GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 4, 2023

Deshra Vines-Leak
Precious Places, LLC
PO Box 310332
Flint, MI 48505

RE: License #:	AS250353604
Investigation #:	2023A0123051
	Lakeside Park AFC

Dear Deshra Vines-Leak:

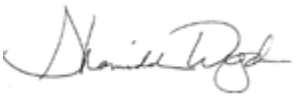
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS250353604
Investigation #:	2023A0123051
Complaint Receipt Date:	06/16/2023
Investigation Initiation Date:	06/16/2023
Report Due Date:	08/15/2023
Licensee Name:	Precious Places, LLC
Licensee Address:	PO Box 310332 Flint, MI 48505
Licensee Telephone #:	(810) 233-6696
Administrator:	Deshra Vines-Leak
Licensee Designee:	Deshra Vines-Leak
Name of Facility:	Lakeside Park AFC
Facility Address:	1526 W. Court Flint, MI 48053
Facility Telephone #:	(810) 233-6696
Original Issuance Date:	05/12/2014
License Status:	REGULAR
Effective Date:	11/12/2022
Expiration Date:	11/11/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 06/08/2023, the fire pulls in the home were disengaged due to Resident A pulling them earlier in the week. On 06/15/2023, they were still disengaged.	Yes
On 06/21/2023, a visitor to the home went to sit down in a chair in the med room and was poked with a used blood sugar lancet.	No

III. METHODOLOGY

06/16/2023	Special Investigation Intake 2023A0123051
06/16/2023	Special Investigation Initiated - Telephone I spoke with Complainant 1 via phone.
06/23/2023	Inspection Completed On-site I conducted an unannounced on-site at the facility.
07/03/2023	Inspection Completed On-site I conducted an unannounced on-site at the facility.
07/19/2023	Contact - Telephone call made I spoke with Individual 1 via phone.
07/19/2023	Contact- Telephone call made I spoke with case manager Jennifer Rickman via phone.
07/19/2023	Contact - Telephone call made I spoke with staff Raina Taylor via phone.
08/01/2023	APS Referral APS referral completed.
08/03/2023	Exit Conference I spoke with licensee designee Deshra Vines-Link via phone.

ALLEGATION: On 06/08/2023, the fire pulls in the home were disengaged due to Resident A pulling them earlier in the week. On 06/15/2023, they were still disengaged.

INVESTIGATION: On 06/16/2023, I spoke with Complainant 1 via phone. Complainant 1 reported that Resident A pulls the fire alarms when having behaviors. The fire pulls were observed hanging loose. Staff reported they called the fire

company to reset the alarms. The pulls were observed to be disengaged on two occasions about seven days apart.

On 06/23/2023, I conducted an unannounced on-site at the facility. I interviewed assistant home manager Rachel Chambers. Staff Chambers stated that when Resident A gets upset, she pulls the fire alarms and does so about three to four times per month. Staff have to allow Resident A to calm down on her own. When the alarm is pulled, the fire doors close, and an audible alarm goes off. Staff then have to call the alarm company to report the false alarm, and then the alarm company shuts off the alarm. Staff Chambers stated that the fire pulls are still disengaged, and she does not know when they will be reset. The smoke alarm will still go off, as it is not connected to the pull station. She stated that the pull stations control the doors, a loud alarm, and the strobe lights. Staff Chambers stated that the fire alarm company been had out two times earlier this month to reset the pull alarms.

On 06/23/2023, I made face to face contact with Resident A. Resident A stated that she did not mean to pull the fire pull alarm, and that she does not know why she does it.

On 06/23/2023, during this on-site, there were two fire pull stations observed to be disengaged. One upstairs by the front door, and the other upstairs across the hall from Resident A's bedroom.

On 07/03/2023, I conducted a follow-up on-site at the facility. The fire pull stations were observed to be reset.

On 07/19/2023, I interviewed staff Raina Taylor via phone. Staff Taylor stated that she was told Resident A has pulled the fire alarms more than once.

On 07/19/2023, I spoke with Resident A's case manager Genesee Health System case manager Jessica Rickman via phone. Jessica Rickman stated that she was not made aware of Resident A pulling the fire alarm, and that it is not a regular behavior that she knows of. There is a new housemate in the home that Resident A does not get along with and it is causing behaviors.

APPLICABLE RULE	
R 330.1803	**Facility environment; fire safety.**
	(1) A facility that has a capacity of 4 to 6 clients shall be equipped with an interconnected multi-station smoke detection system which is powered by the household electrical service and which, when activated, initiates an alarm that is audible in all areas of the home. The smoke detection system shall be installed on all levels, including basements, common activity areas, and outside each sleeping area, but excluding crawl spaces and unfinished

	attics, so as to provide full coverage of the home. The system shall include a battery backup to assure that the system is operable if there is an electrical power failure and accommodate the sensory impairments of clients living in the facility, if needed. A fire safety system shall be installed in accordance with the manufacturer's instructions by a licensed electrical contractor and inspected annually. A record of the inspections shall be maintained at the facility.
ANALYSIS:	On 016/2023, I spoke with Complainant 1 who reported that the fire alarms were observed to be disengaged on two occasions about seven days apart. On 06/23/2023, I conducted an unannounced on-site at the facility and the fire alarm was still disengaged. Resident A was interviewed and stated she did not mean to pull the alarm and does not know why she does it. On 07/03/2023, I observed that the fire alarm had been reset. Staff Rachel Chambers and Staff Raina Taylor reported that Resident A had pulled the fire alarms. Resident A's case manager Jessica Rickman reported not being aware of Resident A pulling the fire alarms. There is a preponderance of evidence that the facility had a non-working smoke detection system that had been disengaged for an extended period of time due to Resident A's behavior.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 06/21/2023, a visitor to the home went to sit down in a chair in the med room and was poked with a used blood sugar lancet.

INVESTIGATION: On 07/03/2023, I conducted an unannounced on-site visit at the facility. I interviewed staff Rachel Chambers and staff Tawana Pharms. Staff Pharms stated that Individual 1 told her that the lancet poked her thumb after picking it up from the chair.

Staff Chambers stated that she was called by staff right after it happened and was told by Individual 1 that Individual 1 sat on the lancet. Staff Chambers stated that the lancet was in the office, and it is purple, and the chairs in the office are wood. She stated that there are two residents who use the lancets, and neither have

communicable diseases. She denied that a lancet has ever been left out before. Both Staff Chamber and Staff Pharms reported that blood sugar checks are done at 8:00 am and 8:00 pm. Staff Chambers stated that about 30 minutes before Individual 1 arrived at the home, staff had to check one resident's vitals who was complaining of being ill. Staff Chambers stated that there is a designated chair for med passes next to the medication cabinet, as well as another chair kept on the other side of the room.

During this on-site, I did not observe any blood sugar lancets in the office, or in the common areas of the facility. In the office, I observed the medication cabinet/file drawer, the designated chair for med passing, and the sharp box for used sharps. Staff Chambers stated that the office is the only room in the home where medication passes are conducted. Staff Chambers stated that staff Raina Taylor reported that she put the sharp she used while checking vitals into the sharps container. Staff Chambers stated that she is not sure if the lancet was ever shown to staff after Individual 1 said they were poked.

On 07/19/2023, I interviewed Individual 1 via phone. Individual 1 stated that they were in the home for a visit when staff walked Individual 1 to the office. Individual 1 then went to sit down, and picked up the lancet to move it by hand and was poked. Individual 1 stated that there were two chairs in the corner across from the medication cabinet where the lancet was in one of the chairs. There were two staff present who were in shock, and one staff present blamed it on third shift staff. Individual 1 stated that this is the only time this has happened and had never seen a lancet before. Individual 1 denied ever seeing a lancet in other areas of the home.

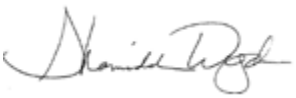
On 07/19/2023, I interviewed staff Raina Taylor via phone. Staff Taylor stated that she let Individual 1 into the office. She stated that Individual 1 went to pick something up from a chair that was situated in the far-right corner of the room. It was a lancet. Individual 1 willingly picked it up and heard Individual 1 say “Ouch. That wasn’t candy.” Staff Taylor stated that the lancet needle was purple. She stated that Individual 1 never sat down on the needle, and she gave Individual 1 an alcohol swab. Staff Taylor stated that prior to this, she has never seen a lancet laying around the facility, and no residents have any incidents of sitting down on one or picking one up.

On 08/03/2023, I conducted an exit conference with licensee designee Deshra Vines- Link via phone. I informed her of the findings and conclusions of this report. She reported that staff were educated about the importance of disposal of blood sugar lancets, and that the fire alarms were reset, and covers were placed over them, so they are not easily tampered with.

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:	On 07/03/2023, I conducted an unannounced on-site at the facility. I did not observe and blood lancet needles laying around the common areas of the home or in the office area. On 07/19/2023, Individual 1 reported that they picked up the lancet needle thinking it was candy. Individual 1 denied ever seeing a lancet needle before. Staff Raina Taylor reported that Individual 1 picked up the lancet from a chair. Staff Taylor denied ever seeing any lancet laying around the facility. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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



08/04/2023

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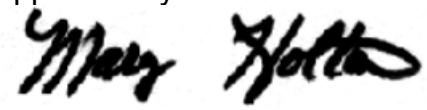
Shamidah Wyden Date
Licensing Consultant

Approved By:



08/04/2023

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Mary E. Holton Date
Area Manager