GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 28, 2021

Constance Yates
86 Yale
Battle Creek, MI 49017

RE: License #: AF130390161
Investigation #: 2021A0581039
Yates Family Home Care

Dear Ms. Yates:

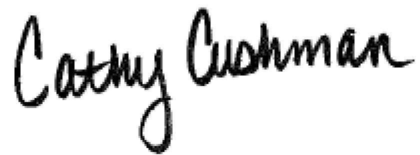
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 284-9730.

Sincerely,



Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
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(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF130390161
Investigation #:	2021A0581039
Complaint Receipt Date:	06/08/2021
Investigation Initiation Date:	06/08/2021
Report Due Date:	07/08/2021
Licensee Name:	Constance Yates
Licensee Address:	86 Yale Battle Creek, MI 49017
Licensee Telephone #:	(269) 965-6613
Administrator:	N/A
Licensee:	Constance Yates
Name of Facility:	Yates Family Home Care
Facility Address:	86 Yale St. Battle Creek, MI 49017
Facility Telephone #:	(269) 579-1164
Original Issuance Date:	02/05/2018
License Status:	REGULAR
Effective Date:	08/03/2020
Expiration Date:	08/02/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is unable to use the facility's bathroom to urinate.	No
The licensee calls residents' names.	No
The licensee makes the residents run errands with her when they do not to go.	Yes
Resident A cannot shower in the facility.	No
Additional Findings	Yes

III. METHODOLOGY

06/08/2021	Special Investigation Intake 2021A0581039
06/08/2021	Special Investigation Initiated - Telephone Interview with Complainant.
06/09/2021	Inspection Completed On-site Interview residents and licensee. Obtained resident documentation.
06/10/2021	Inspection Completed-BCAL Sub. Compliance
06/15/2021	Contact – Telephone call made Interview with Summit Pointe case manager, Dan Shadduck.
06/16/2021	Exit conference with the licensee, Connie Yates.

ALLEGATION:

Resident A is unable to use the facility's bathroom to urinate.

INVESTIGATION:

On 06/08/2021, I received this complaint through the Bureau of Community Health Systems (BCHS) on-line complaint system. The complaint alleged Resident A is unable to use the facility's one resident bathroom because the other residents are always occupying it; therefore, Resident A urinates in bottles and out of his secondary bedroom window.

On 06/09/2021, I completed an unannounced on-site inspection at the facility, as part of my investigation. I interviewed the licensee and residents regarding the allegations.

Licensee Connie Yates confirmed the facility has one resident bathroom on the facility's main floor. She stated residents can use the bathroom whenever they want, which includes Resident A. She stated she has explained to the residents that they may have to wait, on occasion, to use the bathroom, if someone else is using it. She stated she has also talked to them about not waiting to use the bathroom until they feel it is an emergency. She stated Resident A told her he urinates in bottles and out of his window because he must wait to use the bathroom, but Ms. Yates stated there is no need to urinate in bottles because he does not need to wait that long. Ms. Yates showed me pictures of Resident A's bedroom windowsill covered in dried urine.

During my on-site investigation, which lasted for approximately two hours, I had walked by the facility's resident bathroom several times and did not observe anyone utilizing or waiting for it.

I also interviewed Resident A, Resident B, Resident C, Resident D, and Resident E. Resident B, Resident C, Resident D and Resident E all had consistent statements to me regarding their access to the facility's sole resident bathroom. They all stated they had no issues with using the bathroom whenever they wanted or needed to. They also stated they had observed Resident A utilizing the bathroom.

Resident A stated he was unable to use the bathroom due to it always being occupied. Resident A admitted using bottles to urinate in and urinating out of his second story bedroom window instead of waiting to use the facility's bathroom.

On 06/15/2021, I Interviewed Resident A's Summit Pointe case manager, Dan Shadduck, via telephone. Mr. Shadduck stated Resident A urinating in bottles and out of his bedroom could be related to his antisocial personality diagnosis.

APPLICABLE RULE	
R 400.1409	**Resident rights; licensee responsibility.**
	(1) Upon a resident's admission to the home, the licensee shall inform and explain to the resident or the resident's designated representative all of the following resident rights: **(b) The right to exercise his or her constitutional rights, including the right to vote, the right to practice the religion of his or her choice, the right to freedom of movement, and the right of freedom of association.**

	(2) A licensee shall provide the resident and the resident's designated representative with a written copy of the rights outlined in subrule (1) of this rule upon a resident's admission to the home.
ANALYSIS:	Based on my investigation, which included interviews with Resident A, Resident B, Resident C, Resident D, and Resident E, the licensee, Constance Yates, Summit Pointe case manager, Dan Shadduck, and my observation of the facility's bathroom during my unannounced on-site investigation, there is no evidence any of the residents, including Resident A, is unable to freely use or access the facility's sole resident bathroom when they want or need to use it. My investigation indicated Resident A did not want to wait to utilize the facility's bathroom and instead chose to urinate in bottles and out of his second story bedroom window.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The licensee calls residents' names.

INVESTIGATION:

The complaint did not provide additional information other than what is stated in the allegations.

Complainant indicated Ms. Yates was telling Resident A he was "nasty" and "filthy" for urinating in bottles instead of using the bathroom.

Resident A's, Resident B's, Resident C's, Resident D's, and Resident E's statements to me were consistent with each other. All the residents denied Ms. Yates calling them any names or being inappropriate with them. Resident A indicated Ms. Yates had called him "filthy" and "nasty" for not showering and for urinating in bottles.

Ms. Yates denied calling any resident names or being inappropriate with any resident. She acknowledged talking to Resident A about urinating out of his window and told him it was "nasty"; however, she denied calling him names. I provided Ms. Yates consultation during the on-site; stressing to her about word usage and how words/tone of voice could be misconstrued or taken offensively.

APPLICABLE RULE	
R 400.1412	**Resident behavior management; prohibitions.**
	(1) A licensee shall not mistreat or permit the mistreatment of a resident or responsible persons or other occupants of the home. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk of physical or emotional harm.
ANALYSIS:	Based on my interviews with the residents and Ms. Yates, there is no evidence indicating Ms. Yates was mistreating the residents, including Resident A, by being inappropriate with residents or calling any resident inappropriate names.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The licensee makes the residents run errands with her when they do not want to go.

INVESTIGATION:

The complaint alleged when licensee Ms. Yates goes anywhere, she makes the residents go with her even when residents do not want to go. The complaint alleged when Ms. Yates take the residents with her, Resident A ends up having to sit in the trunk of Ms. Yates' vehicle because there are not enough seats. The complaint also alleged if Resident A does not go with Ms. Yates, he must sit on the facility's back porch or find somewhere to go because Ms. Yates does not allow him to be alone in the facility.

Complainant confirmed the allegations. Complainant stated Ms. Yates does not trust leaving Resident A alone in the facility and therefore he either has to go with her while she runs errands, or he will get left at the facility, but will get locked out. Complainant stated Resident A gets locked out of the facility approximately twice a week. Complainant stated when Resident A is locked out of the facility, he will either stay outside or he walks down the street to a relative's home, which is approximately five city blocks away. Complainant further stated if Resident A must go with Ms. Yates, he has to sit in the trunk of Ms. Yate's vehicle because Ms. Yate's vehicle only seats a total of five people.

Ms. Yates denied forcing residents to go with her while she runs errands or goes into the community. Ms. Yates stated if she must go to the store then all the residents choose to go with her. She stated she does not leave any residents home alone because they cannot be left unsupervised in the facility. She stated sometimes

Resident E stays at home, but Ms. Yates' sister supervises her. Ms. Yates stated Resident A choose to go to a local park or to a relative's house rather than go with her into the community. She denied locking him out of the facility if he chooses not to go with her.

Ms. Yates stated she transports residents using her SUV, which can seat seven individuals. She stated the SUV has a front and passenger seat, a middle bench style seat, which seats three people, and two seats in the trunk that fold up or down. Ms. Yates denied any of the residents having to sit in the trunk of the vehicle rather than in a seat.

I observed Ms. Yate's vehicle in her garage. She demonstrated the vehicle's third row seating, which allows her to transport seven individuals at one time all while sitting properly in the vehicle.

Resident A's, Resident B's, Resident C's, and Resident D's statements to me where consistent with the allegations. Resident E stated no residents are left at the facility without supervision. Resident A, Resident B, Resident C, and Resident D stated they have to go with Ms. Yates if she is running errands and needs to leave the facility. They stated they had to go with her even if they did not want to go and would rather stay at the facility. All these residents indicated there had been instances where Resident A had been left outside of the facility while Ms. Yates was running errands and was not allowed to enter the facility because Ms. Yates did not want him inside the facility. All residents interviewed indicated Ms. Yates would lock the facility's doors to prevent Resident A from entering it while she was gone.

Resident C indicated Resident A had ridden in the trunk of Ms. Yates's vehicle and was not in a proper seat. Resident A stated he had ridden in Ms. Yates' trunk, but the third row seating had been put up. He stated while the ride was uncomfortable, he had been sitting in a proper seat.

I informed Ms. Yates she can neither leave the residents alone nor force them to run errands with her due to a lack of supervision, which she acknowledged understanding and would comply with going forward.

APPLICABLE RULE	
R 400.1410	**Resident protection.**
	A licensee or responsible person shall always be on the premises when a resident is in the home.

ANALYSIS:	The licensee is prohibited from requiring residents to be away from the home during the day due to the lack of supervision. If a resident wants or needs to stay or return to the home, a licensee or responsible person must be present. Based on my investigation, which included interviews with all six residents of the facility, licensee Connie Yates, was requiring the residents to either go with her to run errands or denied Resident A from entering the facility due to lack of supervision being available in the facility. There was not sufficient evidence indicating the licensee locking Resident A out of the facility. Additionally, there is no evidence supporting the allegations of Resident A having to ride in Ms. Yate's vehicle trunk when making the residents run errands with her. Ms. Yates' vehicle has third row seating, which allows a total of seven passengers to be transported.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A cannot shower in the facility.

INVESTIGATION:

The complaint indicated Resident A was unable to shower in the facility's sole resident bathroom due to it always being occupied.

Complainant indicated Resident A had not showered in a month because he was unable to utilize the bathroom. Complainant indicated Resident A looked greasy and unshaven from not showering. Complainant indicated Resident A takes "bird baths" by only washing his private areas and armpits.

Ms. Yates stated Resident A can shower whenever he wants, just like all the other residents, but he chooses to only wash his private areas and armpits with a washcloth rather than take a regular shower. Ms. Yates indicated Resident A takes a regular shower approximately twice a week.

Resident A's, Resident B's, Resident C's, and Resident D's statements to me were all consistent with one another indicating all the residents can access the bathroom to shower whenever they wanted or needed to and do not experience any issues with doing so.

Resident A did not appear to be greasy or in need of a shower when I conducted my on-site at the facility. I did not notice any unpleasant odors from Resident A to indicate he needed a shower.

I reviewed Resident A's *Assessment Plan for AFC Residents*, 06/10/2019, which did not indicate Resident A required any assistance with bathing.

APPLICABLE RULE	
R 400.1420	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity for daily bathing.
ANALYSIS:	Based on my investigation, there was no evidence indicating any of the residents, including Resident A, are unable to access the facility's bathroom to shower as necessary or as desired.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

While interviewing Resident B in her bedroom, I observed multiple prescription medication bottles in a clear plastic tote near her bed. When I asked Resident B about the medications, she indicated they were hers. She stated she was able to administer her own medications to herself, as well. I observed Resident B's bedroom door to be a pocket door, which did not have the ability to lock from the outside.

I reviewed Resident B's *Assessment Plan for AFC Residents*, dated 08/13/2020, which stated Resident B is able to "disperse own medication."

Ms. Yates was unable to provide a physician's order stating Resident B can administer her own medication.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise, all the giving, taking, or application of prescription medications shall be supervised by the licensee or responsible person.

ANALYSIS:	There was no physician's order available for review indicating Resident B can administer her own medication, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(5) Prescription medication shall be kept in the original pharmacy-supplied and pharmacy-labeled container, stored in a locked cabinet or drawer, refrigerated if required, and labeled for the specific resident.
ANALYSIS:	Resident B was observed keeping her prescription medication in a clear plastic tote in her bedroom, which did not lock from the outside, rather than a locked cabinet or drawer, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my unannounced on-site inspection, I interviewed Resident B in her bedroom, which was located on the left-hand side of the hallway on the second level of the house. I did not observe a traditional door to the bedroom, but a sliding door that disappeared into a compartment into the facility wall, indicating the door was a pocket door. I observed an attached bolt lock device at the top of the pocket door indicating this was how Resident B locked her bedroom from the inside.

I informed Ms. Yates during the on-site inspection pocket doors are not allowed for resident occupied bedrooms. She stated she was originally licensed with this type of door but stated she would change it in order to be in compliance.

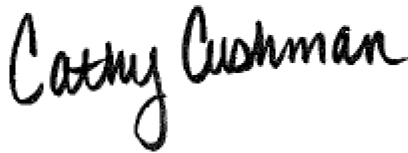
APPLICABLE RULE	
R 400.1431	**Bedrooms generally.**
	(3) Interior doorways of bedrooms occupied by residents shall be equipped with a side-hinged, permanently mounted door equipped with positive-latching, non-locking-against-egress hardware.

ANALYSIS:	Based on my observation, the upstairs bedroom on the left-hand side was a pocket door, which does not meet the requirement of this rule, as required. Additionally, the lock on the inside of the door was observed to be a bolt lock, which does not make the lock non locking against egress.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/16/2021, I completed my exit conference with the licensee, Connie Yates, at the facility. Ms. Yates acknowledged an understanding of the violations and stated she would correct them in order to be in compliance.

IV. RECOMMENDATION

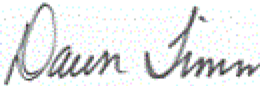
Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.



06/17/2021

Cathy Cushman   Date
Licensing Consultant

Approved By:



06/28/2021

Dawn N. Timm   Date
Area Manager