GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 11, 2022

May Kinnard
Mecca House
53 West Huron
Suite A
Pontiac, MI 48342

RE: License #: AS630012321
Investigation #: 2022A0991014
Mecca House

Dear Ms. Kinnard:

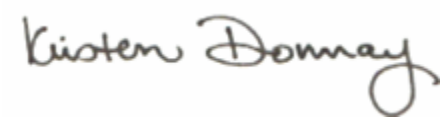
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. 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 (248) 975-5053.

Sincerely,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012321
Investigation #:	2022A0991014
Complaint Receipt Date:	02/09/2022
Investigation Initiation Date:	02/09/2022
Report Due Date:	04/10/2022
Licensee Name:	Mecca House
Licensee Address:	53 West Huron Suite A Pontiac, MI 48342
Licensee Telephone #:	(248) 335-3547
Licensee Designee:	May Kinnard
Name of Facility:	Mecca House
Facility Address:	2278 Richardson Court Waterford, MI 48327
Facility Telephone #:	(248) 666-9278
Original Issuance Date:	01/28/1981
License Status:	REGULAR
Effective Date:	02/01/2021
Expiration Date:	01/31/2023
Capacity:	6
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The residents at Mecca House are being neglected. The facility is short staffed. There have been times when a staff person does not show up for their shift. This has resulted in staff members leaving Resident B alone in the facility. Resident B cannot care for himself and there are concerns for his safety and well-being.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/09/2022	Special Investigation Intake 2022A0991014
02/09/2022	APS Referral Received from Adult Protective Services (APS) - denied for investigation
02/09/2022	Special Investigation Initiated - Telephone Call to complainant
02/09/2022	Referral - Recipient Rights Left message for Office of Recipient Rights (ORR) worker, Dawn Krull
02/10/2022	Inspection Completed On-site Unannounced onsite inspection
02/10/2022	Contact - Document Received Individual Plans of Service (IPOS) and crisis plans for residents, staff schedule
02/10/2022	Contact - Telephone call made To ORR worker, Dawn Krull
02/23/2022	Contact - Telephone call made Left message for complainant
04/06/2022	Contact - Telephone call made Left message for ORR worker, Dawn Krull

04/06/2022	Contact - Telephone call made To licensee designee, May Kinnard
04/06/2022	Contact - Telephone call made Left message for Regina Kinnard
04/07/2022	Contact - Telephone call made To administrative staff Regina Kinnard
04/07/2022	Exit Conference Via telephone with licensee designee, May Kinnard

ALLEGATION:

The residents at Mecca House are being neglected. The facility is short staffed. There have been times when a staff person does not show up for their shift. This has resulted in staff members leaving Resident B alone in the facility. Resident B cannot care for himself and there are concerns for his safety and well-being.

INVESTIGATION:

On 02/09/22, I received a complaint from Adult Protective Services (APS), alleging that the residents at Mecca House are neglected. The facility is short staffed and there have been times when a staff person does not show up for their shift. This has resulted in staff members leaving Resident B alone in the facility. Resident B cannot care for himself and there are concerns for his safety and well-being. APS denied the complaint for investigation. On 02/09/22, I initiated my investigation by contacting the assigned Office of Recipient Rights (ORR) worker, Dawn Krull.

On 02/10/22, I conducted an unannounced onsite inspection at Mecca House. I interviewed direct care worker, Jazmine Stewart. Ms. Stewart indicated that she has worked in the home since December 2021. There are five residents in the home, but one of the residents is currently at Common Ground and may be hospitalized. Ms. Stewart indicated that most of the residents in the home are fairly independent. Resident B requires the most assistance, as he wears briefs and requires prompts and reminders for his activities of daily living. Ms. Stewart indicated that the facility is short staffed. They only have four staff currently working in the home: the home manager, Alberta Jones, direct care workers, Sonja Adams and Deidra McIntosh, and herself. They recently had a few other staff people quit. Staff are expected to stay at the home if the next person scheduled does not show up for their shift. Ms. Stewart did not know of a time when there were no staff in the home or when the residents were left alone. Ms. Stewart stated that scheduling has been an issue in the home. She stated that the upcoming schedule has her working 12-hour shifts, but she is not able to do so because she has children at home.

On 02/10/22, I interviewed the home manager, Alberta Jones. Ms. Jones indicated that she has worked for the company for 25 years. The home is currently short staffed, and scheduling has been an issue. Ms. Jones reported that direct care worker, Alicia Weidman, recently quit. Ms. Weidman was stuck at the facility on 02/04/22 when staff did not come in for the following shift. Ms. Weidman contacted Ms. Jones at 11:00pm. Ms. Jones stated that she could not come in to cover the shift, as she has a child at home and needs more advance notice. Ms. Weidman threatened to drop the residents off at the hospital and to call Adult Protective Services (APS). Regina Kinnard ended up coming in and covering the shift. Ms. Weidman stayed at the home until Ms. Kinnard arrived. The following day, Ms. Kinnard informed Ms. Jones that Alicia Weidman quit. Regina Kinnard is one of the administrative staff who works in the main office. Ms. Jones stated that she did not know if Regina Kinnard was fully trained. Ms. Jones stated that the home currently has only four staff. It is difficult to get coverage for shifts. Ms. Jones has worked 32 hours straight in order to provide coverage for shifts. The administrative staff stated that it is the home manager's responsibility to cover shifts if staff call in or do not show up for their shifts. Ms. Jones stated that she was not aware of a time when there was no staff in the home or when staff left the residents unsupervised. Ms. Jones stated that they always have one staff on shift. The needs of the residents are being met; however, any time they go on an outing or to an appointment, they must take all of the residents.

I reviewed a copy of the staff schedule for the weeks of 01/26/22-02/10/22. The schedule notes that Alicia Weidman was scheduled to work from 3:00pm-11:00pm on 02/04/22. Deidra McIntosh was scheduled to work on 02/04/22 from 11:00pm-7:00am. This was crossed out and NC/NS was written on the schedule indicating that she was a no-call/no-show for the shift. The schedule does not specify who covered the 11:00pm-7:00am shift on 02/04/22.

On 02/10/22, I interviewed Resident A. Resident A stated that he has lived at Mecca House for six or seven months. There was never a time when there was no staff in the home. Resident A stated that the staff are good, and he gets everything he needs. He did not have any concerns about the home and would not change anything.

On 02/10/22, I interviewed Resident B. Resident B stated that he has never been left alone in the home. Someone is on shift 24 hours a day. Resident B stated that staff are at the home "morning, noon, and night." Resident B reported that staff treat him well and all of his needs are being met. He did not have any concerns about the home.

On 02/10/22, I interviewed Resident C. Resident C stated that he just moved into the home last Thursday. Since he has lived at the home, there is always a staff person on shift. He did not know of a time when the staff left the residents alone at the home.

On 02/10/22, I interviewed Resident D. Resident D stated that he has lived in the home for twelve years. Staff are in the home 24 hours a day, seven days week. Staff never leave the residents alone in the home. He stated that staff treat the residents well and all of his needs are being met.

On 04/06/22, I interviewed the licensee designee, May Kinnard, via telephone. Ms. Kinnard indicated that Regina Kinnard is one of the administrative staff who works in the main office. She stated that Regina Kinnard is not fully trained as a direct care worker. Mecca House was short staffed and was having issues with scheduling, so Regina Kinnard filled in so that the home would be covered, and the residents would not be left without staff. Ms. Kinnard stated that she was not sure what training Regina Kinnard had completed.

On 04/07/22, I interviewed administrative staff, Regina Kinnard, via telephone. Regina Kinnard indicated that she is administrative staff and works in the main office for the Mecca House corporation. She has worked for the company on and off for many years and has completed some training in the past. She is also a speech language pathologist by trade, so she has completed some training and fingerprinting for her professional license. Regina Kinnard indicated that she recalled the incident that happened in February when one of the staff at Mecca House, Alicia Weidman, was not going to be relieved from her shift because the next staff did not come in. May Kinnard contacted Regina Kinnard and told her that she called the home manager and all the other staff, but they were not answering their phones or could not come in to cover the shift. At 12:30am, Alicia Weidman called Regina Kinnard. She was screaming at the top of her lungs and was threatening to start up the van, wake up the residents, and drop them off at the hospital if nobody came in to relieve her. Ms. Weidman continued to text Regina Kinnard repeatedly, making threats and being antagonistic by stating that she was warming up the van and was getting ready to drop off the residents at the hospital. Regina Kinnard indicated that she drove to the home and arrived around 2:00am. Ms. Weidman was sitting in the living room in the dark. She got up and left without saying a word. Regina Kinnard stayed at the home for the remainder of the shift until the next staff arrived at 7:00am. The residents were sleeping during this time and did not wake up. Regina Kinnard indicated that she was not aware of a time when the residents were left alone in the home. It is the responsibility of staff to stay at the home until the next person comes on shift. Regina Kinnard indicated that they reached out to all the staff that night, but nobody else was available to cover the shift, so she went to the home in order to ensure the safety and protection of the residents.

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:	Based on the information gathered through my investigation, there is sufficient information to conclude that Mecca House did not have sufficient direct care staff on duty at all times. The residents in the home indicated that they have never been left at

	the facility unsupervised. However, on 02/04/22, direct care worker, Alicia Weidman, threatened to leave her shift when the next staff person did not arrive as scheduled. Administrative staff, Regina Kinnard, came in and covered the shift at the home. Regina Kinnard is not fully trained as a direct care worker and cannot be included in the staffing ratio.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(3) Any individual, including a volunteer, shall not be considered in determining the ratio of direct care staff to residents unless the individual meets the qualifications of a direct care staff member.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that administrative staff, Regina Kinnard, covered a shift at Mecca House on 02/04/22. Ms. Kinnard is not fully trained and does not meet the qualifications of a direct care worker.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the investigation, I reviewed a copy of the staff schedule for the weeks of 01/26/22-02/10/22. The schedule indicates that Alicia Weidman was scheduled to work from 3:00pm-11:00pm on 02/04/22. Deidra McIntosh was scheduled to work on 02/04/22 from 11:00pm-7:00am. This was crossed out and NC/NS was written on the schedule indicating that she was a no-call/no-show for the shift. The schedule does not specify who covered the 11:00pm-7:00am shift on 02/04/22. The staff schedule does not show who covered shifts from 7:00am-3:00pm or 3:00pm-11:00pm on 02/02/22 or 7:00am-1:00pm on 02/03/22.

On 04/07/22, I conducted an exit conference with the licensee designee, May Kinnard, via telephone. I reviewed the findings of the investigation and provided technical assistance to Ms. Kinnard. We discussed having some administrative staff who are trained and fingerprinted so that they can cover shifts in the homes in case of a staffing emergency in the future.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the staff schedule was not updated to reflect scheduling changes when staff called in or did not show up for their shifts.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

04/07/2022

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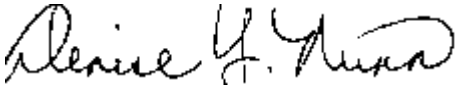
Kristen Donnay Date
Licensing Consultant

Approved By:



04/11/2022

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Denise Y. Nunn Date
Area Manager