GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 30, 2023

Santa Dickendesher
Ordish AFC Home Inc
1975 E Sanilac
Carsonville, MI 48419

RE: License #: AM760308076
Investigation #: 2023A0871035
Ordish AFC Home Inc

Dear Ms. Dickendesher:

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 (57) 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 #:	AM760308076
Investigation #:	2023A0871035
Complaint Receipt Date:	04/17/2023
Investigation Initiation Date:	04/17/2023
Report Due Date:	06/16/2023
Licensee Name:	Ordish AFC Home Inc
Licensee Address:	138 Lexington St Sandusky, MI 48471
Licensee Telephone #:	(810) 648-2648
Administrator:	Santa Dickendesher
Licensee Designee:	Santa Dickendesher
Name of Facility:	Ordish AFC Home Inc
Facility Address:	138 Lexington St Sandusky, MI 48471
Facility Telephone #:	(810) 648-2648
Original Issuance Date:	01/28/2011
License **Status:**	REGULAR
Effective Date:	07/27/2021
Expiration Date:	07/26/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
Staff Rebecca Lietka grabbed Resident A and tried forcing her to her room.	Yes
Additional findings	No

III. METHODOLOGY

04/17/2023	Special Investigation Intake 2023A0871035
04/17/2023	Special Investigation Initiated - Telephone Telephone call to Licensee Santa Dickendesher
04/20/2023	Inspection Completed On-site Interviewed Staff Rebecca Lietka, Tiffany Mills, Resident A, Guardian A1 and Licensee Santa Dickendesher
04/20/2023	Exit Conference Face to face exit conference with Licensee Santa Dickendesher
05/23/2023	APS Referral Through Central Intake to Sanilac County MDHHS
05/24/2023	Inspection Completed-BCAL Sub. Compliance
05/26/2023	Contact – Telephone call Telephone call to Licensee Santa Dickendesher

ALLEGATION:
Staff Rebecca Lietka grabbed Resident A and tried forcing her to her room.

INVESTIGATION:
On April 13, 2023, I received an *AFC Licensing Division – Incident/Accident Report* that was signed and dated on April 12, 2023, by Licensee Santa Dickendesher and Assistant Home Manager Trinity Mills. The IR indicated the following:

Explain what happened indicates "See attachment." The attachments were two statements written, the first one was written by Staff Rebecca Lietka. It indicates "After I came on shift, a client [Resident A] was throwing a screaming fit about dinner and about pop. I and another staff member told her go to her room if she wants to scream. "NO" storms off and sat in activities. I went to her to tell her again to go to her room to calm down. She got up and went to her sister (which is Resident B), which her sister was still eating. In the arch way where [Resident A] was at, I grabbed her arm to guide her towards the way to her room. We struggled, but noticed we bumped into the hand sanitizer stand and she was backing into it. When she bumped into it, she stopped, and I let go. She went to her room and calmed down afterwards. She and her sister sat outside for a bit." The statement was signed and dated by Staff Rebecca Lietka on April 11, 2023.

Assistant Home Manager Tiffany Mills wrote a statement as well and it indicates "During dinner [Resident A] threw away her entire dinner without taking a bite because she didn't like it. I told her before she threw it away if she did, she doesn't. get pop tonight (the agreement with her guardian). She started screaming 'pop tonight.' I tried to explain to her why she wasn't getting any, but it made it worse. So, I told her to go to her room to calm down, she continued to scream 'pop tonight,' so I left her alone so she would calm down by herself (by the activity room). At that time, Rebecca Lietka was there for her shift 4pm-6am. She then tried to tell her to go to her room. While I was wiping down counters and cleaning up dinner dishes, I heard [Resident A] yelling louder so I looked to know why Rebecca had ahold of both of [Resident A's] arms trying to force her to go to her room (in the activity room by the front door). I told Rebecca 'That's not a good idea, you're making it worse, leave her alone.' Rebecca let her go, [Resident A] then went to her room without being told or forced and calmed down."

Action taken by staff indicates "told hold homeowner, wrote IR." Corrective measures states "staff suspended until investigation is done."

On April 20, 2023, I conducted an onsite investigation and interviewed Staff Rebecca Lietka. Ms. Lietka stated when she came in for her shift, the residents were eating dinner. Resident A was refusing to eat dinner and said she was going to throw it away, that she did not like it. Resident A then stood next to her sister (who is also a resident of the facility). Ms. Lietka said Ms. Mills then told Resident A to go to her room. Ms. Mills told Ms. Lietka that Resident A needs to go on her own and that she was making it worse. Ms. Lietka said Resident A "kept on screaming."

Ms. Lietka indicated Resident A was sitting in the living area, not screaming and she told her she needs to go to her room. Ms. Lietka indicated Resident A's sister, Resident B, was standing by her and told Resident A to go to her room. Ms. Lietka said she grabbed Resident A and they struggled and Resident A backed into the hand sanitizer. She hit the back of her head. Ms. Lietka said, "I didn't grab her tight" and after that, she calmed down. Ms. Lietka said she helped her not to fall and then let her go. Resident A and Resident B went to her room, and she calmed down.

I then interviewed Assistant Manager Tiffany Mills. Ms. Mills said she was in the kitchen cleaning up and Resident A put her dinner on the counter. Ms. Mills said Resident A did not want to eat it because she did not like it. Resident A was told if she did not eat her dinner, she would get a pop. Resident A started yelling and Ms. Mills told her she could go back to the table. Ms. Mills told Resident A if she did not eat, she would not get any pop. Resident A was yelling, and Ms. Mills told her to calm down because she gets everyone else upset.

Ms. Mills stated she then observed Ms. Lietka standing by the table and she followed Resident A to a chair in the living room. Ms. Lietka was telling Resident A to 'go to your room.' Ms. Lietka told Resident A two times to go to her room and Ms. Mills told her it was making her worse. Resident A then got up and walked into the archway and Ms. Mills heard Resident A. Ms. Mills said Ms. Lietka then held both of Resident A's arms by her elbows. Ms. Mills said she "was shocked" that Ms. Lietka was holding Resident A. Ms. Mills told Ms. Lietka again that was not a good idea and Ms. Lietka let go of Resident A. Resident A then went to her room and calmed down.

On April 20, 2023, I interviewed Guardian A1, who is guardian for Resident A and her sister. Guardian A1 stated Residents A-B used to live with their mother, who gave them everything they wanted. Guardian A1 said they would go to McDonald's "about once a day" and she would give them pop if they wanted it. Guardian A1 stated Resident A is not allowed to have pop if she does not eat her dinner. Guardian A1 said the sisters were moved into this facility approximately two years ago when their mother passed away, and then she became guardian. Guardian A1 has no concerns about the care Resident A or Resident B receives in the home.

Guardian A1 told me that she takes Resident A to all of her doctor's appointments, dentist appointments, and any other appointments. Guardian A1 said there is no paperwork in regard to having to eat before she gets a pop. Guardian A1 stated Resident A would not eat anything when she moved into the facility, and it was "probably because of the way [Family Member 1] raised her and she got pop every day." Guardian A1 stated she was encouraged to try different food at the facility, and she cannot have pop every day. Guardian A1 stated Resident A has to buy her own pop and she goes to program, and she did not have enough money for both. Guardian A1 said the doctor encourages Resident A to eat because she is so tiny and at one time, was losing weight. Guardian A1 indicated the doctor did tell her she needs to eat before she has a pop and Resident A would tell staff that the doctor

told her she can have pop, without telling them she had to eat first. Guardian A1 stated there is no paperwork about eating before drinking a pop. Guardian A1 said staff encourage Resident A to go to her room when she screams because "it upsets all of the other residents."

Resident A's record was reviewed. I received a copy of Resident's *Assessment Plan for AFC Residents* that was signed and dated on January 23, 2023, by Licensee Santa Dickendesher and Guardian A1. It does not indicate that Resident A needs to go to her room when she becomes upset nor does it state she cannot have a pop if she does not eat her dinner. There is also no documentation from a licensed physician or therapist that Resident A should go to her room when upset or needs to eat her food first before consuming pop.

On April 20, 2023, I conducted a face-to-face exit conference with Licensee Santa Dickendesher. Ms. Dickendesher stated that staff are not to grab residents with their fingers wrapped around the residents. The only time you can grab a resident is to help them if they are falling. Licensee Dickendesher indicated Ms. Lietka struggled with Resident A, and she hit her head on the hand sanitizer that was hanging on the wall. I advised Licensee Dickendesher there would be a rule violation cited.

On May 26, 2023, I telephoned License Dickendesher, and she indicated that because Resident A is very small, about 90 pounds, the doctor wants her to eat a little food before she can have a pop. She said staff only give her a small portion of food because she is so tiny. Staff are following the verbal direction of Guardian A1 and not giving her a pop if she does not eat any of her food. Licensee Dickendesher indicated Resident A does not have to eat all of her food.

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:	Assistant Home Manager Tiffany Mills witnessed Staff Rebecca Lietka grab Resident A by the elbows and struggled with her. Resident A hit her head on the hand sanitizer that was hanging on the wall. Ms. Lietka admitted she grabbed Resident A and struggled with her. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	Ms. Mills reported Ms. Lietka ordered Resident A to go to her room. There are written statements from Ms. Mills and Ms. Lietka that Resident A is told to go to her room when she is upset. Guardian A1 said Resident A cannot have a pop if she does not eat dinner. Resident A's *Assessment Plan for AFC Residents* does not state that she should be sent to her room when upset and that she cannot have a pop until she finishes her meal. There is no written guidance from a physician or licensed professional giving these specific directions of sending Resident A to her room and not allowing Resident A to have pop before finishing her meal. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/30/2023

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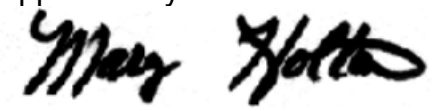
Kathryn A. Huber Date
Licensing Consultant

Approved By:



05/30/2023

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Mary E Holton Date
Area Manager