GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 23, 2021

Debra Field
Field LLC
1415 E. Smith
Bay City, MI 48706

RE: License #:	AS090388270
Investigation #:	2021A0123014
	FIELD HOME II

Dear Ms. Field:

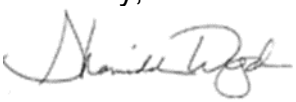
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (810) 787-7031.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090388270
Investigation #:	2021A0123014
Complaint Receipt Date:	02/01/2021
Investigation Initiation Date:	02/02/2021
Report Due Date:	04/02/2021
Licensee Name:	Field LLC
Licensee Address:	1415 E. Smith Bay City, MI 48706
Licensee Telephone #:	(989) 892-6714
Administrator:	Debra Field
Licensee Designee:	Debra Field
Name of Facility:	FIELD HOME II
Facility Address:	1415 E. SMITH ST. BAY CITY, MI 48706
Facility Telephone #:	(989) 892-6714
Original Issuance Date:	10/13/2017
License Status:	REGULAR
Effective Date:	04/10/2019
Expiration Date:	04/09/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents have to assist Resident B when she falls, because staff are not present. The facility is not supervised 24 hours.	No
Resident A's guardian wrote a note to the home to give Resident A her 5:00 am medication at 9:00 pm., for the resident to self-administer in the morning.	Yes
Resident A has an uncontrollable tick and was told to go to her room until it quits. She is forced to get up earlier than other residents because she takes too long to get ready. Ms. Field calls the residents "yahoos." Resident C was forced to clean the bathroom after having diarrhea.	No
The guardian was not notified on July 9, 2020 that Resident A was experiencing severe abdominal pain, and Ms. Field told Resident A to be quiet or she would wake up the other residents. Ms. Field never reported to the guardian about the pain, and Resident A had to tell the guardian about it.	No
There is a concern that staff Kennedy Swaffer is not trained to pass medications.	No
Resident A was supposed to receive $60 from her monthly check for personal spending.	No
Receipts were not provided to the guardian for Resident A's personal spending money.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/01/2021	Special Investigation Intake 2021A0123014
02/01/2021	APS Referral Information received regarding APS referral.
02/02/2021	Special Investigation Initiated - Telephone I spoke with Debra Field via phone.
02/05/2021	Contact - Telephone call made

	I conducted a video call with the facility. I interviewed Resident A and Resident B.
02/19/2021	Contact - Telephone call made I left a voicemail, requesting a return call from Resident A's case manager.
02/19/2021	Contact - Telephone call made I made an attempted call to Resident B's guardian. There was no answer.
02/19/2021	Contact - Telephone call made I spoke with Resident A's guardian, and Resident A via phone.
02/19/2021	Contact - Telephone call made I interviewed staff Kennedy Swaffer via phone.
02/19/2021	Contact- Document Received I received requested documentation via fax.
02/22/2021	Contact - Telephone call received I received a voicemail from case manager Laurel McClure.
02/22/2021	Contact - Telephone call made I made an attempted return call to Ms. McClure. There was no answer.
03/12/2021	Contact- Telephone call made I made a follow-up call to the facility.
03/12/2021	Contact- Telephone call made I left a message for Ms. McClure, requesting a return call.
03/16/2021	Contact- Document received I received requested information via fax.
03/19/2021	Contact- Telephone call made I left a message for Relative 3, requesting a return call.
03/19/2021	Contact- Telephone call received I spoke with Relative 3 via phone.
03/19/2021	Contact- Telephone call made I spoke with Relative 1 and Relative 2 via phone.
03/19/2021	Contact- Telephone call made I spoke with Ms. Field via phone.

03/19/2021	Exit Conference I spoke with Ms. Field via phone.

ALLEGATION: Residents have to assist Resident B when she falls, because staff are not present. The facility is not supervised 24 hours.

INVESTIGATION:
There was no on-site visit conducted due to the COVID-19 pandemic.

On 02/02/2021, I made a call to licensee Debra Field. Ms. Field denied the allegations. Stated that Resident B has gait issues and falls on occasion. She stated that Resident A did help Resident B up once, and that she may have been in another room when it happened.

On 03/12/2021, I made a follow-up call to Ms. Field. She stated that she is present in the home at night, and that all of the residents have phones, and they can reach her by phone if needed.

On 02/05/2021, I interviewed Resident C via Facetime. Resident C denied ever witnessing Resident B fall.

On 03/12/2021, I conducted a follow up interview Resident C via phone. She stated that she can get a hold of Ms. Field during the night by calling Ms. Field's phone. Resident C stated that she has never had to call Ms. Field at night, and she has been living in the home for three years.

On 02/05/2021, I interviewed Resident B via Facetime. Resident B stated that she falls once in a while and has never injured herself from it. She stated that Ms. Field helps her up after a fall, and another resident (not Resident A) has helped her as well. Resident B stated that there is always a staff person present in the home, and that they have never been left alone. She stated that Ms. Field is available during sleeping hours, and that there has never been an issue with not having staff to respond at night.

A copy of Resident B's Assessment Plan for AFC Residents was reviewed. It states that Resident B does not need assistance with walking, and that she uses a walker.

On 02/19/2021, I interviewed Resident A via phone. Resident A stated that she saw Resident B fall more than three times, and she and another resident would help her up. She stated that she does not know where Ms. Field was during those times.

On 02/19/2021, I interviewed staff Kennedy Swaffer via phone. She stated that she has seen Resident B fall once or twice, and that Ms. Field helped Resident B up, and the other time she herself with another resident (not Resident A) helped Resident B up.

An addendum to this facility's Original Licensing Study report dated March 26, 2019 states that the language in the Original Licensing Study report was changed to "The licensee will provide sufficient staffing for the home based on the current needs of the residents" from "all staff shall be awake during sleeping hours."

On 03/19/2021, I interviewed Resident B's son, Relative 3 via phone. Relative 3 denied having any concerns regarding Resident B's care or her falling. Relative 3 stated that he replaced Resident B's walker last week with one that has working brakes. Relative 3 stated that Resident B does not need staff assistance during sleeping hours. Relative 3 stated that as far as he knows, a staff person is always present in the home, and the residents are never left alone.

On 03/19/2021, I conducted a follow up call with Ms. Field. She stated that the facility currently has five residents, and there are no residents who require care during sleeping hours. Ms. Field stated that Resident B's falls are infrequent, and that Resident B wears an alarm button that notifies her when there is an issue. She also confirmed that Resident B has a new walker with working brakes.

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:	Ms. Field denied the allegations. She stated that the facility currently has five residents, and there are no residents who require care during sleeping hours. She stated that she is present in the home at night, and that all of the residents have phones, and they can reach her by phone if needed. Resident B and Resident C both reported that there is always a staff person present in the home. Resident B stated that she falls once in a while and has never injured herself from it. Relative 3 denied having any concerns regarding Resident B's care or her falling. Relative 3 stated that to his knowledge there is always a staff person present in the home. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A's guardian wrote a note to the home to give Resident A her 5:00 am medication at 9:00 pm., for the resident to self-administer in the morning.

INVESTIGATION: On 02/02/2021, I interviewed Ms. Field via phone. Ms. Field stated that she lives in the home and Resident A had access to her when she needed medication and prn's.

On 02/19/2021, I interviewed Relative 1, Resident A's guardian via phone. Relative 1 stated that he wrote Ms. Field a note regarding changing Resident A's medication times, because no staff was awake to give Resident A her 5:00 am meds.

On 02/19/2021, I interviewed Resident A via phone. Resident A stated that her medication is passed at 5:00 am, and that she kept that medication in her room, and gave it to herself.

On 02/19/2020, I received a copy of Resident A's *AFC Resident Medication Record* for July 2020 through September 2020. Medication times are noted as follows: 6:00 am, 11:30 am, 5:00 pm, 10:00 pm for the first medication listed (Ativan 0.5 mg; take one tablet 4x's daily), 6:00 am, 2:00 pm, and 10:00 pm for the second medication (Neurontin 100 mg; take one capsule 3's daily), and 9:00 am for a third medication (Prozac; take one capsule daily). Resident A had a med change in October 2020. After the change she had Lorazepam 1mg (take 1 tablet 3x's daily) at 5:00 am, 1:00 pm, and 9:00 pm per her medication records.

Resident A's *Assessment Plan for AFC Residents* notes that "staff will administer all meds per doctors' orders."

On 03/12/2021, I made a follow-up call to Ms. Field. Ms. Field stated that there are currently no med passes that have to be completed at night. Ms. Field stated that Relative 1 wrote a letter stating that Resident A could take medication early in the morning on her own. She stated that it was one medication for 5:00 am, and that she would give Resident A the pill in a pill cup, and Resident A would have an alarm set for 5:00 am. She stated that she told the guardian to put it in writing. She stated that the script said for Resident A to take the medication every eight hours, and that Resident A's parents did not want to tweak Resident A's med passing times because it was her routine. Ms. Field stated that she did not get permission in writing from a doctor for Resident A to take her medication unsupervised. She stated that the script was being followed.

On 03/12/2021, I conducted a follow up interview Resident C via phone. She stated that Ms. Field is available when she needs medication, and that there is always a staff person present in the home.

On 02/05/2021, I interviewed Resident B via Facetime. Resident B stated that there is always a staff person present in the home, and that they have never been left

alone. She stated that Ms. Field is available during sleeping hours, and that there has never been an issue with not having staff to respond at night.

On 03/16/2021, I received a copy of the note Relative 1 signed giving Resident A permission to take her own medications at 5:00 am.

APPLICABLE RULE	
R 400.14312	**Resident Medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	Relative 1 reported that he wrote a note giving Ms. Field permission to allow Resident A to take her 5:00 am medication unsupervised. Ms. Field stated that Relative 1 did write a note stating that Resident A could take her medication by herself at 5:00 am on her own. Ms. Field reported that she did not get permission in writing from Resident A's physician. A copy of the note Relative 1 signed giving permission for Resident A to take her own medication at 5:00 am was reviewed. Resident A's *Assessment Plan for AFC Residents* notes that "staff will administer all meds per doctors' orders." There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A has an uncontrollable tick and was told to go to her room until it quits. Resident A is forced to get up earlier than other residents because she takes too long to get ready. Ms. Field calls the residents "yahoos." Resident C was forced to clean the bathroom after having diarrhea.

INVESTIGATION: On 02/02/2021, I made a call to licensee Debra Field. Ms. Field stated that Resident A makes a croaking noise, but the family calls it a "tick." Ms. Field stated that the noise Resident A makes is a habit (a comfort thing), but it is very loud and inappropriate. She stated that she had asked Resident A not to do it at the table. She stated that Resident A only excused herself from the table once to do her tic in another room. Ms. Field denied that she made Resident A get up earlier than the other residents to get ready for the day. She stated that there were only a couple of times if they had morning appointments, she would have Resident A get

up earlier because Resident A needed two hours in the bathroom. Ms. Field denied calling anyone a “yahoo.” Ms. Field stated that she herself cleaned the bathroom, and that if Resident C did try to clean, then she went behind Resident C and cleaned the bathroom up as well.

On 02/05/2021, I interviewed Resident C via Facetime. Resident C stated that they got along with Resident A, and that Ms. Field got along with Resident A fine. Resident C stated that she had never seen anyone mistreat Resident A. Resident C stated that Resident A was asked not to make her noise at the table because it was not appropriate. Resident C stated that Resident A can control the noise she makes. She stated that Resident A did comply like Ms. Field wanted her to. Resident C stated that she has made a mess in the bathroom, and that Ms. Field helped her clean it up. Resident C denied ever being called names, including a “yahoo.”

On 02/05/2021, I interviewed Resident B via Facetime. Resident B stated that she got along with Resident A, and that Resident A and Ms. Field got along good. Resident B stated that she did not witness anyone being mean toward Resident A about the noise that she would make, and that Resident A was asked not to do it at the table. She stated that Resident A reacted okay to that request and would go to her bedroom to make the noise. Resident B denied being called any offensive names and denied hearing the word “yahoo” being used.

On 02/19/2021, I interviewed staff Kennedy Swaffer via phone. Staff Swaffer stated that Resident A was treated good, like the other residents are. She stated that sometimes Resident A would cry all day, and make a frog sounding noise all day. She stated that Resident A was never mistreated because of this behavior. She stated that Resident A and Ms. Field got along fine. Staff Swaffer denied witnessing any name calling and has never heard anyone being called “yahoo.” She stated that Ms. Field cleans the bathroom, and she has never seen Resident C have an accident in the bathroom. She denied having any knowledge of Resident C being forced to clean the bathroom.

On 02/19/2021, I interviewed Relative 1, Resident A’s guardian via phone. Relative 1 stated that Ms. Field was causing Resident A’s anxiety to be high, which increased her vocal tic. Relative 1 stated that Ms. Field discharged Resident A from the home before Ms. Field could receive a note from the doctor stating that Resident A’s tic is involuntary.

On 02/19/2021, I interviewed Resident A via phone. Resident A stated that she has a nervous tic, and Ms. Field would not let her do it at the table. Resident A stated that Ms. Field called her and another individual a “couple of yahoos.” Resident A stated that she had to get up at 7:30 am because she took too long getting ready. Resident A stated that Resident C had made a mess in the bathroom, and Ms. Field made Resident C clean it up. She stated that this only happened once.

On 02/19/2020, I received a letter via email from Relative 1. The letter appears to be signed by a Dr. Charles E. Kerr, D.O. and dated for 12/10/2020. The letter states that Resident A has a vocal tic that is a medical condition, and that she is under his care for it. The letter also states that Resident A has no control over it, and it is not intentional.

Ms. Field provided a 30-day discharge notice on 12/09/2020 for Resident A, a day before the note from Resident A's doctor is dated. Resident A moved into the facility on 07/05/2020 and moved out on or around 12/09/2020.

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:	Ms. Field, Resident B, Resident C, and Staff Swaffer denied that Ms. Field called any residents "yahoo." Ms. Field denied that she made Resident A get up earlier than the other residents to get ready for the day. She stated that there were only a couple of times if they had morning appointments, she would have Resident A get up earlier because Resident A needed two hours in the bathroom. Resident A stated that she had to get up at 7:30 am because she took too long getting ready. Ms. Field and Resident C denied that Ms. Field forced Resident C to clean her bathroom. Resident B, Resident C, and Staff Swaffer denied witnessing Ms. Field mistreating Resident A due to her vocal tic. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The guardian was not notified on July 9, 2020 that Resident A was experiencing severe abdominal pain, and Ms. Field told Resident A to be quiet or she would wake up the other residents. Ms. Field never reported to the guardian about the pain, and Resident A had to tell the guardian about it.

INVESTIGATION: On 02/02/2021, I made a call to licensee Debra Field. She denied the allegations. Ms. Field stated that Resident A's relatives are the ones that

took Resident A to the doctor, and to her surgery. She stated that the family did all of the medical transportation for doctor appointments. Ms. Field stated that Resident A told her parents about her stomach pain and that is why they came and picked her up. She stated that she did not know Resident A that well at that time this occurred. She stated that Resident A's relatives would know things before she would know.

On 02/19/2021, I interviewed Resident A via phone. Resident A stated that she was in pain for two days prior to going to the hospital, and that she felt something on her right side. She stated that she did not ask Ms. Field to go to the hospital. She stated that she called her parents, and they took her to the doctor.

On 03/19/2021, I conducted a follow-up call with Relative 1. Relative 1 stated that Resident A called him within about four hours of her experiencing pain. He stated that Resident A said Ms. Field told her to be quiet as to not wake the other residents, and that she will be okay. He stated that they picked Resident A up and took her to get medical treatment that day. He stated that Resident A was away from the facility about a week due to having surgery.

On 03/19/2021, I conducted a follow up call with Ms. Field via phone. She stated that Resident A's family picked her up the morning she was complaining of abdominal pain and took Resident A to the doctor. She stated that they found out Resident A needed surgery, and the surgery got scheduled that day. She stated that Resident A did complain of pain, saying that her gut hurt. Ms. Field denied telling Resident A to be quiet because she would wake the other residents. She stated that she was informed later that day that Resident A had to have surgery.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Ms. Field stated that Resident A's relatives are the ones that took Resident A to the doctor, and to her surgery. She stated that the family did all of the medical transportation for doctor appointments. She stated that Resident A's relatives would know things before she would know. Ms. Field denied telling Resident A to be quiet because she would wake the other residents. Resident A stated that she was in pain for two days prior to going to the hospital, and that she felt something on her right side. She stated that she did not ask Ms. Field to go to the hospital. She stated that she called her parents, and they took her to the doctor.

	Relative 1 stated that Resident A called him within about four hours of her experiencing pain. He stated that they picked Resident A up and took her to get medical treatment that day. He stated that Resident A was away from the facility about a week due to having surgery. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: There is a concern that staff Kennedy Swaffer is not trained to pass medications.

INVESTIGATION: On 02/02/2021, I made a call to licensee Debra Field. Ms. Field stated that Kennedy Swaffer is a staff person, and she is trained in med passing.

On 02/05/2021, I interviewed Resident C via Facetime. Resident C stated that Ms. Field passes medication, and staff Kennedy Swaffer does as well sometimes. Resident C denied having any issues with Staff Swaffer passing medications and stated that Staff Swaffer only uses med cups when passing meds.

On 02/05/2021, I interviewed Resident B via Facetime. Resident B stated that Ms. Field passes the medication, and Staff Swaffer does as well. She stated that Staff Swaffer is just as good at passing meds as Ms. Field, and that she has not complaints about it. She stated that meds are passed in medication cups, and that they are passed to one person at a time.

On 02/19/2021, I interviewed staff Kennedy Swaffer via phone. Staff Swaffer stated that she is trained in medication administration. She stated that she puts the meds in a med cup and passes to one person at a time.

On 02/19/2021, I interviewed Resident A via phone. She stated that Staff Swaffer would pass meds when Ms. Field was not there. She stated that she received her correct medications during med passes.

On 02/19/2021, I received a copy of Staff Swaffer's training verification. She is signed off as being med trained by Ms. Field on 06/23/2020.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:

	(a) Be trained in the proper handling and administration of medication.
ANALYSIS:	Ms. Field stated that Kennedy Swaffer is a staff person, and she is trained in med passing. Resident B and Resident C did not express concern regarding Staff Swaffer passing medications. Staff Swaffer stated that she is trained in medication administration. Resident A stated that Staff Swaffer would pass meds when Ms. Field was not there. She stated that she received her correct medications during med passes. I received a copy of Staff Swaffer's training verification. She is signed off as being med trained by Ms. Field on 06/23/2020. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Resident A was supposed to receive $60 from her monthly check for personal spending. Ms. Field was not providing Resident A with her personal spending money.**

- **Receipts were not provided to the guardian for Resident A's personal spending money.**

INVESTIGATION: On 02/02/2021, I made a call to licensee Debra Field. Ms. Field stated that Resident A moved into the facility back in July 2020. Ms. Field stated that a 30-day notice was given in December 2020. Ms. Field stated that Resident A had went home with her parents in December 2020 and stayed away for several days. Ms. Field stated that she gave Resident A a 30-day written notice and tried to explain that Resident A did not have to immediately move out. She stated that Resident A's family did not understand adult foster care. Ms. Field stated that Resident A's mother is her payee, and that they did not pay any more than the state rate. Ms. Field stated that only $20 to $30 per month was given by Resident A's payee for spending money. She stated that she thinks Resident A's relatives thought that she was supposed to take the spending money out of the AFC monthly cost of care payment. Ms. Field stated that she only handled Resident A's personal money, and Resident A signed for every penny. Ms. Field stated that the case manager was supposed to notify Social Security for Resident A to get her Social Security increase. Ms. Field stated that they only went to the store about three times over the last year,

and mostly ordered items online, so there were no receipts, but Resident A signed for the purchases.

On 02/05/2021, I interviewed Resident B via Facetime. She denied having any issues with her cost of care payments or money and stated that she holds on to her own money.

On 02/05/2021, I interviewed Resident C via Facetime. Resident C stated that she manages her own money, and that she does not have a guardian.

A copy of Resident A's 30-day discharge notice was reviewed. The discharge notice is dated for 12/09/2020, and it states that "Field Home II is unable to provide the level of care for [Resident A]. A copy of the facility's discharge policy was reviewed as well. It is signed by Resident A's guardian and licensee Debra Field on 07/05/2020.

Resident A's *AFC-Resident Care Agreement* was reviewed. It is dated for 07/05/2020. The agreement is to pay the "state rate" on a monthly basis. The specific amount is not noted on the form. The "I agree to have the licensee manage funds and account for financial transactions on my behalf" box is not checked. The *AFC-Resident Care Agreement* is signed by both Relative 1 and Ms. Field.

A copy of Resident A's *Resident Funds Part II* form was reviewed. The documentation has both Ms. Field's and Resident A's signature noted for each transaction between 07/05/2020 and 12/11/2020. The transactions reflect Resident A's personal spending. Resident A's payment for adult foster care services are documented on the *Resident Funds Part II* form as well. Resident A paid $747 in July 2020, and $896.50 for August through December 2020.

A copy of Resident A's fee policy statement signed by Ms. Field and Relative 1 states that $896.50 (state rate) would be paid for a private room.

Resident A's *Resident Funds Record Part 1* was reviewed. Ms. Field noted on this documentation that she was to handle both payment for AFC and Resident A's cash in Section B of the form.

On 02/19/2021, I interviewed Relative 1, Resident A's guardian via phone. Relative 1 stated that the state rate is $896.50, and that Resident A's disability income was $883. Relative 1 stated that they contributed $13 dollars for the cost of care, and $30 for spending money. He stated that they later found out that $40-$60 of Resident A's income was supposed to be personal spending money. Relative 1 stated that he asked for receipts because he has to report to the courts. Relative 1 stated that he never received itemized receipts. Relative 1 stated that Resident A was moved out of the facility before the 30 days, because Resident A did not want to stay there.

On 03/19/2021, I conducted a follow up call with Relative 1. Relative 1 stated that Relative 2 is Resident A's payee. He stated that Relative 2 would write a check for $30 for Resident A's spending money, and that Ms. Field was to take care of the personal spending funds.

On 03/16/2021, I spoke with Ms. Field via phone. She reported that she gave the guardian some receipts, but not all. There were some receipts where Resident A's purchases were made with other purchases from the home. Therefore, there was no itemized receipt to give to the guardian.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(7) A resident shall have access to and use of personal funds that belong to him or her in reasonable amounts, including immediate access to not less than $20.00 of his or her personal funds. A resident shall receive up to his or her full amount of personal funds at a time designated by the resident, but not more than 5 days after the request for the funds. Exceptions to this requirement shall be subject to the provisions of the resident's assessment plan and the plan of services.
ANALYSIS:	Resident A's *AFC- Resident Care Agreement* indicates that she would pay the "state rate" monthly for her cost of care. A copy of Resident A's fee policy statement signed by Ms. Field and Relative 1 states that $896.50 (state rate) would be paid for a private room. Resident A's *Resident Funds Part II* forms reflect that $896.50 was consistently paid for Resident A's cost of care. Resident A's *Resident Funds Part II* form for her personal cash spending was reviewed. A refund of $45.99 was signed by Relative 1 on 12/11/2020. There is no preponderance of evidence to substantiate a rule violation in regard to Ms. Field not providing Resident A with her personal funds.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**

	(13) A licensee shall provide a complete accounting, on an annual basis and upon request, of all resident funds and valuables which are held in trust and in bank accounts or which are paid to the home, to the resident, or to his or her designated representative. The accounting of a resident's funds and valuables which are held in trust or which are paid to the home shall also be provided, upon the resident's or designated representative's request, not more than 5 banking days after the request and at the time of the resident's discharge from the home.
ANALYSIS:	Ms. Field stated that they only went to the store about three times over the last year, and mostly ordered items online, so there were no receipts for some of the purchases. She reported that she provided the guardian with some receipts, but not all. Relative 1 stated that he asked for receipts because he has to report to the courts. Relative 1 stated that he never received itemized receipts. There is a preponderance of evidence to substantiate the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 02/04/2021, I received a copy of Resident A's *Resident Funds Part II* form and her *AFC- Resident Care Agreement*. The resident care agreement form does not have the box checked for "I agree to have the licensee manage funds and account for financial transactions on my behalf. Expenditures of my personal funds over the amount of $___ require my prior written approval." There is no resident or designated representative signatures noted on Resident A's *Resident Funds Part II* form for her AFC cost of care payments. Resident A signed the Resident Funds Part II form her personal cash transactions.

Resident A's *Resident Funds Record Part 1* was reviewed. Ms. Field noted on this documentation that she was to handle both payment for AFC and Resident A's cash in Section B of the form. Relative 1 is listed as legal guardian, and Relative 2 is listed as representative payee in "Section A: The person or persons responsible for the resident's funds is (are)" part of the form.

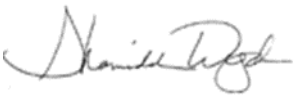
APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(8) All resident funds transactions shall require the signature of the resident or the resident's designated

	representative and the licensee or prior written approval from the resident or resident's designated representative.
ANALYSIS:	On 02/04/2021, I received a copy of Resident A's *Resident Funds Part II* form for cash and for AFC payment. I also reviewed a copy of her *AFC- Resident Care Agreement*. The resident care agreement did not note prior written approval. The *Resident Funds Part II* form for AFC cost of care did not have the required resident or designated representative signatures noted for Resident A's cost of care payments. The *Resident Funds Part II* form for cash had Resident A's signature on it. However, her resident care agreement did not note prior written approval. The guardian or payee signatures were not noted. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/19/2021, I conducted an exit conference with Ms. Field via phone. I informed her of the findings and conclusions.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of this AFC small group home license (capacity 6).



03/23/2021

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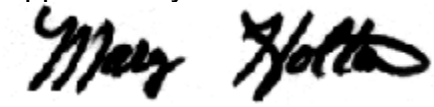
Shamidah Wyden Date
Licensing Consultant

Approved By:



03/23/2021

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Mary E Holton Date
Area Manager