GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 3, 2024

Marva Townsend
Caring Meadows Living Center, Inc.
1001 Lafayette SE
Grand Rapids, MI 49507

RE: License #: AS410309723
Investigation #: 2024A0467023
Vi's Garden

Dear Mrs. Townsend:

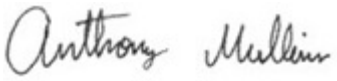
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410309723
Investigation #:	2024A0467023
Complaint Receipt Date:	02/23/2024
Investigation Initiation Date:	02/26/2024
Report Due Date:	04/23/2024
Licensee Name:	Caring Meadows Living Center, Inc.
Licensee Address:	1001 Lafayette SE Grand Rapids, MI 49507
Licensee Telephone #:	(616) 475-5433
Administrator:	Marva Townsend
Licensee Designee:	Marva Townsend
Name of Facility:	Vi's Garden
Facility Address:	1171 Lafayette S.E. Grand Rapids, MI 49507
Facility Telephone #:	(616) 635-2957
Original Issuance Date:	03/10/2011
License Status:	REGULAR
Effective Date:	12/25/2022
Expiration Date:	12/24/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A does not have sheets on his bed.	No
Mrs. Townsend did not provide notice of an emergency discharge to LARA prior to discharging Resident B.	Yes
Resident A's monthly rent is not reflected on his Resident Care Agreement.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/23/2024	Special Investigation Intake 2024A0467023
02/26/2024	APS Referral Complaint received from Kent County APS.
02/26/2024	Special Investigation Initiated - Telephone Spoke to the complainant via phone
02/29/2024	Inspection Completed On-site
04/03/2024	Exit conference completed with licensee designee, Marva Townsend.

ALLEGATION: Resident A does not have sheets on his bed.

INVESTIGATION: On 2/23/24, I received a denied APS complaint from the BCAL online complaint system. The complaint alleged that Resident A does not have sheets on his bed.

On 2/26/24, I spoke to the complainant via phone and she confirmed the allegations.

On 2/29/24, I made an unannounced visit to Sheldon Community House (Day program). Upon arrival, staff assisted Resident A to the main lobby and introductions were made. Resident A immediately recognized me from previous investigations and agreed to discuss the current allegations. Resident A confirmed that he currently does not have sheets on his bed. Resident A stated that staff threw his sheets away when they replaced his mattress due to a bedbug issues. Resident A was adamant that the bedbug issue has been rectified. However, staff have yet to provide him with replacement sheets. Resident A denied any knowledge as to when his sheets will be replaced. Resident A stated that he's "waiting on Marva" to give him new sheets. Resident A shared that he has not asked staff for sheets although he needs them.

On 2/29/24, I made an unannounced onsite investigation to the facility. Upon arrival, AFC staff member, Caroline McCoy answered the door and allowed entry into the

home. Also present in the home was licensee designee, Marva Townsend. Mrs. Townsend assisted me to Resident A's room to observe his bed. Resident A's bed was observed to have a mattress encasement on it, which is common for beds that were previously treated for bedbugs. The bed also had a pillow and a comforter on it. However, there were no sheets observed. Mrs. Townsend stated that Resident A has never asked for sheets. Mrs. Townsend shared that Resident A previously had sheets, but she is unsure as to where they are currently. Mrs. Townsend and I walked to the laundry room, which is where she suspected Resident A's sheets to be. Inside the laundry room, I noticed a plethora of cleaned sheets folded and available for use. Mrs. Townsend stated that if Resident A would have brought this need to the staff's attention, they would have addressed it immediately. Mrs. Townsend provided her staff member, Mrs. McCoy with a set of sheets and asked her to place it on Resident A's bed. Mrs. Townsend stated she was "shocked" by the allegation as she stated that Resident A knows he can call her directly with any needs or questions. Ms. McCoy also stated that "he (Resident A) always said he's good and doesn't want sheets."

On 04/23/2024, I conducted an exit conference with licensee designee, Marva Townsend. She was informed of the investigative findings and aware that it is her responsibility to ensure that all residents have the basic necessities, regardless if they ask for them. Mrs. Townsend agreed to ensure this need is met for all residents moving forward.

APPLICABLE RULE	
R 400.14411	**Linens,**
	(1) A licensee shall provide clean bedding that is in good condition. **The bedding shall include 2 sheets, a pillow case, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.**
ANALYSIS:	Resident A stated that he did not have sheets on his bed. I went to the home and observed this to be true. However, Resident A confirmed that he never asked staff for replacement sheets after his mattress was replaced due to bedbug issues. Mrs. Townsend shared that if Resident A asked for sheets, staff would have addressed the need immediately. Prior to leaving the home, Mrs. Townsend showed me a several clean sheets readily available for Resident A or any resident in need. Mrs. Townsend had her staff place the sheets on Resident A's bed prior to concluding my onsite visit. Based on the information provided, there is not a preponderance of evidence to support the allegation.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Mrs. Townsend did not provide notice of an emergency discharge to LARA prior to discharging Resident B.

INVESTIGATION: On 2/23/34, I received a BCAL online complaint stating that Resident B was removed from the facility on an emergency discharge notice last week due to her behaviors.

On 2/26/24, I spoke to the complainant via phone and she confirmed the allegations. The complainant also listed detailed information regarding Resident B's behaviors and recent hospitalizations.

On 2/29/24, I made an unannounced visit to Sheldon Community House (Day program) and spoke to Resident A. Resident A confirmed that Resident B was kicked out of the home last month on a 24-hour notice although she was not served with documentation. Resident A stated that he told Mrs. Townsend that she needed to serve Resident B with notice prior to discharging her from the home. Mrs. Townsend reportedly responded by stating, "it's none of your business." As a result of Resident B being kicked out of the home, she reportedly planned to file complaints with Adult Protective Services and LARA.

On 2/29/24, I made an unannounced onsite visit to the home. Upon arrival, AFC staff member, Caroline McCoy allowed entry into the home. Present in the home with her was licensee designee, Marva Townsend. Mrs. Townsend and I discussed the case allegations on the porch. Mrs. Townsend confirmed that Resident B was evicted from the home on a 24-hour notice due to ongoing behaviors. Mrs. Townsend stated that Resident B was assaulting staff and residents, making false accusations to the police, and causing the police to be called to the home on numerous occasions over the past few months. Mrs. Townsend stated that Resident B tried bringing men in the home and would return to the home at midnight requesting her medications although it was well past the time that the medications could be passed. Mrs. Townsend stated that Resident B would often state that she knows her rights and felt as if she could do whatever she wanted.

As a result of Resident B's ongoing behaviors, she was recently arrested and has charges pending against her due to assaulting hospital staff and police. Mrs. Townsend stated that Resident B was struggling with her mental health. Mrs. Townsend stated that Resident B was receiving court ordered psychotropic medication via injection. She was reportedly switched from an injection to oral pills, which is when she would often refuse her medications. Mrs. Townsend believed this to be the reason for Resident B's downward spiral. Mrs. Townsend felt as if she was left with no choice other than to discharge Resident B due to her behaviors as she was not getting help from network 180.

Mrs. Townsend was adamant that she provided Resident B's guardian, Tracy Booth with a 24-hour discharge notice. Mrs. Townsend provided me with contact information for Ms. Booth to verify this information. Despite sending the 24-hour notice to Resident B's guardian, Mrs. Townsend confirmed that she forgot to send the notice to me as the licensing consultant.

On 3/14/24, I spoke to Resident B's guardian, Tracy Booth via phone and she agreed to discuss the case allegations. Ms. Booth confirmed that she did in fact receive a 24-hour discharge notice from Mrs. Townsend regarding Resident B. Ms. Booth confirmed that Resident B was discharged from the home due to her behavioral issues. She also shared that this is due to Resident B's personality disorder, which has led her to be placed at Pine Rest psychiatric hospital at the time of this call. Ms. Booth stated that "when she (Resident B) doesn't want to be somewhere, she will keep calling and making false complaints," referring to her time at Vi's Garden AFC. Ms. Booth stated that she has been Resident B's guardian since late summer 2023 and this is the worst she has been. Ms. Booth stated that Resident B needs long term psychiatric care such as a residential placement, which she is exploring for her.

On 04/03/2024, I conducted an exit conference with licensee designee, Marva Townsend. She was informed of the investigative findings and agreed to complete a corrective action plan.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of thesubstantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.** **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible**

	agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. **If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency** **or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**
ANALYSIS:	Mrs. Townsend confirmed that she did not inform licensing of the 24-hour discharge notice issued to Resident B. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's monthly rent is not reflected in his Resident Care Agreement.

INVESTIGATION: On 2/23/24, I received a BCAL online complaint stating that Resident A is being overcharged for rent and it is too much for him to pay.

On 2/26/24, I spoke to the complainant via phone, and she stated that Resident A's rent was increased without his notice. The complainant also stated that Mrs. Townsend reportedly threatened Resident A to increase his rent.

On 2/29/24, I made an unannounced visit to Sheldon Community House and introductions were made with Resident A. Resident A agreed to discuss the case allegations. Resident A stated that on January 1st, 2024, his rent was increased from $1,027.50 to $1,250.00. Resident A stated that Mrs. Townsend told him if he complains, he will be kicked out of the home, "so I'm not complaining." Resident A was asked if he was forced to sign any documentation related to this. He stated, "I was obliged to sign it." Resident A stated that his SSI income only increased $100, so he didn't understand why his rent was increased over $220. Despite signing the

Resident Care Agreement, Resident A stated that he does not agree with the price increase. Resident A stated that Mrs. Townsend told him the increase in rent was to cover the increase in expenses. Resident A stated that he attends Day Program 5 days of week, which is where he eats breakfast and lunch. Due to this, Resident A is not understanding the increased expenses.

On 2/29/24, I made an unannounced onsite investigation at the facility. Upon arrival, AFC staff member, Caroline McCoy answered the door and allowed entry into the home. Also present in the home was licensee designee, Marva Townsend and she was interviewed on the front porch. Mrs. Townsend denied telling Resident A that he would be kicked out of the home if he complained about the rent increase or made any complaints. Mrs. Townsend stated that Resident A has been paying the SSI rate, despite his income being greater than his peers. Mrs. Townsend stated that Resident A previously received special funding through what she believed to be Community Mental Health (CMH). However, this is no longer the case. Due to this, in addition to expenses increases, Resident A's rent was raised along with other residents. Mrs. Townsend acknowledged that Resident A's rent was increased higher than other residents due to having higher income. Mrs. Townsend shared that her only request for Resident A is to provide her with a 30-day discharge notice should he choose to move elsewhere.

At this point, I requested to see a copy of Resident A's resident care agreement to confirm that it reflects his current rent amount of $1,250.00. The Resident Care Agreement that was on file did not reflect a monthly fee/rate. It should be noted that the form was not signed by Resident A, making it invalid. It should also be noted that Resident C and Resident D's Resident Care Agreements need to be updated as well.

On 3/18/24, I received an email from Mrs. Townsend with a signed Resident Care Agreement for Resident A, indicating his current monthly rate.

On 04/03/24 I conducted an exit conference with licensee designee, Marva Townsend. She was informed of the investigative findings and aware that she is being cited due to the resident care agreement not being on file in the home at the time of the onsite investigation. Mrs. Townsend agreed to complete a corrective action plan within 15 days.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.

ANALYSIS:	An current Resident Care Agreement was not on file for Resident A, Resident C, and Resident D during the onsite investigation. Mrs. Townsend provided me with a copy of the form for Resident A 18 days later. However, this form is required to be in each resident's file onsite. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: While onsite on 2/29/24 investigating the allegations listed above, I reviewed Resident A's Medication Administration Record (MAR) to ensure that Mrs. Townsend was completing and updating MARs as a result of special investigation #2024A0467002. Resident A's MAR was not initialed for the following medications on the specified days: Loratadine 10MG Tablet: 2/5-2/8, 2/12-2/17, 2/19-2/23, and 2/25-2/29. Methylphenid Tab 20MG: 2/13-2/17. Tab-a-vite Tab: 2/1-2/9, and 2/12-2/29. Buspirone Tab 10MG: 2/14 and 2/26-2/28 8:00 pm med pass. Buspirone Tab 5MG: 2/14 at 5:00 pm and 8:00 pm and 2/24 at 8:00 pm.

On 04/03/24, I conducted an exit conference with licensee designee, Marva Townsend. She was informed of the investigative findings and aware that a corrective action plan is due within 15 days of receipt of this report. I also informed Mrs. Townsend that this is a repeat violation from the renewal LSR on 12/21/22 and special investigation #2024A0467002.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**

	(c) Record the reason for each administration of medication that is prescribed on an as needed basis. **(d) Initiate a review process to evaluate a resident's condition if a resident requires the repeated and prolonged use of a medication that is prescribed on an as needed basis. The review process shall include the resident's prescribing physician, the resident or his or her designated representative, and the responsible agency.** **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.** **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	Resident A's MAR was not completed as required on several days throughout the month of February. Therefore, a preponderance of evidence exists to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED** **(Repeat violation from 12/19/22 Renewal Licensing Study and Special Investigation Report #2024A0467002).**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, issuance of a provisional license is recommended for the above-cited quality of care violations. R 400.14312(4) is a repeat violation from 12/2022 renewal licensing study report, as well as Special Investigation Report #2024A0467002.

Anthony Mullins 04/03/2024

Anthony Mullins, Licensing Consultant Date

Approved By:

Jerry Hendrick 04/03/2024

Jerry Hendrick, Area Manager Date
Area Manager