 (989) 732-8062.

Sincerely,

Kathryn Huber

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS730382916
Investigation #:	2020A0871001
Complaint Receipt Date:	10/14/2019
Investigation Initiation Date:	10/15/2019
Report Due Date:	12/13/2019
Licensee Name:	Barbara Mitchell
Licensee Address:	4021 Brian Paul Place Bridgeport, MI 48722
Licensee Telephone #:	Unknown
Administrator:	Barbara Mitchell
Licensee Designee:	Barbara Mitchell
Name of Facility:	Golden Hearts Adult Foster Care
Facility Address:	1619 Janes Street Saginaw, MI 48601
Facility Telephone #:	(989) 482-8511
Original Issuance Date:	03/17/2017
License **Status:**	1ST PROVISIONAL
Effective Date:	06/18/2019
Expiration Date:	12/17/2019
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Residents are left unattended for the majority of the day. Resident A is court ordered to be there and is currently suicidal. Other residents appear to be schizophrenic and do not appear to be appropriate for no supervision. Police were contacted regarding resident being suicidal.	Yes
Licensee Barbara Mitchell threatened Resident A.	No
Additional findings	Yes

III. METHODOLOGY

10/14/2019	Special Investigation Intake 2020A0871001
10/15/2019	Special Investigation Initiated - Telephone Telephone contact with Complainant 1 and Family Member 1
10/15/2019	Contact - Telephone call received Telephone contact with Adult Protective Service Worker Katrice Humphrey
10/16/2019	APS Referral Through Central Intake to Saginaw County MDHHS
10/16/2019	Inspection Completed On-site Interviewed Residents B-D, Licensee Barbara Mitchell
10/16/2019	Contact - Face to Face Interviewed APS Worker Katrice Humphrey
10/18/2019	Contact - Face to Face Interviewed Resident A at new AFC home
10/18/2019	Contact - Telephone call made Telephone contact with Case Manager Marchane Canada
10/18/2019	Contact - Telephone call made Telephone contact with Case Manager Destiny Helpap
10/23/2019	Contact - Telephone call made Telephone contact With Case Manager Adam Sewell

10/23/2019	Inspection Completed-BCAL Sub. Non-Compliance
10/23/2019	Exit Conference Telephone exit conference with Licensee Barbara Mitchell

ALLEGATION:
Residents are left unattended for the majority of the day. Resident A is court ordered to be there and is currently suicidal. Other residents appear to be schizophrenic and do not appear to be appropriate for no supervision. Police were contacted regarding resident being suicidal.

INVESTIGATION:

On October 15, 2019, I telephoned Complainant 1. Complaint 1 indicated there was no staff at the facility in the afternoon of October 12, 2019. Complainant 1 stated "there was no one there the previous night." Complainant 1 stated "[Resident H] and all the residents confirmed no one is there at night, usually." Complainant 1 said "Barb (licensee) arrived around 6 after the police were there."

I then contacted Family Member 1. Family Member 1 indicated she arrived at the facility about 1:30 pm on Saturday, October 12, 2019. Family Member 1 stated "[Resident A] came out to the car and was so upset." Resident E told Family Member 1 there nobody was at the facility until about 7-8 am this morning and then left again. Family 1 took Resident E to a nearby store and was gone about an hour. When they returned to the facility, no one was at the facility. Family Member 1 said "I walked through the house" and no staff was there. Family Member 1 said she parked across the street and watched the house. Family Member 1 was really concerned because Resident E "has been very suicidal." Family Member 1 did not know what to do and finally called the police. Family member 1 indicated the police arrived about 20 minutes later and Licensee Barbara Mitchell came about ½ hour later.

On October 16, 2019, Adult Protective Service Worker Katrice Humphrey forwarded me a copy of Saginaw Police Department Case Report #1971705110. The report indicates Officer Steven Lautner arrived at the facility on October 12, 2019 @ 6:54pm. When Officer Lautner and Officer Beyerlein went to the home, he reported "Upon entering the venue, R/O asked [Resident A] where the worker was to which she stated there was not a worker there." Officer Lautner then looked through the house and found other residents but no worker. Officer Lautner reported that he spoke with another resident living in the facility and the resident reported they have been living at the facility for about 6 weeks. The resident told Officer Lautner "usually Barbara is at the house and she leaves at 1500 hours. Through the day, Barbara isn't there constantly and is in and out."

Officer Lautner obtained Licensee Barbara Mitchell's phone number and called her. Licensee Mitchell told Officer Lautner "a worker names Sheka was supposed to be there." Officer Lautner obtained a number from Licensee Mitchell for Sheka Harris but was not the number for Sheka Harris, and it was for another female. Licensee Mitchell told Officer Lautner that was the only phone number she had for Sheka Harris.

After this phone call, Licensee Mitchell arrived at the home. Officer Lautner wrote in his report "At this time, R/O and Barbara agreed there was no worker there when there should have been."

On October 28, 2019, I received a telephone call from Officer Steven Lautner. Officer Lautner said "when I got there, there was no staff there." Officer Lautner reported a resident told him that "Barbara leaves at 3." Officer Lautner said Licensee Mitchell "changed her story several times." Officer Lautner indicated he walked through the facility and that "was no worker there."

On October 16, 2019, I telephoned Licensee Barbara Mitchell. Licensee Mitchell indicated she will have staff at the facility 24/7.

I also conducted an unannounced onsite investigation on October 16, 2019 and interviewed Licensee Mitchell. Licensee Mitchell stated she received a phone call on Saturday, October 12, 2019, that her god mother died, and she wanted to go pay her last respects. Licensee Mitchell stated she called Staff Elaine Taylor to come over and Ms. Taylor came to the facility about 6:00 pm. Licensee Mitchell stated, "I was here the whole day" and was there when Ms. Taylor came to the facility. Licensee Mitchell said she was on her way out to Great Lakes Nursing Home and got a flat tire and she was stranded. Licensee Mitchell stated, "Miss Elaine just left." Licensee Mitchell stated Ms. Taylor "thought she could run and come back." Licensee Mitchell indicated "maintenance men Jerome and Eddy were also here."

I asked Licensee Mitchell if Family Member 1 came into the facility and Licensee Mitchell indicated "she never came in the house." Licensee Mitchell stated Family Member 1 was in her car outside in the backyard. Licensee Mitchell indicated Family Member 1 "was in my face, so out of line, cussed at me." Licensee Mitchell indicated she "worked all Friday night and all-day Saturday." Licensee Mitchell stated Resident A had to get out of Family Member 1's house and she knew nothing about Resident A when she moved into the facility on Friday, October 11, 2019. Licensee Mitchell indicated Resident A and Family Member 1 were not supposed to have contact.

On October 16, 2019, I interviewed Resident F. Resident F said he gets good food and he got his medication on Saturday. Resident F does not remember any police being at the facility and indicated "every time I need them, they were there." I also interviewed Resident G. Resident G indicated "Barbara was here when the police were here." Resident G does not know if any staff were there during the day.

On October 16, 2019, I also interviewed Resident H. Resident H indicated that on Saturday, October 12, 2019, “there were no staff here” and “it happens a lot.” Resident H said Licensee Mitchell gave them their morning meds and “no one was here at lunch.” Resident H indicated Licensee Mitchell “was in and out all day.” Resident H said she gets her evening meds when Licensee Mitchell returns. Resident H said she has not met Staff Elaine Taylor. Resident H also stated, “it’s kind of scary with no staff here.”

Licensee Mitchell provided a phone number for Ms. Taylor and I left two separate messages and did not receive a return phone call. I left Ms. Taylor another message on November 4, 2019. I also went to the address that Licensee Mitchell gave me for Ms. Taylor, but she does not live at that address. On November 4, 2019, Licensee Mitchell stated she is also trying to contact Ms. Taylor and does not know where she is living. Licensee Mitchell also stated she has no other phone number for Ms. Taylor other than the one she gave me.

There are currently four residents living in the facility. All the four residents have case managers. On October 18,2019, I contacted Case Manager Marchane Canada, Case Manager for Resident F; Case Manager Adam Swell, Case Manager for Resident G, and Case Manager Destiny Helpap for Residents H and told them they should be looking for a new placement for the residents, as the residents are being left unsupervised. Case Manager Helpap stated because it was a general AFC, staff did not need to be present 24/7.

On October 18, 2019, Case Manager Canada stated that she did not realize there was not staff at the facility 24/7. She indicated Resident F does need 24/7 care and is difficult to place.

On October 23, 2019, I contacted Case Manager Sewell. Sewell was aware that Licensee Mitchell was on a provisional license because of no staff in the home.

On October 16, 2019, I received a copy of the staff schedule for the week of October 7 to October 13, 2019. On Friday, October 11, 2019, it indicates Staff Elaine Taylor works from 8-3 and Licensee Mitchell works 24 hours. On October 12, 2019, it indicates Licensee Mitchell will be working 24 hours.

On October 18, 2019, I interviewed Resident E at her new AFC home. Resident E said she moved into Golden Hearts on Friday, October 11, 2019. Resident E reported that she got there between 4-5 pm on Friday and Licensee Barbara was there. Resident E said she did get her 8 pm meds. Resident A indicated she was up pretty late on Friday, October 11, 2019, and went downstairs to use the phone. Resident E said, “there was no staff there.” Resident E stated she got up in the morning between 8-9 and she did get her morning meds. Resident E said Licensee Mitchell left and “no one was there.” Resident E said Family Member 1 “came about 1-2 pm and I ran out to the car.” Resident E said Family Member 1 took her to the

store and they were gone for about 1-2 hours. Resident A reported Family Member 1 “was stalking the house” and she went upstairs. Resident E said she was going to call someone to come pick her up to “go get high.” Resident E said she straightened her hair and there was a resident downstairs saying, “white ass honkey.” Resident E did not know if it was directed towards her, but she was the only white resident in the facility. Resident E said she never say any staff there besides Licensee Mitchell.

On November 8, 2019, Adult Protective Service Worker Katrice Humphrey confirmed that she substantiated neglect on Licensee Mitchell for not have staff at the facility.

In SIR 2019A0871025 dated June 4, 2019, it was concluded that the Complainant had to drive a resident back to the facility from day program because there was no staff at the facility to administer the morning medication. On an unannounced onsite investigation on April 18, 2019 when I arrived, there were no staff at the facility. Licensee Barbara Mitchell signed a Corrective Action Plan on June 18, 2019 that indicated “I will be responsible for the rules being followed. Corrective Action – Staff will be available 24/7 for Golden Hearts AFC. Effective immediately.”

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:	Resident E said there were no staff in the facility on Friday night, October 11, 2019. Licensee Barbara Mitchell did pass morning meds on October 12, 2019 and left again. No staff were present in the facility. Family Member 1 and Officer Steven Lautner were at the facility and no staff were present. I confirm violation of this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR 2019A087025 dated June 4, 2019**

ALLEGATION:
Licensee Barbara Mitchell threatened Resident E.

INVESTIGATION:

On October 16, 2019, when I asked Licensee Mitchell about what she said to Resident A, she replied “I never said anything to her.”

On October 18, 2019, when I interviewed Resident E at her new facility, she said Family Member 1 got her belongings from the facility. Resident E remembered she

had a sweatshirt that was left behind, and it was in the dryer. Resident E said she called Licensee Mitchell on Sunday, October 13, 2019 and asked her about the sweatshirt. Licensee Mitchell asked Resident A what happened and then told her "no one is going to believe you." Licensee Mitchell also told Resident E "don't tell anyone."

Family Member 1 also reported to me that Resident E contacted Licensee Mitchell. Resident E told Family Member 1 that Licensee Mitchell did not want Resident E to talk to anyone about what happened.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: (f) The right to voice grievances and present recommendations pertaining to the policies, services, and house rules of the home without fear of retaliation.
ANALYSIS:	Licensee Barbara Mitchell denied that she threatened Resident E. There is not substantial evidence to confirm violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On October 16, 2019, the staff schedule indicated Staff Elaine Taylor was listed as the staff for Friday, October 11, 2019 from 8-3 pm. Licensee Mitchell was listed to work 24 hours on October 11, 2019 and on October 12, 2019. Licensee Mitchell told Officer Lautner that Sheka Harris was supposed to be working on October 12, 2019. Licensee Mitchell told me that Staff Elaine Taylor was scheduled for October 12, 2019. Neither Elaine Taylor nor Sheka Harris was listed on the staff schedule.

In SIR #2019A0871025 dated June 4, 2019, Licensee Mitchell did not have a staff schedule but had a desk calendar with some names on it. Licensee Mitchell provided a Corrective Action Plan dated 06/18/19 that indicated 'Effective immediately, Staff schedule will be posted one moth with the following information: Staff name, schedule date/time and position and any scheduling changes on work schedule.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: (a) Names of all staff on duty and those volunteers who are under the direction of the licensee. (b) Job titles. (c) Hours or shifts worked. (d) Date of schedule. (e) Any scheduling changes.
ANALYSIS:	The staff schedule that was provided to me on October 16, 2019, indicated Staff Elaine Taylor was to work on October 11, 2019 from 8-3, and Licensee Barbara Mitchell was working 24 hours on October 11 and October 12, 2019. The staff schedule did not list job titles, hours, or any schedule changes. I confirm violation of this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR 2019A0871025 dated June 4, 2019.**

INVESTIGATION:

On October 28, 2019, I conducted an unannounced onsite investigation and spoke with Staff Denise Houston. Ms. Houston indicated she was employed at the facility.

On November 1, 2019, I conducted an unannounced onsite investigation and asked Licensee Mitchell for Ms. Houston's file. Licensee Mitchell could not locate it and stated she probably had it at her home. Licensee Mitchell indicated she would fax Ms. Houston's proof of fingerprinting, Medical Clearance and tuberculin test to me. As of this date, I have not received any paperwork for Ms. Houston.

APPLICABLE RULE	
400.734(b)	**This amended section is effective January 9, 2009 except Section 734b(1)(e)(iv) after the word "or" which will not be effective until October 31, 2010.** **Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(2) Except as otherwise provided in subsection (6), an adult foster care facility shall not employ or independently contract

	with an individual who has direct access to residents after April 1, 2006 until the adult foster care facility conducts a criminal history check in compliance with subsections (4) and (5). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. Beginning April 1, 2009, an individual who is exempt under this subsection shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (12). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006. That individual may transfer to another adult foster care facility that is under the same ownership with which he or she was employed or under contract. If that individual wishes to transfer to an adult foster care facility that is not under the same ownership, he or she may do so provided that a criminal history check is conducted by the new facility in accordance with subsection (4). If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under subsection (1)(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	Licensee Barbara Mitchell could not provide proof that Staff Denise Houston had been fingerprinted. I confirm violation of this rule.
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:	Licensee Barbara Mitchell did not have a statement signed by a licensed physician indicating the health of Staff Denise Houston. I confirm violation of this rule.
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:	Licensee Barbara Mitchell could not provide proof that Staff Denise Houston had been tested for tuberculosis. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On October 16, 2019, I observed Resident H's dresser had drawer missing and was broken. Resident H indicated the dresser was not hers and belong to Licensee Mitchell.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	On October 16, 2019, I observed Resident H's dresser had a drawer missing and it was broken. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On October 16, 2019, I also observed a basement window that was broken out and had a board covering it. On November 1, 2019, I opened the front glass door and the handle came out.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(3) All living, sleeping, hallway, storage, bathroom, and kitchen areas shall be well lighted and ventilated.
ANALYSIS:	On October 16, 2019, I observed a board placed across a broken basement window. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	On November 1, 2019, I opened the front glass door and the handle came out. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On October 23, 2019, I conducted a telephone exit conference with Licensee Barbara Mitchell. Ms. Mitchell was informed the findings of the investigation and the revocation of the license is recommended.

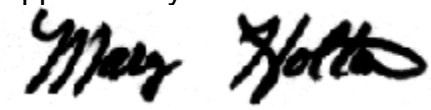
IV. RECOMMENDATION

I recommend revocation of the license of this AFC adult small group home (capacity 1-6).

11/19/2019

Kathryn A. Huber — Date
Licensing Consultant

Approved By:



11/20/2019

Mary E Holton — Date
Area Manager