STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

May 3, 2024

Iemelif Julian
1635 Millard Ave
Madison Heights, MI 48071

RE: License #: AS630398410
Investigation #: 2024A0611020
Genesis Adult Foster Care Home IV

Dear Iemelif Julian:

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.

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 (248) 975-5053.

Sincerely,

Sheena Worthy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630398410
Investigation #:	2024A0611020
Complaint Receipt Date:	03/22/2024
Investigation Initiation Date:	03/26/2024
Report Due Date:	05/21/2024
Licensee Name:	Iemelif Julian
Licensee Address:	1635 Millard Ave Madison Heights, MI 48071
Licensee Telephone #:	(248) 635-7685
Administrator:	Iemelif Julian
Licensee Designee:	Iemelif Julian
Name of Facility:	Genesis Adult Foster Care Home IV
Facility Address:	4906 Danbury Dr Troy, MI 48085
Facility Telephone #:	(248) 635-7685
Original Issuance Date:	07/12/2019
License Status:	REGULAR
Effective Date:	01/12/2024
Expiration Date:	01/11/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The menu is only for display. Most of the residents are given packaged frozen foods.	Yes
The home is understaffed, the staff are not trained, and the staff are sleeping in the laundry room.	Yes
Many residents have developed wounds because they just stay in bed or on the couch. There are no activities provided for the residents.	No
Fire drills are not being completed.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/22/2024	Special Investigation Intake 2024A0611020
03/26/2024	Special Investigation Initiated - On Site I completed an unannounced onsite. I interviewed staff member Adwin Macaraeg, and staff member Marib Olivares. I received a copy of Resident C hospital discharge records.
03/27/2024	Contact - Telephone call made I made a telephone call to the licensee designee Iemelif Julian. The allegations were discussed.
03/28/2024	Contact - Telephone call made I left a voice message for Resident C guardian requesting a call back.
03/29/2024	Contact - Telephone call made I made a telephone call to Resident C guardian. The allegations were discussed.
03/29/2024	Contact - Document Received After work hours on 03/29/24, I received the workforce background clearance letters for three employees, fire drill records, skin check forms for the month of March, and the staff schedule.

04/02/2024	Contact - Telephone call made I made a telephone call to the licensee designee Iemelif Julian. I informed Ms. Julian that I am missing the employee trainings as well as the background clearances for two of her employees.
04/02/2024	Contact - Telephone call made I left a voice message for staff member Maribec Olivares requesting a call back.
04/03/2024	Contact - Document Received I received an additional workforce background clearance and employee trainings.
04/12/2024	Contact - Telephone call made I made a telephone call to Maribec Olivares. Additional information was provided.
04/12/2024	Exit conference I completed an exit conference with the licensee designee Iemelif Julian via telephone.

ALLEGATION:

The menu is only for display. Most of the residents are given packaged frozen foods.

INVESTIGATION:

On 03/22/24, a complaint was received and assigned for investigation alleging that the owner is hiring undocumented people to work for cheap money per day, they don't have proper live in conditions, some are living in the laundry rooms, they don't speak English and they are not trained. There is only one staff per day and night. They sleep and no one is watching the residents. The menu is only for display. Most of the residents are given packaged frozen foods. No fire drills has ever been done. Some staff are working 7 days/nights straight. Many residents have developed wounds because they just stay in bed or on the couch. There are no activities.

It should be noted that contact information for the reporting source was not provided.

On 03/26/24, I completed an unannounced onsite. I interviewed staff member Edwin Macaraeg, and staff member Maribec Olivares. I received a copy of Resident C hospital discharge records.

On 03/26/24, I interviewed staff member Maribec Olivares. Regarding the allegations, Ms. Olivares stated today she served the residents bean soap, a ham sandwich, and a

muffin for lunch. The residents were given orange juice and white grape juice to drink. I observed the menu and saw that the menu is not dated. The menu has meals listed for three meals a day under “meal plan week 1” and under “meal plan week 2”. The meal that was listed under Tuesday for both weeks did not match what Ms. Olivares stated she served to the residents for lunch. Ms. Olivares admitted that she only follows the menu sometimes.

I observed the kitchen and found adequate food in the refrigerator, freezer, and kitchen cabinet. I did not observe any frozen dinners in the freezer.

On 03/26/24, I interviewed Resident T. Resident T stated she ate lunch today, but she cannot remember what she ate.

On 03/26/24, I interviewed Resident S. Resident S stated the food at the home is ok. Resident S stated he ate bean soap and a sandwich for lunch today. Resident S denied being fed frozen food as the food is always cooked.

On 03/27/24, I made a telephone call to the licensee designee Iemelif Julian. Ms. Julian was informed that the menus must be dated at least one week in advance. Ms. Julian stated she will ensure that changes are made to the menus.

On 03/29/24, I made a telephone call to Resident C’s guardian. The guardian stated the residents are not fed frozen meals as the staff cook their meals.

APPLICABLE RULE	
R 400.14313	**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:	During the onsite, I observed the menu and saw the menu was not dated at least one week in advance. Ms. Olivares admitted that she only follows the menu sometimes. I did not observe any substitutions on the menu either.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The home is understaffed, the staff are not trained, and the staff are sleeping in the laundry room.

INVESTIGATION:

On 03/26/24, I interviewed staff member Edwin Macaraeg. Regarding the allegations, Mr. Macaraeg stated there are six residents in the home. Mr. Macaraeg has worked at the AFC group home for four years. Mr. Macaraeg stated all staff members are fully trained. There are two staff members scheduled to work the dayshift and afternoon shift. There is one staff member scheduled to work on the midnight shift. Mr. Macaraeg denied the midnight staff members sleeping during their shift. A staff schedule was not present in the home. Mr. Macaraeg showed me a copy of the staff schedule on his cell phone. Mr. Macaraeg attempted to share the copy of the staff schedule to my cell phone but, I did not receive it.

Ms. Olivares has worked at the AFC group home for five years. Ms. Olivares stated her work schedule varies from week to week. Ms. Olivares stated for this week she started working on Sunday (03/24/24) from 7:00pm to 7:00am along with Mr. Macaraeg. Ms. Olivares stated today her shift ends at 7:00pm, which is her last day to work this week. Ms. Olivares remains in the home during her shift from Sunday to Tuesday. Ms. Olivares stated when her shift ends today, Mr. Macaraeg will remain in the home and another staff member (Claudette Smith) will arrive to the home.

I observed the washer and dryer in the kitchen area. There is no space for anyone to sleep near the washer and dryer or in the kitchen.

Resident T stated she has lived in the AFC group home for about four months. Resident T stated she likes living at the AFC group home and she does not have any complaints. Resident T stated the staff are nice to her. Resident T stated she thinks that three staff members work at the home each day. Resident T stated she spends a lot of time in her bedroom reading.

Resident S stated two staff members work at the home every day and at night. Resident S denied witnessing any staff member fall asleep at the home.

Ms. Julian stated she received the same allegations at her other home in Macomb County. Ms. Julian denied having any undocumented employees. Ms. Julian agreed to email copies of her employees ID, AFC trainings, and background clearances. Ms. Julian stated she does not consider any staff member to be a live-in staff however; Ms. Olivares begins her shift on Sunday’s at 7:00pm and she stays at the AFC group home until Tuesday 7:00pm. Ms. Olivares stated there is no bedroom for Ms. Olivares to sleep in. Ms. Olivares would not definitively say that Ms. Olivares falls asleep during her two-day shift but, she did say that Ms. Olivares probably falls asleep on the couch. Ms. Olivares is the only staff present in the home during the nighttime hours. Mr. Macaraeg works Monday’s through Thursday’s from 7:00am to 7:00pm. Mr. Macaraeg leaves the home at the end of his shift. Mr. Macaraeg and Ms. Olivares work together on Monday’s and Tuesday’s during the daytime. Ms. Julian stated staff member Feliciana Calma works Friday’s, Saturday’s and Sunday’s from 7:00am to 7:00pm. Ms. Calma nickname

is Claudette. Ms. Calma does not have a phone. Ms. Olivares stated when Ms. Calma and Mr. Macaraeg shift ends at 7:00pm, her son Eddie Ibarra works from 7:00pm to 7:00am. Ms. Julian stated Mr. Ibarra is an employee. Ms. Julian stated if Mr. Ibarra is not available to work then she will fill in.

Ms. Julian stated sometimes she does not complete a staff schedule because the staff know their schedules. Ms. Julian stated usually she will submit the staff schedule a week before the new month starts. Ms. Julian denied any staff member sleeping in the laundry room as that is not possible given the washer and dryer are located in the kitchen.

The guardian stated she did not have any concerns pertaining to the home not having enough staff. There are five residents and two staff members at all times. The staff members are always attentive towards the residents and take good care of them. The guardian stated as a former home health aide she knew Resident C was in the right AFC group home.

On 03/29/24, I received the workforce background clearance letters for three employees, and the staff schedule.

On 04/02/24, I reviewed the workforce background clearance for Alexandria Smith dated 04/29/18, Edwin Macaraeg dated 11/19/19, and Maribec Olivares. All three clearances indicate the employees are eligible for employment.

With regards to the schedule, a calendar was submitted for the month of March. The calendar list two staff names for each day, with the exception of 03/26/24 as there was three names listed. The hours or shifts worked for each day was not listed on the calendar. Therefore, it is unclear if one staff member or two staff members worked at the same time or separately. The schedule does not include the job titles of the staff members.

On 04/03/24, I received an email containing a workforce background clearance for Eddie Ibarra and; trainings for Mr. Ibarra, Edwin Macaraeg, Alexandria Smith, Feliciana Agapito, and Maribec Olivares. The email stated that Feliciana Agapito did not complete her training or her background check as she left the company before it could be completed. However, an in-house training form was provided for Ms. Agapito indicating she completed mandatory reporting, medication administration, personal care, supervision and protection, and resident rights. This form was not signed by Ms. Agapito or the trainer. A certificate was also provided for Ms. Agapito stating she completed CPR and first aid on 02/14/23. The in-house training form also indicates Ms. Agapito completed CPR and first aid on 02/14/23.

According to the workforce background clearance dated 05/29/18, Edgardo Ibarra is eligible for employment. Mr. Ibarra in-house training form indicates he was trained in mandatory reporting, medication administration, personal care, supervision and protection, resident rights, safety and fire prevention, prevention and containment of

communicable diseases. Mr. Ibarra signed the training form along with Ms. Julian on 08/08/18. Mr. Ibarra received a certificate for completing CPR and first aid on 03/05/23.

Mr. Macaraeg in-house training form indicates he was trained in mandatory reporting, medication administration, personal care, supervision and protection, resident rights, safety and fire prevention, prevention and containment of communicable diseases. Mr. Macaraeg signed the training form on 01/01/20 along with Mr. Ibarra on 01/01/20. Mr. Macaraeg received a certificate for completing CPR and first aid on 04/02/24.

Ms. Smith in-house training form indicates he was trained in mandatory reporting, medication administration, personal care, supervision and protection, resident rights, safety and fire prevention, prevention and containment of communicable diseases. Ms. Smith signed the training form along with Mr. Ibarra on 08/08/18. Ms. Smith received a certificate for completing CPR and first aid on 01/30/23.

Ms. Olivares in-house training form indicates he was trained in mandatory reporting, medication administration, personal care, supervision and protection, resident rights, safety and fire prevention, prevention and containment of communicable diseases. Ms. Olivares signed the training form along with Mr. Ibarra on 01/15/20. Ms. Olivares received a certificate for completing CPR and first aid on 02/01/23.

On 04/12/24, I made a telephone call to Maribec Olivares. I asked Ms. Olivares if she sleeps in the home when she works from Sunday to Tuesday. Ms. Olivares denies sleeping in the home. Ms. Olivares stated at the end of each twelve-hour shift (7:00pm to 7:00am) she goes home after another staff member arrives to the home. Ms. Olivares stated she must have been confused when she told me during the onsite that she stays in the home from Sunday to Tuesday.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(d) Personal care, supervision, and protection.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Verification of in-house training form was received for each employee confirming each employee received their required trainings, with the exception of Feliciana Agapito. The in-house training form for Ms. Agapito was incomplete as it did not indicate that she completed the safety and fire prevention

	training or the prevention and containment of communicable diseases training, nor did she or the trainer sign the in-house training form. On 04/03/24, an email was sent by the licensee designee Iemelif Julian secretary (Alexandria Smith) stating Ms. Agapito did not complete her trainings as she left the company before it could be completed. Ms. Julian stated that statement is not accurate as Ms. Agapito is a current employee. According to Ms. Agapito CPR/first aid certificate she completed these trainings on 02/14/23. Ms. Agapito in-house training form also indicates that she completed CPR/first aid on 02/14/23. Therefore, Ms. Agapito had ample time to complete the safety and fire prevention and prevention and containment of communicable diseases trainings. There is no evidence to support any staff member sleeping while on duty. Resident S denied witnessing any staff member falling asleep at the home. Ms. Olivares denies sleeping in the home. Mr. Macaraeg denied the midnight staff members sleeping during their shift. Therefore, there is no reason to believe the staff are not providing personal care, supervision or protection for the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.**
ANALYSIS:	I reviewed the schedule for the month of March. The schedule list two staff names for each day, with the exception of 03/26/24 as there was three names listed. The hours or shifts worked for each day was not listed on the schedule. Therefore, it is unclear if one staff member or two staff members worked at the same time or separately. The schedule does not include the job titles of the staff members. Ms. Julian admitted that sometimes she does not complete a staff schedule because the staff know their schedules.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Many residents have developed wounds because they just stay in bed or on the couch. There are no activities provided for the residents.

INVESTIGATION:

On 03/26/24, Ms. Olivares stated the staff facilitate activities with the residents. Ms. Olivares stated currently she is playing bingo with the residents. I observed bingo cards on the dining table where Resident T and two other residents were sitting. However, the two other residents were observed sleeping. Ms. Oliveras stated the staff exercise with the residents twice a day. The staff exercise with the residents at 10:30am to 11:00am and 3:30pm to 4:00pm.

On 03/26/24, Resident T denied playing any games at the AFC group home. Resident T stated she plays games with her daughter when her daughter picks her up from the AFC group home. However, I saw Resident T sitting at the dining table with a bingo card in front of her. Resident T denied having any sores on her buttock. Resident T stated she bathes herself and she does not require any assistance with using the bathroom.

On 03/26/24, I observed Resident C in his bed. Ms. Olivares stated Resident C is non-verbal. Ms. Olivares confirmed that Resident C has bed sores on his body. I observed a large band aid covering the side of Resident C left buttock. Resident C left ankle was wrapped up covering a sore. I also observed Resident C arms to have several dark purplish bruises. Ms. Olivares stated Resident C received the bruises from his recent hospitalization. Resident C was admitted into the hospital on 03/18/24 and discharged on 03/24/24. Ms. Olivares could not explain further how Resident C received the bruises from the hospital.

On 03/26/24, I received a copy of Resident C hospital discharge records. Resident C was admitted on 03/18/24 and discharge on 03/24/24. Resident C was admitted into the hospital with a primary diagnosis of Sepsis. Resident C additional diagnoses were Hypokalemia, recurrent UTI, seizure disorder, toxic metabolic encephalopathy, acute kidney injury, benign prostatic hyperplasia, and peripheral artery disease.

On 03/26/24, I interviewed Resident S. Resident S has lived in the AFC group home for almost a year. Resident S stated there is nothing he doesn’t like about the home. Resident S denied having any bed sores or wounds on his body. Resident S stated the staff make sure he has what he needs as well as the residents. Resident S and Resident C are roommates. Resident S stated Resident C has several health issues and he receives treatment from nurses who come to the home. Resident S stated there has never been a time where Resident C medical needs were not being taking care of.

Resident S stated he exercises twice a day at the home with the staff and the residents. Resident S stated the home provides opportunities to play games but, he chooses not to participate.

On 03/27/24, Ms. Julian stated Resident C passed away this morning as he was placed in hospice following his discharge from the hospital. Ms. Julian stated prior to Resident C hospitalization he was not bed bound as he would exercise with the rest of the residents in the home. When Resident C was discharged from the hospital he was ordered to stay in bed. Ms. Julian denied Resident C having any bed sores or bruises on his arms prior to his hospitalization. Ms. Julian thinks Resident C received the bruises on his arms from the hospital. Ms. Julian could not explain how Resident C received the bruises from the hospital but, she thinks the bruises could have been caused from the hospital giving Resident C injections.

Ms. Julian denies any of the other residents having bed sores. Ms. Julian stated the staff complete a skin check every Saturday for each resident during their bathing time. The skin checks are documented. Ms. Julian agreed to forward a copy of all the skin check forms for the month of March. Ms. Julian stated the daily schedule of the home consist of the residents exercising at 10:30am, lunch at 12:00pm, activities 1:30pm – 2:00pm (bingo, cards), exercise 3:30pm -4:00pm, dinner at 5:00pm, and bedtime is at 7:00pm. The residents do not participate in workshop.

On 03/29/24, I made a telephone call to Resident C's guardian. Regarding the allegations, the guardian stated the allegations are not true. The guardian stated the staff get all the residents up every morning around 7:00am. The residents would then eat breakfast and; then the staff would facilitate a group exercise with all the residents. The staff will also walk with the residents around the home. The residents would then watch T.V, eat lunch, and then play games such as bingo and puzzles. The guardian stated the staff ensured the residents had a structured schedule every day.

The guardian stated for the past six months, Resident C was unable to assist with transferring himself which lead to the staff having to use a hoyer lift. Resident C has lived in the AFC group home for seven years. The guardian stated the AFC group home is always clean and there was never an odor. The guardian would visit the AFC group home every couple of weeks. The guardian stated during her visits, Resident C was always properly groomed, and he looked better than he did when he lived on his own. The guardian stated Resident C would receive sores on his body due to a decrease in activity given his health. When Resident C would sit in his wheelchair his left leg would lean against his right leg which would cause sores. The staff would put a foam pillow between Resident C knees to keep his legs apart. The guardian stated Resident C was not the easiest person to care for but, the staff were very patient with him, and Resident C was friendly with the staff. The guardian stated she would recommend the AFC group home to other people.

The guardian stated the bruises on Resident C's arms were from his hospitalization. The guardian was present with Resident C while he was in the hospital. It is very difficult

for Resident C to receive an IV. The guardian stated Resident C had several IV's in his arms and the hospital staff had to poke him several times within a 48-hour timeframe. The guardian stated every time the hospital staff had to poke Resident C his skin would turn a purplish black color. Resident C has been on blood thinners for over 20 years. The guardian stated about six months ago, Resident C was in the hospital again and that is when he received a bed sore on his hip as he was in the hospital for a while. When Resident C was discharged from the hospital, a wound specialist started to treat him about once a week at the AFC group home. The wound specialist would share Resident C's progress with the guardian.

On 03/29/24, I received skin check forms for the month of March. According to the skin check forms, the residents skin were checked on 03/03/24, 03/10/24, 03/17/24, and 03/24/24. On 03/03/24, all of the residents skin checks were documented as clear except for Resident C as both of his heels were observed to be dry. It was documented to apply lotion three times a day. On 03/10/24, all of the residents skin checks were documented as clear except for Resident R and Resident T. Resident R right hand was observed to be swollen. It was documented that the doctor advised to apply hot compress and monitor condition. Resident T had a small blister on her left foot. It was documented to apply triple antibiotic and monitor. On 03/17/24, all residents skin checks were documented as clear. On 03/24/24, all residents skin checks were documented as clear. A skin check was not completed for Resident C on 03/24/24 as he was being discharged from the hospital on 03/24/24. All of the skin check forms were signed by Eddie Ibarra.

APPLICABLE RULE	
R 400.14317	**Resident recreation.**
	(3) Equipment and materials shall encourage and reinforce all of the following: **(a) Social interaction.**
ANALYSIS:	Ms. Julian stated the daily schedule of the home consist of the residents exercising at 10:30am, lunch at 12:00pm, activities 1:30pm – 2:00pm (bingo, cards), exercise 3:30pm -4:00pm, dinner at 5:00pm, and bedtime is at 7:00pm. Resident C's guardian stated the staff get all the residents up every morning around 7:00am. The residents would then eat breakfast and; then the staff would facilitate a group exercise with all the residents. The staff will also walk with the residents around the home. The residents would then watch TV, eat lunch, and then play games such as bingo and puzzles. The guardian stated the staff ensured the residents had a structured schedule every day.

	Resident S confirmed he exercises twice a day at the home with the staff and the residents. Resident S stated the home provides opportunities to play games but, he chooses not to participate.
CONCLUSION:	VIOLATION NOT ESTABLISHED

R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information gathered, there is no sufficient evidence to support this allegation. Resident T and Resident S denied having any sores and/or wounds on their bodies. Resident C's guardian stated Resident C would receive sores on his body due to a decrease in activity given his health. When Resident C would sit in his wheelchair his left leg would lean against his right leg which would cause sores. The staff would put a foam pillow between Resident C knees to keep his legs apart. Resident C's guardian confirmed that Resident C was receiving care from a wound specialist.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Fire drills are not being completed.

INVESTIGATION:

On 03/26/24, Ms. Olivares stated she has completed a fire drill in the home before, but she does not document the fire drills. Ms. Olivares stated there is an administrative staff that comes to the home during the fire drills and completes the documentation. Ms. Olivares and Mr. Macaraeg do not know where the fire drill records are kept.

On 03/26/24, Resident T stated there have been no fire drills at the AFC group home since she has lived there.

On 03/26/24, Resident S stated fire drills are not practiced in the home.

On 03/27/24, Ms. Julian stated the staff complete fire drills whenever the weather is nice. Ms. Julian also stated the staff complete fire drills every other month.

On 03/29/24, the guardian stated she does not know if the AFC group home conducted fire drills.

On 03/29/24, I received a copy of the fire drill records. According to the fire drills for 2023, there were no fire drills that were conducted during sleeping hours. During the first quarter in 2024, a fire drill was completed in January at 11:00am and a second fire drill completed in February at 4:00pm.

APPLICABLE RULE	
R 400.14318	**Emergency preparedness; evacuation plan; emergency transportation.**
	(5) A licensee shall practice emergency and evacuation procedures during daytime, evening, and sleeping hours at least once per quarter. A record of the practices shall be maintained and be available for department review.
ANALYSIS:	According to the fire drill records for 2023, there were no fire drills that were conducted during sleeping hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

On 03/26/24, I observed a pouch in the refrigerator that contained medication however; the pouch was not locked. Ms. Olivares stated she does not know where the key to the pouch is. I also observed a bottle of Lactulose solution for Resident J in the refrigerator that was not secured in the refrigerator.

On 04/12/24, I completed an exit conference with the licensee designee Iemelif Julian via telephone. Ms. Julian confirmed that Eddie Ibarra legal name is Edgardo Ibarra. Ms. Julian stated the email that was sent to me on 04/03/24, was from her secretary Alexandria Smith on her behalf. Ms. Julian could not explain why Ms. Smith stated Ms. Agapito no longer works for the company. Ms. Julian stated Ms. Agapito is currently on vacation. It was explained to Ms. Julian that Ms. Agapito cannot return to work until she completes a workforce background clearance. Ms. Julian was advised on which allegations were substantiated and that a corrective action plan will be required.

R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a

	licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being §333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	The medication observed in the refrigerator was not locked or secured in the refrigerator.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 04/03/24, I received an email from the licensee designee Iemelif Julian email address. The email stated that Feliciana Agapito did not complete her background check as she left the company before it could be completed.

MCL 400.713(3)	**License required; application; forms; investigation; on-site evaluation; issuance or renewal of license; disclosures; maximum number of persons; stating type of specialized program; issuance of license to specific person at specific location; transferability of license; sale of facility; notice; items of noncompliance; refusal by department to issue or renew license; conditions; unlicensed facility; violation as misdemeanor; penalty; receipt of completed application; issuance of license within certain time period; inspections; report; criminal history and records check; storage of fingerprints in automated fingerprint identification system database; convictions; "completed application" defined.**
	(3) Before issuing or renewing a license, the department shall investigate the activities and standards of care of the applicant and shall make an on-site evaluation of the facility. On-site inspections conducted in response to the application may be conducted without prior notice to the applicant. On-site inspections conducted for renewing a license may be conducted within 12 months before the expiration date of the current license without impact on the license renewal date or the license fee. Subject to subsections (9), (10), and (11), the department shall issue or renew a license if satisfied as to all of the following:

	e. The good moral character of the licensee or licensee designee, owner, partner, director, and person responsible for the daily operation of the facility. The applicant is responsible for assessing the good moral character of the employees of the facility. The person responsible for the daily operation of the facility shall be not less than 18 years of age.
ANALYSIS:	An email that was received from the licensee designee Iemelif Julian stated a background clearance was not completed for staff member Feliciana Agapito.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

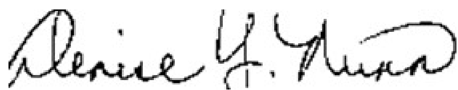
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

04/12/24

Sheena Worthy
Licensing Consultant

Date

Approved By:



05/03/2024

Denise Y. Nunn
Area Manager

Date