



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 11, 2024

Gina Bloom
The Manor
PO Box 98
Jonesville, MI 49250

RE: License #: AM300008366
Investigation #: 2024A1032010
Montgomery House

Dear Gina Bloom:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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) 356-0183.

Sincerely,

A handwritten signature in black ink, appearing to read "Dwight Forde".

Dwight Forde, 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 #:	AM300008366
Investigation #:	2024A1032010
Complaint Receipt Date:	11/22/2023
Investigation Initiation Date:	11/27/2023
Report Due Date:	01/21/2024
Licensee Name:	The Manor
Licensee Address:	PO Box 98, Jonesville, MI 49250
Licensee Telephone #:	(517) 849-2151
Administrator:	Gina Bloom
Licensee Designee:	Gina Bloom
Name of Facility:	Montgomery House
Facility Address:	312 South St, Jonesville, MI 49250
Facility Telephone #:	(517) 826-5291
Original Issuance Date:	09/12/1980
License Status:	REGULAR
Effective Date:	03/26/2022
Expiration Date:	03/25/2024
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

ALLEGATION(S)

	Violation Established?
Resident A is not-properly supervised, causing medical problems.	No
Additional Findings	No

II. METHODOLOGY

11/22/2023	Special Investigation Intake 2024A1032010
11/27/2023	Special Investigation Initiated - Telephone
11/29/2023	Inspection Completed On-site
11/30/2023	Contact - Telephone call received Interview with employee Cody Lonckowski
01/04/2024	Exit Conference

ALLEGATION:

Resident A is not properly supervised, causing medical problems.

INVESTIGATION:

On 11/27/23, I interviewed the complainant via telephone. The complainant advised that Employee #1 did not follow Resident A's assessment plan/special diet plan, resulting in Resident A's hospitalization.

On 11/27/23, I interviewed licensee designee Gina Bloom in the home. Ms. Bloom advised that Resident A was not recently hospitalized. She reported that he had been hospitalized in March 2023, and this happened because of pneumonia. She mentioned that Resident A aspirated his food because sometimes he forgets to

chew his food properly. She advised that while he is on a diabetic diet, the home took the precaution of serving him soft foods to mitigate problems with swallowing. Ms. Bloom offered some context to the source of the complaint, stating that Employee #1 was in a relationship with a former employee at another home, and that after a recent break up, the former employee had been targeting Employee #1. Ms. Bloom stated that Employee #1 has good attendance, and that the residents appear to like him. She denied receiving reports that Employee #1 was providing sub-par supervision to the residents by way of leaving them unattended for long periods of time.

I interviewed home manager Samantha Gow in the home. Ms. Gow reported that Employee #1 actively supervises the residents and will take them outside or engage them in an activity very often.

I interviewed Resident A. Resident A acknowledged that he was hospitalized in March 2023. He stated that he likes living at the home and receives good care.

I interviewed Resident B in the home. Resident B stated that he has been in the home since he was a minor and that he is now 32 years old. He was able to list the names of the employees at the home, including Employee #1, and stated that they are around to provide supervision.

I reviewed Resident A's health care appraisal and assessment plan. Both documents reflect that Resident A is on a diabetic diet. I also reviewed an incident Report from March 2023 that referenced Resident A's hospitalization due to pneumonia.

On 11/28/23, I interviewed Employee #1 via telephone. Employee #1 denied taking very long breaks and not properly supervising the residents. He asserted that he follows Resident A's care plan, to puree Resident A's food to prevent him from choking on his food. He expressed that he enjoys working at the home and is actively engaged in activities with the residents.

APPLICABLE RULE	
R 400.14206	Staffing requirements.
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Interviews with employees and residents revealed that Employee #1 does supervise residents, and that he also follows Resident A's assessment plan.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 1/4/24, I conducted an exit conference with licensee designee Gina Bloom. I shared my findings, and Ms. Bloom agreed with the conclusions.

III. RECOMMENDATION

I recommend no change to the status of this license.

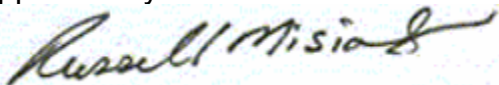


1/11/24

Dwight Forde
Licensing Consultant

Date

Approved By:



1/11/24

Russell B. Misiak
Area Manager

Date