GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 22, 2023

Amber Hernandez-Bunce
Cornerstone I, Inc.
P.O. Box 277
Bloomingdale, MI 49026

RE: License #: AS030243877
Investigation #: 2023A0581018
Cornerstone I, Inc.

Dear Ms. Hernandez-Bunce:

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) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS030243877
Investigation #:	2023A0581018
Complaint Receipt Date:	01/30/2023
Investigation Initiation Date:	01/30/2023
Report Due Date:	03/31/2023
Licensee Name:	Cornerstone I, Inc.
Licensee Address:	98 45th St Bloomingdale, MI 49026
Licensee Telephone #:	(269) 521-4130
Administrator:	Amber Hernandez-Bunce
Licensee Designee:	Amber Hernandez-Bunce
Name of Facility:	Cornerstone I, Inc.
Facility Address:	98 45th Street Bloomingdale, MI 49026
Facility Telephone #:	(269) 521-6028
Original Issuance Date:	01/04/2002
License Status:	REGULAR
Effective Date:	09/20/2022
Expiration Date:	09/19/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATIONS

	Violation Established?
The facility's home manager is borrowing money from residents and not repaying it back.	Yes
The home manager hit Resident A on the head.	No
There's no food in the facility due to direct care staff taking it.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/30/2023	Special Investigation Intake 2023A0581018
01/30/2023	Special Investigation Initiated - Telephone Interview with Van Buren Recipient Rights Officer, Candace Kinzler.
01/30/2023	Referral - Recipient Rights Van Buren RRO received the allegations and is investigating.
02/09/2023	Inspection Completed On-site Unannounced onsite inspection with Ms. Kinzler. Interviewed residents and staff.
02/09/2023	Contact - Document Received Email from Mequesha Merritt, the licensee's Care Coordinator Supervisor for the facility.
02/09/2023	APS Referral Made via telephone.
02/09/2023	Referral – Law Enforcement Via telephone to Allegan County Sheriff's Dept.
02/10/2023	Contact – Document Sent Email to APS specialist, Michael McClennan and Kathleen Woodworth.
02/10/2023	Contact – Face to face Interview with direct care staff/home manager, Jodi Raymond, via MiTeams with RRO and APS.
02/10/2023	Contact - Document Received Email from licensee designee, Amber Bunce.

02/13/2023	Contact - Document Received Email from Ms. Bunce.
02/13/2023	Contact - Document Sent Email to Deputy Tatrow.
02/14/2023	Contact - Document Received Email from Ms. Bunce.
02/15/2023	Contact - Document Received Email from Ms. Bunce.
02/20/2023	Contact - Document Received Email from Ms. Bunce,
02/22/2023	Contact - Telephone call received Interview with Van Buren RRO, Ms. Kinzler.
02/23/2023	Contact - Telephone call made Interview with Resident A.
02/23/2023	Contact - Telephone call made Interview with direct care staff, Howard Fields.
02/23/2023	Contact – Telephone call made Left voicemail with Guardian A1.
02/24/2023	Contact - Document Received Email from Ms. Bunce.
02/24/2023	Contact - Document Received Email from Ms. Merritt.
02/24/2023	Contact - Telephone call made Interview with direct care staff, Ellen McKinney.
03/02/2023	Contact - Document Received Email from Amber Bunce
03/07/2023	Contact - Telephone call made Interview with Ms. Bunce.
03/09/2023	Contact - Document Sent Requested police report from Allegan County Sheriff's Dept.

03/10/2023	Inspection Completed-BCAL Sub. Compliance
03/10/2023	Contact – Telephone call made Re-interview with Resident B.
03/13/2023	Contact – Document Received Allegan County Sheriff's Department police report # 2023-00002573.
03/17/2023	Contact – Document Received Email from Ms. Bunce.
03/07/2023	Exit conference with licensee designee, Amber Bunce, via telephone.

ALLEGATION:

The facility's home manager is borrowing money from residents and not repaying it back.

INVESTIGATION:

On 01/30/2023, the Office of Recipient Rights (ORR) referred Complainants concerns to the Bureau of Community Health Systems (BCHS), which alleged the facility's home manager, Jodi Raymond, was borrowing and taking money from residents.

On 01/30/2023, I confirmed with Van Buren Recipient Rights Officer (RRO), Candace Kinzler, she also received the allegations and was investigating. Ms. Kinzler and I coordinated an unannounced onsite inspection at the facility.

On 02/09/2023, Ms. Kinzler and I conducted an unannounced onsite inspection. We interviewed direct care staff, Howard Fields, who was the sole staff working in the facility. He stated he usually worked the overnight shift and had no knowledge of resident's funds or any staff, including Ms. Raymond, mishandling them.

During the inspection, we interviewed Resident A who stated she had given Ms. Raymond money. She stated in the Fall 2022 she wrote Ms. Raymond a check for $150, which Ms. Raymond was supposed to cash and provide Resident A with the funds; however, this did not occur. Resident A provided Ms. Kinzler and I with the carbon copy of the $150 check she wrote to Ms. Raymond. This carbon copy confirmed Resident A wrote Ms. Raymond a $150 check on 09/29/2022, which indicated "Christmas" in the memo section.

Resident A stated she receives approximately $50 per week in personal spending money, which she indicated Ms. Raymond had given her; however, Resident A stated she never signed any documents acknowledging she received her personal funds. Resident A also stated she had lent Ms. Raymond money with the most recent time being in the past week for $20 because Ms. Raymond needed “gas money.”

Additionally, Resident A stated there had been approximately 2-3 instances where she used her own personal funds to purchase coffee makers for the facility. She stated the facility’s coffee maker broke due to excessive use and rather than wait for Ms. Raymond to request facility funds to purchase the coffee makers she gave Ms. Raymond her own personal funds to purchase them. Resident A stated the purchased coffee makers were for the entire house to use rather than keeping them in her room for personal use. Resident A also stated she purchased coffee drinks for Ms. Raymond at places like Biggby. She stated she and Ms. Raymond would rotate who would purchase drinks for one another, which occurred approximately three times per month.

Resident A also stated Ms. Raymond would bring her friend, Adult A, and Adult A’s minor children, Child A and Child B, into the facility where they would “hang out” for extended periods of time. Resident A stated Child A and Child B were approximately 6 years old and 15 years old, respectively. She stated all three individuals would often go into the facility’s office with Ms. Raymond where she indicated resident working files were located and the facility’s computer. Resident A stated when the children came to the facility Child A often came into her bedroom. Resident A indicated she felt obligated to watch her. She stated she would ask Ms. Raymond and Adult A to give her a break from watching Child A and indicated they would comply with her request. Resident A also stated Child B had cooked the residents’ meals because Ms. Raymond “didn’t want to.”

I re-interviewed direct care staff member Mr. Fields regarding Ms. Raymond bringing Adult A, Child A, and Child B to the facility. He confirmed he had seen them in the facility, primarily at shift changes; therefore, he was unable to provide any detailed information like how long they’d been in the facility, what they were doing, or if they had access to resident documentation/information.

Ms. Kinzler and I interviewed Resident B who stated he also gave Ms. Raymond money. He stated he gave Ms. Raymond approximately $40 to purchase a facility coffee maker around August or September. He stated he also gave her $20 on or around 02/08/2023 for “gas and groceries.” Resident B stated he “felt sorry” and was trying to help Ms. Raymond because he believed she was in “trouble” since she was asking residents for money.

Resident C stated he did not give money to Ms. Raymond.

Resident D and Resident E were unable to be interviewed due to their cognitive and developmental impairments.

Resident F indicated she had just moved into the facility and did not give any money to Ms. Raymond.

During the inspection, the licensee's Care Coordinator Supervisor, Mequeshia Merritt, arrived at the facility. She located the facility's lockbox, which was kept for resident funds; however, no funds were present within the lock box. Ms. Merritt also check the resident's "working files" in the facility's' staff room for Resident Funds II forms and on the computer through the facility's electronic Assisted Living Integrated System (ALIS).

Ms. Merritt located the Resident Funds II forms online in the ALIS program; however, the funds forms indicated all the residents were provided their personal funds and therefore, there were no funds being held at the facility at the time of the onsite investigation.

According to my review of the Resident Funds II forms, none of the residents signed any of the forms acknowledging they received their personal funds except Resident A who signed her Resident Funds II form one time on 09/22/2022 in receipt of $150 in personal funds.

On 02/10/2023, APS specialist, Michael McClennan, indicated in his email to me he had interviewed Resident B who disclosed additional information to him concerning Ms. Raymond. He stated Resident B reported to him Ms. Raymond took $30 from him to purchase Chicken Coop and $20 to purchase Chinese food from a restaurant in a neighboring town.

On 02/13/2023, I interviewed direct care staff and identified home manager, Jodi Raymond, in conjunction with RRO, Ms. Kinzler, and APS specialists, Mr. McClennan and Ms. Woodworth, via MiTeams. The licensee's care coordinator, Ms. Merritt, was also present during the interview. Ms. Raymond stated residents received their personal funds every Tuesday. She stated their personal checks would be delivered to the licensee's main office, where she would pick them up, take them to the bank, cash them, and then give the cash to the residents. She stated residents would sign the Residents Funds II documents indicating they had received their personal funds from her. She stated she used the computer at the facility indicating the residents would sign paper documents and the computer.

Ms. Raymond stated shortly after she started in August or September 2022, Resident A told Resident B to give her money to purchase a coffee maker because the facility's coffee maker broke. She stated Resident B gave her $40 to get a new one, which she purchased; however, Resident B kept the receipt. She stated on or around December 2022, Resident A wrote her a check for $150 to cash and give her

the money because Resident A was having a difficult time getting in touch with her guardian. She stated she gave the cash to Resident A.

Ms. Raymond acknowledged she would go to Biggby with the residents, including Resident A; however, she denied Resident A using her own funds to purchase coffee for both of them. Ms. Raymond stated she used her own money to purchase Resident A's coffee periodically.

Ms. Raymond stated it was "normal" for some of the residents to buy food for all the residents in the facility. She stated for example, Resident B voluntarily purchased Chicken Coop for all the residents and herself.

Ms. Raymond denied ever taking or borrowing money from any of the residents in the facility. Ms. Raymond, when told the Resident Funds II forms did not have any resident signatures acknowledging their receipt of their funds, was unable to explain the missing signatures.

Ms. Raymond stated she brought her friend, Adult A, to the facility, along with Child A and Child B; however, Ms. Raymond initially stated Adult A only came to the facility when she wasn't working indicating Adult A was just picking Ms. Raymond up to take her home after her shift. Ms. Raymond stated Adult A would also bring Child A and Child B with her. Ms. Raymond acknowledged she wasn't supposed to have these individuals in the facility with her; however, she later indicated all three individuals would "visit" with her while she was working as well. Ms. Raymond denied any of these individuals cleaning or making food in the facility. She stated they had been there when dinner was being cooked and served. She stated during these times, Adult A, Child A, and Child B would sit around the table with the residents, but this would occur right before her shift was over. Ms. Raymond acknowledged Child A going into Resident A's bedroom when she visited because Resident A would give her candy. Ms. Raymond denied Resident A being responsible for watching Child A or babysitting her while she was in the facility.

Ms. Merritt stated direct care staff are expected to have residents sign their *Resident Funds II* forms and to keep receipts in the facility's lockbox prior to returning them into the accounting office. She stated after checking with the licensee's accounting officer, she discovered Ms. Raymond hadn't turned in any receipts since October 2022.

Ms. Merritt stated home managers can request "needs funds" for the facility or residents, which are funds from the licensee for direct care staff or the house manager to purchase items that are needed for the residents or the facility. Ms. Merritt indicated Ms. Raymond had been regularly asking for these funds. Merritt stated for example, Ms. Raymond asked for $60 to take residents out in the community, $45 to pay for resident's TB tests, and $30 for additional groceries.

Ms. Merritt stated it was inappropriate for Ms. Raymond to bring Adult A, Child A, and Child B into the facility.

On 02/15/2023, Ms. Bunce stated in an email to me and Ms. Kinzler the licensee purchases Christmas gifts every year for all the residents. She indicated items that are purchased for residents are things like “pajamas, personal care items, games, etc.”.

Ms. Bunce also stated in email the licensee was completing its own investigation and to implement corrective measure to avoid another situation. She indicated in her email Ms. Raymond did not follow the licensee’s procedures.

As part of her corrective action plan, Ms. Bunce stated in her email the licensee’s care coordinators and medical teams were retraining the facility staff on all plans and procedures. She also stated the licensee was auditing all receipts for all the licensee’s home to determine if “funds are being spent appropriately.” She stated the licensee is looking “into different ways to monitor funds because we rely on trusting the managers to do the right thing and obviously that does not always happen.” Ms. Bunce stated Ms. Raymond had been terminated and the licensee was currently looking for a new home manager. She also stated the licensee would be moving into more “in person visits with the care coordinators and more private visits so residents feel comfortable communicating their concerns with staff.” Ms. Bunce also stated, “we will be making sure that everyone gets money/gifts and outings that were promised to them.”

On 02/24/2023, I interviewed direct care staff, Ellen McKinney, via telephone. Ms. McKinney’s statement about how Ms. Raymond would obtain resident funds from the main office and cash their checks was consistent with Ms. Raymond’s statement to me. Ms. McKinney stated she had ridden with Ms. Raymond when Ms. Raymond went to cash resident’s personal checks. She stated she never saw any of the resident’s sign any documentation acknowledging they received their personal funds. Ms. McKinney also stated Resident B didn’t get any Christmas gifts from the licensee; despite Ms. Raymond receiving money from the licensee to purchase gifts. Ms. McKinney stated she never actually observed Ms. Raymond request to borrow or take resident’s personal funds. She stated she only “heard about it” after the investigation started.

Ms. McKinney stated she had seen Adult A, Child A, and Child B in the facility on at least two occasions. She couldn’t recall the date of the first instance, but indicated Ms. Raymond had called in sick to work, but then came with Adult A, Child A, and Child B. Ms. McKinney stated she had been working with the residents so she wasn’t around Ms. Raymond and the other individuals the entire time, but recalled Ms. Raymond staying for “a couple of hours” and indicated she and the Adult A were doing laundry at the facility because she recalled Child B carrying laundry back and forth from their vehicle to the facility. Ms. McKinney stated she observed Child A in

Resident A's bedroom, and saw Adult A, Child A, and Child B in the staff office with Ms. Raymond.

Ms. McKinney stated the second incident occurred on New Year's day. She stated Ms. Raymond was relieving her at 8 pm on New Year's Eve and had brought in Adult A, Child A, and Child B. She stated when she came into work the following day, Resident A had complained about babysitting Child A. Ms. McKinney stated Ms. Raymond reported Child A was just visiting; however, Resident A reported to her Child A wouldn't get out of her bedroom. Ms. McKinney stated there had been other instances where she observed Adult A in the facility, but it was because she came into the facility to get Ms. Raymond because she was providing Ms. Raymond with a car ride home.

On 02/22/2023, Ms. Bunce forwarded me Ms. Raymond's signed acknowledgement, dated 05/22/2022, she received and reviewed the licensee's "Employee Handbook", which contains the licensee's personnel policies, standards, and rules. I also received a copy of the licensee's Employee Handbook, which contained the following on the licensee's "Ethical Practices":

> "All Cornerstone/Hernandez Home AFC, Inc. staff shall not, directly or indirectly, solicit, accept or agree to accept, any gift of money or goods, loans or services or other preferred arrangements for personal benefit under any circumstances which would tend to influence, or have the appearance of influencing, the manner in which they perform their duties. An employee shall not grant or make available to any person a consideration, treatment, advantage or favor beyond that which is the general practice to grant or make available to the public at large."

I also reviewed the licensee's "Financial Policies", which contained additional information supporting the licensee's employees, managers or administrators not ever accepting, taking, or borrowing any personal items or monies of a resident in any of the licensee's adult foster care locations.

The licensee's financial policy also stated, "All fund transactions will require signature of the resident or resident's designated representative and the licensee". Additionally, the financial policy regarding the facility's "petty cash" or facility funds/needs was consistent with what was reported to me by Ms. Bunce. According to the financial policy, "The Home Manager is responsible for all receipts and will be attached to the needs sheet by the Financial Manager".

On 03/02/2023, Ms. Bunce stated in another email she reviewed the facility's documents for residents' funds and receipts and determined there are no outing receipts. She also stated Ms. Raymond did seem to purchase "some Christmas presents" for the residents; however, it was "not enough that would equal $50 a

person.” Ms. Bunce stated Ms. Raymond did not take the residents on any planned outings in December spending $150, which she had requested and believed the residents only received approximately $10 worth of gifts for Christmas rather than the allocated $50. Ms. Bunce stated in her email she believed Ms. Raymond was embezzling money from the licensee by not using the “needs funds” appropriately. Ms. Bunce stated according to receipts reviewed in December 2022 Ms. Raymond spent $220 on “leggings, hot wheel cards and Christmas candy” on 12/15/2022 from Walmart and $65 at Dollar General on 12/22/2022. She also stated there were no receipts for Ms. Raymond taking the residents bowling like Ms. Raymond indicated when she requested the additional needs funds. Ms. Bunce also stated the residents indicated to her they had not gone bowling in December either. Ms. Bunce stated she believed the residents had been getting their personal funds, as required.

On 03/10/2023, I reinterviewed Resident B via telephone. Resident B again confirmed he received his $50 in personal funds from Ms. Raymond every month; however, he stated he never signed any documentation indicating he received these funds. He again stated he gave his own personal funds to Ms. Raymond at her request. He stated he gave her approximately $100 for various things and items like a coffee maker, meals for lunch and dinner like Chicken Coop, gas money and “new pots.” Resident B stated Ms. Raymond never paid him back for the money she borrowed from him. He also stated he never got Christmas presents from the licensee despite him being told by other direct care staff that money was given to Ms. Raymond to purchase him and the other residents Christmas gifts.

Resident B’s statement to me regarding Ms. Raymond bringing individuals into the home was consistent with Resident A’s, Mr. Fields, and Ms. McKinney’s statements to me. He stated they would all “wash clothes, clean up and cook lunch and dinner” while they were in the facility. He indicated all three individuals were come to the facility “once or twice a month” for the day.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(1) A resident shall be assured privacy and protection from moral, social, and financial exploitation.

ANALYSIS:	Based on my interviews with multiple residents and direct care staff, and direct care staff/home manager Jodi Raymond's own admission, she brought her friend, Adult A, and her friends' minor children, Child A and Child B, into the facility when she worked and when she wasn't working multiple times per month over the course of several months; therefore, not assuring resident privacy. During these instances, Child A would go into resident bedrooms, primarily Resident A's, and Child B would assist with making resident's food. Additionally, Adult A, Child A, and Child B were allowed in the staff office and around the staff computer. Subsequently, Ms. Raymond did not assure the privacy of the residents within the facility when she allowed her friend and friend's minor children in home. Additionally, Ms. Raymond misused Resident A's and Resident B's personal funds on numerous occasions; therefore, financially exploiting them. Multiple coffee makers were purchased by Ms. Raymond utilizing Resident A's and Resident B's personal funds; despite the coffee makers being utilized by all residents within the facility, rather than Ms. Raymond utilizing facility funds provided by the licensee to make these purchases. Additionally, Resident A and Resident B provided Ms. Raymond with their personal funds to pay for coffee while on outings, to pay for Ms. Raymond's gas and groceries, and to order take out for all the residents. Additionally, Ms. Raymond cashed a $150 check for Resident A and never provided her with the funds.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(8) All resident fund transactions shall require the signature of the resident or the resident's designated representative and the licensee or prior written approval from the resident or the resident's designated representative.
ANALYSIS:	Based on my review of the resident's *Resident Funds II* forms, residents are not signing this form, as required, indicating they received their personal funds.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(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.
ANALYSIS:	Based on my investigation, direct care staff/home manager, Jodi Raymond took personal funds from Resident A and Resident B on multiple occasions even though Resident A and Resident B consented to providing her with their funds.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The home manager hit Resident A on the head.

INVESTIGATION:

On 02/10/2023, APS specialist, Mr. McClennan stated in an email to me Resident A had reported to him she had been physically assaulted by Ms. Raymond on two occasions. She stated to him on one occasion she was hit on the head with a balled fist at the dining room table and the other occasion she was slapped across the side of the head while at the table. Mr. McClennan stated in his email to me Resident A had no injuries.

Ms. Raymond denied hitting or slapping Resident A in the head. She stated she had never physically abused any of the residents, including Resident A. She denied ever yelling or treating Resident A inappropriately.

On 02/23/2023, I re-interviewed Resident A via telephone regarding the physical assault allegations. Resident A's statement to me was consistent with her statement to APS Specialist Mr. McClennan. She was unable to recall specific dates but indicated both instances occurred right before Ms. Raymond stopped working at the facility. She stated the first incident occurred while Resident A was waiting at the kitchen table for her medications when Ms. Raymond showed up to work "mad." Resident A stated Ms. Raymond came into the facility's kitchen, stated she was mad and then "bopped" Resident A on the top of the head with her fist. She stated Ms. Raymond fist was closed when the incident occurred. She stated there were no other residents or staff around when the incident occurred. Resident A indicated the assault hurt her but stated there were not any injuries. She stated after the incident

took place, she just looked at Ms. Raymond and did not say anything. She was unable to recall if Ms. Raymond said anything to her.

Resident A stated the second incident occurred when Resident A was going to sit at the kitchen table by the window when Ms. Raymond “biffed” her on the left side of her head behind her ear indicating she was hit by Ms. Raymond. Resident A stated she also did not say anything to Ms. Raymond at that time. She stated Ms. Raymond came up to her later and told her she was sorry, but she was having a bad day. She stated she did not recall anyone being present for this incident either. She also did not recall having any injuries; however, she indicated she had a headache from being hit.

Ms. McKinney stated she never saw Ms. Raymond hit or assault any of the residents, including Resident A.

Resident B stated he had no knowledge of Ms. Raymond being physically abusive to Resident A or any of the residents within the facility. He stated he had not seen Ms. Raymond treat any of the residents, including Resident A, inappropriately or disrespectfully.

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 my investigation, which included interviews with Resident A, Resident B, direct care staff, Ellen McKinney, and home manager, Jodi Raymond, there is no evidence supporting Ms. Raymond physically assaulted Resident A by “bopping” or “biffing” her on the side of the head, as alleged.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There's no food in the facility due to direct care staff taking it.

INVESTIGATION:

The complaint alleged the facility's home manager was taking the facility's food home; therefore, there wasn't enough food for residents at the end of the week.

During my onsite inspection, I observed sufficient food in the facility, including the freezer, refrigerator, and cupboards. I observed fruit, vegetables, meat (e.g., bacon, chicken), milk, juice, and snacks. I did not observe a menu during the inspection and upon request to see one, direct care staff, Mr. Fields, stated there was not one.

Resident A stated the facility's food gets delivered on Tuesdays and Ms. Raymond would take extras from the home's food orders with her after it was delivered. She indicated Ms. Raymond would take "the good stuff' like sausage and bacon and leave none of these items for the residents. She confirmed facility staff provide meals to the residents three times per day.

Ms. McKinney stated residents receive three meals per day, which include a variety of ingredients relating to the food pyramid like vegetables, fruit, meat, and starch. She denied any of the residents ever going without a meal or being hungry. Ms. McKinney's stated after groceries were brought back to the facility, Ms. Raymond would indicate residents had "enough of this or enough of that" and would take resident food home. Ms. McKinney indicated when Ms. Raymond first started doing it, she indicated she was thinning out the cabinets or freezers, but then it turned into her taking home food ever week. Ms. McKinney stated there was always food in the house for residents and staff would continue making well rounded meals. She stated there continued to be items like biscuits, sausage, and bacon, which was liked by the residents. Ms. McKinney stated the facility would have menus, but Ms. Raymond wouldn't display them. She indicated they would not follow the menus either as they would "cook what was available in the home."

Ms. Raymond stated she had permission from Karmen Ball, the licensee's Chief Administrative Officer, around Christmas 2022 to take food items home that were expired, expiring, or items in which residents didn't like or there were too many. She stated she took items like "cereal, chicken, mac n cheese, and bread", but indicated it was only one time.

Ms. Raymond stated the facility received menus once a month; however, she indicated she had just gotten them prior to my onsite investigation but had not put them out to be displayed.

Ms. Merit indicated Ms. Ball may have given Ms. Raymond permission about taking the overflow items if residents were not eating something or they had excess of an item.

Resident B did not indicate to me any concerns about there not being food in the facility or staff not providing three meals per day, as required. He did not indicate any concerns there was not a variety of food available 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:	Even though direct care staff/home manager Jodi Raymond took food designated and purchased for residents from the facility, there is no evidence it prevented residents from still having three regular nutritious meals a day.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on my investigation, which included interviews with Resident A, direct care staff/home manager, Jodi Raymond, and direct care staff, Ellen McKinney, Ms. Raymond took resident food from the facility for her own use, which she also admitted doing. Subsequently, by Ms. Raymond taking food that was not hers she was engaging in theft like behavior, which does not make her suitable to meet the emotional needs of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	The facility's menu was not posted during my inspection. Additionally, both direct care staff and residents stated menus were not being posted.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

When Ms. Kinzler and I conducted our unannounced onsite investigation on 02/09/2023 at the facility, direct care staff, Mr. Fields, was unable to locate any resident files within the facility, including the location of *Assessment Plans for AFC Residents*, *Resident Funds II* documents, *Resident Care Agreements*, or any corresponding Community Mental Health plans (e.g., Individual Plans of Service, Behavior Treatment Plans, etc.). Mr. Fields stated he was hired on 01/21/2023 and he primarily had only worked the overnight shift; therefore, he did not have to access resident files or complete paperwork. He indicated it was only his second time working a day shift. Ms. Kinzler queried Mr. Fields on emergency situations like if a resident needed medical attention and what documentation would go with the resident, or who required special diets or specific care. Mr. Fields appeared frazzled and unable to answer our questions regarding emergency situations or locating resident documentation.

On 02/13/2023, Ms. Bunce stated in an email to me and Ms. Kinzler that Mr. Fields was "in-serviced on the goals of all residents on January 10 of this year." She also stated he was trained on how to navigate ALIS during a documentation training. Ms. Bunce stated that due to Mr. Fields being a new staff, she would retrain him in documentation and how to navigate ALIS.

Ms. Bunce indicated in her email that it was "regular practice" for new hires to receive two in-services on plan goals. She stated she had spoken to Mr. Fields on 02/13/2023 and he indicated to her he was "very confused" about what had been asked of him during the investigation, particularly because he did not have access to some resident items like resident funds and when he was asked, he indicated to her that he "froze". Ms. Bunce indicated in her email she would be having a meeting tomorrow with the licensee's care coordinators to discuss the training process on

Individual Plans of Service goals to ensure the right information is getting out to the new hires.

Ms. Bunce also stated in her email that Mr. Fields had worked a total of three shifts outside of his normal night shifts, which is from 11 pm until 7 am. She stated in her email that he should have known where the facility's menus were because he was taught this information in "health, safety, nutrition, and orientation", but she indicated he needed to be retrained in the basic classes, which would be done one on one to help him retain the information better.

Ms. Bunce also stated in her email that she can "trace the staff access in ALIS" and determined Mr. Fields had been in the system several times since he had been "on the floor" and was subsequently unsure why he stated he didn't know how to access resident's Person Centered Plans or how to document on ALIS.

Ms. Bunce forwarded me Resident A's, B's, C's, and D's in-service sheets confirming Mr. Fields had been in-serviced on these resident's plans on 01/10/2023. Ms. Raymond stated new direct care staff shadow staff on their first day. She stated it is during this time new hires also read care plans for each resident and staff show them the kind of care each resident requires. Ms. Raymond stated when the onsite inspection took place it had only been Mr. Field's second time working a day shift and he wasn't aware of the resident's working files.

On 02/20/2023, Ms. Bunce stated in an email she had retrained Mr. Fields and provided the documentation confirming it. Ms. Bunce stated in her email she discovered Mr. Fields' training was a "hybrid of Ionia online classes because we are struggling with training our staff in our own classes due to staffing shortages and covering floor hours". She stated in her email this type of training is "not sufficient" for the job and the licensee has since switched back to their "usual training program."

On 02/22/2023, Ms. Bunce forwarded me Mr. Field's "New Employee Training Checklist", which indicated he submitted an application for employment to the licensee on 11/09/2023, completed 41 hours of training from 11/10/2022 through 01/20/2023 and was hired on 01/20/2023.

On 02/23/2023, I reinterviewed direct care staff, Mr. Fields. He stated at this time, he has worked one month at the facility. He stated when he was hired, he recalled taking the following classes: medication, CPI (behavior intervention techniques), recipient rights, CPR/1st aid. Mr. Fields stated "a few" of the classes had tests at the end of them to test comprehension. Mr. Fields stated he wasn't trained on specific resident plans or goals, but indicated he is able to review "consumer care" on ALIS. He stated he had "looked over" resident plans but had not fully reviewed them. He stated when he was hired, Ms. Raymond spoke to him on the phone and gave him a "run down" of resident's specific care and "what he or she was like". Mr. Fields stated when he was first hired, he didn't know how to access resident plans, or their

assessments and he “forgot” where some of the items were in the staff office. He stated when he was hired, he hadn’t been instructed where resident working files or resident documentation was located in the staff office. He stated he has since gotten a refresher on how to locate everything in the staff office.

While interviewing Mr. Fields, he was able to report specific care required of each resident (e.g., what residents were diabetic, who needed their food cut up prior to eating, and who required assistance with showering and dressing). Mr. Fields stated when he’s working the overnight shift, he does not document as much as a day shift staff because the residents are primarily sleeping.

Ms. McKinney stated she was hired end of August 2022 and had taken two weeks of classes in order to work on the floor in the facility. She stated she took tests after the classes to ensure she understood the content of the material. She also stated she ready and understood all resident plans and had been trained on them by Ms. Raymond and another direct care staff.

Resident B stated he had observed Mr. Fields caring for the residents within the facility like assisting them with showers or preparing their food. He indicated he primarily worked the overnight shift. Resident B did not indicate either he nor any of the residents were not receiving the care they required or could not receive assistance from Mr. Fields, if it was requested.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.** **(b) Be capable of appropriately handling emergency situations.**

ANALYSIS:	During my unannounced onsite investigation on 02/09/2023, direct care staff, Howard Fields, could not locate resident files, including the location of *Assessment Plans for AFC Residents*, *Resident Funds II documents*, *Resident Care Agreements*, or any corresponding Community Mental Health plans (e.g., Individual Plans of Service, Behavior Treatment Plans, etc.). Additionally, Mr. Fields was unable to describe resident care, how to access resident documentation, and what to provide medical personnel in emergency type situations indicating he was not suitable to meet the needs of the residents or capable of appropriately handling emergency situations, including an inspection regarding the quality of care of vulnerable adults.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/21/2023, I conducted my exit conference with licensee designee, Amber Bunce, via telephone. Ms. Bunce agreed with my findings and the severity of the violations identified in the report. She indicated she would submit an acceptable corrective action plan once she's reviewed the report.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

Cathy Cushman

03/21/2023

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Cathy Cushman Date
Licensing Consultant

Approved By:

Dawn Timm

03/22/2023

_____

Dawn N. Timm Date
Area Manager