GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 19, 2024

Thomas Hart
Independent Living Solutions, LLC
2786 Cecelia Street
Saginaw, MI 48602

RE: License #: AS730285023
Investigation #: 2024A0580046
Saginaw Valley AFC

Dear Thomas Hart:

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,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730285023
Investigation #:	2024A0580046
Complaint Receipt Date:	08/07/2024
Investigation Initiation Date:	08/07/2024
Report Due Date:	10/06/2024
Licensee Name:	Independent Living Solutions, LLC
Licensee Address:	2786 Cecelia Street Saginaw, MI 48602
Licensee Telephone #:	(989) 752-6142
Administrator:	Thomas Hart
Licensee Designee:	Thomas Hart
Name of Facility:	Saginaw Valley AFC
Facility Address:	2786 Cecelia Saginaw, MI 48602
Facility Telephone #:	(989) 752-6143
Original Issuance Date:	01/31/2007
License Status:	REGULAR
Effective Date:	08/26/2023
Expiration Date:	08/25/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
AFC staff neglected to take Resident A to dialysis to treat kidney failure on Saturday, 08/03/2024. Resident A has been consistently going to dialysis on Tuesdays, Thursdays, and Saturdays.	Yes

III. METHODOLOGY

08/07/2024	Special Investigation Intake 2024A0580046
08/07/2024	Special Investigation Initiated - Telephone Call to the complainant.
08/16/2024	Inspection Completed On-site Unannounced onsite inspection.
08/22/2024	Contact - Telephone call made Call to Licensee designee, Tom Hart.
08/26/2024	Contact - Document Received Documents requested received via email.
09/16/2024	Contact - Telephone call made Call to staff, Lacresha Burt-Parker.
09/16/2024	Contact - Telephone call made Call to Emily Burke, TTI Case Mgr for Resident A.
09/16/2024	Contact - Telephone call made Call to Chelene Scott, Home Manager.
09/17/2024	Contact - Telephone call received Call from staff, Lashonda Fenn.
09/18/2024	Contact - Telephone call made Call to Fresenius Kidney Care, Saginaw, MI.
09/18/2024	Contact - Telephone call made Call to Ashley Thornton-Conway, Clinical Supervisor, TTI.

09/18/2024	Contact - Telephone call received Call from Emily Burke, TTI Case Mgr for Resident A.
09/19/2024	Contact - Telephone call made Call to Licensee Hart.
09/19/2024	Exit Conference Exit conference with Licensee Hart.

ALLEGATION:

Reported that the AFC staff neglected to take Resident A to dialysis to treat kidney failure on Saturday, 08/03/2024. Resident A has been consistently going to dialysis on Tuesdays, Thursdays, and Saturdays.

INVESTIGATION:

On 08/07/2024, I received a complaint via BCAL Online Complaints. This complaint was denied by Adult Protective Services for investigation.

On 08/08/2024, I placed a call to the referral source. There was no response.

On 08/16/2024, I conducted an unannounced onsite inspection at Saginaw Valley AFC. Contact was made with direct staff member Willie Scott, who stated that he was not working on 8/3/2024, the day in question, and has no knowledge regarding the allegations.

While onsite, I interviewed Resident A while in his room. Resident A was adequately dressed, while lying on his bed. No concerns regarding his care were noted. Resident A stated on 08/03/2024, staff members, identified as Lashonda Fenn and Lacresha Burt-Parker, forgot to take him to Dialysis. Resident A stated that while most of the home is the staff are good, these 2 staff lie and pick with him all the time. Resident A did not inquire directly with staff Lashonda Fenn and Lacresha Burt- Parker about taking him to dialysis for fear of retaliation.

While onsite, I observed 1 resident sitting in the living room while 2 other residents were observed in their bedrooms.

On 08/22/2024, I spoke with Licensee, Tom Hart, who stated that it was his understanding that Resident A refused to go to dialysis.

On 08/26/2024, I received a copy of the Individual Plan of Service (IPOS) for Resident A, completed by Saginaw Mental Health, effective 01/24/2024, which states that AFC

staff will bring Resident A to and from Dialysis on his routine days weekly. The days of dialysis are Tuesdays, Thursdays and Saturdays.

On 09/16/2024, I spoke with staff, Lacresha Burt-Parker who recalled that on the day in question, Resident A refused to go to dialysis. Staff Burt-Parker stated that admittedly, Staff Burt-Parker did not document Resident A's refusal on the day in question, however, Staff Burt Parker did complete documentation that Resident A refused to go to dialysis. Resident A also signed a document stating that Resident A refused to attend.

On 09/16/2024, I placed a call to Emily Burke, Training and Treatment Innovation (TTI) Case Manager (CM) for Resident A. There was no answer. A voice mail message was left requesting a return call.

On 09/16/2024, I followed-up with Home Manager, Chelene Scott, requesting a copy of the document signed by Resident A, in which Resident A reportedly refused to attend dialysis. Manager Scott retrieved the document, however, she indicated that it is signed and dated 08/10/2024, not 08/03/2024, the date of the missed appointment.

On 09/17/2024, I received a call from staff, Lashonda Fenn, who stated that staff, Lacresha Burt-Parker was assigned to work with Resident A on 08/03/2024, however, to her knowledge, Resident A refused to attend dialysis on that day, which was documented.

On 09/18/2024, I spoke with Marcia Krause, Social Worker (SW) at Fresenius Kidney Care, where Resident A attends dialysis treatment. SW Krause stated that with the exception of Saturday 08/03/2024, Resident A has not missed any of his scheduled dialysis appointments for the month of August. When Resident A came for dialysis the following Tuesday, 08/06/2024, Resident A stated that he did not attend due to staff at the home not having transportation. SW Krause has worked with Resident A two years and knows him well. Resident A has expressed at least one other time that Resident A was not transported to dialysis due to lack of transportation at the home. Resident A has also expressed that there are 2 staff in the home that treat him poorly.

On 09/18/2024, I placed a call to Ashley Thornton-Conway, Clinical Supervisor at TTI. There was no answer. A voice mail message was left requesting a return call from either herself or CM Burke.

On 09/18/2024, I spoke with CM Burke, who stated that on 08/03/2024, Resident A called the crisis line and left several messages, stating that Saginaw Valley AFC staff did not transport him to dialysis. The messages were left over the weekend so on Monday 08/05/2024, she verbally spoke with Resident A who reiterated the claim that he was not taken to dialysis on 08/03/2024.

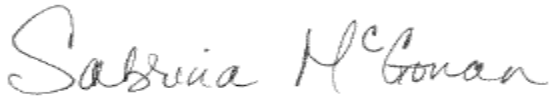
On 09/19/2024, I conducted an exit conference with Tom Hart, Licensee designee. Toma Hart indicated that he understands the need for a violation and will ensure that Resident A is transported to his appointments as required.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	It was reported that the AFC staff neglected to take Resident A to dialysis to treat kidney failure on Saturday 08/03/2024. He has been consistently going to dialysis on Tuesdays, Thursdays, and Saturdays. Resident A stated on 08/03/2024, staff members, identified as Lashonda Fenn and Lacresha Burt- Parker, forgot to take him to Dialysis. Licensee, Tom Hart, stated that it was his understanding that Resident A refused to go to dialysis. The IPOS for Resident A states that AFC staff will bring Resident A to and from Dialysis weekly on his routine days of Tuesdays, Thursdays and Saturdays. Staff, Lacresha Burt-Parker stated that on 08/03/2024, Resident A refused to go to dialysis. Staff Burt-Parker stated that she documented his refusal, which Resident A signed. Home Manager, Chelene Scott, stated that the refusal to attend the appointment document is signed and dated 08/10/2024, not 08/03/2024, the date of the missed appointment. Staff, Lashonda Fenn, stated that staff, Lacresha Burt-Parker was assigned to work with Resident A on 08/03/2024, however, to her knowledge, he refused to attend dialysis on that day. Marcia Krause, Social Worker at Fresenius Kidney Care, stated that with the exception of Saturday 08/03/2024, Resident A has not missed any of his scheduled dialysis appointments for the month of August. The following Tuesday, 08/06/2024, Resident A stated to her that he did not attend dialysis on 08/03/2024 due to staff at the home not having transportation. Emily Burke, Case manager for Resident A, stated that on 08/03/2024, Resident A called the crisis line and left several messages, stating that Saginaw Valley AFC staff did not transport him to dialysis. CM Burke also verbally spoke with

	Emily Burke, Case manager for Resident A, stated that on 08/03/2024, Resident A called the crisis line and left several messages, stating that Saginaw Valley AFC staff did not transport him to dialysis. CM Burke also verbally spoke with Resident A who reiterated the claim that he was not taken to dialysis on 08/03/2024. Based on the interviews conducted with Saginaw Valley AFC staff, Licensee Tom Hart, Resident A, Marcia Krause, Social Worker at Fresenius Kidney Care, and Emily Burke, Case Manager, and a review of the IPOS for Resident A, there is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

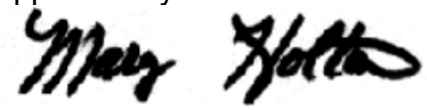
Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.



September 19, 2024

Sabrina McGowan — Date
Licensing Consultant

Approved By:



September 19, 2024

Mary E. Holton — Date
Area Manager