GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 26, 2021

Joyce Peterson
60407 M43 Highway
Bangor, MI 49013

RE: License #: AS800362293
Investigation #: 2021A0581042
Joyful Living

Dear Ms. Peterson:

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
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS800362293
Investigation #:	2021A0581042
Complaint Receipt Date:	06/22/2021
Investigation Initiation Date:	06/22/2021
Report Due Date:	08/21/2021
Licensee Name:	Joyce Peterson
Licensee Address:	60407 M43 Highway Bangor, MI 49013
Licensee Telephone #:	(269) 639-9430
Administrator:	Joyce Peterson
Licensee Designee:	N/A
Name of Facility:	Joyful Living
Facility Address:	328 Edgell Street South Haven, MI 49090
Facility Telephone #:	(269) 637-4823
Original Issuance Date:	04/26/2016
License Status:	REGULAR
Effective Date:	10/26/2020
Expiration Date:	10/25/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The facility has insufficient staff at the facility as the licensee, Joyce Peterson, is the only staff working.	Yes
The licensee, Joyce Peterson, mistreated Resident A by screaming at her, slapping, and pulling her hair on or around 06/20/2021.	No
Additional Findings	Yes

III. METHODOLOGY

06/22/2021	Special Investigation Intake 2021A0581042
06/22/2021	Referral - Recipient Rights Allegan RRO received allegations; therefore, a referral isn't necessary.
06/22/2021	APS Referral Confirmed with Adult Protective Services specialist, Mike Hartman, that he also received the allegations and is investigating. No referral necessary.
06/22/2021	Special Investigation Initiated - Telephone Interview with Complainant.
06/22/2021	Contact - Telephone call made Interview with Mike Hartman, APS.
06/22/2021	Contact - Telephone call made Interview with Allegan RRO, Charles Redman.
06/22/2021	Contact - Document Sent Requested police reports from South Haven Police Dept.
06/22/2021	Contact - Document Received Email from South Haven PD stating police report # 21-728 from 06/21/21 was not finished, but when it was, they would forward to me.
06/22/2021	Contact - Document Sent

	Requested police reports from Van Buren Sheriff's Police Dept.; however, the FOIA coordinator, Cat Brooks, stated there were none.
06/23/2021	APS Referral- Confirmed with APS Specialist Michael Hartman that the complaint is being investigated by APS.
06/28/2021	Contact - Telephone call received Interview with Joyce Peterson.
06/28/2021	Contact - Face to Face Picked up AFC documentation from Ms. Peterson in Kalamazoo.
06/29/2021	Contact - Document Received Received email from APS. Mr. Hartman, confirming APS was closing its case.
07/09/2021	Contact - Telephone call made Interview with Ms. Peterson.
07/12/2021	Contact - Document Received Received additional staff documentation and schedules from Ms. Peterson.
07/15/2021	Inspection Completed-BCAL Sub. Compliance
07/26/2021	Exit conference with the licensee, Joyce Peterson.

ALLEGATION:

The facility has insufficient staff at the facility as the licensee, Joyce Peterson, is the only staff working.

INVESTIGATION:

On 06/22/2021, I received this complaint through the Bureau of Community Health Systems (BCHS') on-line complaint system. The complaint indicated the licensee, Joyce Peterson, is operating the facility without any staff except herself.

On 06/22/2021, I confirmed with Allegan County Recipient Rights Officer (RRO), Mandy Padget, Allegan Officer of Recipient Rights (ORR) had received the allegations and was investigating. Ms. Padget stated when ORR completed its site review several months ago, Ms. Peterson indicated at that time she was the only direct care staff working in the facility.

On 06/23/2021, I reviewed Resident A's, Resident B's, and Resident C's Allegan Community Mental Health's Psychosocial Assessments. According to Resident A's psychosocial assessment, dated 03/29/2021, she requires "24/7 supports to manage her behavioral concerns, and to assist with activities of daily living (personal care, transportation, medical appointments, money management, household management, meal preparation, community integration, etc.)".

According to Resident B's psychosocial assessment, dated 04/12/2021, she requires "considerable support in most areas due to impulsivity and poor decision making which can and has affected her health and safety. [Resident B] struggles with future thinking and needs daily reminders, prompts, and interventions to manage daily activities".

According to Resident C's psychosocial assessment, dated 06/12/2021, he requires the following:

> …a full assist for most ADL's and needs support and a walker for mobility and requires a wheelchair for longer. Based on his current level of functioning, [Resident C] requires monitoring for health and safety at all times. He is a fall risk and needs full assistance with feeding to avoid choking and aspirating. [Resident C] is a full assist for all ADLs at this time.

On 06/23/2021, I confirmed with Van Buren Adult Protective Services (APS) Specialist, Mike Hartman, he had also received the allegations and was investigating.

On 06/24/2021, I conducted an unannounced on-site at the facility, as part of my investigation. The licensee, Joyce Peterson, was not present in the facility at the time of my on-site due to having a scheduled appointment. There were two individuals in the facility acting in the capacity of direct care staff, Roberta "Robin" Simpson, and Kenneth Bray.

Ms. Simpson indicated she works at the facility as a direct care staff several days per week, typically Wednesdays through Fridays from 8 am until 6 pm. She stated she was hired in 2020; however, due to a limited number of residents at the facility during that time (i.e., Covid pandemic), she took some time off and had been working more since the admission of two female residents.

The second individual, Mr. Bray, stated he also assists with the residents; however, he stated he doesn't assist the residents by himself because he had not completed his training with Community Mental Health. Mr. Bray stated he assisted residents only when there was another staff in the facility like Ms. Simpson or Ms. Peterson. Mr. Bray stated he was in the process of being hired, but had yet to obtain his

fingerprints, training, or anything else related to being a direct care staff. Neither Mr. Bray nor Ms. Simpson were able to provide me with a direct care staff schedule during the on-site inspection, indicating Ms. Peterson would be able to provide one to me.

Ms. Simpson and Mr. Bray indicated Ms. Peterson sleeps overnights at the facility and is available to assist the residents, if needed. They denied anyone else working as a direct care staff at the facility.

I interviewed Resident A and Resident B as they were both verbal. Both residents indicated there were three direct care staff working at the facility, which were Ms. Peterson, Ms. Simpson, and Mr. Bray. I was unable to interview Resident C or Resident D due to them being nonverbal.

On 06/28/2021, I interviewed the licensee, Joyce Peterson, via telephone. She confirmed she lives at the facility and sleeps there at night. She stated she has "motion detectors" in resident bedrooms so if a resident gets up in the middle of the night she's alerted. She stated the facility is staffed with at least one direct care staff in a 24 hour period and she is typically at the facility. She stated Ms. Simpson works three to four days per week around 10 hours per day. She stated Mr. Bray was in the process of being hired, but he was not left alone with residents. Ms. Peterson stated Mr. Bray was attending training at Allegan Community Mental Health and had obtained fingerprints. I agreed to meet Ms. Peterson to obtain confirmation of background checks for Ms. Simpson and Mr. Bray, their initial medicals and TB results, confirmation of their direct care staff training, and the facility's staff schedule for the last two months.

On 06/28/2021, I reviewed the staff schedules provided by Ms. Peterson, which consisted of schedules for only Ms. Simpson and Mr. Bray. According to Ms. Peterson's staff schedule, Ms. Simpson worked at the facility May 4th-6th, May 11th-13th, May 17th-20th, and May 25th-May 28th. The schedule also indicated Ms. Simpson worked at the facility June 1st-4th, June 8th-11th, June 15th-19th, and June 29th-30th. The schedule neither included specific times frames worked by staff nor did it include the specific days/times Ms. Simpson worked while at the facility.

The schedule provided by Ms. Peterson indicated Mr. Bray had training with Ms. Peterson from May 24th-27th, June 1st-4th, and June 14th-18th.

Ms. Peterson also provided me with copies of Resident A's Resident B's, Resident C's, and Resident D's *Assessment Plans for AFC Residents* (assessment plan)*, Health Care Appraisals* (HCA)*, and Resident Care Agreements (RCA)*.

According to Resident A's assessment plan, dated 01/25/2021, Resident A requires assistance with all her Activities of Daily Living (ADLs) such as eating, toileting, bathing, grooming, dressing, personal hygiene, and walking/mobility. Resident A's HCA, dated 04/08/2021, indicated Resident A is fully ambulatory and is diagnosed

with Down's Syndrome, high blood pressure with chronic kidney disease and hypothyroidism.

Resident B's assessment plan, dated 06/15/2021, was missing the first page, but indicated Resident B doesn't require assistance with any ADL's. Resident B's HCA indicated she is also fully ambulatory and has a diagnosis of severe manic bipolar I disorder with psychotic features and is mood congruent.

According to Resident C's assessment plan, dated 10/15/2020, indicated Resident C requires assistance with all his ADL's including eating due to aspiration and walking to prevent falls. Resident C's HCA was not included with his documentation; therefore, I was unable to review it.

Resident D's assessment plan, which was missing the second and fourth pages and therefore, had neither dates nor signatures indicating when it was completed and reviewed. Due to the assessment plans second page missing, there was no indication what kind of assistance Resident D requires with his ADL's. According to Resident D's HCA, dated 11/04/2020, his primary diagnosis is cerebral palsy, and he is fully ambulatory.

On 07/09/2021, I contacted the licensee, Joyce Peterson, again to obtain clarification on her staffing situation. Ms. Peterson stated Mr. Bray was hired the end of May, but she denied him immediately working at the facility because he had scheduled annual leave. She again stated he didn't work by himself until he completed his fingerprints. She stated his actual first day of working was 06/24/2021.

On 07/12/2021, Ms. Peterson sent me additional copies of her staff schedule for April 2021, May 2021, and June 2021. According to these schedules, only Ms. Paterson and Ms. Simpson worked at the facility in April and May. The schedules indicated Ms. Simpson and Ms. Peterson primarily split the workdays into 12 hours shifts with Ms. Simpson working the day shift while Ms. Peterson worked the night shift. The May schedule indicated Ms. Peterson worked 24 hours shifts for a total of nine days as Ms. Simpson had the day "Off". The schedules did not indicate any other staff were scheduled to working during Ms. Peterson's 24 hours shifts.

The staff schedules indicated Mr. Bray started training at the facility on 05/24/2021. The schedule further indicated Mr. Bray started working overnight shifts on 06/05/2021. The schedule indicated Mr. Bray was the only night staff working 06/06/2021, 06/07/2021, 06/08/2021, 06/09/2021, 06/12/2021, 06/13/2021, and 06/14/2021 as the schedule had Ms. Peterson identified as "off" during these overnight shifts, which further indicates Mr. Bray was working alone in the facility during these times.

I also reviewed Ms. Peterson's Original Licensing Study Report (LSR), dated 03/26/2016, which indicated she would have direct care staff awake during sleeping hours.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) The 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:	Based on my investigation, which included interviews with the licensee, Joyce Peterson, direct care staff, Roberta Simpson and Kenneth Bray, Resident A, Resident B, Allegan Community Mental Health Recipient Rights Officers, Mandy Padget and Charles Redman, my review of the resident's *Assessment Plans for AFC Residents* and their Allegan County CMH Psychosocial Assessments, resident *Health Care Appraisals*, and my review of Ms. Peterson's staff schedules for May and June 2021, there is evidence indicating Ms. Peterson did not have sufficient staff on duty when she was scheduled to work at the facility for 24 hour shifts multiple days in a row and throughout the month. In addition, Ms. Peterson indicated in her original licensing study report direct care staff would be awake during sleeping hours; however, based on my interviews with Ms. Peterson and staff, Ms. Peterson sleeps in the facility at night. Additionally, Ms. Peterson's staff schedules indicate Mr. Bray was the only direct care staff working the overnight schedule on 06/06/2021, 06/07/2021, 06/08/2021, 06/09/2021, 06/12/2021, 06/13/2021, and 06/14/2021 prior to him being deemed competent as a direct care staff. Subsequently, having Mr. Bray as the only staff on shift during these times indicates the facility did not have sufficient staff on duty for the supervision, personal care, and protection of residents as specified in their assessment plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The licensee, Joyce Peterson, mistreated Resident A by screaming at her, slapping, and pulling her hair on or around 06/20/2021.

INVESTIGATION:

The complaint indicated licensee Joyce Peterson screamed at Resident A, in addition to, hitting her in the face and pulling her hair on or around 06/20/2021.

Allegan County RRO Charles Redman stated he had interviewed Resident A and her statement to him was consistent with the allegations.

On 06/23/2021, I reviewed South Haven Police Department's police report #21-728. According to this report, Officer Deboer reported to the facility on 06/21/2021 at approximately 6:50 pm due to concerns Resident A had been assaulted by Ms. Peterson. Officer Deboer interviewed both Ms. Peterson and Resident A. Ms. Peterson stated to Officer Deboer she and Resident A had been in the facility's backyard when Resident A became upset, so she took her in the basement to talk to her. Ms. Peterson stated to Officer Deboer Resident A told her she didn't want to reside in the facility any longer and she had only been expressing this since Resident B recently moved in. Ms. Peterson reported to Officer Deboer when Resident A gets upset, she throws things and indicated Resident A had thrown soap on the floor. Ms. Peterson stated to Officer Deboer she took Resident A's wrists and led Resident A to the soap and instructed her to pick it up; however, Resident A refused to pick it up and then started yelling and throwing more things. Ms. Peterson stated she contacted Resident A's guardian and while Resident A was talking to her guardian Resident A reported Ms. Peterson had slapped her and pulled her hair. Ms. Peterson stated to Officer Deboer after she heard Resident A make those allegations, she immediately contacted Allegan Community Mental Health.

Officer Deboer also interviewed Resident A, who's statement to him was consistent with the allegations. Resident A reported to Officer Deboer she had thrown soap on the ground and it was after she did that, Ms. Peterson slapped her in the face and pulled her hair. Officer Deboer indicated in his report he did not observe any marks or bruises on Resident A while he was interviewing her. While Officer Deboer was interviewing Resident A, she expressed she wanted to kill herself. Officer Deboer contacted an ambulance who then transported Resident A to the hospital for evaluation.

During my on-site inspection, I interviewed Ms. Simpson and Mr. Bray. Neither Ms. Simpson nor Mr. Bray stated they were present when the incident with Resident A and Ms. Peterson occurred and therefore, had no information to provide regarding the allegations. They denied Ms. Peterson being aggressive or acting inappropriately with residents while they were present, including Resident A.

I interviewed Resident A whose statement to me was consistent with the allegations. Resident A stated she had a “behavior” on Monday and Ms. Peterson hit her in the face and pulled her hair twice. Resident A stated the incident occurred while she was in the downstairs bathroom. I asked Resident A what behavior she was displaying that led up to the incident and she stated she had thrown a bottle of soap in the bathroom. Resident A stated Ms. Peterson forced her to the floor to pick up the soap by taking her arms and leading her to the soap. Resident A stated she took the phone from Ms. Peterson, stayed in the bathroom, and contacted police. She stated no other residents or staff were around her when the incident occurred as the other residents were upstairs. Resident A stated she did not have any marks or bruises from the incident with Ms. Peterson. I asked Resident A how Ms. Peterson talks to her, and she stated she talks to her “regularly.” She denied Ms. Peterson yelling at her or calling her names.

I interviewed Resident B who stated she had been at the facility when the incident between Resident A and Ms. Peterson allegedly occurred. She stated Resident A was “acting out”, which included Resident A throwing a pillow at one of the other residents who is nonverbal. Resident B stated Ms. Peterson tried talking to Resident A by saying “stop that” and “stop.” Resident B denied ever seeing Ms. Peterson hit or assault Resident A. She stated she did not recall hearing any disturbances or arguments occurring even when Resident A and Ms. Peterson were downstairs. Resident B stated she feels safe in the facility. She stated Ms. Peterson is “nice” and indicated she will “raise her voice”; however, she denied her calling any of the residents any names, yelling or screaming at anyone.

I attempted to interview the facility’s remaining two residents; however, Resident C was sleeping, and Resident D had limited verbal capabilities and was not responding to my questions.

Ms. Peterson stated Resident B was admitted to the facility on 06/15/2021 and is higher functioning than Resident A. She stated since Resident B’s admission, Resident A had been displaying more behaviors, which Ms. Peterson believed to be because she was jealous of Resident B. Ms. Peterson stated she has been trying to work with Resident A on being more patient and respectful; however, Resident A continued to “act out” by screaming, yelling, and throwing things at the other residents. Ms. Peterson stated Resident A also threatens to harm or kill herself when she’s displaying behaviors.

Ms. Peterson acknowledged the alleged incident with Resident A; however, she denied assaulting, slapping, or pulling her hair. Ms. Peterson stated Resident A had talked to her guardian and after her conversation with her she started demonstrating behaviors. Ms. Peterson stated she tried calming Resident A down by taking her outside and distracting her with putting a swing out. She stated she tried talking to Resident A; asking her what she wanted, but Resident A stated she didn’t want anything. Ms. Peterson stated Resident A started to get loud so Ms. Peterson asked her to go downstairs with her in the basement where Resident A’s bedroom is

located. Ms. Peterson stated Resident A went into the facility bathroom and shut the bathroom door. Ms. Peterson stated she was concerned about Resident A, due to her history of threatening to harm herself, so she went into the bathroom. She stated Resident A threw a bar of soap at her. Ms. Peterson stated she asked Resident A to pick up the bar of soap, but Resident A refused. Ms. Peterson stated she then took Resident A's hands and guided her to the bar of soap to pick it up. Ms. Peterson stated Resident A was yelling at her saying she was hitting her. Ms. Peterson stated she told Resident A she needed to calm down and that she wasn't hitting her. Ms. Peterson stated Resident A was swinging her hands and arms around trying to hit her so Ms. Peterson grabbed her arms to stop her from hitting her. Ms. Peterson stated the maneuver was similar to putting Resident A in a bear hug. She stated it lasted for "a second or so". She stated the whole incident with Resident A lasted for approximately five minutes. She stated when Resident A yelled to be let go, Ms. Peterson let her go. Ms. Peterson stated she contacted Resident A's guardian to see if talking to Resident A would help; however, Ms. Peterson stated Resident A told her guardian she had hit her. Ms. Peterson stated she contacted Allegan's crisis line, but no one called her back. Ms. Peterson stated the police also came out to the facility. Ms. Peterson stated the remaining three residents were upstairs and did not observe the incident. She stated no other staff were on shift at the time.

ON 06/29/2021, Adult Protective Services specialist, Mike Hartman, informed me South Haven Police Department would not be seeking any charges against Ms. Peterson for the alleged assault of Resident A and APS would be closing its case with no 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:	Based on my investigation, which included interviews with Allegan Community Mental Health Recipient Rights Officers, Mandy Padget and Charles Redman, the licensee, Joyce Peterson, direct care staff, Robin Simpson and Kenneth Bray, Resident A, Resident B, Adult Protective Services Specialist, Mike Hartman, and my review of South Haven Police Department's report # 21-728, there is no evidence indicating Ms. Peterson slapped and pulled Resident A's hair on or around 06/20/2021.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

I requested Ms. Peterson provide me with copies of Resident A's, Resident B's, Resident C's, and Resident D's *Assessment Plans for AFC Residents* (assessment plan), which she provided to me on 06/28/2021.

In my review of the documentation Ms. Peterson provided to me for the four residents, I determined all four residents are involved with local community mental health agencies (responsible agencies) and have guardians.

Resident A's assessment plan was dated 01/25/2021 by the licensee, Ms. Peterson; however, there was no indication on the assessment plan it had been reviewed with Resident A's guardian or her responsible agency.

Resident B's assessment plan was dated 06/15/2021 by Ms. Peterson and signed by Resident B, there was no indication the assessment plan had been reviewed by Resident B's guardian or her responsible agency.

Resident C's assessment plan was missing the second and fourth pages; therefore, there was no signature date indicating the date it was completed or who it was reviewed with.

Resident D's assessment plan was not dated and had only been signed by Ms. Peterson.

APPLICABLE 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:	Based on my review of Resident A's, Resident B's, Resident C's, and Resident D's *Assessment Plans for AFC Residents*, there is indication the licensee, Joyce Peterson, is not reviewing or completing the resident assessment plans with the resident's designated representatives or his or her responsible persons, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Mr. Bray stated to me during the on-site inspection at the facility that he had not yet obtained his fingerprints, but he indicated he was not being left alone with the residents do to not completing his required trainings through CMH. During my on-site inspection, I requested to review the facility's staff schedules; however, neither him nor the facility's other direct care staff, Ms. Simpson, could provide them to me.

Resident A and Resident B both indicated the only staff working in the facility were Mr. Bray, Ms. Simpson, and Ms. Peterson.

Ms. Peterson indicated Mr. Bray was hired the end of May to work at her facility. She indicated he was never alone with the residents while shadowing her and Ms. Simpson.

Ms. Peterson initially provided me with one sheet of documentation indicating her staff schedules for May and June 2021. According to this staff schedule, Mr. Bray had training with Ms. Peterson from May 24th-27th, June 1st-4th, and June 14th-18th. On 07/09/2021, during a telephone interview with Ms. Peterson I asked if she had staff schedules with more specific information. Ms. Peterson provided additional staff schedules to me on 07/12/2021. According to these schedules, Mr. Bray worked 12 hour nights at the facility from 06/06/2021 through 06/09/2021 and again from 06/12/2021 through 06/14/2021 while Ms. Peterson was listed as "off" on the schedule. Ms. Simpson was also scheduled on the same days as Mr. Bray, but the schedules indicated she was working 12 hours day shifts.

On 06/28/2021, I obtained staff documentation from Ms. Peterson. Ms. Peterson provided documentation confirming Mr. Bray had fingerprints completed on the morning of 06/28/2021. Ms. Peterson indicated Mr. Bray was completing his initial medical that day as well.

On 07/12/2021, Ms. Peterson sent me additional staff documentation. Ms. Peterson provided me with Mr. Bray's initial medical clearance; however, the section which was to be completed by Mr. Bray's physician was not filled out. For example, though the document indicated Mr. Bray had a prior TB skin test completed on a future date of 07/29/2021, the area in which indicated the TB test results was not completed. Additionally, the section indicating if Mr. Bray possessed the ability to work with and around dependent adults was also not completed. The document was neither signed by a physician nor had a date for when it as reviewed by Mr. Bray's physician.

This is a repeat violation of Adult Foster Care Facility Licensing Act rule MCL 400.734b. According to the 2020 Renewal Licensing Study Report, dated 10/01/2020, Ms. Peterson failed to get fingerprints for her husband, Charles Peterson, who she indicated was assisting the residents in the facility and/or taking them on outings. Ms. Peterson submitted a corrective action plan, dated 10/21/2020, which indicated she would obtain fingerprints for Mr. Peterson. On 10/30/2020, Ms. Peterson provided verification of her CAP by submitting confirmation Mr. Peterson's fingerprints had been completed through the Workforce Background Check.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of

	a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	Based on my review of Ms. Peterson's staff schedules and my interviews with Mr. Bray, Ms. Peterson, Resident A and Resident B, there is evidence direct care staff, Kenneth Bray, had been assigned to work the night shift at the facility when no other staff was identified as working. Subsequently, Ms. Peterson failed to conduct a background check on Mr. Bray prior to him having direct access to residents within the facility, as required.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE RENEWAL LSR dated 10/01/2020 and CAP dated 10/21/2020].**

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.
ANALYSIS:	Ms. Peterson did not provide documentation signed by a physician or his or her designee attesting to direct care staff, Kenneth Bray's physical health within 30 days of Mr. Bray's employment, assumption of duties or occupancy in the home, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.
ANALYSIS:	Ms. Peterson did not provide documentation confirming direct care staff, Kenneth Bray, had current TB testing prior to his employment, assumption of duties, or occupancy within the home, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my investigation, I requested staff schedules from Ms. Peterson. The first document provided by Ms. Peterson was one document with the names of her staff and the days they worked in May and June. Ms. Peterson provided additional staff schedules on 07/12/2021 for May and June 2021; however, these schedules did not indicate the actual hours staff worked, their job titles, or any scheduling changes, as required.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	Based on my review of the licensee's staff schedules, they were not sufficient in meeting all the requirements of the rule, as required. Ms. Peterson did not indicate on her staff schedules the job titles of staff, the actual hours they worked at the facility and if there were any changes, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/26/2021, I conducted my exit conference with the licensee, Joyce Peterson, via telephone. Ms. Peterson acknowledged an understanding of the violations, including the repeat finding, and stated she would provide an acceptable corrective action plan to address the violations.

IV. RECOMMENDATION

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

07/26/2021

Cathy Cushman Date
Licensing Consultant

Approved By:

07/26/2021

Dawn N. Timm Date
Area Manager