STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

July 30, 2021

JoAnn Freeland
Golden Years Adult Foster Care Home, Inc.
90 E. Hallett Street
Hillsdale, MI 49242

RE: License #: AM300302646
Investigation #: 2021A0122021
Golden Years AFC Homes Inc.

Dear Ms. Freeland:

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) 284-9720.

Sincerely,

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM300302646
Investigation #:	2021A0122021
Complaint Receipt Date:	07/06/2021
Investigation Initiation Date:	07/08/2021
Report Due Date:	09/04/2021
Licensee Name:	Golden Years Adult Foster Care Home, Inc.
Licensee Address:	90 E. Hallett Street Hillsdale, MI 49242
Licensee Telephone #:	(616) 795-2433
Administrator:	JoAnn Freeland
Licensee Designee:	JoAnn Freeland
Name of Facility:	Golden Years AFC Homes Inc.
Facility Address:	1885 S. Osseo Road Osseo, MI 49266
Facility Telephone #:	(517) 523-2100
Original Issuance Date:	06/29/2010
License **Status:**	REGULAR
Effective Date:	01/22/2021
Expiration Date:	01/21/2023
Capacity:	11
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 07/03/2021, Staff member, Amber Grant, was antagonizing Resident A by opening/shutting the door in her face as she was attempting to go into the facility.	Yes
Amber Grant hit Resident A with the door during the incident on 07/03/2021.	No

III. METHODOLOGY

07/06/2021	Special Investigation Intake 2021A0122021 APS Denied Referral
07/08/2021	Special Investigation Initiated - Telephone Completed interviews with Complainant 1 and Nicole Turpin, Home Manager.
07/12/2021	Contact – Telephone Call made. Completed interview with Katie Smith, Staff member.
07/19/2021	Contact – Telephone Call made. Resident A
07/20/2021	Exit Conference Discussed findings with JoAnn Freeland
07/27/2021	Contact – Telephone Call made. Attempted phone call made to Amber Grant.
07/27/2021	Contact – Telephone call made Interview with Relative A.
07/28/2021	Onsite Inspection Interview with Resident A.
07/29/2021	Contact – Telephone Call Made. Attempted phone call made to Amber Grant.

ALLEGATION: On 07/03/2021, Staff member, Amber Grant, was antagonizing Resident A by opening/shutting the door in her face as she was attempting to go into the facility.

INVESTIGATION: On 07/08/2021, Complainant 1 reported the following: On 07/03/2021, it was observed that Resident A was on the front porch crying with one other staff member. Attempts were made to figure out what was going on. Staff member, Amber Grant, went inside the facility and Resident A made an attempt to follow her. Amber Grant was observed slamming the door in Resident A's face. Resident A made several attempts to enter the facility but when she was unsuccessful due to Amber Grant's actions she gave up and sat back down on the porch.

On 07/08/2021, Home Manager, Nicole Turpin, stated that Amber Grant had been observed slamming the door in Resident A's face and this had been reported to her by Complainant 1. Ms. Turpin stated Resident A was assessed and no medical injuries were noted. Ms. Turpin is uncertain what happened to incite the incident involving Resident A and Amber Grant, however Ms. Grant has submitted a 3-day notice stating her resignation from employment. She discussed the incident briefly with staff member, Katie Smith.

On 07/12/2021, staff member Katie Smith confirmed that she observed staff member Amber Grant, slam the door in Resident A's face on 07/03/2021. Ms. Smith also reported that Ms. Grant used inappropriate language when interacting with Resident A. She observed Ms. Grant state the following: tell Resident A to "shut-up and go sit the fuck down." Also, when Resident A asked for assistance with washing her hair, Ms. Grant responded by saying, "You don't need help, don't be stupid."

Ms. Smith stated she intervened by verbally redirecting Resident A and offering her support. She did not observe any wound or injury on Resident A after her interaction with Ms. Grant. Ms. Smith stated she did not get an opportunity to report the incident to management, prior to her doing so she discussed the incident with Ms. Turpin after it was reported by Complainant 1. Amber Grant and Katie Smith were the only staff present during the incident of 07/03/2021.

On 07/19/2021, I attempted to complete an interview with Resident A. Resident A was unable to participate in an interview due to cognitive inability.

On 07/27/2021, I completed an interview with Relative A. Relative A stated she had been informed of the incident between Resident A and Amber Grant by a letter from Complainant 1. Per Relative A she discussed the issue with Nichole Turbin and was informed by Ms. Turbin that Amber Grant was no longer employed by Golden Years Adult Foster Care Home, Inc. She discussed the incident with Resident A and received no additional information other than what was already stated in the letter from Complainant 1. Relative A reported that she visits with Resident A monthly and

she has no issues and/or concerns regarding the care she is receiving from staff members of Golden Years Adult Foster Care Home, Inc.

On 07/28/2021, an onsite inspection was completed. I observed Resident A to be very social. She discussed her lunch meal, calendar with future outings, and room decorations. Resident A was observed to be comfortable interacting with other residents, staff, and within her surroundings.

Several attempts were made on 07/27/2021 and 07/29/2021 to contact and complete an interview with Amy Grant. However, the telephone number provided for Ms. Grant is not in working order.

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:	An allegation was received that on 07/03/2021, Staff member, Amber Grant, was antagonizing Resident A by opening/shutting the door in her face as she was attempting to go into the facility. On 07/12/2021, Staff member, Katie Smith, confirmed that she observed Amber Grant open/shut the door in Resident A's face several times on 07/03/2021. Ms. Smith further stated that Ms. Grant used profanity toward Resident A and spoke to her in a disrespectful manner. Based upon my investigation Resident A was not treated with dignity during the above incident with staff member, Amber Grant.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Amber Grant hit Resident A with the door during the incident on 07/03/2021.

INVESTIGATION: On 07/12/2021, staff member Katie Smith confirmed that she observed staff member Amber Grant, slam the door in Resident A's face on 07/03/2021. Ms. Smith did not observe Ms. Grant hit Resident A with the door but after the incident she completed a physical check of Resident A. Ms. Smith reported that she did not observe wound or injury on Resident A after her interaction with Ms. Grant on 07/03/2021.

An onsite inspection was completed on 07/28/2021. Resident A was observed to be comfortable in her surroundings, interacting well with other residents and staff members.

During my interview on 07/08/2021 with Home Manager, Nicole Turpin, she assessed Resident A on 07/03/2021 for injury and found the same; Resident A was not injured during her interaction with Ms. Grant.

On 07/19/2021, I attempted to complete an interview with Resident A. Resident A was unable to participate in an interview due to cognitive inability.

On 07/27/2021, I completed an interview with Relative A. Relative A stated she had been informed of the incident between Resident A and Amber Grant by a letter from Complainant 1. Per Relative A she discussed the issue with Nichole Turbin and was informed by Ms. Turbin that Amber Grant was no longer employed by Golden Years Adult Foster Care Home, Inc. She discussed the incident with Resident A and received no additional information other than what was already stated in the letter from Complainant 1. Relative A reported that she visits with Resident A monthly and she has no issues and/or concerns regarding the care she is receiving from staff members of Golden Years Adult Foster Care Home, Inc.

Several attempts were made on 07/27/2021 and 07/29/2021 to contact and complete an interview with Amber Grant. However, the telephone number provided for Ms. Grant is not in working order. The only staff present during the incident of 07/03/2021 were Amber Grant and Katie Smith.

An exit conference was completed on 07/20/2021 with JoAnn Freeland. Ms. Freeland agreed with my findings and will submit a corrective action plan to address all rule violations.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.

ANALYSIS:	On 07/03/2021, staff member, Amber Grant, hit Resident A with the door. Neither Katie Smith nor Nicole Turpin assessed that Resident A received an injury due to her interaction with Ms. Grant on 07/03/2021. Based upon my investigation direct care staff, Amber Grant, did not inflict pain on Resident A during the incident on 07/03/2021.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan, I recommend no change in the status of the license.

07/29/2021

Vanita C. Bouldin — Date
Licensing Consultant

Approved By:

07/30/2021

Mary Holton — Date
Area Manager