GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 28, 2024

Robert Gulley
606 E High Street
Ishpeming, MI 49849

RE: License #: AF520379592
Investigation #: 2024A0873017
High Street Assist Living

Dear Mr. Gulley:

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 (616) 356-0100.

Sincerely,

Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(906) 250-9318

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF520379592
Investigation #:	2024A0873017
Complaint Receipt Date:	05/06/2024
Investigation Initiation Date:	05/06/2024
Report Due Date:	07/05/2024
Licensee Name:	Robert Gulley
Licensee Address:	606 E High Street Ishpeming, MI 49849
Licensee Telephone #:	(906) 204-4378
Licensee Designee:	Terry Peterson
Name of Facility:	High Street Assist Living
Facility Address:	606 E High Street Ishpeming, MI 49849
Facility Telephone #:	(906) 204-4378
Original Issuance Date:	10/21/2016
License Status:	REGULAR
Effective Date:	05/28/2023
Expiration Date:	05/27/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A had unsupervised access to his own medication.	No
Additional Findings	Yes

III. METHODOLOGY

05/06/2024	Special Investigation Intake 2024A0873017
05/06/2024	APS Referral Referred by APS
05/06/2024	Special Investigation Initiated - Telephone Interview with APS Bohen
05/13/2024	Inspection Completed On-site
05/13/2024	Contact - Face to Face Interview with licensee Gulley and responsible person Peterson
05/13/2024	Contact - Telephone call made Call to SW Morgan, no answer
06/19/2024	Contact - Telephone call made Call to SW Morgan, no answer
06/24/2024	Inspection Completed On-site
06/24/2024	Contact - Face to Face Interview with responsible person Peterson
06/25/2024	Inspection Completed-BCAL Full Compliance
06/25/2024	Exit Conference With licensee Gulley

ALLEGATION:

Resident A had unsupervised access to his own medication.

INVESTIGATION:

On 5/3/24, I received a referral from adult protective services regarding Resident A. The complaint alleged that Resident A was found on the floor of the home, unresponsive, on the morning of 5/2/24. Resident A was transported to the hospital.

On 5/6/24, I interviewed adult protective services worker Christina Bohen. Ms. Bohen reported that Resident A was referred to High Street as an emergency admission. Licensee Robert Gulley picked Resident A up from the hospital and brought him to the home. Resident A left the hospital in possession of his own medication. Later, at the home, Resident A swallowed all of his medications in an attempt to kill himself. He was found unresponsive on the floor by the home's responsible person, Terry Peterson.

On 5/13/24, I interviewed licensee Robert Gulley and responsible person Terry Peterson at the home. Mr. Gulley reported that he had been in contact with the social worker a couple days before Resident A's discharge and had been expecting paperwork to arrive by email. On the day that Mr. Gulley picked Resident A up from the hospital the paperwork had still not arrived but Resident A was discharged. Licensee Gulley took Resident A to the home and at least twice asked Resident A if he had been discharged with any medications. Resident A denied he had been discharged with medications. Mr. Peterson also reported that he had separately asked Resident A about his medications and Resident A reported that he did not have any. Resident A appeared normal, ate breakfast at the home, had lunch outside the home, and came back but did not eat dinner. Mr. Peterson found Resident A the next morning, unresponsive, on his bedroom floor. Resident A was taken the hospital.

On 6/24/24, I conducted an interview with Mr. Peterson at the home who confirmed that Resident A is not living there. He was unsure of Resident A's whereabouts. Mr. Peterson reiterated that on several occasions, both he and Mr. Gulley asked Resident A about his medications and each time Resident A reported he did not have any. Mr. Peterson told me Resident A seemed like a good person and he is disappointed it didn't work out.

On 6/24/24, I interviewed Ms. Bohen to confirm that the hospital allowed Resident A to leave the hospital with Mr. Gulley with his medications in his personal possession. During the course of this investigation, I was unsuccessful in contacting the hospital social worker but Ms. Bohen reported to me that the hospital social worker told her that Resident A was in possession of medications that day he was discharged to the care of Mr. Gulley.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise, all the giving, taking, or application of prescription medications shall be supervised by the licensee or responsible person.
ANALYSIS:	After interviewing Mr. Gulley, Mr. Peterson, and Ms. Bohen, I find no evidence that the home was neglectful in their medication duties, taking Resident A at his word that he was not prescribed or given any medications upon discharge from the hospital.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

Mr. Gulley stated that the hospital social worker contacted him about having Resident A return to the home. Mr. Gulley refused the admission on account of Resident A's suicide attempt. Mr. Gulley stated he returned Resident A's cashier's check for rent for the month.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria;**
	(14) A licensee who discharges a resident pursuant to subrule (13) of this rule shall notify the resident's designated representative and responsible agency within 24 hours before discharge. Such notification shall be followed by a written notice to the resident's designated representative and responsible agency stating the reasons for discharge.
ANALYSIS:	The homes refusal to allow Resident A to return was essentially a discharge from the home that was not consistent with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/25/24, I explained the findings of this report to Mr. Gulley. Mr. Gulley explained again that he had had several meetings with the hospital social worker leading up to the discharge and he was supposed to received discharge paperwork from her but never did. He assumed Resident A would have the discharge paperwork upon

release, which he did not. At that point Mr. Gulley assumed the paperwork would be in his email when he got home. In the future Mr. Gulley will insure he receives discharge paperwork before admission.

On 6/28/24, I contacted the licensee through email to explain the additional finding and requirement for a corrective action plan.

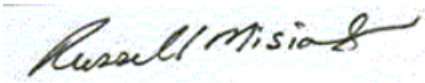
IV. RECOMMENDATION

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

6/28/24

Garrett Peters Date
Licensing Consultant

Approved By:



6/26/24

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Russell B. Misiak Date
Area Manager