GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

March 18, 2024

Kenyatta McGruder
354 E Gracelawn Ave
Flint, MI 48505

RE: License #:	AS250279080
Investigation #:	2024A0123019
	Loving Care A.F.C. Home

Dear Kenyatta McGruder:

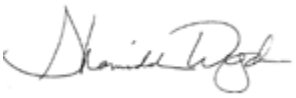
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS250279080
Investigation #:	2024A0123019
Complaint Receipt Date:	02/02/2024
Investigation Initiation Date:	02/06/2024
Report Due Date:	04/02/2024
Licensee Name:	Kenyatta McGruder
Licensee Address:	354 E Gracelawn Ave Flint, MI 48505
Licensee Telephone #:	(810) 394-5594
Administrator:	Kenyatta McGruder
Licensee Designee:	N/A
Name of Facility:	Loving Care A.F.C. Home
Facility Address:	2112 Raskob Street Flint, MI 48504
Facility Telephone #:	(810) 407-8430
Original Issuance Date:	01/06/2006
License Status:	REGULAR
Effective Date:	08/26/2023
Expiration Date:	08/25/2025
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 02/01/2024, Resident A presented to the hospital by foot, after Resident A walked 20 minutes from the AFC home around 10pm. There are ongoing concerns that Resident A is supposed to be monitored at the AFC home and that Resident A was able to leave without supervision.	Yes
Resident A presented with an odor of urine and Resident A's clothes looked unkempt. Resident A's clothes were dirty and wrinkled and Resident A's hair was disheveled.	Yes
Resident A complained that the AFC home didn't have any food. Resident A gives food away to neighborhood cats, then gets upset when Resident cannot get any more food.	No
Additional Findings	Yes

III. METHODOLOGY

02/02/2024	Special Investigation Intake 2024A0123019
02/05/2024	APS Referral Information received regarding APS referral.
02/06/2024	Special Investigation Initiated - On Site I conducted an unannounced on-site at the facility. Staff and residents were interviewed.
02/06/2024	Contact- Telephone call I spoke with licensee Kenyatta McGruder.
02/08/2024	Contact - Document Received Requested documentation received via fax.
02/15/2024	Contact- Telephone call made I spoke with Relative 1 via phone.
02/27/2024	Contact- Telephone call made I left a voicemail requesting a return call from Resident A's case manager.
03/01/2024	Inspection Completed On-site- I conducted an unannounced follow-up on-site.
03/05/2024	Contact- Telephone call made

	I attempted to contact Resident A's case manager. The case manager was out of the office.
03/07/2024	Contact- Telephone call made I conducted a follow-up call with licensee Kenyatta McGruder.
03/11/2024	Contact- Document Received Requested documentation received via email.
03/15/2024	Contact- Telephone call made I made a third attempted call to Resident A's case manager.
03/18/2024	Exit Conference I conducted an exit conference with licensee Kenyatta McGruder via phone.

ALLEGATION:

- **On 02/01/2024, Resident A presented to the hospital by foot, after Resident A walked 20 minutes from the AFC home around 10pm. There are ongoing concerns that Resident A is supposed to be monitored at the AFC home and that Resident A was able to leave without supervision.**

- **Resident A presented with an odor of urine and Resident A's clothes looked unkempt. Resident A's clothes were dirty and wrinkled and Resident A's hair was disheveled.**

- **Resident A complained that the AFC home didn't have any food. Resident A gives food away to neighborhood cats, then gets upset when Resident cannot get any more food.**

INVESTIGATION: On 02/06/2024, I conducted an unannounced on-site visit at the facility. I interviewed Resident A, Resident B, Resident C, and staff Jackie Townsend.

Resident A reported getting into a fight with the home manager then walked to Hurley Medical Center. Resident A waited in the hospital waiting room because Resident A needed to think. Resident A was starving and had not eaten in a week. Resident A stated that the facility only had meat and vegetables, no food that Resident A wanted to eat. Resident A stated that Resident A can leave the facility on and walks in the community about once a week independently. Resident A stated that Resident A told staff at the hospital that Resident A did not want to be admitted because Resident A was not sick, just upset, and hungry. Resident A stated that Resident A walked to the hospital at night and was wearing a coat. Resident A reported showering daily, and independently does laundry and hygiene tasks. Resident A stated that Resident A's clothing was dirty the day Resident A walked to

the hospital. Resident A reported wearing adult briefs. Resident A stated that Resident A left the AFC home in a hurry due to being upset. Resident A's clothing appeared to be clean during this on-site, but an odor of urine was detected. Resident A stated that the hospital called Resident A's brother, who brought Resident A back to the home. Resident A denied feeding the cats in the neighborhood any food. Resident A stated that Resident A only gives the cats water. Resident A stated that the home needs groceries.

Staff Jackie Townsend was interviewed. Staff Townsend stated that the residents in the home are provided with three meals per day. Staff Townsend stated that she lives in the home but does not cook nor serve the meals. Licensee Kenyatta McGruder cooks and serves the meals. Staff Townsend stated that Resident A was informed that if Resident A does not like living in the home, Resident A can move, but Resident A's family told Resident A that Resident A is not moving anywhere else. Resident A wears a brief and is independent with hygiene tasks. Resident A can go in the community on unsupervised and sets up their own transportation. Resident A is a picky eater and is the only resident who has complaints about the food served. Staff Townsend denied getting into a fight with Resident A and stated that Resident A probably got into it with another resident the night Resident A walked to Hurley Medical Center. Resident A will feed the outdoor neighbor's cats but has been told not to do this. Staff Townsend stated that there are no animals in the home. Staff Townsend stated that she and licensee Kenyatta McGruder does the residents' laundry. Staff Townsend stated that Resident A showers every morning and has regular incontinence issues in Resident A's bed.

Resident B was interviewed. Resident B stated that she has lived in the home for about 12 years. Resident B loves living here. Resident B stated that three meals per day and snacks are provided at night. Resident B stated that Resident B eats lunch at program when Resident B attends. Resident B stated that last night's dinner was beef stew chunks with sauce over rice and gravy, corn, and green beans. Resident B reported getting enough food to eat. Resident B stated that their snacks consist of cold lunch sandwiches, chips, something sweet, and juice. Resident B stated that sausage, oatmeal, and coffee is served on Saturdays, and they eat cereal and toast during the week. Resident B stated that staff does the laundry. Resident B stated that Resident B gets along with Resident A sometimes, and that Resident A will get food and share the food with everyone. Resident A is very caring. Resident B stated that Resident B has not heard any concerns about the food being served, except from Resident A who will say "*that's not filling*." Resident B stated that staff does a good job with the laundry and denied noticing any odor from anyone else in the home. Resident B appeared clean and appropriately dressed during this interview.

Resident C was interviewed. Resident C stated that Resident C has resided in the home for close to five years. Resident C stated that they sometimes get four meals a day, and that Resident C gets enough to eat and drink. Resident C stated that the licensee Kenyatta McGruder "*makes sure everything is straight*." Resident C stated that staff washes Resident C's clothing and that Resident C keeps clean clothes.

Resident C stated that Resident C bathes about three times per week. Resident C appeared clean and appropriately dressed during this interview.

During this on-site, I confirmed that the facility has a working washer, dryer, and laundry detergent. I observed the food supply in the home to be low in the upstairs freezer, refrigerator, and downstairs freezer. There were canned goods, ramen noodles, and boxed goods in the cabinet. The pantry and upstairs freezer were locked. Staff Townsend stated that she did not have the key.

On 02/06/2024, I interviewed licensee designee Kenyatta McGruder via phone. She stated Resident A has a legal guardian. Staff have been unable to get Resident A to change clothing, and when they have difficulty with this, they contact Relative 1 and Resident A's case manager. Resident A will leave the facility when Resident A does not get their way. Resident A gets mad and will feed food to the next-door neighbor's cats. Relative 1 was supposed to petition Resident A so Resident A could get prescribed medications adjusted. Resident A has bipolar and schizophrenia. Resident A is the only resident in the home that wears briefs. Resident A will urinate in a brief due to a delusion that someone is following Resident A, so Resident A will not go to the bathroom. Resident A will also layer clothing. Resident A regularly leaves the home and walks. Relative 1 takes Resident A grocery shopping. By 02/02/2024, Resident A had consumed all of Resident A's food. She stated that if she does not buy the food Resident A wants, Resident A will pick a fight with other residents, and feed Resident A's food to the outdoor cats. Kenyatta McGruder stated that she was present in the home on the night of 02/01/2024, and there was no fight between Resident A and anyone else. Resident A just grabbed their bags, slammed the door, and left the home without informing staff where Resident A was going. She stated that she contacted Resident A's Relative 1 as she observed Resident A walking up Flushing Road towards Hurley Medical Center. Staff McGruder stated that Resident A's case manager and Relative 1 provide Resident A with transportation, and that Resident A does not have any community restrictions.

On 02/08/2024, I received requested documentation via fax. Resident A's *Assessment Plan for AFC Residents* is dated 10/11/2023. According to the assessment plan, Resident A requires no assistance with any personal care needs other than medication. The assessment plan also has yes checked for *Moves Independently in Community*.

On 02/15/2024, I made a call to Resident A's brother, Relative 1. Relative 1 stated that Resident A is not capable of being in the community on their own. Relative 1 stated that Resident A called Relative 1 complaining of being hungry. Relative 1 stated that he received a call from Hurley Medical Center who told him that Resident A was at the hospital. Relative 1 stated that he spoke with licensee Kenyatta McGruder as well. Relative 1 stated that he agreed to pick Resident A up from the hospital. When he arrived, Resident A would not get into his vehicle. A couple hours later, Relative 1 went back to the hospital and took Resident A back to the facility. Relative 1 stated that is not normal for Resident A to take off at night but has a

history of walking off. Relative 1 stated that he tried to get Resident A signed into the hospital for evaluation that night. Relative 1 stated that Resident A not getting enough to eat is a delusion. Relative 1 stated that he purchases groceries for Resident A in the middle of the month. Resident A will not eat what the facility cooks. Relative 1 stated that he does have hygiene concerns. Relative 1 stated that Resident A does what Resident A wants to do and is capable of bathing independently. Relative 1 stated that he has visited the facility during mealtimes, and the meals look sufficient. Relative 1 stated that Resident A did have an odor the night he picked Resident A up from Hurley Medical Center, and Resident A needed a bath. Relative 1 stated that he supplies Resident A with soap, briefs, etc. Relative 1 stated that Resident A wets the bed and will leave the sheets on the bed. Relative 1 stated that Resident A has had these behaviors since last summer. Relative 1 stated that Resident A refuses to change clothing or wear new clothing.

On 02/27/2024, 03/05/2024, and 03/15/2024, I made unsuccessful attempts to contact Resident A's case manager. My call was not returned.

On 03/01/2024, I conducted an unannounced follow-up on-site at the facility. I observed the pantry and the deep freezer in the kitchen to still be locked. The food supply in the kitchen still appeared to be low. There was little food in the kitchen cabinets. There were individual paper lunch bags with residents' lunches in the refrigerator.

During this on-site, I went upstairs to observe Resident A and Resident A's bedroom. Resident A's bedroom had multiple large black garbage bags sitting on the bed. Resident A's bedroom was observed to have a very strong odor of urine, and Resident A's bed sheets were soaked with urine. There were also two laundry baskets filled with garbage bags containing items as well.

I interviewed Resident A during this on-site. I asked Resident A what was served for breakfast. Resident A reported eating toast, and tea. Used tea bags, as well as a couple of cold pieces of toast in a bowl were observed on the dining room table. I asked Resident A what was for lunch. Resident A retrieved a brown paper lunch bag from the refrigerator. The contents of the bag included a single serving size bag of Lay's Classic chips, a cold sandwich in a plastic sandwich bag, a small Baker's Treat dessert, and a Little Hug Fruit Barrels lunch drink. Resident A stated that spaghetti, green beans, vanilla wafers, and apple sauce was served for dinner yesterday. Resident A reported leaving the facility yesterday and going to a local church. When asked if Resident A informed staff where Resident A was going, Resident A said they did not tell staff about their whereabouts. When asked if Resident A utilizes the sign-out sheet, Resident A stated, "*not too often*."

Photos were taken of the kitchen, including the refrigerator, stove, locked pantry, and locked deep freezer, and the contents of the kitchen cabinet, and countertop where food was stored. Photos were also taken of the condition of Resident A's

bedroom. Staff Townsend did not have access to the pantry or deep freezer during this visit.

I interviewed Resident B. Resident B stated that they have a sandwich, chips, drink, and a treat for lunch today and that licensee Kenyatta McGruder brought the lunches over. Resident B stated that Licensee McGruder cooks their meals.

I spoke with staff Jackie Townsend. Staff Townsend stated that they do have a sign in/sign out sheet for the residents (observed in the living room by the front entrance), and that Resident A signs out when Resident A wants to and tells Staff Townsend that it is none of staff's business where Resident A goes.

During this on-site, I was handed the home phone. Licensee Kenyatta McGruder was on the line. She stated that she was out grocery shopping right now and agreed to send photos of the food supply after the grocery store trip.

On 03/07/2024, I made a follow-up phone call to licensee Kenyatta McGruder. She stated that the night Resident A left the home and walked to the hospital, she saw Resident A walking on Flushing Rd. because that is the route Licensee McGruder takes home and she happened to see Resident A walking. She stated that she knew Resident A was at Hurley Medical Center after the hospital social worker called Licensee McGruder and asked her to pick Resident A up from the hospital. She stated that the time between being home and getting the call from the hospital was about 20 minutes. She stated that she told the hospital social worker that she was unaware that was where Resident A was going and gave the social worker Relative 1's phone number. She stated that residents are supposed to sign out every time they leave the facility, and that Resident A is the only resident who leaves the facility on their own. Licensee McGruder stated that for a while, Resident A would sign in and out, but stopped because Resident A thought the facility was sending people to where Resident A was going. Resident A then started refusing to sign out. Licensee McGruder stated that Resident A will get will not follow the rules. Resident A used to have a cell phone Resident A would use to keep Licensee McGruder aware of Resident A's whereabouts. Relative 1 confiscated the phone due to Resident A canceling medical appointments. Licensee McGruder stated that there are house rules that Resident A does not follow, and there is a 9:00 pm curfew.

In regard to hygiene, Licensee McGruder stated that Resident A will be in the bathroom with the water running every morning, but she does not think that Resident A is actually showering, and Resident A does not change clothing. Resident A will go to the bathroom for a shower without prompting from staff. Resident A refuses to let staff wash Resident A's laundry and tells staff that Relative 1 will take Resident A to the laundromat. Resident A thinks someone is stealing clothing. The case manager was notified of this behavior. I inquired about the multiple stuffed garbage bags observed on Resident A's bed on 03/01/2024. Licensee McGruder stated that the bags are filled with dirty laundry and used adult briefs that are soiled. The other residents complain about the odor, and about Resident A threatening the other

residents. Licensee McGruder stated that Resident A threw away brand new bed sheets and a comforter Licensee McGruder purchased for Resident A. She stated that she has also replaced Resident A's mattress multiple times. Resident A will urinate in an adult brief until the brief falls apart. There has been no progress in Resident A's behaviors in the last year.

Licensee McGruder stated that the pantry and freezer are locked due to Resident A's behavior of eating up all of the home's food. She stated that she cooks the meals for the facility, and that food does not last a day in the home because Resident A will eat the food up. She stated that she has not given Staff Townsend a key because she does all of the grocery shopping and cooking for the home. She stated that some of the other residents keep their own snacks and drinks in their room. She stated that the residents in the home do not receive food stamps, and she grocery shops weekly. Relative 1 also comes in monthly with groceries for Resident A, that Resident A will eat up within a couple of days. Relative 1 buys anything Resident A asks for.

During this call I received photos of the food supply in the home. The pantry, and deep freezer were filled a variety of food items, as well as the refrigerator and freezer. The food supply appeared sufficient.

On 03/11/2024, I received requested weight records for Resident A, Resident B, Resident C, and Resident D. Each resident's recorded weights seem to be consistent, with no weight loss recorded over recent months, just slow weight gain over time. I also received a copy of a 30-day notice written by licensee Kenyatta McGruder for Resident A, due to Resident A's non-compliance with house rules. It is dated 03/05/2024. Copies of the facility's menus were obtained and reviewed as well. The meals appear to be balanced, and substitutions are handwritten on the menu to reflect changes.

APPLICABLE RULE	
MCL 400.707	**Definitions; R to T**.
	(7) "Supervision" means guidance of a resident in the activities of daily living, including 1 or more of the following: **(d) Being aware of a resident's general whereabouts even though the resident may travel independently about the community.**
ANALYSIS:	On 02/06/2024, I conducted an unannounced on-site at the facility. I interviewed Resident A. Resident A confirmed she walked to Hurley Medical Center. Resident A reported having access to the community and leaves the facility to go on walks. During a follow-up on-site on 03/01/2024, Resident A reported leaving the facility and does not tell staff about their whereabouts. Resident A confirmed not using the sign-in/sign out sheet at the facility.

	Staff Jackie Townsend was interviewed and stated that Resident A can go in the community unsupervised and Resident A sets up transportation. Staff Townsend reported that Resident A refuses to use the facility's sign-in/sign-out sheet. Licensee Kenyatta McGruder reported that Resident A regularly leaves the facility and goes on walks and does not have community restrictions. Resident A did not inform staff where Resident A was going the night of 02/01/2024. Resident A's assessment plan has yes checked for moving independently in the community. Relative 1 reported that Resident A is not capable of being in the community alone. There is a preponderance of evidence to substantiate a rule violation in regard to the facility being unaware of Resident A's general whereabouts when Resident A leaves the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident's physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.
ANALYSIS:	On 02/06/2024, I conducted an unannounced on-site at the facility. I observed Resident A's clothing on the surface to not appear disheveled or dirty, however Resident A smelled of urine. Resident A reported taking showers daily, independently managing hygiene, and washing clothing independently. Staff Townsend was interviewed and stated that staff does the laundry, Resident A showers every morning, but has regular incontinence issues. Licensee Kenyatta McGruder stated that she does not

	think that Resident A is actually showering, and Resident A does not change clothing. Resident A refuses to let staff wash Resident A's laundry. Resident A will urinate in an adult brief until the brief falls apart. There has been no progress in Resident A's behaviors in the last year. Relative 1 reported having hygiene concerns for Resident A. Relative 1 confirmed that on the night of 02/01/2024, Resident A did have an odor the night Relative 1 picked Resident A up from Hurley Medical Center, and that Resident A needed a bath. Relative 1 stated that Resident A leaves urine-soaked sheets on the bed and refuses to change clothing. This behavior has been ongoing for a year. On 03/01/2024, I conducted a follow-up on-site at the facility. I observed urine-soaked sheets on Resident A's bed, as well as multiple garbage bags on the bed. Licensee Kenyatta McGruder reported that the bags are filled with soiled clothing and used adult briefs. Resident A's room as well as the upstairs hallway in front of the bedroom door had a strong smell of urine. Resident A's *Assessment Plan for AFC Residents* dated 10/11/2023 states Resident A requires no assistance with any personal care needs other than medication. Based on the evidence the care and services provided to Resident A in the facility are not meeting a standard for maintaining and improving Resident A's physical condition. It was reported that Resident A's behaviors have declined over the last year. The assessment plan also does not indicate how staff are addressing issues regarding hygiene and incontinence. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	On 02/06/2024, I conducted an unannounced on-site at the

	facility. I interviewed Resident A who stated that Resident A had been starving and had not eaten in a week, then stated that the facility had no food that Resident A wanted to eat. Staff Jackie Townsend was interviewed and reported that the facility serves three meals per day, and that Resident A is the only resident that complains about the food being served. Resident B and Resident C were interviewed and reported that they receive at least three meals a day and snacks. Both stated they get enough food to eat. Weight records were reviewed for each resident, and no issues were noted. Menus were reviewed for the facility, and the meals planned consist of a balance of different meats/protein, vegetables, fruit, beverages, etc. Unannounced on-sites were conducted on 02/06/2024 and 03/01/2024. A low supply of food was observed in the home. However, licensee Kenyatta McGruder reported that she keeps the pantry and deep freezer locked due to Resident A's behaviors of eating up and wasting food. Kenyatta McGruder stated that she shops weekly, and food does not last in the home due to Resident A. She stated that she cooks all of the meals for the residents, and some resident safekeep drinks and snacks in their room. On 03/07/2024, during a follow-up phone call, I received photo documentation of their being food fresh food supply in the home's refrigerator and freezer, as well as food in the pantry and deep freezer. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 02/06/2024, I requested a copy of Resident A's *Health Care Appraisal* from licensee Kenyatta McGruder. On 02/08/2024, I received a faxed copy of the health care appraisal which is dated 07/30/2019.

On 03/01/2024, I conducted an unannounced follow-up on-site at the facility. I spoke with licensee Kenyatta McGruder via phone, who confirmed that the 07/30/2019 *Health Care Appraisal* is the most up to date appraisal due to Resident A's non-compliance with follow-up annual doctor's appointments.

On 03/07/2024, I made a follow-up phone call to licensee Kenyatta McGruder. Licensee McGruder stated that she does not know the last time Resident A had a medication review. Resident A's case manager is responsible for transportation to the appointments, and Relative 1 drops off monthly medication refills to the facility. Resident A has not seen a doctor.

APPLICABLE RULE	
R400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	On 02/06/2024, I requested a copy of Resident A's *Health Care Appraisal* from licensee Kenyatta McGruder. On 02/08/2024, I received a faxed copy of the health care appraisal which is dated 07/30/2019. Licensee Kenyatta McGruder reported that Resident A cancels doctors appointments regularly and has not been to the doctor to get an up-to-date health care appraisal completed. There is a preponderance of evidence to substantiate a rule violation. Resident A's last health care appraisal was completed in July 2019.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 02/06/2024, I requested a copy of Resident A's *Assessment Plan for AFC Residents.* On 02/08/2024, I received a faxed copy of Resident A's assessment plan dated 10/11/2023. The only signatures noted on the assessment plan are licensee's Kenyatta McGruder, and Resident A's. Resident A's case manager and guardian's signature are not noted.

APPLICABLE RULE	
R400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	On 02/06/2024, I requested a copy of Resident A's *Assessment Plan for AFC Residents.* On 02/08/2024, I received a faxed copy of Resident A's assessment plan dated 10/11/2023. Resident A's legal guardian and case manager's signature were not included on the signature page of the assessment plan. There is a preponderance of evidence to substantiate a rule violation. The written assessment plan did not appear to be completed by all applicable parties.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: I conducted two unannounced on-site visits during the course of this investigation on 02/06/2024 and 03/01/2024. During both on-site visits, there did not appear to be a weekly menu posted in the facility. On 02/08/2024, I received a copy of a menu for 01/29/2024 through 02/11/2024. This document was not observed in the home to be prominently displayed.

On 03/07/2024, I made a follow-up phone call to licensee Kenyatta McGruder. She stated that she posts the menus in the home and she would have to go to Resident A's room and look for the menu, because Resident A will take the menu down.

APPLICABLE RULE	
R400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.

ANALYSIS:	I conducted two unannounced on-site visits during the course of this investigation on 02/06/2024 and 03/01/2024. During both on-site visits, there did not appear to be a weekly menu posted in the facility. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 03/01/2024, I conducted an unannounced follow-up on-site. I went upstairs to observe Resident A and Resident A's bedroom. Resident A's bedroom had multiple large black garbage bags sitting on the bed. Resident A's bedroom was observed to have a very strong odor of urine, and Resident A's bed sheets were soaked with urine. There were also two laundry baskets filled with garbage bags as well.

On 03/07/2024, I spoke with licensee Kenyatta McGruder via phone. I inquired about the multiple stuffed garbage bags observed on Resident A's bed on 03/01/2024. Licensee McGruder stated that the bags are filled with dirty laundry and used adult briefs that are soiled. The other residents complain about the odor.

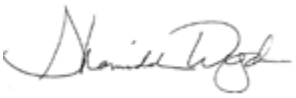
APPLICABLE RULE	
R400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	I conducted an unannounced on-site visit during the course of this investigation on 03/01/2024. I observed Resident A's bedroom. Outside of Resident A's bedroom in the hallway there was a noticeably strong odor of urine. Inside Resident A's bedroom I observed Resident A's bedroom to be unclean, with urine-soaked sheets, and multiple garbage bags on the bed. On 03/07/2024, I made a follow-up phone call to licensee Kenyatta McGruder. I inquired about the multiple stuffed garbage bags observed on Resident A's bed on 03/01/2024. Licensee McGruder stated that the bags are filled with dirty laundry and used adult briefs that are soiled, and that the other residents complain about the odor. There is a preponderance of evidence to substantiate a rule violation.

CONCLUSION:	VIOLATION ESTABLISHED

On 03/18/2024, I conducted an exit conference with licensee Kenyatta McGruder. I informed Kenyatta McGruder of the findings and conclusions.

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of this AFC small group home license (capacity 1-5).



03/18/2024

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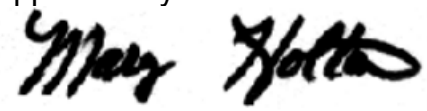
Shamidah Wyden Date
Licensing Consultant

Approved By:



03/18/2024

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Mary E. Holton Date
Area Manager