GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 18, 2024

Cheryl Thomas-Hardy
PO Box 4317
Saginaw, MI 48606

| RE: License #: | AS730354102 |
| --- | --- |
| Investigation #: | 2024A0872036 |
| | Iowa's Place |

Dear Cheryl Thomas-Hardy:

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 (517) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222


enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS730354102 |
| | |
| **Investigation #:** | 2024A0872036 |
| | |
| **Complaint Receipt Date:** | 04/22/2024 |
| | |
| **Investigation Initiation Date:** | 04/22/2024 |
| | |
| **Report Due Date:** | 06/21/2024 |
| | |
| **Licensee Name:** | Cheryl Thomas-Hardy |
| | |
| **Licensee Address:** | 4462 E. Lakecress Drive<br>Saginaw, MI 48603 |
| | |
| **Licensee Telephone #:** | (989) 737-4010 |
| | |
| **Administrator:** | Cheryl Thomas-Hardy |
| | |
| **Licensee Designee:** | Cheryl Thomas-Hardy |
| | |
| **Name of Facility:** | Iowa's Place |
| | |
| **Facility Address:** | 2308 Iowa<br>Saginaw, MI 48601 |
| | |
| **Facility Telephone #:** | (989) 737-4010 |
| | |
| **Original Issuance Date:** | 05/14/2014 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 11/14/2022 |
| | |
| **Expiration Date:** | 11/13/2024 |
| | |
| **Capacity:** | 5 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established?** |
|---|---|
| On 04/18/24, Resident A was observed with a bruise under his right eye, going down his cheek, bruising and bleeding of his nose, bruising on both sides of his neck, left ear was swollen and his left hand was swollen and bruised. Licensee designee said he tripped over his walker and fell on 04/15/24 and 04/18/24. Resident A was transported to the hospital and said, "That lady beat me up" indicating the licensee designee. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 04/22/2024 | Special Investigation Intake<br>2024A0872036 |
| 04/22/2024 | Special Investigation Initiated - Letter<br>I made an APS complaint via email |
| 04/22/2024 | APS Referral<br>I made an APS complaint |
| 04/23/2024 | Contact - Document Sent<br>I exchanged emails with APS Worker, Rebecca Robelin |
| 05/09/2024 | Inspection Completed On-site<br>Unannounced |
| 05/13/2024 | Contact - Document Received<br>I exchanged emails with APS Robelin |
| 06/10/2024 | Contact - Document Received<br>AFC documentation received from LD Hardy-Thomas |
| 06/17/2024 | Contact - Telephone call made<br>I spoke to Guardian A1 |
| 06/18/2024 | Inspection Completed-BCAL Sub. Compliance |
| 06/18/2024 | Exit Conference<br>I conducted an exit conference with LD Thomas-Hardy |

**ALLEGATION: On 04/18/24, Resident A was observed with a bruise under his right eye, going down his cheek, bruising and bleeding of his nose, bruising on both sides of his neck, left ear was swollen and his left hand was swollen and bruised. Licensee designee said he tripped over his walker and fell on 04/15/24 and 04/18/24. Resident A was transported to the hospital and said, "That lady beat me up" indicating the licensee designee.**

**INVESTIGATION:** On 05/09/24, I conducted an unannounced onsite inspection of Iowa's Place Adult Foster Care facility. I interviewed staff Jonathon Hardy, the licensee designee (LD), Cheryl Thomas-Hardy, and Residents B, C, and D. I interacted with Resident E and obtained AFC paperwork related to this complaint. Resident A was not at the facility and LD Thomas-Hardy said he would not be returning.

Resident B said that she moved into this facility in April 2024. She said that she does not know Resident A and does not think she ever met him. I asked her if she has any concerns about staff treatment of the residents and she said no. Resident B said that all the staff is "nice," none of the staff has ever mistreated her or yelled at her and she has never seen or heard any staff mistreat any of the residents.

Resident C said that she has been at this facility "for a long time." She said that she remembers Resident A and said that he used to bother her. Resident C told me that Resident A was "noisy and he would wake me up." I asked Resident C if she ever saw any of the staff or any of the other residents physically harm Resident A or any of the other residents and she said no. She said that the staff are "good", and she likes living here.

Resident D said that he just moved into this a few days ago. He said that he shares a room with Resident E. Resident D told me that he likes this AFC home because things are "quiet." Resident D said that his last AFC home was "chaotic", and everyone used to yell a lot. Resident D told me that he never met Resident A and he has not heard anything about him. I asked Resident D if any of the staff have been verbally or physically abusive and he said no. He said that he gets along "okay" with his roommate and he does not have any concerns.

I observed Resident E who was in the bedroom with Resident D. Resident E is basically non-verbal and did not answer any of my questions. Resident E was clean, dressed appropriately, and was properly supervised by staff.

Staff Hardy confirmed that Resident A resided at this facility until recently. Staff Hardy said that while a resident of Iowa's Place AFC, Resident A's mental condition declined, and his behaviors increased. Staff Hardy said that Resident A began experiencing a lot of falls and injuries. Most recently, Resident A was outside, and he tried to get up out of his chair. Resident A fell and bruised his eye. Later that night, Resident A got up out of bed, tripped over his walker and bruised his ear. Staff Hardy said that Resident A's case manager came over the next morning, saw the bruises and called an ambulance,

transporting Resident A to the hospital. Staff Hardy said that none of the staff or residents ever physically assaulted Resident A.

LD Thomas-Hardy said that Resident A was admitted to her facility in 2023. LD Thomas-Hardy said that in January 2024, his doctor changed his medications which caused his behavior to become “strange.” LD Thomas-Hardy said that in addition to exhibiting strange behaviors, Resident A also began experiencing a lot of falls and injuries. Resident A was in and out of the hospital on several occasions since January 2024 and he became harder to care for. According to LD Thomas-Hardy, on 04/15/24, Resident A flipped out of his wheelchair and fell, injuring his eye. A couple days later, she found him in his room, on the floor. On that occasion, he suffered a swollen ear. LD Thomas-Hardy said that on 04/18/24, Resident A’s case manager came to see him and when she saw his injuries, she called an ambulance and had him transported to the hospital. LD Thomas-Hardy said that she served Resident A with a 30-day discharge notice, and Resident A will not be returning to her facility because his level of care is too much for her staff to handle.

On 04/23/24, I exchanged emails with APS Worker, Rebecca Robelin. APS Robelin said that Resident A gave several different versions of how he received the injuries that caused him to be hospitalized and she is not able to determine exactly what happened.

On 05/13/24, I interviewed Guardian A1 via telephone. Guardian A1 confirmed that Resident A resided at Iowa’s Place AFC for over a year. Guardian A1 said that Resident A has been in AFC placements for years. Guardian A1 said that Resident A suffers from mental health issues, and he displays problematic behaviors. According to Guardian A1, while Resident A resided at Iowa’s Place AFC, his psychiatrist began changing his medications which caused Resident A to begin “acting strange.” Guardian A1 said that Resident A began exposing himself in public and to other people. His speech also became incoherent, and he was not directable. Guardian A1 said that LD Thomas-Hardy served Resident A with a 30-day discharge notice, but his behaviors started becoming normal, so she let him stay. However, Resident A began having problems again and he was in and out of the hospital, so LD Thomas-Hardy implemented the 30-day discharge notice again because she was having problems caring for him.

According to Guardian A1, LD Thomas-Hardy was “the best placement for him.” Guardian A1 said that LD Thomas-Hardy was patient with Resident A, and he feels she did her best to care for him. Whenever there were issues, LD Thomas-Hardy always notified him and made sure she communicated any concerns. Guardian A1 said that in April 2024, LD Thomas-Hardy sent him pictures of Resident A, telling him that Resident A had some unexplained bruises. Guardian A1 said that Resident A had bruising around his face and his ears. Resident A was transported to the hospital due to his injuries and he is still there because no other AFCs and no nursing homes will accept him into their facilities because of his behaviors.

Guardian A1 said that Resident A has a history of self-harm. Resident A scratches himself until he bleeds. Resident A has low hemoglobin and bruises easily. Guardian A1

said that Resident A also sticks his fingers in his bottom and then puts his feces covered fingers in his ears. Because of this, Resident A often has ear infections and swollen ears. Guardian A1 told me that while in the hospital, Resident A has continued putting his feces covered fingers in his ears, so hospital staff have put mittens on his hands to stop him from doing so. Guardian A1 told me that Resident A is still incoherent, and he is not able to communicate effectively with hospital staff or with Guardian A1.

Guardian A1 said that when Resident A was admitted to the hospital, he had numerous marks on his face and neck. Resident A's left ear was also swollen and bruised. Guardian A1 said that when Resident A was first questioned about his injuries, he said, "that lady beat me." When asked again, Resident A said that a man beat him. When he was asked a third time, he said that he was beat with a baseball bat. Guardian A1 told me that he does not believe that LD Thomas-Hardy or any of the staff physically harmed Resident A in any way. He said that he believes that most of Resident A's injuries are self-inflicted. Guardian A1 also said that since Resident A had a history of exposing himself to Resident C, she may have gotten angry at him and hit him. Guardian A1 said that he feels Resident A received good care while a resident of Iowa's Place AFC. Guardian A1 agreed to send me pictures of Resident A's injuries.

On 05/13/24, I exchanged emails with APS Robelin. She said that she has concluded her investigation. She said that she did not substantiate against LD Thomas-Hardy or any of the staff and ended up substantiating "unknown perpetrator" due to Resident A's injuries.

On 05/14/24, I reviewed several photographs of Resident A sent to me by Guardian A1. The photos showed Resident A's face, arm, and ear. Resident A had significant bruising under his left eye and down his face. Resident A also had a significantly swollen left ear and bruises on his neck.

On 06/12/24, I reviewed AFC paperwork related to this complaint. Resident A was admitted to this facility on 02/03/23 and was discharged on 04/26/24. According to Resident A's Health Care Appraisal, he is diagnosed with schizophrenia, intellectual disabilities, hypertension, prediabetes, hyperlipidemia, and seborrheic keratosis with vermicide features (skin growths). Resident A's Assessment Plan states that he "is always trying to hurt himself to get attention." Resident A requires staff assistance with eating/feeding, showering, dressing, and personal hygiene. Resident A wears briefs but does not know how to put them on himself and he requires staff assistance with wiping his bottom after using the bathroom. Resident A understands verbal communication and follows instructions "when he wants to."

I reviewed numerous Incident/Accident Reports (IR) related to Resident A. The first IR dated 02/27/24 at 3am by LD Thomas-Hardy. It stated, "(Resident A) was messing around in his dresser, pulled the whole drawer out. He (was) yelling ouch, clothes, and drawer both on floor." The action taken by staff was, "Checked both feet, right foot red mark, no bleeding, looked a little red." The corrective measures taken by staff were,

“We took everything out of (his) room, clothes, bedding off other bed. He’s messing around getting into everything since medication change Jan 30th, 2024.”

The next IR dated 03/22/24 was completed by LD Thomas-Hardy. It stated, “Was giving (Resident A) a shower, went to get more body wash, came back (he) was urinating in tub and bleeding from top of head.” The action taken by staff was, “Called 911, grabbed a towel and put pressure on it to his head.” No corrective measures were listed.

According to the IR dated 04/15/24 completed by LD Thomas-Hardy, “We were coming in to eat dinner. (He) flipped over in his wheelchair. He was asked to sit until I took (another resident) in first. (Resident A) walked in and stated he fell. The actions taken by staff were, “Checked for bruises, he was getting a black eye asked was he hurting or had any pain he said no. His right eye was swelling up.” No corrective measures were listed.

I reviewed an IR dated 04/18/24 completed by LD Thomas-Hardy regarding Resident A. According to this document, “I heard him, went into room, he’s on the floor under his walker, covers everywhere, he fell somehow when he got out of bed.” The actions taken by staff were, “Helped him up. Cleaned him up. His nose bled a little, checked for bruise. Legs red a little but might be from Monday’s fall.” No corrective measures were listed.

On 06/17/24, I spoke to Guardian A1 via telephone. According to Guardian A1, approximately one week ago Resident A was placed at Medilodge in Frankenmuth, Michigan. Guardian A1 said that Resident A’s mental status has steadily declined. Resident A no longer recognizes family members, and he is not able to carry on a conversation. Resident A has been diagnosed with psychosis, schizophrenia, and severe dementia.

According to Guardian A1, after leaving Iowa’s Place AFC, Resident A remained in the hospital for several days. Resident A was discharged to a nursing home but he only lasted 1.5 days after which time he was evicted due to staff not being able to care for him. While at the nursing home, Resident A fell and bruised his face. Resident A was again sent to the hospital and no placements would accept him, so he stayed in the hospital for several weeks. While there, Resident A continually tried getting out of bed, exposing himself, and trying to go in other patient’s room. The hospital eventually had to assign someone to sit with him 24/7 and they also placed an alarm on his bed, so they knew if he tried to get up.

Guardian A1 said that Resident A was eventually accepted to another AFC facility in Pinconning, Michigan. Resident A was there for only 5 days and they “kicked him out” because they could not take care of him. While living at that AFC home, Resident A fell more than once, causing injuries to his face. When Resident A was discharged from there, Resident A went back to the hospital. Resident A remained in the hospital for another week and was interviewed by Caro inpatient hospital as well as other AFC facilities and they were unable to find a placement for him. Resident A was finally

accepted into Medilodge where he remains. Guardian A1 said that yesterday, staff at Medilodge called to tell him that Resident A fell, reinjuring his face.

Guardian A1 told me that he does not believe that anyone at Iowa's Place deliberately harmed Resident A in any way. He said that Resident A has received numerous injuries, often to his face, and due to low hemoglobin levels, he bruises quickly and severely.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14308** | **Resident behavior interventions prohibitions.** |
| | **(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.** |
| **ANALYSIS:** | Residents B, C, D, and E said that they have never seen any of the staff being physically abusive to any of the residents.<br><br>The licensee designee, Cheryl Thomas-Hardy and staff Jonathon Hardy said that none of the staff have ever been physically abusive toward Resident A or any of the residents.<br><br>Guardian A1 said that he does not believe that LD Thomas-Hardy or any other individuals were physically abusive toward Resident A.<br><br>I conclude that there is insufficient evidence to substantiate this rule violation. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:** According to the IR dated 04/15/24 completed by LD Thomas-Hardy, "We were coming in to eat dinner. (He) flipped over in his wheelchair. He was asked to sit until I took (another resident) in first. (Resident A) walked in and stated he fell. The actions taken by staff were, "Checked for bruises, he was getting a black eye asked was he hurting or had any pain he said no. His right eye was swelling up." No corrective measures were listed.

I reviewed an IR dated 04/18/24 completed by LD Thomas-Hardy regarding Resident A. According to this document, “I heard him, went into room, he’s on the floor under his walker, covers everywhere, he fell somehow when he got out of bed.” The actions taken by staff were, “Helped him up. Cleaned him up. His nose bled a little, checked for bruise. Legs red a little but might be from Monday’s fall.” No corrective measures were listed.

On 05/13/24, I conducted an unannounced onsite inspection of Iowa’s Place AFC. According to the licensee designee, Cheryl Thomas-Hardy, and staff Jonathon Hardy, on 04/15/24 Resident A tripped over his walker, bruising his eye. During the early morning hours of 04/18/24, Resident A fell in his bedroom, injuring his ear. LD Thomas-Hardy and Staff Hardy said that they did not seek outside medical attention for Resident A.

On 05/14/24, I reviewed several photographs of Resident A sent to me by Guardian A1. The photos showed Resident A’s face, arm, and ear. Resident A had significant bruising under his left eye and down his face. He also had a significantly swollen left ear and bruises on his neck.

On 04/18/24, I conducted an exit conference with the licensee designee, Cheryl Thomas-Hardy. I discussed the results of my investigation and told her which rule violation I am substantiating. LD Thomas-Hardy told me that the only reason she did not send Resident A to the hospital after his fall is because his guardian asked her not to. We discussed her responsibility to seek medical attention under this rule and she agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14310** | **Resident health care.** |
| | **(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.** |
| **ANALYSIS:** | On 04/15/24, Resident A fell while outside and received an injury to his eye. During the early morning hours of 04/18/24, Resident A fell and received an injury to his ear.<br><br>LD Thomas-Hardy did not seek medical attention for Resident A’s injuries until 04/18/24 at which time his case manager called 911 and had him transported to the hospital. |

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|---|---|
| | I reviewed several photographs of Resident A sent to me by Guardian A1. The photos showed Resident A's face, arm, and ear. Resident A had significant bruising under his left eye and down his face. He also had a significantly swollen left ear and bruises on his neck.<br><br>I conclude that there is sufficient evidence to substantiate this rule violation. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

Susan Hutchinson June 18, 2024

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|---|---|
| Susan Hutchinson<br>Licensing Consultant | Date |

Approved By:

Mary Holton June 18, 2024

| | |
|---|---|
| Mary E. Holton<br>Area Manager | Date |