GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 29, 2021

Debra McCovery
Alternative Community Living, Inc.
70 Lafayette
Pontiac, MI 48342

RE: License #: AM250294261
Investigation #: 2021A0779021
Genesee Regional Crisis Residential Unit

Dear Ms. McCovery:

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 (810) 787-7031.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(517) 899-5659

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AM250294261 |
| | |
| **Investigation #:** | 2021A0779021 |
| | |
| **Complaint Receipt Date:** | 03/16/2021 |
| | |
| **Investigation Initiation Date:** | 03/16/2021 |
| | |
| **Report Due Date:** | 05/15/2021 |
| | |
| **Licensee Name:** | Alternative Community Living, Inc. |
| | |
| **Licensee Address:** | 70 Lafayette<br>Pontiac, MI 48342 |
| | |
| **Licensee Telephone #:** | (248) 338-7458 |
| | |
| **Administrator:** | Mary Baldwin |
| | |
| **Licensee Designee:** | Debra McCovery |
| | |
| **Name of Facility:** | Genesee Regional Crisis Residential Unit |
| | |
| **Facility Address:** | 304 W. Tobias<br>Flint, MI 48503 |
| | |
| **Facility Telephone #:** | (810) 233-4093 |
| | |
| **Original Issuance Date:** | 12/14/2010 |
| | |
| License **Status:** | REGULAR |
| | |
| **Effective Date:** | 08/02/2019 |
| | |
| **Expiration Date:** | 08/01/2021 |
| | |
| **Capacity:** | 12 |
| | |
| **Program Type:** | MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A has been allowed to leave the facility without staff knowing and no one from the facility notified Resident A's guardian. | Yes |
| Resident A did not receive any medications during his stay here. | No |

## III. METHODOLOGY

| | |
|---|---|
| 03/16/2021 | Special Investigation Intake<br>2021A0779021 |
| 03/16/2021 | Special Investigation Initiated - Telephone<br>Spoke to Resident A's CMH case manager. |
| 03/16/2021 | Contact - Telephone call made<br>Spoke to Resident A's guardian |
| 03/16/2021 | Contact - Telephone call made<br>Interview conducted with Resident A. |
| 03/18/2021 | APS Referral<br>Complaint was referred to APS centralized intake. |
| 03/24/2021 | Inspection Completed On-site |
| 04/06/2021 | Contact - Telephone call made<br>Interview conducted with nurse, Nancy Blackhurst. |
| 04/08/2021 | Contact - Telephone call made<br>Interview conducted with staff person, Angela Royster. |
| 04/14/2021 | Exit Conference<br>Conducted with administrator, Mary Baldwin |
| 04/29/2021 | Contact – Telephone cal made<br>Interview with Mary Baldwin. |

**ALLEGATION:**

Resident A has been allowed to leave the facility without staff knowing and no one from the facility notified Resident A's guardian.

**INVESTIGATION:**

On 3/16/21, a phone conversation took place with Resident A's GHS case manager, Mohammad Kone, who confirmed that Resident A went to this facility from the hospital on 3/12/21. He reported that Resident A has a guardian but is free to be in the community unsupervised and normally lives in his own apartment, with out-patient psychiatric services/therapy in place. Mr. Kone stated that he sees or at least speaks with Resident A 4-6 days per week. Mr. Kone reported that he received an email from facility staff on 3/15/21 stating that Resident A walked away from the facility. Mr. Kone stated that he spoke to Resident A on 3/15/21, who told him that he left the facility because he did not want to take his medication.

On 3/16/21, a phone conversation took place with Resident A's guardian, who confirmed that Resident A left this facility on 3/15/21. Guardian A1 stated that she had spoken to Resident A after he walked home several miles without the facility staff knowing he had left. She stated that facility staff never called her to let her know that Resident A left the facility. Guardian reported that Resident A suffers from schizoid-effective disorder and Bi-polar disorder and has a history of not wanting to take his medications. She stated that Resident A is currently at his apartment and is safe.

On 3/16/21, a phone interview was conducted with Resident A, who was at home in his own apartment. Resident A stated that he checked himself out of this facility because he did not want to take his medications and that staff knew that he had left. Resident A then went off on a long tangent about how bad society is. Attempts were made to get Resident A refocused but he was not able to answer any further specific questions.

On 3/24/21, an on-site inspection was conducted. Multiple residents were viewed to be clean, well groomed and appeared well. An interview was conducted with administrator, Mary Baldwin, who stated that when the hospital wanted to discharge Resident A, Guardian A1 was contacted and approved the placement of Resident A to this facility on 3/12/21. Ms. Baldwin found notes in their computer system indicating that Resident A left the facility "against medical advice" (AMA) at 3:52 PM on 3/15/21. Ms. Baldwin stated that there was no incident report or other documentation describing the situation regarding Resident A leaving the facility. She reported that it appears that staff did not call Guardian A1 to notify her of Resident A leaving.

Resident A's assessment plan was reviewed and it confirmed his mental illness issues. It stated that Resident A is quite independent and able to perform all his activities of daily living on his own.

On 4/8/21, a phone interview was conducted with staff person, Angela Royster, who stated that she was the staff person that was working on 3/15/21, when Resident A left the facility. Ms. Royster stated that Resident A told her that he was leaving and going home to his apartment. She stated that she tried to get him to stay and made sure that Resident A understood that he was leaving the facility AMA. Ms. Royster reported that she sent Resident A's case manager an email regarding Resident A leaving, but admitted that she did not contact Guardian A1. She stated that she did not complete an incident report or any other written documentation regarding the incident.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14311** | **Investigation and reporting of incidents, accidents, illnesses, absences, and death.** |
| | **(5) A licensee shall submit a written report to the resident's designated representative and responsible agency in all instances where a resident is absent without notice. The report shall be submitted within 24 hours of each occurrence.** |
| **ANALYSIS:** | It was confirmed that Resident A left this facility AMA at 3:52 PM on 3/15/21. Staff person, Angela Royster, contacted Resident A's responsible agency by emailing Resident A's GHS case manager, Mohammad Kone, but failed to contact Resident A's designated representative, Guardian A1. There was no formal documentation written regarding Resident A leaving the facility or being provided to Guardian A1; therefore, violation of this rule is warranted. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

Resident A did not receive any medications during his stay here.

**INVESTIGATION:**

On 3/16/21, GHS case manager, Mr. Kone, stated that Resident A was admitted to the hospital on Friday 3/12/21 and discharged to this facility the same day. Mr. Kone stated that Resident A has significant mental health issues, which results in Resident A taking himself to the hospital frequently and that he is not surprised that the hospital did not do anything regarding Resident A's medication and just quickly discharged him to this facility. He reported that when Resident A is out in the community, he receives services from the medication delivery systems (MDS). He stated that MDS delivers medication

to Resident A twice daily and that Resident A is not allowed to keep his medications in the home. Mr. Kone stated that the MDS pharmacy prescriptions stopped once Resident was admitted to this facility and would not deliver medications to this facility. He stated that it was this facility's responsibility to have Resident A evaluated by their psychiatrist and prescribe and/or make any changes to Resident's medications that they feel necessary. Mr. Kone stated that it was normal for Resident A to arrive at this facility without any medication and due to him arriving on the weekend, the facility was not able to get Resident A new scripts and medication until Monday 3/15/21.

On 3/16/21, Resident A confirmed that he did not take any medications during his brief stay at this facility. He stated that his medications were offered to him on 3/15/21 but he did not want to take them and that it why he left the facility.

On 3/24/21, part-time facility nurse, Jennifer Webb, stated that Resident A arrived late in the evening on Friday 3/12/21 and that she did a medical assessment on him first thing Saturday morning. She confirmed that Resident A came to this facility straight from the hospital and arrived without any medications or prescriptions.

On 4/6/21, facility nurse, Nancy Blackhurst, stated that the facility psychiatrist does not work on Saturday's, but did have a virtual appointment with Resident A on Sunday 3/14/21. She stated that the pharmacy does not have a 24/7 pharmacy available on the weekends and that by the time the psychiatrist wrote prescriptions for Resident A on Sunday, the pharmacy was closed for the day. Ms. Blackhurst reported that she called the new scripts into the pharmacy first thing Monday 3/15/21, but that Resident A left the facility AMA that day, without taking any of his medication. Ms. Blackhurst stated that it is unfortunately not uncommon for Residents to come to this facility straight from the hospital without any medication.

On 4/29/21, a phone conversation took place with administrator, Mary Baldwin, to clarify Resident A's medication issue upon admission to this facility. Ms. Baldwin stated that Resident A came to their facility from the hospital emergency room and was never actually admitted to the hospital; therefore, Resident A did not have any discharge papers from the hospital. She reported that Resident A was placed at this facility by his GHS case manager, Mr. Kone, and Guardian A1, who were fine with him being evaluated by their psychiatrist for a medication review. Ms. Baldwin stated that GHS or Guardian A1 did not provide this facility with any medication or prescriptions for Resident A and that the pharmacy that Resident A and GHS were using would not deliver and/or provide medications to the facility.

| **APPLICABLE RULE** | |
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| **R 400.14312** | **Resident medications.** |
| | **(2) Medication shall be given, taken, or applied pursuant to label instructions.** |

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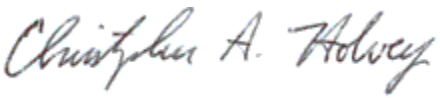
|---|---|
| **ANALYSIS:** | Insufficient evidence was found to warrant a rule violation regarding this allegation. Resident A came to this facility from the hospital and arrived without any medications or actual prescriptions. Resident A arrived during late evening on Friday 3/12/21 and a virtual appointment was set up and kept with a psychiatrist on Sunday 3/14/21 to address the medication issue. Due to the pharmacy not being open on Sunday after the appointment concluded, Resident A's prescriptions were filled on the morning of Monday 3/15/21, but Resident A left the facility AMA that day before taking any medications. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

On 4/14/21, an exit conference was conducted with administrator, Mary Baldwin, who was informed that this investigation warranted one licensing rule violation. She was informed that a written corrective action plan was required to address that rule violation.

## IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, I recommend that the status of this facility's license remain unchanged.



4/29/2021

Christopher Holvey Date
Licensing Consultant

Approved By:

04/29/2021

Mary E Holton Date
Area Manager