

GRETCHEN WHITMER GOVERNOR STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

MARLON I. BROWN, DPA DIRECTOR

September 17, 2024

Joyce Peterson 60407 M43 Highway Bangor, MI 49013

RE: License #: AS800362293 Investigation #: 2024A1031044 Joyful Living

Dear Ms. Peterson:

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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) 356-0183.

Sincerely,

Kristy Duda, Licensing Consultant Bureau of Community and Health Systems Unit 13, 7th Floor 350 Ottawa, N.W. Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS800362293
Investigation #:	2024A1031044
Complaint Receipt Date:	06/26/2024
Investigation Initiation Date:	06/26/2024
Depart Due Date:	00/05/0004
Report Due Date:	08/25/2024
Licensee Name:	Joyce Peterson
Licensee Address:	60407 M43 Highway
	Bangor, MI 49013
Licensee Telephone #:	(269) 639-9430
Name of Facility:	Joyful Living
Eacility Address	229 Edgell Street
Facility Address:	328 Edgell Street South Haven, MI 49090
Facility Telephone #:	(269) 637-4823
Original Issuance Date:	04/26/2016
License Status:	REGULAR
Effective Deter	00/07/0000
Effective Date:	06/07/2022
Expiration Date:	06/06/2024
	000012024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED
	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Licensee put Resident A's belongings in the yard.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/26/2024	Special Investigation Intake 2024A1031044
06/26/2024	Special Investigation Initiated - Letter
06/28/2024	APS Referral
07/01/2024	Contact - Telephone Interview with Complainant.
07/01/2024	Inspection Completed On-site
07/08/2024	Contact - Telephone Interview with Joyce Peterson.
07/11/2024	Contact - Telephone Interview with Kyle Bell.
07/11/2024	Contact - Document Received and Reviewed.
07/24/2024	Contact - Telephone Interview with Resident A.
08/01/2024	Contact – Document Requested.
08/12/2024	Contact – Document Requested, Received, and Reviewed.
08/15/2024	Exit Conference held with Licensee.

ALLEGATION:

Licensee put Resident A's belongings in the yard.

INVESTIGATION:

On 7/1/24, I interviewed Complainant #1 via telephone. Complainant #1 reported she contacted the licensee on 5/8/24 requesting a copy of Resident A's identification card and was informed by the licensee that a 30-day notice was issued for Resident A. Complainant #1 reported she was not informed that a notice was issued.

Complainant #1 reported she contacted Resident A's case manager, Kyle Bell, and he reported he was aware that a 30-day notice had been issued and he was working on finding Resident A another home to move to. Complainant #1 reported there was initially a plan in place to move Resident A to his new home on 6/5/24. Complainant #1 reported she received a call from the licensee on 6/4/24 telling her that Resident A's personal belongings were outside, and they needed to be picked up. Complainant #1 reported the licensee said Resident A had hit another person in the facility and they had an upcoming licensing inspection and needed his bedroom cleaned. When Complainant #1 arrived at the facility, Resident A was sitting outside visibly upset, his face was red, and he was sweating due to it being 90 degrees outside. Complainant #1 observed Resident A's belongings in the backyard with a tarp placed over some of his belongings. Complainant #1 reported Resident A's dresser was duct taped shut and did not have his belongings removed and other belongings were shoved into garbage bags. Complainant #1 reported the licensee said Resident A moved out all of his belongings by himself. Complainant #1 reported Resident A does not have the physical ability to move such a large item as a dresser up the stairs from his bedroom to the back yard of the home.

On 7/1/24, I reviewed pictures that were submitted by Complainant #1. The pictures showed Resident A's belongings which included a chair, dresser, and other items in black garbage bags that were on the ground in the backyard.

On 7/8/24, I interviewed the licensee Joyce Peterson via telephone. Ms. Peterson reported that she did place Resident A's belongings outside. Ms. Peterson reported she did this to make it easier for the family to load his belongings instead of having to come in and out of the home. Ms. Peterson reported she did submit a 30-day notice for Resident A to move from the home the first week of May 2024. Ms. Peterson reported she did not provide this written notice to Resident A's guardian. Ms. Peterson reported Resident A moved out his belongings as well because he wanted to move. Ms. Peterson reported she Resident A did not appear to be distressed during the move. Ms. Peterson reported the family loaded Resident A's belongings into their vehicles and Resident A moved out that day.

On 7/11/24, I interviewed Resident A's case manager Kyle Bell through Van Buren Community Mental Health (VBCMH). Mr. Bell reported he spoke with Ms. Peterson a week prior to Resident A's belongings being placed in the yard and she informed him that Resident A's belongings needed to be out of the facility due to an upcoming inspection. Mr. Bell reported Ms. Peterson informed him that Resident A had assaulted someone in the home that same day. Mr. Bell reported Ms. Peterson previously submitted a 30-day notice to VBCMH via mail and email. Mr. Bell reported the 30-day notice dated 5/7/24 was received on 5/9/24. Mr. Bell reported he received pictures from Resident A's guardian on 6/5/24 and the pictures showed Resident A's personal belongings in the yard.

On 7/11/24, Mr. Bell emailed me the 30-day notice for Resident A that was received by VBCMH. The letter dated 5/7/24 written by Ms. Peterson and it read that she was

submitting a 30-day notice and Resident A needed to be placed in a new home. Ms. Peterson wrote that Resident A stated on numerous occasions that he did not like living in the home and he hates staff, calls staff names, and is being verbally aggressive. Mr. Peterson wrote that she felt Resident A would be happier in another facility as he has become very violent, argumentative, and physically aggressive. Ms. Peterson wrote that when Resident A was asked to complete tasks in the home, and he would state that he does not like doing those tasks and feels he would be happier in another home.

On 7/24/24, I interviewed Resident A via telephone. Resident A reported Ms. Peterson put his stuff outside and he did not know why. Resident A reported this made him upset. Resident A reported he did throw some stuff and thinks this made her upset. Resident A reported Ms. Peterson "was mean" and told him he had to move from the facility in 30 days.

APPLICABLE RULE	
R 400.14315	Handling of resident funds and valuables.
	(16) Personal property and belongings that are left at the home after discharge shall be inventoried and stored by the licensee. The resident and designated representative shall be notified by the licensee, by registered mail, of the existence of property and belongings. Personal property and belongings that remain unclaimed, or for which arrangements have not been made, may be disposed of by the licensee after 30 days from the date that written notification is sent to the resident and the designated representative.
ANALYSIS:	Based on interviews and the review of documentation, there was evidence found to support that Ms. Peterson did not properly store Resident A's items as required by this rule. Ms. Peterson put Resident A's personal belongings outside of the facility without communicating with Resident A's guardian and prior to the 30-day notice deadline.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

Complainant #1 and Mr. Bell both reported that Ms. Peterson stated she needed to move Resident A's belongings out of the home due to an upcoming licensing

inspection and Resident A's bedroom not being clean. They both reported Ms. Peterson put Resident A's belongings outside of the facility on 6/4/24. When Complainant #1 arrived at the facility, Resident A was sitting outside visibly upset, his face was red, and he was sweating due to it being 90 degrees outside.

On 6/6/24, I completed an onsite inspection for the renewal of the license.

On 8/11/24, I reviewed the licensing file, and the home had a recent special investigation which resulted in a delayed renewal. I reviewed SIR 2024A1031029 dated 6/12/24. The facility received a licensing violation for R 400.14301(4)(2). It was determined that the licensee was not able so ensure that Resident A's needs were met due to their history of physical aggression. Ms. Peterson admitted that she was not able to use appropriate behavioral interventions due to a resident's aggressive behavior and physical size.

Resident A reported Ms. Peterson put his stuff outside and he did not know why. Resident A reported this made him upset. Resident A reported he did throw some stuff and thinks this made her upset. Resident A reported Ms. Peterson "was mean" and told him he had to move from the facility in 30 days.

APPLICABLE RULE	
R 400.14201	Qualifications of administrator, direct care staff, licensee, and members of household
	(9) A licensee and the administrator shall possess all of the following qualifications:
	(a) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.
ANALYSIS:	Ms. Peterson did not demonstrate the ability to meet Resident A's emotional needs as he was confused and upset that his belongings were placed outside of the facility. It was reported by two individuals that Ms. Peterson expressed Resident A needed to be out of the facility due to an upcoming licensing inspection and his room not being clean. I conducted an onsite licensing renewal inspection two days after Resident A's belongings were placed outside and he was moved from the facility.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

Complainant #1 reported they never received a written 30-day notice from Ms. Peterson. Complainant #1 reported they were informed by Ms. Peterson via telephone that a 30-day notice had been issued after it was submitted to the VBCMH case manager.

Ms. Peterson reported she did not provide Resident A's guardian with a written 30day notice. Ms. Peterson reported she submitted a written request to Resident A's case manager, Mr. Bell.

Mr. Bell reported Ms. Peterson submitted a 30-day notice to VBCMH via mail and email. Mr. Bell reported the 30-day notice dated 5/7/24 was received on 5/9/24.

APPLICABLE RULE		
R 400.14302	Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.	
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.	
ANALYSIS:	Ms. Peterson reported that she did not provide Resident A's guardian with a written 30-day notice.	
CONCLUSION:	VIOLATION ESTABLISHED	

INVESTIGATION:

Complainant #1 reported that Resident A was required to use his personal funds to purchase toilet paper.

Ms. Peterson reported she did have Resident A use their own personal funds to purchase toilet paper as they used one roll of toilet paper every three days. Ms. Peterson reported Resident A was also responsible for purchasing his own hygiene products such as body wash, shampoo, and toothpaste.

On 8/13/24, I reviewed Resident A's *Individual Plan of Service (IPOS), behavior plan, Funds I, Resident Care Agreement, and Assessment for AFC Residents.* There was not a documented need for Resident A to purchase his own toilet paper due to excessive use of toilet paper. The licensee agreed to provide personal care services.

APPLICABLE RULE	
R 400.14314	Resident hygiene.
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Ms. Peterson did not provide Resident A with necessary basic hygiene products such as toilet paper and required him to buy his own toilet paper due to using one roll every three days. There is no documented need in Resident A's assessment plans that he is required to buy his own toilet paper.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend issuance of a provisional license.

8/15/24

Kristy Duda Licensing Consultant

Date

Approved By:

Russell Misial

9/17/24

Russell B. Misiak Area Manager

Date