GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 3, 2021

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

RE: License #: AS500403212
Investigation #: 2021A0990023
Gruber Home

Dear Ms. Ott:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (248) 975-5053.

Sincerely,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500403212
Investigation #:	2021A0990023
Complaint Receipt Date:	09/03/2021
Investigation Initiation Date:	09/07/2021
Report Due Date:	11/02/2021
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Eva Hemphill
Licensee Designee:	Paula Ott
Name of Facility:	Gruber Home
Facility Address:	6545 Twenty-Four Mile Shelby Twp., MI 48047
Facility Telephone #:	(586) 781-3494
Original Issuance Date:	01/20/2021
License Status:	REGULAR
Effective Date:	07/20/2021
Expiration Date:	07/19/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Per incident report, on 07/19/2021 prior to 7:00 am direct care staff Unique Futch and Daisy Prim got into a verbal argument inside the home. The argument was recorded and included Ms. Futch admitting to sleeping on shift.	Yes

III. METHODOLOGY

09/03/2021	Special Investigation Intake 2021A0990023
09/07/2021	Contact - Document Sent I emailed the Reporting Person (RP).
09/07/2021	Contact - Document Sent I emailed Ms. Potts, licensee designee (LD) and Eva Hemphill administrator (Adm). I requested several documents from the employee record.
09/07/2021	Contact - Document Sent I emailed Amber Sultes, Macomb County Office of Recipient Rights Investigator.
09/07/2021	Special Investigation Initiated - Letter I emailed LD/Adm.
11/01/2021	Contact - Telephone call made I called Unique Futch- direct care worker. I left a detailed message.
11/01/2021	Contact - Telephone call made I left a detailed message for Ms. Prim.
11/03/2021	Contact - Telephone call made I called Daisy Prim-direct care staff. Left detailed message.
11/03/2021	Contact - Telephone call made I conducted a phone interview with Ms. Futch.
11/03/2021	Contact - Telephone call made I conducted a phone interview with Dawn Krull, ORR investigator. Ms. Krull emailed me several documents.

11/18/2021	Contact - Document Received I reviewed Ms. Prim and Ms. Futch training records and background checks.
11/18/2021	Contact - Document Received I reviewed documents received from the Office of Recipient Rights (ORR).
11/29/2021	Contact - Telephone call made I left a detailed voice message with the administrator Eva Hemphill-Adm regarding the exit conference.
11/29/2021	Exit conference I conducted an exit conference Eva Hemphill.

ALLEGATION:

Per incident report, on 07/19/2021 prior to 7:00 am the direct care staff Unique Futch and Daisy Prim got into a verbal argument inside the home. The argument was recorded and included Ms. Futch admitting to sleeping on shift.

INVESTIGATION:

On 09/03/2021, I received the above allegations.

On 11/03/2021, I conducted a phone interview with Ms. Futch. Ms. Futch recalled the incident that occurred on 07/19/2021 with direct care staff Daisy Prim. Ms. Futch said that they both worked the midnight shift and she fell asleep on shift. Ms. Futch was told that she was asleep for a few hours on the front couch. Ms. Futch said that when she woke up around 6AM she began preparing a resident's lunch and was getting ready to wake residents and change diapers. Ms. Futch said that the residents were still asleep, and she became irritated because Ms. Prim made a smart remark about her sleeping on the shift. Ms. Futch said that she used profanity and they both were yelling at each other. The residents are non-verbal. During the verbal argument with Ms. Prim, Ms. Futch recorded the audio. Ms. Futch said that she was written-up due to the incident but was terminated about a month later for sleeping on the shift again. Ms. Futch said that she understood it was wrong for her to sleep during the shift. Ms. Futch said that she always worked the midnight shift.

On 11/03/2021, I conducted a phone interview with Dawn Krull, ORR investigator. Ms. Krull emailed me several documents. Ms. Krull said that she reviewed the incident report a month after the incident occurred. Ms. Krull substantiated her investigation against Ms. Futch for Neglect Class III for sleeping during shift. Ms. Krull did not interview Ms. Futch but attempts were made. Ms. Krull said that the video was never sent but the transcript of the audio was sent to her. Ms. Krull interviewed Ms. Prim who

informed her that she was tired of Ms. Futch sleeping during her shift and confronted her about it. Ms. Krull was informed by the home manager (name not provided) that Ms. Futch admitted to sleeping on shift. Ms. Krull said that Ms. Futch was caught again sleeping on shift and was terminated. Ms. Krull said that the home submitted a remedial plan that was acceptable.

In 11/18/2021, I reviewed Ms. Prim and Ms. Futch training records and background checks. Both Ms. Prim and Ms. Futch were fully trained. Ms. Futch was terminated on 08/03/2021 for violation of company policy for sleeping on the shift.

On 11/18/2021, I reviewed documents received from the Office of Recipient Rights (ORR). I reviewed the staff policies which indicates "all shifts are awake to ensure the health and safety of the individual served and employees." I observed that two residents require full staff assistance with emergencies. There is one resident that requires hourly bed checks. The ORR report documents that Ms. Futch was given a "Performance Correction Advisory" on 07/20/2021 for the first sleeping incident. I observed a photo of Ms. Futch sleeping on a recliner with a blanket. I reviewed the audio transcript in which Ms. Futch admitted to sleeping on the shift and used profanity.

On 11/29/2021, I conducted an exit conference via email. I informed the Eva Hemphill and Paula Ott of the violation found and requested a call back if they would like to discuss further. I received a phone call from Ms. Hemphill. Ms. Hemphill was informed of the violation and that the report had to be approved and a corrective action plan would ne required if the violation stands. Ms. Hemphill confirmed that there are to be two staff on shift for resident's needs. Ms. Hemphill confirmed that none of the residents would be able to be interviewed due to limited cognitive abilities.

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:	On 07/19/2021, direct care staff Dominique Futch and Daisy Prim engaged in a verbal argument at 6AM while the residents were asleep. The argument occurred because Ms. Futch slept during the midnight shift. Ms. Prim recorded the argument and the audio that confirmed Ms. Futch admitted to sleeping during her shift. On 11/03/2021, Ms. Futch admitted to sleeping on the shift and engaging in a verbal argument with Ms. Prim. Ms. Futch was

	caught sleeping again on 08/02/2021 and was terminated from the company. There are two residents that require full assistance during emergencies and one resident that requires hourly checks. Based on this, there is evidence that the residents were not always attended to because Ms. Futch was asleep and there should be two staff attending to residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

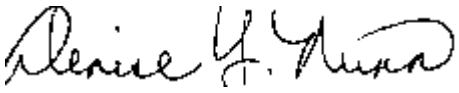
IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change to the license.

11/29/2021

LaShonda Reed — Date
Licensing Consultant

Approved By:



12/03/2021

Denise Y. Nunn — Date
Area Manager