

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

October 25, 2021

Darin Crite Crites Adult Foster Care Inc P O Box 48087 Oak Park, MI 48237

> RE: License #: AM820010103 Investigation #: 2021A0901033

Crites AFC #1

Dear Mr. Crite:

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.

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 (313) 456-0380.

Sincerely,

Regina Buchanan, Licensing Consultant Bureau of Community and Health Systems Cadillac Pl. Ste 9-100

3026 W. Grand Blvd Detroit, MI 48202 (313) 949-3029

Regina Buchanon

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM820010103
Investigation #:	2021A0901033
Complaint Receipt Date:	08/25/2021
Investigation Initiation Date:	08/26/2021
Report Due Date:	10/24/2021
•	
Licensee Name:	Crites Adult Foster Care Inc
Licensee Address:	P O Box 48087
	Oak Park, MI 48237
Licensee Telephone #:	(313) 701-9595
	(0.0) 101 000
Administrator:	Darin Crite
/ tallimotrator:	Bailli Onto
Licensee Designee:	Lenora Crite
Elections Beergines.	Editora Office
Name of Facility:	Crites AFC #1
rume of Fuelity:	Grico 7 ii O ii 1
Facility Address:	4327 Avery
Tuomity Address.	Detroit, MI 48208
	Bettott, Wil 40200
Facility Telephone #:	(313) 833-8418
r demity receptione #.	(010) 000-0410
Original Issuance Date:	08/05/1992
Original issuance bate.	00/00/1002
License Status:	REGULAR
License Gtatas.	THE GOLF III
Effective Date:	01/31/2021
Lifective Date.	01/31/2021
Expiration Date:	01/30/2023
Expiration Date.	01/00/2020
Capacity	12
Capacity:	12
Brogram Type:	
Program Type:	PHYSICALLY HANDICAPPED

DEVELOPMENTALLY DISABLED
MENTALLY ILL
AGED

I. ALLEGATION(S)

Violation Established?

Staff Leon picks on Resident A and does not like Michael.	No
Leon does not serve Resident A a plate of food and there is not enough food in the home.	No
The home smells like it has a lack of cleanliness. The home smells mildewy and like a dirty mop.	No
Additional Findings	Yes

II. METHODOLOGY

08/25/2021	Special Investigation Intake 2021A0901033
08/25/2021	APS Referral
08/26/2021	Special Investigation Initiated - Telephone Tonya Lowman, Case Manager
08/30/2021	Inspection Completed On-site Resident A Staff, Ronald Brown
09/01/2021	Contact - Telephone call made Licensee Designee, Darin Crite
09/01/2021	Contact - Telephone call made Staff, Leon Hose
09/02/2021	Contact - Document Received IPOS
10/21/2021	Referral - Recipient Rights
10/21/2021	Exit Conference Licensee Designee, Darin Crite

ALLEGATION:

Staff, Leon, picks on Resident A and does not like Michael.

INVESTIGATION:

On 08/26/2021, I made a telephone call to Tonya Lowman, Resident A's case manager from The Development Centers. Ms. Lowman stated Resident A feels threatened by Leon but that Resident A was unable to give details why.

On 08/30/2021, I conducted an onsite inspection at the facility and interviewed Resident A. He denied feeling threatened by Leon but stated he thinks Leon does not like him. He explained that Leon does things like not cut his hair or wash his clothes when he tells him to and has called him names in the past. He was not able to give examples of the name calling. Resident A explained that the clothes are washed every week, but he is normally gone and wants his clothes washed when he gets back. He denied expressing his concerns to Darin Crite, the licensee designee, and stated no one has witnessed the name calling.

During the onsite inspection on 08/30/2021, I interviewed staff, Ronald Brown, he denied seeing any of the staff mistreat the residents.

On 09/01/2021, I made a telephone call to Mr. Crite. He stated Resident A never complained to him about Leon. He also stated Leon has been working for him for several years and there has been no complaints about mistreatment. Mr. Crite also gave me Leon's contact information.

On 09/01/2021, I made a telephone call to Leon. He denied the allegations and denied calling Resident A names. He stated he did not know why Resident A felt he did not like him because he has nothing personal against him and he treats all the residents the same. Leon also explained that he is not required to cut the residents' hair but does it for free in his spare time, and often Resident A gets his own haircut. He stated laundry is done 1-2 times a week on specified wash days. Resident A normally misses his wash day because he is always gone and does not sort his clothes to be washed.

On 09/02/2021, I received a copy of Resident A's Individual Plan of Service, which specified laundry as one of his goals. He is required to sort his dirty clothes for washing.

APPLICABLE R	ULE
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:	Based on the information obtained during this investigation, there is a lack of evidence to support the allegations. There is no indication that Resident A's protection and safety is not being attended to. He denied feeling threatened by Leon and was unable to give specific accounts of mistreatment besides not getting his hair cut and his clothes washed when he wants. Leon is not obligated to cut the residents' hair and Resident A, according to his treatment plan, is supposed to participate with laundry, but is often gone on wash day. Furthermore, Leon denied the allegations and denied calling Resident A names.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Leon does not serve Resident A a plate of food and there is not enough food in the home.

INVESTIGATION:

On 08/30/2021, I conducted an onsite inspection at the facility and interviewed Resident A. He denied the allegations. He stated they get 3 meals a day and plenty to eat. He indicated that he does not always like the food they cook and sometimes buys his own food for them to cook.

During the onsite inspection on 08/30/2021, I observed the food supply. The pantry was fully stocked with dry goods and the refrigerator and freezer was fully stocked as well. Staff, Ronald Brown, was present and indicated the residents get 3 meals a day as well as snacks.

On 09/01/2021, I made a telephone call to Leon. He denied the allegations and stated there is always plenty to eat and that the residents get 3 meals a day. He explained that Resident A is often gone most of the day and misses his meals. He always saves him a plate of food, but he often comes home with his own food. Leon also explained that Resident A has a BRIDGE card and sometimes buys his own

food and wants them to cook him separate meals from everyone else. They try to accommodate him when they can.

APPLICABLE RU	LE
R 400.14313	Resident nutrition.
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on the information obtained during this investigation, there is a lack of evidence to confirm the allegations. Resident A denied the allegations and reported getting 3 meals a day as required. In addition to this, staff denied the allegations and reported the residents receive 3 meals a day. There was also an abundant supply of food observed in the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The home smells like it has a lack of cleanliness. The home smells mildewy and like a dirty mop.

INVESTIGATION:

On 08/26/2021, I made a telephone call to Tonya Lowman, Resident A's case manager from The Development Centers. She stated she has not observed the home to be dirty as in not cleaned, but when she visited last month, it had a dirty mildew smell.

On 08/30/2021, I conducted an onsite inspection at the facility. It was observed to be clean and during previous unannounced onsite inspections it was always observed to be clean. I did not smell a mildew odor, but the home did have a slight odor. However, it was not intense or overbearing.

On 08/30/2021, I made a telephone call to Lakeitha Stevens, the licensing consultant for the facility. She stated the home has always had a slight odor, but it was nothing concerning to her. She felt the odor was contributed to the population they cared for and the fact that it is a much older home.

On 09/01/2021, I made a telephone call to Darin Crite, the licensee designee. He explained that the home has all male residents and some of them are not very clean, which causes an odor.

APPLICABLE RU	LE
R 400.14403	Maintenance of premises.
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based on the information I obtained during this investigation, there is a lack of evidence to confirm the allegations. The home was observed to be clean. Although a slight odor was detected, it was not alarming.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 08/30/2021, I conducted an onsite inspection at the facility. When I requested to see the menu, staff, Ronald Brown, could not locate it. He stated it was normally on the refrigerator, but it was not there. There were menus posted on the wall in the dining room. They were not dated, and Mr. Brown stated they were old and that they did not use them.

APPLICABLE RU	LE
R 400.14313	Resident nutrition.
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	Based on the information obtained during this investigation, updated menus were not written and posted in the facility.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 08/30/2021, I conducted an onsite inspection at the facility. While observing the food supply I noticed that there were not thermometers in the refrigerator and freezer located in the kitchen. I asked staff, Ronald Brown, for assistance, and he could not locate thermometers either. Everything in the freezer was covered with frost and ice and the refrigerator did not feel cold.

On 09/01/2021, I made a telephone call to Darin Crite, the licensee designee. He indicated that he was aware of the refrigerator not working properly and that it was in the process of being replaced.

APPLICABLE R	RULE
R 400.14402	Food service.
	(3) All perishable food shall be stored at temperatures that
	will protect against spoilage. All potentially hazardous food shall be kept at safe temperatures. This means that all cold foods are to be kept cold, 40 degrees Fahrenheit or below,
	and that all hot foods are to be kept hot, 140 degrees
	Fahrenheit or above, except during periods that are

	necessary for preparation and service. Refrigerators and freezers shall be equipped with approved thermometers.
ANALYSIS:	Based on the information obtained during this investigation, it is unknown if the food was kept at safe temperatures, because the refrigerator and freezer were not equipped with thermometers. In addition to this, Mr. Crite reported that the refrigerator was not working properly and was being replaced.
CONCLUSION:	VIOLATION ESTABLISHED

III. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

Regina Buchanon	
	10/21/2021
Regina Buchanan	Date
Licensing Consultant	

Approved By:

10/25/2021
Date