GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Marcia Tevelde
Northern Comfort Specialized Care, Inc.
547 Michigan Ave.
Manistique, MI 49854

November 6, 2024

RE: License #: AS770308910
Investigation #: 2024A0234017
Northern Comfort Spec. Care

Dear Ms. Tevelde:

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,

Maria DeBacker

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

(906) 280-8531

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS770308910
Investigation #:	2024A0234017
Complaint Receipt Date:	09/11/2024
Investigation Initiation Date:	09/11/2024
Report Due Date:	11/10/2024
Licensee Name:	Northern Comfort Specialized Care, Inc.
Licensee Address:	547 Michigan Ave. Manistique, MI 49854
Licensee Telephone #:	(906) 450-5723
License Designee	Marcia Tevelde
Name of Facility:	Northern Comfort Spec. Care
Facility Address:	8082 W US Hwy 2 Manistique, MI 49854
Facility Telephone #:	(906) 450-5723
Original Issuance Date:	10/28/2010
License Status:	REGULAR
Effective Date:	10/27/2023
Expiration Date:	10/26/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Facility refused to take the resident in the community for outings	No
Staff are directing resident to hit self rather than inanimate objects	Yes
Resident A was sent to the hospital by ambulance and facility refused to take her back to the facility	Yes

III. METHODOLOGY

09/11/2024	Special Investigation Intake 2024A0234017
09/11/2024	APS Referral
09/11/2024	Special Investigation Initiated - On Site
09/11/2024	Contact - phone call from Courtney Aversa
09/25/2024	Contact - phone call from Courtney Aversa
10/02/2024	Contact email APS referral
10/22/2024	Contact – phone call to guardian
10/26/2024	Contact – phone call to guardian
11/04/2024	Contact – phone call to guardian
11/04/2024	Exit conference – license designee Marcia Tevelde

ALLEGATION:

Facility refuses to take the client in the community for outings

INVESTIGATION:

On 9/11/24 an unannounced investigation was conducted at the facility.

On 9/11/24, staff Brittany Schuette was interviewed at the facility. Ms. Schuette stated that Resident A was taken into the community two times per week with her guardian.

On 9/11/24, Courtney Aversa, home manager, was interviewed by phone. Ms. Aversa stated that Resident A was taken into the community two times a week by her guardian.

On 9/12/24, Ms. Aversa emailed the written assessment plan. The behavioral goal in the written assessment read that Resident A will access the community twice per week for an activity of her choosing.

On 11/4/24, License designee Marcia Tevelde was interviewed by phone. She stated that Resident A's guardian took Resident A into the community two times a week.

On 10/22/24, 10/26/24, and 11/4/24 attempts to contact Guardian A were made with no answer or response. There is no indication that Guardian A does not want to take Resident A in the community.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(4) A licensee shall provide all of the following: **(d) An opportunity for privacy and leisure time.**
ANALYSIS:	Resident was taken in the community 2 times per week by guardian.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff were directing client to hit herself rather than inanimate objects

INVESTIGATION:

On 9/11/24, staff Brittany Schuette was interviewed at the facility. Ms. Schuette stated that Resident A was very difficult and can be violent. Resident A had a one-on-one staff requirement and staff follow and observe her at all times. Ms. Schuette

stated that she does not have trouble with Resident A very often but was trained to redirect Resident A's behaviors and is trained in Safety Care if needed.

On 9/12/24, home manager Courtney Aversa was interviewed by phone. Ms. Aversa stated that she was informed by the Guardian A1 that if Resident A was hitting things that a redirection to "pat" her legs was helpful in deescalating behavior. Ms. Aversa stated that it seemed to work but she was told by a CMH (community mental health) worker that in the past this action caused injury, so Ms. Aversa instructed staff to stop redirecting Resident A to "pat" her legs.

The written assessment plan for Resident A was reviewed and did not include patting her palms on her legs.

On 11/4/24, license designee Marcia Tevelde was interviewed by phone. She stated that the guardian had advised staff that Resident A calmed down when redirected to pat her palms on her legs. Ms. Televde stated that a CMH worker did not like that staff redirected Resident A in this was and advised against it. Staff were no longer allowed to redirect Resident A to do that.

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	Staff did redirect Resident A to "pat" her palms on her legs rather than follow the written behavior plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was sent to the hospital by ambulance and staff refused to take her back to the facility

INVESTIGATION:

On 9/25/24, Ms. Aversa was interviewed by phone. She called to state that her staff are quitting due to Resident A's ongoing violent behavior. She stated that she has only herself and one other staff who are willing to work with Resident A. During this discussion she stated that she had to go and would call back, but she did not call back.

On 10/2/24, I received an email that read a referral had been denied investigation by APS. It read that Resident A was taken to the hospital by ambulance and that the facility refused to take her back. CMH and the Ombudsman also called to state that Resident A was in the hospital and the facility refused to take her back. All stated that the facility staff all quit, and Ms. Aversa had no one to work with Resident A.

On 11/4/24, Ms. Aversa stated that Resident A was repeatedly banging her head and physically attacking staff. She stated that all of her staff quit, and she felt they could no longer care for her properly as she required a one-on-one staff ratio and she no longer had enough employees to keep her and the other residents safe.

On 11/4/24, Ms. Televde stated that Resident A was sent to the hospital via ambulance as she had a cut on her head from banging it on the floor repeatedly. At that time, they had no staff that were willing to work with Resident A. She stated that Ms. Aversa was working extremely long hours and no longer felt that the home could safely care for Resident A.

On 9/18/24 the facility provided CMH with a verbal 30-day notice for removal and a written notice was provided on 9/25/24 according to Ms. Aversa. CHM was aware that all of the facility staff had walked out due to Resident A's violent behaviors and Ms. Aversa did not have staffing to provide one-on-one services. CMH has withdrawn their contract with the facility.

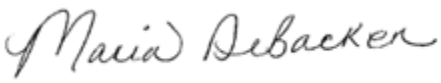
APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; emergency discharge;.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:**

	(i) The reason for the proposed discharge, including the specific nature of the substantial risk. **(ii) (ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) (iii) The location to which the resident will be discharged, if known.** **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**
ANALYSIS:	The facility did not provide a written notice 24 hours prior to discharge.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/4/24, an Exit conference was held with license designee Marcia Televde by phone. Ms. Televde is aware of the findings of this report and understands the rule violations.

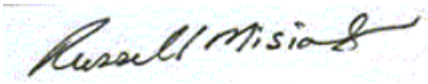
IV. RECOMMENDATION

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



_____11/6/24_____
Maria Debacker Date
Licensing Consultant

Approved By:



11/6/24
_____
Russell B. Misiak Date
Area Manager