



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

February 17, 2023

Thomas Hart  
Independent Living Solutions, LLC  
2786 Cecelia St.  
Saginaw, MI 48602

RE: License #: AS730296476  
Investigation #: 2023A0576015  
Cardinal Care AFC

Dear Mr. Hart:

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 (517) 643-7960.

Sincerely,

A handwritten signature in cursive script that reads "C. Garza".

Christina Garza, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909  
(810) 240-2478

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS730296476
<b>Investigation #:</b>	2023A0576015
<b>Complaint Receipt Date:</b>	12/29/2022
<b>Investigation Initiation Date:</b>	01/03/2023
<b>Report Due Date:</b>	02/27/2023
<b>Licensee Name:</b>	Independent Living Solutions, LLC
<b>Licensee Address:</b>	2786 Cecelia St., Saginaw, MI 48602
<b>Licensee Telephone #:</b>	(989) 752-6142
<b>Administrator:</b>	Thomas Hart
<b>Licensee Designee:</b>	Thomas Hart
<b>Name of Facility:</b>	Cardinal Care AFC
<b>Facility Address:</b>	2700 Cecelia St., Saginaw, MI 48602
<b>Facility Telephone #:</b>	(989) 401-2802
<b>Original Issuance Date:</b>	09/18/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/18/2021
<b>Expiration Date:</b>	03/17/2023
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, ALZHEIMERS AGED, TRAUMATICALLY BRAIN INJURED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
There is concern Resident A is being intimidated by staff.	No
There is concern Resident A is not being fed regularly.	No
Resident A's family brings her snacks however she is not given her snacks. Concern staff may be eating Resident A's snacks	No
Additional Findings	Yes

**III. METHODOLOGY**

12/29/2022	Special Investigation Intake 2023A0576015
12/29/2022	APS Referral
01/03/2023	Special Investigation Initiated - Telephone Left message for Relative A to return call
01/05/2023	Contact - Telephone call made Interviewed Relative A
02/08/2023	Inspection Completed On-site Interviewed Staff, Jason Tillman, Home Manager, Steven Ball, and Resident A
02/14/2023	Contact - Telephone call made Interviewed Danita Rider, Case Manager
02/15/2023	Contact - Telephone call made Interviewed Resident B
02/17/2023	Exit Conference Exit Conference conducted with Licensee Designee, Thomas Hart

**ALLEGATION:**

There is concern Resident A is being intimidated by staff.

## **INVESTIGATION:**

On December 28, 2022, I received this intake from Adult Protective Services (APS). The intake was denied for APS investigation.

On January 5, 2023, I interviewed Relative A who reported Resident A “gets into it” with staff. When Resident A enters the living room, staff leave the room. Relative A has requested to speak with staff however they refuse.

On February 8, 2023, I completed an unannounced on-site inspection at Cardinal Care AFC and interviewed Staff, Jason Tillman. Mr. Tillman reported he has worked at the facility for 5 years. Regarding Resident A, she has resided at the home for 2 years. Staff are not disrespectful to Resident A and do not mistreat her. Resident A is prone to staring and staff will address this behavior with her. Resident A and staff sometimes have disagreements however they do not attempt to intimidate Resident A. Staff will correct Resident A and sometimes she gets mad when they do this. Mr. Tillman advised staff are nice to Resident A.

On February 8, 2023, I interviewed Home Manager, Steven Bell regarding the allegation. Mr. Bell denied staff intimidate Resident A or are disrespectful toward her. Resident A often stares at people and staff will ask her if she is okay. Staff will explain to Resident A how staring could be misunderstood by others. However, staff do not get upset with Resident A for staring.

On February 8, 2023, I interviewed Resident A who reported she has lived at her home for 2 years. Resident A advised her home is “okay”. Resident A was asked if staff intimidate her however, she advised she did not understand what “intimidate” meant. Resident A was asked if she felt safe at her home, and she confirmed she does. Resident A denied staff scare her or are mean to her. Staff do not say mean or rude things to her. Resident A denied any concerns regarding her home and denied staff are mistreating her in any manner. Resident A did indicate she would like to live with her relatives.

On February 14, 2023, I interviewed Resident A’s Case Manager, Danita Rider from Saginaw County Community Mental Health Authority. Ms. Rider visits Cardinal Care AFC home twice per month and she is the case manager for 2 residents who reside at the facility. Ms. Rider denied witnessing or being aware of staff mistreating Resident A and Resident A has never disclosed to Ms. Rider that staff are mean to her. Resident A has reported that staff “do too much” however Resident A was unable to elaborate further on what that meant. Resident A has never reported to Ms. Rider that she feels unsafe at her home. Ms. Rider denied any concerns about Cardinal Care AFC and believes the home is a good home. Ms. Rider advised that it is possible the staff could put more effort in assisting Resident A as she is somewhat “child-like” and has some cognitive limitations.

On February 15, 2023, I interviewed Resident B who reported she has lived at her home for 4 years. Resident B gets along well with staff and staff are not mean to her. Resident B denied staff are disrespectful toward her. Resident B denied that staff are rude or mean to any residents of the home. Staff will sometimes raise their voice however this does not scare Resident B.

<b>APPLICABLE RULE</b>	
<b>R 400.14305</b>	<b>Resident protection.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	<p>It was alleged that Resident A was being intimidated by staff. There is not a preponderance of evidence to conclude a rule violation.</p> <p>Staff, Jason Tillman and Home Manager, Steven Bell deny Resident A is being intimidated by staff. Resident A denied that staff are mean to her or that she feels unsafe at her home. Resident B was interviewed and denied staff are mean toward her or any residents of the home. Danita Rider, Resident A's case manager who frequently visits the home, denied witnessing or being aware of staff mistreating Resident A.</p> <p>There is not a preponderance of evidence to conclude Resident A's safety and protection is not attended to at all times.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

There is concern Resident A is not being fed regularly.

**INVESTIGATION:**

On January 3, 2023, I left a message for Relative A to return call. On January 5, 2023, I interviewed Relative A who reported Resident A calls Relative A daily and reports she is hungry.

On February 8, 2023, I completed an unannounced on-site inspection to the home. I interviewed Staff, Jason Tillman regarding the allegations. Mr. Tillman advised Resident A is provided 3 meals per day as well as snacks. Resident A likes to eat

snacks such as chips, ramen noodles, and often does not like to eat the meals that are provided to her. Resident A likes to eat “restaurant food”, which they do not get every day. The home buys snacks for the residents, which they eat quickly including Resident A.

On February 8, 2023, I interviewed Home Manager, Steven Bell who has worked at the home for 8 years. The allegation was discussed with Mr. Bell to which he denied. Mr. Bell reported Resident A can be a picky eater and likes to eat out, which the home occasionally does (i.e., KFC, Pizza). According to Mr. Bell, residents are free to eat what they want and when and Resident A exercises this right.

On February 8, 2023, I interviewed Resident A regarding the allegation. Resident A reported she receives enough food to eat at her home. Resident A can pick her own snacks to eat and will pick sandwiches. Resident A receives breakfast, lunch, and dinner and staff cook her meals. Resident A reported she was leaving soon to get tacos from a restaurant for lunch.

On February 8, 2023, I viewed the home to have current menus posted. The home had ample food in the cupboards, refrigerator, and freezer.

On February 14, 2023, I interviewed Danita Rider, Resident A’s Case Manager from Saginaw County Community Mental Health Authority. Ms. Rider advised she visits with Resident A and another resident at Cardinal Care AFC at least twice per month. Ms. Rider had no concerns regarding Resident A not being fed properly at her home. Ms. Rider advised Resident A has cooking skills and Ms. Rider has witnessed Resident A making herself macaroni and cheese. Ms. Rider saw Resident A at her home on February 9, 2023, around lunch time and Resident A was just waking up. Staff had prepared Resident A breakfast and lunch and saved the meals for her. Resident A has never complained to Ms. Rider that she is hungry or that she is not being fed. Ms. Rider advised Resident A appears physically healthy, and she does not appear to be losing any weight.

On February 15, 2023, I interviewed Resident B. Resident B has resided at her home for 4 years. Regarding the allegation, staff cook for the residents and Resident B gets enough food to eat. Resident B receives breakfast, lunch, dinner, and snacks. Resident B denied being hungry at her home and if she ever was, she can get herself something to eat.

<b>APPLICABLE RULE</b>	
<b>R 400.14313</b>	<b>Resident nutrition.</b>
	<b>(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.</b>

<b>ANALYSIS:</b>	<p>It was alleged that Resident A is not being fed regularly. Upon conclusion of investigative interviews and an unannounced on-site inspection to the home, there is not a preponderance of evidence to conclude a rule violation.</p> <p>Resident A denied the allegation and advised she receives adequate food. Resident B was also interviewed and reported to receiving enough to eat. The residents report to receiving breakfast, lunch, dinner, and snacks at their home. Resident A's Case Manager, Danita Rider was interviewed and denied any concerns regarding Resident A's meals or that she is not being fed properly. The home was viewed to have menus posted and ample food for the residents. There is not a preponderance of evidence to conclude Resident A is not being provided 3 regular meals daily.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

Resident A's family brings her snacks however she is not given her snacks. Concern staff may be eating Resident A's snacks.

**INVESTIGATION:**

On January 3, 2023, I left a message for Relative A to return call. On January 5, 2023, I interviewed Relative A who reported relatives take Resident A snacks however Resident A does not get them.

On February 8, 2023, I completed an unannounced on-site inspection to the home. I interviewed Staff, Jason Tillman regarding the allegation to which he denied. Mr. Tillman was not aware of Resident A's family bringing her snacks and advised he has never known this to occur.

On February 8, 2023, I interviewed Home Manager, Steven Bell who has worked at the home for 8 years. Mr. Bell denied Resident A's family members have brought her snacks to the home. On one occasion, a relative brought Resident A sugar and residents go through sugar quickly.

On February 8, 2023, I interviewed Resident A regarding the allegation. Resident A denied that her relatives bring her snacks and she reported she buys snacks herself. Resident A eats her snacks and staff do not eat them.



On February 15, 2023, I interviewed Resident B. Resident B reported she buys herself snacks. Resident B denied anyone takes her snacks. Resident B reported staff do not anything that belongs to her.

<b>APPLICABLE RULE</b>	
<b>R 400.14315</b>	<b>Handling of resident funds and valuables.</b>
	<b>(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.</b>
<b>ANALYSIS:</b>	<p>It was reported that Resident A's family brings her snacks and there are concerns staff eat Resident A's snacks. Upon conclusion of investigative interviews, there is not a preponderance of evidence to conclude a rule violation.</p> <p>Resident A was interviewed and denied relatives bring her snacks to the home. Staff, Jason Tillman and Home Manager, Steven Bell deny Resident A's relatives bring her snacks. Resident B reported she buys herself snacks and no one takes her snacks. Resident B denied staff take any of her belongings.</p> <p>There is not a preponderance of evidence to conclude that staff take valuables from Resident A.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On February 8, 2023, I completed an unannounced on-site inspection at the home. I spoke with Home Manager, Steven Bell and requested to see Resident A's weight record. Mr. Bell advised Resident A has not been having her weight recorded at the home and could not produce her weight record.

<b>APPLICABLE RULE</b>	
<b>R 400.14310</b>	<b>Resident health care.</b>
	<b>(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.</b>
<b>ANALYSIS:</b>	On February 8, 2023, during an on-site inspection to the home I requested to view Resident A's weight record. Home Manager, Steven Bell advised Resident A has not had her weight recorded monthly and could not produce Resident A's record.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

ON February 17, 2023, I conducted an Exit Conference with Licensee Designee, Thomas Hart. I advised Mr. Hart I would be requesting a corrective action plan with regard to the cited rule violation.

#### IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change in the license status is recommended.

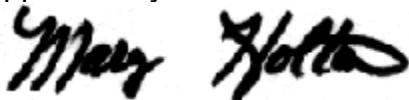


2/17/2023

Christina Garza  
Licensing Consultant

Date

Approved By:



2/17/2023

Mary E. Holton  
Area Manager

Date