GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 23, 2023

Patty Williams
711 Main St.
Omer, MI 48749

RE: License #:	AS090291142
Investigation #:	2023A0123033
	Guardian Angels

Dear Mrs. Williams:

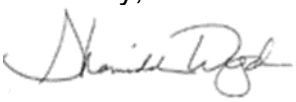
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS090291142
Investigation #:	2023A0123033
Complaint Receipt Date:	04/03/2023
Investigation Initiation Date:	04/06/2023
Report Due Date:	06/02/2023
Licensee Name:	Patty Williams
Licensee Address:	711 Main St. Omer, MI 48749
Licensee Telephone #:	(989) 415-6174
Administrator:	Patty Williams
Licensee:	Patty Williams
Name of Facility:	Guardian Angels
Facility Address:	611 Litchfield Rd Bay City, MI 48706
Facility Telephone #:	(989) 316-2205
Original Issuance Date:	09/10/2007
License Status:	REGULAR
Effective Date:	04/07/2022
Expiration Date:	04/06/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was walking the streets of West Branch, MI. He did not know his last name and had no identification. He was brought to Ascension Standish Hospital to be checked out. Resident A has a history of leaving for the day, but he always returns home before bedtime. This is the first time he has left the Bay City, MI area.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/03/2023	Special Investigation Intake 2023A0123033
04/04/2023	APS Referral Received information regarding APS referral.
04/06/2023	Special Investigation Initiated - On Site I conducted an unannounced on-site.
04/06/2023	Contact - Telephone call made I made an attempted call to the licensee Patty Williams.
04/06/2023	Contact - Telephone call made I left a message requesting a call from Resident A's public guardian.
04/06/2023	Contact - Telephone call received I spoke with Ms. Williams via phone.
04/06/2023	Contact - Telephone call received I spoke with Guardian 1 via phone.
04/19/2023	Contact - Telephone call made I made a call to Chris Shores, Resident A's MDHHS adult services case manager. I left a message.
04/20/2023	Contact - Document Received Requested documentation received from Ms. Williams.
04/25/2023	Contact - Telephone call received I spoke with Mr. Shores.
5/22/2023	Contact- Document Received

	I received requested information via fax.
05/23/2023	Exit Conference- I spoke with Patty Williams via phone.

ALLEGATION: Resident A was walking the streets of West Branch, MI. He did not know his last name and had no identification. He was brought to Ascension Standish Hospital to be checked out. Resident A has a history of leaving for the day, but he always returns home before bedtime. This is the first time he has left the Bay City, MI area.

INVESTIGATION: On 04/06/2023, I conducted an unannounced on-site at the facility. While knocking on the door, I saw Resident A approaching the home. I attempted to interview Resident A on the porch, however it was difficult understanding all of his responses. Resident A did confirm that he went to Standish, MI. He stated that he went via bus. He stated that he tripped over the sidewalk and had to go to the hospital in Standish. Resident A was observed wearing jeans, a polo shirt, a leather coat, a winter hat, and shoes.

On 04/06/2023, before leaving the facility I attempted to contact Resident A's public guardian and licensee designee Patty Williams via phone. While leaving the facility, I received a return call from Ms. Williams. She stated that Resident A usually sticks around Bay City, MI. Resident A told the police he got to Standish by Grey Hound bus. Resident A just got a public guardian this month. She stated that the other residents and staff may be out on an outing right now. She stated that Resident A is always outside. She stated that she gave Resident A a 30-day discharge notice at the end of February 2023, and that they are trying to find him a more structured facility. Resident A has lived at Guardian Angels for 11 years. He has a history of panhandling and is currently on probation for stealing from Walmart. She stated that she picked Resident A up from the hospital and took him back to the facility. She stated that Resident A just does what he does and does not tell staff where he is going. She stated that he was issued the discharge notice due to Resident A's current health issues, refusing medications, and walking the streets.

On 04/06/2023, I received a return call from Guardian 1. Guardian 1 stated that she is aware of the 30-day notice, and it is Resident A's case manager who needs to make a referral for him to be placed in a specialized AFC home.

On 04/25/2023, I spoke with Resident A's Adult Community Placement worker Chris Shores from MDHHS. He stated that Resident A has lived in this home for a long time. Resident A is non-compliant with care. He was just recently appointed a public guardian. He stated that he heard that Resident A went to West Branch, MI, and that he told Ms. Williams to tell the guardian that Resident A needs a new placement. He stated that Ms. Williams has done a good job considering the circumstances, and that Resident A is not being neglected. Resident A can go out in the community on his own, but he's never known for Resident A to go that far in the past. He stated

that Resident A is not in any true danger, and that he has been wandering the streets for a long time.

On 04/20/2023, licensee Patty Williams provided photos of documentation via text. A photo of a second 30-day discharge notice was received. It is dated 04/03/2023, and states that it is being issued due to Resident A's non-compliance with house rules and a decline in his health. Ms. Williams noted that Resident A received three 30-day notices, one in May 2022, January 2023, and April 2023. Ms. Williams provided calendar documentation for January through April 2023 with notes tracking days that Resident A refused to sign in and out, and hospitalizations. On the April 2023 calendar it notes Resident A's non-compliance for April 3rd through April 10th. For 04/03/2023, it notes that the facility received a call from the Standish police that Resident A was in Standish. Ms. Williams went to pick him up, and returned him to Bay City at 4:30 pm, but Resident A did not come home until 9:00 pm. The following day, Resident A "*left before dark (did not tell staff) did not return until 5:30 am*." On 04/05/2023, he left before supper, didn't inform staff, and did not return until 3:00 am. On 04/06/2023, the calendar notes that staff left to get Easter supplies at 12:00 pm. Resident A was previously asked to stay but did not, and returned home before the home did. The calendar also notes that he left after lunch on 04/07/2023, did not tell staff, and returned around 3:00 pm.

A copy of Resident A's *Health Care Appraisal* dated 08/19/2022 states that Resident A is fully ambulatory. A copy of Resident A's *Assessment Plan for AFC Residents* dated 10/07/2022 states that Resident A can *move independently in the community* and does not need any personal care assistance other than verbal prompting. "*Walking around town*" is noted for both his recreational and exercise activities.

On 05/22/2023, I received a faxed copy of Resident A's Bay Arenac Behavioral Health Plan of Service dated 11/21/2022. There are no restrictions noted in his plan regarding access to the community. His plan states that he enjoys going walking each day and spends his day away from the home. It does not indicate he has to sign in and out.

APPLICABLE RULE	
R 400.707	**Definitions; R to T.**
	Sec. 7. (7) "Supervision" means guidance of a resident in the activities of daily living, including all of the following: (d) Being aware of a resident's general whereabouts even though the resident may travel independently about the community.
ANALYSIS:	Licensee Designee Patty Williams, and MDHHS case manager Christopher Shores both reported that Resident A is capable of being in the community on his own. Resident A's assessment plan and *Plan of Service* both indicate that Resident A has community access rights.

	However, Ms. Williams stated that Resident A does not tell staff where he is going and does not sign out. She provided documentation that notes specific days Resident A refused to inform staff that he was leaving the home, and he refuses to sign in and out. Resident A was not informing staff of his coming and goings, therefore the facility was not aware of Resident A's general whereabouts. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 04/06/2023, I conducted an unannounced on-site at the facility. While knocking on the door, I saw Resident A approaching the home. I knocked at the front door and side door of the home multiple times and there was no response. Resident A appeared to be locked out of the facility.

On 04/06/2023, before leaving the facility I attempted to contact Resident A's public guardian and licensee designee Patty Williams via phone. While leaving the facility, I received a return call from Ms. Williams. She stated that the other residents and staff may be out on an outing right now. She stated that Resident A is always outside.

On 04/20/2023, licensee Patty Williams provided photos of documentation via text, including calendar documentation for Resident A. On 04/06/2023, the calendar notes that staff left to get Easter supplies at 12:00 pm. Resident A was previously asked to stay but did not, and returned home before the home did.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	On 04/06/2023, I conducted an unannounced on-site at the facility. There was no response at the door. During my unannounced on-site, Resident A returned to the home, and the home was unstaffed upon his return. There is a preponderance of evidence to substantiate a rule

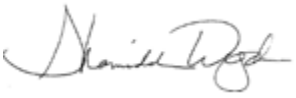
	violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/23/2023, I conducted an exit conference with licensee designee Patty Williams. I informed her of the findings and conclusions.

On 05/23/2023, I conducted a follow-up exit conference with licensee designee Patty Williams. I informed her of the additional finding.

IV. RECOMMENDATION

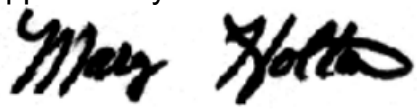
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home (capacity 6).



05/23/2023

Shamidah Wyden Date
Licensing Consultant

Approved By:



05/23/2023

Mary E. Holton Date
Area Manager