GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 22, 2022

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

RE: License #: AS250010737
Investigation #: 2022A0572057
Richfield House

Dear Ms. Barnes:

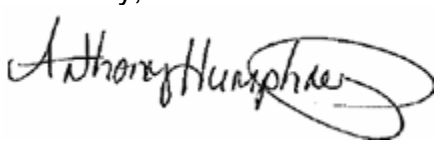
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 643-7960.

Sincerely,



Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010737
Investigation #:	2022A0572057
Complaint Receipt Date:	09/26/2022
Investigation Initiation Date:	09/28/2022
Report Due Date:	11/25/2022
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Regina Wheaton
Licensee Designee:	Paula Barnes
Name of Facility:	Richfield House
Facility Address:	4478 Vassar Rd Flint, MI 48506
Facility Telephone #:	(810) 736-1203
Original Issuance Date:	12/11/1985
License **Status:**	REGULAR
Effective Date:	05/21/2022
Expiration Date:	05/20/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's IPOS (Individual Plan of Services) requires that resident is repositioned every 2 hours, 24 hours a day. Resident was not repositioned at all between the times of 9:00 a.m. and 11:57 a.m. on 9/23/2022. Documentation shows that resident has had new skin breakdown for most of September. Staff present: Regina Wheaton, Robin Prince, Deloris Hampton, and Diana Howlett-Alamqdashi were present.	Yes

III. METHODOLOGY

09/26/2022	Special Investigation Intake 2022A0572057
09/28/2022	Contact - Document Sent Complainant.
09/28/2022	Special Investigation Initiated - On Site Staff, Delores Hampton and Regina Wheaton.
10/04/2022	Contact - Telephone call made Recipient Rights Investigator, Kim Nguyen-Forbes.
11/15/2022	Contact - Face to Face Home Manager, Robin Prince.
11/15/2022	Contact - Telephone call made Staff, Diana Howlett-Almqdashi
11/15/2022	Contact - Telephone call made Case Manager, Sara Kipmiller.
11/18/2022	Contact - Telephone call made Recipient Rights, Kim Nguyen-Forbes
11/21/2022	Inspection Completed-BCAL Sub. Compliance
11/21/2022	Exit Conference Licensee Designee, Paula Barnes.

11/22/2022	APS referral APS Referral was made.

ALLEGATION:
Resident A's IPOS requires that resident is repositioned every 2 hours, 24 hours a day. Resident was not repositioned at all between the times of 9:00 a.m. and 11:57 a.m. on 9/23/2022. Documentation shows that resident has had new skin breakdown for most of September. Staff present: Regina Wheaton, Robin Prince, Deloris Hampton, and Diana Howlett-Alamqdashi were present.

INVESTIGATION:
On 09/26/2022, the local licensing officed received a complaint for investigation. Recipient Rights also conducted their own investigation.

On 09/28/2022, I made an unannounced visit to Richfield House, located in Genesee County Michigan. Interviewed were, Staff, Delores Hampton and Regina Wheaton. Resident A was in the hospital during both of my unannounced onsite visits. I observed the two other residents in the home, and they appeared to be attended to and receiving adequate care and supervision.

On 09/28/2022, I interviewed staff Delores Hampton regarding the allegation. She informed that all residents in the home needs to be repositioned every two hours. When asked was this completed for Resident A on 09/23/2022, she stated, "Yes."

On 09/28/2022, I interviewed Administrator, Regina Wheaton regarding the allegation. She informed that Resident A does need to be repositioned every two hours and she has a wound care specialist. Resident A refuses a lot and when she does, it can become very difficult to reposition her. At the time, she was sitting doing artwork and did not want to be moved. When she put her foot down, that was a signal that she did not want to be moved.

On 10/04/2022, I spoke with Recipient Rights, Kim Nguyen-Forbes. She informed that she is scheduling interviews for tomorrow.

On 11/15/2022, I interviewed Home Manager, Robin Prince regarding the allegation. She informed that Resident A is required to be repositioned every two hours and put a bandage on her wound. She has a wound care specialist, and she indicates that the wound looks good. She was present the day of the complaint.

On 11/15/2022, I reviewed the Repositioning Schedule for Resident A, and it indicates that Resident A was repositioned every two hours.

On 11/15/2022, I reviewed Resident A's Service Plan and it indicates that staff are required to reposition Resident A every two hours.

On 11/15/2022, I reviewed the notes from the wound care specialist for 09/23/2022 and she indicated that the wound was getting better.

On 11/15/2022, I reinterviewed staff Delores Hampton regarding the allegation. She informed that Resident A is able to reposition herself and they are not supposed to force her to reposition if she does not want to.

On 11/15/2022, I called staff, Staff, Diana Howlett-Almqdashi regarding the allegation. She informed that Resident A can reposition herself. A lot of times when staff reposition Resident A, she will move herself back to the previous position. Staff are to reposition Resident A every two hours, but sometimes she will not allow for them to touch her. When asked if there is any documentation indicating when Resident A does not allow staff to reposition her, she informed that they did not have any documentation and that they just inform the next shift. When asked if there anything in the plan that states that Resident A can reposition herself, she informed that the staff are supposed to reposition Resident A. Ms. Howlett-Almqdashi informed that the wound care specialist was there the same day, after dinner and said that the wound looks better.

On 11/15/2022, I interviewed Resident A's Case Manager, Sara Kipmiller regarding the allegation. She informed that she has not personally witnessed staff not repositioning Resident A. She does not have any concerns regarding Resident A care at the facility. She is currently at the hospital, and she is not doing good and may be receiving Hospice Care once released from the hospital.

On 11/18/2022, I spoke with Recipient Rights, Kim Nguyen-Forbes. She informed that she substantiated against both staff that were working on that day because Visitor #1 witnessed staff not repositioning Resident A. When asked if she reviewed the Repositioning Schedule for Resident A, she said she did but does not trust it because when she asked for it, it was sent prefilled. During her interview with the staff, she was told that they repositioned Resident A before Visitor #1 arrived at the home. Ms. Nguyen-Forbes says that this doesn't make sense as Resident A was scheduled to be repositioned at 10am and Visitor #1 was there from 9am until 11:57am, so there still needed to be one completed around 10am.

On 11/21/2022, contact was made with Visitor #1. Visitor #1 informed that they were present at the home on 09/23/2022 and witnessed that staff did not reposition Resident A between the times of 9am and noon. In Resident A's Service Plan, in the objective section, it indicates that she is to be repositioned every two hours and this was not done.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Staff denied that Resident A was not repositioned every two hours on 09/23/2022. Both staff indicated that Resident A can reposition herself, however; the service plan indicates that staff must reposition Resident A. They also indicated that she sometimes doesn't want to be repositioned, so they don't force her to move, but they did not document those days in which she refuses to be repositioned. Recipient Rights were involved and did not trust the Repositioning Schedule due to times being prefilled. Visitor #1 was present from 9am to 11:57am and did not observe Resident A being repositioned.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/21/2022, I held an Exit Conference with Ms. Paula Barnes regarding the special investigation. She was informed of the results of the investigation.

IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this small adult foster care group home, pending the receipt of an acceptable corrective action plan (Capacity 1-6).

11/22/2022

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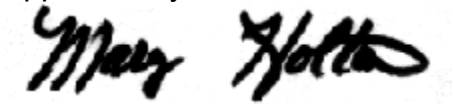
Anthony Humphrey Date
Licensing Consultant

Approved By:



11/22/2022

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Mary E. Holton Date
Area Manager