GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 22, 2021

Paula Ott
Central State Community Services, Inc.
Suite 201
2603 W Wackerly Rd
Midland, MI 48640

RE: License #: AS250010981
Investigation #: 2022A0779001
Parkside FAIS

Dear Ms. Ott:

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 (906) 226-4171.

Sincerely,

Christopher A. Holvey

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010981
Investigation #:	2022A0779001
Complaint Receipt Date:	10/13/2021
Investigation Initiation Date:	10/13/2021
Report Due Date:	12/12/2021
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Sharon Butler
Licensee Designee:	Paula Ott
Name of Facility:	Parkside FAIS
Facility Address:	8358 Neff Rd Mt Morris, MI 48458
Facility Telephone #:	(810) 687-7751
Original Issuance Date:	03/04/1993
License **Status:**	1ST PROVISIONAL
Effective Date:	06/23/2021
Expiration Date:	12/22/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff Tyquandra Thames left two residents home alone during 3rd shift on October 13, 2021. First shift arrived early and found no staff at the home.	Yes

III. METHODOLOGY

10/13/2021	Special Investigation Intake 2022A0779001
10/13/2021	APS Referral Complaint was referred to AFC licensing by APS centralized intake.
10/13/2021	Special Investigation Initiated - Telephone Spoke to recipient rights.
10/13/2021	Contact - Telephone call made Spoke to staff person, Tamikia Phifer.
10/13/2021	Contact - Telephone call made Spoke to home manager, Deja Bennett.
10/13/2021	Contact - Telephone call made Spoke to administrator, Jamilla Cheatom.
10/13/2021	Contact - Telephone call made Spoke to staff person, Tyquandra Thames.
10/14/2021	Inspection Completed On-site
10/14/2021	Contact - Telephone call made Spoke to Resident A's legal guardian.
10/14/2021	Contact - Telephone call made Spoke to Resident B's guardian.
11/01/2021	Contact - Document Received Received copy of ORR report via email.
11/04/2021	Contact - Telephone call made Interview conducted with staff person, Ashanti Walker.
11/15/2021	Exit Conference Conducted with licensee designee, Paula Ott

ALLEGATION:

Staff Tyquandra Thames left two residents home alone during 3rd shift on October 13, 2021. First shift arrived early and found no staff at the home.

INVESTIGATION:

On October 13, 2021, a phone conversation took place with recipient rights officer, Matt Potts, who confirmed that he is investigating the same allegation. Mr. Potts stated that he had already spoken to both the 1st and 3rd shift staff. He stated that 1st shift staff, Tamikia Phifer, told him that she arrived to work early at 6:20am and there was no 3rd shift staff at the home. She told Mr. Potts that the fire door was closed and the couch was pushed up against the door. Mr. Potts reported that 3rd shift staff, Tyquandra Thames, told him that she was just outside taking out the trash and smoking, but never left the premises.

On October 13, 2021, a phone interview was conducted with staff person, Tamikia Phifer, who confirmed that she was the 1st shift staff working this morning. Ms. Phifer stated that she got to work early at 6:20am, knocked on the front door for about three minutes and no one answered. She stated that the front door was unlocked, so she went inside to find no staff present, the fire/emergency door closed to the hallway and the couch pushed up against the door. Ms. Phifer reported that Resident C was asleep and Resident D, who is non-mobile, was awake in his bed. She stated that both residents were fine. She stated that she texted the home manager, Deja Bennett, to report the situation. Ms. Phifer reported that the 3rd shift worker assigned to work that night, Tyquandra Thames, showed up at the front door at approximately 6:40-6:45am and said that she had to run her boyfriend home so she could bring her car back. Ms. Phifer stated that she has no idea how long the residents were left unsupervised before she arrived to the home at 6:20am.

On October 13, 2021, a phone interview was conducted with home manager, Deja Bennett. She stated that at 6:32am, Ms. Phifer had texted her a picture of the couch pushed up against the emergency door and stating that there was no 3rd shift staff at the home. Ms. Bennett stated that she called the home and Ms. Phifer told her that 3rd shift staff, Ms. Thames, had returned to the home, so she spoke to Ms. Thames. She stated that Ms. Thames told her that she left the home to take boyfriend home and came back.

On October 13, 2021, a phone interview was conducted with program manager, Jamilla Cheatom, who stated that Ms. Bennett had called her to say that Ms. Phifer and Ms. Thames were at the home and not getting along, so she went to the home to talk to them. Ms. Cheatom reported that she told Ms. Thames that she was suspended pending further investigation into the matter and made her leave the home. Ms. Cheatom stated that due to there currently only being two residents at this home, Ms. Thames was the only 3rd shift staff working last night.

On October 13, 2021, a phone interview was conducted with staff person, Ms. Thames, who confirmed that she was the 3rd shift staff person working last night. Ms. Thames stated that the allegations of her leaving the property during her shift are not true. She stated that at about 6:25am, she went out the front door to take the trash out and that while out there, she smoked a cigarette. She admitted that during this time, Resident C and Resident D were left in the home unsupervised. Ms. Thames claims that she was only outside for 5-6 minutes and that when she tried to get back inside the home, the front door was locked. She stated that she rang the doorbell and Ms. Phifer, who came in early, answered the door and let her in. Ms. Thames reported that she did not see Ms. Phifer arrive to the home. Ms. Thames denied telling Ms. Phifer and/or Ms. Bennett that she left the home to take her boyfriend home or that she shut the emergency door to the hallway or moved the couch against the door.

On October 14, 2021, an on-site inspection was conducted. Resident D was viewed to be in his bed and appeared to be doing fine. Resident D was visibly clean and well-groomed. Due to his cognitive deficiencies, Resident D was not able to be interviewed. It was confirmed that Resident C had recently moved to another AFC home. Due to Resident C being non-verbal and also having severe cognitive deficiencies, he was not able to be interviewed.

On October 14, 2021, a phone conversation took place with Resident D's legal guardian, Guardian D1. She stated that up until 3rd shift staff leaving the home on September 5, 2021, she has not had any issues with this home regarding lack of supervision of Resident D. Guardian D1 reported that Resident D is non-mobile but does try to get up on his own at times. She stated that she has no concerns with the actual care that this home provided to Resident D.

On October 14, 2021, a phone conversation took place with Resident C's guardian, Guardian C1. She stated that she is not aware of there being any supervision issues at this home. Guardian C1 confirmed that Resident C is non-verbal but stated that he is very mobile and can be quite active at times. Guardian C1 stated that this home provided her and Resident C with a 30-day discharge notice and that Resident C was moved out of this home on October 13, 2021. She stated that Resident C was not moved due to care related issues.

On November 1, 2021, a copy of the Office of Recipient Rights summary report was received via e-mail. Recipient rights officer, Matt Potts, documented in the reported that a GHS psychologist confirmed that Resident C has a history of elopement and poor safety skills; therefore, if Resident C would have woken to find no staff present, it is very possible that he would have walked out/away from the facility. Mr. Potts documented in his report that he is substantiating neglect of Resident C.

On November 4, 2021, a phone interview was conducted with staff person, Ashanti Walker, who confirmed that she is a 3rd shift worker at this home and that she was aware of the current allegations that were made. Ms. Walker stated that this is not common practice among 3rd shift staff and that she knows not to leave residents alone

and/or unsupervised and not to ever shut the emergency fire doors to the hallway. Ms. Walker claims that this type of behavior has never been talked about amongst 3rd shift staff as something they can get away with.

There were two residents present at this home at the time of the incident on October 13, 2021. Assessment Plans for AFC Residents were reviewed for both Resident C and Resident D and confirmed the need for both residents to require AFC services. Both Resident C and Resident D require some level of staff intervention in order to complete all their activities of daily living. The plans state that Resident C and Resident D require staff supervision while the community.

SIR #2021A0501024 dated May 26, 2021, substantiated a violation to Rule 400.14303 (2). The investigation found that staff did not follow a resident's Assessment Plan for AFC Residents or GHS Individual Plan of Service when they left the resident, with known swallowing issues, unattended during a meal on April 7, 2021. The resident choked and later passed away from his injuries on April 13, 2021. This investigation also cited multiple repeat violations to Rules 400.14301 (4), (6), and (8); as well as one violation to Rule 400.14301 (10). These rule violations were in reference to the home having incomplete/unsigned resident care agreements and resident assessment plans and an outdated/expired resident health care appraisal. This report recommended a six-month provisional license be issued contingent upon receipt of an acceptable corrective action plan (CAP). On June 21, 2021, this home submitted a CAP, which stated that the staff in question was terminated, the home was staffed with all new staff persons who were trained on all resident diet orders, and that all resident assessment plans, resident care agreements and health care appraisals had been updated.

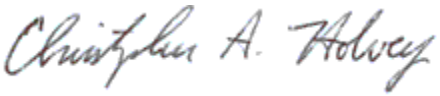
SIR #2021A0779042 dated October 20, 2021, substantiated a violation to Rule 400.14206 (2). The investigation found that on September 5, 2021, staff person, Shaqunda Williams, left four residents of this home unsupervised when she left her 3rd shift before the 1st shift staff person, Robin Prince, arrived to relieve her. On September 8, 2021, Home manager, Robin Prince stated that when she arrived to work at approximately 6:08 am, the door to the home was locked, the home was dark and there was no answer at the door. She stated that she went to Resident A's bedroom window, knocked to wake him up and that Resident A had to let her into the home. On September 9, 2021, Resident A confirmed that Ms. Prince had knocked on his bedroom window, that he had to let her into the home and that there were no other staff present at the home except Ms. Prince. This report recommended that the home remain on provisional license that the home was already on, contingent upon receipt of an acceptable plan of correction. On November 2, 2021, this home submitted a CAP, which stated that staff person, Shaqunda Williams, had been terminated, the home has installed cameras on the home facing the driveway, that program managers would be doing random 3rd shift unannounced checks at the home, that the program coordinator's home ratio has been changed from 1:5 to 1:4, that the home has hired a new and more experienced home manager, and that additional training was provided to staff.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A 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:	On October 13, 2021, staff person, Tamikia Phifer, stated that she got to work early at 6:20am, knocked on the front door for about three minutes and no one answered. She stated that the front door was unlocked, so she went inside to find no staff present, the fire/emergency door closed to the hallway and the couch pushed up against the door. Ms. Phifer reported that the 3rd shift worker assigned to work that night, Tyquandra Thames, showed up at the front door at approximately 6:40-6:45am On October 13, 2021, staff person, Tyquandra Thames, stated that at about 6:25am, she went out the front door to take the trash out and that while out there, she smoked a cigarette. She claims that she was only outside for 5-6 minutes, but admitted that during this time, the residents were left in the home unsupervised. Regardless of whether Ms. Thames left the property or not, there were several minutes where there were no staff inside the home, leaving the residents unsupervised. There was sufficient evidence found to prove that Resident C and Resident D were left unsupervised and not provided the supervision and/or protection as specified in their resident care agreement and assessment plans.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2021A0779042 dated October 20, 2021.**

On November 15, 2021, an exit conference was conducted with licensee designee, Paula Ott. She was advised that the outcome of this investigation has resulted in a recommendation of revocation of this license.

IV. RECOMMENDATION

Due to the repeat violations regarding the quality of resident care while on a provisional status, revocation of this adult foster care small group license is recommended.

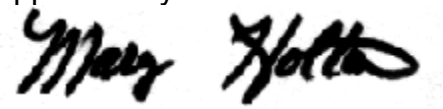


11/15/2021

_____

Christopher Holvey Date
Licensing Consultant

Approved By:



11/16/2021

_____

Mary E Holton Date
Area Manager