GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 27, 2021

Joanna Casas
2002 Brockway
SAGINAW, MI 48602

RE: License #: AS730391908
Investigation #: 2021A0871019
Rise Again AFC Home

Dear Ms. Casas:

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

I. IDENTIFYING INFORMATION

License #:	AS730391908
Investigation #:	2021A0871019
Complaint Receipt Date:	03/03/2021
Investigation Initiation Date:	03/03/2021
Report Due Date:	05/02/2021
Licensee Name:	Joanna Casas
Licensee Address:	2002 Brockway Saginaw, MI 48602
Licensee Telephone #:	(989) 332-2457
Administrator:	Joanna Casas
Licensee Designee:	N/A
Name of Facility:	Rise Again AFC Home
Facility Address:	2002 Brockway Saginaw, MI 48602
Facility Telephone #:	(989) 332-2457
Original Issuance Date:	01/18/2019
License **Status:**	REGULAR
Effective Date:	07/18/2019
Expiration Date:	07/17/2021
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was home alone with no staff present.	Yes
Additional Findings.	Yes

III. METHODOLOGY

03/03/2021	Special Investigation Intake 2021A0871019
03/03/2021	Special Investigation Initiated - On Site
03/25/2021	Contact – Telephone call me Phone contact with Licensee Joanna Casas.
04/08/2021	Inspection Completed On-site No one at facility.
04/09/2021	Inspection Completed-BCAL Sub. Non-Compliance
04/09/2021	Exit Conference Telephone exit conference with Licensee Joanna Casas.
04/21/2021	APS Referral Through Central Intake to Saginaw County MDHHS.
04/21/2021	Contact – Telephone call made Telephone call to Licensee Joanna Casas.
04/21/2021	Contact – Telephone call made Telephone call to Resident A's Case Manager Brenda Pruitt.
04/21/2021	Contact – Telephone call made Telephone call to Resident B's Case Manager Bree Farley.
04/21/2021	Contact – Telephone contact made Telephone call to Resident C.
04/21/2021	Contact – Telephone call made Telephone call to Resident B.
04/21/2021	Contact – Document received

	Received Resident A and B's *Assessment Plan for AFC Residents.*

ALLEGATION:

Resident A was home alone with no staff present.

INVESTIGATION:

On March 3, 2021, I conducted an unannounced onsite inspection at the facility. When I knocked on the door, no one came to the door. I knocked again and someone answered "I can't open the door. I'm the only one here right now. She [Licensee Joanna Casas] is at an appointment." I asked to whom I was speaking, and she replied "[Resident A]." Resident A then called Licensee Casas and advised her that I was at the facility.

On March 3, 2021, Licensee Casas returned to the facility in approximately five minutes. I explained to Licensee Casas that this is very serious leaving the residents alone. Licensee Casas said Resident B had an appointment and that is where she was and indicated she was gone about 20 minutes. Licensee Casas indicated she wants to close her license.

On April 21, 2021, I interviewed Resident B via telephone. Resident B stated she "was never left alone" and that "she (Licensee Casas) is my best friend." Resident B had no complaints about living at Rise Again AFC.

On April 21, 2021, I telephoned Resident A's Case Manager Brenda Pruitt. Ms. Pruitt indicated Resident A does not have a guardian. Ms. Pruitt stated, "this is the first I heard that [Resident A] was left alone." Ms. Pruitt said Resident A would go to group and then tell her that she was going to her sister's. Resident A never told Ms. Pruitt that she had been left alone.

On April 21, 2021, I telephoned Resident B's Case Manager Bree Farley. Ms. Farley advised that Resident B does not have a guardian. Ms. Farley stated she was unaware that Resident B had been left alone in the past.

On April 21, 2021, I Licensee Casas emailed me a copy of Resident A's *Assessment Plan for AFC Residents* that was signed and dated by Licensee Casas and Resident A on May 1, 2019. The *Assessment Plan for AFC Residents* indicates that Resident A "Moves Independently in Community."

On April 21, 2021, I Licensee Casas emailed me a copy of Resident B's *Assessment Plan for AFC Residents* that was signed and dated by Licensee Casas and Resident

B on May 17, 2019. The *Assessment Plan for AFC Residents* indicates that Resident B "Moves independently in Community."

On April 21, 2021, I telephoned Resident A at her new adult foster care home. Resident A said she "is doing real good" and that now she lives with her sister. Resident A did remember speaking to me at Rise Again AFC when Licensee Casas was not there.

On April 21, 2021, a referral was made with Adult Protective Services. Adult Protective Services was informed of the allegation of this investigation.

SIR #2021A0871001 dated November 10, 2020 substantiated violation to Rule 400.14303(2). The investigation found that on September 20, 2020, Saginaw City Police Officer Jordan LaDouce responded to the facility and there were no staff present. Resident C, who had just recently moved into the home, called the police because she was scared and there were no staff at the facility. On October 16, 2020 at an unannounced onsite inspection, Resident A told me there were no staff there, but Licensee Joanna Casas' son was in the basement. On October 19, 2020, while I was onsite, I did not observe any staff in the facility, but the licensee's son was in the basement. On both occasions, Licensee Joanna Casas' son never came upstairs to see who was in the facility. This report recommended a provisional license be issued contingent upon receipt of an acceptable plan of correction.

On February 25, 2021, a corrective action plan was received. Ms. Casas sent a corrective action plan stating that she agreed to the six-month provisional license and she would have staff in the home while residents are present. This corrective action plan was signed by Ms. Casas and dated 12/20/20.

On March 3, 2021, a corrective action plan disapproval letter was sent to Ms. Casas. The corrective action plan was disapproved due to Ms. Casas failing to provide corrective measures for violations to for Rule 400.14205(1) and Rule 400.14205(5) and Rule 400.14208(3).

On Mach 3, 2021, I advised Licensee Casas that she still needed to submit an appropriate corrective action plan for the previous investigation (SIR #2021A0871001) and that each rule violation needed to be addressed. I had a copy of SIR #2021A0871001 and went through the report and told her that I needed a corrective action plan that addressed each violation. Licensee Casas understood what was needed. This report also found violations pertaining to direct care staff requirements being obtained and documented and failure to maintain a staff schedule. The report was sent to Licensee Casas on November 10, 2020 and an acceptable corrective action plan was due by November 28, 2020. As of this date, an acceptable corrective action plan has not been received for SIR 2021A087101.

On March 25, 2021, I called Licensee Casas and advised her that I still needed an acceptable corrective action plan. Licensee Casas advised me that she wanted her license closed on April 1, 2021 and that Resident A was moving to a different adult foster care home and Resident B was moving in with her.

On April 9, 2021, I conducted a telephone exit conference with Licensee Joanna Casas. I advised Licensee Casas that the department is recommending revocation of her license and she would not be able to apply for an adult foster care license for five years. Licensee Casas said she did not intend to apply for another license. Licensee Casas advised that Resident A has moved out and Resident B is going to stay with her.

APPLICABLE RULE	
R 400.14303	**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:	On March 3, 2021, Resident A was home alone and told me she could not answer the door because she was the only one there. Licensee Casas did return home in approximately five minutes with Resident B. I confirm violation of this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2021A0871001 dated November 10, 2020.**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A's *Assessment Plan for AFC Residents* was not updated annually and was signed and dated on May 1, 2019. Resident B's *Assessment Plan for AFC Residents* was not updated annually and was signed and dated on May 17, 2019.

APPICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if

	applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A's *Assessment Plan for AFC Residents* was signed and dated by Licensee Joanna Casas and Resident A on May 1, 2019 Resident B's *Assessment Plan for AFC Residents* was signed and dated by Licensee Joanna Casas for Resident B on May 17, 2019. The plans were not updated annually. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Due to the willful and substantial violation cited in this report, I recommend revocation of this adult foster care small group license.

04/22/2021

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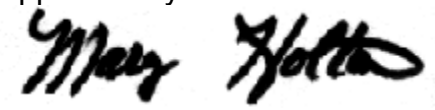
Kathryn A. Huber Date
Licensing Consultant

Approved By:



04/23/2021

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Mary E Holton Date
Area Manager