



RICK SNYDER  
GOVERNOR

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

MIKE ZIMMER  
DIRECTOR

August 3, 2015

Mr. Rex Lanyi  
1900 N. Prospect Road  
Ypsilanti, MI 48198

RE: Fairfax Manor III (AL810244189)

Dear Mr. Lanyi:

A *Notice of Intent to Revoke* the adult foster care license of Fairfax Manor III was issued on November 25, 2014. A representative of Fairfax Manor Healthcare Associates signed for and accepted the certified copy of the *Notice* on December 17, 2014.

A written request to appeal this decision was not received within 30 days of receipt of the *Notice*. This letter is to notify you that the license for Fairfax Manor III is revoked, effective August 7, 2015.

Please note that the Adult Foster Care Facility Licensing Act requires that a person or corporation deemed to be providing adult foster care must be licensed. Therefore, it is incumbent upon you to properly and timely discharge remaining residents in care. For additional information, please refer to MCL 400.731.

Sincerely,

A handwritten signature in cursive script that reads "Larry Horvath".

Larry Horvath, Director  
Bureau of Community and Health Systems

cc: Jay Calewarts, Director, Adult Foster Care & Camps Licensing Division  
Ardr Hunter, Area Manager



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

November 25, 2014

Rex Lanyi  
Fairfax Manor Health Care Associates, Inc.  
1900 Prospect Road  
Ypsilanti, MI 48198

License #: AL810244189  
SIR #: 2014A0122037

Dear Mr. Lanyi:

Enclosed is a copy of a NOTICE OF INTENT TO REVOKE YOUR LICENSE to operate an adult foster care large group home, alleging that you have violated the Adult Foster Care Facility Licensing Act. Your options are as follows:

- 1) You may appeal the Notice of Intent and attend a pre-hearing compliance conference. A Notice of Compliance Conference, which provides the date, time, location, and guidelines of the conference, is enclosed.
- 2) You may appeal the Notice of Intent, waive the compliance conference, and proceed directly to an administrative law hearing.
- 3) You may choose not to appeal the Notice of Intent.

If you choose to appeal the Notice of Intent, the Department must receive your WRITTEN APPEAL within 30 days of your receipt of this Notice. If the Department does not receive your written appeal within 30 days of your receipt of this Notice, you will have WAIVED YOUR RIGHT to an administrative law hearing and the proposed action will be final.

Sincerely,

Jerry Hendrick, Director  
Adult Foster Care Division  
Bureau of Children and Adult Licensing

Enclosures

Cc: Ardra Hunter, Area Manager

COPY

STATE OF MICHIGAN  
MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING

In the matter of

License #: AL810244189  
SIR #: 2014A0122037

Rex Lanyi  
Fairfax Manor Health Care Associates, Inc.

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NOTICE OF INTENT TO  
REVOKE LICENSE

The Michigan Department of Human Services, by Jerry Hendrick, Director, Adult Foster Care Division, Bureau of Children and Adult Licensing, provides notice of the intent to revoke the license of Licensee, Fairfax Manor Health Care Associates, Inc. to operate an adult foster care large 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 August 8, 2003, Licensee was issued a license to operate an adult foster care large group home, with a current licensed capacity of 20, at 1900 Prospect Road, Ypsilanti, Michigan 48198.
2. Resident A is diagnosed with Parkinson's disease and is prescribed several medications to alleviate her symptoms. On multiple occasions during the summer months of 2014, the Licensee failed to administer Resident A's medications as prescribed, as evidenced by the following:

- a. According to an April 2014 physician's order in Resident A's file, Doctor James Gramprrie prescribed Resident A the medication Carb/Levo to be administered six times daily.
- b. On July 24, 2014, Licensing Consultant Vanita Bouldin interviewed Resident A. Resident A stated that not receiving her medication on time is "problematic" and interferes with her mobility. Resident A reported receiving her medication on time approximately three of the seven days per week. Resident A stated that she sometimes has to prompt the Licensee's staff to administer her medication on time.
- c. In July 2014, Ms. Bouldin reviewed Resident A's July 2014 medication records at the Licensee's facility. The medication records maintained by the Licensee are electronic. When printed, there is a notation in the bottom corner of the document that specifies the print date. Ms. Bouldin observed the medication record for Resident A printed on July 24, 2014. With the exception of medications administered on July 23, 2014, the record printed on July 24, 2014, was blank. The medication record printed on July 29, 2014, contained staff initials as administering medications to Resident A on July 24, 2014.
- d. On July 24, 2014, Ms. Bouldin interviewed Shannon Rodriguez, Director of the Licensee's facility. Ms. Rodriguez reported that the pharmacy for the facility provides the Licensee with medication logs. Ms. Rodriguez admitted to Ms. Bouldin that the pharmacy recently listed the wrong dosage times on residents' medication records. Ms. Rodriguez further

admitted that the Licensee's staff administered medications to residents based upon the erroneous times listed on medication records, and not at times as indicated on the actual prescription.

3. On multiple occasions during the summer months of 2014, the Licensee failed to administer Resident B's medications as prescribed, as demonstrated by the following:
  - a. On or about July 11, 2014, Resident B's physician prescribed Resident B a regimen of daily injections of Enoxaparin Sodium to regulate his blood levels. Between July 11, 2014, and July 13, 2014, the Licensee's staff failed to administer Resident B's injections as prescribed. Resident B was to receive these injections between July 11, 2014, and July 15, 2014.
  - b. On July 23, 2014, Resident B was prescribed a second regimen of daily injections of Enoxaparin Sodium. Between July 25, 2014, and July 28, 2014, the Licensee's staff failed to administer Resident B's injections as prescribed.
4. The Licensee failed to properly document the administration of medication to Resident B. On July 24, 2014, Ms. Bouldin reviewed Resident B's medication log at the Licensee's facility. Resident B's Enoxaparin Sodium injections were not listed on Resident B's medication log.
5. On multiple occasions during the summer months of 2014, the Licensee failed to assure that Resident B was transported to his scheduled medical appointments on time, as demonstrated by the following:

- a. On July 3, 2014, Resident B arrived to his physician's appointment 50 minutes late.
  - b. On July 11, 2014, Resident B arrived to his physician's appointment 45 minutes late.
  - c. On July 16, 2014, Resident B arrived for a scheduled blood draw nine minutes late. Resident B was scheduled to see a nutritionist following the blood work. The appointment with the nutritionist was cancelled due to Resident B's late arrival.
  - d. On July 23, 2014, Resident B arrived to his physician's appointment one hour and twenty minutes late.
6. On September 18, 2014, the Licensee admitted Resident C to the facility [Resident C is referred to as Resident A in SIR #2015A0122004]. Resident C is diagnosed with schizoaffective disorder and PICA disorder. On August 26, 2014, CareLink Network completed a functional assessment tool regarding Resident C's care. This plan states, in part, the following:
- a. "[Resident C] understands the importance of maintaining compliance with medications and treatment; however, consumer has an extensive history of PICA, which has placed her at significant risk. In fact, she recently swallowed five batteries which she was able to expel. Following this though, she had an abdominal hernia repair following which she was placed in rehab due to several abdominal drains and some challenges with pain and ambulation."

- b. "It is strongly recommended that this consumer have a safety and behavior plan developed. She admitted that when she becomes frustrated and stressed out, she swallow [sic] inanimate objects...A behavior and safety plan would outline in clear terms what consumer should do to manage the urge of swallowing inanimate/inedible objects and also provide guidelines for residential staff to work with consumer."
  - c. "The main concern with this consumer is related to her episodes of PICA which have placed her at significant medical risk...Initially, consumer should be on a 1:1 staff to ensure her safety and the safety of others."
  - d. "DCW staff will need to be trained/instructed in the behavior plan and safety plan – both of which should be reviewed with AFC staff and consumer at least monthly."
  - e. "Consumer has expressed an interest in going into a SIL...It was discussed with her that she will start out with 1:1 staffing in an AFC environment; she will be reassessed by RCM within 90 days and depending on her progress and comfort level as well as guardian input, then transition plan can be developed to work on transitioning off the 1:1 and eventually to a less restrictive environment."
7. On October 22, 2014, Ms. Bouldin conducted an inspection of the Licensee's facility and interviewed Ms. Rodriguez. Ms. Rodriguez indicated that the Licensee discontinued providing one-to-one supervision for Resident C, as she no longer required this level of care. Ms. Bouldin reviewed Resident C's file at the facility. There was no documentation in the file noting that Resident C had been

reassessed according to her functional assessment tool and that one-to-one supervision was no longer necessary. Resident C also did not have a behavior plan on file, nor was there any documentation indicating that a behavior or safety plan was being developed for Resident C.

8. Resident C is prescribed the narcotic pain medication Hydrocodone. The Licensee failed to safeguard Resident C's medication from theft, as evidenced by the following:
  - a. On September 18, 2014, Pharma Scriptx, the pharmacy used by the Licensee's facility, filled a prescription for 31 tablets of Hydrocodone for Resident C.
  - b. On October 22, 2014, Ms. Bouldin reviewed Resident C's medication log at the Licensee's facility and observed the following:
    - i. Between September 18, 2014, and September 30, 2014, the Licensee's staff administered 14 tablets of Hydrocodone to Resident C.
    - ii. Between October 1, 2014, and October 22, 2014, the Licensee's staff administered 10 tablets of Hydrocodone to Resident C.
  - c. During the October 22, 2014, inspection of the Licensee's facility, Ms. Bouldin requested to view Resident C's Hydrocodone medication. The Licensee's staff informed Ms. Bouldin that Resident C was out of her Hydrocodone medication. According to Resident C's medication log, Resident C should have had seven tablets of Hydrocodone available to her at the Licensee's facility.

9. On October 28, 2014, Ms. Bouldin conducted an inspection of the Licensee's facility. During the inspection, Ms. Bouldin requested to review Resident C's assessment plan and resident care agreement. This documentation should have been completed when Resident C was admitted to the facility on September 18, 2014. Office staff person Courtney Strimtle admitted to Ms. Bouldin that the Licensee did not complete an assessment plan and care agreement for Resident C.
10. The Licensee's history of repeated noncompliance with adult foster care licensing rules demonstrates a lack of administrative capability to assure the appropriate care, supervision and protection of residents. During the past two years, the Bureau of Children and Adult Licensing has conducted six special investigations and renewal inspections of the Licensee's facility that established the following rule violations:
  - a. On October 2, 2012, Licensing Consultant Karen Davis initiated a special investigation of the Licensee's facility [SIR #2013A0772003]. Ms. Davis cited the Licensee for two rule violations, including the failure to assure the personal care, protection and safety of residents, in violation of R 400.15305(3). The Licensee was found in violation of this rule after the following incident occurred at the facility:
    - i. On September 29, 2012, the Licensee's staff failed to provide adequate supervision to Resident F at the facility. Resident F was watching television in the community area of the facility. Resident F

was left unsupervised by staff in the common area for approximately 20 minutes.

ii. While unsupervised, Resident F left the common area and entered Resident E's bedroom undetected by staff. Resident E proceeded to physically attack Resident F. Direct care worker Vanessa Leath eventually found Resident F in Resident E's bedroom. Upon entering Resident E's room, Ms. Leath observed Resident F lying on the floor. Resident E was standing over Resident F, kicking her.

iii. Resident F sustained a broken nose as a result of this incident.

- b. On April 26, 2013, the Licensee submitted a written corrective action plan that addressed the rule violations cited during Ms. Davis' October 2012 special investigation.
- c. On February 14, 2014, Ms. Bouldin initiated a special investigation of the Licensee's facility [SIR #2014A0122018]. Ms. Bouldin cited the Licensee for one rule violation after the facility received a disapproval rating during a February 2014 environmental health inspection. On April 21, 2014, the Licensee submitted a written corrective action plan that addressed the rule violations cited during this special investigation.
- d. On April 16, 2014, Licensing Consultant Jeff Bozsik conducted a renewal inspection of the Licensee's facility. Mr. Bozsik cited the Licensee with five rule violations, including the following:
- i. The Licensee failed to update resident assessment plans annually, in violation of R 400.15301(4).

- ii. The Licensee failed to update resident care agreements annually, in violation of R 400.15301(9).

On April 16, 2014, the Licensee submitted a written corrective action plan that addressed the rule violations cited during this renewal inspection.

- e. On May 8, 2014, Ms. Bouldin initiated a special investigation of the Licensee's facility [SIR #2014A0122027]. Ms. Bouldin cited the Licensee with two rule violations, including the following:

- i. The Licensee failed to schedule a sufficient number of direct care staff to meet the needs of residents, in violation of R 400.15206(2). During the spring months of 2014, 12 of the 14 residents living at the facility had a documented risk of falling at the facility. The Licensee regularly scheduled three direct care workers per shift to provide care and supervision to residents. Direct care workers were unable to meet the residents' increased needs for supervision and protection from falling. As a result, Resident G [referred to as Resident A in SIR #2014A0122027] fell multiple times at the facility in May and April of 2014.

- ii. The Licensee failed to provide personal care to Resident G and assure her safety, in violation of R 400.15305(3). This was a repeat violation. Resident G required emergency medical treatment on three occasions in April and May of 2014 as a result of injuries sustained at the Licensee's facility. On May 7, 2014, Resident G fell

at the facility and sustained multiple facial injuries. Resident G was treated at a local hospital where she was found to have poor hygiene in her vaginal area. Resident G's vagina was swollen, reddened, and had a green discharge and blood emanating from her cervix.

- f. On June 27, 2014, the Licensee submitted a written corrective action plan that addressed the rule violations cited during Ms. Bouldin's May 2014 special investigation. Due to the severity of the rule violations found during this investigation, the Licensee was issued a first provisional license on July 14, 2014.
- g. As of the date of this Notice, the Licensee's adult foster care license remains at a first provisional status. MCL 400.717 provides the following: "A provisional license may be issued to an adult foster care facility that has previously held a temporary or regular license... If the provisional license is issued for deficiencies in the quality of care provided in the adult foster care facility; the provisional license is not renewable. If the quality of care deficiencies are corrected and intervening deficiencies of any kind are not incurred, a regular license shall be issued."
- h. On August 13, 2014, Ms. Bouldin concluded a special investigation of the Licensee's facility [SIR # 2014A0122036]. Ms. Bouldin found that the Licensee failed to assure the protection and safety of Resident H [Resident H is referred to as Resident A in SIR #2014A0122036]. On July 8, 2014, Resident H climbed out of her bedroom window and eloped from the facility. Resident H walked to a

nearby adult foster care facility. Resident H was transported to a local hospital emergency room after having difficulty breathing. Ms. Rodriguez was made aware of Resident H's whereabouts, but failed to provide the hospital with information regarding Resident H's mental and physical health. As a result, hospital personnel were unaware of Resident H's mental status, and Resident H was able to walk out of the emergency room. Resident H was later found wandering around an apartment complex near the hospital. Resident H was eventually located by law enforcement and was transported back to the Licensee's facility.

- i. On October 6, 2014, the Licensee submitted a written corrective action plan to address the violation of R 400.15305(3) cited in Ms. Bouldin's August 2014 special investigation. This was the Licensee's third violation of this rule during a three-month time period.
- j. The violations cited in this Notice each relate to deficiencies in the quality of care provided in the Licensee's facility.

## COUNT I

The conduct of the Licensee, as set forth in paragraphs 2 through 5 and 7 through 10 above, evidences a violation of:

**R 400.15201**      **Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**

(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.

## COUNT II

The conduct of the Licensee, as set forth in paragraphs 6 and 7 above, evidences a violation of:

**R 400.15206**      **Staffing requirements.**

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

[NOTE: This is a repeat violation as referenced in paragraph 10(e) of this Notice.]

### COUNT III

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

**R 400.15301      Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**

(4) At the time of admission, and at least annually, a written assessment plan shall be completed with licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.

[NOTE: This is a repeat violation as referenced in paragraph 10(d) of this Notice.]

### COUNT IV

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

**R 400.15301      Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**

(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party...

## COUNT V

The conduct of the Licensee, as set forth in paragraphs 2 through 8 above, evidences a violation of:

**R 400.15305      Resident protection.**

(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.

[NOTE: This is a repeat violation as referenced in paragraphs 10(a), 10(e) and 10(h) of this Notice.]

## COUNT VI

The conduct of the Licensee, as set forth in paragraphs 2 and 3 above, evidences a violation of:

**R 400.15312      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 §333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

## COUNT VII

The conduct of the Licensee, as set forth in paragraphs 2 through 4 above, evidences a violation of:

**R 400.15312      Resident medications.**

(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.

(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.

## COUNT VIII

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

**R 400.15312      Resident medications.**

(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.

NOTICE IS GIVEN that Licensee is offered the opportunity to show compliance with all lawful requirements for retention of the license. If Licensee appeals the Notice of Intent and compliance is not shown, formal proceedings will commence pursuant to the Adult Foster Care Facility Licensing Act, 1979 PA 218, as amended, MCL 400.701 et seq., rules promulgated thereunder, and the Administrative Procedures Act, 1969 PA 306, as amended; MCL 24.201 et seq. Should formal proceedings commence, you have the right to attorney representation at your own expense.

LICENSEE IS NOTIFIED that pursuant to MCL 400.722(3) of the Adult Foster Care Facility Act, Licensee has 30 days from the date of receipt of the Notice of Intent to file a written appeal of the proposed action. The appeal shall be addressed to Kelly Maltby, Departmental Analyst, Bureau of Children and Adult Licensing, Michigan Department of Human Services. Your written appeal must include your name and license number, and must be submitted using one of the following methods:

- Mail your written appeal to the Bureau of Children and Adult Licensing, P.O. Box 30650, Lansing, MI 48909. It is recommended that you obtain some type of delivery confirmation;
- Fax your written appeal to the Bureau of Children and Adult Licensing at (517) 284-9709. It is recommended that you keep a copy of your fax confirmation as proof of submittal; or
- Email your written appeal to [DAUappeals@Michigan.gov](mailto:DAUappeals@Michigan.gov). It is recommended that you keep a copy of the sent email as proof of submittal.

LICENSEE IS FURTHER NOTIFIED that failure to file a written appeal of this action within 30 days will result in revocation of the license.

DATED: 12/1/2014

  
Jerry Hendrick, Director  
Adult Foster Care Division  
Bureau of Children and Adult Licensing

This is the last and final page of a NOTICE OF INTENT in the matter of AL810244189, consisting of 18 pages, this page included.

KMM

STATE OF MICHIGAN  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING

In the matter of

License #: AL810244189  
SIR #: 2014A0122037

Rex Lanyi

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**NOTICE OF COMPLIANCE CONFERENCE**

**Date:** January 14, 2015

**Time:** 2:30 p.m. to 4:30 p.m.

**Location:** Washtenaw County DHS, 22 Center St., Conference Room G, Ypsilanti, MI  
48198

Pursuant to the Administrative Procedures Act, MCL 24.292(1), you are afforded the opportunity to attend an informal compliance conference. The purpose of the compliance conference is to allow you to show that you were in compliance with the Adult Foster Care Facility Licensing Act and the licensing rules promulgated thereunder. You have the right, at your expense, to have an attorney represent you at the compliance conference. You may also bring **one** support person to the compliance conference.

To enable a thorough discussion of the Notice of Intent at the compliance conference, please bring any documents, pictures, etc. that you would like the Department to consider. You may also submit documents to the Department prior to the compliance conference by emailing them to [DAUappeals@Michigan.gov](mailto:DAUappeals@Michigan.gov).

If you are unable to attend the compliance conference at the scheduled date and time, you may request, in writing, that the Department change the date and/or time. The Department will make all reasonable attempts to accommodate your request, but will not reschedule the compliance conference to a date more than 10 days after the scheduled date. If you promptly notify the Department of your inability to attend the

compliance conference as scheduled, the Department may be able to schedule the compliance conference to a date earlier than originally scheduled.

If you are unable to show that you were in compliance with the Adult Foster Care Facility Licensing Act and licensing rules, and a resolution cannot be reached, the Department will forward the matter to the Michigan Administrative Hearing System for the scheduling of a formal administrative hearing. The Michigan Administrative Hearing System will subsequently notify you of the date, time, and location of the administrative hearing.

All Department meetings and hearings are conducted in compliance with the Americans with Disabilities Act in buildings that accommodate mobility-impaired individuals and have accessible parking. If you require additional accommodations to participate in the compliance conference, please notify the Department at least one week in advance to make the necessary arrangements.

Please direct all written communications regarding the compliance conference or administrative hearing, including your license number, to the individual listed below:

Kelly Maltby, Departmental Analyst  
Disciplinary Action Unit  
Bureau of Children and Adult Licensing  
Michigan Department of Human Services  
Victor Office Center  
201 North Washington Square, 4<sup>th</sup> Floor  
P.O. Box 30650  
Lansing, MI 48909-8150

STATE OF MICHIGAN  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING

In the matter of

License#: AL810244189  
SIR #: 2014A0122037

Rex Lanyi

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PROOF OF SERVICE

The undersigned certifies that a copy of a Notice of Intent to revoke the license in the above matter was served upon the following persons by mailing the same to them at their address of record by certified mail on December 9, 2014.

Rex Lanyi  
1900 Prospect Road  
Ypsilanti, MI 48198



Kristine Manion, Executive Secretary  
Bureau of Children and Adult Licensing