GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 5, 2022

Peggy Root
411 Silver Street
Reading, MI 49274

RE: License #: AM300008365
Investigation #: 2022A1032018
Heritage House AFC

Dear Ms. Root:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616)-240-3850

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM300008365
Investigation #:	2022A1032018
Complaint Receipt Date:	08/15/2022
Investigation Initiation Date:	08/16/2022
Report Due Date:	09/14/2022
Licensee Name:	Peggy Root
Licensee Address:	411 Silver Street Reading, MI 49274
Licensee Telephone #:	(517) 283-1478
Name of Facility:	Heritage House AFC
Facility Address:	121 West State Street Reading, MI 49274
Facility Telephone #:	(517) 283-3152
Original Issuance Date:	08/02/1993
License Status:	REGULAR
Effective Date:	04/23/2022
Expiration Date:	04/22/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Ms. Root did not allow Resident A access to the telephone	No
Ms. Root uses derogatory language toward Resident A.	No
Ms. Root used physical force against Resident A.	No
Ms. Root does not feed Resident A proper meals.	No
Additional Findings	No

III. METHODOLOGY

08/15/2022	Special Investigation Intake 2022A1032018
08/16/2022	Special Investigation Initiated - On Site
09/02/2022	Contact - Telephone call made Telephone call with complainant.
09/14/2022	Contact - Face to Face Interview conducted with Resident A, C and D
09/23/2022	Contact - Telephone call made Interview with Lifeways case manager Richard Jansen
10/05/2022	Exit Conference With Licensee Peg Root

ALLEGATION:

Ms. Root did not allow Resident A access to the telephone.

INVESTIGATION:

On 8/16/22, I interviewed Licensee Peg Root in the home. Ms. Root denied that she restricts residents' phone calls, but asks that between 12 and 3, they observe quiet time. She describes this as them either being outside or in their rooms watching television. She stated that Resident A uses the phone very often to socialize with family members, so she asked that Resident A limit her calls to three a day. The onsite inspection occurred during this quiet time period, and I observed a resident using the phone for business purposes after an incoming call came for him. Ms. Root stated that Resident A had left to spend time with family members and was not due to return for another week.

On 9/2/22 I interviewed the complainant. The complainant noted that at this time there did seem to be any animosity between Resident A and Ms. Root.

On 9/13/22, I interviewed Resident A in the home. Resident A stated that Ms. Root makes them have 'quiet time' between noon and 3PM. She was asked if she could go into the community during that time and she said no. She then asked if I had a cigarette, then asked if I wanted to take a walk with her. I replied no. She then informed Ms. Root that she was leaving to go into the community, terminated the interview, then left the home.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable**

	amount of change shall be available in the group home to enable residents to make change for calling purposes.
ANALYSIS:	The home has a quiet time policy, which Ms. Root has acknowledged. However residents are not barred from using the phone during quiet time. There are other times during the day that the phone may be used, and incoming phone calls are delivered to the residents, per my observation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Ms. Root uses derogatory language toward Resident A.

INVESTIGATION:

Ms. Root denied that she uses derogatory language toward Resident A. She stated that often, Resident A will present with poor hygiene, and she would prompt Resident A to take showers, change her clothing etc. Ms. Root stated that Resident A would be non-compliant with her medication regimen, and she would encourage Resident A to tale her medication. According to Ms. Root, these prompts would often result in Resident A using profanity toward her. Ms. Root stated that she does not respond, but has set boundaries by telling Resident A that the profanity was not needed.

Resident B denied that Ms. Root uses profanity toward the other residents, or that Ms. Root used profanity toward Resident A during the incident with the rocking chair.

On 9/13/22, Resident A reported that since her return to the home, rapport between her and Ms. Root has improved.

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:	Based on interviews with Ms. Root and some residents, there is insufficient evidence to establish a violation. Residents and Ms. Root denied that Resident A was mistreated. Resident A's case manager acknowledged that while there is tension between Ms. Root and Resident A, that there was no retaliation when Resident A returned.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Ms. Root used physical force against Resident A.

INVESTIGATION:

Ms. Root stated that she observed Resident A in a rocking chair. The chair kept hitting the rail molding behind it. Ms. Root stated that she asked Resident A to move the rocking chair away from the wall, so that it would not hit or destroy the molding. She stated that Resident A became upset and refused to comply, cursing at her. She stated that she asked Resident A to get up so that the chair would not strike the molding. She stated that Resident A refused, and Ms. Root then dragged the chair away from the wall. She denied that Resident A fell as a result of this action.

I interviewed Resident B in the home. Resident B reported being in the home since 2004. He stated that he observed Ms. Root politely ask Resident A stop hitting the wall with the rocking chair, when Resident A began to curse at Ms. Root. He denied seeing Ms. Root throw Resident A out of the chair. He stated that he receives good care generally in the home.

On 9/13/22, Resident A stated that she is medication compliant at this time, but has had issues sleeping at night. She reported that she has had issues with falling but that the doctor's office has not provided any suggestions to avoid falling. She stated that her falls are not due to any medication issues, nor does she have any medical issues that would cause falls. She denied suffering from vertigo. Resident A reported that she was in a rocking chair, and Ms. Root asked her to get up because the chair was scaping the rail molding on the wall. Resident A stated that Ms. Root tipped her out of the chair. She denied sustaining any injuries as a result. Resident A stated that after the incident she stayed at a relative's home for about a week.

I interviewed Resident C in the home after Resident A left. Resident C stated that Ms. Root asked Resident A to get off the rocking chair so that it would stop hitting the holding. Resident C stated that Resident A did not comply, so Ms. Root scooted the chair away from the wall. Resident C denied that Resident A ever fell out of the chair, or that Ms. Root pushed Resident A out of the chair.

On 9/23/22, I interviewed Lifeways case manager Richard Jansen. He confirmed receiving similar allegations. He added that after Resident A had returned to the home after being away for a week, that things were more cordial between Resident A and Ms. Root. He stated that Resident A had denied any retaliation from Ms. Root.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based on interviews conducted with Ms. Root and some of the residents, there is insufficient evidence to establish a violation. The residents denied that Resident A fell out of the chair and Resident A denied suffering from any injuries.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Ms. Root does not feed Resident A proper meals.

INVESTIGATION:

Ms. Root stated that Resident A would often complain about the food in very derogatory terms. She provided a copy of the menu. The menu appeared to be varied and provided nutritious options. There were 4 boxes of Chicken Helper observed on the counter. The home was supplied with ample food.

Resident B stated that the food in the home is satisfactory and had no complaints.

On 9/13/22, I interviewed Resident A, who provided no input on the food served in the home.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on observations of the food menu and observations of the meal being prepared during an onsite inspection, there is insufficient evidence to establish a violation. Residents expressed satisfaction with meals prepared and Resident A did not provide any information regarding poor meals.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend no change to the status of this license.

10/5/22

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Dwight Forde Date
Licensing Consultant

Approved By:

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Russell B. Misiak Date
Area Manager