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

In the matter of

License #: AS730382916
SIR #: 2020A0871001
2020A0576012

Barbara Mitchell

_____/

ORDER OF SUMMARY SUSPENSION
AND NOTICE OF INTENT TO REVOKE LICENSE

The Michigan Department of Licensing and Regulatory Affairs, by Jay Calewarts, Division Director, Adult Foster Care and Camps Licensing Division, Bureau of Community and Health Systems, orders the summary suspension and provides notice of the intent to revoke the license of Licensee, Barbara Mitchell, to operate an adult foster care small group home pursuant to the authority of the Adult Foster Care Facility Licensing Act, 1979 PA 218, as amended, MCL 400.701 et seq., for the following reasons:

1. On or about March 17, 2017, Licensee was issued a license to operate an adult foster care small group home with a licensed capacity of six at 1619 Janes Street, Saginaw, Michigan 48601.
2. Prior to the issuance of the license, and during subsequent modifications of the statutes and rules, Licensee received copies of the Adult Foster Care Facility Licensing Act and the licensing rule book for

adult foster care small group homes. The Act and rule book are posted and available for download at www.michigan.gov/lara.

Previous Licensing Violations

3. On April 11, 2019, Licensing Consultant Kathryn Huber initiated *Special Investigation #2019A0871025* after the Bureau received a licensing-related complaint and cited Licensee, in part, for the following violations:
    a. Licensee failed to have sufficient direct care staff on duty at all times, as required by Rule 400.14206(2). On April 18, 2019, during an on-site inspection, Ms. Huber observed residents in the home without a direct care staff person present.
    b. Licensee failed to maintain an accurate daily staff schedule with all the required information at the home, as required by Rule 400.14208(3)(a) through (e). On April 18, 2019, Licensee did not have a staff schedule that contained names of staff, hours worked, and job titles. Licensee provided Ms. Huber with a desk calendar that had not been updated since February 2019. Some of the weekday calendar dates did not have contain a staff person's name, and none of the weekend calendar dates contained names of a staff person on duty.
4. On June 4, 2019, Ms. Huber issued *Special Investigation Report #2019A0871025* recommending the issuance of a six-month, first provisional license upon receipt of an acceptable written corrective action plan. On June 19, 2019, Licensee submitted an acceptable corrective action plan, and a six-month, first provisional license was issued effective June 18, 2019.

Current Allegations

5. Licensee failed to have sufficient direct care staff on duty at all times and maintain a ratio of at least one direct care person for every 12 residents in the home. Specifically:

    a. On October 11, 2019, sometime after 8:00 p.m., Licensee left the facility after administering medication to Resident E, leaving all the residents alone without a direct care staff person on duty.

    b. On October 12, 2019, when Resident E woke up between 8:00 a.m. and 9:00 a.m., Licensee was at the home. Sometime after administering Resident E's morning medications, Licensee left the facility leaving Resident E and the other residents alone without a direct care person on duty.

    c. On October 12, 2019, at approximately 1:30 p.m., Family Member 1 arrived at the facility. Resident E came out to the Family Member 1's car and was upset. Resident E told Family Member 1 that there had been no direct care staff at the facility since that morning. Family Member 1 drove Resident E to the store and returned to the facility about an hour later. Family Member 1 walked through the home and found no direct care staff present. Family Member 1 then went out to her car and watched the house due to Resident E stating that she was suicidal. At 6:49 p.m., Family Member 1 called Saginaw Police Department.

d. On October 12, 2019, at 6:54 p.m., Saginaw Police Officer Steven Lautner was dispatched to the licensed home. When Officer Lautner entered the home, there were residents present but no direct care staff. Officer Lautner contacted Licensee who stated the someone named Sheka was supposed to be there. Licensee arrived at the home at short time later and acknowledged that there was no staff person at the home when there should have been.

e. On October 12, 2019, while at the home, Officer Lautner spoke to another resident who indicated that there was never a direct care staff person at the home after 3:00 p.m. The other resident stated that Licensee is in and out of the facility all day.

f. On October 16, 2019, during an on-site inspection, Resident H told Ms. Huber that there was no staff present at the home on October 12, 2019, and that "it happens a lot." Resident H stated that Licensee is "in and out all day" and that "it's kind of scary with no staff there."

g. On November 8, 2019, Adult Protective Services Worker Katrice Humphrey informed Ms. Huber that she was substantiating Licensee for neglect of residents for not having staff present at the home.

h. On December 13, 2019, between 2:30 p.m. and 2:45 p.m., Resident F's case manager, Marchare Canada, arrived at the home. There were three residents in the home with no staff person present. Ms. Canada remained in the home for about an hour, and no direct care staff

arrived at the home. Ms. Canada called Licensee who stated that there was supposed to be a staff person in the home.

i. On January 6, 2020, Licensing Consultant Christina Garza conducted an on-site investigation at the home and interviewed Licensee who stated that Denise Wilson, a new staff person, was working at the home by herself on December 13, 2019, and was there when Licensee left the home at 2:45 p.m. However, when Ms. Garza reviewed the staff schedule, there was no indication that Denise Wilson had been scheduled to work at the facility on December 13, 2019.

j. During the interview on January 6, 2020, Ms. Garza asked Licensee for Denise Wilson's phone number and to review her employee file. Licensee denied having her phone number and stated that Ms. Wilson stole her employee file.

6. Licensee did not have verification that all staff were tested for communicable tuberculosis prior to employment, as evidenced by the following:

a. During an on-site inspection on November 1, 2019, Ms. Huber asked Licensee for Ms. Hudson's employee file. Licensee stated that she could not locate it and that she probably had it at her home. Licensee told Ms. Huber that she would fax her proof of tuberculosis testing for Ms. Hudson, but she never did.

b. During an on-site inspection on January 6, 2020, Ms. Garza asked Licensee for Denise Wilson's employee file. Licensee was unable to

provide written verification that Ms. Wilson had been tested for communicable tuberculosis prior to her employment.

7. Licensee failed to maintain an accurate daily staff schedule with all the required information at the home. Specifically:
    a. On October 16, 2019, the staff schedule at the home listed Licensee as the only staff scheduled to work on October 12, 2019. However, Licensee told Officer Lautner that Sheka Harris was scheduled to work on October 12, 2019, while telling Ms. Huber that Direct Care Staff Elaine Taylor was scheduled to work. Neither Ms. Hudson nor Ms. Taylor were listed on the staff schedule as working on October 12, 2019. The staff schedule also did not list any job titles, hours, or any schedule changes.
    b. On January 6, 2020, Licensee told Ms. Garza that Denise Wilson was working at the home when she left on December 13, 2019, at approximately 2:45 p.m. However, when Ms. Garza reviewed the staff schedule dated from November 18, 2019, until January 11, 2020, Denise Wilson was not listed as being scheduled to work on December 13, 2019.
8. Licensee failed to complete a criminal background check for Denise Wilson prior to her hire date and her caring for residents. During an interview with Ms. Garza, Licensee stated that Ms. Wilson worked for two days at the facility prior to her leaving during her shift on December 13, 2019. Licensee admitted

that she did not complete a criminal background check through the Bureau's Workforce Background Check Unit for Ms. Wilson prior to her employment.

9. Licensee failed to maintain the home to adequately provide for the health, safety, and well-being of residents. On October 16, 2019, there was a board covering a basement window. On November 1, 2019, during an on-site inspection, Ms. Huber attempted to open the glass front door, and the handle came out of the door.

COUNT I

The conduct of Licensee, as set forth in paragraphs 5(a) through 5(j) above, evidences a willful and substantial violation of:

R 400.14206

> (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.

[**NOTE**: By this reference, paragraph 3(a) is incorporated into this Count for the purpose of demonstrating willful and substantial violation of the above rule.]

COUNT II

The conduct of Licensee, as set forth in paragraphs 5(a) through 5(j) above, evidences a willful and substantial violation of:

R 400.14206

> (1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.

COUNT III

The conduct of Licensee, as set forth in paragraphs 7(a) and 7(b) above, evidences a willful and substantial violation of:

R 400.14208

(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information:

(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.

(b) Job titles.

(c) Hours or shifts worked.

(d) Date of schedule.

(e) Any scheduling changes.

[**NOTE**: By this reference, paragraph 3(b) is incorporated into this Count for the purpose of demonstrating willful and substantial violation of the above rule.]

COUNT IV

The conduct of Licensee, as set forth in paragraphs 6(a) and 6(b) above, evidences a willful and substantial violation of:

R 400.14205

(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.

COUNT V

The conduct of Licensee, as set forth in paragraph 9 above, evidences a willful and substantial violation of:

R 400.14403

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

COUNT VI

The conduct of Licensee, as set forth in paragraph 8 above, evidences a willful and substantial violation of:

MCL 400.734b

(2) Except as otherwise provided in subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents after April 1, 2006 until the adult foster care facility conducts a criminal history check in compliance with subsections (4) and (5). ...

DUE TO THE serious nature of the above violations and the potential risk they represents to vulnerable adults in Licensee's care, emergency action is required. Therefore the provision of MCL 24.292 of the Administrative Procedures Act of 1969, as amended, is invoked. Licensee is hereby notified that the license to operate an adult foster care small group home is summarily suspended.

EFFECTIVE 6:00 p.m., on February 7, 2020, Licensee is ordered not to operate an adult foster care small group home at 1619 Janes Street, Saginaw, Michigan 48601 or at any other location or address. Licensee is not to receive adults for care after that time or date. Licensee is responsible for informing case managers or guardians of adults in care that the license has been suspended and that Licensee can no longer provide care.

HOWEVER, BECAUSE THE Department has summarily suspended the license, an administrative hearing will be promptly scheduled before an administrative law judge. Licensee MUST NOTIFY the Department and the Michigan Office of Administrative Hearings and Rules in writing within seven calendar days after receipt of this Notice if Licensee wishes to appeal the summary suspension and attend the administrative hearing. The written request must be submitted via MAIL or FAX to:

Michigan Office of Administrative Hearings and Rules
611 West Ottawa Street, 2nd Floor
P.O. Box 30695
Lansing, Michigan 48909
Phone: 517-335-2484
FAX: 517-335-6088

MCL 24.272 of the Administrative Procedures Act of 1969 permits the Department to proceed with the hearing even if Licensee does not appear. Licensee may be represented by an attorney at the hearing at his or her own expense.

DATED: 2-7-2020

Jay Calewarts, Division Director
Adult Foster Care and Camps Licensing Division
Bureau of Community and Health Systems

This is the last and final page of the ORDER OF SUMMARY SUSPENSION AND NOTICE OF INTENT in the matter of Barbara Mitchell, AS730382916, consisting of 11 pages, this page included.

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