GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 17, 2024

Marion Mustar
1568 E. Beaver Rd.
Kawkawlin, MI 48631

RE: License #: AF090299125
Investigation #: 2024A0576049
M & M Adult Foster Care

Dear Marion Mustar:

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,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF090299125
Investigation #:	2024A0576049
Complaint Receipt Date:	08/26/2024
Investigation Initiation Date:	08/28/2024
Report Due Date:	10/25/2024
Licensee Name:	Marion Mustar
Licensee Address:	1568 E. Beaver Rd. Kawkawlin, MI 48631
Licensee Telephone #:	(989) 671-8906
Name of Facility:	M & M Adult Foster Care
Facility Address:	1568 E. Beaver Rd. Kawkawlin, MI 48631
Facility Telephone #:	(989) 671-8906
Original Issuance Date:	02/25/2009
License **Status:**	REGULAR
Effective Date:	08/27/2023
Expiration Date:	08/26/2025
Capacity:	5
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
On 8/20/24, Resident A had a fall in the shower and went unchecked by staff for over an hour.	No
Additional Findings	Yes

III. METHODOLOGY

08/26/2024	Special Investigation Intake 2024A0576049
08/26/2024	APS Referral
08/28/2024	Special Investigation Initiated - Letter Reviewed Incident Report (IR)
08/29/2024	Contact - Document Sent Sent email to Julie Anderson, Adult Protective Services (APS)
09/03/2024	Contact - Document Received Received email from Julie Anderson
09/10/2024	Inspection Completed On-site Interviewed Licensee, Marianne Muster and Resident A
09/16/2024	Contact - Telephone call made Interviewed Peter, Case Manager Saginaw Psychological
09/16/2024	Contact - Telephone call made Interviewed Staff, Lynette Lawler
09/17/2024	Exit Conference

ALLEGATION:

On 8/20/24, Resident A had a fall in the shower and went unchecked by staff for over an hour.

INVESTIGATION:

On August 28, 2024, I reviewed an AFC Licensing Division Incident / Accident Report (IR) dated for August 25, 2024, and authored by Licensee, Marion Mustar. The IR documented that on August 20, 2024, Resident A was in the shower and the shower

mat was not down. Resident A slipped in the shower and bumped her face causing some swelling and discoloration time passed. Staff checked on Resident A while in the shower however they were not aware that she fell. Resident A was given some Tylenol and an ice pack for the injury. Corrective measures include putting the mat down in the shower and staying with Resident A the time she is in the shower.

On August 29, 2024, I sent an email to Julie Anderson, Bay County Adult Protective Services (APS) Investigator. On September 3, 2024, Investigator Anderson confirmed she is investigating the matter involving Resident A. Investigator Anderson interviewed staff, and two residents (including Resident A). Resident A is very quiet and did not say a lot. She is not afraid of staff, feels safe and well cared for. Investigator Anderson denied concerns of abuse or neglect.

On September 10, 2024, I conducted an unannounced on-site inspection at M&M Adult Foster Care and interviewed Licensee, Marianne Muster. Licensee Muster reported Resident A has lived at the home since April 2024, and she presents no behavior issues. Resident A has a history of drug use including overdose causing loss of some function including limited speech. Resident A can answer yes and no, and it is otherwise hard for her to get words out. Licensee Muster explained that Resident A does not require assistance in the shower. Resident A can walk and wash herself and her hair. Regarding the allegations, Staff Lynette Lawler was at the home supervising the residents while Licensee Muster was out of the home. No one heard Resident A fall and she did not call for help or scream. Resident A took a shower, got dressed, and did not report anything. Resident A's Case Manager, Peter Dutcher came to the home about a half hour after Resident A got out of the shower and he noticed bruising to Resident A's face. Case Manager Dutcher told Staff Lawler about the injury to Resident A. Resident A uses a lot of shampoo, and the shower can be slippery. There is a bathmat for residents to use when they shower however staff did not put the mat on the shower floor before Resident A took a shower. According to Licensee Muster, Case Manager Dutcher initially reported that Resident A fell in the shower. Upon learning of Resident A's fall, she was provided Tylenol and an ice pack for swelling.

On September 10, 2024, I interviewed Resident A. Resident A was in her bedroom and watching television. Resident A appeared clean, was wearing clean clothing, and did not appear to be under any duress. Resident A was interviewed, and her speech was slow and somewhat difficult to understand. Resident A was able to respond to yes or no questions. Resident A was asked if she liked her home and she confirmed she did. Resident A confirmed that staff treat her well. The allegations were discussed with Resident A and she confirmed that she fell in the shower and that it is slippery in the shower. Nothing hurt when Resident A fell, and she did not tell anyone that she fell. Resident A confirmed she had a bruise on her face from the fall and she denied someone hit her causing the bruise.

On September 10, 2024, I viewed Resident A's Health Care Appraisal and AFC Assessment Plan. The assessment plan indicated Resident A is 41-years old. Resident A is alert to her surroundings, understands verbal communication, and can

communicate her needs. Resident A does not require assistance with toileting, bathing, grooming, dressing, personal hygiene, or walking.

While at the home, I viewed the shower area, which had just been used by a resident. The shower was wet and very slippery. There was no non-skid surfacing installed.

On September 16, 2024, I interviewed Peter Dutcher, Resident A's Case Manager from Saginaw Psychological. Case Manager Dutcher reported that he came to visit with Resident A and noticed swelling to Resident A's face. Resident A was not very clear as to what happened as she struggles with communication due to a stroke. Resident A can answer yes or no, and Case Manager Dutcher asked Resident A if she fell, and she said yes. Case Manager Dutcher asked Resident A if anyone hit her, and she denied. Case Manager Dutcher stated Resident A had taken a shower on the day he came to visit her, and she may have gotten out of the shower shortly before he arrived because Resident A's hair was still wet. Case Manager Dutcher reported that Resident A has lived at the home since April 2024, and he has no concerns with staff hitting or otherwise mistreating residents. Case Manager Dutcher reported that M&M AFC Home is one of the better run homes he is familiar with.

On September 16, 2024, I interviewed Staff, Lynette Lawler. Staff Lawler reported that Resident A was taking a shower, and she was "in and out" checking on her. Resident A got out of the shower and Staff Muster was helping her dry her hair. Staff Muster did not notice any injury to Resident A and Resident A did not report that she fell. After Resident A got out of the shower and dressed, she went to eat breakfast. About 15 minutes later, Resident A's case manager came to speak with Resident A. The case manager notified Staff Muster that Resident A had swelling under her right eye and Staff Muster viewed swelling to the right side of her face. Staff Muster asked Resident A if she fell, and she confirmed she did.

APPLICABLE RULE	
R 400.1412	**Resident behavior management; prohibitions.**
	(1) A licensee shall not mistreat or permit the mistreatment of a resident by responsible persons or other occupants of the home. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk of physical or emotional harm.
ANALYSIS:	It was alleged that Resident A fell in the shower and was left unchecked for over an hour. Upon conclusion of investigative interviews and a review of documentation, there is not a preponderance of evidence to conclude a rule violation.

	On August 20, 2024, Resident A fell in the shower unbeknownst to staff and Resident A did not tell anyone she fell. Resident A was interviewed and confirmed she fell in the shower and denied anyone harmed her. Staff, Lynette Lawler reported she checked on Resident A while she was showering at least 3 times and was not aware she fell. Staff Lawler became aware of Resident A falling from Resident A's case manager who noticed some swelling to Resident A's face when he arrived at the home to visit her. According to Resident A's AFC Assessment Plan, Resident A does not require any assistance with showering. There is not a preponderance of evidence to conclude Resident A was mistreated by staff.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On September 10, 2024, I conducted an unannounced on-site inspection at M&M Adult Foster Care. I viewed the shower area, which had just been used by a resident. The shower was wet and very slippery. There was no non-skid surfacing installed.

On September 19, 2024, I conducted an exit conference with Licensee, Marion Muster. I advised Licensee Muster I would be requesting a corrective action plan for the cited rule violation. Licensee Muster reported she ordered non-stick surfacing for the shower and will be installing them.

APPLICABLE RULE	
R 400.1426	**Maintenance of premises.**
	(9) Handrails and nonskid surfacing shall be installed in showers and bath areas.
ANALYSIS:	On September 10, 2024, I conducted an unannounced on-site inspection at M&M Adult Foster Care. I viewed the shower area. There was no non-skid surfacing installed.
CONCLUSION:	**VIOLATION ESTABLISHED**

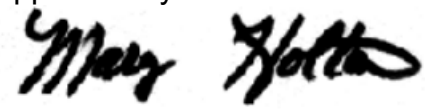
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change to the license status is recommended.

9/17/2024

Christina Garza Date
Licensing Consultant

Approved By:



9/17/2024

Mary E. Holton Date
Area Manager