GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 1, 2023

Robert Lee
254 South Main St
Pigeon, MI 48755-0739

RE: License #: AM320008401
Investigation #: 2023A0871029
Lees Afc Home II

Dear Mr. Lee:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM320008401
Investigation #:	2023A0871029
Complaint Receipt Date:	03/14/2023
Investigation Initiation Date:	03/14/2023
Report Due Date:	05/13/2023
Licensee Name:	Robert Lee
Licensee Address:	254 South Main St Pigeon, MI 48755-0739
Licensee Telephone #:	(989) 453-2947
Administrator:	Robert Lee
Licensee Designee:	N/A
Name of Facility:	Lees Afc Home II
Facility Address:	80 Berne Street Pigeon, MI 48755-0739
Facility Telephone #:	(989) 453-2947
Original Issuance Date:	07/13/1988
License **Status:**	REGULAR
Effective Date:	07/10/2021
Expiration Date:	07/09/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was presented to the emergency room with 80-degree body temperature. The story from the AFC is ever changing.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/14/2023	Special Investigation Intake 2023A0871029
03/14/2023	APS Referral From Huron County MDHHS
03/14/2023	Special Investigation Initiated - Telephone Received telephone call from Huron County Adult Protective Service Worker Brandon Fannion
03/30/2023	Inspection Completed On-site Interviewed Licensee Robert Lee and Household Member Cassandra Lee
04/27/2023	Inspection Completed On-site Interviewed Licensee Robert Lee, received Resident A's assessment plan
04/27/2023	Contact - Telephone call made Telephone call to Asst. Guardian Ashley Kidd
05/01/2023	Exit Conference Telephone exit conference with Licensee Robert Lee
05/01/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:
Resident A was presented to the emergency room with 80-degree body temperature. The story from the AFC is ever changing.

INVESTIGATION:
On March 14, 2023, I received a telephone call from Adult Protective Service Worker Brandon Fannion. Mr. Fannion reported that Resident A was found outside of the AFC home laying in the snow. Household Member Cassandra Lee and a neighbor dragged him back into the facility. Mr. Fannion reported Resident A was confused and had had an 80-degree body temperature. Resident A was nonverbal because of hypothermia. Ms. Lee reported that Resident A was out for 10 minutes, and then the story changed that he was outside for 12-15 minutes. Their story is not consistent with Resident A's body temperature of 80 degrees. According to the hospital staff, it would take several hours of being outside to get this body temperature. Mr. Fannion reported Resident A was going to be transferred to another hospital.

On March 30, 2023, I conducted an unannounced onsite investigation and interviewed Licensee Robert Lee. Mr. Lee stated that he works part-time for the postal service and got up at 6 am to go to work. Mr. Lee indicated he left the facility at 6:45 am and went to a local store and got Ms. Lee "a pop and a donut" and then returned to the facility. Mr. Lee indicated there was about one inch of snow on the ground and that his tracks were the only tracks on the ramp when he returned. Mr. Lee said he left a little before 7 am after stopping back at the facility to go to work. He said that when he left, he noticed that his footprints were the only ones on the ramp. Mr. Lee reported that a next-door neighbor found Resident A about 7:20 am and the neighbor and Household Member Casandra Lee brought him in. Mr. Lee stated Ms. Lee then called 911 and Resident A was taken to Scheurer Hospital. Mr. Lee reported this was the first time Resident A had gone out of the facility without their knowledge and was surprised because Resident A "hated being cold."

I told Mr. Lee that I did not receive a copy of the *AFC Licensing Division – Incident/Accident Report* regarding the incident. Mr. Lee reported that he mailed me a copy and then provided me a copy of the incident report. The report stated, 'See attached sheet' and was written for what happened, action taken by staff and corrective measures. The attached sheet that was written by Household Member Cassandra Lee states "On Monday, March 13th around 7:20 the neighbor next door was knocking on the door. When I answered the door, he said that there was someone laying outside. I grabbed my coat, shoes and went out there to see [Resident A] laying on the sidewalk. I tried to get him up, but I only could get him to sit up with no help from [Resident A]. The neighbor was watching and then helped me get [Resident A] inside. [Resident A] was laying on the floor with a comforter over him. I then called 911. They came did a blood monitor on him to check his sugar level. They said it was at 300, then proceeded to take him to the hospital. I gave them his med sheet and phone number.

Once [Resident A] was transported to the hospital, I called Bob at work. He was surprised to find out what happened. I asked him if he had seen [Resident A] and he said, 'no.'

He got up just before 6 AM to go to work at the post office. While up he heard [Resident B] come out from his bedroom, go to the bathroom, and then sit in his chair. He heard someone else go to the bathroom a little while later, afterwards heard them head back towards their bedroom. He left around 6:45 to go to the Pigeon One Stop to get me a fountain pop and a doughnut along with getting a couple bottles of pop for himself. He brought the stuff back, put drink in frig and walked back out to the car, then headed to work. There was snow on the ground from overnight. Bob said when he left the first time there was no tracks on the ramp. When he came back the only tracks on it were his when he headed to the car. His was the only set of tracks on the ramp when he left for work."

The attached sheet was signed and dated by Cassandra Lee and Robert Lee on 03/13/2023.

On March 30, 2023, at the unannounced onsite investigation, I also interviewed Household Member Cassandra Lee. Ms. Lee indicated she was in her bedroom and there was a resident sitting in the living room with headphones on. Ms. Lee asked him why he did not see Resident A go out the door, but she got no response. Ms. Lee said the neighbor knocked at her door and said, "you have a gentleman out here." Ms. Lee said she could sit him up and so the neighbor and her brought him in the house. Ms. Lee said she put a blanket on him and called 911. Ms. Lee reported Resident A nothing on his feet and a long sleep shirt on. Resident A also had a depend on. Ms. Lee said the social worker from Scheurer Hospital called and asked if they would take Resident A back. Ms. Lee said Resident A is not back but has been transferred for physical therapy.

On April 27, 2023, I conducted an unannounced onsite investigation and Mr. Lee provided me with a copy of Resident A's *Assessment Plan for AFC Residents* that was signed by Licensee Robert Lee on May 1, 2021. It indicates that Resident A cannot move independently in the community and "Needs supervision in community, will go as far sitting outside when warmer." Mr. Lee also advised that Resident A has been placed in a nursing home.

On April 27, 2023, I telephoned Guardian A1, and she advised that she received a call from the hospital asking permission to treat Resident A and she asked why he had hypothermia. The hospital staff advised that Resident A had been outside for a while. Guardian A1 received a call back about 20 minutes later and was advised that his internal body temperature was 80 degrees. Guardian A1 said "it seemed very low to me." Guardian A1 telephoned the facility and was advised that Resident A was outside "10-12 minutes." Guardian A1 told the nurse that the AFC home advised her that Resident A was out 10-12 minutes and Nurse John (she did not get his last name) "literally started laughing." Nurse John advised her that Resident A had to have been outside "at least a couple of hours" to get the body temperature of 80 degrees. Guardian A1 said according to the AFC, Resident A "had to be dragged back into the home because he could not walk." Guardian A1 indicated that Resident A is now in a nursing home and doing quite well. Resident A's health is

declining and now he is a fall risk. Guardian A1 said the nursing home calls about once a week and will advise on how Resident A is doing.

APPLICABLE RULE	
R 400.14305	**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:	Household Member Cassandra Lee first said that Resident A was outside for 10 minutes but then changed her story and said it was 12-15 minutes. ER Nurse John laughed at the time frame and said it had to be at least a couple of hours for his internal body temperature to get to 80 degrees. There is substantial evidence to confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
Resident A's *Assessment Plan for AFC Residents* was signed and dated by Licensee Robert Lee on May 1, 2021.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A's *Assessment Plan for AFC Residents* was signed by Licensee Robert Lee on May 1, 2021. Resident A's assessment plan had not been updated within the past year. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On May 1, 2023, I conducted a telephone exit conference with Licensee Robert Lee. Mr. Lee was advised there is two rule violations cited. According to the hospital nurse, Resident A was outside more than 15 minutes to cause his body temperature to drop to 80 degrees. Resident A's assessment plan had not been updated within the past year.

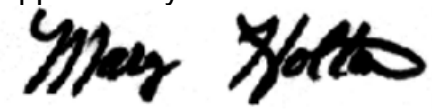
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care medium group home remain unchanged (capacity 1-12).

05/01/2023

Kathryn A. Huber — Date
Licensing Consultant

Approved By:



05/01/2023

Mary E. Holton — Date
Area Manager