GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 8, 2021

Snehlata Singh
4302 Chestnut Grove Lane
Beltsville, MD 20705

RE: License #: AS750385878
Investigation #: 2021A1030031
Lynn AFC Home

Dear Ms. Singh:

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 (517) 284-9730.

Sincerely,

Nile Khabeiry, LMSW

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS750385878
Investigation #:	2021A1030031
Complaint Receipt Date:	08/20/2021
Investigation Initiation Date:	08/24/2021
Report Due Date:	10/19/2021
Licensee Name:	Snehlata Singh
Licensee Address:	4302 Chestnut Grove Lane Beltsville, MD 20705
Licensee Telephone #:	(240) 423-6930
Administrator:	Snehlata Singh
Licensee Designee:	Snehlata Singh
Name of Facility:	Lynn AFC Home
Facility Address:	815 West Street Three Rivers, MI 49093
Facility Telephone #:	(240) 423-3517
Original Issuance Date:	02/11/2019
License Status:	REGULAR
Effective Date:	08/10/2021
Expiration Date:	08/09/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Lynn AFC prevented egress from the facility by securing the windows, bedroom door and front door.	Yes
The facility is infested with bedbugs and is not treating the facility properly.	No

II. METHODOLOGY

08/20/2021	Special Investigation Intake 2021A1030031
08/24/2021	Contact - Face to Face- Interview with Mary Scialabba
08/24/2021	Contact - Face to Face- Interview with licensee designee
08/24/2021	Special Investigation Initiated - Face to Face Interview with Rebecca Roberts
08/24/2021	Contact - Face to Face- Interview with Resident B
08/24/2021	Contact - Face to Face- Interview with Resident C
08/24/2021	Contact - Face to Face- Interview with Resident D
08/24/2021	Contact - Telephone call made- Interview with Guardian A1
08/24/2021	Contact - Telephone call made- Interview with Anna Farley
09/08/2021	Contact- Email- New referral received Intake # 181886
09/10/2021	Contact - Face to Face- Interview with Mary Scialabba
09/10/2021	Contact - Face to Face- Interview with Resident B
09/10/2021	Contact - Face to Face- Interview with Resident C
09/10/2021	Contact - Face to Face- Interview with Resident D
09/10/2021	Exit Conference with licensee designee, Snehlata Singh.

ALLEGATION:

Lynn AFC prevented egress from the facility by securing the windows, bedroom, and front door.

INVESTIGATION:

On 08/24/2021, I interviewed Rebecca Robins who works next to Lynn AFC. Ms. Robins reported she witnessed one of the direct care staff nailing the windows shut at Lynn AFC. Ms. Robins provided a picture taken of an older female, later identified as Lynne AFC direct care staff member, Mary Scialabba hammering a nail into the outside window frame. Ms. Robins reported she is concerned as that could posed a safety issue for the residents.

On 08/24/2021, I conducted an on-site investigation at Lynn AFC located at 815 West Street Three Rivers, MI. I made contact with direct care staff member Mary Scialabba and interviewed her regarding the allegation. Ms. Scialabba reported Resident A is no longer residing at the facility. Ms. Scialabba reported Resident A entered the facility on 08/03/2021 and started having behavioral problems a couple of days after moving in. Ms. Scialabba reported Resident A eloped several times and was found in the neighbor's home, cars and would run into the into traffic. Ms. Scialabba reported she and licensee designee tried everything to manage Resident A's behaviors but were not able to successfully manage Resident A's behaviors. Ms. Scialabba reported she did nail the windows shut from the outside because Resident A crawled out of the windows to elope. Ms. Scialabba confirmed that the picture taken of a woman hammering a nail into the window frame was in fact her. I inspected the windows and noted there were nail holes in the windows. I ensured all windows were no longer nailed shut and were fully operable. I toured the home including Residents A's former bedroom and noted there was a lock installed on the inside of a sliding glass door which would have prevented egress from the inside of the room when locked and could only be opened with a small key. I instructed Ms. Scialabba to remove the lock while I was on-site which was done. Ms. Scialabba reported Resident A was never restrained or tied down, however they did attempt to prevent her from eloping from the facility.

On 08/24/2021, I interviewed License Designee, Snehlata Singh regarding the allegation. Ms. Singh reported she accepted Resident A on 08/03/2021 and discharged her on 08/20/2021. Ms. Singh reported she did complete a discharge notice and indicated it was sent to Resident A's legal guardian, CMH case worker and AFC licensing consultant, Eli Deleon. Ms. Singh reported she was not informed about Resident A's behavioral problems and was not able to manage Resident A's behaviors as she and Ms. Scialabba are the only staff members who work at the facility. Ms. Singh reported Resident A was psychotic and they were unable to sleep for a couple of days as they tried to keep Resident A from eloping. Ms. Singh reported she called Resident A's case manager, Anna Farley many times asking for help however was not provided any assistance until she eventually took Resident A to Borgess Hospital on 08/20/2021. Ms. Singh reported she was not provided enough support from CMH and

called Resident A's legal guardian as well as Adult Protective Services. Ms. Singh reported Resident A was not physically restrained but direct care staff members did nail the windows shut and used a rope tied to the outside doorknob to the wheelchair ramp handrail to prevent the door from being opened from the inside. Ms. Singh reported she knew she was in violation of AFC licensing rules but does not believe she had a choice given the circumstances.

On 08/24/2021, I interviewed Resident B regarding the allegations. Ms. Liddy reported she has lived at the AFC for eight years. Resident B reported she does not like living at the home because she does not get to date her boyfriend. Resident B reported she has never witnessed anyone being tied up or restrained but she does get threatened by direct care staff. Resident B reported they have told her "if you don't stay here we can't help you." Resident B reported the windows were nailed shut when Resident A was living in the home.

On 08/24/2021, I interviewed Resident C regarding the allegations. Resident C reported is unsure how long she has lived at this facility but thinks it's been "a long time." Resident C reported she likes it here sometimes. Resident C reported Resident A did have problems while she lived in the home. Resident C reported Resident A was noted tied up or restrained inside the home but the windows were nailed shut because she climbed out her bedroom window.

On 08/24/2021, I interviewed Resident D regarding the allegations. Resident D reported she has been living at Lynn AFC for a long time. Resident D reported she likes living at this facility. Resident D reported Resident A used to climb out her bedroom window. Resident D reported the windows were nailed shut by the direct care staff, but she never saw the direct care staff restrain Resident A.

On 08/24/2021, I interviewed Resident A's legal guardian Michianna Guardianship Services. Guardian A1 reported she has been Resident A's representative payee for several years and was appointed as her guardian at an emergency hearing on 08/18/2021. Guardian A1 reported Lynn AFC did everything they could to provide adequate care for Resident A but were not equipped to manage her behaviors. Guardian A1 reported the facility did not receive enough support from CMH and she called the case worker, Anna Farley and Ms. Farley's supervisor, Brain Scott but did not receive any return phone calls. Guardian A1 reported Resident A is now hospitalized at Bronson Lakeview in Paw Paw, MI. and is still extremely delusional.

On 08/24/2021, I spoke with Resident A's CMH case worker, Anna Farley. Ms. Farley reported Resident A was placed at Lynn AFC after she was released from a psychiatric hospital in Indiana. Ms. Farley reported Resident A began eloping by jumping out of the window. Ms. Farley reported the facility called law enforcement when Resident A eloped and eventually took her to Borgess Hospital where she was placed in a psychiatric hospital. Ms. Farley reported she does not have any knowledge of the facility preventing egress through the doors or windows.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	Rule 403. (1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based on my investigation which included my personal observations of Lynn AFC, interviews with direct care staff member, Mary Scialabba, licensee designee, Snehlata Singh Guardian A1, CMH case manager, Anna Farley and Resident B, Resident C and Resident D this violation will be established. During the on-site inspection I received a picture of Mary Scialabba hammering nails into the window frame and witnessed nail holes in the window frames on the outside of the residence. I also witnessed a lock on the inside of a sliding glass door in the bedroom that was occupied by Resident A which prevented egress from the bedroom. Ms. Singh admitted to securing a rope between a wheelchair ramp handrail and the doorknob to prevent Resident A from eloping through the door. Licensee designee, Snehlata Singh admitted to knowing she was in violation of licensing rules when she made the decision to securing the windows and door preventing egress from the facility thus making the home unsafe for all residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
The facility is infested with bedbugs and is not treating the facility properly.

INVESTIGATION:

On 09/08/2021, I received an additional referral that reported the facility has a bed bug infestation and are not treating the problem appropriately.

On 09/10/2021, I made an on-site inspection regarding this additional allegation and spoke with direct care staff member, Mary Scialabba. Ms. Scialabba reported the facility has been dealing with bed bugs but has been treating with pest control products as well as cleaning and doing laundry. I noted bed bug pesticides (liquid and bug bombs) in an empty bedroom. I also noted the bed was stripped of linens and the room had been cleaned and vacuumed.

On 09/10/2021, I interviewed Resident B, Resident C and Resident D regarding the allegations. All residents reported the facility does have a problem with bed bugs and

the direct care staff and homeowner treat the bed bugs with spray and bombs. All three residents report the problem seems to be getting better and none had bed bug bites.

On 09/10/2021, I interviewed licensee designee, Snehlata Singh regarding the allegations. Ms. Singh reported she did have a resident who brought bed bugs into the home, but they have been working hard to treat the problem. Ms. Singh reported she and direct care staff member Mary Scialabba spray, bomb and do laundry every day. Ms. Singh reported she checked into having the home professionally treated but cannot afford the thousands dollar cost of this process. Ms. Singh reported the problem is improving and she will continue until there are no more bed bugs.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	Based on my investigation which included my personal observations of Lynn AFC, interviews with direct care staff member, Mary Scialabba, licensee designee, Snehlata Singh and Resident B, Resident C and Resident D this violation will be not established. All parties interviewed acknowledged a problem with bed bugs, however the facility has been addressing the infestation by spraying, bombing, and doing laundry on a daily basis. Furthermore, there has been improvement and treatment will continue until the bed bugs are successfully eradicated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

III. RECOMMENDATION

Based on acceptance of an approved corrective action plan, I recommend no change in license status.

10/2/2021

Nile Khabeiry Date
Licensing Consultant

Approved By:

10/08/2021

Dawn N. Timm Date
Area Manager