GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 20, 2023

Karen Barry
Bay Valley Adult Foster Care Inc.
5113 Reinhardt Lane
Bay City, MI 48706

RE: License #:	AL090084487
Investigation #:	2023A0123030
	Bay Valley AFC Inc.

Dear Ms. Barry:

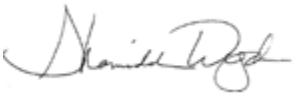
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL090084487
Investigation #:	2023A0123030
Complaint Receipt Date:	03/08/2023
Investigation Initiation Date:	03/08/2023
Report Due Date:	05/07/2023
Licensee Name:	Bay Valley Adult Foster Care Inc.
Licensee Address:	5113 Reinhardt Lane Bay City, MI 48706
Licensee Telephone #:	(989) 450-8769
Administrator:	Karen Barry
Licensee Designee:	Karen Barry
Name of Facility:	Bay Valley AFC Inc.
Facility Address:	5113 Reinhardt Lane Bay City, MI 48706
Facility Telephone #:	(989) 450-8769
Original Issuance Date:	01/07/1999
License Status:	REGULAR
Effective Date:	05/09/2021
Expiration Date:	05/08/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Karen Barry changed Resident A's medication schedule.	Yes
Karen Barry and staff was observed yelling and being rude toward Resident A. Resident A was given coffee at night, and Resident A cannot be given coffee at night because of the caffeine.	No
Staff neglected to provide Resident A with hygiene care (no baths, showers, tooth brushing).	Yes
Karen Barry refused to refund Resident A's $3,400 deposit.	No
Karen Barry texted Resident A's hospice workers saying he needs to find a new place to live. Karen said she was kicking him out because the staff and residents are scared of Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

03/08/2023	Special Investigation Intake 2023A0123030
03/08/2023	Special Investigation Initiated - Telephone I spoke with Complainant 1 via phone.
03/16/2023	Inspection Completed On-site I conducted an unannounced on-site at the facility. I interviewed staff.
03/16/2023	Contact - Telephone call received I received a voicemail from licensee designee Karen Barry.
03/17/2023	APS Referral- APS referral completed.
03/17/2023	Contact - Telephone call made I spoke with Ms. Barry via phone.
03/17/2023	Contact - Document Sent I sent a follow-up email to Ms. Barry requesting documentation.
03/21/2023	Contact - Document Received Requested documentation received via email.

04/04/2023	Contact - Telephone call made I interviewed All Valley Hospice nurse Kelly Green, RN.
04/07/2023	Contact- Telephone call made I interviewed staff Jordyn Cook via phone.
04/17/2023	Contact- Telephone call made I spoke with Relative 1 via phone.
04/17/2023	Contact-Telephone call made I spoke with staff Diane Pabalis via phone.
04/18/2023	Inspection Completed On-site I conducted an on-site inspection.
04/20/2023	Contact- Telephone call made I conducted a follow-up call with Witness 1.
04/20/2023	Exit Conference I spoke with licensee Karen Barry.

ALLEGATION: Karen Barry changed Resident A's medication schedule.

INVESTIGATION: On 03/08/2023, I spoke with Complainant 1 via phone. Complainant 1 stated that licensee designee Karen Barry reported that Resident A received a dose of Seroquel at 3:00 pm on 03/05/2023. On 03/06/2023 at 5:00 pm, Resident A was under the influence of Seroquel at the dining room table. Within 24 hours of Resident A residing in the facility, Ms. Barry demanded that Resident A's doctor be contacted to put Resident A on sleep medication. Ms. Barry was informed that Resident A had sundowner's, and Ms. Barry ensured Resident A's family that she could handle Resident A's care.

On 03/08/2023, I spoke with Witness 1 via phone. Witness 1 stated that Ms. Barry complained that Resident A was not sleeping. Resident A got a Seroquel prescription from his physician. Ms. Barry changed Resident A's medication dosage. Resident A was acting doped up at 3:00 pm on 03/05/2023. Witness 1 stated that Resident A should not receive his medication that early, and then try to keep him awake until bedtime. Witness 1 stated that it seemed like it was their plan to keep Resident A doped up.

On 03/16/2023, I conducted an unannounced on-site visit at the facility. I interviewed staff Sara Fauver and staff Holly Ballard. Staff Ballard stated that the Seroquel prescription was a very low dose. Staff Fauver stated that the medication was

brought in the next day after Resident A moved in. They both stated that they believe he had already had a script for the medication prior to moving in.

On 03/17/2023, I spoke with licensee designee Karen Barry via phone. She stated that All Valley Hospice provided Resident A with his Seroquel script. She stated that Resident A was not prescribed Seroquel prior to moving into her facility. She stated that he was prescribed 100 mg of Seroquel, and that it was too high of a dose, and it had Resident A drugged out. She stated that a doctor in the past (not Resident A's doctor) told her that you can never increase a dosage, but you can lower it, so she gave Resident A 50 mg at 3:00 pm, and 50 mg at bedtime. She stated that either she or her staff let the hospice nurse know about the medication adjustment.

On 03/21/2023, I received requested documentation via fax. A copy of Resident A's *Assessment Plan for AFC* Residents dated 03/03/2023, is signed by Ms. Karen Barry, as well as Relative 1. The assessment has "*yes*" checked for *taking medication*, and "*guidelines*" is written in the description box.

A copy of Resident A's physician order for Seroquel 100 mg, i.h.s. (one tab at bedtime) was received. The script is dated for 03/04/2023 and is signed by Dr. Mohammed Asim-Kahn.

A copy of Resident A's medication administration record for March 2023 was received and reviewed. On one page, Resident A's Quetiapine (Seroquel) 100 mg- 1 tablet daily at bedtime was passed on 03/04/2023 by staff. Two other entries appeared to be added to the medication administration record for the Quetiapine, one for "*take half tab twice daily, given at 3:00 pm and 9:00 pm*, and another that says, "*take half at bed (50 mg)*." There is one staff initial for 03/05/2023 for the "*take half tab twice daily*", and no staff initials for the third Quetiapine entry. On a second page it has Quetiapine 100 mg- take half tab daily, there are two staff initial entries for 03/05/2023 and 03/06/2023 at 3:00 pm.

On 04/04/2023, I spoke with All Valley Hospice nurse Kelly Green, RN via phone. She stated that she received a call on 03/04/2023 that Resident A was agitated and threatening staff. Ms. Barry asked for specific medication to be started for Resident A to control his behaviors. Resident A did not have a history of using any psychotropic medication. Nurse Green stated that she arrived at the home to do an assessment on Resident A, and Resident A was at his baseline, not exhibiting any behaviors during her visit. She stated that she spoke with Relative 1 who said Resident A only had one agitation episode in the past and that it was not an ongoing problem. Nurse Green stated that she then spoke with Dr. Mohammed Asim-Khan who approved the script. Relative 1 delivered the filled script to the home on 03/04/2023. The script was for the medication to be given at bedtime because Resident A's behaviors were at night. She stated that she heard that staff were giving him the Seroquel during the day, and that Relative 1 reported that Resident A was sleepy during the day. She stated that during a visit to the facility on 03/06/2023, she asked staff for Resident A's medication, and staff reported to her

that the Seroquel was written over to be given twice per day per Ms. Barry. Kelly Green, RN stated that Ms. Barry was never instructed by Dr. Kahn to change Resident A's dosage.

On 04/17/2023, I interviewed Relative 1 via phone. Relative 1 stated that she witnessed Ms. Barry in Resident A's face telling him to stay awake. She stated that Ms. Barry was being loud saying "come on [Resident A] you gotta stay awake", right in Resident A's ear as she (Relative 1) walked into Resident A's room. She stated that she had asked Ms. Barry what was going on, and Ms. Barry replied that they were trying to fix Resident A's television, and that she had given him Seroquel at 3:00 pm. Relative 1 stated that later that day she called hospice and reported to hospice that Ms. Barry adjusted Resident A's Seroquel dosage. She stated that she told Ms. Barry that she did not want Resident A taking Seroquel during the day, and the hospice nurse informed her (Relative 1) that Ms. Barry could not adjust the script.

On 04/17/2023, I interviewed staff Diane Pabalis via phone. She stated that she does not recall passing Resident A any medication and had no knowledge of Ms. Barry adjusting any medication.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with the following provisions: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**
ANALYSIS:	A copy of Resident A's physician order for his Seroquel 100 mg was obtained and reviewed. The order was for Resident A to be administered one 100 mg tab at night. Karen Barry, the licensee designee reported that she adjusted Resident A's prescription to a half dose twice a day. Resident A's medication administration records document this change, and notes that he was provided the half dose twice on 03/05/2023 and on 03/06/2023 at 3:00 pm. All Valley Hospice nurse Kelly Green, RN reported that Ms. Barry was never instructed by Dr. Mohammed Asim- Kahn to adjust Resident A's prescription medication.

	There is a preponderance of evidence to substantiate a rule violation in regard to adjusting Resident A's prescription.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Karen Barry and staff was observed yelling and being rude toward Resident A. Resident A was given coffee at night, and Resident A cannot be given coffee at night because of the caffeine.

INVESTIGATION: On 03/18/2023, I spoke with Complainant 1 via phone. Complainant 1 stated that on 03/05/2023 Ms. Barry was in Resident A's bedroom. Resident A was half comatose because he was given Seroquel at 3:00 pm. Ms. Barry was observed shaking Resident A. Resident A's facial expressions indicated that he wanted Ms. Barry to get away from him. On 03/06/2023, Resident A was observed sitting at the dining room table, under the influence of Seroquel again, with a cup of coffee getting ready to eat dinner. Staff were told that Resident A should not have coffee in the evening because he would be up all night.

On 03/08/2023, I spoke with Witness 1 via phone. Witness 1 stated that Resident A was drinking coffee on 03/06/2023 at dinner time. Staff said they give him coffee all day for him to stay up. Witness 1 stated that on 03/04/2023, Ms. Barry was all in Resident A's face, touching his face, legs, and shaking him.

On 03/17/2023, I spoke with licensee designee Karen Barry via phone. She denied the allegations. She stated that the allegations are an insult, and that they love their residents.

On 04/04/2023, I spoke with All Valley Hospice nurse Kelly Green, RN via phone. She stated that she never observed Resident A and Ms. Barry together, and communication was done via text message.

On 04/07/2023, I interviewed staff Jordyn Cook via phone. She stated that she works first shift on weekends. She stated that either on 03/04/2023 or 03/05/2023 Resident A had a behavior. She stated that Ms. Barry handled Resident A the best she could. Resident A was yelling and complaining about his room. Ms. Barry was able to redirect him. Resident A calmed down, and Ms. Barry got Resident A some water. She stated that Ms. Barry was stern with Resident A, and it was necessary. She stated that Ms. Barry called Relative 1 who was dismissive/unhelpful. She stated that she heard that staff on another shift also got the same reaction when Resident A had a behavior. She denied observing Ms. Barry be rude to Resident A.

On 04/17/2023, I interviewed Relative 1 via phone. Relative 1 stated that she witnessed (on 03/05/2023) Ms. Barry in Resident A's face telling him to stay awake. She stated that Ms. Barry was being loud saying "come on [Resident A] you gotta

stay awake", right in Resident A's ear as she (Relative 1) walked into Resident A's room. She stated that Ms. Barry was not being mean to Resident A (in that moment) but was (being mean) because he was given his Seroquel at 3:00 pm. Relative 1 stated that on 03/06/2023, she went to the facility with hospice, and saw that staff had served Resident A coffee for dinner, and Resident A was "out of it."

On 04/17/2023, I interviewed staff Diane Pabalis via phone. She stated that she heard from others that Resident A had behaviors. She denied witnessing Resident A and Ms. Barry interact.

On 04/20/2023, I spoke with licensee designee Karen Barry. She stated that decaffeinated coffee is served in the evening.

APPLICABLE RULE	
R 400.15305	**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:	Licensee designee Karen Barry and Staff Jordyn Cook denied the allegations. Relative 1 reported that Ms. Barry was being mean due to having given Resident A Seroquel during the day, and not at the prescribed time. Witness 1 stated that Ms. Barry was observed in Resident A's face, touching his face, legs, and shaking him. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Staff neglected to provide Resident A with hygiene care (no baths, showers, tooth brushing).

INVESTIGATION: On 03/08/2023, I spoke with Complainant 1 via phone. Complainant 1 stated that on 03/06/2023, Resident A went to Relative 1's home. Resident A smelled and his toothbrush was unused.

On 03/16/2023, I conducted an unannounced on-site visit at the facility. I interviewed staff Sara Fauver and staff Holly Ballard. They stated that Resident A was independent with brushing his teeth. Staff Fauver stated that Resident A did not

really like staff assisting him. They reported that Resident A was added to the shower schedule for Mondays and Thursdays.

On 03/17/2023, I spoke with licensee designee Karen Barry via phone. Ms. Barry stated that Resident A was very good with his personal care, and that Resident A was independent physically. She stated that she believes his shower days were Friday and Tuesday, and that she thinks he got a shower on 03/03/2023.

On 03/21/2023, I received requested documentation via fax. A copy of Resident A's *Assessment Plan for AFC* Residents dated 03/03/2023, is signed by Ms. Karen Barry, as well as Relative 1. The assessment plan is checked "yes" for Resident A needing assistance with bathing, grooming, and personal hygiene. In the description boxes regarding what the needs are for bathing, grooming, and personal hygiene, and how they will be met, it only says "*age.*"

On 04/04/2023, I spoke with All Valley Hospice nurse Kelly Green, RN via phone. She stated that she visited on 03/06/2023. She stated that Resident A looked disheveled, like his hair was not combed. She stated that there was nothing over-the-top noticeable in regard to hygiene, and that Resident A was only in the home for three days. She stated that Resident A has a history of incontinence and refusing showers. She stated that she cannot say that he was overwhelmingly unkept/dirt, and that sometimes patients with dementia are not willing to do personal care.

On 04/17/2023, I interviewed Relative 1 via phone. Relative 1 stated that Resident A can do personal care independently if you set things up for him. Resident A had new personal care items (i.e. toothbrush, toothpaste, razors) that were not opened. She stated that she had to shower Resident A the night of 03/06/2023 because he smelled of urine, unshaven, and his hair was greasy. She stated that Resident A had the same clothing on from days before, and it was like the staff were afraid of Resident A.

On 04/17/2023, I interviewed staff Diane Pabalis via phone. She stated that she does not assist with showers, and she is not sure if staff showered Resident A or not.

On 04/18/2023, I conducted a renewal inspection at the facility. I observed 17 residents during this inspection. They appeared clean and appropriately dressed. No issues were noted during this on-site in regard to hygiene.

On 04/20/2023, I made a follow-up call to Witness 1. Witness 1 stated that on 03/06/2023, Resident A had not been showered. Resident A had a toothbrush and razor that had not been opened during his stay at the facility. His hair was messed up like it he had just woken up, and it was greasy. Witness 1 stated that they had to shower Resident A, as he had a body odor. Resident A had clearly not had any self-care completed during his stay, and you could tell his teeth had not been brushed.

Resident A had clothing had also not been changed. Witness 1 stated they had to shower and provide personal care to him the night he moved out of the facility.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Staff Sara Fauver and Staff Holly Ballard reported that Resident A was independent with personal care and did not like staff assisting him. They stated that he was added to the shower schedule for Monday and Thursday. Ms. Barry stated that Resident A was independent in personal care, and believes he showered on 03/03/3023, the day he moved in. His assessment plan was reviewed and stated he needed assistance with bathing, grooming, and personal hygiene. Kelly Green RN stated that on 03/06/2023, Resident A looked disheveled. She stated that she cannot say that he was overwhelmingly unkept/dirt, and that sometimes patients with dementia are not willing to do personal care. Relative 1 stated that she had to shower Resident A the night of 03/06/2023 because he smelled of urine, unshaven, and his hair was greasy. She stated that Resident A had the same clothing on from days before. Witness 1 stated that Resident A did not appear to have had any personal care done during his stay, his clothing had not been changed, his hair was greasy, he had an odor, and you could tell his teeth had not been brushed. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Karen Barry refused to refund Resident A's $3,400 deposit.

INVESTIGATION: On 03/18/2023, I spoke with Complainant 1 via phone. Complainant 1 stated that a request was made to Ms. Barry to refund Resident A's deposit of $3,400. Ms. Barry told Relative 1 that the deposit was non-refundable, and it was because of Resident A's behavior, she (Ms. Barry) kicked Resident A out of the home. Relative 1 never received a copy of any of Resident A's paperwork, none of the agreements or policies. Relative 1 did not recall signing a discharge or refund policy, and Ms. Barry did not provide a discharge notice.

On 03/08/2023, I spoke with Witness 1 via phone. Witness 1 stated that this is a bad situation, and Ms. Barry will not give a refund for a situation she caused.

On 03/17/2023, I spoke with licensee designee Karen Barry via phone. She stated that she did not give Relative 1 a copy of signed documentation. She stated that Relative 1 did sign the paperwork, including his *AFC Resident Care Agreement* and *AFC Assessment Plan*. She stated that she sent a text to Relative 1 stating that the $3,400 was a non-refundable deposit. She stated that Relative 1 "jump the gun" and moved Resident A out.

On 03/21/2023, I received requested documentation via fax. A copy of Resident A's *AFC- Resident Care Agreement* signed by Relative 1 and Ms. Barry on 03/03/2023 was reviewed. The basic fee is noted to be $3,400.

In *Section A: The person or persons responsible for the resident's funds is (are)* of the *Resident Funds Record Part 1 (*dated and signed by Ms. Barry on 03/03/2023*)* has Relative 1 listed as Resident A's legal guardian. *Section B* has *Payment for AFC* checked in regard to the applicable accounts managed by the licensee.

A copy of the *Resident Funds Part II* was obtained and reviewed as well. There is one entry dated 02/27/2023 for a "non-refundable deposit" of $3,400. Karen Barry's signature is written in the licensee or licensee designee signature box.

A copy of an untitled document describing the basic service rate, adjustments to rates, absences from Bay Valley House, refund policy, and discharge policy date 03/03/2023, is signed by Relative 1 and Ms. Barry.

Under "*Refund Policy*," it states: *No refund will be given under any circumstance*. Under "*Discharge Policy*," it states: *We require a 30-day notice if the resident will be removed from our home, so we may have that room occupied by another resident. We will give a 30-day notice unless we are unable to provide the care to the resident or the resident is in danger of harming him or herself or other residents in the home, at that time we will have no option but to discharge the resident without notice.*

On 04/04/2023, I spoke with All Valley Hospice nurse Kelly Green, RN via phone. She stated that Ms. Barry held Resident A's room for a month prior to Resident A moving into the facility.

On 04/17/2023, I interviewed Relative 1 via phone. She stated that Ms. Barry did not tell her to pick Resident A up from the facility, but that Ms. Barry did send her a text on 03/07/2023 stating that Resident A is not welcomed back. She stated that Ms. Barry refused to give her the $3,400 deposit back. She denied that Ms. Barry held Resident A's room for him prior to him moving in. She also stated that Ms. Barry told hospice that they needed to find him a new place to stay. Relative 1 stated that Ms. Barry did not give Resident A time to adjust.

Relative 1 provided screenshots of texts between herself and Ms. Barry. Relative 1 asked Ms. Barry via text if she told hospice they would need to find a different place for Resident A. Ms. Barry responded back that the other residents and staff are scared of Resident A. Another text from Relative 1 states that she took Resident A home the night prior, and that she would be by later to get the rest of his belongings. She also asked for the deposit back. Ms. Barry replied that she did not receive a check for the month of March, and that the deposit is non-refundable.

APPLICABLE RULE	
R 400.15315	**Handling of resident funds and valuables.**
	(14) A licensee shall have a written refund agreement with the resident or his or her designated representative. The agreement shall state under what conditions a refund of the unused portion of the monthly charge that is paid to the home shall be returned to the resident or his or her designated representative. The refund agreement shall provide for, at a minimum, refunds under any of the following conditions: **(a) When an emergency discharge from the home occurs as described in R400.15302.** **(b) When a resident has been determined to be at risk pursuant to the provisions of sections 11 and 11a to 11f of Act No. 280 of the Public Acts of 1939, as amended, being {{400.11 and 400.11a to 400.11f of the Michigan Compiled Laws.**
ANALYSIS:	On 03/06/2023, Relative 1 reported that she went and picked Resident A up to remove him from the facility. Relative 1 did so without providing a 30-day notice, and prior to Ms. Barry providing a formal discharge notice. Relative 1 stated that Ms. Barry had notified hospice that Resident A needed a new placement.

	Ms. Barry reported that Relative 1 moved Resident A out. She stated that she did tell hospice and Relative 1 that Resident A would have to find a new placement. She stated that Relative 1 “jumped the gun” and moved Resident A out. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Karen Barry texted Resident A’s hospice workers saying he needs to find a new place to live. Karen said she was kicking him out because the staff and residents are scared of Resident A.

INVESTIGATION: On 03/18/2023, I spoke with Complainant 1 via phone. Complainant 1 stated that on 03/06/2023, Ms. Barry called Resident A’s hospice provider and told them that Resident A needed a new place to live. Ms. Barry did not reach out to Resident A’s family to inform them. Ms. Barry informed Relative 1 later that day that Resident A has behaviors and was disrupting the home and the other residents.

On 03/08/2023, I spoke with Witness 1 via phone. Witness 1 stated that Ms. Barry assured that she could meet Resident A’s needs. Resident A is not aggressive. Witness 1 stated that staff said Resident A was mean, aggressive, and that no one cares for Resident A.

On 03/16/2023, I conducted an unannounced on-site visit at the facility. I interviewed staff Sara Fauver and staff Holly Ballard. Staff Fauver stated that Resident A was only in the home for about two days, and the second day is when his behavior got worse. Staff Fauver stated that Resident A flipped out on her after she explained to him that she had to turn his TV off because the cable service provider was there to fix the cable. She stated that Resident A could snap pretty quick. Resident A would chase them. Staff Ballard stated that Resident A cornered her in the bathroom. He was very aggressive and behavioral compared to what they are used to.

On 03/17/2023, I spoke with licensee designee Karen Barry via phone. She stated that Resident A’s behaviors were really bad, and more challenging than they are used to. She stated that on 03/06/2023, she received a text message from one of her staff persons stating that Resident A was a risk to other residents and staff, and that staff Jordyn Cook was not comfortable working with Resident A. She stated that Resident A moved in on a Friday (03/03/2023). She stated that she told Relative 1 that Resident A would have to leave, and that she told hospice that Resident A needed a new placement. She stated that Relative 1 “jumped the gun” and moved Resident A out.

On 04/04/2023, I spoke with All Valley Hospice nurse Kelly Green, RN via phone. She denied that she received a text message from Ms. Barry stating that Resident A needed to move. She stated that she only received a text message regarding the Seroquel medication. She stated that Ms. Barry may have spoke with her boss because he was assisting with finding Relative 1 a placement.

On 04/17/2023, I interviewed Relative 1 via phone. She stated that Ms. Barry did not tell her to pick Resident A up from the facility, but that Ms. Barry did send her a text on 03/07/2023 stating that Resident A is not welcomed back. She stated that Ms. Barry refused to give her the $3,400 deposit back. She denied that Ms. Barry held Resident A's room for him prior to him moving in. She also stated that Ms. Barry told hospice that they needed to find him a new place to stay. Relative 1 stated that Ms. Barry did not give Resident A time to adjust.

On 04/17/2023, I interviewed staff Diane Pabalis via phone. She stated that on 03/06/2023, the family came in after dinner and took Resident A home. She stated that she did not know Resident A was going to leave that day. She denied having any knowledge of Ms. Barry telling the family that Resident A had to leave.

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.**
ANALYSIS:	On 03/06/2023, Relative 1 reported that she went and picked Resident A up to remove him from the facility. Relative 1 did so without providing a 30-day notice, and prior to Ms. Barry providing a formal discharge notice. Relative 1 stated that Ms. Barry had notified hospice that Resident A needed a new placement. Ms. Barry reported that Relative 1 moved Resident A out of the home.

	There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 03/17/2023, I requested via email a copy of Resident A's *Health Care Appraisal* from licensee designee Karen Barry.

On 03/21/2023, I received documentation via email from Ms. Barry. On the front page of the documentation sent, Ms. Barry wrote "*Health Care Appraisal* wasn't completed; in process (30 days)."

On 04/04/2023, I spoke with hospice nurse Kelly Green, RN via phone. She stated that Resident A was not an emergency placement. Relative 1 wanted to move Resident A closer to her, and a move to Bay Valley House was also more affordable. Prior to the move to this facility, Resident A was at another adult foster care home.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	On 03/21/2023, I received requested documentation. Ms. Barry wrote a note stating that the Health Care Appraisal was not completed. Hospice nurse Kelly Green, RN reported that Resident A was not an emergency placement. There is a preponderance of evidence to substantiate a rule violation as Resident A's Health Care Appraisal was not

	completed within 90 days before his admission to the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 03/18/2023, I spoke with Complainant 1 via phone. Relative 1 never received a copy of Resident A's paperwork, none of the agreements or policies. Relative 1 did not recall signing a discharge or refund policy.

On 03/17/2023, I spoke with licensee designee Karen Barry via phone. She stated that she did not give Resident A's relatives a copy of signed documentation.

On 03/17/2023, I requested via email copies of Resident A's admission and discharge polices from licensee designee Karen Barry.

On 03/21/2023, I received requested documentation via email from Ms. Barry. I received two documents, one entitled *Resident Admission Agreement*, and a second untitled document that includes information about refunds and discharges.

On 04/04/2023, I review the file for this facility, including the original admission police, fee statement, and discharge policies this facility submitted in December 1998. The admission policy at that time met the minimum policy requirements from rules R102(1)(c), 103(1)(a), and R301. The discharge policy at that time, met the minimum policy requirements from R302(3), R302(4), and R302(5).

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(1) A home shall have a written admission and discharge policy. The policy shall be made available to a resident and his or her designated representative.

ANALYSIS:	On 03/17/2023, I requested via email a copy of Resident A's admission and discharge policies. On 03/21/2023, I received two documents, an admission agreement, and an untitled document regarding discharges. The forms did not match the original policies submitted at the time of original licensure. The forms requested on 03/17/2023 had changes did not meet the minimum policy requirements. Relative 1 also did not receive copies of the policies. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 03/18/2023, I spoke with Complainant 1 via phone. Complainant 1 stated that a request was made to Ms. Barry to refund Resident A's deposit of $3,400. Ms. Barry told Relative 1 that the deposit was non-refundable, and it was because of Resident A's behavior, she (Ms. Barry) kicked Resident A out of the home. Relative 1 never received a copy of any of Resident A's paperwork, none of the agreements or policies. Relative 1 did not recall signing a discharge or refund policy.

On 03/17/2023, I spoke with licensee designee Karen Barry via phone. She stated that she sent a text to Relative 1 stating that the $3,400 was a non-refundable deposit.

On 03/21/2023, I received requested documentation via fax. A copy of an untitled document describing the basic service rate, adjustments to rates, absences from Bay Valley House, refund policy, and discharge policy date 03/03/2023, is signed by Relative 1 and Ms. Barry.

Under "*Refund Policy*," it states: *No refund will be given under any circumstance*. Under "*Discharge Policy*," it states: *We require a 30-day notice if the resident will be removed from our home, so we may have that room occupied by another resident. We will give a 30-day notice unless we are unable to provide the care to the resident or the resident is in danger of harming him or herself or other residents in the home, at that time we will have no option but to discharge the resident without notice.*

On 04/04/2023, I review the file for this facility, including the original admission police, fee statement, and discharge policies this facility submitted in December 1998. The refund agreement at that time met the minimum policy requirements/mandatory provisions for refund R400.15315(14).

APPLICABLE RULE	
R 400.15315	**Handling of resident funds and valuables.**
	(14) A licensee shall have a written refund agreement with the resident or his or her designated representative. The agreement shall state under what conditions a refund of the unused portion of the monthly charge that is paid to the home shall be returned to the resident or his or her designated representative. The refund agreement shall provide for, at a minimum, refunds under any of the following conditions: **(a) When an emergency discharge from the home occurs as described in R400.15302.** **(b) When a resident has been determined to be at risk pursuant to the provisions of sections 11 and 11a to 11f of Act No. 280 of the Public Acts of 1939, as amended, being {{400.11 and 400.11a to 400.11f of the Michigan Compiled Laws.**
ANALYSIS:	On 03/17/2023, I requested a copy of Resident A's refund policy. On 03/21/2023, I received a copy of the documentation. The refund policy did not meet the requirements of this rule. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 03/18/2023, I spoke with Complainant 1 via phone who reported Relative 1 never received a copy of any of Resident A's paperwork, none of the agreements or policies.

On 03/17/2023, I spoke with licensee designee Karen Barry via phone. She stated that she did not give Resident A's relatives a copy of signed documentation.

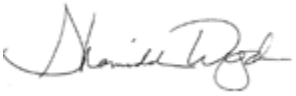
APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(8) A copy of the signed resident care agreement shall be provided to the resident or the resident's designated representative. A copy of the resident care agreement shall be maintained in the resident's record.

ANALYSIS:	On 03/17/2023, Ms. Barry reported that she did not provide Relative 1 with copies of any signed documentation. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 04/20/2023, I spoke with licensee Karen Barry via phone. I informed her of the findings and conclusions.

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC large group home license (capacity 1-20).

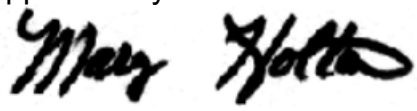


04/20/2023

_____

Shamidah Wyden Date
Licensing Consultant

Approved By:



04/20/2023

_____

Mary E. Holton Date
Area Manager