

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

December 15, 2021

Carolyn Frisby 9378 Lyle Meadow Lane Clio, MI 48420

> RE: License #: AF250372767 Investigation #: 2022A0123004

> > Carolyn Assisted Living AFC

Dear Ms. Frisby:

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. 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 (906) 226-4171.

Sincerely,

Shamidah Wyden, Licensing Consultant Bureau of Community and Health Systems

411 Genesee P.O. Box 5070 Saginaw, MI 48607 989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF250372767
Investigation #:	2022A0123004
Complaint Receipt Date:	11/01/2021
Complaint Receipt Date.	11/01/2021
Investigation Initiation Date:	11/03/2021
Report Due Date:	12/31/2021
Licensee Name:	Carolyn Frisby
Licensee Address:	9378 Lyle Meadow Lane
Licensee Address.	Clio, MI 48420
	, , , , , , , , , , , , , , , , , , , ,
Licensee Telephone #:	Unknown
Administrator:	N/A
Licensee Designee:	N/A
Licensee Designee.	IVA
Name of Facility:	Carolyn Assisted Living AFC
Facility Address:	9378 Lyle Meadow Lane
	Clio, MI 48420
Facility Telephone #:	(810) 429-7827
racinty relephone #.	(010) 429-1021
Original Issuance Date:	04/17/2015
License Status:	REGULAR
Effective Date:	40/47/2024
Effective Date:	10/17/2021
Expiration Date:	10/16/2023
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED
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	AGLU

II. ALLEGATION(S)

Violation Established?

Licensee Carolyn Frisby has not been providing appropriate care to Resident A. Ms. Frisby leaves Resident A in her room and does not take her out in the community to do activities.	No
Resident A has not received her medications since July 2021.	No
Resident A has not been to the dentist, has a ton of plaque on her teeth, and tons of earwax in her ears.	No
Resident A does not have a coat. Her clothing is too small.	No
On 11/03/2021, licensee Carolyn Frisby left the residents unsupervised in the home.	Yes

III. METHODOLOGY

11/01/2021	Special Investigation Intake 2022A0123004
11/01/2021	APS Referral- Information received regarding APS Referral.
11/03/2021	Special Investigation Initiated - On Site I conducted an unannounced visit to the facility.
11/03/2021	Contact - Telephone call made I conducted a follow-up Facetime call with the facility.
11/12/2021	Contact - Telephone call made I spoke with Guardian 1 via phone.
11/19/2021	Contact - Telephone call made I left a message requesting a return call from Resident A's case manager.
11/19/2021	Contact - Telephone call received I spoke with Resident A's case manager via phone.
12/02/2021	Inspection Completed On-site I conducted an unannounced follow-up visit at the facility.
12/07/2021	Contact - Telephone call made

	I left a voicemail requesting a return call from Resident B's Relative 2.
12/13/2021	Contact- Telephone call made I made a second attempt to contact Resident B's Relative 2. There was no answer.
12/13/2021	Contact- Telephone call made I attempted to contact Resident A's Relative 1. There was no answer, and the mailbox was full. I sent a text message requesting a call back.
12/14/2021	Contact- Telephone call made I made a second attempt to contact Relative 1 via phone. There was no answer.
12/14/2021	Contact- Telephone call made I left a message requesting a return call from case manager Tanisha Parham via phone.
12/14/2021	Contact- Telephone call made I made a call to Resident C's public guardian's office.
12/15/2021	Exit Conference I spoke with licensee Ms. Frisby via phone.

ALLEGATION:

- Licensee Carolyn Frisby has not been providing appropriate care to Resident A. Ms. Frisby leaves Resident A in her room and does not take her out in the community to do activities.
- Resident A has not received her medications since July 2021.
- Resident A has not been to the dentist, has a ton of plaque on her teeth, and tons of earwax in her ears.
- Resident A does not have a coat. Her clothing is too small.

INVESTIGATION: On 11/03/2021, I conducted an unannounced on-site visit at the facility. Licensee Carolyn Frisby, Relative 1, and Resident A, Resident B, and Resident C were present. Ms. Frisby denied the allegations. She stated that Resident A's niece has taken over guardianship for Resident A, since Resident A's former guardian (Resident A's sister) passed away. She stated that she cooks, cleans, and takes her residents to their appointments, etc. She stated that they are working on scheduling eye and dental appointments for Resident A. Ms. Frisby stated that before the pandemic they did outings often.

Relative 1 stated that she has no concerns regarding Resident A getting her medications. Relative 1 stated that she visits the home daily. She stated that she is happy with Resident A's care.

Resident A stated that the allegations are not true. She stated that she is receiving appropriate care and that she gets out of the home to get fresh air. She stated that she goes on walks and gets her medication daily. Resident A stated that she bathes and feeds herself. She was observed during this on-site sitting at the dining room table. She stated that she has access to the whole home.

A copy of Resident A's assessment plan was obtained during this visit. The Assessment Plan for AFC Residents is dated for 10/01/2018. The assessment plan indicates that Resident A moves independently in the community, and does not need help with personal care needs, except medication administration. The assessment plan also indicates that she is not active in an adult activity program, senior center, workshop or job, or school. In the *Medical or Dental Follow-ups needed* section of the assessment plan it has "N/A" written in the box.

An AFC Licensing- Health Care Appraisal dated for 09/06/2021 was obtained. It is signed by Laura Svinarich- PAC (physician assistant certified). The appraisal notes that Resident A is diagnosed with HTN, bipolar disorder, schizophrenia, and hyperlipidemia. Resident A is fully ambulatory, and her physical exam was normal. Resident A was noted to be alert and oriented, not susceptible to hyper/hypothermia, and is on a general diet.

Resident B was observed during this on-site and appeared to be asleep in a recliner chair in the living room. Resident B appeared to be clean and appropriately dressed.

On 12/07/2021 and 12/13/2021, I made two unsuccessful attempted calls to Resident B's Relative 2 via phone.

Resident C was observed in her bed asleep during this on-site. She appeared clean and appropriately dressed as well.

The home was observed to be clean and orderly. There was plenty of food observed in the refrigerator, freezer, and pantry.

On 11/03/2021, I conducted a follow-up Facetime call with Ms. Frisby. I observed Resident A's prescription medication in her bubble packs, as well as her medication administration sheets. There were no issues noted. Resident A had four bubble packs including Aripiprazole 5 mg, Olanzapine 20 mg, Metoprolol Succinate ER 25, and Vitamin D.

On 11/03/2021, I spoke with Resident A's temporary guardian, Guardian 1 via phone. Guardian 1 stated that based on the cost of care Resident A is paying, that she would move Resident A because her current placement is not worth the monthly

cost of care. Guardian 1 stated that Resident A is not being taken to any social activities, and that a doctor and a nurse stated that Resident A needs to have outside visits in the community, but Ms. Frisby said no due to the COVID-19 pandemic. Guardian 1 stated that Resident A has seen her psych doctor recently, and a visiting physician does come in every three months to visit. Guardian 1 stated that the previous guardian was not taking Resident A to her dental appointments. Guardian 1 stated that Resident A's case manager thought Resident A was not receiving her medications but according to the pharmacists' records, the prescriptions have been getting refilled.

On 11/19/2021, I spoke with Resident A's case manager Tanisha Parham via phone. Ms. Parham stated that Ms. Frisby is hands on with Resident A. She denied having any concerns regarding Resident A's care. She stated that the computer records indicated that Resident A was out of medication, but the pharmacy did confirm that Ms. Frisby picked up Resident A's medications. She stated that Resident A is receiving her medications as prescribed. She stated that this issue was rectified. She stated that Ms. Frisby has COVID-19 fears, but that she (Ms. Frisby) was informed that Resident A needed to get out of the home to do activities, and at least go for a walk, or to the library, etc. She stated that about two to three weeks ago there was a conversation about this, and that to her knowledge, Resident A was not participating in any activities or outings. Ms. Parham stated that Resident A has not been to the dentist in about three to five years since she has lived in this home. Ms. Parham stated that she is unsure if Resident A has a coat, and that she has no concerns regarding Resident A's clothing. She stated that she has seen Resident A appropriately dressed. She stated that she does not know the condition of Resident A's teeth or ears.

On 12/02/2021, I conducted an unannounced follow-up visit at the facility. I conducted the following interviews:

I interviewed Resident A alone in a resident bedroom. Resident A stated that she has been doing fine. She stated that she has not been to the dentist lately and has not been since residing in this home. I observed Resident A's teeth and did not observe any visible built-up plaque. She stated that she brushes twice a day and denied ever having a lot of plaque build-up. She stated that she has a physician whom she last saw back in the summertime, and that Ms. Frisby takes her to her appointments. Resident A stated that she has a coat. She stated that she gets out of the home every once in a while, and will go to the store or something like that. She stated that she sits on the back deck when the weather is good. She stated that she has not been to any activities lately because COVID-19 stopped that. She denied that Ms. Frisby is holding her back from any activities. Resident A denied having issues with ear wax. She stated that Ms. Frisby tells them to wash their ears out good. She stated that Ms. Frisby makes sure that they get what they need. Resident A was observed wearing clothing that appeared clean and appropriately fitting. She stated that her underwear fits her. She stated she gained weight and is fed well. Resident A stated that some of her clothing does not fit, but she has enough clothing for about a week and a half. She stated that Ms. Frisby does laundry as soon as clothing gets dirty. Resident A stated that it is her choice that she has not bought any new clothing lately.

Ms. Frisby stated that Resident A's previous guardian used to give Resident A an allowance. She stated that Resident A has three coats, one coat she currently cannot fit. She stated that she is going to replace this coat for Resident A with a bigger coat. I observed Resident A's three coats during this on-site. Ms. Frisby stated that Resident A has refused to go to a dentist and that Relative 1 said she would set an appointment for Resident A. Ms. Frisby stated that Resident A's previous guardian never took Resident A to the dentist. She stated that when she asks Resident A if she wants to go out somewhere, Resident A refuses. She stated that she does not think Resident A likes being around people much. She stated that they do take walks. Ms. Frisby stated that Resident A had a little plaque between her bottom middle teeth and denied any issues with ear wax. She stated that she gives reminders daily regarding hygiene. She denied that Resident A's clothing is too small. She stated that she buys Resident A new clothing. Ms. Frisby stated that Guardian 1 stopped Resident A's services including her visiting physician, pharmacy, and CMH services when Guardian 1 was going to move Resident A to another facility.

I interviewed Resident C in a resident bedroom. Resident C stated that they receive three meals per day, she is independent with personal care, and goes by herself to her doctor appointments.

Resident C's resident file was observed during this on-site. I observed recent physician contact notes and appointments in her file.

On 12/14/2021, I made a call to Resident C's public guardian's office. I spoke with Individual 1, assistant to Guardian 1. Individual 1 stated that there have been no personal care concerns reported regarding Resident A. Individual 1 stated that Resident A moved to another home as of yesterday.

APPLICABLE RULE		
R 400.1408	Resident care; licensee responsibilities.	
	(4) A licensee shall provide all of the following: (c) Opportunity for community-based recreational activities.	
ANALYSIS:	Ms. Frisby, Relative 1, and Resident A denied the allegations. Ms. Frisby stated that prior to the COVID-19 pandemic they did outings often. Resident A stated that she gets out of the home to get fresh air and goes on walks. She stated that she has access to the whole home.	
	Resident A stated that she has not been to any activities	

	lately because COVID-19 stopped that. She denied that Ms. Frisby is holding her back from any activities, and that she gets out of the home occasionally. Ms. Frisby stated that when she asks Resident A if she wants to go out somewhere, Resident A refuses.
	Guardian 1 and case manager Tanisha Parham stated that to their knowledge Resident A has not been to any social activities.
	There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RU	APPLICABLE RULE	
R 400.1418	Resident medications.	
	(1) Prescription medication, including tranquilizers, sedatives, dietary supplements, or individual special medical procedures, shall be given or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy container which shall be labeled for the specific resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being (33.1101 et. seq. of the Michigan Compiled Laws.	
ANALYSIS:	Ms. Frisby and Resident A denied the allegations. Relative 1 denied having any concerns regarding medications. Resident A's medications bubble packs and medication administration record was observed. No issues were noted. Guardian 1 and Ms. Parham reported that there was an error with Ms. Parham's records, and it was verified through the pharmacy that Resident A is getting her prescriptions. There is no preponderance of evidence to substantiate a rule violation.	
CONCLUSION:	VIOLATION NOT ESTABLISHED	

APPLICABLE RULE		
R 400.1420	Resident hygiene.	
	(6) A licensee shall afford a resident the opportunity to	

	receive assistance in bathing, dressing, or personal hygiene from a member of the same sex, unless otherwise stated in the home's admission policy or written resident care agreement.
ANALYSIS:	Relative 1 did not express any concerns regarding Resident A's personal care.
	Ms. Frisby stated that Resident A had refused to go to a dentist, and that Resident A's previous guardian did not take Resident A to a dentist. Frisby stated that Resident A had a little plaque between her bottom middle teeth and denied any issues with ear wax. She stated that she gives reminders daily regarding hygiene.
	Resident A stated that she receives appropriate care. I observed Resident A's teeth and did not observe any visible built-up plaque. She stated that she brushes twice a day and denied ever having a lot of plaque build-up.
	Resident A's assessment plan does not indicate needing assistance with personal care activities. Resident A denied having issues with ear wax.
	Resident A, Resident B, and Resident C were observed on 11/03/2021 and on 12/02/2021. There were no concerns noted regarding their personal hygiene.
	Ms. Parham denied having any concerns regarding Resident A's care but stated that she does not know the condition of Resident A's teeth or ears.
	There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.1420	Resident hygiene.
	(4) A licensee shall afford a resident opportunities and instruction when necessary, to dress as fashion and
	season warrant.
ANALYSIS:	Resident A and Ms. Frisby both denied the allegations. On
	12/02/2021, I observed during an on-site that Resident A had
	three coats.
	Ms. Frisby stated that Resident A has three coats, one coat

she currently cannot fit. She stated that she is going to replace this coat for Resident A with a bigger coat. She denied that Resident A's clothing is too small. She stated that she buys Resident A new clothing.

Resident A was observed wearing clothing that appeared clean and appropriately fitting on 11/03/2021 and 12/02/2021. She stated that her underwear fits her. Resident A stated that some of her clothing does not fit, but she has enough clothing for about a week and a half. Resident A stated that it is her choice that she has not bought any new clothing lately.

Ms. Parham stated that she is unsure if Resident A has a coat, and that she has no concerns regarding Resident A's clothing. She stated that she has seen Resident A appropriately dressed.

There is no preponderance of evidence to substantiate a rule violation.

CONCLUSION:

VIOLATION NOT ESTABLISHED

ALLEGATION: On 11/03/2021, licensee Carolyn Frisby left the residents unsupervised in the home.

INVESTIGATION: On 11/12/2021, I spoke with Guardian 1 via phone. She stated that she was informed by a relative that Ms. Frisby left the residents alone with Relative 2, who is not a staff person.

On 11/19/2021, I spoke with Resident A's case manager Tanisha Parham via phone. Ms. Parham stated that Ms. Frisby has been looking for additional staff, but she does not know if Ms. Frisby has any staff.

On 12/02/2021, I conducted an unannounced on-site visit at the facility. Resident A was interviewed and stated that Ms. Frisby has never left relatives alone with the residents.

On 12/02/2021, I conducted an unannounced on-site visit at the facility. Ms. Frisby stated that on 11/02/2021, Resident B's daughter Relative 2 was at the home sitting with Resident B, and that Resident C was present at the facility as well, while she (Ms. Frisby) left the home. She stated that Relative 2 is not a staff person. Ms. Frisby stated that on 11/03/2021, she asked Relative 1 to come and sit with Resident A so she (Ms. Frisby) could leave the home to go to an appointment. Ms. Frisby stated that her responsible person Ricky Tasley was not available on those two days.

On 12/07/2021 and 12/13/2021, I made two unsuccessful attempted calls to Resident B's Relative 2 via phone.

On 12/13/2021, and 12/14/2021, I made two unsuccessful attempted calls to Resident A's Relative 1.

APPLICABLE RULE		
R 400.1410	Resident protection.	
	A licensee or responsible person shall always be on the premises when a resident is in the home.	
ANALYSIS:	Complainant 1 and Ms. Frisby both reported that Ms. Frisby has left the facility while the residents were present. Ms. Frisby stated that this occurred twice on 11/02/2021 and on 11/03/2021. She stated that she left the home while Relative 1 and Relative 2 stayed at the home with the residents, and that her responsible person was not available. There is a preponderance of evidence to substantiate a rule violation.	
CONCLUSION:	VIOLATION ESTABLISHED	

On 12/15/2021, I conducted an exit conference with license Carolyn Frisby. I informed her of the findings and conclusion.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of this AFC family home license (capacity 4).

No 11 le Delle	
Transfer de la constitución de l	12/15/2021
Shamidah Wyden	Date
Licensing Consultant	
Approved By:	
May Holle	12/15/2021
Mary E Holton	Date
Area Manager	