GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 17, 2022

Donitia Strickland
RSR Serenity LLC
47640 Gratiot Avenue
Chesterfield, MI 48051

RE: License #: AL500408375
Investigation #: 2022A0604013
Sandalwood Village III

Dear Ms. Strickland:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Kristine Cilluffo

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500408375
Investigation #:	2022A0990010
Complaint Receipt Date:	02/15/2022
Investigation Initiation Date:	01/07/2022
Report Due Date:	03/17/2022
Licensee Name:	RSR Serenity LLC
Licensee Address:	47640 Gratiot Avenue Chesterfield, MI 48051
Licensee Telephone #:	(586) 949-6220
Administrator:	Donitia Strickland
Licensee Designee:	Donitia Strickland
Name of Facility:	Sandalwood Village III
Facility Address:	47640 Gratiot Avenue Chesterfield, MI 48051
Facility Telephone #:	(586) 949-6220
Original Issuance Date:	11/01/2021
License Status:	TEMPORARY
Effective Date:	11/01/2021
Expiration Date:	04/30/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility is short staffed.	Yes
Multiple residents fall with little to no documentation or follow up on injuries.	No
Medications are missing and narcotics counts are off.	Yes
Two diabetic residents are sharing an insulin pen.	No
Special diets are not being followed. No diabetic menu for residents.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/06/2022	Special Investigation Intake Intake #184379 - special investigation received for Sandalwood Village.
01/07/2022	Contact- Telephone call made Complainant interviewed by Adult Foster Care Licensing Consultant, LaShonda Reed.
01/10/2022	Comment Intake re-assigned to Adult Foster Care Licensing Consultant, Kristine Cilluffo
01/11/2022	Inspection Completed On-site Interviewed Jennifer Morgan and Ms. Washington
01/11/2022	Contact - Document Sent Email to and from Jennifer Morgan. Informed Ms. Morgan Sandalwood must have one staff per building/license.
01/11/2022	Contact - Telephone call received Received message from Jennifer Morgan
01/11/2022	Contact- Telephone call received Received message from Monika Sarin

01/12/2022	Contact - Document Received Received menu, incident reports, facility information from Jennifer Morgan by email.
01/13/2022	Contact - Telephone call made TC to Monika Sarin
01/18/2022	Contact - Document Received Received menus and narcotics counts from Jennifer Morgan by email.
01/28/2022	Contact- Telephone call received TC from Monika Sarin
01/28/2022	Contact- Document Received Received additional staff files by email from Jennifer Morgan
02/16/2022	Contact- Document Received Received email from Monika Sarin with clearance form, training records, diploma, medical and TB test to qualify Donitia Strickland as licensee designee/administrator
02/17/2022	Exit Conference Completed exit conference via Microsoft Teams with AFC Licensing Consultants LaShonda Reed and Eric Johnson, Monika Sarin, Jennifer Morgan and Donitia Strickland.
02/18/2022	Contact- Document Received Received email from Monika Sarin with letter appointing Donitia Strickland as Licensee Designee/Administrator and Ms. Strickland's resume.

ALLEGATION:

Facility is short staffed.

INVESTIGATION:

On 01/06/2022, a complaint was received regarding Sandalwood Village. It was determined during investigation that the allegations involved all three facilities on property, Sandalwood Village I, II and III. It was alleged that multiple residents fall with little to no documentation or follow up on injuries. Resident medications are missing. Narcotic book count off with no accountability. The facility is using the same insulin pens for two diabetic residents with no familial relation. There is little to no staff. One staff has been left alone to cook, clean pass medications and toilet 17 residents. Zero to little

staff therefore residents are not getting toileted and cleaned up for hours at a time. Zero staff accountability for missing and or no charting being done. There are no proper policies or procedures put into place. Resident paper charts missing. There is dishonesty on medications given to patients in charting system. The facility is overworking staff. Staff are having to work from 3:00 pm to 9:00 am the next day due to no call no shows that are never replaced with better staff and never held accountable. Incorrect charting done i.e. nowhere to properly document occurrences on your shift for other staff knowledge. No proper diet given for diabetic residents. Improper follow up on resident injuries, doctor schedule visits and so on.

A prior complaint was received on 1/4/2022 regarding fire safety concerns. On 01/05/2022, licensing consultant LaShonda Reed, conducted an unannounced onsite at Sandalwood Village. On 01/05/2022, she conducted an unannounced onsite at Sandalwood Village. Sandalwood Village consists of two large and one medium connected facilities (Sandalwood Village I, Sandalwood Village II, and Sandalwood Village III). During the unannounced investigation, Ms. Reed interviewed staff Shaundria Washington-Med Tech and David Reygaert-cook/maintenance staff. Ms. Reed was informed that there are a total of 17 residents and three direct caregivers present for all three facilities. Ms. Washington was working as a caregiver that day along with Ashley Massa. A third caregiver was observed but name was not provided. Ms. Reed observed several residents sitting at tables and in living room areas throughout the home. Ms. Reed interviewed Mr. Reygaert who was in the kitchen preparing lunch. The lunch being served for the day was frozen/breaded fish fillet, French fries, Jell-O, juice/coffee. For breakfast, Mr. Reygaert said he served waffles, sausage, fruit cocktails/peaches and coffee.

Mr. Reygaert said that he has worked at the company as a maintenance worker for seven years and has acted as the cook for two weeks. Mr. Reygaert also said that he worked as a cook for six months as well as maintenance but more as a cook recently. On 01/04/2022, Mr. Reygaert arrived at the home at 6:30AM and there was one caregiver present (name unknown). Mr. Reygaert prepared breakfast since the staff person that was present left at 7:30AM without announcing it. Mr. Reygaert said that there was no direct care staff present. Mr. Reygaert said that breakfast was not served until 10:30AM because the next staff person did not arrive to get the residents up until 8:30AM. Mr. Reygaert purchased dinner yesterday with his personal money which was pizza and breadsticks. Mr. Reygaert also said that on Friday 12/31/2021 when he arrived Jennifer Morgan the proposed licensee designee/administrator informed him that she was leaving for Las Vegs for vacation. Mr. Reygaert said that when he went into the kitchen, he found it dirty, with old food and molded food in the refrigerator. Mr. Reygaert cleaned the kitchen. Ms. Reed observed the kitchen to be clean.

Mr. Reygaert said that he is not formally trained as a cook but has had food serving training. Mr. Reygaert said he is aware of which residents require special diets. Ms. Reed observed the menus posted in the kitchen area. Mr. Reygaert said that his last day working for the company is tomorrow. Mr. Reygaert said that the company has changed, and he is the last staff that worked under the previous owners. There is a high

staff turnover, lack of staff training, and the new administration does not listen to concerns. Mr. Reygaert has requested tools and a ladder which have not been provided. Donitia Strickland who is the assistant manager at Sandalwood Valley arrived at Sandalwood Village. Ms. Strickland said that there are three sides to the facility and there are 13 residents combined, three staff that float and one cook.

On 01/07/2022, AFC Licensing Consultant, LaShonda Reed interviewed Complainant. She stated that Resident C reported that she sat in her own body fluids for over two hours and not changed on New Year's weekend.

On 01/11/2022. I completed an unannounced onsite investigation. I interviewed interim Licensee Designee, Jennifer Morgan and Staff/Nurse, Shaundria Washington.

On 01/11/2022, I interviewed Jennifer Morgan. Ms. Morgan has been appointed as the new Licensee Designee/Administrator after Shella Minor was terminated on 12/23/2021. Ms. Morgan stated that there was a huge pushback from staff due to the change in ownership and they found Ms. Minor was not completing required documents. Ms. Morgan stated that she does not believe the facility has frequent falls due to lack of staffing. She believes that incident reports have been completed for falls. Ms. Morgan stated that they typically have 3½ staff on day shift (three staff and one partial shift), two staff on afternoons and two staff on midnights. They currently have a total of 17 residents in all three buildings. Ms. Morgan stated that during the holidays there were times were they only had one staff on midnight shift for all three buildings. Ms. Morgan was advised that each building should always have at least one staff per shift. Ms. Morgan stated that residents do not have to wait to be changed due to staffing levels. Staff check on residents every hour.

APPLICABLE RULE	
R 400.15305	**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:	Residents need for protection and safety were not being met at Sandalwood Village. The facility did not have enough staff to provide adequate care and supervision for residents. Resident C reported that she sat in her own body fluids for over two hours and not changed on New Year's weekend.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	Sandalwood Village has does not have adequate staffing. Sandalwood Village I, II and II are connected and located on the same property. According to Jennifer Morgan, they typically have two staff on afternoon shift and two staff on midnight shift. During the holidays there were occasions where they had one staff on shift. The staff on schedule are covering all three buildings. Ms. Morgan has been advised that there should be at least one staff on shift for each licensed building.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Sandalwood Village has not provided adequate staffing to provide supervision, personal care and protection for residents. The facility has operated with one to two staff on afternoon and midnight shifts to care for residents in all three buildings.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Multiple residents fall with little to no documentation or follow up on injuries.

INVESTIGATION:

On 01/07/2022, AFC Licensing Consultant, LaShonda Reed interviewed Complainant. The Complainant stated that Resident F, Resident G, Resident H and Resident I had injuries from falls around the holiday and those wounds were not documented in resident chart or incident report completed. None of the residents reported to have injuries, reside at Sandalwood Village III.

On 01/12/2022, I received an email from Jennifer Morgan. Ms. Morgan provided incident reports that documented injuries for Resident F, Resident G, Resident H and Resident I.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.** **(b) Any accident or illness that requires hospitalization.**
ANALYSIS:	There is not enough information to determine that incident reports are not being completed for injuries. Jennifer Morgan provided an incident report for each resident alleged to have an injury from fall. The incident reports were not required to be sent to licensing as they did not result in hospitalization. None of the residents resided at Sandalwood Village III.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **Medications are missing and narcotics counts are off.**
- **Two diabetic residents are sharing insulin pen.**

INVESTIGATION:

On 01/11/2022, I completed an unannounced onsite investigation. I interviewed interim Licensee Designee, Jennifer Morgan and Staff/Nurse, Shaundria Washington.

On 01/11/2022, I interviewed Jennifer Morgan. Ms. Morgan stated that the facility has one medication cart for all three buildings. She determined that narcotic counts were not being done correctly. She found discrepancies when narcotic counts were reviewed in December 2021. She also found medications that were discontinued that had not been destroyed. Ms. Morgan stated that she is not aware of any missing medications. She indicated there may have been an issue where staff could not find medications. The facility uses the Quick Mar system for medications. Ms. Morgan stated that they do not have any missing resident files. Ms. Morgan stated that Resident C and Resident D are the two diabetic residents at Sandalwood Village. She stated that they both use the same brand of insulin pen, however, both have their own.

On 01/11/2022, I reviewed medications with Staff/Nurse, Shaundria Washington. I observed that Resident C and Resident D each had their own insulin pens in the medication cart. Their names were written with a marker on the pens. Ms. Washington stated that she started at Sandalwood Village about two weeks ago. When she first started, there were issues with medication counts. She encountered a med tech who did not think they had to count medications. I reviewed medications for Resident C and Resident E. Resident E had a pill pack for Quetiapine 1 pm in the medication cart that was discontinued. Resident E resides at Sandalwood Village II.

On 01/28/2022, I interviewed owner, Monika Sarin. Ms. Sarin also stated that several medications were located that had been discontinued, however, Ms. Minor did not dispose of them properly.

On 01/07/2022, AFC Licensing Consultant, LaShonda Reed interviewed Complainant. The Complainant believed that Resident C's insulin (Lantis) was given to another resident because hers was empty. This was observed on 01/03/2022. Complainant said that there is dishonesty in charting. She brought this to Ms. Morgan's attention, and she responded that there is a lack of staffing so she will not address the charting issues. Complainant said that staff person Robin (has been employed there for five years) refused to do shift charting and threw away the shift charting book that Ms. Gibson started so that staff can be aware of what occurred on the shift for concerns. She called it the "staff communication log."

On 01/13/22, AFC Licensing Consultant Eric Johnson conducted an interview with Med tech/assistant manager Shaundria Washington. Ms. Washington stated that she started working at the facility on 12/22/21. According to Ms. Washington, she is a licensed nurse, and she has also been trained on medication administration by the facility. Ms. Washington is a contracted employee through another company. According to Ms. Washington, until 01/12/22, the only staff that were trained to pass medications were Ms. Jennifer Morgan and herself. Ms. Washington stated that if she is not present, then Ms. Morgan will pass the residents medication. No other staff has passed medication to residents outside of Ms. Washington and Ms. Morgan from 12/22/21 to 01/13/22. Ms. Washington has worked every day since 12/22/21, except for one or two days. She was unable to tell me which days she missed. Ms. Washington stated that she normally starts her shift around 08:30 AM to about 7 PM or later. According to Ms. Washington,

medications can be passed within a time window. The morning meds are passed between 8 AM and 11 AM. Evening meds are passed between 4 PM and 7PM.

On 01/18/2022, Mr. Johnson conducted a phone interview with former staff Ms. Dasha Ware. According to Ms. Ware, anyone is allowed to pass meds even if they are not trained. If Ms. Ware or other staff did not feel like cooking or passing meds because it was not their job, they just wouldn't do it and the next staff who came in would have to do it.

On 01/18/22, Mr. Johnson interviewed staff Shyisha Bracey via telephone. According to Ms. Bracey, she was not trained to pass meds or cook but if there was no med tech or cook, then it was requested that she or other direct care staff would complete those tasks. If direct care staff on shift did not want to do it, then they wouldn't pass medications or cook until the next staff arrives. Therefore, medications are often given late. Ms. Bracey stated that there were a few times that she passed some residents medications due to the high number of call offs.

On 01/19/22, Mr. Johnson interviewed staff Robin Bassett. According to Ms. Bassett, she has not witnessed untrained staff passing medications, but she has heard from other staff members that it has occurred on other shifts. Ms. Bassett stated that medications are to be given to residents within a one-hour timeframe. Medications are often given to the residents late (pass the one-hour window). Ms. Washington has been the only med tech for the last month and she is often late for her shift, which causes the residents to receive their medications late.

On 01/19/22, Mr. Johnson interviewed staff Frankie Dawkins. Ms. Dawkins stated that she is unaware of untrained staff passing medications.

On 01/19/2022, Mr. Johnson interviewed interim Licensee Designee Ms. Jennifer Morgan. Ms. Morgan stated that prior to 01/12/2022, Ms. Washington was the only trained Med Tech. Ms. Morgan stated that she is also trained to administer medications.

Medication administration trainings for staff were requested from Jennifer Morgan but have not received.

APPLICABLE RULE	
R 400.15312	**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.**

ANALYSIS:	On 02/17/2022, Sandalwood Village did not provide verification of medication administration training for staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	There is not enough information to determine that Resident C and Resident D are sharing the same insulin pen. During the onsite investigation, I observed that Resident C and Resident D had their own insulin pens.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Special diets are not being followed. No diabetic menu for residents.

INVESTIGATION:

On 01/07/2022, AFC Licensing Consultant, LaShonda Reed interviewed Complainant. The Complainant stated that the cook is making the same meal for all residents. The meals are not bad but are not to be served to diabetic residents such as desserts are not sugar free and corn beef and cabbage. There are no alternate meals served.

On 01/11/2022. I completed an unannounced onsite investigation. I interviewed new Licensee Designee, Jennifer Morgan. Ms. Morgan stated that there are two diabetic residents at Sandalwood Village. Resident C resides at Sandalwood Village III and Resident D resides at Sandalwood Village I.

I received Resident C's health care appraisal during the onsite investigation. Resident C was prescribed a 2000 calorie/ADA diet. Ms. Morgan provided copy of a menu from Gordon's Food Service. Ms. Morgan stated that she believed Gordon's menu met diabetic menu requirements, however, there were no substitutions listed on menu. Ms. Morgan provided a copy of a menu on 01/12/2022 by email that had diabetic residents' initials at bottoms with handwritten note to "please use sf" (sugar free).

I completed an exit conference on 02/17/2022 via Microsoft Teams with AFC Licensing Consultants LaShonda Reed and Eric Johnson, Monika Sarin, Jennifer Morgan and Donitia Strickland. We informed Sandalwood Village of findings and recommendation

for revocation of license. They were also informed that they would have an opportunity to request a compliance conference.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	There are no menus to confirm that Resident C from Sandalwood Village III) and Resident D (from Sandalwood Village I) have been provided a diabetic diet.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(5) Records of menus, including special diets, as served shall be provided upon request by the department.
ANALYSIS:	There were no records of menus for Resident C who requires a diabetic diet.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 12/21/2021, I emailed Jennifer Morgan and Monika Sarin a letter listing documents needed to quality new Licensee Designee/Administer, as I was notified that there was an open investigation regarding Shella Minor that could possibly result in her termination. Licensee Designee/Administrator, Shella Minor, was terminated on 12/23/2021. Jennifer Morgan was identified as individual who would fill Ms. Minor's position. On 01/03/2022, a clearance, medical and TB test were provided for Ms. Morgan. No additional documents were received to quality Ms. Morgan as licensee designee/administrator. Ms. Morgan indicated on 01/11/2022 that she is a licensed Nursing Home Administrator.

On 01/28/2022, I received a phone call from Monika Sarin regarding appointing Donitia Strickland as licensee designee/administrator instead of Jennifer Morgan. On 02/16/2022, I received clearance forms, training records, diploma, medical and TB test for Ms. Strickland. On 02/18/2022, I received letter from Monika Sarin requesting to appoint Ms. Strickland as Licensee Designee/Administrator for all their facilities along with her resume documenting Ms. Strickland's experience.

APPLICABLE RULE	
R 400.15202	**Administrator; qualifications**
	(1) A home shall have an administrator who shall not have less than 1 year of experience working with persons who are mentally ill, developmentally disabled, physically handicapped, or aged.
ANALYSIS:	Sandalwood Village III did not have an approved licensee designee and administrator for almost two months, from 12/24/21 until 02/18/22. Licensee designee/administrator, Shella Minor, was terminated on 12/23/2021. Jennifer Morgan was initially identified to fill her position, however, all requested documents were not received to qualify Ms. Morgan. On 01/28/2022, Owner Monika Sarin indicated that she was considering appointing Donitia Strickland as licensee designee/administrator. All requested documents were received for Ms. Strickland on 02/18/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

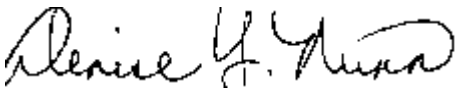
IV. RECOMMENDATION

I recommend revocation of the license.

03/10/2022

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



03/10/2022

Denise Y. Nunn — Date
Area Manager