GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 24, 2023

Connie Mayer
9201 Lakeside Drive
Perrinton, MI 48871

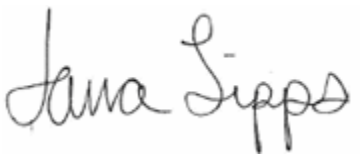
RE: License #: AF290298715
Investigation #: 2023A1033029
Connie's Lakeside Elder Care

Dear Ms. Mayer:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 2/16/23, during the on-site investigation, you requested your license be closed at the conclusion of this investigation. Your written request to close your license will serve as your corrective action plan.

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,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF290298715
Investigation #:	2023A1033029
Complaint Receipt Date:	02/14/2023
Investigation Initiation Date:	02/16/2023
Report Due Date:	04/15/2023
Licensee Name:	Connie Mayer
Licensee Address:	9201 Lakeside Drive Perrinton, MI 48871
Licensee Telephone #:	(989) 533-9028
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Connie's Lakeside Elder Care
Facility Address:	9201 Lakeside Drive Perrinton, MI 48871
Facility Telephone #:	(989) 640-2548
Original Issuance Date:	03/13/2009
License Status:	REGULAR
Effective Date:	02/11/2022
Expiration Date:	02/10/2024
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Chris Mayer and Citizen 1 have been providing direct care to residents without proper workforce background check clearance.	No
The licensee, Connie Mayer, is not physically capable of providing for resident care due to her own physical limitations.	No
Responsible person, Christopher Mayer, uses “meth” and marijuana. He yells and slams doors around residents.	No
Resident A had a fall with injury and Ms. Mayer was not aware of the fall until the day after the event.	No
Additional Findings	Yes

III. METHODOLOGY

02/14/2023	Special Investigation Intake 2023A1033029
02/14/2023	APS Referral Complaint stemmed from denied APS referral.
02/15/2023	Contact - Telephone call made- Attempt to interview Citizen 1, voicemail message left.
02/16/2023	Special Investigation Initiated – Telephone call made- Interview with Citizen 1 via telephone.
02/16/2023	Inspection Completed On-site- Interview with Licensee, Connie Mayer, Responsible Person, Christopher Mayer, and Resident A. Review of resident records and resident medications completed.
02/16/2023	Exit Conference- Completed on-site with licensee, Connie Mayer.
03/14/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Chris Mayer and Citizen 1 have been providing direct care to residents without proper workforce background check clearance.

INVESTIGATION:

On 2/14/23 I received an online complaint regarding Connie's Lakeside Elder Care adult family home (the facility). The complaint alleged that responsible person, Christopher Mayer, and Citizen 1 had been providing direct care to residents at the facility without having proper Michigan Workforce Background Check clearance. On 2/16/23 I interviewed Citizen 1, via telephone. Citizen 1 reported he had been living at the facility, off and on, for a period of ten years. Citizen 1 reported he would provide for resident care needs when licensee Connie Mayer required assistance. Citizen 1 reported he has changed incontinence briefs and administered medications to residents of the facility. Citizen 1 further reported he had not been required to complete a Michigan Workforce Background Check because he has a prior felony on his record that would exclude him from providing direct care to residents. Citizen 1 reported Mr. Mayer also has a criminal history and has not gone through proper background checks to provide direct resident care.

On 2/16/23 I completed an on-site investigation at the facility. I interviewed licensee Connie Mayer. Ms. Mayer reported Citizen 1 did not reside in the facility and has not been providing direct resident care. Ms. Mayer reported she had hired Citizen 1 as her landscaper, and he assumed their relationship was more than this business arrangement. Ms. Mayer reported Citizen 1 has been in the facility and has interacted with the residents, but he has never provided direct care for residents such as changing an adult brief. Ms. Mayer reported Citizen 1 has stored some of his tools in her garage and she has since had to issue him an eviction notice for his belongings and has filed a personal protection order against Citizen 1 due to physical threats, he has made against her. Ms. Mayer was able to provide documentation of these legal actions during this investigation. Ms. Mayer reported Chris Mayer is her son and resides in the home with her. She reported he does provide for resident care by preparing meals and providing resident supervision. Ms. Mayer reported Mr. Mayer does not provide for resident personal care. Ms. Mayer reported she has documentation of completed Michigan Workforce Background Check for Mr. Mayer, however she was not able to produce this documentation during the on-site investigation. Ms. Mayer reported that she has been preparing to close the facility and sell the home and reported her records to be in boxes that were not accessible to her on this date.

On 2/16/23, during on-site investigation, I interviewed Mr. Mayer. Mr. Mayer reported he provides for meals and supervision for the residents at the facility. Mr. Mayer reported Citizen 1 did not reside at the facility. He reported Citizen 1 would sometimes stay the night but did not live at the facility. Mr. Mayer reported Citizen 1 did not ever provide direct resident care or supervision.

On 2/16/23, during the on-site investigation, I attempted to interview Resident B however Resident B has advanced dementia and became upset with questions asked of her on this date. It was too difficult to determine Resident B's understanding of the questions asked during this interview. Resident B is currently the only resident residing at the facility.

On 3/14/23 I emailed Katelyn Haskin, Department Analyst with the State of Michigan, Licensing and Regulatory Affairs Department, to inquire whether Mr. Mayer had been cleared through the Michigan Workforce Background Check system. Ms. Haskin reported, via email, that Christopher Mayer was "fingerprinted and found eligible" under the Michigan Workforce Background Check system.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(3) An individual who applies for employment either as an employee or as an independent contractor with an adult foster care facility or staffing agency and who has not been the subject of a criminal history check conducted in compliance with this section shall give written consent at the time of application for the department of state police to conduct a criminal history check under this section, along with identification acceptable to the department of state police. If the individual has been the subject of a criminal history check conducted in compliance with this section, the individual shall give written consent at the time of application for the adult foster care facility or staffing agency to obtain the criminal history record information as prescribed in subsection (4) or (5) from the relevant licensing or regulatory department and for the department of state police to conduct a criminal history check under this section if the requirements of subsection (11) are not met and a request to the federal bureau of investigation to make a determination of the existence of any national criminal history pertaining to the individual is necessary, along with identification acceptable to the department of state police. Upon receipt of the written consent to obtain the criminal history record information and identification

	required under this subsection, the adult foster care facility or staffing agency that has made a good faith offer of employment or an independent contract to the individual shall request the criminal history record information from the relevant licensing or regulatory department and shall make a request regarding that individual to the relevant licensing or regulatory department to conduct a check of all relevant registries in the manner required in subsection (4). If the requirements of subsection (11) are not met and a request to the federal bureau of investigation to make a subsequent determination of the existence of any national criminal history pertaining to the individual is necessary, the adult foster care facility or staffing agency shall proceed in the manner required in subsection (5). A staffing agency that employs an individual who regularly has direct access to or provides direct services to residents under an independent contract with an adult foster care facility shall submit information regarding the criminal history check conducted by the staffing agency to the adult foster care facility that has made a good faith offer of independent contract to that applicant.
ANALYSIS:	Based upon interviews with Citizen 1, Ms. Mayer, Mr. Mayer, and documentation from Ms. Haskin, it can be determined the licensee is not allowing residents to be cared for, or supervised, by individuals who have not completed a Michigan Workforce Background Check clearance. Ms. Haskin confirmed Chris Mayer was cleared through this system and Ms. Mayer & Mr. Mayer confirmed Citizen 1 did not provide for resident care while he was working as a landscaper at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Licensee Connie Mayer is not physically capable of providing for resident care due to her own physical limitations.

INVESTIGATION:

On 2/14/23 I received an online complaint alleging that licensee Connie Mayer is not physically capable of providing for resident care needs due to her own physical limitations. On 2/16/23 I interviewed Citizen 1, via telephone. Citizen 1 reported Ms. Mayer has experienced numerous health issues in recent years which have left her with physical limitations. Citizen 1 reported Ms. Mayer is not capable of changing incontinence briefs, providing showers, or managing resident medications. He

further reported Ms. Mayer will frequently fall asleep and forget to administer medications as they are prescribed.

On 2/16/23 I completed an on-site investigation at the facility. I interviewed Ms. Mayer during this investigation. Ms. Mayer reported she has experienced some health issues and recently had a surgery on 12/1/22. Ms. Mayer reported she currently has two residents, but Resident A is currently in a local rehabilitation facility and most likely will not be returning to the home. Ms. Mayer reported that despite her health challenges she can provide the care in the resident assessment plans due to the assist from Mr. Mayer and a contracted agency that Resident B's son, Citizen 2, hired to provide for Resident B's showers. Ms. Mayer reported Resident B is incontinent, but she can still change her incontinence briefs as Resident B stands by the toilet to be changed. She reported that she is not able to provide for her showers, but Resident B's son is aware of this and has hired his own outside home health agency to provide for the showers weekly. Ms. Mayer reported that prior to Resident A, experiencing a fall at the facility, she was able to provide for his care needs as he was ambulating independently with the assist of a walker. Ms. Mayer further reported she is in the process of closing the facility due to her own health and being ready to retire. She reported she has communicated these concerns and plans with AFC Licensing Consultant, Bridget Vermeesch.

During on-site investigation, on 2/16/23, I interviewed Mr. Mayer. Mr. Mayer reported he assists Ms. Mayer with resident care, including resident mobility transfers, meals, and supervision. Mr. Mayer reported licensee Ms. Mayer can provide for resident care at this time.

On 2/14/23 I received an email from Ms. Vermeesch, reporting licensee, Connie Mayer, has requested that her license be closed, and this process has been in preparation contingent upon sale of the home.

During on-site investigation, on 2/16/23, I reviewed the *Assessment Plan for AFC Residents* form for Resident A and Resident B. Neither Resident A nor Resident B have indications on this form that they require a two-person physical assistance with mobility or transfers.

APPLICABLE RULE	
R 400.1404	**Licensee, responsible person, and member of the household; qualifications.**
	(3) A licensee or responsible person shall possess all of the following qualifications: **(b) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.**

ANALYSIS:	Based upon interviews with Citizen 1, Ms. Mayer, Mr. Mayer, and reports from Ms. Vermeesch, the licensee can meet the physical needs of the current residents by utilizing Mr. Mayer as an additional direct care provider and the outside home health personal care provider that Resident B's son has hired for her weekly showers. Ms. Mayer has further reported that she has intended to close the facility and is working with Ms. Vermeesch to follow through on this request.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Responsible person, Christopher Mayer, uses "meth" and marijuana. He yells and slams doors around residents.

INVESTIGATION:

On 2/14/23 I received an online complaint, alleging that Mr. Mayer uses "meth" and marijuana drugs, while working as a responsible person at the facility. The complaint further alleged that Mr. Mayer yells and slams doors around the residents. On 2/16/23 I interviewed Citizen 1 via telephone. Citizen 1 reported that he has been present in the home when Mr. Mayer has been running through the house, slamming doors, and has witnessed him yelling at the residents. Citizen 1 reported Mr. Mayer uses meth and marijuana in the home. Citizen 1 reported he has never directly observed Mr. Mayer use these substances but that there are rumors around the local town that he does use both meth and marijuana.

On 2/16/23 I completed an on-site investigation at the facility. I interviewed Ms. Mayer regarding the allegation. Ms. Mayer reported Mr. Mayer is her son and resides at the facility with her. She reported Mr. Mayer does not use meth or marijuana and does not scream and yell at the residents or slam doors. Ms. Mayer reported Citizen 1 had recently arrived at the facility, unannounced, intoxicated and assaulted her. She reported she had called the police and Citizen 1 was taken to the local jail for these actions.

On 2/16/23 I interviewed Mr. Mayer regarding the allegation. Mr. Mayer reported he does not use meth or marijuana and there are rumors going around the local community that he has been using these substances due to Citizen 1 spreading these rumors. Mr. Mayer reported he does not provide care for the residents while under the influence of alcohol or any drugs. During the on-site investigation, Mr. Mayer did not appear to be under the influence of drugs. He presented as calm and well composed. He answered questions in a logical manner and interacted with Resident B in an appropriate manner.

APPLICABLE RULE	
R 400.1404	**Licensee, responsible person, and member of the household; qualifications.**
	(5) All responsible persons and members of the household shall be of good moral character and suitable temperament to assure the welfare of residents.
ANALYSIS:	Based upon interviews with Citizen 1, Ms. Mayer, and Mr. Mayer it can be established that there is not adequate evidence to suggest Mr. Mayer is not of good moral character and suitable temperament to provide for the welfare of the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A had a fall with injury and Ms. Mayer was not aware of the fall until the day after the event.

INVESTIGATION:

On 2/14/23 I received an online complaint alleging Resident A experienced a fall, with injury, at the facility but Ms. Mayer was not aware of the fall until the next day. On 2/16/23 I interviewed Citizen 1, via telephone. Citizen 1 reported Resident A had a fall in the bathroom of the home, on an unknown date, which resulted in an admission to the Carson City Hospital due to fractured ribs. Citizen 1 reported not observing the fall directly. Citizen 1 reported Ms. Mayer did not observe the fall and did not know about the fall until the next day. Citizen 1 alleged that due to Ms. Mayer's physical health issues she is not able to provide appropriate supervision for Resident A, which results in a fall.

On 2/16/23 I completed an on-site investigation at the facility. I interviewed Ms. Mayer regarding the allegation. Ms. Mayer reported Resident A walks with the assist of a walker. Ms. Mayer reported that on the date of the alleged fall, she had been watching a movie with Resident A. She reported Resident A got up and walked to the bathroom. She reported that when Resident A returned from the bathroom, about an hour later, he acknowledged he had fallen in the bathroom and hit his side against the bathtub. Ms. Mayer reported Resident A stated he was okay, and they decided he did not require medical attention. Ms. Mayer reported the following morning Resident A developed symptoms of pain and they had him transported to the Carson City Hospital emergency department. Ms. Mayer reported that once at the emergency department Resident A had been diagnosed with a "cracked rib." Ms. Mayer reported that at this time Resident A is at a local rehabilitation center as he is not walking well since his injury. Ms. Mayer reported that if Resident A's physical

health does not improve, she may not be able to have him return to the facility as she is aware she cannot provide for his care if he were to require further assistance with ambulation/mobility.

During on-site investigation, on 2/16/23, I interviewed Mr. Mayer. Mr. Mayer reported that he was not present in the home when Resident A fell in the bathroom.

During on-site investigation, on 2/16/23, I reviewed the *Assessment Plan for AFC Residents* form for Resident A. The form indicates that Resident A walks with the assist of a walker, but also reports that he does not require assistance from others when walking with his walker.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physicians instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until a written assessment is made and it is determined that the resident is suitable pursuant to the following provisions: **(a) The amount of personal care, supervision, and protection required by the resident is available in the home.**
ANALYSIS:	Based upon interviews with Citizen 1, Ms. Mayer, and Mr. Mayer, as well as review of the *Assessment Plan for AFC Residents* form for Resident A, it cannot be established that appropriate amounts of supervision and protection were not provided to Resident A by Ms. Mayer. Ms. Mayer reported knowing Resident A experienced the, unwitnessed, fall in the bathroom and that Resident A had identified he felt okay after the event. Ms. Mayer reported the next day medical attention was sought for Resident A after it was discovered that the injury appeared to be more severe than initially assessed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During on-site investigation, on 2/16/23, Ms. Mayer reported that she did not complete and submit an incident report for the unwitnessed fall, with injury, for Resident A, which led to a hospitalization at Carson City Hospital.

APPLICABLE RULE	
R 400.1416	**Resident health care.**
	(4) A licensee shall make a reasonable attempt to contact the resident's next of kin, designated representative, and responsible agency by telephone, followed by a written report to the resident's designated representative and responsible agency within 48 hours of the following: **(b) Any accident or illness requiring hospitalization.**
ANALYSIS:	Based upon interview with Ms. Mayer, it can be established that Ms. Mayer did not complete a written incident report regarding the fall Resident A experience resulting in hospitalization.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During on-site investigation, on 2/16/23, I requested to review the Medication Administration Records (MARs) for Resident A and Resident B. Ms. Mayer reported she has not been continuing to document medication administration on the MARs. She reported that she has not documented medication administration on a MAR since January 2022. I reviewed the available MARs and the most recent MARs available for review were from January 2022.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions: **(a) Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years.**
ANALYSIS:	Based upon interview with Ms. Mayer and observations made during on-site investigation, Ms. Mayer has not been documenting medication administration for Resident A and Resident B for at least the last year. She did not have two years of MARs available for review at the time of the on-site investigation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Based upon request of licensee, Connie Mayer, the license will be closed at the conclusion of this investigation as the correction action plan for this investigation.

03/15/2023

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Jana Lipps Date
Licensing Consultant

Approved By:

03/24/2023

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Dawn N. Timm Date
Area Manager