GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 11, 2025

Karon Lee
Michigan Community Services, Inc.
PO Box 317
Swartz Creek, MI 48473

RE: License #:	AS090010213
Investigation #:	2025A0123021
	Nebobish Road CLF

Dear Karon Lee:

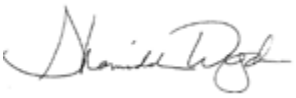
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090010213
Investigation #:	2025A0123021
Complaint Receipt Date:	02/05/2025
Investigation Initiation Date:	02/06/2025
Report Due Date:	04/06/2025
Licensee Name:	Michigan Community Services, Inc.
Licensee Address:	5239 Morrish Rd. Swartz Creek, MI 48473
Licensee Telephone #:	(810) 635-4407
Administrator:	Karon Lee
Licensee Designee:	Karon Lee
Name of Facility:	Nebobish Road CLF
Facility Address:	1405 W. Nebobish Road Essexville, MI 48732
Facility Telephone #:	(989) 892-0948
Original Issuance Date:	08/07/1986
License Status:	REGULAR
Effective Date:	02/28/2023
Expiration Date:	02/27/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 01/30/2025, Resident A asked staff Christina Baldwin for a breathing treatment, but Staff Baldwin told Resident A no because she did not think Resident A needed one.	Yes

III. METHODOLOGY

02/05/2025	Special Investigation Intake 2025A0123021
02/06/2025	Special Investigation Initiated - Letter
02/06/2025	APS Referral APS referral completed.
02/11/2025	Inspection Completed On-site I conducted an unannounced on-site at the facility.
02/19/2025	Contact - Telephone call made I made a follow-up call to the facility. Interviewed home manager Anita Willette.
02/24/2025	Inspection Completed On-site Follow-up on-site at facility. Interviewed Resident A.
03/03/2025	Contact - Telephone call made I spoke with Relative 1.
03/03/2025	Contact - Telephone call made I interviewed staff Creona Berry.
03/03/2025	Contact - Telephone call made I left a voicemail for staff Kathryn Ollila.
03/05/2025	Contact - Telephone call made I left a voicemail requesting a return call from staff Christina Baldwin.
03/05/2025	Contact- Document sent Sent email requesting documentation.
03/07/2025	Contact- Telephone call made

	I attempted to contact staff Christina Baldwin.
03/07/2025	Contact- Telephone call made I attempted to contact staff Kathryn Ollila.
03/07/2025	Contact- Telephone call received I received a voicemail from staff Christina Baldwin.
03/07/2025	Contact- Telephone call made I interviewed staff Christina Baldwin.
03/11/2025	Exit Conference I spoke with licensee designee Karon Lee via phone.

ALLEGATION: On 01/30/2025, Resident A asked staff Christina Baldwin for a breathing treatment, but Staff Baldwin told Resident A no because she did not think Resident A needed one.

INVESTIGATION: On 02/11/2025, I conducted an unannounced on-site at the facility. I spoke with assistant home manager Antonio Johnson. Staff Johnson stated that staff Christina Baldwin was recently fired. Staff Johnson stated that Resident A felt Staff Baldwin was picking on them. Staff Johnson stated that Resident A is currently not present, as they are on leave of absence with family.

During this on-site, I observed five residents in the home. They appeared clean and appropriately dressed.

On 02/19/2025, I interviewed home manager Anita Willette via phone. Staff Willette stated that she was not on shift when the incident occurred, which was reportedly on 01/30/2025. Staff Willette stated that she reported to work the next morning (01/31/2025), and nothing was brought to her attention. Then the next day (two days later on 02/01/2025), Resident A and Relative 1 spoke with her. Relative 1 told Staff Willette that she told Resident A to hang up the phone on 02/01/2025 and ask staff for a breathing treatment. Resident A was told no, and that Relative 1 does not know what they are talking about. Staff Willette stated that there was no breathing treatment documented. Resident A is supposed to get an Albuterol inhaler every six hours as needed for bronchial spasms. Staff Willette stated that Resident A is usually visibly short of breath when the Albuterol is needed. Staff Willette stated that there were no witnesses. Resident A moved into the facility in November 2024 and staff are still learning Resident A. Staff Willette stated that Staff Baldwin employment was terminated for a different incident that was not directly resident related. Staff Baldwin stated that Resident A does get worked up during calls with Relative 1, and she thinks Relative 1 may have thought Resident A was going to start a coughing episode.

On 02/20/2025, I received requested documentation via email. Resident A's *Assessment Plan for AFC Residents* dated 12/05/2024 notes that staff will prepare and administer all medications. A copy of Resident A's medication administration records for January 2025 confirms that Resident A's Albuterol Neb 0.083% (inhale the contents of one amp via nebulizer every six hours as needed for Bronchospasm) was not documented as passed by staff on 01/30/2025. Resident A only used the Albuterol on 01/12/2025, 01/13/2025, 01/14/2025, and 01/16/2025 during the month of January 2025 for wheezing, cough, and congestion.

A photo of staff Christina Baldwin's written statement was received. The photo was not a clear photo of the whole written statement, as some of the writing was cut out of the photo. In summary per the written statement, it appears to say that Resident A received a call from Relative 1 around 10:30 pm on 01/31/2025. Resident A was lying back in a chair. Relative 1 asked Resident A to get off the phone and request a breathing treatment. Staff Baldwin listened to Resident A. Did not hear any wheezing or coughing, and did not give Resident A a breathing treatment because she did not feel like he needed it, nor was having any difficulty breathing. Resident A went back to sleep.

On 02/24/2025, I conducted a follow-up on-site at the facility. I interviewed Resident A. Resident A stated that they asked staff Christina Baldwin for a breathing treatment, and Staff Baldwin said no. Resident A asked a couple more times. Relative 1 was on the phone and heard Staff Baldwin tell Resident A no. Resident A stated they do not think it was right for Staff Baldwin to refuse the breathing treatment. Resident A stated Staff Baldwin said "*I don't hear nothing. You don't sound like you need a breathing treatment.*" Resident A stated that they felt as though they needed the breathing treatment at that time, because Resident A felt they could not breath. Resident A stated it took a while to get past the breathing episode because Staff Baldwin refused them the treatment. Resident A stated that all the other staff are nice, and their needs are being met.

On 03/03/2025, I interviewed staff Creona Berry via phone. Staff Berry worked on 01/31/2025 with staff Christina Baldwin. Staff Berry stated that the day staff Christina Baldwin expressed her thoughts regarding the situation between herself, Resident A, and Relative 1, was not the day that the incident happened. Staff Berry stated that she did not witness the incident, but Staff Baldwin expressed to her that Relative 1 asked her to give Resident A a breathing treatment. Staff Baldwin commented that she was not going to take orders from Relative 1. Staff Berry stated that when Resident A has phone conversations, Resident A talks on speaker so she is not sure if Staff Baldwin spoke directly with Relative 1. Staff Berry stated she didn't realize that Staff Baldwin did not give Resident A the breathing treatment until after Staff Baldwin was fired. Staff Berry stated that the last time she worked with Staff Baldwin, Staff Baldwin pulled her to the side and told her she thought she (Staff Baldwin) was going to get into trouble regarding the situation with Resident A. Staff Berry stated that the best way to handle the situation would have been to call management or contact the nurse, as the breathing treatment is an as needed treatment.

On 03/03/2025, I interviewed Relative 1 via phone. Relative 1 stated that they were on the phone with Resident A. Relative 1 told Resident A to ask staff for a breathing treatment. Relative 1 stated that Resident A sounded like they had mucus in their throat. It did not sound really bad, but it was enough to give Resident A a breathing treatment. Resident A uses a nebulizer. Resident A told Relative 1 that Staff Baldwin stood by Resident A and told Resident A that Relative 1 didn't really know. Relative 1 stated that Resident A has a rod in their back that messes with Resident A's breathing on and off. Relative 1 stated that they know when Resident A needs a breathing treatment but guessed that Staff Baldwin did not think Resident A needed one. Staff Baldwin did not give Resident A the breathing treatment. Relative 1 stated that signs Resident A needs a breathing treatment is that Resident A has difficulty speaking, swallowing, and you can hear the mucous in Resident A's throat. Relative 1 stated that they did not understand why the staff refused to give Resident A a treatment because Relative 1 has asked staff to do so in the past. Relative 1 stated that Staff Willette asked Relative 1 to contact her or the assistant home manager moving forward. Relative 1 stated that they did not find out until the next day that Resident A did not get the breathing treatment.

On 03/05/2025, I received documentation from licensee designee Karon Lee via email. The first page is titled "*Employee Status Change Report*" and is dated 02/05/2025. It notes that staff Christina Baldwin was terminated at will per MCSI policy. The second page is a copy of notes from a staff meeting held on 02/25/2025, noting that staff went over breathing disorders and bronchospasms. It notes "*Staff are to administer medications using procedures for which they have been trained If not following P.O. (physician order)/holding medications always call home manager or on call nurse.*"

On 03/05/2025, I sent a follow up email to LD Karon Lee and area manager Lisa Kalisz inquiring whether Resident A's Individual Plan of Service (IPOS) addresses the use of the breathing treatment. Lisa Kalisz responded back stating that it does not as Resident A does not have nursing services, and it is not addressed in an IPOS. There is only the physician order. It should be noted the physician order provided does not detail Resident A's specific symptoms for bronchospasms.

On 03/07/2025, I interviewed staff Christina Baldwin via phone. Staff Baldwin stated that there was issues with Relative 1 starting when Resident A moved into the home. Relative 1 had asked staff to give Resident A a breathing treatment once before, and she addressed this with management who said they would talk to Relative 1. On the day of the incident, Resident A was in their wheelchair sleeping. Relative 1 called to speak with Resident A. Resident A was dozing off and on. After the call, Resident A told Staff Baldwin "*[Relative 1] said I need a breathing treatment*." Staff Baldwin stated that she stood and listened to Resident A. Resident A was not congested, coughing, or sneezing. She stated that she told Resident A "*[Relative 1] can't call here telling staff you need a breathing treatment. You don't need one*." Staff Baldwin stated that Resident A went to sleep after the call. Staff Baldwin stated that she spoke with management around 4:30 am the next morning when management

arrived at the home. Staff Baldwin stated that she felt that because she worked in the home, she felt she could make that decision. Staff Baldwin denied that she said anything about Relative 1 not having knowledge, it was just that she was there with Resident A, and did not feel Resident A needed the breathing treatment. Staff Baldwin stated that she worked in the home for seven years, but it did not dawn on her to contact the nurse. Staff Baldwin stated that she realizes now that would have been the thing to do. Staff Baldwin stated that she feels the home should have a protocol in place to prevent this. Staff Baldwin stated that she did not make an outlandish judgement, and it is unfair she lost her job due to something that she was hired her to do which is pass medications and make decisions on whether or not a resident does or does not need a treatment. Staff Baldwin stated that it was not explained to her why she was fired. Staff Baldwin then stated that Resident A said he needed the breathing treatment "*only because [Relative 1] said so.*"

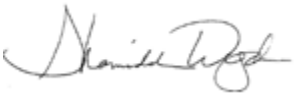
On 03/11/2025, I conducted an exit conference with licensee designee Karon Lee. She stated that Staff Baldwin was terminated, and they have already in-serviced staff. I informed LD Lee of the findings and conclusion.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	On 02/19/2025, I interviewed home manager Anita Willette. Staff Willette stated that Resident A is usually visibly short of breath when the Albuterol is needed. Staff Willette stated that there were no witnesses. A copy of Resident A's medication administration records for January 2025 confirm that Resident A is prescribed Albuterol Neb 0.083% (inhale the contents of one amp via nebulizer every six hours as needed for Bronchospasm). The assessment plan and physician order for Resident A's Albuterol does not specify the symptoms Resident A exhibits when the PRN is needed. On 02/24/2025, I conducted a follow-up on-site at the facility. I

	interviewed Resident A. Resident A stated that they felt as though they needed the breathing treatment at that time, because Resident A felt they could not breath. Resident A stated it took a while to get past the breathing episode because Staff Baldwin refused them the treatment. On 03/03/2025, I interviewed Relative 1 via phone. Relative 1 stated that Resident A sounded like they had mucus in their throat. It did not sound really bad, but it was enough to give Resident A a breathing treatment. On 03/07/2025, I interviewed staff Christina Baldwin via phone. In summary, Staff Baldwin reported that she did not provide Resident A with their breathing treatment because she felt Resident A did not need it. There is a preponderance of evidence to substantiate a rule violation. Resident A reported they requested an as needed breathing treatment stating they felt they could not breath. Staff Baldwin did not provide the breathing treatment, did not contact management, and did not contact a nurse.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 3-6).



03/11/2025

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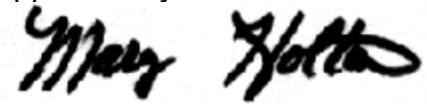
Shamidah Wyden Date
Licensing Consultant

Approved By:



03/11/2025

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Mary E. Holton Date
Area Manager