GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 17, 2022

Detra Davie
Oakland Assisted Living & Respite Center
3345 E. Commerce Rd.
Commerce Twp., MI 48382

RE: License #: AS630283826
Investigation #: 2022A0605028
Oakland Assisted Living & Respite

Dear Ms. Davie:

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,

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS630283826 |
| | |
| **Investigation #:** | 2022A0605028 |
| | |
| **Complaint Receipt Date:** | 03/21/2022 |
| | |
| **Investigation Initiation Date:** | 03/21/2022 |
| | |
| **Report Due Date:** | 05/20/2022 |
| | |
| **Licensee Name:** | Oakland Assisted Living & Respite Center |
| | |
| **Licensee Address:** | 3345 E. Commerce Rd.<br>Commerce Twp., MI 48382 |
| | |
| **Licensee Telephone #:** | (313) 658-7300 |
| | |
| **Administrator/Licensee Designee:** | Detra Davie |
| | |
| **Name of Facility:** | Oakland Assisted Living & Respite |
| | |
| **Facility Address:** | 23161 Sussex Oak Park, MI 48237 |
| | |
| **Facility Telephone #:** | (313) 658-7300 |
| | |
| **Original Issuance Date:** | 01/05/2007 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 10/27/2021 |
| | |
| **Expiration Date:** | 10/26/2023 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A has been going around the neighborhood, unsupervised, ringing random doorbells at multiple different hours of the night. This has been ongoing issue and police have escorted him home on many occasions. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 03/21/2022 | Special Investigation Intake<br>2022A0605028 |
| 03/21/2022 | Special Investigation Initiated - Telephone<br>I contacted the reporting person (RP) regarding the allegations. |
| 03/24/2022 | Inspection Completed On-site<br>I conducted an unannounced on-site investigation. I interviewed direct care staff (DCS) Amexem Cook-Bey, home manager William Davie, licensee designee Detra Davie, Resident A, Resident B, Resident C, and Resident D regarding the allegations. I reviewed Resident A's individual plan of service (IPOS). |
| 03/24/2022 | Contact - Telephone call made<br>I contacted Office of Recipient Rights (ORR) Darlita Paulding who is also investigating these allegations. |
| 03/29/2022 | Contact - Face to Face<br>I along with ORR Darlita Paulding conducted another unannounced on-site investigation. |
| 04/07/2022 | Contact - Telephone call made<br>I left message for DCS Elaine Taylor and attempted to leave message for Resident A's case manager's supervisor Kim Dunbrecht, but her voicemail was full. |
| 04/07/2022 | Contact - Telephone call received<br>I interviewed DCS Elaine Taylor regarding the allegations. |
| 04/07/2022 | Contact - Telephone call made<br>I interviewed DCS Princess Chapman regarding the allegations. |

| | |
|---|---|
| 04/07/2022 | Contact - Telephone call received<br>I interviewed DCS Elaine Taylor regarding the allegations. |
| 05/05/2022 | Contact - Document Sent<br>Request to Oak Park Police Department (OPPD) was made on-line requesting police contact at this facility pertaining to Resident A within the last year. |
| 05/05/2022 | Contact - Telephone call made<br>Left message for ORR Darlita Paulding. |
| 05/05/2022 | Contact - Telephone call received<br>Return call from ORR Darlita Paulding. |
| 05/05/2022 | Contact - Telephone call made<br>Left message for CNS supports coordinator Devon Cage. |
| 05/05/2022 | Contact - Document Received<br>I received police reports from Oak Park Police Department. |
| 05/05/2022 | Contact - Telephone call received<br>Return call from CNS supports coordinator Devon Cage. |
| 05/09/2022 | Exit Conference<br>Telephone call with licensee designee Detra Davie with my findings. |

**ALLEGATION:**

**Resident A has been going around the neighborhood, unsupervised, ringing random doorbells at multiple different hours of the night. This has been ongoing issue and police have escorted him home on many occasions.**

**INVESTIGATION:**

On 03/21/2022, intake #185950 was assigned for investigation regarding Resident A going around the neighborhood ringing doorbells for about a month now. He has been taken by the police back to the home on many occasions. He has rung the neighbors' doorbell on at least three different occasions; 7:15pm, another time at 12:15 am and on another night 10:30pm.

On 03/21/2022, I contacted the reporting person (RP) regarding the allegations. The RP stated they spoke with the staff (name unknown) at this home regarding Resident A coming to their home at least three different times ringing their doorbell. The RP stated, "staff told me they can't do anything to keep him in the house," so Resident A continues

to ring their doorbell. The RP stated other neighbors have also complained about Resident A and neighbors continue calling the police and the police return Resident A back to the group home. The RP stated last night the police was contacted again because Resident A was sitting on several of the neighbors' porches. The RP stated there is no supervision by the group home.

On 03/24/2022, I conducted an unannounced on-site investigation. Present were direct care staff (DCS) Amexem Cook-Bey, Residents A, B, C, D, E, and F. I asked Ms. Cook-Bey how many residents were living at this group home and Ms. Cook-Bey stated, "four," but then Resident C spoke up and stated, "No, there's six residents living here." I requested all the residents' names and date of births, so Ms. Cook-Bey brought out all the residents' medications from the medication cabinet and there were medications for a total of six residents, not four.

I attempted to interview Resident A regarding the allegations but was unsuccessful as I was unable to understand what Resident A was saying. Resident A has a traumatic brain injury (TBI). I observed Resident A to have unsteady gait. He made several attempts to go into Resident C's bedroom without permission. Resident C told Resident A to leave her bedroom on several occasions. DCS Ms. Cook-Bey was having difficulty redirecting Resident A from Resident C's bedroom.

I interviewed Resident B regarding the allegations. Resident B moved in a year ago. Resident B stated there are six residents residing at this group home. Resident B stated Resident A has a "head injury," and that Resident A "doesn't listen or understand." Resident B stated, "Resident A needs to be watched better by staff." Resident B stated there is only one DCS on shift and when residents leave the home, residents must sign in and out. Resident B stated Resident A and Resident E have left the group home around 3AM some nights and "staff don't do anything to stop them from leaving." Resident B stated the police have come to the home to drop Resident A off because Resident A was observed by neighbors going to their garbage and trying to go into neighbors' homes.

I interviewed Resident C regarding the allegations. Resident C moved into this group home on 04/23/2011. Resident C stated there are six residents living at this grop home. Resident C stated she signs in and out whenever she leaves the group home. Resident C stated, "I'm tired of Resident A walking into my room and doesn't wait until I say to enter." She stated that Resident A usually leaves the group home when Resident C is sleeping. Resident C stated she has seen police bring Resident A back to the group home after he leaves the group home because neighbors have been complaining about Resident A. Resident C stated that staff let Resident A leave and don't do anything about it.

I interviewed Resident D regarding the allegations. Resident D has been living at this group home for about 11-12 years. Resident D stated she has no information regarding Resident A as she usually stays in her bedroom. Resident D stated there are six

residents residing at this group home. Resident D stated she has no concerns about staff or living here as she likes this group home.

I interviewed DCS Amexem Cook-Bey regarding the allegations. Ms. Cook-Bey began working for this corporation since last summer. She works the midnight shift. Ms. Cook-Bey stated there is only one staff member per shift. Ms. Cook-Bey stated all the residents residing at this home have community access. She stated the process for residents to leave the home is that they must sign in and sign out. Ms. Cook-Bey stated Resident A leaves the home and Ms. Cook-Bey tells him to not leave at night, but she cannot stop him from leaving because he has community access. Ms. Cook-Bey stated, "I just tell him to sign out." I reviewed the sign in/out sheet and according to the sheet, Resident A only signed out three times from 10/2021-03/22/2022. Ms. Cook-Bey stated she is the only staff on shift; therefore, she cannot watch Resident A all the time because she has other duties she must attend to; laundry and house cleaning. Ms. Cook-Bey stated she has not received any complaint about Resident A ringing neighbors' doorbells, but that there was a past complaint about Resident A knocking on neighbors' doors. Ms. Cook-Bey stated she has no other information to provide.
She stated she does not have access to Resident A's assessment plan and contacted licensee designee Detra Davie who advised Ms. Cook-Bey that Ms. Davie was on her way to the home.

The licensee designee Detra Davie and her husband who is also the home manager William Davie arrived at the home. I interviewed Mr. Davie regarding the allegations. Mr. Davie stated he works all shifts and that there is no lack of supervision at this home. He stated there are no locks in the home and all the residents have community access; therefore, they can come and go as they please if they sign in and out. Mr. Davie stated Resident A has a TBI and has difficulty communicating, but that staff do their best to keep him safe. He stated that Resident A's individual plan of service (IPOS) from CNS Healthcare stated that Resident A has community access; therefore, Resident A can leave at night. Mr. Davie stated they are working with Resident A's psychiatrist to have Resident A's medications changed which may help with Resident A waking up at night and wanting to leave. Mr. Davie stated he does not have any other information to provide.

I interviewed licensee designee Detra Davie regarding the allegations. Ms. Davie stated Resident A has a TBI and has been residing at this home for about two years. She stated the last couple of days, Resident A was going to neighbors' homes and rummaging threw their trash. She stated if this behavior continued, she was going to contact Resident A's case coordinator Devon Cage. Ms. Davie stated she was not aware that Resident A was going to neighbors' homes and ringing their doorbells or trying to enter their homes. Ms. Davie stated she has tried contacting Ms. Cage a few times this month, but Ms. Cage's mailbox is full. Ms. Davie stated that Resident A has full community access as do all the other residents. Ms. Davie stated there are two staff members per shift even though all the residents and DCS Ms. Cook-Bey reported there is only one staff member per shift. Ms. Davie stated she was running late this morning, but that she and Mr. Davie work the morning shift. Ms. Davie stated residents including

Resident A are only required to sign in and out when they want to leave the home. I advised Ms. Davie that according to the sign in and out sheet, Resident A has only signed out three times. She stated she cannot locate the sign in sheet at this time. I requested to review Resident A's IPOS. I reviewed the IPOS, and Resident A does have community access; however, according to the IPOS, Resident A must sign in and out and when Resident A does not sign in or out, then the staff must sign him out. I advised Ms. Davie that according to the sign in/out sheet, staff members are not following Resident A's IPOS by ensuring that Resident A is signed out and in when he leaves the home. Ms. Davie stated she did not have the staff schedule showing there are two staff members per shift but will send the staff schedule via email.

On 03/24/2022, I contacted via telephone Office of Recipient Rights (ORR) worker Darlita Paulding. Ms. Paulding was sent the allegations via email. She stated she will be investigating these allegations. Ms. Paulding stated she has not received any incident reports (IR) regarding Resident A for eloping and that the last IR she received regarding Resident A was in 10/2021. Ms. Paulding stated Ms. Davie called her months ago regarding concerns of Resident A smoking in the house, but Ms. Davie never reported to Ms. Paulding that Resident A was leaving the home and harassing neighbors or eloping from the home. I agreed to meet Ms. Paulding at the home to conduct an unannounced on-site investigation on 03/29/2022.

On 03/29/2022, I along with ORR Darlita Paulding conducted an unannounced on-site investigation. Ms. Paulding arrived at the home about 10 minutes early around 9:50AM. Ms. Paulding stated 10 minutes after she arrived, Ms. Davie and Mr. Davie also arrived at the home; therefore, there was only one staff member on the midnight and early morning shift. Present were Ms. Davie, Mr. Davie, Ms. Cook-Bey (who left shortly after we arrived) and Residents A, B, C, and D. Ms. Davie stated she was "running late," again and that is why there was only one staff member on shift from 8AM-10AM. She stated that when there are two staff members here, they watch Resident A, but Resident A says, "I'm a grown man," when staff attempt to prevent him from leaving. Ms. Davie stated she nor staff can restrain Resident A and all they can do is try to encourage him from leaving. Ms. Davie stated she has not written any IR's because the police never came to the door when Resident A was brought back to the group home after eloping. Ms. Davie stated the midnight staff Ms. Cook-Bey has never reported to Ms. Davie that police dropped Resident A off at the home. Ms. Davie stated she received a call from a neighbor last week stating that Resident A was in her backyard looking for empty bottles. Ms. Davie stated again she was never aware that Resident A was ringing neighbors' doorbells or trying to enter their homes. Ms. Davie stated Resident A is no longer a good fit for this home and will be requesting Ms. Cage to seek alternative placement as Resident A requires a higher level of care.

Ms. Davie provided a staff schedule that was handwritten. She stated during the day shift 8AM-8PM there are two staff members, but only one staff member during the midnight shifts 8PM-8AM. The schedule showed that Mr. and Mrs. Davie are on the schedule on Mondays-Thursdays from 8AM-8PM, but twice when I arrived at the home unannounced, neither Mr. nor Mrs. Davie were present from 8AM-10AM when there is

supposed to be two staff members on shift as both arrived at the home around 10AM both times.

On 04/07/2021, I contacted DCS Elaine Taylor via telephone regarding the allegations. Ms. Taylor has been working for this corporation since 08/2021. She works 24-hour shifts Saturdays with Princess Chapman and Sundays. Ms. Taylor stated there are only four residents residing at this home. She stated all the residents have community access and when the residents leave, they must sign in and out. Ms. Taylor stated, “Resident A likes to do what he wants. We can’t tell him what to do.” She reported that the police have brought Resident A back to the group home when he leaves and does not return. The police do not say anything, they just bring him back. Ms. Taylor stated she asks Resident A to sign in and out, but Resident A refuses and then begins to tear the sign in/out book. She stated since she has been working at this home, the police have brought Resident A back to the home twice around 12AM. The police did report to Ms. Taylor that Resident A was found in a neighbor’s yard, or a neighbor called the police saying there is a man outside their home without a coat. She does not recall when the police came to the home. Ms. Taylor stated currently Resident A has a 1:1 staff which is Ms. Taylor. She stated, “I go where Resident A goes.” Ms. Taylor stated she reported these concerns to Ms. Detra. Ms. Detra advised Ms. Taylor she will be contacting Resident A’s case coordinator.

On 04/07/2022, I interviewed DCS Princess Chapman regarding the allegations. Ms. Chapman has worked for this corporation since 04/2021. She works Fridays-Sundays 8AM-8PM. On Saturdays, she works with Elaine Taylor and on Fridays and Sundays she works with the home manager William Davie. Ms. Chapman stated there are only four residents residing at this home. She stated Resident A only left the home once during her shift since she has worked at this home. She stated, “A neighbor came to the home and asked if Resident A lived here, because Resident A was in our yard.” Ms. Chapman stated, “We try to redirect him because we can’t leave and walk with him because he does not have a personal caregiver, so I ask him to sign out and he does, and he is gone for two hours but then comes back.” Ms. Chapman stated the police have never brought Resident A back to the home during her shift since she has worked here. She stated, “Resident A doesn’t understand he cannot leave but understands everything else. The only thing I do for him is watch and feed him when he’s here. So, when he leaves the home, he does his own thing.”

On 05/05/2022, I followed up with ORR Darlita Paulding via telephone. Ms. Paulding stated Resident A has been discharged from this home and will be moving to a higher level of care placement. She stated Resident A’s case coordinator Devon Cage was out of the office all of 03/2022; therefore, Ms. Cage has not spoken to Detra Davie regarding Resident A. Ms. Paulding spoke with Ms. Cage this morning and Ms. Cage stated Resident A leaving the home, ringing doorbells, and trying to enter homes was a new behavior that she was unaware of. Ms. Cage advised Ms. Paulding that Resident A has full community access without any restrictions. Ms. Cage recommended to Ms. Davie a 1:1 staff for Resident A, but Ms. Davie advised Ms. Cage that due to insufficient staffing at this home, she cannot do the 1:1 staff for Resident A.

On 05/05/2022, I contacted Resident A's case coordinator Devon Cage with CNS Healthcare. Ms. Cage stated she was out the entire month of 03/2022; therefore, she did not speak with Ms. Davie until recently regarding Resident A. Resident A has resided at this home for about two years. Ms. Cage stated she spoke with Ms. Davie in 04/2022 as Ms. Davie was reporting that Resident A's behavior increased as Resident A was eloping; therefore, Resident A needed an appropriate placement. Ms. Davie reported to Ms. Cage that Resident A "is too much," and "requires eyes on him because he's going into the community and being disruptive." Ms. Cage asked Ms. Davie if Ms. Davie can offer enhanced 1:1 staffing for Resident A and Ms. Davie stated, "No," due to staffing concerns. Ms. Cage stated Resident A is difficult to engage and there is some communication concerns as it is difficult to understand Resident A when he speaks. Ms. Cage stated Resident A has a TBI and now medical needs that would require him to be in a higher level of care placement. Ms. Cage stated Ms. Davie issued a 30-day discharge notice; therefore, Ms. Cage has found an alternative appropriate placement for Resident A.

On 05/05/2022, I requested police reports from Oak Park Police Department for any contact with this home within the last year. I received multiple police reports regarding a "missing persons," filed with this police department. On 09/24/2021, Princess Chapman contacted the police reporting Resident A missing. On 10/04/2021, William Davie contacted the police and reported Resident A missing, and Ms. Chapman spoke with police on 10/06/2021 stating that Resident A had returned home. On 10/19/2021, Resident A had been missing for 24 hours when Mr. Davie made a report to police. On 04/02/2022, a staff member (unknown) called police and reported Resident A missing, but then called back and stated that Resident A returned.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14206** | **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:** | Based on my investigation and the staff schedule submitted by licensee designee Detra Davie, there were insufficient direct care staff on duty on 03/24/2022 and 03/29/2022 from 8AM-10AM. According to the staff schedule, there are two staff members during the day hours 8AM-8PM Mondays-Thursdays. Ms. Davie and the home manager William Davie are both scheduled to work the day shift hours; however, both were not present during my unannounced on-site investigations when I arrived at the home around 10:00AM. In addition, Resident A |

| | |
|---|---|
| | continues to elope from the home during the midnight shift when there is only one staff on shift. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| **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:** | Based on my investigation and review of Resident A's IPOS, staff were not signing Resident A in and out when Resident A refused to sign in and out. According to Resident A's IPOS dated 03/08/2021, "staff will prompt individual to sign out, however, if he does not sign out then staff will document the time that the individual left the home." I reviewed the sign-in and out sheets and Resident A had only signed out three times from 10/2021-03/2022. Staff were not documenting the times Resident A was leaving the home when Resident A refused to sign out. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

During my unannounced on-site investigation on 03/24/2022, I observed a total of six residents at this home, Residents A, B, C, D, E, and F. Resident's E and F were sleeping in their beds. I interviewed Residents B and C who both reported that there are six residents living at this home which included Resident E and Resident F. I observed Resident E's and F's medications that were kept in a locked cabinet at this home. Licensee Designee Detra Davie stated that Resident E and Resident F reside at her other semi-independent living homes nearby but that she keeps all their medications here. Ms. Davie did not have resident records for Resident E and Resident F.

On 05/05/2022, I received police records from Oak Park Police Department dated 03/03/2022 where police received a call from a resident who no longer is residing at this facility regarding an argument between that resident and his roommate Resident E. The DCS on shift told police they contacted the owner who was going to come to the home and move their rooms.

On 05/09/2022, I conducted the exit conference via telephone with licensee designee Detra Davie. I advised Ms. Davie of my findings and asked if she wanted to discuss the rules that were being substantiated. Ms. Davie stated, “No, I’m not going to argue them. I’m just going to submit a corrective action plan to address these violations.”

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14105** | **Licensed capacity.** |
| | (2) Any occupant of a home, other than the licensee or persons who are related to the licensee, live-in staff or the live-in staff's spouse and minor children, or a person related to a resident who is not in need of foster care, shall be considered a resident and be counted as a part of the licensed capacity. |
| **ANALYSIS:** | Based on my investigation and the police report, Resident E resides at this home and should be considered a resident and be counted as a part of the licensed capacity. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| **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. A resident record shall include, at a minimum, all of the following information:<br>(a) Identifying information, including, at a minimum, all of the following:<br>(i) Name.<br>(ii) Social security number, date of birth, case number, and marital status.<br>(iii) Former address.<br>(iv) Name, address, and telephone number of the next of kin or the designated representative.<br>(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.<br>(vi) Name, address, and telephone number of the preferred physician and hospital.<br>(vii) Medical insurance.<br>(viii) Funeral provisions and preferences.<br>(ix) Resident's religious preference information.<br>(b) Date of admission. |

| | |
|---|---|
| | (c) Date of discharge and the place to which the resident was discharged.<br>(d) Health care information, including all of the following:<br>(i) Health care appraisals.<br>(ii) Medication logs.<br>(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.<br>(iv) A record of physician contacts.<br>(v) Instructions for emergency care and advanced medical directives.<br>(e) Resident care agreement.<br>(f) Assessment plan.<br>(g) Weight record.<br>(h) Incident reports and accident records.<br>(i) Resident funds and valuables record and resident refund agreement.<br>(j) Resident grievances and complaints. |
| **ANALYSIS:** | Based on my investigation and review of the police report, licensee designee Detra Davie did not have for my review resident records for Resident E and Resident F who are residing at this home. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.

Frodet Dawisha 05/12/2022

Frodet Dawisha Date
Licensing Consultant

Approved By:

Denise Y. Nunn 05/17/2022

Denise Y. Nunn Date
Area Manager