GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 23, 2021

Linda K. M. Quaye and Samuel Quaye
15357 Chippewa Street
Buchanan, MI 49107

RE: License #: AS110237511
Investigation #: 2022A0581001
Samlind Services US-31

Dear Mr. and Mrs. Quaye:

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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS110237511
Investigation #:	2022A0581001
Complaint Receipt Date:	10/01/2021
Investigation Initiation Date:	10/01/2021
Report Due Date:	11/30/2021
Licensee Name:	Linda K. M. Quaye and Samuel Quaye
Licensee Address:	15357 Chippewa Street Buchanan, MI 49107
Licensee Telephone #:	(269) 683-4108
Administrator:	Linda K. M. Quaye
Licensee Designee:	N/A
Name of Facility:	Samlind Services US-31
Facility Address:	2031 US-31 North Niles, MI 49120
Facility Telephone #:	(269) 683-4108
Original Issuance Date:	09/28/2001
License Status:	REGULAR
Effective Date:	12/04/2020
Expiration Date:	12/03/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided with adequate protection and supervision when she eloped from the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/01/2021	Special Investigation Intake 2022A0581001
10/01/2021	APS Referral APS received the allegations as well; no referral is necessary.
10/01/2021	Special Investigation Initiated - Telephone Interview with APS, Jacob Pehur
10/06/2021	Inspection Completed On-site Interviewed licensee and resident.
10/08/2021	Contact – Document Received Staff training record.
10/08/2021	Contact – Telephone call made Attempted phone call to direct care staff, Tamandani Joshua.
11/17/2021	Contact – Telephone call made Another attempted phone call to Mr. Joshua.
11/19/2021	Exit conference with licensee, Linda Quaye, via telephone.

ALLEGATION:

Resident A was not provided with adequate protection and supervision when she eloped from the facility.

INVESTIGATION:

On 10/01/2021, I received this complaint as a referral from Adult Protective Services (APS). The complaint alleged Resident A has a diagnosis of dementia and “is very confused”. The complaint alleged on 09/30/2021, Resident A was found

approximately 10 miles from the facility by Michigan State Police, and she was unable to provide her name, birthdate or where she lived. The complaint alleged the facility has a locked gate and it was unknown how Resident A got out of the facility to wander away.

On 10/01/2021, I confirmed with Berrien County APS specialist, Jacob Pehur, he had also received the allegations and was investigating; therefore, no referral was necessary. Mr. Pehur indicated he interviewed the facility's licensee, Linda Quaye, who stated to him she had transported Resident A on 09/30/2021 from the facility to Ms. Quaye's other facility in Buchanan. Ms. Quaye indicated to Mr. Pehur Resident A wandered away from the facility in Buchanan and not the Niles facility, contrary to what was indicated in the complaint.

On 10/06/2021, I conducted an unannounced on-site investigation at the facility, as part of my investigation. Due to no one being present at the facility, I went to the licensee's neighboring facility approximately 10 minutes (seven miles) away in Buchanan, which is where the alleged incident occurred. The licensee's husband, Sam Quaye, was present at this facility. He stated Ms. Quaye was not at the facility in Niles because she had taken residents to medical appointments but would be back to the facility soon. Mr. Quaye called Ms. Quaye in my presence and confirmed she would be back to the facility in approximately 20 minutes. I asked to interview any direct care staff members who were working when Resident A eloped, but Mr. Quaye indicated direct care staff, Tamandani aka "TJ" Joshua, was no longer working at the facility. He stated Mr. Joshua quit because he didn't want to "deal with any special investigations." Mr. Quaye was unable to provide a working or valid phone number for Mr. Joshua but indicated he or his wife could provide it to me at a later date.

When I arrived at the facility, I interviewed Ms. Quaye regarding the incident with Resident A. She stated on 09/30/2021 she had taken the facility's three female residents to her other licensed AFC facility in Buchanan. She stated having the residents visiting with one another is a regular and normal occurrence for social interaction, but she also indicated the residents wanted to go shopping with her. She stated she had stopped at the other facility to pick up the facility's two male residents to have them come along with her to the store.

Ms. Quaye stated when she got to the Buchanan facility, direct care staff, Mr. Joshua, told her Resident A could stay with him at the facility, indicating Resident A didn't want to go shopping with her, so Ms. Quaye got into her vehicle and left the facility with four residents. Ms. Quaye stated she didn't realize Resident A was missing from the facility until the police showed up to the Niles facility around 3:40 pm. Ms. Quaye indicated she didn't talk in depth to Mr. Joshua after the incident occurred, but indicated he thought Resident A had gotten back into Ms. Quaye's car to go to the store with her. Ms. Quaye indicated there had been a "miscommunication issue" between her and Mr. Joshua. She stated he had been

new to working at the facility, had only been working at the facility for a couple months, but since the incident occurred, he was no longer employed.

Ms. Quaye stated she believed the facility was staffed appropriately for the residents, but indicated she was looking to hire someone to work the weekends. Ms. Quaye denied forcing the residents to go to the store with her or leaving the residents at the other facility due to lack of staffing. Additionally, I requested Ms. Quaye send me Mr. Joshua's staff file for review.

I attempted to interview Resident A regarding the incident; however, the interview was unsuccessful due to Resident A's confusion. She stated she did not recall ever walking away from the facility or any other facility.

I reviewed Resident A's *Assessment Plan for AFC Residents*, dated 05/05/2021, which indicated Resident A is unable to move independently in the community. It also indicated Resident A can become confused in new settings. I reviewed Resident A's *Health Care Appraisal*, dated 02/24/2021; however, I was unable to interpret her diagnosis due to the physician's illegible handwriting. I also reviewed an after-visit summary, dated 10/06/2021, from Resident A visiting her doctor, which indicated Resident A was seen to address "late onset Alzheimer's disease without behavioral disturbance.

I attempted to contact Mr. Joshua via telephone to interview him regarding the allegations; however, I was unable to reach him.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Upon my review of Resident A's *Assessment Plan for AFC Residents*, dated 05/05/2021, Resident A is unable to independently be out in the community and experiences confusion; however, on or around 09/30/2021, the licensee, Linda Quaye, transported Resident A from the facility where she resides and is familiar to Ms. Quaye's other facility, approximately 7 miles away, where Resident A was able elope from the facility without staff knowledge. My investigation indicates Ms. Quaye and the direct care staff at that particular facility, Tamandani Joshua, did not communicate who was responsible for supervising Resident A as both individuals thought Resident A was with the other person when Ms. Quaye left the facility with the remaining residents to go shopping. Subsequently, neither Ms. Quaye nor Mr. Joshua provided Resident A with the protection and supervision she required, which allowed her to wander away from the facility before being picked up by police.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

During my on-site inspection, I requested to review Mr. Joshua's staff file; however, Ms. Quaye indicated it was not kept at the facility. On 10/08/2021, Ms. Quaye sent me an email indicating she only had Mr. Joshua's training file and no additional information for him. She indicated in her email "he may have taken it as he left".

APPLICABLE RULE	
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.**
ANALYSIS:	The licensees did not have an employee/staff file for direct care staff, Tamandani Joshua, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my on-site inspection, I also requested to review the facility's staff schedule. Ms. Quaye indicated there was no staff schedule available for review due to it only being her and the other licensee, Samuel Quaye, working. Ms. Quaye stated she works during the day at the facility and Mr. Quaye works nights and then he'll work during the day at their other facility while she works at night. She indicated they both sleep at night.

Ms. Quaye was informed during the on-site inspection that even with limited staffing, a staff schedule is still required.

APPLICABLE RULE	
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.**
ANALYSIS:	The licensees were not maintaining a daily staff schedule, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/19/2021, I conducted the exit conference with the licensee designee, Linda Quaye, via telephone. Ms. Quaye acknowledged the findings and agreed to submit an acceptable plan of correction.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

11/19/2021

Cathy Cushman Date
Licensing Consultant

Approved By:

11/23/2021

Dawn N. Timm Date
Area Manager