GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 28, 2024

Theresa and Randell Huston
2479 Hadden
Muskegon, MI 49441

RE: License #:	AF610395832
Investigation #:	2024A0356017
	Glenside Manor AFC

Dear Theresa and Randell Huston:

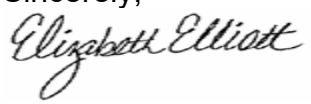
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS COMPLAINT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AF610395832
Investigation #:	2024A0356017
Complaint Receipt Date:	12/26/2023
Investigation Initiation Date:	12/27/2023
Report Due Date:	02/24/2024
Licensee Name:	Theresa Huston and Randell Huston
Licensee Address:	2479 Hadden Muskegon, MI 49441
Licensee Telephone #:	(231) 759-0453
Administrator:	N/A
Licensee Designee:	Randell and Theresa Hudson, Licensees
Name of Facility:	Glenside Manor AFC
Facility Address:	2479 Hadden Muskegon, MI 49441
Facility Telephone #:	(231) 759-0453
Original Issuance Date:	02/11/2019
License Status:	REGULAR
Effective Date:	08/11/2023
Expiration Date:	08/10/2025
Capacity:	6
Program Type:	MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
The conditions in the home are poor.	Yes
Licensee Randy Huston was verbally aggressive with former Resident A and others.	Yes
Resident A's personal care needs were not attended to at the facility.	Yes
Resident A's medications were not administered as prescribed.	No
Resident A did not have a bed in her room at the facility.	No

III. METHODOLOGY

12/26/2023	Special Investigation Intake 2024A0356017
12/26/2023	APS Referral Denied
12/27/2023	Special Investigation Initiated - Telephone D. Wentworth, legal guardian.
12/27/2023	Contact - Document Received additional information received from central office.
12/28/2023	Inspection Completed On-site
12/28/2023	Contact - Face to Face Randy and Theresa Huston, Eric Huston, Resident's B, C, D & E.
01/02/2024	Contact - Document Sent Facility documents.
01/03/2024	Contact - Document Received Facility document.
01/03/2024	Contact - Telephone call made. Health West and Net Work 180 re: supports coordinator.
02/21/2024	Contact-Document sent. Email to D. Wentworth, guardian (email).

02/22/2024	Contact-Telephone call made. HCCC Integrated Health, Valerie Stein, RN. D. Wentworth, guardian.
02/23/2024	Contact-Telephone call received. D. Wentworth and Greg Wentworth.
02/28/2024	Exit Conference-Theresa Huston, Licensee.

ALLEGATION: The conditions in the home are poor.

INVESTIGATION: On 12/26/2023, I received a Bureau of Child and Adult Licensing online complaint. The complainant reported the home smells “very bad as soon as the door opens,” and it is difficult getting into the home because “boxes and garbage are stacked higher than your head.” The complainant reported that Resident A had to be “bear hugged and turned sideways to shuffle through the door out of the room.” The complainant reported the door would not open enough to get Resident A’s walker through it due to boxes and other items, making it hard to navigate through the home. The complainant reported there is a pathway through the home, dirty dishes, mold in the kitchen and dog feces on the floor. There was a big space heater to heat the living room and it was blocking the door to the room. In addition, there were large industrial extension cords in living room. The complainant reported the conditions of the home are poor.

On 12/27/2023, I interviewed Dawn Wentworth via telephone. Ms. Wentworth confirmed she is Resident A's legal guardian through Shoreline Guardianship Services and was appointed on 11/28/2023. Ms. Wentworth stated she saw Resident A at the facility on 12/18/2023 at approximately 11:15a.m. and picked Resident A up at the facility on 12/19/2023 at approximately 3:30p.m. and moved her to a new facility. Ms. Wentworth stated she stepped in animal feces upon entrance through the front door, there was a strong malodorous smell of urine and rotten food and when she picked Resident A up to move her, there was a black heater with extension cords into the living room, there were boxes and bags stacked high, almost ceiling height creating difficulty in getting Resident A out the door with her walker. In an interview with Greg Wentworth on 02/23/2024, Shoreline Guardianship Services, he stated he was with Ms. Wentworth on 12/18/2023 and 12/19/2023 when they went to the home to move Resident A and he concurred with the information provided by Ms. Wentworth.

On 12/28/2023, I conducted an unannounced inspection at the home and entered the home through the back/side door which led me into the back room of the home. Upon entering the home, I detected a smell due to animals in the home. This is the entrance to the home that I always use. In this room there is a table and chairs, boxes, bags, and items stacked up around the entire room creating a cluttered atmosphere. I observed residents moving back and forth through the room to exit through the door for the smoking area outside and they appeared to be able to move

through the room without issue. However, if a resident needed to use a walker to ambulate, the area would be difficult to get through due to clutter. The area open to walk through is not a pathway but space is limited due to clutter. Ms. Huston stated this area is part of their (the Licensee's) living area and other than an exit from the home for the residents, they (the residents) do not use or spend any time in the room.

I interviewed Randy and Theresa Huston, Licensees and staff, Eric Huston. Mr. E. Huston and Mr. R. Huston stated Ms. Wentworth came to the facility on 12/18/2023 and again on 12/19/2023 to move Resident A out. Mr. R. Huston stated he and Ms. Huston were at the home on 12/18/2023 during Ms. Wentworth's initial visit but were in Chicago on 12/19/2023 when Ms. Wentworth came to pick Resident A up and Mr. E. Huston was working. Mr. R. Huston stated some of the boxes stacked in the living room are from Christmas and have not been put away yet, but they are not creating such clutter that the door in the living room cannot open enough for a person to move through even with a walker. Mr. E. Huston stated the item that Ms. Wentworth described as a heater is not a heater, it is a "blower" to help dry the carpets after they are cleaned. Mr. E. Huston stated the blower is near the door leading from the living room to the front entrance hallway. Ms. Huston stated the blower near the living room door blows cool air only and normally it is stored in a storage room. Ms. Huston stated usually they wait until after hours to scrub the carpets and they are usually dry by morning but in some circumstances, they cannot wait until night to clean the carpets. Ms. Huston stated the blower is the same type used in many professional settings and it blows more air that a fan so things dry faster and more consistently, it does not blow warm or hot air and is not a heater/space heater. Mr. R. Huston and Mr. E. Huston stated their dog was downstairs when Ms. Wentworth and her assistant came to pick Resident A up, but the cat "squatted" in front of Ms. Wentworth and her assistant and defecated on the floor. Mr. R. Huston stated Resident E picked the feces up immediately and disposed of it. Mr. R. Huston stated this cat tends to defecate on the floor. They are aware of it and try to prevent it from occurring but when it does, they pick up the feces immediately. Mr. R. Huston, Ms. Huston, and Mr. E. Huston stated there are 3 cats and one dog at the facility and they continually work on the upkeep of the home.

I viewed a Blink video dated 12/18/2023 showing the living room of the home. The Christmas tree is up in front the front window, there are boxes stacked behind the door leading from the living room to the entryway of the front of the home. The door opens approximately ½-¾ of the way open. The boxes are stacked almost the entire height of the door, the rest of the living room is clear and appears uncluttered and free from anything piled up.

I viewed a Blink video dated 12/19/2023, the video showed Ms. Wentworth picking Resident A up and assisting her in moving out the door from the living room and into the front entry way of the home. I observed Resident A walk out the door with her walker with Ms. Wentworth's assistance. Resident A and her walker just fit through the doorway. Ms. Wentworth did not have to put Resident A in a bear hug or move

her sideways to get out the door. I observed a resident bend down with a piece of towel and pick something off the floor in the living room.

I inspected the living room and resident dining room and observed a stack of boxes behind the door. The door leading from the living room to the front entryway of the home opens wide enough with the boxes on the other side to allow for a person to exit or enter the doorway without turning sideways to get through but does not open fully. I observed the “space heater” near the door in the living room. The space heater is a blower used to dry carpets. I have seen this blower used in the home in the past after Mr. R. Huston shampooed the carpet and the blower is not a space heater, it does not emit hot air, it acts as a fan. Aside from the boxes behind the living room door, the overall condition of the living room and dining room was adequate except for the cat litter box located in the Northeast corner of the living room. Outside of the litterbox on the living room carpet was multiple piles of feces and the box needed to be cleaned as it was full of cat feces.

Note: Special Investigation, SI2023A0356017 dated 02/03/2023 cited R 400.1426(1) Maintenance of premise due to animal feces in the home. Mr. R. Huston and Ms. Huston submitted a corrective action plan (CAP) on 03/03/2023. Special Investigation, SI2023A0356040 dated 05/30/2023 cited the same rule, R 400.1426(1) Maintenance of premise due to animal feces in the home. A CAP was submitted on 08/03/2023.

I inspected the kitchen, and the sink was empty, the dishes were done, the countertops were cluttered but I did not observe dirty dishes or mold.

I inspected the upstairs and all resident rooms which were in adequate condition.

I inspected the upstairs bathroom, and the toilet had a large amount of human feces in it. The toilet had no water in it and it appeared as though it was not able to be flushed.

Note: Special Investigation, SI 2023A0356017 dated 02/03/2023 cited R. 400.1426(1) Maintenance of premise due to the same issue, the toilet was not in working order with large amounts of human waste sitting in the bowl of the toilet. A CAP was submitted on 03/03/2023.

On 12/28/2023, I interviewed Resident B, C, D and E individually at the home. Resident’s B, C, D and E stated they can ambulate freely around the home and are not hindered by any type of clutter or boxes. Resident’s B, C, D and E stated the dog and/or cat poops on the carpet but Residents D & E clean it up. Resident E stated he cleans dog and/or cat feces up “everyday” and “I don’t mind picking it up.”

On 02/28/2024, I conducted an exit conference with co-licensee, Theresa Huston via telephone. Ms. Huston stated she will review the contents of the report with Randy Huston, co-licensee and submit a corrective action plan.

APPLICABLE RULE	
R 400.1426	**Maintenance of premises.**
	(1) The premises shall be maintained in a clean and safe condition.
ANALYSIS:	The complainant reported the home smells bad. It is excessively cluttered throughout the home, and there are dirty dishes, mold in the kitchen, a space heater in use and animal feces on the floor. Upon entrance to the home, there is a strong animal smell and upon an inspection of the upstairs bathroom, I observed a large amount of human feces in the toilet and the toilet appeared not to be in working order. I observed animal feces outside the litter box on the living room carpet. The residents reported that the dog and/or cats defecate on the floor every day and that Residents D & E clean it up each day. The “space heater” is an air blower used to quickly dry carpets that have been shampooed. The blower uses cool air only and acts as a fan and not a space heater. During an unannounced inspection the kitchen did not have dishes piled up or mold. Based on investigative findings, I found the conditions in the home to be poor and based on the repeated issues with the upstairs toilet not being in working order and the continuous issue of animal feces on the floor in the home, a violation of this applicable rule is established. *Note: SI2023A0356017 dated 02/03/2023 cited R 400.1426(1) Maintenance of premise due to animal feces in the home and the non-working upstairs toilet. Mr. R. Huston and Ms. Huston submitted a corrective action plan (CAP) on 03/03/2023 stating the toilet was in working order and it would be checked 2-3 times daily to make sure it was flushed, and the carpets would be cleaned due to animal feces on the floor. *Note: SI2023A0356040 dated 05/30/2023 cited the same rule, R 400.1426(1) Maintenance of premise due to animal feces in the home. Mr. R. Huston and Ms. Huston submitted a CAP on

	08/03/2023 stating they have scrubbed the carpets and are changing the litter boxes more frequently.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED**

ALLEGATION: Licensee Randy Hudson was verbally aggressive with former Resident A and others.

INVESTIGATION: On 12/26/2023, I received a Bureau of Child and Adult Licensing online complaint. The complainant reported Randy is verbally abusive towards Resident A. Randy was verbally abusive towards Resident A on Tuesday, December 21, 2023, he told her to, "sit the fuck down"! Resident A was removed within 48 hours. *Note: During this investigation, it was determined that this allegedly occurred on 12/18/2023 and not on 12/21/2023.

On 12/27/2023, I interviewed Dawn Wentworth via telephone. Ms. Wentworth stated when she went to the home on 12/18/2023 to drop off personal care products for Resident A, Ms. Wentworth stated she asked Resident A if she (Resident A) remembered her. Resident A stood up to move closer to Ms. Wentworth and that is when Mr. R. Huston told Resident A to "sit the fuck down." Ms. Wentworth stated she heard him say it to Resident A and so did her office manager that was with her that day, Greg Wentworth. Ms. Wentworth stated Resident A has been moved out of the home and is no longer a resident. Ms. Wentworth stated Mr. R. Huston has also been verbally aggressive with the Hackley Care doctor's office also.

On 12/28/2024, I conducted an unannounced inspection at the home and Mr. R. Huston opened the door, saw it was me and slammed the door shut. I stood on the porch for a minute and Mr. R. Huston then opened the door a second time and allowed me to come in. Mr. R. Huston was extremely upset that a complaint had been filed. The dog was barking, and Mr. R. Huston yelled at the dog that was down the steps to "shut the fuck up." Mr. R. Huston stated he has never told Resident A to "sit the fuck down," Mr. R. Huston was incensed that anyone would accuse him of talking like that to a resident or to anyone else. Mr. R. Huston was so upset that he left the room for a few minutes. Mr. R. Huston and Ms. Huston stated the complainant reported this occurred on Tuesday, December 21, 2023, and December 21st was a Thursday, not a Tuesday and Resident A had been moved out of the facility on December 19, 2023, so the report that he told Resident A to sit the fuck down, never occurred because the resident was not in the home on the dates provided in the complaint. In addition, Mr. R. Huston stated he and Ms. Huston were not at the home on 12/19/2023 when Resident A was moved from the home. Mr. R. Huston and Ms. Huston stated they were at the home on 12/18/2023 when Ms. Wentworth came to see Resident A but at no time did Mr. R. Huston yell at Resident A, any of the other residents or anyone at the doctor's office.

On 12/28/2024, I interviewed Mr. E. Huston at the home. Mr. E. Huston stated he has never heard Mr. R. Huston speak to any of the residents including Resident A in a derogatory way. Mr. E. Huston stated he has never heard Mr. R. Huston tell Resident A to “sit the fuck down.”

On 12/28/2024, I interviewed Resident’s B, C, D & E individually at the home. Resident’s B, C, & E stated Mr. R. Huston has never used profanity towards them or Resident A. Resident B laughed and said “no!” when I asked if he has ever heard Mr. R. Huston tell Resident A to sit the fuck down. Resident D stated he has heard Mr. R. Huston say “shut the fuck up” in general but is not sure who it was directed to. Resident D stated he “tries not to know things” that go on around the house. Resident A is no longer living in this facility and is not available to be interviewed.

On 12/28/2023, I reviewed the HCCC (Hackley Community Care Clinic) Integrated Health Clinic notes dated 11/28/2023, written by Dr. Gabriel DeVivo, DO. The notes documented, *‘Her (Resident A) AFC home seems to have a somewhat antagonistic relationship with this office, with significant concern expressed from this office’s staff in the EMR and in person for the rude, sometimes vulgar language used by the owner when contacting this office.’*

On 02/22/2024, I interviewed Valerie Stein, RN at HCCC Integrated Health. Ms. Stein stated Mr. R. Huston has been verbally aggressive with her when she went to the home to conduct a Clozaril draw for another resident. I reviewed notes written by Shelondrea Johnson, RMA (registered medical assistant) dated 07/28/2023, ‘*The caregiver, Randy Huston called our office demanding to speak with Karel (Schram, PAC) in a very rude tone. I attempted to explain that Karel was not in today and no longer conducts phone appointments. The caregiver was extremely rude yelling and telling me, “I better talk to Karel right now,” I again tried to explain to him that Karel was not available and I could help him, the caregiver continued to scream and curse at me demanding to talk to Karel. I then asked him what was the patients name that he had a concern about and he told me the patient. I then asked would he allow me to assist him and he yelled, “no, I only want to talk to Karel, I am tired of her giving these residents medications”. I then asked what medication did he have in question? He responded, “that doesn’t matter and since I can’t talk to Karel I am not giving her this new medication.” I then tried to tell the caregiver that it was very vital that the patient is given all prescribed medications for the safety of the patient. He continued to yell and scream and curse. I told the caregiver I was going to disconnect the call due to the rudeness and screaming. I then disconnected the call.’*

On 02/23/2024, I interviewed Greg Wentworth, Shoreline Guardianship Services. Mr. Wentworth stated he was at the home on 12/18/2023 and heard Mr. R. Huston tell Resident A to “sit the fuck down” when she stood up and began to move towards Ms. Wentworth, her legal guardian.

On 02/28/2024, I conducted an exit conference with co-licensee, Theresa Huston via telephone. Ms. Huston stated she will review the contents of the report with Randy

Huston, co-licensee and submit a corrective action plan.

APPLICABLE RULE	
R 400.1404	**Licensee, responsible person, and member of the household; qualifications.**
	(3) A licensee or responsible person shall possess all the following qualifications: (b) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.
ANALYSIS:	The complainant reported Mr. R Huston is verbally abusive towards Resident A. Ms. Wentworth and Mr. Wentworth reported they heard Mr. R. Huston tell Resident A to “sit the fuck down” on 12/18/2023. Ms. Wentworth stated Mr. R. Huston has also been verbally aggressive with the Hackley Care doctor’s office also. During an unannounced inspection, Mr. R. Huston opened the door, saw it was me and slammed the door shut. I heard Mr. R. Huston yell at the dog to “shut the fuck up.” Mr. R. Huston stated he has never told Resident A to “sit the fuck down.” Mr. R. Huston, Ms. Huston and Mr. E. Huston stated at no time did Mr. R. Huston yell at Resident A or any of the other residents or anyone he deals with including doctors. Residents B, C and E reported they have never heard Mr. R. Huston use profanity towards them or Resident A. Resident D stated he has heard Mr. R. Huston say “shut the fuck up” in general but is not sure who it was directed to. Dr. Gabriel DeVivo, DO documented in HCCC Integrated Health notes that the home has an antagonistic relationship with the office and rude, sometimes vulgar language is used by the owner of the AFC home when contacting the HCCC office. Ms. Stein reported, and Ms. Johnson documented in doctor office notes that their interactions with Mr. R. Huston were described as rude, with Mr. R. Huston yelling, he was demanding, screaming, and cursing.

	Based on investigative findings, there is a preponderance of evidence to show that Mr. R. Huston is not suitable to meet the physical, emotional, social, and intellectual needs of the residents. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's personal care needs were not attended to at the facility.

INVESTIGATION: On 12/26/2023, I received a Bureau of Child and Adult Licensing online complaint. The complainant reported when Resident A was removed from the home, staff at the home gave Resident A a laundry basket with her dirty clothes. It is unknown if they had ever been washed. Resident A was soaked past her knees as if she had not been changed at all that day. There was "crud" built between her fingers as if she had not been washed in a long time. When she was given food, she ate as if she had not eaten in a while. Mats of hair were cut out of her head. She had a beard, and her toenails are so long that they are bending and cutting into her skin. Her skin is so thin and fragile from not being cleaned or lotion. Resident A has lived in this AFC home since June 2023.

On 12/27/2023, I interviewed Dawn Wentworth via telephone. Ms. Wentworth stated she agreed with the information provided in the complaint and stated she found Resident A's personal care needs were not attended to when she saw her on 12/18/2023 and 12/19/2023.

On 12/28/2024, I conducted an unannounced inspection at the home and interviewed Mr. R. Huston, Ms. Huston, and Mr. E. Huston. Mr. R. Huston, Ms. Huston, and Mr. E. Huston stated they provided care to Resident A per her assessed needs. Mr. R. Huston and Ms. Huston stated they constantly went back and forth with Healthwest about the feasibility of Resident A being in their home as she required more care than what they could provide. Mr. R. Huston stated they issued a 30-day discharge notice several months ago, in May 2023, but Resident A did not have a guardian at that time and case management did not or was not able to find placement for her, so she remained in the home. Nonetheless, Mr. R. Huston, Ms. Huston, and Mr. E. Huston stated they provided care to Resident A per her assessed needs. Ms. Huston stated when Resident A left the home, Mr. E. Huston made sure she had gone to the bathroom and was dry. Mr. R. Huston stated it is possible Resident A became wet between the time Mr. E. Huston got her ready and when Ms. Wentworth came to pick Resident A up. Mr. E. Huston gave Ms. Wentworth all Resident A's clean clothing just out of the dryer and kept her dirty clothing to wash and send to her after they were all done. Ms. Huston stated they were trying to prevent anyone from making accusations that she was sent out with dirty clothing. Ms. Huston stated they were notified at 2:45p.m. on 12/19/2023 that

Resident A would be picked up at 4:00p.m. to move her and because they were given such little notice that Resident A was being moved out, they did not have all her clothing washed. Mr. R. Huston stated he just recently shaved Resident A but her hair grows fast, and he offered to trim her nails but she refused to allow him to do that. Ms. Huston stated she gave Resident A a brush and instructed her to scrub under her nails but stated she is not sure how good of a job Resident A did. Mr. R. Huston and Ms. Huston stated Resident A was fed three meals daily, they prompted her to eat, they did not need to assist her with eating, and she ate her meals without any issues.

On 12/28/2024, I interviewed Resident's B, C, D & E individually at the home. The residents stated they can complete their own activities of daily living including grooming, dressing, personal hygiene, bathing, and toileting. The residents stated they cut their own nails and keep up on their own personal hygiene. The residents stated Mr. R. Huston, Mr. E. Huston and/or Ms. Huston wash their clothes and provide with them with meals each day, breakfast, lunch, and dinner. The residents stated they eat a variety of meals that include, tacos, sandwiches, pizza, Manwich, and chili dogs. Residents B, C, D & E stated they do not have any issues with their personal care at the facility. Residents B, C, D & E stated they did not notice that Resident A's personal care needs were met or not met at the home. The residents appeared to be properly groomed, dressed in clothing that appeared clean and appropriate to the time of year and weather.

On 12/28/2023, I reviewed the HCCC (Hackley Community Care Clinic) Integrated Health Clinic notes dated 11/28/2023, written by Dr. Gabriel DeVivo, DO. The notes documented Resident A was there with Health West worker, Trey Wyrick. Resident A was seen for edema and weight. The notes documented the following information; '*Patient last weight was 154.6 lbs. with a BMI of 23.86 on 08/23/23. Today's weight is 135.4lbs. with a loss of 19.2 lbs. since last visit. Diet: home provides meals. She reports that she may or may not finish her meals. Per home staff, they have not been giving her the Ensure as they feel she has been eating a lot. It looks like this is available as a P.R.N. (as needed) 3 times daily with meals. Review of records is notable for a substantial number of concerning deficits in care. Although the patient has been referred to a number of specialists and studies (e.g. podiatry for rams horn toenails, GI, a DEXA scan) these do not appear to have been scheduled. Her Health West team has currently been designated to help schedule these appointments, but it is not clear if they have consistently been listed as the correct contact when ordering consultations and studies. When discussing my candid concerns regarding her (Resident A's) significant unintentional weight loss, she said she would try to do better at scheduling her appointments, though she clearly does not possess the capacity to do this. I have fairly significant concerns about the level of attention she is or is not receiving from her AFC, however their lack of representation or of any documentation from them leave me very uncertain if this is warranted or not. I asked her if she felt like she was safe at her present AFC, and she said that she generally did. She seemed more concerned regarding some of the other people there than she does regarding ownership and management in our conversations today. She*

does admit she hoped it would be better than it seems to be turning out to be but did not elaborate. She doesn't seem to have anybody that she socializes with there, which probably isn't great for her mental health. She did mention the death of one of the cats she has lived with, which may be contributing to some underappreciated depression.'

On 12/28/2023, I reviewed a letter provided from Ms. Wentworth from Resident A's new placement dated 1219/2023, *'Just wanted you to know that (Resident A) received a shower tonight, they did have to cut her hair a little (which they asked her permission for) to get a few of the knots out. Her skin is very fragile, dry, and they've slathered her with lotion. She will be put on our list for podiatry ASAP! She had her nails cut and beard shaved.'*

On 01/03/2024, I reviewed Resident A's Assessment Plan for AFC Residents dated 04/17/2023, signed by Ms. Huston and Amy Adamo, Health West supports coordinator. The assessment plan documented Resident A does not need any staff assistance with bathing, grooming, hair care, teeth, nails, dressing, personal hygiene. The assessment plan documented Resident A's need for assistance with eating and feeding but there is nothing written describing Resident A's needs or how they will be met. The assessment plan documented that Resident A does not have a special diet.

On 02/28/2024, I conducted an exit conference with co-licensee, Theresa Huston via telephone. Ms. Huston stated she will review the contents of the report with Randy Huston, co-licensee and submit a corrective action plan.

APPLICABLE RULE	
R 400.1408	**Resident care; licensee responsibilities.**
	(1) A licensee shall provide basic self-care and habilitation training in accordance with the resident's written assessment plan.
ANALYSIS:	The complainant reported Resident A's personal care needs were not attended to at this home. Ms. Wentworth reported Resident A's personal care needs were not attended to when she saw her on 12/18/2023 and 12/19/2023. Mr. E. Huston. Mr. R. Huston and Ms. Huston stated Resident A's care needs were attended to according to her assessed needs. Dr. Gabriel DeVivo, DO documented a weight loss of 19.2 lbs. from 08/23/2023 to 11/28/2023. He documented concern for

	the level of attention Resident A is or is not receiving from her AFC home and documented the lack of communication from the AFC to the doctor's office. The assessment plan documented Resident A does not need any staff assistance with bathing, grooming, hair care, teeth, nails, dressing, personal hygiene. The assessment plan documented Resident A's need for assistance with eating and feeding but there is nothing written describing Resident A's needs or how they will be met. The assessment plan documented that Resident A does not have a special diet. Based on investigative findings, the assessment plan documented Resident A did not require assistance with any personal care but that she did require assistance with eating/feeding. While staff at the facility report they assisted Resident A with personal care needs, the facility is not providing care per Resident A's assessed needs because the assessment plan documented that Resident A requires assistance with eating. In addition, it is clear that Resident A's Assessment Plan did not provide an accurate depiction of her actual care needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's medications were not administered as prescribed.

INVESTIGATION: On 12/26/2023, I received a Bureau of Child and Adult Licensing online complaint. The complainant reported the facility does not have a "med list" for Resident A. The complainant reported Mr. Huston stated they do not need a medication list at the home, they just administer the medication to Resident A. The complainant reported Mr. Huston refused to give Resident A medication the doctor prescribed, and they gave Resident A, 4 out of her 11 medications and that is all they had been giving her.

On 12/27/2023, I interviewed Ms. Wentworth via telephone. Ms. Wentworth stated when she picked Resident A up to move her and met with Mr. E. Huston, he stated they did not have a medication list, so he wrote the medications down on a white, lined piece of paper and gave it to her. Ms. Wentworth reported that Mr. R. Huston told the Hackley care doctor that he would not give Resident A prescribed medications because it caused Resident A to urinate more.

On 12/27/2023, I reviewed a white piece of paper with medications handwritten on it. The paper documented Ibuprofen 600mg, Atorvastatin 20mg, Paliperidone 5mgs, Docusate Sodium 100mgs.

On 12/28/2023, I conducted an unannounced inspection at the facility and interviewed Mr. R. Huston, Ms. Huston, and Mr. E. Huston. Mr. R. Huston stated he never refused to give Resident A any medications that the doctor prescribed. Mr. R. Huston and Mr. E. Huston stated they did not tell Ms. Wentworth they do not use a MAR (medication administration record). Mr. E. Huston stated the day Ms. Wentworth picked Resident A up to move her, she called and gave Mr. E. Huston approximately 25 minutes to gather all her belongings. Mr. R. Huston stated he and Ms. Huston were in Chicago, it was 12/19/2023 and Mr. E. Huston was working and unable to get the copy machine to make a copy of the MAR, so he wrote the medications Resident A was taking while in the home on a piece of paper and gave it to Ms. Wentworth. Mr. R. Huston stated at one point, the doctor's office called and wanted to start Resident A on Iron pills but "we never saw it, we never got any paperwork from the doctor's office" and therefore, Iron was never received or administered to Resident A. Mr. R. Huston stated Resident A has never been on 11 medications and the medications documented on the MAR are accurate. Mr. E. Huston confirmed the information provided by Mr. R. Huston.

On 12/28/2023, I reviewed Resident A's MARs for the months of November and December 2023. The MARs documented Resident A's medications as Amlodipine 10mg, 8:00a.m., Ibuprofen 600mg, 8:00a.m., 5:00p.m., Paliperidone 6mg, 5:00p.m., DOK (Docusate) 8:00a.m., Atorvastatin 20mg, 5:00p.m., Ensure, 8:00a.m., 12:00p.m., 5:00p.m. The medications are signed by either Randy or Eric Huston as administered to Resident A on each day and at each time prescribed as documented on the MAR. The Amlodipine 10mg and Ensure three times daily were not included on the handwritten list of medications provided to Ms. Wentworth on the date Resident A moved.

On 12/28/2023, I reviewed Resident A's Resident Care Agreement for AFC Residents. The agreement was dated 04/17/2023 and signed by Ms. Huston and Health West supports coordinator Amy Adamo. The Resident Care Agreement documented the home does not transport or provide any transportation for the resident which would leave appointments up to the resident, the resident's designated representative and/or responsible agency.

On 12/28/2023, I interviewed Residents B, C, D, & E individually at the home. The residents stated they get their medications each day as prescribed. The residents reported as far as they know, every resident in the home got their medications each day.

On 12/28/2023, I reviewed the HCCC (Hackley Community Care Clinic) Integrated Health Clinic notes dated 11/28/2023, written by Dr. Gabriel DeVivo, DO. The notes documented; *'briefly prescribed 15 days of Lasix this summer but no longer taking diuretics.' In addition, the notes documented, 'the owner (of the AFC) has previously refused to give her (Resident A) medication prescribed by this office, and has not consistently sent representation, paper communication, or even a MAR to*

appointments.' The notes documented Ensure is available as a PRN (as needed) 3 times daily with meals.

On 02/22/2024, I interviewed Valerie Stein, RN at HCCC Integrated Health. Ms. Stein stated and sent the notes for review, that on 07/27/2023, Karel Scram, PAC (Physician Assistant) ordered Furosemide (Lasix), 20mg tablet, 1 tablet daily with a banana for 15 days, no refill. Ms. Stein reported Mr. R. Huston called the clinic and spoke to Shelondrea Johnson, RMA (registered medical assistant) on 07/28/2023 and stated he would not give Resident A this medication unless he was able to speak to Karel Scram about it. Ms. Stein stated on 07/28/2023, Ms. Johnson spoke to Ms. Huston who called the office and Ms. Huston stated she would make sure Resident A took the medication. Ms. Stein stated the Furosemide medication was picked up on 07/08/2023 from Mercy Health Pharmacy and she assumed the medication was administered to Resident A.

On 02/28/2024, I conducted an exit conference with co-licensee, Theresa Huston via telephone. Ms. Huston stated she will review the contents of the report with Randy Huston, co-licensee and submit a corrective action plan.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(1) Prescription medication, including tranquilizers, sedatives, dietary supplements, or individual special medical procedures, shall be given, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy container which shall be labeled for the specific resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being ' 33.1101 et. seq. of the Michigan Compiled Laws.
ANALYSIS:	The complainant reported Mr. Huston stated they do not need a medication list at the home, Mr. Huston refused to give Resident A medication the doctor prescribed, and they gave Resident A, only 4 out of her 11 medications. Ms. Wentworth reported Mr. E. Huston stated they did not have a medication list, so he wrote the medications down on a piece of paper. Ms. Wentworth reported that Mr. R. Huston told the Hackley care doctor that he would not give Resident A prescribed medications because it caused Resident A to urinate more. I reviewed a white piece of paper with medications handwritten on it.

	I reviewed Resident A's MARs for the months of November and December 2023. The medications are signed as administered to Resident A on each day and at each time prescribed as documented on the MAR. In reviewing Resident A's MARs vs. the handwritten paper provided to Ms. Wentworth, the Amlodipine 10mg and ensure three times daily were not included on the handwritten list of medications. Mr. R. Huston stated he never refused to give Resident A any medications the doctor prescribed. Mr. R. Huston and Mr. E. Huston stated they did not tell Ms. Wentworth they do not use a MAR and Mr. E. Huston stated he wrote the medications out because the copy machine was not working, and he was unable to provide a copy of the MAR. The Resident Care Agreement documented the home does not transport, leaving appointments up to the resident, the resident's designated representative and/or responsible agency. Residents B, C, D, & E stated they get their medications each day as prescribed. The residents reported every resident in the home got their medications each day. Dr. DeVivo's notes documented the owner of the AFC has previously refused to give Resident A medication prescribed by this office. Ms. Stein confirmed that initially Mr. R. Huston refused to give Resident A Furosemide, but the medication was picked up from the pharmacy and Ms. Stein assumed the medication was administered to Resident A. Based on investigative findings, there is not a preponderance of evidence to show that Resident A's medications were not administered as prescribed and therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A did not have a bed in her room at the facility.

INVESTIGATION: On 12/26/2023, I received a Bureau of Child and Adult Licensing online complaint. The complainant reported concerns that Resident A did not have a

bed at the facility and Mr. Huston did not allow anyone into the room she was in to see if she had a bed. The complainant reported that Resident A reported that she was sleeping on an air mattress.

On 12/27/2023, I interviewed Ms. Wentworth via telephone. Ms. Wentworth stated Mr. R. Huston refused to allow her to see Resident A's bedroom and Resident A reported she had a blow-up mattress to sleep on.

On 12/28/2023, I conducted an unannounced inspection and interviewed Mr. Huston, Mrs. Huston, and Eric Huston at the facility. Mr. & Mrs. Huston and Eric Huston stated they never refused to allow anyone in Resident A's room and stated Resident A has always had a bed to sleep in, never an air mattress.

On 12/28/2023, I inspected Resident A's room at the facility and there was a bed in the room on a frame and the bed met the specifications in the applicable rule. I inspected all the resident rooms in the facility and all rooms have beds on a frame that meet the specifications in the applicable rule.

Note: On 08/03/2023 I conducted an inspection at the facility for the purpose of the renewal of the license. At that time, I inspected all resident rooms including Resident A's and at that time, Resident A had a bed in the room on a frame and the bed met the specifications in the applicable rule.

On 12/28/2023, I interviewed Residents B, C, D, & E individually at the home. Each of the Resident's stated they have beds and have never seen any resident, including Resident A using an air mattress in their rooms at the facility.

On 02/28/2024, I conducted an exit conference with co-licensee, Theresa Huston via telephone. Ms. Huston stated she will review the contents of the report with Randy Huston, co-licensee and submit a corrective action plan.

APPLICABLE RULE	
R 400.1433	**Bedroom furnishings.**
	(3) A licensee shall provide a resident with a bed that is not less than 36 inches wide and 72 inches long, with comfortable springs in good condition, a clean protected mattress which is not less than 5 inches thick or 4 inches thick if of synthetic construction, and with a pillow.
ANALYSIS:	The complainant reported Resident A stated she was sleeping on an air mattress at the facility. Ms. Wentworth stated she was not allowed to see Resident A's bedroom and Resident A reported she had a blow-up mattress to sleep on.

	Mr. Huston, Mrs. Huston, and Eric Huston stated Resident A had a bed in her room at the facility and never slept on an air mattress. I inspected Resident A's room at the facility and there was a bed in the room on a frame and the bed met the specifications in the applicable rule. I inspected all resident rooms in the facility and the rooms have beds on a frame that meet the specifications in the applicable rule. On 08/03/2023 I conducted an inspection at the facility for the purpose of the renewal of the license. At that time, I inspected all resident rooms including Resident A's and at that time, Resident A had a bed in the room on a frame and the bed met the specifications in the applicable rule. Residents B, C, D, & E stated they have beds and have never seen any resident, including Resident A using an air mattress in their rooms at the facility. Based on investigative findings, there is not a preponderance of evidence to show that Resident A was sleeping on an air mattress in her room at the facility. Therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Repeat Violations:
SI2023A0356017 dated 02/03/2023 cited R 400.1426(1) Maintenance of premise due to animal feces in the home and the non-working upstairs toilet. Mr. R. Huston and Ms. Huston submitted a corrective action plan (CAP) on 03/03/2023 stating the toilet was in working order and it would be checked 2-3 times daily to make sure it was flushed, and the carpets would be cleaned due to animal feces on the floor.

SI2023A0356040 dated 05/30/2023 cited the same rule, R 400.1426(1) Maintenance of premise due to animal feces in the home. Mr. R. Huston and Ms. Huston submitted a CAP on 08/03/2023 stating they have scrubbed the carpets and are changing the litter boxes more frequently.

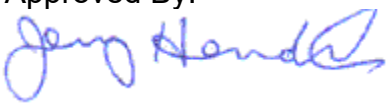
As a result of the quality of care and maintenance of premises violations cited in this report, including the above-noted repeat violations from previous special

investigations, I recommend the issuance of a provisional license. This recommendation is contingent on the licensee submitting an acceptable Corrective Action Plan.

02/28/2024

Elizabeth Elliott Date
Licensing Consultant

Approved By:



02/28/2024

Jerry Hendrick Date
Area Manager