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

In the matter of

License #: AS500394497
SIR #: 2021A0465018

True Tender Loving Care Adult Fostering LLC

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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, True Tender Loving Care Adult Fostering LLC, 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 October 10, 2018, Licensee was issued a license to operate an adult foster care small group home with a licensed capacity of 5 at 45492 Lone Pine Lane, Macomb Township, MI 48044.
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. On or about August 23, 2021 the Department issued an AMENDED NOTICE OF INTENT TO REFUSE TO RENEW license number AS500394497 based off the findings of a Renewal Licensing Study Report completed on or about April 13, 2021 by Licensing Consultant Stephanie Gonzalez. Licensee appealed the Department's recommendation to refuse to renew and an administrative hearing to resolve that recommendation has been scheduled. Due to the recommendation to refuse to renew being unresolved those findings of fact are being included with this ORDER OF SUMMARY SUSPENSION AND NOTICE OF INTENT TO REVOKE license number AS500394497.

FINDINGS IDENTIFIED IN THE AMENDED NOTICE OF INTENT TO REFUSE TO RENEW

4. On or about April 13, 2021 Ms. Gonzalez completed a Renewal Licensing Study Report for the adult foster care small group home called The Charlton Home (hereafter referred to as "the facility") and cited Licensee with the following licensing rule violations:
   a. MCL 400.734b(2). Direct care staff members Madonna Shaffer, Donna (last name unknown) and Marlene (last name unknown) did not have a Workforce Background Check completed and available for Ms. Gonzalez's review.

b. R 400.14203(1)(a). Licensee Designee and Administrator, Andrea Charlton, stated she has not completed any trainings during the last two years and did not have training information available for review at the time of Ms. Gonzalez's inspection.

c. R 400.14208(1)(a-i). Ms. Gonzalez reviewed Ms. Shaffer's employee file and confirmed that the file did not contain verification of training, verification of reference checks and verification of medical clearance/annual health review. Ms. Charlton confirmed to Ms. Gonzales that she did not have documentation of these items available for review at the time of the inspection. Ms. Shaffer also confirmed that the direct care staff member Donna was hired approximately one month prior to Ms. Gonzalez's inspection and Marlene was hired on [redacted]. Ms. Shaffer stated that Donna and Marlene are left alone with the residents and provide direct care to the residents. Ms. Shaffer further confirmed that she does not have employee files for either staff member. Ms. Gonzalez reviewed Ms. Shaffer's employee file and confirmed that it did not contain documentation of training, verification of reference checks or the medical clearance/annual health review.

d. R 400.14208(3)(a-e). The only employee schedules available for review were for March 2021 and April 2021. Ms. Gonzalez confirmed that the direct care staff members Donna and Marlene were not listed on either employee schedule, despite Ms. Shaffer confirming to Ms. Gonzalez that Donna and Marlene had been employed since March 2021.

e. R 400.14301(10). Ms. Gonzalez confirmed that Resident B was admitted to the facility on March 26, 2020 but she was unable to locate a health care appraisal in Resident B's resident file. Resident D was admitted to the facility on October 6, 2020 but Ms. Gonzalez was unable to locate a health care appraisal in his file.

f. R 400.14301(4). Ms. Gonzalez reviewed Resident A's resident file and confirmed that Resident A was admitted to the facility on November 6, 2019. Ms. Gonzalez located Resident A's *Assessment Plan for AFC Residents* which was signed and dated by Guardian A1 on April 2, 2021 but was unable to locate the *Assessment Plan for AFC Residents* completed at the time of Resident A's admission or for the year 2020.

g. R 400.14312(4)(b)(i-vi). Ms. Shaffer confirmed to Ms. Gonzalez that at the start of her shift each morning she prepares all resident medications for both morning and afternoon medication administration times, places the medication in Solo cups and initials the medication book at the beginning of her morning shift. Per the language of this rule, these steps are required to be completed at the time each resident takes their medication, not in advance of the time that residents receive their medication.

h. R 400.14312(6). Ms. Gonzalez inspected the Solo cups Ms. Shaffer uses to place the residents' daily medications in at the beginning of her shift each morning. The Solo cups are small, clear plastic cups and did not contain any information for each individual resident or any medication label information.

i. R 400.14315(3). Ms. Gonzalez reviewed the resident files for Resident A, Resident B, Resident C and Resident D and confirmed that the files did not contain a Resident Funds Part II form. Ms. Charlton admitted to Ms. Gonzalez that she did not complete the Resident Funds Part II form for Resident A, Resident B, Resident C and Resident D.

j. R 400.14315(9). Ms. Gonzalez reviewed the resident files for Resident B, Resident C and Resident D and confirmed that none of the files contained the Resident Funds Part I form. Ms. Charlton admitted that she did not have the Resident Funds Part I forms available for review at the time of the inspection.

k. R 400.14316(1)(a)(i-ix). Ms. Gonzalez reviewed Resident D's file and confirmed that it did not contain a copy of the required weight record. Ms. Charlton admitted to Ms. Gonzalez that she did not have this required information for Resident D.

l. R 400.14318(5). During her inspection Ms. Gonzalez was unable to locate a record confirming that the facility has practiced emergency fire drills during daytime, evening and sleeping hours at least once per quarter. Ms. Charlton admitted to Ms. Gonzalez that she has not completed fire drills the previous two years.

m. R 400.14401(2). During her inspection Ms. Gonzalez measured the kitchen sink water temperature and confirmed that it measured at 123.5 degrees Fahrenheit, which was above the maximum allowed temperature of 120 degrees Fahrenheit.

FINDNGS IDENTIFIED IN SPECIAL INVESTIGATION REPORT 2021A0465018

5. On September 9, 2021 at 11:00 a.m. Ms. Gonzalez conducted an unannounced on-site investigation of the facility due to complaint allegations the Department received. Upon her arrival Ms. Gonzalez knocked on the front door of the facility and rang the two doorbells next to the door. Ms. Gonzalez heard the door handle move and then the door latch shut. Ms. Gonzalez looked into the facility window and observed a female staff member directing a female resident away from the living room area. Ms. Gonzalez again knocked on the facility door and rang the doorbell but staff did not respond. At 11:05 a.m. Ms. Gonzalez contacted Ms. Charlton via telephone and informed her that she was at the facility to conduct an on-site investigation. Ms. Charlton stated to Ms. Gonzalez “We are gone. No one is home.” Ms. Gonzalez informed her that she observed a female staff member and a female resident in the living room. Ms. Charlton stated that she felt that she was being harassed and would not allow Ms. Gonzalez to enter the facility until she knew her legal rights. Ms. Gonzalez informed Ms. Charlton of licensing rule R 400.14103(3) that requires Licensees to comply with all special investigations. Ms. Charlton stated that she wanted to know what the complaint allegations were and then abruptly ended the call with Ms. Gonzalez. At 11:18 a.m. Ms. Charlton again contacted Ms. Gonzalez and informed her that a staff member would allow her to enter the facility, but the staff member was busy attending to a resident. At 11:27 a.m. Ms. Gonzalez contacted Ms. Charlton and informed her that she was going to be leaving the

facility momentarily and that failure to grant her access to the facility would be considered a failure to comply with a special investigation. Ms. Charlton continued to state that she was not failing to comply with the investigation, that a staff member was continuing to assist with a staff member. At 11:30 a.m. Ms. Gonzalez left the facility due to Licensee's failure to comply with her right to conduct a special investigation.

6. On September 16, 2021 at 11:00 a.m. Ms. Gonzalez arrived at the facility to conduct an on-site investigation. Ms. Gonzalez had to wait until 11:30 a.m. until staff allowed her to enter the facility. Upon her entry Ms. Gonzalez interviewed direct care worker Kajia Wardlaw, who stated that she has been working at the facility for approximately [redacted]. Ms. Gonzalez asked Ms. Wardlaw to provide her with copies of the resident records for her review but Ms. Wardlaw stated that the resident records are locked in the basement of the facility and that she did not have a key to the door accessing the basement. Ms. Gonzalez telephoned Ms. Charlton and requested access to the resident records and Ms. Charlton confirmed that the resident records are locked in the basement of the facility and that Ms. Wardlaw does not have a key to the door leading to the basement. Ms. Gonzalez instructed Ms. Charlton to provide her with copies of the resident records, including resident assessment plans, by 8:00 a.m. on September 17, 2021. On September 17, 2021 Ms. Charlton informed Ms. Gonzalez that she is unable to obtain the resident records until September 21, 2021. As of the date of issuance of this

Order of Summary Suspension and Notice of Intent to Revoke Ms. Charlton has failed to comply with this requirement.

7. During her September 16, 2021 on-site investigation Ms. Gonzalez attempted to review the resident medication cabinet. Ms. Wardlaw stated “It’s kind of embarrassing, but I lost the key to the med cabinet this morning. I don’t know where it is. But Ms. Charlton knows, and she is going to bring me a key later this evening. I don’t have access to any medical documents at all. I can’t access the medication administration records or medications.” Ms. Wardlaw stated that the facility does not utilize an electronic medication documentation system to record the administering of resident medications, the facility utilizes paper medication logs for documenting the administering of resident medications. Ms. Wardlaw stated that she had administered medications to the residents this morning, but she was unable to provide Ms. Gonzalez with the paper medication log she had just claimed the facility utilizes. Ms. Wardlaw assumed that none of the residents were scheduled to receive additional medications until 8:00 p.m. but she was unable to provide documentation to confirm this. Ms. Wardlaw stated that she does not believe any residents have PRN prescription orders, but she was also unable to provide documentation to confirm this. Ms. Wardlaw admitted to Ms. Gonzalez that if a resident required medication prior to Ms. Charlton arriving at the facility with a spare key to the medication cabinet she would be unable to administer the medication. Ms. Wardlaw was also unable to provide any

documentation to confirm that she has been trained to administer medications to residents of the facility.

8. After speaking with Ms. Wardlaw regarding the medication violations Ms. Gonzales spoke with Ms. Charlton via telephone. Ms. Charlton stated that she was aware that Ms. Wardlaw lost the medication cabinet key and could not access resident medications, or the medication administration logs. Ms. Charlton stated that she planned on arriving at the facility at 5:00 p.m. with the spare key to the medication cabinet. Ms. Gonzalez instructed Ms. Charlton to provide her with all resident medication administration records for the months of August 2021 and September 2021 as well as Ms. Wardlaw's employee file no later than 8:00 a.m. on September 17, 2021. On September 17, 2021 Ms. Charlton forwarded to Ms. Gonzalez via email the *Medication Administration Records* for Resident A, Resident B, Resident C and Resident D for August 2021, but she did not provide the *Medication Administration Record* for September 2021. As of the writing of this *Order of Summary Suspension and Notice of Intent to Revoke* Ms. Charlton has failed to provide to the department a copy of the September 2021 *Medication Administration Records.* The August 2021 *Medication Administration Records* provided by Ms. Charlton were electronic PDF files, not the paper files Ms. Wardlaw claimed the facility uses to record resident medications. The PDF files Ms. Gonzalez received only contained Ms. Charlton's typed initials for the entire month of August 2021. Additionally, the signature and initial lines at the bottom of the document contained no signature or initials. When reviewing

the August 2021 *Medication Administration Record* Ms. Gonzalez observed the following discrepancies:

a. Resident B is prescribed Glipizide 5mg Tab to be administered twice daily before meals. Ms. Gonzalez observed that for the entire month of August Ms. Charlton initialed that the second dose was being administered to Resident B at 8:00 p.m., which is presumably after dinner.

b. Resident C is prescribed Furosemide (Lasix) 40mg Tab to be administered every other day. Ms. Charlton initialed that she administered this medication to Resident C every day, not every other day as prescribed, for the month of August 2021.

9. During her September 16, 2021 on-site investigation Ms. Gonzalez was unable to locate any meal menus or special diet menus for her review. Ms. Gonzalez asked Ms. Wardlaw for the resident meal menus and special diet menus but Ms. Wardlaw stated “We do have a meal menu, but I don’t use it. I just cook whatever I decide to make.” Ms. Wardlaw confirmed that the facility does not currently have a written meal menu for review and there is not a meal menu posted in the facility. Ms. Wardlaw stated “We have three residents that are diabetic, and all four residents have low sodium diets.” Ms. Wardlaw informed Ms. Gonzalez that she does not have documentation to prove that Resident A, Resident B, Resident C and Resident D are currently prescribed special diets by a physician. Ms. Wardlaw also stated that she was unable to provide Ms. Gonzalez with copies of resident health care

appraisals to confirm if the residents were prescribed special diets by a physician due to the resident health care appraisals being locked in the basement of the facility. Ms. Wardlaw stated that she did not have a key to access the basement of the facility. Ms. Gonzalez spoke to Ms. Charlton on the telephone and Ms. Charlton stated that she would provide to Ms. Gonzalez copies of the resident meal menus by 8:00 a.m. on September 17, 2021. Ms. Charlton later emailed Ms. Gonzalez that she would email the resident meal menus to her by September 21, 2021. As of the writing of this Order of Summary Suspension and Notice of Intent to Revoke Ms. Charlton has failed to comply with this request.

10. During the September 16, 2021 on-site investigation of the facility Ms. Wardlaw informed Ms. Gonzalez that she and one other female staff member are the staff members that work at the facility. Ms. Gonzales reviewed the facility staff schedules for July 2021, August 2021 and September 2021. Upon her review Ms. Gonzalez observed that there were three staff members listed on the staff schedules and the two staff members other than Ms. Wardlaw were only listed by their first names: Linda and Celina. The staff schedules also did not include staff job titles and hours or shifts worked. Per the staff schedules that Ms. Gonzalez reviewed the staff member named Celina began working at the facility on [redacted], Ms. Wardlaw began working at the facility on [redacted]1 and the staff member named Linda began working at the facility on [redacted]. Ms. Gonzalez confirmed that Ms. Wardlaw and the staff member named Celina were both listed on the staff

schedules for July 2021, August 2021 and September 2021. Ms. Charlton confirmed that all employee files are locked in the basement of the facility and that Ms. Wardlaw does not have a key to access the basement. Ms. Gonzalez instructed Ms. Charlton to provide her with all employee files by 8:00 a.m. on September 17, 2021.

11. On September 17, 2021 Ms. Charlton provided Ms. Gonzalez with Ms. Wardlaw's employee file but she failed to provide Ms. Gonzalez with the employee files for staff members Celina, Linda or Sandra Deh. Due to this failure Ms. Charlton was unable to prove that staff members Celina, Linda and Ms. Deh had completed the necessary trainings to meet the qualifications of an adult foster care direct care worker. Upon review of Ms. Wardlaw's employee file Ms. Gonzalez observed the *Michigan Workforce Background Check Consent and Disclosure* letter signed and dated by Ms. Wardlaw on July 4, 2021, the same date that she was listed on the facility staff schedule. Ms. Gonzalez reviewed Ms. Wardlaw's *Michigan Workforce Background Check* letter and confirmed that Ms. Wardlaw [redacted] to work in an adult foster care facility effective [redacted] which is 53 days after Ms. Wardlaw was listed on a facility staff schedule. Ms. Wardlaw's cardiopulmonary resuscitation (CPR) and first aid training certificate of training identified a completion date of August 28, 2021. Ms. Gonzalez reviewed Ms. Wardlaw's *Training Record,* but the *Training Record* document was a checklist with no additional information listed regarding the specific training material provided. On the training record, there is a column titled

Medication Administration and Documentation with no signature of completion by Ms. Wardlaw. The *Training Record* only contains Ms. Charlton's signature, but there were no signatures of completion by Ms. Wardlaw, nor any documentation of the training provided or confirmation of competency for the required trainings. Additionally, Ms. Wardlaw's employee file did not contain the following required documents: employment application, physician's statement attesting to Ms. Wardlaw's physical health, written documentation of testing for communicable tuberculosis, verification of experience, education, training, reference checks and verification of the receipt of personnel policies and job descriptions. Ms. Gonzalez reviewed the staff schedules that Ms. Charlton submitted to her and Ms. Gonzalez confirmed that the staff schedule was a mock schedule, not an official staff schedule. At 1:33 p.m. on this date Ms. Charlton emailed Ms. Gonzalez informing her that she is physically unable to obtain the requested staff schedules for Linda and Celina until September 21, 2021. As of the writing of this *Order of Summary Suspension and Notice of Intent* Ms. Charlton has failed to comply with this request.

12. On September 17, 2021 Ms. Gonzalez spoke with Guardian B1 who stated that he visited Resident B in July, 2021 and that the only staff member present at the facility during his visit was a staff member named Celina, proving that Ms. Charlton had employed Celina in the role of a direct care staff member.

13. On September 20, 2021 and again on September 21, 2021 Ms. Gonzalez attempted to contact Ms. Charlton via telephone and email in order to complete an exit conference to discuss the findings of her complaint allegations and the recommendation for the status of license number AS500394497. As of the writing of this *Order of Summary Suspension and Notice of Intent* Ms. Charlton has failed to comply with this request.
14. On September 28, 2021 Ms. Gonzalez received an email from Katelyn Haskin of the Department of Licensing and Regulatory Affairs – Workforce Background Check. Ms. Haskin reviewed the facility's workforce background check account which confirmed that no one by the name of [redacted] has completed a *Michigan Workforce Background Check.* The email identified three staff members who have completed the *Michigan Workforce Background Check* to qualify to work at an adult foster care facility: [redacted], with a fingerprint date of [redacted]; the staff member identified by [redacted], with a fingerprint date of [redacted]; and [redacted], with a fingerprint date of [redacted].
15. As of the date of issuance of this *Order of Summary Suspension and Notice of Intent to Revoke,* Ms. Charlton has failed to comply with Ms. Gonzalez's request to provide employee files for Celina Wardlaw, Sandra Deh or the staff member named Linda.

COUNT I

The conduct of Licensee, as set forth in paragraphs 4(a), 10, 11, 12 & 14 above, evidences a willful and substantial violation of:

MCL 400.734b	**Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.

COUNT II

The conduct of Licensee, as set forth in paragraphs 4(k) & 6 above, evidences a willful and substantial violation of:

R 400.14316 Resident records.

(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information:

(a) Identifying information, including, at a minimum, all of the following:

(i) Name.

(ii) Social security number, date of birth, case number, and marital status.

(iii) Former address.

(iv) Name, address, and telephone number of the next of kin or the designated representative.

(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.

(vi) Name, address, and telephone number of the preferred physician and hospital.

(vii) Medical insurance.

(viii) Funeral provisions and preferences.

(ix) Resident's religious preference information.

(b) Date of admission.

(c) Date of discharge and the place to which the resident was discharged.

(d) Health care information, including all of the following:

(i) Health care appraisals.

(ii) Medication logs.

(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.

(iv) A record of physician contacts.

(v) Instructions for emergency care and advanced medical directives.

(e) Resident care agreement.

(f) Assessment plan.

(g) Weight record.

(h) Incident reports and accident records.

(i) Resident funds and valuables record and resident refund agreement.

(j) Resident grievances and complaints.

COUNT III

The conduct of Licensee, as set forth in paragraphs 4(g), 7, 8 & 11 above, evidences a willful and substantial violation of:

R 400.14312 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:

(a) Be trained in the proper handling and administration of medication.

(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.

(c) Record the reason for each administration of medication that is prescribed on an as needed basis.

COUNT IV

The conduct of Licensee, as set forth in paragraphs 4(d), 10 & 11 above, evidences a willful and substantial violation of:

R 400.14208 Direct care staff and employee records.

(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.

COUNT V

The conduct of Licensee, as set forth in paragraphs 4(c), 10, 11 & 15 above, evidences a willful and substantial violation of:

R 400.14208 Direct care staff and employee records.

(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information:

(a) Name, address, telephone number, and social security number.

(b) The professional or vocational license, certification, or registration number, if applicable.

(c) A copy of the employee's driver license if a direct care staff member or employee provides transportation to residents.

(d) Verification of the age requirement.

(e) Verification of experience, education, and training.

(f) Verification of reference checks.

(g) Beginning and ending dates of employment.

(h) Medical information, as required.

(i) Required verification of the receipt of personnel policies and job descriptions.

COUNT VI

The conduct of Licensee, as set forth in paragraphs 10 & 11, above, evidences a willful and substantial violation of:

R 400.14204 Direct care staff; qualifications and training.

(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas:

(a) Reporting requirements.
(b) First aid.
(c) Cardiopulmonary resuscitation.
(d) Personal care, supervision, and protection.
(e) Resident rights.
(f) Safety and fire prevention.
(g) Prevention and containment of communicable diseases.

COUNT VII

The conduct of Licensee, as set forth in paragraph 11, above, evidences a willful and substantial violation of:

R 400.14205 Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.

(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.

COUNT VIII

The conduct of Licensee, as set forth in paragraph 11, above, evidences a willful and substantial violation of:

R 400.14205 **Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**

(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 IX

The conduct of Licensee, as set forth in paragraphs 5, 6, 8, 9, 11, 13 & 15 above, evidences a willful and substantial violation of:

R 400.14103 **Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**

(3) The failure of an applicant or licensee to cooperate with the department in connection with an inspection or investigation shall be grounds for denying, suspending, revoking, or refusing to renew a license.

COUNT X

The conduct of Licensee, as set forth in paragraphs 8(a), 8(b), above, evidences a willful and substantial violation of:

R 400.14312 Resident medications.

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

COUNT XI

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

R 400.14313 Resident nutrition.

(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.

COUNT XII

The conduct of Licensee, as set forth in paragraphs 4(a-m) & 5 through 15 above, evidences a willful and substantial violation of:

R 400.14201 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.

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.

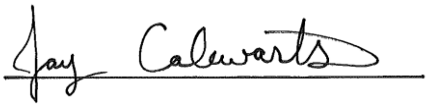
EFFECTIVE 6:00 PM, on October 4, 2021, Licensee is ordered not to operate an adult foster care small group home at 45492 Lone Pine Lane, Macomb Township, MI 48044 or at any other location or address. Licensee is not to receive adults for care after that time or date. Licensee is responsible for informing 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: 517-335-7519
FAX: 517-763-0155

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: 10-04-2021



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 True Tender Loving Care Adult Fostering LLC, AS500394497, consisting of 23 pages, this page included.

JNH

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

In the matter of

License #: AS500394497
SIR #: 2021A0465018

True Tender Loving Care Adult Fostering LLC

_____/

PROOF OF SERVICE

The undersigned certifies that a copy of the *Order of Summary Suspension and Notice of Intent* was personally served upon the person below on ___/___/____ at ___:___ a.m. or p.m.

True Tender Loving Care Adult Fostering LLC
Andrea Charlton

Served by:

_____
Adult Foster Care Licensing Consultant
Adult Foster Care and Camps Licensing Division
Bureau of Community and Health Systems