GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 2, 2023

Jonathan Harland
Community Home & Health Services LLC
657 Chestnut Ct
Gaylord, MI 49735

RE: License #: AS160382146
Investigation #: 2024A0009003
Harrison

Dear Mr. Harland:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame 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 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 (616) 356-0100.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS160382146
Investigation #:	2024A0009003
Complaint Receipt Date:	10/11/2023
Investigation Initiation Date:	10/11/2023
Report Due Date:	11/10/2023
Licensee Name:	Community Home & Health Services LLC
Licensee Address:	657 Chestnut Ct Gaylord, MI 49735
Licensee Telephone #:	(989) 732-6374
Licensee Designee/Admin.:	Jonathan Harland
Name of Facility:	Harrison
Facility Address:	2154 Harrison St Cheboygan, MI 49721
Facility Telephone #:	(231) 627-7750
Original Issuance Date:	05/27/2016
License Status:	REGULAR
Effective Date:	11/27/2022
Expiration Date:	11/26/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff do not attend to Resident A's needs. They smoke outside the home and have family over to visit.	No
Staff use derogatory language with residents.	No
Some bedroom windows do not have screens.	Yes
The stove in the home does not work and the toilet is loose.	No

III. METHODOLOGY

10/11/2023	Special Investigation Intake 2024A0009003
10/11/2023	Special Investigation Initiated – Telephone call made to Community Mental Health (CMH) recipient rights officer Amanda Dixon
10/18/2023	Inspection Completed On-site Interviews with home manager Holly Grenier and Resident A
11/1/2023	Contact – Telephone call made to CMH recipient rights officer Amanda Dixon
11/1/2023	Contact – Telephone call made to Resident A's Representative
11/02/2023	Exit conference with licensee designee Jonathan Harland

ALLEGATION: Staff do not attend to Resident A's needs. They smoke outside the home and have family over to visit.

INVESTIGATION: I made an unannounced site visit at the Harrison adult foster care facility on October 18, 2023. I observed the inside of the garage due to the garage door being open at the time of my arrival. I noted two chairs and two tables, each holding an ash tray located in the garage at that time. Home manager Holly Grenier was present at the time of the visit. I asked her about the evidence I could see that there was smoking happening in the garage. She said that usually the smoking occurs in the driveway. I told her my concern was that staff were in the garage and not supervising residents. She said that there were currently three staff present in the home and that there are always at least two. She said that one staff person may smoke a cigarette for about five minutes at a time but then go back into the home when they are done. I pointed out the two tables and chairs which looked like a smoking area. Ms. Grenier stated that the only time there would be two people smoking outside the home would be at shift change when staff discuss the prior shift's events and needs for the incoming shift. She stated that meant there

would be at least four staff present at that time, meaning at least two staff still in the home while two spoke outside. Ms. Grenier stated that they have “high-functioning” residents at the home. She denied that any of the residents in the home require “eyes on” supervision. She said that they check on residents throughout the day and do “bed checks” every 30 minutes during the night.

I spoke with Resident A during my site visit at the Harrison adult foster care home on October 18, 2023. She said that she thought the staff are lazy. They often go outside to smoke, look at their phones and might even watch television while they are eating. She stated that they do care for the residents when they are not engaged in these other activities. She said that staff cook meals, clean the home and do her laundry. She said that she just doesn’t appreciate them “on the couch, with their feet kicked up watching soap operas”. Resident A stated that one staff has even had family members stop by whom she talks to in the driveway. I asked her how much time that staff person usually spends in the driveway with the family member. Resident A said that it might be as much as 10 minutes sometimes.

I spoke with home manager Holly Grenier again during my site visit at the Harrison home on October 18, 2023. I asked Ms. Grenier about the report that the family members of staff sometimes stop by. She said that one staff person was “written up” because her daughter had stopped by to talk to her. Two staff who are related once exchanged a child as they were trading off shifts. Another staff person’s husband did stop by to grab a debit card from his wife and the same husband helped her once when she was having car trouble. Ms. Grenier said that it is not an usual practice for family members to stop by and she said that if a staff person does run out to talk to them there is still always a staff person remaining in the home.

I reviewed Resident A’s written assessment from CMH dated December 22, 2022. It assessed, *“(Resident A) benefits from having support from staff to manage her medications, make sure she is eating and maintaining her ADLs (Activities of Daily Living). (Resident A) is forgetful and struggled to manage her housekeeping and taking care of her physical and mental health needs when she was living independently in the community. (Resident A) also is isolated socially with no friends or family in regular contact and tends towards negative moods and having people around her is a support and distraction from her inner state.”*

I spoke with Resident A’s Representative by telephone on November 1, 2023. She stated that Resident A can experience severe manic episodes. It can be difficult to differentiate what is truthful during those times. Resident A’s Representative did say that usually when she shows up at the Harrison home, there is a staff person outside smoking. She said that she agrees with Resident A that the staff there do not seem to work very hard. She acknowledged however that Resident A believes all the staff at the home should be working for her personally, though. Resident A’s Representative said that she plans on speaking with CMH soon about finding a new adult foster home for Resident A since Resident A continuously speaks of not wanting to be at the Harrison home.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A stated that staff at the facility are lazy, often smoke cigarettes outside and have family members stopping over. No evidence that her basic needs are not being met was discovered through this investigation. She reported that the staff cook meals, clean the home and do her laundry. In addition, Resident A's written assessment plan does not indicate that she requires anything from staff that has not been provided. The home manager acknowledged that staff smoke in the garage or in the driveway for up to five minutes at a time, but that there is always at least one staff in the home at all times. The home manager also reported that family members have stopped by for various reasons but only for short periods of time and do not take significant time away from staffs' work duties. Resident A is provided supervision, protection, and personal care as defined in the act and as specified in her written assessment plan.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff use derogatory language with residents.

INVESTIGATION: During my site visit at the Harrison adult foster care home on October 18, 2023, I asked home manager Holly Grenier about the report of staff using derogatory language with the residents. Ms. Grenier denied that staff ever use derogatory language with residents. She said that it is Resident A who uses derogatory language with the staff. Ms. Grenier said that it has been very stressful for her and the staff since Resident A came to live there and that they struggle with her verbally abusing them. Ms. Grenier said that staff are very close to quitting because of their daily struggles with Resident A. Community Mental Health (CMH) does try to help and put a behavior plan in place but it doesn't help. They have tried to follow the plan but it is difficult to redirect Resident A when she is screaming. The most they can do sometimes is to keep her from verbally abusing the other residents which she often tries to do. Ms. Grenier said that they are doing the best they can with her and that she would never have accepted Resident A if she had known she

is as verbally abusive as she is. She said that all CMH told them about Resident A was that she cries sometimes and that they were working on adjusting her medication.

I spoke with Resident A during my site visit at the Harrison adult foster care home on October 18, 2023. I asked her about the report of staff using "derogatory" language with residents. She said that the staff talk about their problems at home in the facility. She said that they are always talking about their "drama life". Resident A said that when she makes comments about this, they tell her that she shouldn't be "eavesdropping". She said that this bothers her. Resident A said that she understands that she is a sensitive person and can take things like that personally. She said that she can become focused on very little things like that. I asked her what else she would consider derogatory. She said that she doesn't like that the other residents are so loud. She said that there is always a lot of "ruckus" that she doesn't appreciate. I asked if she could tell me specifically what staff had said or done that she considers "derogatory". She said that Ms. Grenier told her, "You'll see reality all your life" and "Don't ever let anyone say anything bad about you". I said that it sounded like Ms. Grenier was tying to help her. Resident A admitted that maybe she was sometimes but wanted me to know that the staff have told her she is being "nasty" before. I told Resident A that it had been reported that she sometimes yells at other residents. Resident A said that she does yell at the other residents when they are being loud. They tell her she has "an attitude" but Resident A said that it is the staff who have the attitude. Resident A admitted again that she is a very sensitive person and that it is possible that this is affecting how she sees things.

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: (f) Subject a resident to any of the following: (i) Mental or emotional cruelty. (ii) Verbal abuse. (iii) Derogatory remarks about the resident or members of his or her family.
ANALYSIS:	Resident A stated she was told she was being "nasty" when she was verbally attacking staff or other residents. She was also told she had an "attitude" by staff according to her report. While possibly unprofessional, comments like this are not considered to be mentally or emotionally cruel, verbally abusive or necessarily derogatory given their context.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Some bedroom windows do not have screens.

INVESTIGATION: Home manager Holly Grenier took me around the side and back of the home during the time of my inspection there on October 18, 2023. I noted that a bedroom window in the back corner of the home was missing a screen. I observed the screen on the ground leaning on the house. The screen appeared bent and possibly in an inoperable condition. Ms. Grenier stated that they have a resident who "sneaks" smokes in her bedroom. She broke the screen by pushing on it when smoking. The resident is not allowed to smoke in her bedroom and Ms. Grenier agreed that this is dangerous. She said that they do not allow it and try to correct it when they know it is happening. The resident does have an appropriate place outside of the home to smoke. Ms. Grenier also reported that she has submitted a "work order" for a replacement screen to be put in place.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(7) Each habitable room shall have direct outside ventilation by means of windows, louvers, air-conditioning, or mechanical ventilation. During fly season, from April to November, each door, openable window, or other opening to the outside that is used for ventilation purposes shall be supplied with a standard screen of not less than 16 mesh.
ANALYSIS:	One resident bedroom window did not have a screen in place during the site visit on October 18, 2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The toilet is loose and the stove in the home does not work.

INVESTIGATION: During my site visit to the Harrison home on October 18, 2023, I checked the residents' bathroom with home manager Holly Grenier. I asked Ms. Grenier about the report that one of the toilets is loose. She said that there is a resident who lives there who has a motorized wheelchair. She often backs up from the sink and hits the toilet with her wheelchair. This repeated striking has led to the toilet being loose. She showed me that it had recently been tightened and caulked around the base. The caulking did look to have been applied recently and the toilet was mostly steady. There was a little bit of give but nothing that should cause a safety concern to a resident. Ms. Grenier said that she continues to monitor it to make sure it is steady. I tested the toilet mechanism to ensure that it was working properly at the time of the visit.

I asked Ms. Grenier about the report that the stove was not working properly. She said that it is true that it was not working properly for a short time. She said that the thermostat was faulty and that it had needed to be replaced. Sometimes it would not cook hot enough and other times it would cook too hot. Since the thermostat was replaced, it works fine. She said that it had been not working properly for a week or two. They could still use it to cook during that time but it was not ideal. They also use the microwave, air-fryer and crock pot to cook meals so there are other options in which to prepare meals. She denied any meals were missed or the residents inconvenienced during the short time the stove was malfunctioning.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	The toilet was repaired by the time of my site visit on October 18, 2023. It is unknown whether it was ever inoperable but there is a second resident bathroom in the home which could have been used during that time. The oven in the home was faulty during a one or two-week period but it could still be used during that time. There were also other options for cooking meals during that timeframe. Information was not discovered through this investigation which indicated that the home is not maintained to provide adequately for the health, safety, and well-being of the occupants.
CONCLUSION:	VIOLATION NOT ESTABLISHED

I conducted an exit conference with licensee designee Jonathan Harland by telephone on 11/02/2023. I told him of the findings of my investigation and gave him the opportunity to ask questions.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

11/02/2023

Adam Robarge Date
Licensing Consultant

Approved By:

11/02/2023

Jerry Hendrick Date
Area Manager