GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 20, 2019

Tamisha Turner
A Caring Home of Michigan, LLC
P.O. Box 81
Walled Lake, MI 48390

RE: License #: AS630298741
Investigation #: 2019A0617006
Chateau of Novi

Dear Ms. Turner:

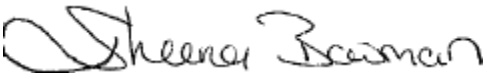
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS630298741
Investigation #:	2019A0617006
Complaint Receipt Date:	07/22/2019
Investigation Initiation Date:	07/24/2019
Report Due Date:	09/20/2019
Licensee Name:	A Caring Home of Michigan, LLC
Licensee Address:	45750 Eleven Mile Novi, MI 48374
Licensee Telephone #:	(248) 252-8888
Administrator:	Tamisha Turner
Licensee Designee:	Tamisha Turner
Name of Facility:	Chateau of Novi
Facility Address:	45750 Eleven Mile Novi, MI 48374
Facility Telephone #:	(248) 380-4663
Original Issuance Date:	01/22/2009
License Status:	REGULAR
Effective Date:	02/26/2018
Expiration Date:	02/25/2020
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
According to an incident report dated 07/18/19, a staff member hung up the receiver of the phone while Resident R was using it. Resident R was told the office was closed and she would have to use the cordless phone. There is a concern regarding access to the telephone as well as physical intervention. .	No
Additional Findings	Yes

III. METHODOLOGY

07/22/2019	Special Investigation Intake 2019A0617006
07/24/2019	Special Investigation Initiated - On Site I conducted an unannounced onsite inspection. I interviewed the house manager, Lashawn Goldman, and I spoke to the licensee, Tamisha Turner over the phone. I received a copy of the house rules, Resident R's incident reports, and a letter from Resident R's guardian.
08/06/2019	Contact - Document Received The licensee designee, Tamisha Turner provided me a copy of Resident R’s 30-day discharge letter, assessment plan, medication administration record (MAR), and a duplicate copy of the letter from Resident R’s guardian.
08/09/2019	Contact - Telephone call made I made a telephone call to staff member, Mellisa Cardwell. The allegations were discussed.
08/09/2019	Contact - Telephone call made I made a telephone call to Resident R's guardian, Jennifer Carney. A message was left requesting a call back.
08/20/2019	Contact - Document Received I received a copy of a police report from the Novi police department regarding the allegations.
08/20/2019	Contact - Telephone call made I left a voice message for the complainant requesting a call back.
08/20/2019	Contact - Document Received Dawn Krull from Oakland Community Health Network provided a copy of incident report number 521539 to me via email. This incident report was already received during my onsite.

08/20/2019	Inspection Completed-BCAL Sub. Compliance
08/20/2019	Exit Conference I conducted an exit conference with the licensee designee, Tamisha Turner.

ALLEGATION:

According to an incident report dated 07/18/19, a staff member hung up the receiver of the phone while Resident R was using it. Resident R was told the office was closed and she would have to use the cordless phone. There is a concern regarding access to the telephone as well as physical intervention.

INVESTIGATION:

On 07/24/19, I conducted an unannounced onsite inspection. I interviewed the house manager, Lashawn Goldman, and I spoke to the licensee, Tamisha Turner over the phone. I received a copy of the house rules, Resident R's incident reports, and a letter from Resident R's guardian.

On 07/24/19, I interviewed Lashawn Goldman. Ms. Goldman stated staff member Mellisa Cardwell is not present as she works the midnight shift. The midnight shift is from 7:00 pm to 7:00 am. Ms. Goldman stated Resident R is not present in the home because she was admitted into the hospital on 07/19/19. Resident R was admitted into the AFC group home on 07/01/19. Ms. Goldman stated that Resident R has been exhibiting negative behaviors in the home such as; hitting staff and eloping from the home. Resident R is described as high functioning however; she has a diagnosis of Schizophrenia and Bipolar disorder.

During my interview on 07/24/19, with Ms. Goldman, she stated that Resident R told Ms. Cardwell on 07/18/19 at 7:00 pm, she wanted to leave the home. Ms. Cardwell informed Resident R that she cannot leave the home after 7:00 pm. Resident R proceeded to leave the home after she was told not to. Ms. Cardwell contacted Ms. Goldman and informed her that Resident R left the home and she was knocking on the neighbor’s doors. Ms. Cardwell then contacted the police. Resident R was returned to the home by the police without any further incidents. Ms. Goldman arrived at the AFC group home the following morning at 7:00 am. Ms. Goldman stated around 2:30 pm Resident R said she wanted to leave the home to get cigarettes. Ms. Goldman informed Resident R that she cannot leave because it was too hot and there was a storm outside. Ms. Goldman stated that Resident R started to use profanity against her and then she left the home. Ms. Goldman called the police and the police returned Resident R back to the home. The police then called an ambulance to have Resident R transported to Providence hospital. Resident R was later transferred from Providence Hospital to Samaritan Psychiatric Hospital.

Ms. Goldman stated there is only one staff member that works during the midnight shift. Therefore, no other staff member witnessed the incident that took place on 07/18/19. Ms. Goldman does not know when Resident R will be discharged from the hospital as the hospital will not release any information over the phone. Ms. Goldman stated when Resident R is ready for discharge the hospital will contact Ms. Turner. I requested to review Resident R's file however; Resident R's records were not in her file. Ms. Goldman stated Resident R's records had not been transferred from her previous AFC group home as of yet. The only records that were in Resident R's file was progress notes, a letter from Resident R's guardian, and a discharge summary.

On 07/24/19, Ms. Goldman contacted the licensee, Tamisha Turner. I spoke to Ms. Turner over the phone. Ms. Turner stated prior to Resident R admittance into Chateau of Novi, she had resided in two previous AFC group homes which are associated with the same corporation as Chateau of Novi. Resident R's last AFC group home was in Inkster, MI; and her file has not been sent to Chateau of Novi as of now. Ms. Turner stated she has Resident R's file in her office. I explained to Ms. Turner that she is required to maintain a record for each resident in the home. Ms. Turner stated she will provide a copy of Resident R's assessment plan and 30-day discharge notice. Resident R does not have a behavior plan.

Ms. Turner stated she submitted a 30-day notice to Resident R's guardian due to her eloping from the home. Ms. Turner believes the 30-day notice is dated for 07/06/19. Ms. Turner stated Resident R has a history of calling cab companies and the police to the AFC group homes. Ms. Turner described an incident when Resident R left the home and was walking in the rain. Following that incident, Ms. Turner asked Resident R's guardian to write a letter outlining restrictions for Resident R's access to the community. I received a copy of this letter. The letter is dated 07/10/19 and signed by Jennifer Carney. The details of this letter consist of the following:

1. Resident R is to stay within a ½ mile radius with staff supervision
2. Resident R is to limit her off-site walks to no longer than one hour
3. Walks/off-site access can be up to four times daily but must fall between 8:00 am and no later than 6:00 pm. Resident R will return to the home by 7:00 pm
4. If Resident R would like to attend church or other activities it must be approved by our office or arranged with house manager with full details

On 07/24/19, I interviewed Ms. Turner over the phone regarding the allegations. Ms. Turner stated she was not present, but she was informed about the incident. Ms. Turner stated she does not believe Resident R was told she cannot use the phone. Ms. Turner stated Resident R is always in the office using the phone to call a cab or her guardian. Resident R also excessively uses the copy machine, the fax machine, and the computer in the office. Ms. Turner stated residents including Resident R can use the phone whenever they want to. The residents have unlimited calls to their guardian or the police. There are no rules regarding which phone the residents can use. The residents can choose to use the cordless phone or the office phone. Ms. Turner explained that the office is never closed to the residents as it is apart of their home. However, Ms. Turner

stated if Resident R was told the office was closed it was said to her in order to redirect her as a result of her behavior. Ms. Turner was informed about Resident R making a police report stating a staff member pushed Resident R. Ms. Turner does not believe a staff member would push Resident R. Resident R has a history of lying and making up allegations. Ms. Turner stated she had these same issues with Resident R at the previous AFC home in Inkster, MI. Resident R's primary doctor is Dr. Batah. Dr. Batah stopped prescribing Resident R psychotropic medications because she would refuse to take them. Resident R is only prescribed medications for physical conditions.

During the onsite, I reviewed the house rules. According to the house rules, the residents are allowed to use the phone during the hours of 7:00 am-9:00 pm. In case of an emergency residents may use the phone anytime to call a doctor, case manager, or their guardian.

On 07/24/19, I received a copy of three incident reports from Ms. Goldman during the onsite. The first incident report is dated 7/18/19 at 8:00 pm. The incident report was completed by staff member Mellisa Cardwell. The incident report states Resident R walked into the staff office attempting to look around. Resident R told Ms. Cardwell she was in the office to use the phone. Ms. Cardwell informed Resident R that the office was closed, and she needed to use the cordless phone. Resident R continued using the office phone. Ms. Cardwell hung up the receiver and redirected Resident R. Resident R pushed Ms. Cardwell's arm and held the phone up in an upward position as if she was going to hit her. Resident R then threw the phone. Resident R threatened to call the police; and then she left the home. Ms. Cardwell contacted the police while Resident R was outside knocking on the neighbor's doors. Resident R made a false police report stating Ms. Cardwell pushed her.

The second incident report is dated for 07/08/19. This incident report is regarding Resident R signing herself out at 6:30 pm to the leave the home. Resident R had not returned to the home by 10:00 pm therefore; the staff called the police. Resident R was returned to the home by the police.

The third incident report is dated for 07/09/19. This incident report is regarding Resident R calling a cab to pick her up from the home. When the cab arrived at the home, Resident R decided to not leave in the cab but to walk down the street to collect trash off the corner. Resident R was brought back to the home by the police.

On 08/06/19, Ms. Turner provided me a copy of Resident R's 30-day discharge letter, assessment plan, medication administration record (MAR), and a duplicate copy of the letter from Resident R's guardian. The discharge letter is dated for 07/09/19; and addressed to Jamesa McCarthy. According to the discharge letter, Resident R is being asked to move out by 08/08/19. There were no behavioral issues documented in Resident R's assessment plan. Resident R is prescribed Aspirin 81mg, Atorvastatin 80 mg, Culturelle 15 BIL, Fluticasone 50mcg, Folic Acid 1mg, Hydrocort, Levothyroxin 200mcg.

On 08/09/19, I made a telephone call to staff member, Mellisa Cardwell. Regarding the allegations, Ms. Cardwell stated on 07/18/19, she saw Resident R in the office rambling through the drawers and looking at the employee's phone numbers on the wall. Ms. Cardwell asked Resident R what she was doing, and Resident R stated she was trying to use the phone. Ms. Cardwell knew Resident R only stated she wanted to use the phone to give an excuse for why she was in the office, as Ms. Cardwell saw Resident R looking through paperwork. Therefore, Ms. Cardwell redirected Resident R to leave the office and use the cordless phone. Ms. Cardwell denies telling Resident R the office was closed. Ms. Cardwell stated the residents are welcomed to use every room in the house. Resident R proceeded with picking up the desk phone in the office. Ms. Cardwell then hung up the receiver. Resident R pushed Ms. Cardwell's hand. Ms. Cardwell told Resident R not to put her hands on her. Resident R yelled at Ms. Cardwell and cursed at her. Resident R then threw the phone at Ms. Cardwell. Ms. Cardwell stated the phone did not hit her as she moved out of the way. Resident R left the home. Ms. Cardwell stood at the doorway and asked Resident R to return to the home. Resident R proceeded to knock on two neighbors' doors. Ms. Cardwell contacted the police. When the police arrived, Resident R told the police that Ms. Cardwell pushed her. Ms. Cardwell stated she did not touch Resident R. Ms. Cardwell and Resident R completed an incident report. Resident R informed the police that she did not want to press charges. Ms. Cardwell stated Resident R has a history of telling lies.

On 08/20/19, I received a copy of a police report from the Novi Police department dated 07/18/19. According to the police report, Resident R stated she attempted to make a phone call in the office when Ms. Cardwell hung up the phone and told Resident R that she was not allowed in the office. Resident R stated she received permission from another caregiver earlier in the day to go in the office and use the phone. Resident R stated she attempted to move Ms. Cardwell's hand away but never touched Ms. Cardwell. Ms. Cardwell then took the phone from her and in doing so, the phone hit Resident R in her left arm. Resident R stated she was not injured but she believed that Ms. Cardwell did it purposefully. Resident R stated she then told Ms. Cardwell she was going to call the police and Ms. Cardwell told her she could not call the police. Resident R said she began to walk out of the office and Ms. Cardwell began screaming at her. Resident R stated they were now in the hallway outside of the office when Ms. Cardwell pushed her on the left arm with her right arm. Ms. Cardwell attempted to push Resident R two or three more times with both hands but did not touch her. Resident R told Ms. Cardwell she was going to leave the residence and Ms. Cardwell told her she could not leave.

According to the police report, Ms. Cardwell stated she found Resident R in the office looking around. Ms. Cardwell asked Resident R what she was doing, and Resident R told her she was going to use the phone. Ms. Cardwell told Resident R not to use the phone in the office as she needed to use either her cell phone or the cordless phone. Ms. Cardwell stated the residents are not allowed in the office because there are resident files in there. Ms. Cardwell said Resident R attempted to use the phone, but she hung it up. Ms. Cardwell stated Resident R became angry with her, and she began screaming at her and then pushed her hand away. Ms. Cardwell stated Resident R told

her she was going to call the police. Ms. Cardwell told Resident R she could call the police, but she has to use a different phone. Resident R then attempted to leave the residence. Ms. Cardwell told Resident R she was not allowed to leave, but Resident R left. Ms. Cardwell stated while she was calling the police, Resident R went to the neighbor's houses and was knocking on their doors and shouting for them to open the door.

On 07/19/19, Detective Penzak met with Resident R. Resident R stated she was not injured during the incident. The only physical contact was when Ms. Cardwell tried to grab the phone from Resident R. Resident R stated Ms. Cardwell scraped against her arm as she was reaching. Resident R does not believe the contact was intentional. The status of this police complaint is closed.

On 08/20/19, I conducted an exit conference with the licensee designee, Tamisha Turner. The findings and recommendations of the special investigation were discussed. Ms. Turner was notified that a corrective action plan will be required.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	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.**
ANALYSIS:	According to the police report dated 07/18/19, Resident R informed Detective Penzak that the only physical contact she had with Ms. Cardwell was when Ms. Cardwell tried to grab the phone from her. Resident R stated Ms. Cardwell scraped against her arm as she was reaching. Resident R does not believe the contact was intentional.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for**

	long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.
ANALYSIS:	Based on my findings, Resident R was not denied access to using a telephone as she was only instructed to use the cordless phone as oppose to the office phone.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based on my findings, Ms. Cardwell did not use any form of punishment or any physical force towards Resident R. Resident R was not denied access to using a telephone as she was only instructed to use the cordless phone as oppose to the office phone.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

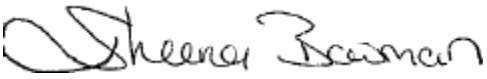
INVESTIGATION:

During my onsite on 07/24/19, I spoke to Ms. Turner over the phone. Ms. Turner stated prior to Resident R admittance into Chateau of Novi, she had resided in previous AFC group homes which are associated with the same corporation as Chateau of Novi. Resident R's last AFC group home was in Inkster, MI; and her file has not been sent to Chateau of Novi as of now. Ms. Turner stated she has Resident R's file in her office. I explained to Ms. Turner that she is required to maintain a record for each resident in the home.

APPLICABLE RULE	
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.
ANALYSIS:	During my onsite on 07/24/19, Resident R's file was not in the AFC group home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

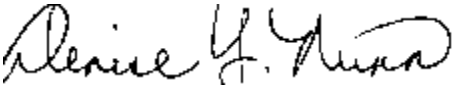
Contingent upon receipt of an acceptable corrective action plan. I recommend no change in the license status.



08/20/19

Sheena Bowman — Date
Licensing Consultant

Approved By:



08/20/2019

Denise Y. Nunn — Date
Area Manager