



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 14, 2021

Marva Townsend
733 Prince LLC
733 Prince SE
Grand Rapids, MI 49507

RE: License #: AS410362376
Investigation #: 2022A0467008
Princeton AFC

Dear Mrs. Townsend:

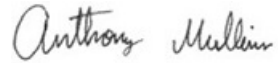
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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 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 (616) 356-0183.

Sincerely,

A handwritten signature in cursive script that reads "Anthony Mullins".

Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410362376
Investigation #:	2022A0467008
Complaint Receipt Date:	12/03/2021
Investigation Initiation Date:	12/03/2021
Report Due Date:	02/01/2022
Licensee Name:	733 Prince LLC
Licensee Address:	733 Prince SE, Grand Rapids, MI 49507
Licensee Telephone #:	(616) 635-2957
Administrator:	N/A
Licensee Designee:	Marva Townsend
Name of Facility:	Princeton AFC
Facility Address:	733 Prince, Grand Rapids, MI 49507
Facility Telephone #:	(616) 259-7848
Original Issuance Date:	11/14/2014
License Status:	REGULAR
Effective Date:	05/14/2021
Expiration Date:	05/13/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED, ALZHEIMERS, MENTALLY ILL, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Residents are left to sit on the front porch for an extended period of time after returning home from Day Program due to staff not being present.	Yes

III. METHODOLOGY

12/03/2021	Special Investigation Intake 2022A0467008
12/03/2021	Special Investigation Initiated - Telephone
12/07/2021	Inspection Completed On-site
12/14/2021	Exit conference completed with licensee designee, Marva Townsend

ALLEGATION: Residents are left to sit on the front porch for an extended period of time after returning home from Day Program due to staff not being present.

INVESTIGATION: On 12/3/21, I received a complaint from Kent County network 180 Recipient Rights. The complaint alleged that Resident A and other residents are being left alone on the porch for up to 45 minutes every Tuesday through Thursday after returning home from their Day Program. Resident A has addressed this concern with the owner/licensee, Marva Townsend and she has reportedly stated, "I'll get there when I get there."

On 12/3/21, I spoke with the complainant and she informed me that she has spoken to Resident A and he expressed concerns for this chronic issue of having to wait on the porch for staff to arrive at the home. Resident A has attempted to address this issue with Mrs. Townsend with no success. Resident A and his peers return home from Day Program at 1:40 pm Tuesday through Thursday. The complainant stated that Resident A and his peers have to wait on the porch from 1:40 pm until 2:30 pm. The complainant stated that Resident A told her that he has a lung disease and is unable to be in the cold for a long period of time.

On 12/7/21, I made an unannounced onsite inspection. Upon arrival, residents were observed getting off the city bus and walking to the home. Residents waited on the porch for 7 minutes prior to staff member Ruby Boulrege arriving to the home and allowing entry. I interviewed the residents individually at the dining room table. Resident A stated that he has resided at the home for approximately four months. When asked if he has ever waited outside on the front porch for staff to arrive to allow entry, Resident A stated "yes." Resident A shared that he and other residents

have to wait on the porch for staff every week after returning home from Day Program. Resident A stated that approximately one-and-a-half months ago, he and other residents had to wait outside for more than two hours. Resident A stated that he and other residents return from Day Program around 1:40 pm. Per Resident A, staff are supposed to be at the home by 2:00 pm "but it's usually a lot longer." Resident A stated that he has discussed his concern with Mrs. Townsend, and she responded by saying she lost her phone although she originally told him she received his messages. Resident A stated that he and other residents are not allowed to be in the home without staff being present, which is why they must wait on the porch.

Due to ongoing issues at the home, Resident A is moving to a new AFC. Resident A showed me copies of text messages between he and Mrs. Townsend where he states that he is on the porch. One text message in particular that Resident A sent Mrs. Townsend dated 10/13/21, at 1:55 pm states, "where's whoever is working today. We've been on the porch for a long time." There was no response from Mrs. Townsend. On 11/23/21 at 2:24 pm, Resident A sent Mrs. Townsend a text message stating "Hey Marva, just wondering are you coming or is someone else. We are just out on the porch and there's no sign of anyone coming yet." Mrs. Townsend responded 41 minutes later apologizing and stating that she lost her phone and staff member Monique was supposed to be there. Resident A responded at 3:11 pm stating he's glad Mrs. Townsend is coming. It is unknown as to exactly when Mrs. Townsend arrived at the home. However, based on the residents returning home from day program at 1:40 pm and the time the messages were exchanged between Mrs. Townsend and Resident A, it is evident that the residents were on the porch for at least an hour-and-a-half on 11/23/21. There are other messages as well from Resident A to Mrs. Townsend expressing his concern for being left on the porch due to no staff being present.

Resident B was interviewed and stated that she has resided at the home for five years. Resident B and other residents attend Day Program Tuesday through Thursday every week from 8:30 am until 1:30 pm. Resident B stated that they usually arrive home at 1:40 pm. Resident B stated that she and other residents have had to wait on the porch until staff arrive at the home to allow entry. Resident B stated that staff always apologized if they were late but she was unable to recall how long she and other residents have waited outside for staff to arrive. Resident B stated that Mrs. Townsend lets them know which staff member will be coming to let them in the home by relaying the information to Resident A via text.

Resident C was interviewed and he stated that he has resided at the home for a couple of years. Resident C stated that he and other residents attend Day Program on Tuesdays and returns home around 1:30 pm. Resident C stated that he and other residents have to wait on the porch for approximately one hour every Tuesday prior to staff arriving at the home to open the door. Resident C stated that he prefers to be inside and he has not addressed this with Mrs. Townsend.

After speaking to the residents, I spoke with Ms. Ruby Boulrege. Ms. Boulrege works 1-2 per days per week and stated that residents return from day program around 2:00 pm and she arrives to the home before them. Ms. Boulrege stated that staff should be at the home at 1:45 pm. She did acknowledge that this past summer, there were times when staff did not arrive to the home until 2:15 pm. Ms. Boulrege stated that staff aren't as early to work in the summer months as they are during the winter months.

On 12/7/21, I spoke to Mrs. Townsend via phone regarding the allegation. Mrs. Townsend confirmed that residents have had to wait on the porch for staff in the past. However, she was adamant that this is no longer the case. Mrs. Townsend stated that earlier in the summer, a few residents wanted to take the earlier bus home from Day Program and sit on the porch. When this information was relayed to her, Mrs. Townsend stated that she asked residents to take the bus at their normal scheduled time to prevent this from occurring. Mrs. Townsend shared that approximately three weeks ago, her staff member Monique Carey did not arrive to work as scheduled, causing residents to be left on the porch. Mrs. Townsend stated that the residents "weren't on the porch that long, probably 30 to 40 minutes." Staff close by were able to come to the home and allow residents entry. As a result of Ms. Carey not showing up to work as scheduled, Mrs. Townsend stated that she has already reprimanded her and made her aware that if a similar situation were to occur, she would not be able to keep her as staff. Mrs. Townsend stated that during the summer months, residents wanted to sit on the porch too. Despite being told that residents stated they have waited for staff longer than an hour, Mrs. Townsend stated she does not believe this to be true.

On 12/14/2021, I conducted an exit conference with Mrs. Townsend. I informed her of the investigative findings and she was understanding of the outcome. Mrs. Townsend is aware that a corrective action plan is due within 15 days and agreed to complete it.

APPLICABLE RULE	
R 400.14206	Staffing requirements.
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Three residents were interviewed regarding the allegation and all stated that they have waited on the porch for staff to arrive at the home. Resident A and C stated that they have waited for an hour or longer on several occasions.

	<p>Ms. Boulrege acknowledged that staff members arrived late to the home in the summer months.</p> <p>Mrs. Townsend acknowledged that her staff member did not arrive to work a few weeks ago, causing residents to be left on the porch for 30 to 40 minutes.</p> <p>Based upon the information obtained from all interviewed parties, a preponderance of evidence does exist to support the allegation.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Anthony Mullins

12/14/2021

Anthony Mullins
Licensing Consultant

Date

Approved By:

Jerry Hendrick

12/14/2021

Jerry Hendrick
Area Manager

Date