GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 29, 2025

Tamika Ruth
514 S. Ortman Street
Saginaw, MI 48601

RE: License #: AS730377214
Investigation #: 2025A0572012
Annie's Home Care

Dear Tamika Ruth:

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:

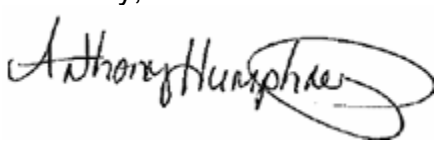
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (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 #:	AS730377214
Investigation #:	2025A0572012
Complaint Receipt Date:	12/03/2024
Investigation Initiation Date:	12/04/2024
Report Due Date:	02/01/2025
Licensee Name:	Tamika Ruth
Licensee Address:	514 S. Ortman Street Saginaw, MI 48601
Licensee Telephone #:	(989) 714-1271
Administrator:	Tamika Ruth
Licensee Designee:	N/A
Name of Facility:	Annie's Home Care
Facility Address:	514 N. Warren Avenue Saginaw, MI 48607
Facility Telephone #:	(989) 401-7835
Original Issuance Date:	11/16/2015
License Status:	REGULAR
Effective Date:	05/16/2024
Expiration Date:	05/15/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 10/12/2024, Resident C was seen crawling around Hwy I675. AFC home knew Resident C was missing and was not concerned about where Resident C went.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/03/2024	Special Investigation Intake 2025A0572012
12/03/2024	APS Referral APS made referral.
12/04/2024	Special Investigation Initiated - Letter APS, Erica Partlow
12/17/2024	Inspection Completed On-site Staff Roderick York, and Resident C.
01/22/2025	Contact - Telephone call made Licensee, Tamika Ruth.
01/24/2025	Contact - Face to face Staff Roderick York.
01/24/2025	Contact - Telephone call made Resident E's Case Manager, Denita Rider.
01/27/2025	Exit Conference Licensee, Tamika Ruth.

ALLEGATION:
On 10/12/2024 Resident C was seen crawling around Hwy I-675. AFC home knew Resident C was missing and was not concerned about where Resident C went.

INVESTIGATION:
On 12/03/2024, the local licensing office received a complaint for investigation. Adult Protective Services (APS) made the referral to licensing for further investigation.

On 12/04/2024, Licensing Consultant, Susan Hutchinson made contact with APS Investigator Erica Partlow regarding her knowledge of the complaint. She informed that she had seen Resident C on 11/08/2024 at the home. Erica Partlow substantiated for self-neglect, as Resident C is not attending his mental health appointments which could assist with medication and treatment.

On 12/17/2024, I made an onsite at Annie's Home Care, located in Saginaw County Michigan. Interviewed were, Staff Roderick York, and Resident C.

On 12/17/2024, I interviewed Staff, Roderick York regarding the allegation. Roderick York informed that Resident C is currently at the Soup Kitchen and should be returning soon. Resident C is able to go out into the community on his own and often walks there and a couple other places around the neighborhood. Roderick York informed that he is aware of the allegation and informed that Resident C had left the home while he was away from his desk, which is the front entrance of the home. Staff York noticed that Resident C was gone, but Resident C did not tell him that he was leaving. Resident C normally tells him that Resident C is leaving to go walk to the store or the Soup Kitchen, so that’s where he expected him to be as he never goes anywhere else. Resident C arrived back home via ambulance and appeared to be fine and only asked for a cigarette. Resident C doesn’t use drugs but has been caught multiple times attempting to bring alcohol in the home.

On 12/17/2024, I interviewed Resident C regarding the allegation. Resident C had just returned from the Soup Kitchen. Resident C denied crawling on the highway but remembered being taken to the hospital. Resident C informed that the hospital staff never said anything was wrong with him and dropped him off at home. Resident C denied being hurt or injured. Resident C indicated that he left because he doesn’t really like the home because there are too many rules. Resident C told emergency staff that he was walking to Flint because he does not like his home. Resident C did not let anyone know that he was leaving and does not have a reason for not telling anyone where he was going. Resident C explained that he was not sneaking out, he was just leaving and did not plan on coming back. Resident C denied being upset with staff and only upset with the fact that he has to live there. Resident C denied any other concerns with the home and informed that staff treats him nice. Resident C indicated that he does not have a case manager or guardian.

On 12/17/2024, I reviewed Resident C's Assessment Plan and he is able to go out into the community on his own without supervision. The Assessment Plan is dated for 01/20/2024.

On 01/22/2025, I interviewed Licensee, Tamika Ruth regarding the allegation. Tamika Ruth informed that Resident C comes and goes as he pleases. Resident C will not attend any of his scheduled doctor's appointments. Resident C is able to go out into the community on his own. Resident C is very alert and can tell you who the President is and what day it is today. Resident C's issues stemmed from a car accident that negatively impacted his frontal lobe. When she got the call from MMR that Resident C was walking to Flint, she told them that he was probably hitching a ride to Flint to see his brother. They were upset with her because he was by himself, but she told them that Resident C is able to go out in the community on his own but they appeared to not like that response and hung up on her. Tamika Ruth believes that Resident C may have told Roderick York that he was going to the store for some cigarettes. Maybe that was his intentions, but then decided he was going to go to Flint instead. Resident C does not sign out, but normally tells them where he is going and they will make note of that. Resident C always he always comes back home with the exception of this incident. Resident C has not gone anywhere lately due to the cold weather.

On 01/24/2025, I made an unannounced onsite to Annie's Home Care to review other documentation. The most recent Healthcare Appraisal is from 01/20/2023. Resident C is diagnosed with Depression and Anxiety. According to Staff, Roderick York, Resident C does not have a CMH Case Manager or a Guardian. While reviewing Resident C's file, the Resident Care Agreement indicates that the home will provide transportation to and from doctor's appointments and shopping days. Roderick York is not aware of when the last time Resident C had been to the hospital for a medical appointment,

On 01/24/2025, I spoke with Resident A regarding medical appointments. Resident A goes to the doctor and goes to appointments on her own.

On 01/24/2025, I spoke with Resident B regarding medical appointments. Resident B go to doctor's appointments and Licensee, Tamika Ruth provides the transportation.

APPLICABLE RULE	
MCL 400.707	**Definitions; R to T.**
	(7) "Supervision" means guidance of a resident in the activities of daily living, including 1 or more of the following: **(d) Being aware of a resident's general whereabouts even though the resident may travel independently about the community.**

ANALYSIS:	Based on the interviews of the staff, Licensee and review of Resident C's file, there is enough evidence to establish a violation of licensing rules. Resident C was found on the highway, walking to Flint which is about a 37-minute drive in a car. Staff, Roderick York was not aware that Resident C had gone as Resident C had not told him where he was going and there is no sign out sheet.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:
On 01/24/2025 I made an unannounced visit to the home and Staff, Roderick York was in the corner, on the floor sleeping. Unknown person opened the front door for me and woke Roderick York up for me.

INVESTIGATION:
On 01/24/2025, I made an unannounced onsite to Annie's Home Care. Upon entering the home, Staff, Roderick York was sleeping on the floor. An unknown person let me in the house and led me to where Roderick York was sleeping. The unknown person had to shake Staff York several times in order to wake him. Roderick York informed that he has a bedroom upstairs and that Licensee, Tamika Ruth had been getting on him about sleeping downstairs. Staff York indicated that he sleeps there in case of emergencies, if they have visitors or if the phone rings. Regarding the unknown person who opened the door, Roderick York informed that he is a friend of his and he helps out with the cleaning. Staff York denied that his friend resides in the home and does not work there. His friend also does not pass any medications to the residents. Roderick York's friend name is Tomas Espinoza, and he has not been fingerprinted. Roderick York was informed that he cannot sleep on the floor, especially if he is the only staff member working. He was also informed that his friend cannot be in the home, as a volunteer, unless he passes a background check.

On 01/24/2025, I spoke to a few of the residents in the home regarding a separate investigation. They had eaten breakfast and lunch and appeared to be doing well.

On 01/24/2025, I spoke with Resident E's Case Manager, Denita Rider who has been in the home, confirmed that Staff, Roderick York sleeps on the floor on the side of the office desk. She had mentioned it to the Licensee, Tamika Ruth about the staff person sleeping on the floor.

On 01/27/2025, I held an exit conference with Licensee, Tamika Ruth regarding the allegations. Tamika Ruth was informed that Staff, Roderick York was sleeping on floor while his friend was supervising the residents. Tamika Ruth indicated that she had told Roderick York not to be sleeping on the floor in the living room and does not understand why he does that when there's an extra bedroom upstairs but indicated that she will correct this. Tamika Ruth also informed that Roderick's friend is a volunteer and does

not receive any payment. Tamika Ruth utilizes Tomas Espinoza when she has to transport residents to and from appointments or if she has to go to the store. Tamika Ruth said she searched online to see if Tomas Espinoza had any criminal history and was not aware that volunteers are required to be fingerprinted. Tamika Ruth indicated that he will no longer house sit for the residents.

Special Investigation Report (SIR) #2023A0580024 dated 4/19/2023 concluded violation to R400.14408(2) due to observation of a bed in the dining room and staff, Mr. Bulger's admission that he sleeps on the bed in the dining room. The corrective action dated 06/14/2023 and signed by Licensee Ruth, stated that bed was removed from the dining room on 05/15/2023.

Special Investigation Report SIR 2025A0580003 dated 12/13/2024 cited violation to R 400.14408(2) due to Staff York sleeping in the living room area. Due to willful and substantial rule violations, a provisional license was recommended, continent upon receipt of a corrective action plan. An acceptable corrective action plan has not been received.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(2) A living room, dining room, hallway, or other room that is not ordinarily used for sleeping or a room that contains a required means of egress shall not be used for sleeping purposes by anyone.
ANALYSIS:	I observed Staff, Roderick York sleeping on the floor, near the office desk. Roderick York informed that he sleeps on the floor, but was told by Licensee, Tamika Ruth not to sleep downstairs. Based on the interview conducted and observation of Roderick York Sleeping on the floor, there is sufficient evidence to support this rule violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR 2023A0580024 dated 04/19/2023.** **SIR 2025A0580003 dated 12/13/2024**

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Roderick York is the only staff on shift and was downstairs sleeping on the floor. A friend of Roderick York was supervising the resident's while he was sleep. There is sufficient evidence to support this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(3) Any individual, including a volunteer, shall not be considered in determining the ratio of direct care staff to residents unless the individual meets the qualifications of a direct care staff member.
ANALYSIS:	During my investigation, Tomas Espinoza was working as a volunteer staff in the home. There is no employee record, trainings, or background checks for this individual. There is sufficient evidence to support this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:
During onsite on 01/24/2025, I reviewed Resident C's Case file. The Healthcare Appraisal was dated for 01/20/2023.

INVESTIGATION:
On 01/24/2025, I reviewed Resident C's case file to review documents. While reviewing those documents, I observed a date of 01/20/2023 for the healthcare appraisal. There was no other healthcare appraisal on file for Resident C.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(2) A licensee shall maintain a copy of the annual health care appraisal on file for not less than 2 years.
ANALYSIS:	Based on the information received from Resident C's file, Resident C's last health care appraisal was completed on 1/20/2023. There is enough evidence to establish a rule violation as the healthcare appraisal on file for Resident A is outdated.
CONCLUSION:	**VIOLATION ESTABLISHED**

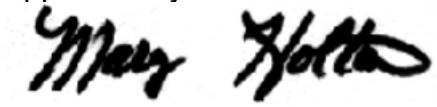
IV. RECOMMENDATION

SIR #2025A0580003 dated 12/13/2024 recommended a provisional license due to willful and substantial rule violations. An acceptable corrective action plan has not yet been received. Contingent upon receipt of an acceptable corrective action plan, I continue to recommend modification of the license to a provisional due to willful and substantial rule violations.

01/28/2025

Anthony Humphrey — Date
Licensing Consultant

Approved By:



01/29/2025

Mary E. Holton — Date
Area Manager