GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 16, 2025

Deshra Vines-Leak
Precious Places, LLC
PO Box 310332
Flint, MI 48531

RE: License #: AS250415731
Investigation #: 2025A0572010
Victoria's House Of Hope

Dear Ms. Vines-Leak:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 12/23/2024, I received an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250415731
Investigation #:	2025A0572010
Complaint Receipt Date:	11/22/2024
Investigation Initiation Date:	11/22/2024
Report Due Date:	01/21/2025
Licensee Name:	Precious Places, LLC
Licensee Address:	PO Box 310332 Flint, MI 48531
Licensee Telephone #:	(810) 233-6696
Administrator:	Deshra Vines-Leak
Licensee Designee:	Deshra Vines-Leak
Name of Facility:	Victoria's House Of Hope
Facility Address:	1219 North Dye Rd. Flint, MI 48532
Facility Telephone #:	(810) 233-6696
Original Issuance Date:	04/10/2024
License **Status:**	REGULAR
Effective Date:	10/10/2024
Expiration Date:	10/09/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
• Victoria's House refused to assist Resident A move to new home. If Resident A's move was not done, the elderly mother would have to take Resident A home with her.	No
• Victoria's House sent Resident A to a new home with no current physician's orders and expired prescriptions. Medications were not packed correctly or labeled. • Victoria's House sent other consumers' physician's orders/paperwork to Resident A's new home.	No Yes

III. METHODOLOGY

11/22/2024	Special Investigation Intake 2025A0572010
11/22/2024	APS Referral
11/22/2024	Special Investigation Initiated - Telephone Contact with Supports Coordinator Tammy Lafella
12/23/2024	Inspection Completed On-site Staff, Erika Jenkins.
12/23/2024	Inspection Completed-BCAL Sub. Compliance
12/23/2024	Corrective Action Plan Received
01/09/2025	Contact - Face to Face Staff, Lisa Perryman.
01/09/2025	Contact - Telephone call made Home Manager, Tameka Miller.
01/09/2025	Contact - Telephone call made Attempted contact of Resident A's Family Member #1.
01/14/2025	Contact - Telephone call made Resident A's Family Member #1.
01/14/2025	Exit Conference

	Licensee Designee, Deshra Vines.
01/16/2025	Contact - Telephone call made Recipient Rights, Pat Shepard.
01/16/2025	Exit Conference Licensee Designee, Deshra Vines.
01/16/2025	Inspection Completed-BCAL Sub. Compliance
01/16/2025	Corrective Action Plan Requested and Due on 01/31/2025
01/16/2025	Corrective Action Plan Approved

ALLEGATION:
Victoria's House refused to assist Resident A to move to new home. if Resident A's move was not done, the elderly mother would have to take Resident A home with her.

INVESTIGATION:
On 11/22/2024, the local licensing office received a complaint for investigation. Adult Protective Service (APS) referred the complaint to licensing.

On 11/22/2024, contact was initiated with Supports Coordinator Tammy Lafella. Tammy Lafella confirmed the that the allegations were regarding Victoria's House of Hope refusing to assist Resident A's elderly mother in placement of Resident A, expired medications were sent with no physician orders, and the allegation that another residents' information was mixed in with Resident A's paperwork.

On 12/23/2024, I made an unannounced onsite to Victoria's House Of Hope, located in Genesee County Michigan. I was able to interview staff, Erika Jenkins. Resident A was not interviewed as Resident A had already moved to another placement prior to the investigation.

On 12/23/2024, I interviewed Staff, Erika Jenkins regarding the allegations. Erika Jenkins informed that Resident A had become very violent towards staff and residents, so they issued a 30-day discharge notice. They tried working with Resident A and the Guardian, but they ultimately had to issue another 30-day discharge notice as Resident A fractured a staff member's finger and was violent towards another resident. Resident A's Guardian did not want to move Resident A, but the home had no choice because they had to protect staff and residents. Resident A's Guardian moved Resident A on the 30th day of the discharge notice. The Guardian said that she would move Resident A. The home informed that they would transport if the Guardian was unable to. Erika Jenkins did not see anything

unusual with how they discharged Resident A from the home and denied forcing the Guardian to complete the transport.

On 01/09/2025, I interviewed Staff, Lisa Perryman from Resident A's current placement. Lisa Perryman informed that Resident A is currently in the hospital and does not have a return date. Lisa Perryman is unaware of the issues regarding Resident A move to their home.

On 01/09/2025, I made an attempt to contact Resident A's Guardian/Family Member #1 via phone. The 1st phone number used, the mailbox was full and could not leave a message. The 2nd phone number used; I was able to leave a message.

On 01/09/2025, I contacted Home Manager, Tameka Miller, from Resident A's current placement. She informed that the Guardian had transported Resident A to their home.

On 01/14/2025, I contacted Resident A's Guardian regarding the allegation. Resident A's Guardian informed that she does not know anything about any issues regarding the move as the home gave multiple 30-day discharge notices and was trying to work with them, but Resident A became a danger to the other residents and staff. Resident A had injured a staff member, and it was getting to a point where staff did not want to work there as long as Resident A was still there. Resident A's Guardian agreed to move Resident A, but did not want to because Resident A had been with the home for maybe 16 years and they treated Resident A like family.

On 01/14/2025, I contacted Licensee Designee, Deshra Vines-Leak regarding the allegation. Deshra Vines-Leak informed that in all of her years in the business, they have always completed their discharge in the same manner and there was never an issue. They attempted to work with the family because Resident A had been with them for many years. They issued the 30-day discharge notice and the Guardian transported Resident A to the new placement. Deshra Vines-Leak believes that maybe the new placement has some issues but is not aware of the Guardian having any issues with the discharge.

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.**
	(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: **(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:	Based on my interviews of staff and Guardian, there is not enough evidence to issue a rules violation. Victoria's House of Hope issued a 30-Day Notice, it was received and the Guardian moved Resident A to a new placement.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Victoria's House sent Resident A to a new home with no current physician's orders and expired prescriptions. Medications were not packed correctly or labeled.**
- **Victoria's House sent other consumers' physician's orders/paperwork to Resident A's new home.**

INVESTIGATION:

On 12/23/2024, I interviewed Staff, Erika Jenkins regarding the allegations. Erika Jenkins informed that her and the Assistant Manager were gathering Resident A's paperwork together and someone else's script may have gotten mixed in with it. This error was between her and the Assistant Manager, Joslin Thigpen. Staff Jenkins informed that if they (New Placement) say it happened, then they take full responsibility for it. Erika Jenkins explained that something must have been misfiled and that's how the error may have occurred. The Licensee Designee was contacted and she put in some correct measures to ensure that it doesn't happen again. Ericka Jenkins gave me a copy of the Corrective Action Plan that was written for Recipient Rights. Erika Jenkins does not know exactly what script or paperwork was sent accidentally. Staff Jenkins was only informed of what was alleged. Regarding the

medications not being packed correctly or mislabeled, the new home pass their meds with single-packed meds, while Victoria's House of Hope use bubble packs, which have multiple medications in one pack. The new home questioned how they are supposed to identify each medication. They tried to explain that all the medications for the time of day are in one bubble pack and it has the correct amount, dosage and the pack tells you what color the medication is. According to Erika Jenkins, there were absolutely no outdated medications given to the current placement. They explained that this is how their pharmacy sends the medications, but the new placement can change pharmacies and/or have them send them the way that they currently receive medications for their home.

The Corrective Action Plan was written on 12/18/2024 and states, "Both staff have been counseled and made aware of the requirement to protect the consumers personal information including but not limited to protected health information. We recognize that there was a failure in our system and the way the file was prepared, and we made changes to ensure this does not happen again." The Licensee Designee, Deshra Vines-Leak signed the CAP and will ensure that it is followed.

On 01/09/2025, I interviewed Staff, Lisa Perryman from Resident A's current placement. She heard that there were some issues regarding the medications, but she was off. Lisa Perryman informed that I would have to contact the Home Manager for more information.

On 01/09/2025, I made an attempt to contact Resident A's Guardian/Family Member #1 via phone. The 1st phone number used, the mailbox was full and could not leave a message. The 2nd phone number used; I was able to leave a message.

On 01/09/2025, I contacted Home Manager, Tameka Miller, from Resident A's current placement. Tameka Miller informed that the medications did not match the script that was given to them, but not sure why. They had meds, but no current scripts. They only had old scripts. They had to start a new med sheet. in their home, they write all the scripts and dosage themselves. The Med Coordinator had found documentation of another resident, mixed in with Resident A's paperwork. It was about 3 or 4 sheets of paper. Tameka Miller is unsure of what was in the paperwork and the Med Coordinator shredded it, so they no longer have it. Tameka Miller informed that everything ended up working out and would have had to deny the placement if it hadn't.

On 01/14/2025, I contacted Resident A's Guardian, regarding the allegation. The Guardian informed that she heard about another resident's paperwork or script being mixed in with Resident A's paperwork but is unsure if this actually happened as she has worked with the Licensee Designee, Deshra Vines-Leak for years and they always have their paperwork in order and it's also been readily available within a short period of time as everything has always been in order. The guardian informed that she cannot say the same thing about the current placement as they have things that have been missing and she is lucky to have her own copies. Victoria's House of

Hope has always done a wonderful job with Resident A and does not believe that they would have mixed another resident's paperwork or script in with Resident A's. During their initial tour of the home, the Licensee Designee met them out to the new placement and brought the initial paperwork to the home. Staff, Erika Jenkins brought the rest of the paperwork afterwards and did not observe any issues. Regarding the scripts, the Guardian informed that she was a foster parent for over 30 years and indicated that Victoria's House of Hope receive their medications from the pharmacy differently than the current placement and sees no issue with it. She informed that when she was a foster parent, she passed medications both ways and explained that the current placement did not understand it because it was different and thought it was wrong. The Guardian further explained that Victoria's House of Hope receives the bubble pack from their pharmacy with all the medications in one bubble, so when it's time to pass meds, they are all in one bubble pack. They only issue is when there's a med change, staff have to remember what medication in the bubble pack not to administer and dispose of. The current home receives each medication individually and write in their resident's medications.

On 01/14/2025, I contacted Licensee Designee, Deshra Vines-Leak regarding the allegation. Deshra Vines-Leak informed that she heard about a breach of confidentiality but does not know what it was the current home never sent it back to them. LD Vines-Leak does not know if they still have it or if it was shredded. They heard this from Recipient Rights, but never got anything from them either. Because they were told it happened, she wrote a corrective action plan for the breach of confidentiality. Deshra Vines-Leak informed that the new placement took issue with the way they received the medications from the pharmacy. They tried to explain to them that all the medications are in the bubble pack and during med time, they pop the bubble pack and all the medications for that specified time goes into the cup. There are indicators on the side of the bubble pack, indicating which medications are in the pack.

On 01/14/2025, I held exit conference with Licensee Designee, Deshra Vines-Leak regarding the allegations. I informed that I did not see any rules violations, but that I did receive a copy of the Corrective Action Plan written for Recipient Rights and suggested that the home maintain that corrective measure to ensure that confidential records are not misfiled and sent out incorrectly.

On 01/16/2025, I contacted Pat Shepard of Recipient Rights regarding the allegation. Pat Shepard informed that she was told that there were papers of another resident, in Resident A's packet. Pat Shepard is unsure of what document it was as it was shredded, but it's the assumption that it was a script because the current facility were asking the home for Resident A's current prescription scripts. Victoria's House of Hope did not deny that it happened. Pat Shepard informed that she was given a first name of the resident whose confidential information was included with Resident A's and it was found that Victoria's House of Hope has a resident in their home with that same first name.

On 01/14/2025, due to additional information, I conducted another exit conference with Licensee Designee, Deshra Vines-Leak regarding the allegation. Deshra Vines-Leak was informed that a violation was established and that the Corrective Action Plan submitted to Recipient Rights, will be accepted for this special investigation.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	Based on my interviews of staff and Guardian, there is not enough evidence to issue a rules violation. Victoria's House of Hope utilizes the bubble packs which is how the pharmacy that they use sends them Resident A's medications. Medications were correctly packed and labeled.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(q) The right to confidentiality of records as stated in section 12(3) of the act.**
ANALYSIS:	Based on my interviews of staff and Guardian, there is enough evidence to issue a rules violation., Licensee Designee, Deshra Vines-Leak, and Recipient Rights, Pat Shepard confirm that another resident's information was sent to Resident A's new placement. The licensee designee reported she completed a correction action plan. The staff of Victoria's House of Hope and the Guardian was not aware of what was mixed in with

	Resident A's paperwork. Staff at the new placement was unable to produce the paperwork as evidence as they shredded it upon reviewing it.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this small adult foster care group home. A Corrective Action Plan has been received and approved (Capacity 1-6).

01/16/2025

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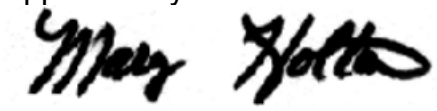
Anthony Humphrey Date
Licensing Consultant

Approved By:



01/16/2025

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Mary E. Holton Date
Area Manager