



RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS

MIKE ZIMMER
DIRECTOR

August 19, 2015

Jeremiah Cheff
Hilltop Estates Inc
P.O. Box 95
Atlas, MI 48411

RE: Docket # 15-004817-DHS
License AL630007349

Dear Mr. Cheff:

On or about July 13, 2015 you were mailed a copy of the Final Decision and Order upholding the Department of Licensing and Regulatory Affairs' intention refuse to renew your license to operate an adult foster care large group home. In accordance with that Final Decision and Order, your license is revoked and is now no longer in effect as of July 13, 2015. It is further understood that you will not receive adults for care now, or in the future, without being legally licensed to do so.

Sincerely,

Jay Calewarts, Director
AFC and Camps Licensing Division

JC: sb

cc: Denise Nunn, Area Manager

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

In the matter of:

Hilltop Estates, Inc.,
Petitioner

Jeremiah Cheff,
Owner-Licensee Designee

v

Bureau of Children and Adult
Licensing,
Respondent.

Docket No. 15-004817-DHS

Agency No. AL 630007349

Agency: LARA

Case Type: BCAL

Filing Type: Appeal

Issued and entered
this 3rd day of July, 2015 by
Mike Zimmer, Department Director

RECEIVED
JUL 16 2015
BUREAU OF CHILDREN
AND ADULT LICENSING

FINAL DECISION AND ORDER

This matter began with Respondent's October 30, 2014 Notice of Intent to Refuse to Renew Petitioner's license to operate an adult foster care large group home under the Adult Foster Care Facility Licensing Act, 1979 PA 218 (Act), MCL 400.701 *et seq.*¹ A hearing regarding the matter at issue was held by Administrative Law Judge David M. Cohen (ALJ) on March 11, 2015.

On April 21, 2015, the ALJ issued a Proposal for Decision (PFD) that contained findings of fact and conclusions of law regarding the Respondent's Notice of Intent to Refuse to Renew Petitioner's license, with the proposal the Department Director adopt the findings of fact and conclusions of law, including that the Petitioner committed willful and substantial violations as specified in the Proposed Decision part of the PFD.

¹ At the time of the issuance of the Notice of Intent, the Bureau of Children and Adult Licensing (Respondent) was organizationally a part of the Department of Human Services (DHS), and now is under the Department of Licensing and Regulatory Affairs (LARA) in accord with Executive Order 2015-4.

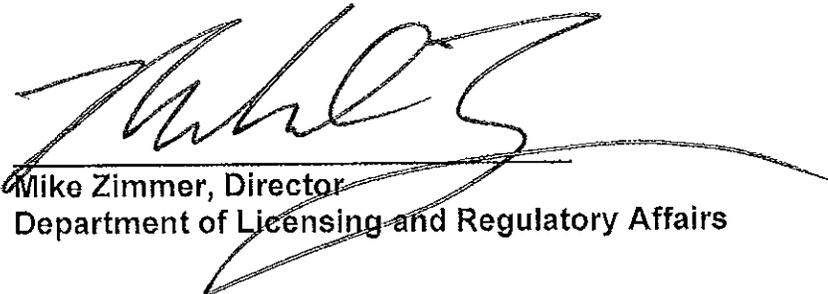
Further, it was proposed that the Department Director take action on the Notice of Intent as deemed appropriate under the Act.

Parties were notified of the right to file Exceptions to the PFD. After review of the hearing record, it is evident no Exceptions or Responses to Exceptions were timely filed. Now, therefore, after review of the hearing record and the ALJ's Proposed Decision, the following Order is entered:

ORDER

NOW THEREFORE, IT IS ORDERED that:

1. The ALJ's Proposal for Decision (PFD) is adopted in its entirety and is incorporated by reference, and made a part of this Final Decision and Order (see attached PFD).
2. The actions of the Bureau of Children and Adult Licensing to Refuse to Renew the Petitioner's license are AFFIRMED.


Mike Zimmer, Director
Department of Licensing and Regulatory Affairs

STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM

IN THE MATTER OF:

Docket No.: 15-004817-DHS

Hilltop Estates/Jeremiah Cheff,
Petitioner

Case No.: AL 630007349

v

Agency: Department of
Human Services

Bureau of Children and Adult Licensing,
Respondent

Case Type: DHS BCAL

Filing Type: Appeal

Issued and entered
this 21st day of April, 2015
by: David M. Cohen
Administrative Law Judge

PROPOSAL FOR DECISION

PROCEDURAL HISTORY

This matter was initiated on October 30, 2014, with the Bureau of Children and Adult Licensing (BCAL or Respondent) issuing a Notice of Intent to Refuse to Renew License, regarding the license of Hilltop Estates, Inc. (Licensee or Petitioner) to operate an adult foster care large group home pursuant to the authority of the Adult Foster Care Facility Licensing Act (the Act), 1979 PA 218, as amended, MCL 400.701 et seq.

A March 11, 2015 hearing was convened as scheduled, and the matter proceeded until its conclusion. All testimony was taken at the Michigan Administrative Hearing System. Petitioner's Owner/Licensee Designee Jeremiah Cheff was present at the hearing and the Petitioner was represented by Attorney Anthony Della Pelle. Assistant Attorney General Kelley McLean represented Respondent at the proceeding. BCAL Area Manager Denise Nunn was present at the hearing, but did not testify.

WITNESSES

For Respondent:

Oakland County Sanitarian Jeremy Fruk
Licensing Consultant Cindy Adams

For Petitioner:

Licensee Designee Jeremiah Cheff

SUMMARY OF EXHIBITS

RESPONDENT EXHIBITS

<u>Exhibit</u>	<u>Description</u>
1.	Environmental Health Inspection Request and corresponding Environmental Health Inspection Report
2.	A September 2014 BCAL Renewal Inspection Report
3.	A September 2011 BCAL Special Investigation Report
4.	A November 2011 correspondence indicating acceptance of a Corrective Action Plan (CAP). A copy of the CAP is attached to the correspondence
5.	An October 2013 BCAL Special Investigation Report
6.	A February 2014 correspondence indicating acceptance of a CAP and the issuance of a First Provisional License. A copy of the February 2014 CAP is attached to the correspondence
7.	Licensee's June 2014 Renewal Application

The Petitioner did not move to admit any exhibits at the proceeding.

ISSUES AND APPLICABLE LAW

In the present matter, the Notice of Intent to Refuse to Renew License sets forth seven counts against the Petitioner/Licensee averring that the Petitioner has committed multiple willful and substantial violations of the Act, or rules promulgated under the Act.

More specifically, it is averred that the Petitioner is in violation of Rule 400.5401(1)(4)(5)(7)&(8), Rule 400.15402(1)(2)&(5), Rule 400.15403(1)(3)(4)&(5), Rule 400.15312(2)&(4)(b)(i)(ii)(iii)(iv)(v)(vi), Rule 400.15201(2), and Rule 400.15305(3), and that, as such, grounds exist to refuse to renew Petitioner's license to operate the adult foster care large group home or to take other action under the Act.

The relevant sections provide in pertinent part as follows:

R 400.5401

(1) Private water systems shall be in compliance with R325.10101 et seq. of the Michigan Administrative Code. A bacteriological report confirming water quality shall be required during

the initial inspection and every 2 years thereafter .. Group homes that use a community approved water system need not be in compliance with this requirement.

(4) All garbage and rubbish that contains food wastes shall be kept in leakproof, nonabsorbent containers. The containers shall be kept covered with tight-fitting lids and shall be removed from the home daily and from the premises at least weekly.

(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.

(7) Each habitable room shall have direct outside ventilation by means of windows, louvers, air-conditioning, or mechanical ventilation. During fly season, from April to November, each door, openable window, or other opening to the outside that is used for ventilation purposes shall be supplied with a standard screen of not less than 16 mesh.

(8) Hand-washing facilities that are provided in both the kitchen and bathroom areas shall include hot and cold water, soap, and individual towels, preferably paper towels.

R 400.15402

(1) All food shall be from sources that are approved or considered satisfactory by the department and shall be safe for human consumption, clean, wholesome and free from spoilage, adulteration, and misbranding.

(2) All food shall be protected from contamination while being stored, prepared, or served and during transportation to a facility.

(5) A home shall be properly equipped as required by the health authority, to prepare and serve adequate meals.

R 400.15403

(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

(3) All living, sleeping, hallway, storage, bathroom, and kitchen areas shall be well lighted and ventilated.

(4) A roof, exterior walls, doors, skylights, and windows shall be weathertight and watertight and shall be kept in sound condition and good repair.

(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair.

R 400.15312

(2) Medication shall be given, taken, or applied pursuant to label instructions.

(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:

(b) Complete an individual medication log that contains all of the following information:

(i) The medication.

(ii) The dosage.

(iii) Label instructions for use.

(iv) Time to be administered.

(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.

(vi) A resident's refusal to accept prescribed medication or procedures.

R 400.15201

(2) A licensee shall have the financial and administrative capability to operate a home to provide the level of care and program stipulated in the application.

R 400.15305

(3) A resident shall be treated with dignity and his or her personal needs, including protection and

safety, shall be attended to at all times in accordance with the provisions of the act.

SUMMARY OF EVIDENCE

The following is intended only as a brief summary drawn from relevant evidence presented at the March 2015 hearing. The present matter involves Petitioner's appeal of Respondent's Notice of Intent to Refuse to Renew License to operate an adult foster care large group home. In addition to the above-referenced exhibits, testimony was solicited from three witnesses at the proceeding.

Testimony of Sanitarian Jeremy Fruk

The first witness at the proceeding was Sanitarian Jeremy Fruk. Mr. Fruk testified that he is employed with the Oakland County Health Division and has worked in his present position for approximately five years.

The witness stated that his job duties require him to perform inspections at Adult Foster Care Homes, and Mr. Fruk estimated that he performs approximately ten such inspections each year.

Turning to the specific matter at issue, the witness indicated that he performed a July 23, 2014 inspection of the Licensee's facility. The witness stated that he arrived at the site at 2:00 p.m. and was present at the home for approximately an hour and ten minutes.

The witness was shown the Environmental Health Inspection Report he authored and this was admitted at the proceeding as Exhibit 1. Mr. Fruk recalled that two of the Licensee's employees/workers were present in the home while he conducted the inspection, but he could not recall the names of the individuals who were present.

Mr. Fruk indicated that the purpose of the inspection was to determine if environmental hazards were present in the home. Responding to a direct question, the witness testified that environmental hazards were found during the course of the inspection.

As to the specific environmental hazards that were observed on July 23, 2014, the witness stepped through the findings which were recorded in the Environmental Health Services Inspection Report he authored (Exhibit 1 at Page 4-5).

Mr. Fruk's testimony, drawing from the report he authored, related that the specific violations found at the home included:

- Rule 401(3) - a sewer drain line was not capped in the basement
- Rule 401(5) - there was an infestation of bed bugs present in the home
- Rule 401(7) - an upstairs bedroom was missing a screen
- Rule 401(8) - the upstairs bathrooms were missing soap and hand towels
- Rule 402(1) - a severely dented can was observed on a shelf

Rule 402(2)(A) - raw shelled eggs were stored next to ready to eat cheese

Rule 402(5) - the facility did not have test strips available to test sanitizer levels

Rule 403(3) - low lighting was observed in the kitchen and other lower level areas

Rule 403(4)(A) - exterior back entrance doors had rotting wood and were in disrepair

Rule 403(5)(A) - a hole was observed in a bedroom closet wall. The hole was described as circular and about eight inches in diameter. Additionally, soiled carpet was noted, and it was indicated that this was a concern as it could serve to harbor bed bugs.

Rule 411(1) - bedding issues were noted which related to the aforementioned issue of the bed bug infestation.

Although the Environmental Health Services Inspection Report also mentions a violation of Rule 401(4), noting that a dumpster was missing a lid, this was not mentioned in the direct testimony of Mr. Fruk.

The witness stated that he had not personally inspected the property prior to the July 2014 visit, but indicated that it had been previously inspected by a co-worker, Mr. Kevin Paladino. Mr. Fruk related that he was told by his colleague, prior to arriving at the home, to take precautions due to the bed bug issue which had been previously observed, and the witness recalled that he rolled his pant legs and was careful in moving bedding so as to minimize contact with bed bugs. Mr. Fruk clearly related that he personally observed bed bugs in every bed of the facility.

Mr. Fruk acknowledged that at the culmination of his report, he recommended that the facility receive a "D" rating, noting that there was substantial noncompliance with environmental requirements.

During cross-examination, the witness indicated that Mr. Paladino had accompanied him during the July 23, 2014 inspection. Mr. Fruk also acknowledged during cross-examination that the bed bug infestation had previously existed, dating back prior to the current license/owner of the facility.

As to issues other than the bed bug infestation, Mr. Fruk indicated that he could not say whether work was being performed on the sewer drain which was observed without a cap. The witness did acknowledge that there were two dumpsters on the property, and one contained an appropriate lid. Mr. Fruk could not recall if the uncovered dumpster was being used at the time of the inspection.

As to the window screen, the witness recalled having a conversation with someone at the home where it was indicated that a resident at the facility sometimes popped the screen out of the window.

Mr. Fruk recalled that hand towels and soap were located in an upstairs closet, but reiterated that the home was still in noncompliance with the rules as soap and towels needed to be located at the sink. The witness spoke about his inspection being "a snapshot in time", indicating that he views conditions as they exist at the time of inspection.

Also during cross-examination, Mr. Fruk defended his finding of a violation regarding the raw eggs in the refrigerator, noting that there was still a possibility for the eggs to contaminate food even if they were placed in a cardboard container. The witness was directed to the exact wording of Rule 400.15402(2), and continued to maintain that the rule was violated by the storing mechanism of the eggs. The witness opined that possibly a plastic container to hold the eggs would be a sufficient storage mechanism.

The witness was asked how a determination was made regarding what constituted "insufficient lighting", and it was indicated, to the effect, that inspectors make a diligent attempt to make certain that they aren't citing for something unwarranted, and while not retracting his finding, the witness acknowledged that the determination of low lighting was based upon observation and that it was a judgment call.

Mr. Fruk was asked about the sanitizers (test strips), and acknowledged that he was unaware whether the Licensee had been told previously about what was needed or not needed regarding sanitizers.

On re-direct examination, the witness agreed that the requirement that windows be screened did not provide for an exception if a resident removed a screen. The witness also reaffirmed his position regarding the storage mechanism of eggs in the home's refrigerators.

Testimony of Licensing Consultant Cindy Adams

The second witness at the proceeding was Licensing Consultant Cindy Adams. Ms. Adams testified that she has been an Adult Foster Care Licensing Consultant for the past three years, and previously worked for thirteen years in the field of adult protective services. The witness estimated that she conducted approximately forty five special investigations during the course of the past year, and conveyed that investigations are a component of her duties as a licensing consultant.

Turning to the present matter, the witness indicated that the facility at issue had changed ownership prior to her involvement with the home, and that Mr. Cheff is the current individual responsible for the facility. Ms. Adams related that the home is licensed for up to twenty residents and that the residents in the facility had histories of mental illness.

Licensing Consultant Adams indicated that she was assigned to conduct a special investigation of the Licensee's facility in or around July 2013. Ms. Adams recalled that the special investigation was initiated after receiving a complaint which contained a number of averred rule violations. After conducting an investigation, Licensing Consultant Adams substantiated violations regarding resident records and a concern over a resident not receiving treatment after sustaining a fall in the home. Violations were also noted regarding refrigeration issues, and issues pertaining to the sanitary and physical conditions at the facility. The witness specifically recalled that there was a dumpster with trash overflowing out of it, and that the lawn was not maintained at the

property. Additionally, there was a roof leak and other issues pertaining to the physical condition of the home.

After initiating disciplinary action against the Licensee, the matter was resolved, and the facility was placed on a provisional license which was issued sometime during February 2014.

On August 18, 2014, while still on a provisional license, the home became subject to an inspection pertaining to the annual renewal of its license. Licensing Consultant Adams testified to being onsite at the home for the renewal inspection, and recalled that Licensee Designee Cheff and his wife were also present at the residence.

During the August 2014 inspection, Licensing Consultant Adams recalled noting several concerns pertaining to medication errors/medication disbursement issues at the home. Additionally, the witness specifically remembered observing bed bugs in one of the resident's beds.

Other issues noted during the August 2014 inspection included a crack which was observed in a window on an exterior rear door of the facility.

The witness stated that at the time of the renewal inspection she had received the environmental inspection report prepared by Oakland County, and was aware of the violations noted on the report.

Responding to questioning regarding medication errors, the witness recalled that there were indications of several medications not having been administered. Also, the witness remembered seeing that one upcoming dose of a resident's medicine was *pre-initialed* as having been disbursed.

Further, the witness noted that on August 12, 2014, August 16, 2014, August 17, 2014 and August 18, 2014 the medication log was missing initials by staff members to indicate the proper disbursement of medication.

The witness remembered that she questioned staff as to a disbursement issue, and was told that a resident had left that morning before the medication could be given. Ms. Adams explained that this was not an adequate explanation for not administering the medication, as this explanation should have been noted in the medication log and was not noted.

Ms. Adams identified the report she authored after the August 2014 inspection, and this was admitted as Exhibit 2. Additionally, the witness testified as to violations which were repeat in nature and Exhibit 3, Exhibit 4, Exhibit 5, and Exhibit 6 were admitted for the purpose of documenting what had been indicated as repeat violations noted during August 2014.

The final exhibit admitted at the proceeding was the Licensee's June 2014 License Renewal Application (Exhibit 7). The witness indicated that licensees have to reapply every two years to continue their licensure.

Licensing Consultant Adams was asked as to how the Oakland County Environmental Report factors into the license renewal process. The witness related that if a facility receives an "A" rating, this is entered into the computer system and no further action is necessary. Anything less than an "A" rating, as in the present instance where the home had received a "D" rating, requires that a special investigation be initiated to ensure that the home is addressing the issues that have been noted. Ms. Adams indicated that, in this instance, the special investigation was concurrent with the August 2014 renewal inspection.

Of note, the witness spoke about the provisional license status of the Licensee, indicating to the effect that there was a zero tolerance policy for quality of care violations when a licensee was on a provisional license, and that several quality of care violations were noted during the August 2014 inspection.

Licensing Consultant Adams conveyed that it wasn't a single violation which led to the decision to seek denial of the license renewal, but the totality of the violations/concerns that had been noted.

On cross examination, the witness reiterated that during her August 2014 inspection she observed bed bugs in only one resident's bed, and agreed with the representation that this was indicative that progress had been made on the bed bug infestation issue, as the prior environmental inspection had observed bed bugs in all resident beds. Ms. Adams also expressed a belief that the Licensee was meeting the expressed conditions of the corrective action plan which addressed the bed bug infestation issue, but added that it was not sufficient to eliminate the bed bug issue.

The cross-examination stepped through each of the violations that had been noted during the July 2014 environmental inspection, and the witness generally agreed that the items on the list had been addressed. As to the missing screen on an upstairs window, Ms. Adams recalled that the screen was still missing, but agreed that she did not note this deficit in her report. Additionally, Ms. Adams stated that she acknowledged to the Licensee that she was not personally aware of what test strips were needed for sanitization, and recalled that the Licensee Designee indicated that they would contact the health department to determine what was needed for compliance.

Licensing Consultant Adams was also questioned regarding how she was able to make her determinations regarding medication dispersal, and the witness spoke of medication packaging such as blister packs as opposed to medication stored in bottles.

Additionally, in regards to the medication issues, the witness did not dispute a representation that the employee responsible for the medication errors was promptly terminated by the Licensee.

Responding to a question, Ms. Adams characterized Licensee Designee Cheff as responsive to the issues, but elaborated saying that it was "yes" and "no" in that some violations remained unaddressed. However, upon further questioning, the witness indicated that the issues raised in the July 2014 environmental inspection were addressed by the Licensee.

On re-direct examination, the licensing consultant averred that it would be the Oakland County Health Department that would be responsible to verify that the issues raised in the Environmental Health Inspection Report were properly addressed. The witness stated that the facility was required to have an "A" rating to achieve renewal, and that there was no indication that this rating had been achieved at the time of the renewal inspection. On re-cross examination the witness agreed that she did look at the areas noted on the environmental inspection report during the time of her renewal inspection.

Testimony of Licensee Designee/Owner Jeremiah Cheff

The final witness at the proceeding was called by Petitioner, and it was Licensee Designee/Owner Jeremiah Cheff.

Mr. Cheff testified that he purchased the adult foster care home approximately four or five years ago, and that unbeknownst to him at the time, the facility was infested with bed bugs. Mr. Cheff related that several efforts had been made to address the bed bug issue including the use of *Terminex* and other services. The witness recalled that he first learned of the bed bug issue when informed of the concern by residents; and that when he investigated he personally determined that it was a problem.

The witness stated that, in an effort to curtail the bed bug situation, all of the carpets in the home have now been torn out, and that beds and other furniture had been replaced. The witness indicated that ultimately *Dawn Soap* turned out to be effective in efforts to rid the home of the infestation. The witness testified directly that the bed bug problem has now been eliminated.

Mr. Cheff was next asked about the missing sewer pipe cap/drain cap that was noted in the environmental report. Mr. Cheff indicated that work was being performed on the pipes. The witness opined that the work was necessary, as residents had likely flushed something inappropriate down the toilet in the home. Mr. Cheff conveyed that the missing cap was promptly replaced.

Mr. Cheff related that the lidless dumpster at issue circa July 2014 was the original dumpster that was present onsite when he purchased the home. Mr. Cheff noted that a previous complaint was made regarding the dumpster not having a lid, and this resulted in his immediately purchasing a new dumpster. The witness stated that during the time at issue, the lidless dumpster was not being used and did not contain any garbage.

The Licensee Designee was asked about other issues that had been noted during the July 2014 environmental inspection. Mr. Cheff indicated that the window screen and hole in the upstairs closet were both repaired and/or replaced as soon as they were brought to his attention.

As to the soap and hand towels in the upstairs bathrooms, the testimony related that the supplies were on hand in an upstairs closet and at the moment of the inspection the sinks had not had their supplies replenished.

Mr. Cheff speculated that the dented can of food probably resulted from something falling during purchase. The witness related that he would not normally purchase anything dented, and that any dented cans that were discovered would be pitched/discarded.

Mr. Cheff clearly expressed that he would have previously believed that the eggs, which were contained in a cardboard box within the refrigerator, were being properly stored. The testimony, as with the other environmental issues, related that the home is now in compliance with the rule at issue.

Regarding testing strips, the witness indicated that they were onsite in a back stock closet, but that they were not often needed as the facility did not use bleach for cleaning, but relied on other acceptable agents such as *Pinesol*.

It was also indicated that burnt out light bulbs were replaced to address the lack of lighting, and that the doors at issue in the rear of the home were also replaced after the July 2014 Environmental Inspection.

Turning to the issue of medication records, Mr. Cheff expressed that he would not challenge that Licensing Consultant Adams was accurate in what she observed. Mr. Cheff related that the employee at issue was new, and was terminated as a result of the issues noted. Mr. Cheff conveyed that a supervisor reviews the medication logs weekly to check that the home is in compliance with its requirements, and that a nurse practitioner also conducts a monthly review to ensure that everything is in order. It was clearly indicated that all employees undertake the required training.

At the summation of his direct testimony, Mr. Cheff indicated that he is the Licensee Designee for sixteen facilities. The witness acknowledged that one other home he owned was closed due to medication issues, but clearly conveyed that the other operating homes were in good order. While Mr. Cheff indicated that mistakes were made, the witness articulately expressed his personal belief that the State was being rigid in how they viewed the matter, and indicated that he did wish to continue to do business and keep his license.

On cross-examination, the witness was asked regarding the certainty of his explanations as to the cause of the missing sewer cap, window screen and dented can. Mr. Cheff represented that he was certain regarding the sewer cap being off due to work being

performed, and averred to the effect that he was reasonably certain that a resident had removed the window screen and that the can likely fell and was dented through that mechanism.

Also on cross-examination, the witness acknowledged that the test strips at issue were not where they needed to be at the time of the BCAL inspection.

In summation, the witness agreed that he assumed responsibility for the operation when he purchased the home from its prior owner.

FINDINGS OF FACT

Based on the entire record in this matter the following findings of fact are established:

1. The Licensee was issued a license to operate an adult foster care large group home, with a current licensed capacity of 20, at 841 Auburn Road, Pontiac, Michigan 48342 (Hearing Record).
2. The Licensee's facility was previously owned and operated by another individual. In November 2010, the previous owner, responding to legal issues which had been raised against him, entered into a Settlement Agreement with the Bureau of Children and Adult Licensing (BCAL), and terminated his ownership interest in the Licensee's facility. Hilltop Estates, Inc. was sold at that time to current Licensee Designee and Administrator Jeremiah Cheff. Mr. Cheff subsequently assumed all operational responsibilities of the Licensee's facility (Testimony of Licensee Designee Cheff).
3. The October 2014 Notice of Intent to Refuse to Renew License averred that an April 26, 2011 renewal inspection of the Licensee's facility noted fourteen rule violation, including violations of R 400.15312(2) and R 400.15312(4). However, having reviewed the entire record in this matter, this Administrative Law Judge finds that allegations pertaining to the April 2011 renewal inspection were not specifically addressed at the hearing. The hearing record does indicate that there was an April 2011 renewal inspection (See Exhibit 3, at Page 9). Further, there is also indication that a June 2011 Licensing Study Report noted a violation of R 400.15312, and that this was addressed in an October 2011 CAP (See Exhibit 5, at Page 13).
4. On August 3, 2011, Licensing Consultant Sharon King initiated a special investigation of the Licensee's facility (SIR #2011A0610035) (Exhibit 3). Ms. King cited the Licensee for five rule violations, including the following:
 - a. The Licensee failed to administer a resident's topical hydrocortisone medication as prescribed. This was a repeat violation of R 400.15312 (Exhibit 3, at Pages 6-8).

- b. The Licensee failed to properly record the administration of medication to residents (Exhibit 3, at Pages 3-8).
5. On October 6, 2011, the Licensee submitted a written corrective action plan that addressed rule violations cited during the April 2011 renewal inspection (See Exhibit 5, at Page 13).
6. On November 14, 2011, the Licensee submitted a written corrective action plan that addressed the rule violations cited during Ms. King's August 2011 special investigation (Exhibit 4).
7. The October 2014 Notice of Intent to Refuse to Renew License averred that there was a late January 2013 special investigation of the Licensee's facility (SIR #2013A0602009), which found that the Licensee failed to assure resident protection due to multiple fire safety violations at the facility. It was further averred that the Licensee submitted a written corrective action plan that addressed the fire safety violations cited during this special investigation. Such conduct would be a violation of R 400.15305(3). However, the hearing record does not establish the contents of the January 2013 special investigation.
8. On July 16, 2013, Licensing Consultant Cindy Adams initiated a special investigation of the Licensee's facility (SIR #2013A0602034) (Exhibit 5). Ms. Adams ultimately cited the Licensee for 12 licensing rule violations. The resulting October 2013 Special Investigation Report notes the following:
 - a. On August 28, 2013, the Oakland County Health Division conducted an environmental health inspection of Licensee's facility. At that time it was noted that the facility was noncompliant with areas including: insect and rodent control, garbage-rubbish-solid waste collection storage and removal, proper screening of doors and windows, satisfactory lighting, ventilation and temperature control, fencing, maintenance of the general premises in a clean and safe condition, and clean and safe maintenance of toilet and bathing facilities (Exhibit 5, at Page 7).
 - b. On September 27, 2013, Ms. Adams inspected the Licensee's facility. Ms. Adams observed over twenty health, maintenance and safety violations, including the following (Exhibit 5, at Pages 8-11):
 - i. Broken eggs were in an egg carton in the refrigerator.
 - ii. Dead bugs were on the bottom and inside the interior door of the refrigerator.
 - iii. The Licensee stored food on the floor of the pantry.
 - iv. Dead bugs were underneath the storage cabinets in the pantry where Licensee stored non-perishable food.

- v. The front door was dirty and scratched.
 - vi. The plastic mattress protectors on residents' mattresses were torn, stained, and partially covered with dead bed bugs.
 - vii. The open window in the staff bedroom did not have a screen, and the screen for the window open in one bedroom was torn.
 - viii. Ms. Adams observed flies and bugs flying throughout the facility.
 - ix. Empty food wrappers and trash were piled on the floors of two bedrooms.
 - x. There was a hole in the ceiling of a resident's bedroom, and water stains and peeling paint surrounded the hole. Standing water was located in a garbage bag and bucket. Bugs flew away from the water when the garbage bag was moved.
 - xi. Gnats covered a bag of trash located inside the closet of a resident's bedroom. The bag had a foul odor.
 - xii. The window tracks in two bathrooms were filled with dead bugs.
 - xiii. The window screen in one bathroom was torn.
 - xiv. The baseboards in one bathroom were dirty and contained peeling paint.
 - xv. There was a gap between the sink and the countertop in one bathroom.
 - xvi. A wood board was covering a window on the east side of the facility.
 - xvii. A wood board was detached from a wall on the east side of the facility, exposing insulation.
 - xviii. The dumpster lacked a cover and was overflowing with trash.
9. Due to the quantity and severity of the rule violations cited during Ms. Adams' special investigation, BCAL issued a Notice of Intent to Revoke the license of Hilltop Estates, Inc. on or about November 19, 2013. The Notice of Intent to Revoke cited numerous rule violations (Hearing Record):
10. On February 14, 2014, the Licensee submitted a written corrective action plan that addressed the rule violations cited in the Notice of Intent to Revoke. On February 24, 2014, the Licensee entered into a Settlement Agreement with BCAL to resolve the violations in the Notice of Intent. BCAL agreed to the issuance of a first provisional license effective February 24, 2014. The license for Hilltop Estates, Inc. remains at a provisional status (Hearing Record and Exhibit 6).
11. On July 23, 2014, Sanitarian Jeremy Fruk from the Oakland County Health Division conducted an environmental health inspection of the Licensee's facility (Exhibit 1 and testimony of Sanitarian Fruk). Mr. Fruk observed 12 violations regarding the maintenance and safety of the facility, including the following:

- a. A sewer drain line in the basement storage room was not capped, in violation of R 400.5401(1).
- b. The facility's dumpster was not equipped with a lid, in violation of R 400.5401(4).
- c. Bed sheets and mattresses in all bedrooms were infested with bed bugs, in violation of R 400.5401 (5) and R 400.5411 (1). Mr. Fruk observed live and dead bed bugs, as well as blood stains on residents' bedding.
- d. A window screen was missing in a bedroom on the upper floor, in violation of R 400.5401(7).
- e. The upstairs bathrooms were not stocked with soap and hand towels, in violation of R 400.5401(8).
- f. There was a severely dented can of food in the dry storage area, in violation of R 400.5402(1).
- g. Raw eggs were being stored in the refrigerator next to ready-to-eat cheese. A boxed food item was being stored on the floor of the dry storage area, in violation R 400.5402(2).
- h. The home was not stocked with test strips for the facility's sanitizer, in violation of R 400.5402(5).
- i. There was insufficient lighting in the kitchen, downstairs bathroom and dry storage room, in violation of R 400.5403(3).
- j. The exterior doors at the back entrances were rotting and were in disrepair, in violation of R 400.5403(4).
- k. There was a hole in the closet wall of bedroom #5. There were gaps in the wall molding on the second floor, in violation of R 400.5403(5).

12. On August 18, 2014, Ms. Adams conducted a renewal inspection of the Licensee's facility (Exhibit 2 and testimony of Licensing Consultant Adams). During the inspection, Ms. Adams reviewed the Licensee's medication administration procedures and found the following violations:

- a. On August 12, 2014, the Licensee failed to record the administration of Resident E's Vitamin D medication. This is a repeat violation.
- b. On August 16, 2014, and August 17, 2014, the Licensee failed to record the administration of Resident E's Seroquel medication. This is a repeat violation.
- c. On August 16, 2014, the Licensee failed to administer Resident E's Lisinopril medication to Resident E. Lisinopril is a blood pressure medication. This is a repeat violation.
- d. On August 17, 2014, the Licensee failed to administer the 5 p.m. dose of Resident E's Tramadol medication to Resident E. Tramadol is a medication prescribed to treat moderate to severe pain. This is a repeat violation.
- e. On August 17, 2014, and August 18, 2014, the Licensee failed to record the administration of Resident E's Lisinopril medication. This is a repeat violation.

- f. On August 18, 2014, Ms. Adams reviewed Resident F's medication log. Ms. Adams observed that the Licensee's staff had documented administering Resident F's medication to Resident F that day. Although the medications were documented as being administered, Resident F did not actually receive the following prescribed medications:
 - i. A multivitamin;
 - ii. Cogentin Benztropine;
 - iii. Lisinopril; and
 - iv. Zantac.
 - g. On August 18, 2014, Ms. Adams reviewed Resident G's medication log. The Licensee's staff documented the administration of medication to Resident G in advance for the following day. On August 18, 2014, the staff had already initiated administering the August 19, 2014, dose of Resident G's Lisinopril medication. This is a repeat violation.
13. On August 18, 2014, Ms. Adams inspected the Licensee's facility for bedbug infestation. Ms. Adams observed live bedbugs and smeared blood on the mattress in bedroom #1 (Exhibit 2, at Page 4). This is a repeat violation (See Exhibit 5, at Page 11).
14. On August 18, 2014, Ms. Adams observed that the window on the back exterior door of the facility was cracked. This is a repeat violation (Exhibit 2, at Pages 4-5).

CONCLUSIONS OF LAW

The principles that govern judicial proceedings also apply to administrative proceedings. The burden of proof is on the Respondent to prove, by a preponderance of the evidence, that Petitioner/Licensee has violated the administrative rules promulgated under the Act as alleged in the Notice of Intent to Refuse to Renew License. A preponderance of evidence is evidence which is of a greater weight or more convincing than evidence offered in opposition to it. It is simply that evidence which outweighs the evidence offered to oppose it *Martucci v Detroit Commissioner of Police*, 322 Mich 270 (1948).

In this case, Respondent alleged that Petitioner/Licensee committed willful and substantial violations of the Act, such that grounds exist to refuse to renew the Petitioner's license to operate an adult foster care large group home.

The Administrative Law Judge (ALJ) evaluates the testimony and evidence elicited at the hearing and renders a proposed decision setting forth an opinion as to whether the Petitioner/Licensee has in fact committed willful and substantial violations of the Act, rules or terms of the license. If a willful and substantial violation is determined, the Director of the Department is statutorily empowered to take appropriate adverse action against the license. Thus, the words "willful and substantial" must be evaluated.

Rule 1 of the Administrative Rules for Adult Foster Care Facility Licensing and Child Care Organizations contested case hearings provides the following pertinent definitions:

R400.16001

Rule 1. (1) As used in these rules:

(a) "Act" means Act No. 116 of the Public Acts of 1973, as amended, being §722.111 et seq. of the Michigan Compiled Laws.

* * *

(c) "Noncompliance" means a violation of the act or act 218, an administrative rule promulgated under the act or act 218, or the terms of a license or a certificate of registration.

(d) "Substantial noncompliance" means repeated violations of the act or act 218 or an administrative rule promulgated under the act or act 218, or noncompliance with the act or act 218, or a rule promulgated under the act or act 218, or the terms of a license or a certificate of registration that jeopardizes the health, safety, care, treatment, maintenance, or supervision of individuals receiving services or, in the case of an applicant, individuals who may receive services.

(e) "Willful noncompliance" means, after receiving a copy of the act or act 218, the rules promulgated under the act or act 218 and, for a license, a copy of the terms of a license or a certificate of registration, an applicant or licensee knew or had reason to know that his or her conduct was a violation of the act or act 218, rules promulgated under the act or act 218, or the terms of a license or a certificate of registration.

* * *

In the present matter, the Notice of Intent to Refuse to Renew License sets forth seven counts asserting allegations against the Petitioner/Licensee.

Count I – Rule 400.5401(1)(4)(5)(7)&(8)

By this charge Respondent avers that the Licensee failed in multiple ways to meet the environmental health requirements for the home. The hearing record establishes that the Licensee is in violation of environmental health rules, including R 400.5401(1)(4)(5)(7)&(8).

It was clearly established that Oakland County Health Division Sanitarian Jeremy Fruk and Sanitarian Kevin Paladino, in the normal course of their duties, conducted a July 23, 2014 environmental health inspection of the Licensee's facility. At that time multiple maintenance/safety violations were noted.

In the opinion of this Administrative Law Judge, the most pronounced environmental health issue noted during the July 2014 Health Division Inspection concerned the determination that the home was infested with bed bugs in violation of R 400.5401(5). This rule, quoted above, requires that an insect/pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.

The testimony of Sanitarian Fruk related that all beds in the facility were infested with bed bugs. Further, the hearing record explicitly noted that live bugs, dead bugs, and smeared blood marks were all observed (Testimony of Sanitarian Fruk and Exhibit 1).

The testimony of Licensing Consultant Adams indicated that she witnessed live bed bugs in one bed when she subsequently inspected the home during August 2014. The Renewal Inspection Report authored by Ms. Adams notes that "blood smears" were also seen on the mattress where the bed bugs were noted (Exhibit 2, at Page 4).

This bed bug infestation had pre-existed the summer of 2014, as a prior 2013 Oakland County Health Division Inspection and BCAL Special Investigation noted that residents were sleeping on mattresses containing live and dead bed bugs (Exhibit 5, at Page 11). The testimony of the Licensee Designee related that the bed bug issue existed before his purchase of the home, but he learned of it only after becoming the owner of the facility.

While the Petitioner represented at the hearing that it fulfilled the requirements of a Corrective Action Plan (CAP) (Exhibit 6) to address the bed bug issue, this argument was not persuasive. Rule 400.5401(5) clearly requires a licensee to carry out insect and pest programs in a manner that will continually protect the health of the residents at the home. If a year after having been noted during 2013 inspections, the bed bugs were so rampant that they were still found in every bed of the home, it is evident that the Licensee had not fulfilled its duty to protect the health of residents.

The Petitioner represented that the infestation was reduced soon after the July 2014 inspection, and this is supported by the testimony of Licensing Consultant Adams who found bed bugs in only one bed a month after Oakland County had noted them in all beds in the home. Further, per the testimony of the Licensee Designee, the infestation was ultimately eliminated. However, this reality only indicates that it was possible to rid the home of the infestation, but as of mid-July 2014 the necessary steps had not yet been taken. The persistence of bed bugs was a direct impediment to the health, safety and wellbeing of facility residents.

A violation of Rule 400.5401(1) was another of the concerns noted during the July 2014 Health Division inspection. Specifically, a sewer drain line in the basement storage room was not capped. R 400.5401(1) speaks to the need for water systems to be in compliance with the Michigan Administrative Code.

Additionally, Sanitarian Fruk noted that, as of the July 23, 2014 inspection, a window screen was missing in a bedroom on the upper floor, in violation of R 400.5401(7). Licensing Consultant Adams' testimony recalled that the screen was still missing during her August 2014 inspection. While having cited the violation, Ms. Adams acknowledged that the missing screen was not noted as still being at issue in her Renewal Inspection Report (See Exhibit 2, at Page 12).

Damaged window screens were noted to be at issue during September 2013, approximately a year earlier when the home was inspected (Exhibit 5, at Page 12). In addressing the issue through a February 2014 CAP, the Licensee wrote that "all damaged/missing screens have been repaired/replaced/installed in the home. Screens will be checked during monthly facility audits" (Exhibit 6).

The Licensee was also found to be in violation of Rule 400.5401(8) during the July 2014 inspection, as it was noted that the home's upstairs bathrooms were all missing soap/towels during the inspection (Testimony of Sanitarian Fruk and Exhibit 1). This violation had been previously noted during 2013 (Exhibit 5, at Page 12). The February 2014 CAP, in addressing the issue, avers that "soap and paper towels or hand towels will be maintained in bathrooms and kitchen. For continual compliance, this will be part of the monthly facility audit conducted by the Area Supervisor" (Exhibit 6).

During cross-examination, Sanitarian Fruk acknowledged that soap and hand towels were observed in an upstairs storage closet, but maintained that the violation was appropriately noted as the soap and towels were not where they were required to be at the time of the inspection.

Additionally, the July 2014 inspection found a violation of Rule 400.5401(4), noting that the home's dumpster was not equipped with a lid. A component of Rule 400.5401(4) requires that all garbage potentially containing food waste be kept covered with tight-fitting lids. The Licensee's home had been found in violation of this rule approximately one year earlier (Exhibit 5, at Page 11), and the Licensee/Petitioner agreed to a corrective action plan regarding this issue (Exhibit 6).

Regarding the dumpster lid issue, the Licensee Designee testified credibly that there were two dumpsters on the premises. One of the dumpsters, the original one which was present when the home was purchased, did not have a lid. However, the second dumpster, purchased to correct the garbage disposal issue, did have a proper lid. The Licensee Designee related that the uncovered dumpster was not being utilized and contained no trash. Further, the record indicates that the dumpster at issue has now been removed from the property.

In summation of Count I, the hearing record establishes willful and substantial violations of Rule 400.5401(5)(7) and (8). A July 2014 Oakland County Health Division inspection noted that the Licensee's home was infected with bed bugs. Further, it was established that an upstairs window of the home was without a required screen and that upstairs bathrooms did not contain soap and hand towels. The issues of bed bugs, window screens, and the necessity of placing soap/hand towels in the bathroom were all previously cited as violations during past interactions with the Oakland County Health Division and/or BCAL.

As these violations had been previously cited, the Licensee knew of its obligation to comply with the rules at issue. As such, they are willful violations. The deficiency in compliance with these rules is also substantial as the shortcomings were of a nature that they necessarily jeopardized the health, safety, care, treatment, maintenance, or supervision of the residents in the care of the Licensee.

As discussed above, a violation of Rule 400.5401(1) is also found, but the hearing record is not sufficient to indicate this specific violation as being willful and substantial in nature. This Administrative Law Judge accepts the Petitioner/Licensee's argument that the drain cap had been removed for a repair and was immediately replaced. Given that this specific issue is not indicated to have arisen previously, there was not a willful and substantial violation of Rule 400.5401(1).

Further, the Licensee's arguments as to compliance with Rule 400.5401(4) are accepted by this Administrative Law Judge. As the dumpster at issue was not being used, it does not meet the criteria indicative of a violation of R 400.5401(4), which speaks to containers being used to contain garbage and rubbish.

However, as noted above, the hearing record establishes willful and substantial violations of Rule 400.5401(5)(7) and (8).

Count II-R 400.15402(1)(2)(5)

By this charge Respondent asserts that the Licensee failed to properly maintain in the home food which met the criteria of being free from contamination and/or spoilage and fit for human consumption. Further, it was alleged that the home was not properly equipped, as required by the health authority, to serve adequate meals. The hearing record establishes a willful and substantial violation of Rule 400.15402(1)(2)&(5).

The Inspection Report compiled by Sanitarian Fruk noted the following violations of Rule 400.15402:

Rule 402(1) Observed a severely dented can stored on shelving in dry storage room. All foods shall be safe for human consumption, clean, wholesome and free from spoilage, adulteration, and misbranding. Discard or return dented cans of food. Employee discarded dented can of food.

Rule 402(2) (A) Observed raw shelled eggs stored next to ready to {eat} cheese. All food shall be protected from contamination while being stored. Store raw shelled eggs below and away from all ready to eat foods. (B) Observed a box of dry foods stored on the floor in the dry storage room. All food must be stored at least 6 inches off the floor. Store all food at least six inches off the floor.

Rule 402(5) Observed no test strips available to test sanitizer levels. Test strips for approved sanitizers must be provided. Provide test strips for approved sanitizers used in facility (Exhibit 1, at Environmental Health Services Inspection Report Supplement).

These findings, noted in the Inspection Report correlated closely with Sanitarian Fruk's hearing testimony and recollection of the July 2014 inspection.

There was a prior violation noted of Rule 400.15402(2). The hearing record indicates that during a September 27, 2013 inspection of the Licensee's home the facility was noted to be in violation of the rule due to "dead bugs on the inside door and at the bottom of the refrigerator. The freezer contained food that was stored in open containers causing possible contamination of the food. I {Licensing Consultant Adams} also observed cracked eggs in the refrigerator" (Exhibit 5, at Page 7).

The Licensee had a duty to ensure a sanitary and safe food environment for residents of the home, but fell short of meeting this obligation in the present matter. The testimony of Sanitarian Fruk and contents of Exhibit 1 demonstrate that there were multiple violations of Rule 400.15402. It is of note to this Administrative Law Judge that the Licensee/Petitioner was cited for a September 2013 violation of Rule 400.15402(2), and that the violations noted at that time included concerns with the manner of how eggs were being stored in the home's refrigerator. Similarly, the July 2014 Rule 400.15402(2) violation noted by Sanitarian Fruk also concerned the manner in which eggs were being stored in the refrigerator. As such, I find that the violation of Rule 400.15402(2) was willful as the Licensee knew of his obligation to properly store items such as eggs in the refrigerator.

Further, the violations of Rule 400.15402(1)&(5) also meet the definitions of willful violations as defined above, as the Licensee knew or should have known of the need for compliance with the regulations governing food safety and general issues of sanitation.

All of these violations constitute substantial violations given that an increased potential of food contamination inherently poses a risk to the health, safety, care, treatment, maintenance, or supervision of the residents in the home.

Count III - R 400.15403(1) (3)(4)&(5)

By this charge Respondent asserts that the Licensee committed numerous rule violations pertaining to the maintenance of the facility. The hearing record establishes a willful and substantial violation of Rule 400.15403(1)(3)(4)&(5).

Rule 400.15403(3)

This rule provides that all living, sleeping hallway, storage, bathroom, and kitchen areas shall be well lighted and ventilated. As noted above, during the July 2014 environmental inspection conducted by Sanitarian Fruk, the Licensee's home was found in violation of this specific rule, as it was noted that there was "low lighting in kitchen, downstairs bathroom, and dry storage room. All living, sleeping, hallway, storage, bathroom, and kitchen areas shall be well lighted and ventilated" (Exhibit 1, at Environmental Health Services Inspection Report Supplement). Mr. Fruk's testimony related his professional opinion that there was low lighting in the lower level of the home. The witness did acknowledge that such a determination was inherently a matter of personal judgment, but still conveyed to the effect that there is an effort to ensure propriety in making such determinations. Conversely, Licensee Designee Cheff testified that the issue was only a matter of some burnt out light bulbs and that these were promptly replaced.

Rule 400.15403(4)

This rule requires that a home's roof, exterior walls, doors, skylights, and windows shall be weathertight and watertight and shall be kept in sound condition and good repair. Again, the July 2014 inspection found a violation of this rule, noting in pertinent part that the exterior back entrance doors of the home showed signs of rotting and disrepair, and that paint was observed to be peeling from the exterior walls on the back side of the building (Exhibit 1, at Environmental Health Services Inspection Report Supplement).

The testimony of Licensee Designee Cheff acknowledged that the rear doors at issue were in disrepair, and indicated that they were promptly replaced after he was notified of the issue.

Rule 400.15403(5)

This rule provides that floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair. Regarding this rule, the inspection report notes that a hole was observed in a closet wall. Also, it was noted that there were "gaps in cove base located in upstairs hallway and upstairs bedrooms", and it was also noted that stairwell carpet was soiled and possibly harboring bed bugs.

During the hearing, Licensee Designee Cheff noted that, upon being brought to his attention, the hole in the closet was promptly repaired and that the carpet in the home has now been replaced as part of the effort to eliminate the bed bug infestation.

Violations of Rule 400.15403 were also noted in the October 2013 Special Investigation Report authored by Licensing Consultant Adams. Amongst these violations, a lack of compliance was specifically noted regarding Rule 400.15403(3)&(5):

The subject report authored at that time notes that there was a hole in the ceiling of one room, issues with window maintenance, and a failure to maintain a clean and sanitary environment for residents (Exhibit 5, at Page 8-9).

Rule 400.15402(1) requires that a licensed home be constructed, arranged, and maintained so as to provide adequately for the health, safety, and well-being of occupants. The above noted violations of Rule 400.15402(3)(4)&(5), determined during the July 2014 inspection, all demonstrate that there were significant issues with the general maintenance of the home as encompassed in the wording of Rule 400.15402(1).

While the Licensee Designee/Owner of the home testified that the window screen was replaced, holes repaired and rugs torn out, these stand as remedial measures for the Director's consideration. However, the reality is that the violations did exist and that they were willful as the Licensee knew of the need to meet the building maintenance criteria outlined under Rule 400.15402, and the violations were also substantial as defined above, as there were multiple building maintenance issues which all presented a risk to the health, safety, care, treatment, maintenance, or supervision of the residents.

Count IV & Count V - R 400.15312(2)&(4)(b)(i)(ii)(iii)(iv)(v)(vi)

By this charge, Respondent asserts that the Petitioner/Licensee failed to dispense medication to residents in compliance with label instructions. Further, it is alleged that the Petitioner/Licensee failed in numerous ways to properly maintain resident medication logs. The hearing record provides multiple examples of a willful and substantial violation of Rule 400.15312(2)&(4)(b)(i)(ii)(iii)(iv)(v)(vi).

The testimony of Licensing Consultant Adams and the 2014 Renewal Licensing Study Report Ms. Adams authored, both credibly detailed the numerous medication errors that she found during her August 18, 2014 renewal inspection of the Licensee's facility (Testimony of Licensing Consultant Adams and Exhibit 2, at Pages 3-4). The 2014 Licensing Study Report notes in pertinent part that:

On 8/16/2014, Lisinopril 10mg was not administered to Resident E. On 8/17/2014, Resident E's 5 pm Tramadol 50mg was not administered. On 8/18/2014, Resident F's Multi-vitamin, Congentin Benzotropine 1mg, Lisinopril 20mg and Zantac 150mg were not administered but staff initials were documented in the medication log book as being administered.... On 8/12/2014, there were no staff initials in the medication log book for Resident E's Vitamin D 50,000 units. On 8/16/2014 and 8/17/2014, there were no staff initials in the medication log book for Resident E's Seroquel 25mg. On 8/17/2014 and 8/18/2014 there were no staff initials in the medication log book for Resident E's Lisinopril 10mg. On 8/18/2014, Resident G's Lisinopril 20mg was initialed by staff on 8/19/2014 (Exhibit 2, at Pages 3-4).

While numerous medications, involving multiple residents, were either not administered or not recorded as being administered, in the opinion of this Administrative Law Judge the most egregious concerns stemmed from observations concerning the medications of Resident F and Resident G.

As noted above, the review of Resident F's medication log indicated that the Licensee's staff had documented administering Resident F's medication to Resident F that day. Although the medications were documented as being administered, Resident F did not actually receive his medications, which included a multivitamin, Cogentin Benztropine, Lisinopril and Zantac. Licensing Consultant Adams was credible in explaining that she was able to make this and other determinations through mechanisms which included comparisons with the medication log and actual blister packs of prescribed medication.

Moreover, as quoted above, on August 18, 2014 Resident G's medication log showed "documentation" that Resident G's medication had been administered for the following day. Specifically, on August 18, 2014, the staff had already initialed administering the August 19, 2014, dose of Resident G's Lisinopril medication.

The proper administration of resident medication, including disbursement of medications and/or logging of medications disbursed had been a previous issue for the Petitioner/Licensee. This Administrative Law Judge notes that the Petitioner/Licensee was the subject of a September 2011 Special Investigation which found numerous medication deficiencies in the Licensee's home. By way of a specific example, it was noted that the Licensee had inappropriately administered a hydrocortisone medication to a resident twice a day during the month of April, even though the medication was to only be applied once a day (Exhibit 3, at Page 6). Inexplicably, there was no record of the medication being applied at all during the month of May. However, after May, the medication was listed as being applied daily between the months of June and August. The records of the post May applications did not correlate with the absence of the medication from the facility during an onsite inspection, and it was further contradicted by the determination that the medication had not been prescribed again or refilled since the prior March (Exhibit 3, at Pages 6-7). Clearly, medication logging and disbursement was a repeat violation when it was observed during the August 2014 renewal inspection.

The testimony of Licensee Designee Cheff detailed that the home had initiated safe guards to ensure that medication disbursements were being handled, and this included a monthly audit of records by a nurse practitioner. While this practice is commendable, the reality is that the practices in place were not sufficient to avoid serious medication disbursement/logging violations. As was indicated during the hearing, the inspections of the home are a snapshot of that moment in time. On August 18, 2014, the snapshot noted by Licensing Consultant Adams was one of a serious deficiency in rule compliance.

Respondent has established willful and substantial violations of Rule 400.15312(2)&(4)(b)(i)(ii)(iii)(iv)(v)(vi). The violations are willful as the Licensee knew of the need to properly dispense medications and also the obligation to properly maintain

individual medications logs for the residents in the home. Additionally, the nature of the violation, sounding in the direct medical care of residents, is such that it inherently posed a risk to the health, safety, care, treatment, maintenance, or supervision of the residents in the adult foster care large group home.

Count VI - Rule 400.15201(2)

By this charge, Respondent asserts that the Licensee failed to demonstrate the financial and administrative capability to operate a home to provide the level of care and program required. The hearing record establishes a willful and substantial violation of MCL 400.15201(2).

As already noted, Licensing Consultant Adams testified to the effect that the Licensee was responsive to concerns raised, yet violations were still evident when the home was inspected during August 2014. Further, the Licensee Designee's testimony clearly related that many remedial measures were taken after July 2014 in an effort to cure deficiencies in the home.

However, while the hearing record establishes that there were efforts to bring the home into compliance, the reality is that the home had been found to have multiple rule violations during interactions with BCAL dating back to at least 2011, and that while on a provisional license, quality of care issues were noted during the August 2014 inspection. These quality of care issues included serious concerns over the proper disbursement of resident medication. This history is indicative of a legally willful and substantial violation of Rule 400.15201(2) regarding the administrative capability of those in charge of the home at issue.

This Administrative Law Judge notes that the Licensee Designee was credible in relating that significant issues with the home predated its current ownership. Still, the home was purchased circa 2010, and significant physical plant issues were documented during the summer of 2014. These issues, and the profound issues pertaining to the handling of resident medication, should not have been present in Petitioner's home during the 2014 renewal inspection. Also, as the home was under a provisional license, the Licensee should have been on a heightened notice regarding the need to focus its administrative capability to ensure that no quality of care issues were present and this clearly did not happen.

In making this finding, it is not a paradox to note that the Licensee Designee's testimony, summarized above, clearly conveyed that efforts were being taken to bring the home into rule compliance. Further, there was nothing in the record to contradict Licensee Designee Cheff's testimony that he owns multiple homes and that the other facilities are all operating without any significant issues. However, the violation of Rule 400.15201(2) was established regarding Hilltop Estates.

Respondent has established by a preponderance of the evidence, a willful and substantial violation of Rule 400.15201(2).

The Licensee knew of the need to demonstrate appropriate administrative capability to operate a home which provided an appropriate level of care, and this did not occur.

Additionally, the nature of the violation is such that it demonstrates substantial noncompliance as defined above. A failure to demonstrate necessary administrative capability necessarily jeopardizes the health, safety, care, treatment, maintenance, or supervision of individuals receiving services.

Count VII - Rule 400.15305(3)

By this charge, Respondent asserts that residents in the Licensee's home were not treated with dignity and their personal needs, including protection and safety were not attended to at all times in accordance with the provisions of the Act. The hearing record establishes a willful and substantial violation of Rule 400.15305(3).

The analysis provided regarding the previous counts in the Notice of Intent demonstrates that there was a failure to ensure the dignity and personal needs of the residents in the facility.

As of July 2014, the home was infested with bed bugs to such an extent that the insects were observed in every one of the resident's beds. The hearing record clearly establishes that the bed bug infestation reached back to at least the year 2010 when the current owner purchased the facility. As such, it appears that residents were living with bed bugs for at least four years before sufficient actions were taken to rid the home of the insects.

Moreover, the failure to properly administer medications to residents correlates directly to being a failure to provide for the personal needs of the residents. The testimony of Licensing Consultant Adams and her documentation made regarding the August 2014 inspection were unambiguous in conveying that there was a significant breakdown in fulfilling the obligation to properly administer medications. Multiple residents were indicated to have been observed with medication log issues, and one resident was pre-initialed as having received a medication dosage which was due to be administered on the following day.

As such, noting all of the above, Respondent has established by a preponderance of the evidence, a willful and substantial violation of Rule 400.15305(3). The Licensee knew of the need to treat residents with dignity and to be respectful of their personal needs. As such the violation was willful in nature. Additionally, it is axiomatic that the nature of the violation is such that it demonstrates substantial noncompliance as defined above.

Based on the totality of the record in this case, the undersigned Administrative Law Judge concludes that Respondent has proven by a preponderance of the evidence that Petitioner's conduct, as set forth in the above analysis evidences willful and substantial violations of Rule 400.5401(5)(7)&(8), Rule 400.15402(1)(2)&(5), Rule

400.15403(1)(3)(4)&(5), Rule 400.15312(2)&(4)(b)(i)(ii)(iii)(iv)(v)(vi), Rule 400.15201(2), and Rule 400.15305(3).

A violation of Rule 400.5401(1) was also found, but this specific violation was not legally willful or substantial. Further, the violation of Rule 400.5401(4) alleged as a component of Count I in the Notice of Intent to Refuse to Renew License was not established at the hearing.

PROPOSED DECISION

The undersigned Administrative Law Judge proposes that the Director adopt the above findings of fact and conclusions of law, conclude that Petitioner has committed willful and substantial violations of Rule 400.5401(5)(7)&(8), Rule 400.15402(1)(2)&(5), Rule 400.15403(1)(3)(4)&(5), Rule 400.15312(2)&(4)(b)(i)(ii)(iii)(iv)(v)(vi), Rule 400.15201(2), and Rule 400.15305(3), and take action on the Notice of Intent as deemed appropriate under the Act.

EXCEPTIONS

If any party chooses to file Exceptions to this Proposal for Decision, the Exceptions filed within twenty one (21) days after the Proposal for Decision is issued and entered. If an opposing party chooses to file a Response to the Exceptions, it must be filed within fourteen (14) days after Exceptions are filed. All Exceptions and Responses to Exceptions must be must be and served on all parties to the proceeding and filed with the:

Michigan Administrative Hearing System
Cadillac Place
3026 West Grand Blvd, Suite 2-700
Detroit, Michigan 48202
Fax: (313) 456-3681


David M. Cohen
Administrative Law Judge