STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING
ORLENE HAWKS
DIRECTOR

June 10, 2021

Kimberly Rocca-Riffle
Creative Lifestyles, Inc.
Suite 400
52188 Van Dyke
Shelby Township, MI 48316

RE: License #: AS500262291
Investigation #: 2021A0465015
Carol Manor

Dear Ms. Rocca-Riffle:

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,

Stephanie Gonzalez, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 514-9391

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500262291
Investigation #:	2021A0465015
Complaint Receipt Date:	04/13/2021
Investigation Initiation Date:	04/16/2021
Report Due Date:	06/12/2021
Licensee Name:	Creative Lifestyles, Inc.
Licensee Address:	Suite 400 52188 Van Dyke Shelby Township, MI 48316
Licensee Telephone #:	(586) 997-9401
Administrator:	Kimberly Rocca-Riffle
Licensee Designee:	Kimberly Rocca-Riffle
Name of Facility:	Carol Manor
Facility Address:	13311 Carol Warren, MI 48093
Facility Telephone #:	(586) 759-4630
Original Issuance Date:	03/16/2004
License Status:	REGULAR
Effective Date:	09/15/2020
Expiration Date:	09/14/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 3/17/2021, Resident A was denied phone access by direct care staff, Alesia Brown.	No
Resident A is not allowed to go into the community.	No
Direct care staff, Alesia Brown, treated Resident A in a disrespectful manner.	No
On 3/17/2021, Resident A was denied transportation to the hospital for medical care.	No
Resident A is being denied access to her personal funds.	No
Additional Findings	Yes

III. METHODOLOGY

04/13/2021	Special Investigation Intake 2021A0465015
04/16/2021	Special Investigation Initiated - Telephone Contacted Complainant
05/04/2021	Inspection Completed On-site Interviews were completed with Ms. Gaffney, Ms. Wallace and Resident A. Resident A's *AFC-Information Record, Assessment Plan for AFC Residents, Health Care Appraisal* were reviewed; Observed Resident A and the facility to be organized and clean.
05/07/2021	Contact - Telephone call made Left voice mail for CMH case manager. Requested return call.
05/21/2021	Contact - Telephone call made Spoke to Guardian A1
05/24/2021	Exit Conference Held with Ms. Rocca-Riffle

ALLEGATION:

On 3/17/2021, Resident A was denied phone access by direct care staff, Alesia Brown.

INVESTIGATION:

On 4/13/2021, a complaint was received, alleging that on 3/17/2021, Resident A was denied phone access by direct care staff Alesia Brown. The complaint indicated that on 3/17/2021, Resident A was on the phone, complaining about medical issues, and the phone call was ended by Ms. Brown. Ms. Brown refused to allow Resident A to get back on the phone.

On 4/16/2021, I spoke to Complainant via email exchange. Complainant confirmed that the information contained in the complaint is accurate.

On 5/4/2021, I conducted an onsite investigation at the facility. I completed interviews with Ms. Gaffney, Ms. Wallace and Resident A. I reviewed Resident A's Resident A's *AFC-Information Record, Assessment Plan for AFC Residents* and *Health Care Appraisal*. I observed Resident A to be well-groomed and the facility organized in a clean manner. At the time of the onsite investigation, Ms. Gaffney informed me that Ms. Brown is no longer employed by the facility for reasons unrelated to this special investigation.

I interviewed Resident A, who stated that she likes living at the facility. When interviewed regarding this complaint, Resident A stated, "I don't remember anything happening with the phone. I can use the phone as much as I want, and staff are nice to me." Resident A denied this allegation is true.

I interviewed direct care staff, Essie Gaffney, who stated that she has been working at the facility for several years. Ms. Gaffney stated that all residents, including Resident A, have access to a telephone as needed. Ms. Gaffney denied any knowledge of a time when Resident A was denied access to a telephone for personal use.

On 5/22/2021, I interviewed Guardian A1 via telephone. Guardian A1 stated that she is not aware of a time when Resident A was denied access to a telephone. Guardian A1 believes the facility is providing Resident A with consistent telephone access as needed.

I attempted to contact Ms. Brown via telephone to conduct an interview regarding this complaint and have not received a return call as of the date of this report.

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:	Resident A denied any knowledge of a time when she was denied access to a telephone by any staff, including Ms. Brown. Resident A did not report any telephone access concerns and denied that this complaint is accurate. Ms. Gaffney denied any knowledge of a time when Resident A was denied access to a telephone for personal use. Guardian A1 is not aware of a time when Resident A was denied access to a telephone. Guardian A1 believes the facility is providing Resident A with consistent telephone access as needed. Based on the information above, there is not sufficient information to confirm that, on 3/17/2021, Resident A was denied access to a telephone for personal use.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A is not allowed to go into the community.

INVESTIGATION:

On 4/13/2021, a complaint was received, alleging that direct care staff are refusing to allow Resident A to go in the community. The complaint did not provide any additional information.

On 4/16/2021, I spoke to Complainant via email exchange. Complainant confirmed that the information contained in the complaint is accurate.

On 5/4/2021, I conducted an onsite investigation at the facility. I interviewed Resident A, who stated that she has not been able to go into the community due to the pandemic. Resident A stated, “I want to go out and go places, but I can’t right now. I hope to be able to go back out and go places again soon.” Resident A acknowledged that the current community access restrictions in place at the facility are due to the global

COVID-19 pandemic. Resident A did not vocalize any concerns related to the care and services being provided by direct are staff at the facility.

I interviewed Ms. Gaffney, who stated that, due to the current COVID-19 pandemic, there are restrictions and limitations to community access and outings at this time. Ms. Gaffney stated that the facility is adhering to all COVID-19 protocols and safety measures required by the CDC and the State of Michigan.

On 5/22/2021, I interviewed Guardian A1, who stated that Resident A's access to the community is currently limited as a safety precaution. Guardian A1 said, "We are in the middle of a global pandemic. Everyone is limited to community access as a safety precaution. I know that the facility has begun to gradually allow residents to re-integrate into the community for outings, but it is very limited and a slow process." Guardian A1 believes the facility is providing adequate care and community access to Resident A when appropriate and safe. Guardian A1 did not vocalize any concerns related to community access.

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: **(h) The right to participate in the activities of social, religious, and community groups at his or her own discretion.**
ANALYSIS:	Resident A has not been able to go into the community due to the pandemic. Resident A acknowledged that the current community access restrictions enforced by the facility are due to the global COVID-19 pandemic. Resident A is unhappy with the negative impact that COVID-19 has had on her life but denied any current concerns related to the facility specifically. According to Ms. Gaffney, due to the current COVID-19 pandemic, there are restrictions and limitations to community access and outings at this time for all residents, including Resident A. Guardian A1 believes the facility is providing adequate care and community access to Resident A when appropriate and safe. Guardian A1 did not vocalize any concerns related to community access.

	Based on the information above, the facility is adhering to COVID-19 safety protocols and precautions and is allowing community access when appropriate and safe to do so.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Direct care staff, Alesia Brown, treated Resident A in a disrespectful manner.

INVESTIGATION:

On 4/13/2021, a complaint was received, alleging that on 3/17/2021, Ms. Brown yelled at Resident A and treated her in a disrespectful manner.

On 4/16/2021, I spoke to Complainant via email exchange. Complainant confirmed that the information contained in the complaint is accurate.

On 5/4/2021, I conducted an onsite investigation at the facility. At the time of my onsite investigation, Ms. Gaffney informed me that Ms. Brown is no longer employed by the facility for reasons unrelated to this special investigation.

I interviewed Resident A, who stated she is familiar with Ms. Brown. Resident A stated, "I like living here. I liked {Ms. Brown}. She was nice. She never yelled at me." Resident A denied recalling a time when Ms. Brown, or any other direct care staff, yelled at her or treated her in a disrespectful manner. Resident A did not vocalize any concerns related to being treated with dignity and respect by direct care staff at the facility.

I interviewed Ms. Gaffney, who stated that she has never treated any resident, including Resident A, in a disrespectful manner. Ms. Gaffney stated that she has never observed any direct care staff treat residents in a disrespectful or rude manner. Ms. Gaffney denied that this allegation is true.

On 5/22/2021, I interviewed Guardian A1 via telephone. Guardian A1 stated, "I have no concerns regarding the staff at the facility. I have no concerns and don't believe staff are treating {Resident A} rudely." Guardian A1 did not vocalize any concerns related to this allegation.

I attempted to contact Ms. Brown via telephone to conduct an interview regarding this compliant and have not received a return call as of the date of this report.

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: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**
ANALYSIS:	Resident A did not vocalize any concerns related to being treated in a disrespectful manner by Ms. Brown, nor any other direct care staff. According to Ms. Gaffney, she has never treated any resident in a disrespectful manner and has never observed any other direct care staff treat Resident A in a disrespectful manner. Guardian A1 has never observed a direct care staff treat Resident A in a disrespectful manner. Guardian A1 did not vocalize any concerns related to allegation. Based on the information above, the facility is treating Resident A with dignity and respect.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

On 3/17/2021, Resident A was denied transportation to the hospital for medical care.

INVESTIGATION:

On 4/13/2021, a complaint was received, alleging that on 3/17/2021, Resident A was denied needed medical care. The complaint read that on 3/17/2021, Resident A's Lymphedema flared up and she needed to go the hospital. The complaint stated that direct care staff refused to call 911 or transport Resident A to the hospital.

On 4/16/2021, I spoke to Complainant via email exchange. Complainant confirmed that the information contained in the complaint is accurate.

On 5/4/2021, I conducted an onsite investigation at the facility. I reviewed Resident A's record. The *AFC-Resident Information and Identification Record* read that Resident A

was admitted to the facility on 10/5/2020. The *Health Care Appraisal* read that Resident A has a medical diagnosis of Severe Intellectual Disability, Schizophrenia, Lymphedema and GERD. The *Assessment Plan for AFC Residents* read that Resident A has Lymphedema on her legs and has a history of seeking emergency medical treatment for this when she does require emergent medical care. The document read that there are specific guidelines in place to prevent outside medical treatment, including only seeking medical treatment if the swelling exceeds a specific measurement or are unable to stop the blisters from leaking. The preventative measurements include applying leg compressions two times per day and administering prescribed medication as ordered to assist with medical management of the swelling.

I interviewed Resident A, who reported that she is provided needed medical care for her feet. Resident A stated, "The staff help me all the time with my feet. I have had swollen feet my whole life and I have to try and stay off my feet as much as possible to help. They {staff} put medicine on my feet and wrap them and they take me to hospital if I need to go." Resident A denied any knowledge of a time when she was denied medical attention by direct care staff.

I interviewed Ms. Gaffney, who reported that she is familiar with Resident A's Lymphedema medical needs. Ms. Gaffney stated, "{Resident A} has had swollen feet her entire life and sometimes her feet get blisters on them. She is supposed to stay off her feet several hours per day, but sometimes she wants to walk around a lot. We have a protocol in place to make sure {Resident A} does not go to the hospital unless it is medically necessary. We created the plan with Resident A's primary care doctor and {Guardian A1}. When {Resident A's} feet blisters leak, we apply ointment and gauze to the blistered areas. If we are able to get the leaking to stop, then we do not send {Resident A} to the hospital. {Resident A} immediately wants to go the hospital anytime her feet begin to hurt, or her blisters begin to leak, but these are things we can manage in the facility without having to send her to the hospital. I was working on 3/17/2021 and I was the one that provided medical care to {Resident A}. {Resident A} had a few foot blisters that began to leak but I applied medication to the blisters and was able to get the leaking to stop. {Resident A} did ask to go to the hospital but it was not medically necessary for her to go to the hospital. We provide good care to {Resident A} and we are trained on how to manage her medical condition." Ms. Gaffney reported that on 3/17/2021, Resident A did not require emergent medical care transport to a hospital.

On 5/22/2021, I interviewed Guardian A1 via telephone. Guardian A1, who stated, "{Resident A} likes to go to the hospital and likes receiving attention from medical staff. {Resident A} asks to go to the hospital frequently, even though it is not medically needed. I, the medical doctors, and the facility have implemented specific guidelines to ensure that {Resident A} does not go to the hospital if not necessary. The facility has been given directive to only send {Resident A} to the hospital if her feet blisters leak and are unable to be stopped by staff at the facility or her feet are inflamed past the specified measurement." Guardian A1 reported that she believes the facility is providing Resident A with consistent and adequate medical care as needed.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	The *Health Care Appraisal* indicated that Resident A has a medical diagnosis of Severe Intellectual Disability, Schizophrenia, Lymphedema and GERD. The *Assessment Plan for AFC Residents* indicates that Resident A has Lymphedema on her legs and has a history of seeking emergency medical treatment when not medically necessary. There are specific guidelines in place to prevent outside medical treatment, including only seeking medical treatment if unable to stop the blisters from leaking or the swelling exceeds a specific measurement, as well as leg compressions two times per day and administering prescribed medication as ordered to assist with medical management of the swelling. According to Resident A, she is provided needed medical care for her feet by direct care staff as needed. Resident A denied any knowledge of a time when she was denied medical attention by direct care staff. Ms. Gaffney was working on 3/17/2021 and provided medical care to Resident A. Resident A had two blisters on her foot that were leaking, to which she applied ointment and gauze. The foot blisters stopped leaking and Resident A did not require emergent medical care transport to a hospital. Ms. Gaffney denied knowledge of a time when Resident A was denied medical care transport to a hospital when needed. According to Guardian A1, Resident A has a history of asking to go to the hospital frequently when not medically necessary. The facility has been given directive to only send Resident A to the hospital if her feet blister leakage is unable to be stopped by staff or her feet are swollen past a specific measurement. Guardian A1 believes the facility is providing Resident A with consistent and adequate medical care as needed. Based on the information above, the facility is providing adequate medical care to Resident A as needed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A is being denied access to her personal funds.

INVESTIGATION:

On 4/13/2021, a complaint was received, alleging that Resident A is being denied access to her personal funds. The complaint stated that direct care staff are refusing to give Resident A her personal funds.

On 4/16/2021, I spoke to Complainant via email exchange. Complainant confirmed that the information contained in the complaint is accurate.

On 5/4/2021, I conducted an onsite investigation at the facility. I interviewed Resident A, who stated that she has no concerns related to her personal funds. Resident A stated, "Whenever I ask for money, the staff give me my money. I get to spend my money on what I want to." Resident A denied any knowledge of a time when she was denied access to her personal funds. Resident A did not vocalize any concerns and denied this allegation is true.

I interviewed Ms. Gaffney, who stated that all residents, including Resident A, are allowed access to their personal funds when requested. Ms. Gaffney stated that she is not aware of a time when Resident A was denied access to her personal funds when requested.

On 5/22/2021, I interviewed Guardian A1 via telephone. Guardian A1 stated, "The staff give {Resident A} her personal funds when she asks. The staff are very good at managing {Resident A's} funds." Guardian A1 did not vocalize any concerns related to this allegation.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(7) A resident shall have access to and use of personal funds that belong to him or her in reasonable amounts, including immediate access to not less than $20.00 of his or her personal funds. A resident shall receive up to his or her full amount of personal funds at a time designated by the resident, but not more than 5 days after the request for funds. Exceptions to this requirement shall be subject to the provisions of the resident's assessment plan and the plan of service.
ANALYSIS:	Resident A stated has no concerns related to her personal funds. Resident A denied any knowledge of a time when she

	was denied access to her personal funds. Resident A did not vocalize any concerns and denied this allegation is true. According to Ms. Gaffney, all residents, including Resident A, are allowed access to their personal funds when requested. Ms. Gaffney is not aware of a time when Resident A was denied access to her personal funds when requested. Guardian A1 believes that direct care staff are very good at managing Resident A's funds." Guardian A1 did not vocalize any concerns related to this allegation. Based on the information above, the facility is allowing Resident A access to her personal funds when requested.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite investigation on 5/4/2021, I reviewed Resident A's record. I was unable to locate a Funds Part II document, nor any other funds transaction document, for Resident A. I observed three separate envelopes with Resident A's name on them, that contained money in each envelope in increments of $10.00, $8.00 and $44.00. However, there were no receipts in the envelopes nor a transaction sheet to specify when funds have been disbursed and what the funds were spent on.

I interviewed direct care staff, Kiesha Wallace, who stated she is the person that oversees the funds for Resident A. Ms. Wallace stated, "We do not manage {Resident A's} personal funds but we do keep her personal funds in the locked office area. We give personal funds to her whenever she asks for money, but we don't manage her money." Ms. Wallace acknowledged that the facility is holding Resident A's funds in the office, an area that is only accessible to direct care staff. Ms. Wallace admitted that direct are staff are not documenting each time they give Resident A money from her personal funds. Ms. Wallace stated that she did not realize the facility was required to document all funds transactions for Resident A.

On 5/24/2021, I conducted an exit conference with Ms. Rocca-Riffle. Ms. Rocca-Riffle is in agreement with the findings of this report.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization

	for a substitute form has been granted, in writing, by the department.
ANALYSIS:	During the onsite investigation on 5/4/2021, I reviewed Resident A's record. I was unable to locate a Funds Part II document, nor any other funds transaction document, for Resident A. I observed three separate envelopes with Resident A's name on them, that contained money in each envelope in increments of $10.00, $8.00 and $44.00. However, there were no receipts in the envelopes nor a transaction sheet to specify when funds have been disbursed and what the funds were spent on. Ms. Wallace acknowledged that the facility is holding Resident A's funds in the office, an area that is only accessible to direct care staff. Ms. Wallace acknowledged that direct are staff are not documenting each time they give Resident A money from her personal funds. Ms. Wallace did not realize the facility was required to document all funds transactions for Resident A. Based on the information above, the facility is not completing a transaction form on file for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

6/9/2021

Stephanie Gonzalez Date
Licensing Consultant

Approved By:

6/10/2021

Denise Y. Nunn Date
Area Manager