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

In the matter of

License #: AM410382191
SIR #: 2019A0464018

James Kaman

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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, James Kaman, 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 7, 2018, Licensee was issued a license to operate an adult foster care small group home with a licensed capacity of 11 at 2022 Collingwood Avenue, Wyoming, Michigan 49519.
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.

3. Licensee, James Kaman, Household Member and Direct Care Staff Amy Holleman, and Direct Care Staff Tracy Lewis-Stroh are not suitable to meet the needs and assure the welfare of the residents, as demonstrated by the following:

    a. The facility, as known as Collingwood AFC, is in one-half of a duplex home. Licensee and Ms. Holleman, Licensee's long-time girlfriend, reside in the other half of the duplex.

    b. [redacted]

        i. [redacted]

        ii. [redacted]

[redacted]

[redacted]

vi. [redacted]

[redacted]

vii. [redacted]

[redacted]

viii. [redacted]

[redacted]

ix. [redacted]

x. [redacted]

xi. [redacted]

[redacted]

xii. [redacted]

xiii. [redacted]

xiv. [redacted]

c. On January 3, 2019, Licensing Consultant Megan Aukerman, accompanied by [redacted] conducted an on-site inspection at the facility. Both Licensee

and Ms. Holleman were present and acknowledged that police officers had come to the home on December 10, 2018. Both Licensee and Ms. Holleman denied any physical altercation occurred on that date, and both stated that Licensee's shirt had ripped after Ms. Holleman tried to prevent herself from falling. Licensee told Ms. Aukerman that he was going to call the prosecutor and try to have the charges against Ms. Holleman dropped. Licensee and Ms. Holleman stated that police had been to home only once before and that residents have never witnessed any of their arguments.

d. On January 17, 2019, Ms. Aukerman, accompanied by [redacted] conducted an on-site inspection at the home. When they arrived, Resident A, who was standing outside smoking a cigarette, stated, "You don't want to go in there. There is a lot going on." Resident A stated that Licensee and Ms. Holleman are "always fighting" and that he has called the police in the past due to their loud arguments. While Ms. Aukerman was speaking to Resident A, [redacted] officers arrived at the home after receiving a call of a domestic dispute.

e. On January 17, 2019, during the inspection, Licensee told Ms. Aukerman that he thinks Ms. Holleman is "losing her mind" and that he does not want her at the home because she was putting residents at risk.

f. On February 3, 2019, Licensee sent a text message to Ms. Aukerman stating that Ms. Lewis-Stroh has "lost her mind" and [redacted] officers had been to the facility. He indicated that Ms. Lewis-Stroh was refusing to leave the facility and that police were blaming him for the incident. He sent another text a short time later indicating that he was no longer at the facility and that his mother was at the home caring for residents.

g. On February 4, 2019, Ms. Aukerman conducted an on-site inspection at the home. Patricia Kaman, Licensee's sister, was at the home caring for residents at Licensee's request. Ms. Kaman informed Ms. Aukerman that Ms. Lewis-Stroh had barricaded herself in the office where the personnel files are kept. When Ms. Aukerman attempted to speak to Ms. Lewis-Stroh, Ms. Lewis-Stroh initially refused to let her enter the office, stating that there was a large dog inside the room with her. She then came out and told Ms. Aukerman that she had been working at the facility for about three weeks, and she and Licensee were involved in a romantic relationship. She said that on January 31, 2019, Licensee wrongfully terminated her and tried to kick her out of the home.

h. [redacted]

[redacted]

i. On February 4, 2019, Licensee left a voicemail message for Ms. Aukerman stating, "I am far away out of town and do not know what I will be doing or when I will be back."

j. On February 5, 2019, at approximately 1:00 a.m., Licensee sent Ms. Aukerman three separate emails stating that Ms. Lewis-Stroh was crazy and needs to be removed from the facility. He indicated that he feels she is a risk to residents.

4. Licensee failed to ensure that direct care staff were trained in medication administration before administering medications to residents. Specifically:

a. On January 17, 2019, when interviewed by Ms. Aukerman, Licensee denied that Ms. Lewis-Stroh was administering medication by herself and stated that he was currently in the process of training her to pass medications.

b. During an interview with Ms. Aukerman on January 17, 2019, Ms. Lewis-Stroh stated that she has been working at the facility for about one week and acknowledged that she has been giving residents their medications. She did not have any documentation to show that she had been trained in medication administration.

c. On January 17, 2019, Ms. Aukerman and Ms. Andrews interviewed Residents A, B, C, D, E, F, G, and H separately. All eight residents

stated that Ms. Lewis-Stroh had administered their medications without Licensee's supervision on several occasions.

5. Licensee failed to ensure that direct care staff completed a criminal history background check prior to employment and allowing staff access to residents. Ms. Lewis-Stroh began working at the facility on or around January 10, 2019, and during that time, had access to residents and administered medications. On January 17, 2019, Licensee and Ms. Lewis-Stroh admitted to Ms. Aukerman that Ms. Lewis-Stroh had not submitted her fingerprints for the required background check.
6. Licensee failed to obtain written evidence that Direct Care Staff Tracy Lewis-Stroh had been tested for communicable tuberculosis prior to employment. On January 17, 2019, during an interview with Ms. Aukerman, Licensee admitted that he had not obtained verification of tuberculosis testing for Ms. Lewis-Stroh, who at that time had been employed at the facility for approximately a week.
7. Licensee failed to ensure that direct care staff supervised residents while taking their medication. On January 17, 2019, during an interview with Ms. Aukerman, Licensee admitted that he always gave some of the residents their medications for the entire day if they were scheduled to leave the facility, allowing residents to self-administer.

COUNT I

The conduct of Licensee, as set forth in paragraphs 3(a) through 3(j) above, evidences a willful and substantial violation of:

R 400.14201

(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.

COUNT II

The conduct of Licensee, as set forth in paragraphs 3(a) through 3(j) above, evidences a willful and substantial violation of:

R 400.14201

(9) A licensee and the administrator shall possess all of the following qualifications:

(a) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.

(b) Be capable of appropriately handling emergency situations.

(c) Be capable of assuring program planning, development, and implementation of services to residents consistent with the home's program statement and in accordance with the resident's assessment plan and care agreement.

COUNT III

The conduct of Licensee, as set forth in paragraphs 4(a) through 4(c) above, evidences a willful and substantial violation of:

R 400.14312

(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:

(a) Be trained in the proper handling and

administration of medication.

COUNT IV

The conduct of Licensee, as set forth in paragraph 5 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). ...

COUNT V

The conduct of Licensee, as set forth in paragraph 7 above, evidences a willful and substantial violation of:

R 400.14312

> (3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.

COUNT VI

The conduct of Licensee, as set forth in paragraph 6 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.

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, 2019, Licensee is ordered not to operate an adult foster care small group home at 2022 Collingwood Avenue, Wyoming, Michigan 49519 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 Administrative Hearings System (MAHS) 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 Administrative Hearings System
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: 2-7-19

Jay Calewarts

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 James Kaman, AM410382191, consisting of 14 pages, this page included.

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