GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 18, 2022

Paul Semian
Caring Hands Home Care;dba Attendant Care of MI
51145 Nicolette
Chesterfield Twp, MI 48047

RE: License #: AS630318254
Investigation #: 2022A0991020
Estates of Oakland

Dear Mr. Semian:

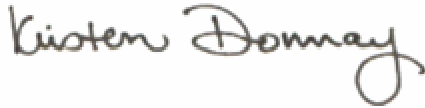
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS630318254
Investigation #:	2022A0991020
Complaint Receipt Date:	03/16/2022
Investigation Initiation Date:	03/17/2022
Report Due Date:	05/15/2022
Licensee Name:	Caring Hands Home Care;dba Attendant Care of MI
Licensee Address:	51145 Nicolette Chesterfield Twp, MI 48047
Licensee Telephone #:	(248) 608-9961
Licensee Designee:	Paul Semian
Name of Facility:	Estates of Oakland
Facility Address:	1401 E Buell Road Oakland, MI 48363
Facility Telephone #:	(586) 228-9991
Original Issuance Date:	03/28/2013
License Status:	REGULAR
Effective Date:	09/28/2021
Expiration Date:	09/27/2023
Capacity:	6
Program Type:	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff are supposed to take Resident A grocery shopping every week, but they do not take him because the facility is short staffed.	Yes
Staff made derogatory remarks about Resident A by stating, “The Mexican don’t eat dinner.” Staff yell and swear at Resident A.	No
Staff do not follow the posted menu. Staff only cook dinner and do not prepare breakfast or lunch. There is not enough food in the home, because they do not have staff to get groceries.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/16/2022	Special Investigation Intake 2022A0991020
03/17/2022	Special Investigation Initiated – Telephone Call to Resident A
03/17/2022	APS Referral Adult Protective Services (APS) referral made to Centralized Intake
03/22/2022	Inspection Completed On-site Interviewed staff and residents
03/30/2022	Contact - Document Received Received additional allegations
04/13/2022	Contact - Telephone call made To Resident A
04/21/2022	Contact - Document Sent Requested resident care agreement and assessment plan
04/27/2022	Contact - Document Received Received requested documents
05/11/2022	Contact - Telephone call made

	Interviewed staff, Catherine Mayer, via telephone
05/11/2022	Contact - Telephone call made Interviewed staff, Katherine Horton, via telephone
05/11/2022	Contact - Telephone call made Interviewed staff, Kathryn Gliniecki, via telephone
05/11/2022	Contact - Telephone call made Interviewed staff, Harold Cloud, via telephone
05/13/2022	Exit Conference Via telephone with licensee designee, Paul Semian

ALLEGATION:

Staff are supposed to take Resident A grocery shopping every week, but they do not take him because the facility is short staffed.

INVESTIGATION:

On 03/17/22, I received a complaint which alleged that staff are supposed to take Resident A grocery shopping every week, but they have not been taking him due to being short staffed. I made a referral to Adult Protective Services (APS) on 03/17/22, but it was denied for investigation.

On 03/17/22, I interviewed Resident A via telephone. Resident A stated that there are five residents in the home and there is usually only one staff person on shift. They are supposed to take Resident A shopping once a week, but they have not been able to do this because there are not enough staff in the home. Resident A stated that they can never go anywhere due to being short staffed. On 03/22/22, I conducted an unannounced onsite inspection and interviewed Resident A again. Resident A reiterated that the facility is short staffed, and they cannot provide transportation. He stated that they have one person who is the runner for three different homes, which is 18 people. Resident A stated that he did not know if he would get to go grocery shopping this week.

On 03/22/22, I interviewed Resident B. Resident B stated that staff will take the residents shopping, but it has to be set up in advance. They will ask the program manager, Stephen, if they can go shopping next week and usually someone will take them.

On 03/22/22, I interviewed Resident D. Resident D stated that the home is so far understaffed that they do not have anyone to provide transportation. They used to have a runner who would transport them, but they no longer have anyone in this position, so they do not have transportation. Resident D stated that he has needed deodorant,

underwear, and socks for three months, but he has not been able to go to the store. He told the program manager and staff, but they have not taken him, so he is just waiting it out. Resident D stated that he used to work at Kroger, but now they do not have enough staff to drive him. He never leaves the house now.

On 03/22/22, I interviewed direct care worker, Bashar Mutammara. Mr. Mutammara indicated that staff take Resident A shopping every week, usually on Saturday. Resident A likes to buy his own frozen meals. Staff always transport him. Mr. Mutammara indicated that the program manager, Stephen Slaght, has documentation regarding when Resident A goes shopping.

On 03/22/22, I interviewed the program manager, Stephen Slaght. Mr. Slaght stated that they are experiencing a staffing shortage. Staff quit and walk off the job. They try to transport the residents at least once a week to get what they need. Harold Cloud is the transporter who typically takes the residents out. The schedule varies each week depending on staffing. Mr. Slaght indicated that they are in the process of rebuilding the program and are getting residents involved in work programs. Resident D had an appointment with an external work program yesterday. The program is responsible for setting up transportation. Resident D also has access to the community through a recreational therapy program that provides transportation. Mr. Slaght stated that Resident A is transported to go shopping once a week. They do not document the dates that Resident A is transported to go shopping. He gets paid on Wednesdays, so they try to take him before the weekend.

On 05/11/22, I interviewed direct care worker, Harold Cloud. Mr. Cloud indicated that he did transport Resident A to go shopping. Resident A was supposed to go shopping once a week. He usually went on Wednesdays when he got paid. Mr. Cloud stated that Resident A was only transported when there was enough staff on shift. There were some weeks when Resident A could not be transported due to the facility being short staffed.

I reviewed a copy of Resident A's resident care agreement dated 08/21/22. It indicated that the basic fees include the following transportation: weekly transport to grocery.

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 the information gathered through my investigation, there is sufficient information to conclude that the facility did not have sufficient staff to provide the services specified in Resident A's resident care agreement. Resident A's care agreement

	noted that the facility would provide weekly transport for groceries; however, according to Resident A and the transporter, Harold Cloud, there were times when the facility did not have enough staff to transport him. The program manager did not have documentation showing the dates that Resident A was transported.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff made derogatory remarks about Resident A by stating, "The Mexican don't eat dinner." Staff yell and swear at Resident A.

INVESTIGATION:

On 03/17/22, I received a complaint alleging that a staff person, Cathy, made derogatory remarks about Resident A by stating, "The Mexican don't eat dinner." Resident A is the only individual who is Mexican in the home, and felt he was being discriminated against. On 03/30/22, I received additional allegations that a staff person, Harold, yelled and swore at Resident A on 03/22/22 after not giving Resident A his medications when Resident A requested them, because the staff person was busy.

On 03/17/22, I interviewed Resident A via telephone. Resident A indicated that he moved into the home about three weeks ago. Resident A stated that last week a staff person named Cathy was preparing dinner for the residents. She told the other residents what she was making for dinner and what they could eat. Cathy then stated, "The Mexican doesn't eat." Resident A stated that he is the only Mexican in the house, so he felt that this comment was directed towards him. Resident A stated that Cathy does not work in the home regularly, but she was filling in from another home. Resident A stated that other staff yell and scream at him. He indicated that staff get upset if he asks for his medications at a certain time. One staff person told him that he would get his medications last, because he asked for them. Resident A could not recall which staff person made this statement.

On 03/22/22, I conducted an unannounced onsite inspection at the Estates of Oakland. I interviewed direct care worker, Bashar Mutammara. Mr. Mutammara stated that he has worked in the home for over six years. Mr. Mutammara stated that he never made any derogatory remarks towards Resident A and has never been verbally aggressive towards Resident A. Resident A is very particular about when he gets his medications and will argue with staff about this. If staff try to pass his 8:00am medications at 7:57am, Resident A will yell that it is too early, but other times he will ask staff to pass his medications an hour early. Mr. Mutammara stated that there is usually only one staff person on shift, so he has never observed any other staff person being verbally aggressive or demeaning towards Resident A.

On 03/22/22, I interviewed the program manager, Stephen Slaght. Mr. Slaght indicated that he was not aware of staff making any racial comments or derogatory remarks about Resident A. He stated that there was an incident on Sunday, 03/20/22, with Resident A and staff, Cathy Mayer. Ms. Mayer was preparing dinner around 4:45pm and Resident A was demanding his medications 15 minutes early. Ms. Mayer told Resident A that she was busy and that she would pass his medications at 5:00pm. Mr. Slaght indicated that Resident A can be racist and demeaning towards women. He got in Ms. Mayer's face and was threatening to hit her. Ms. Mayer called 911 and the sheriff came out to the home. Resident A reported that Mr. Mayer called him a "dick." Mr. Slaght indicated that he did not witness the incident, so he does not know what words were exchanged. Mr. Slaght indicated that there are three staff named Cathy who work or cover shifts at the home.

On 03/22/22, I interviewed Resident A. Resident A stated that there was an incident with staff, Cathy Mayer, over the weekend. Resident A was watching basketball and wanted to take his medications at halftime. When he asked Ms. Mayer for his medications, she told him that he needed to wait until 5:00pm. Resident A stated that Ms. Mayer was not busy at the time, and he is allowed to take his medication any time between 4:15-5:45pm. They began arguing and Ms. Mayer called Resident A "a dick." Resident A "got up into her face" and said, "Tell me that again." Ms. Mayer called the police. The police made Ms. Mayer pass medications while they were there and then everything was fine. Ms. Mayer usually works at another home and has not been at the home since this incident.

On 03/22/22, I interviewed Resident B. Resident B stated that he never heard staff make any comments about Resident A being Mexican. He indicated that there was an incident between Resident A and staff, Cathy Mayer, over the weekend. Resident A was demanding something from Ms. Mayer and then said that she called him a "dick." Resident A started threatening Ms. Mayer and Resident B. Ms. Mayer called the police and they came out and talked to Resident A. Resident B stated that Resident A is aggressive and hit another resident earlier that week.

On 03/22/22, I interviewed Resident C. Resident C stated that the police came to the home that weekend because Resident A threatened to punch staff in the face when she told him no. Resident C stated that staff do not threaten Resident A or call him names. The staff care about what they do in the home and treat the residents well. Everyone got along well until Resident A moved into the home. Now the tension in the home is astronomical and Resident C feels uncomfortable.

On 03/22/22, I interviewed Resident D. Resident D stated that Resident A is a loose cannon who freaks out on everyone. He punched another resident. Resident D stated that he never heard staff make mean comments or derogatory remarks towards Resident A or the other residents. On one occasion, staff was trying to get Resident A to calm down. The more she tried to calm him down, the worse he got. The staff said, "Fine, you will be the last to get your medications." Resident D reported that Resident A

threatened to “beat her ass.” Staff did not say anything or respond. She called the police, and they came out to the home.

On 04/13/22, I interviewed Resident A via telephone regarding the additional allegations of staff, Harold, yelling and swearing at him. Resident A stated that about two weeks ago, he went to get his medications. Harold was helping someone else and told him to hold on because he was busy. About 45 minutes later, Harold told him to come take his medications. Resident A told him no and that he would take them when he was ready. Resident A reported that Harold told him, “It’s not fucking right,” and that he should “act fucking right.” Resident A stated that staff should not use cuss language because they are getting paid to watch the residents. Harold was not being respectful. Resident A wanted to take his medications during a commercial break, but Harold was helping someone else and would not give Resident A his medications when he first asked for them.

On 05/11/22, I interviewed direct care worker, Catherine Mayer, via telephone. Ms. Mayer indicated that she does not typically work at the Oakland home, but she has filled in shifts at that location. Resident A has a history of telling lies and causing problems. She stated that she had to call the police on Resident A on one occasion. He came out demanding his medications at 4:00pm. Ms. Mayer told him that he had to wait until 5:00pm and Resident A got in her face and started yelling and spitting. Another resident came out of his room. Ms. Mayer stated that she could not have another resident trying to come to her defense, so she called the police. She stated that she did not swear or call Resident A “a dick” during this altercation. She probably raised her voice as she was trying to redirect him and was telling him to get out of her face. Ms. Mayer stated that she never made a comment such as, “The Mexican doesn’t eat.” She indicated that she does not even know Resident A’s nationality. Ms. Mayer noted that Resident A has moved to another home and is no longer residing at the Oakland home.

On 05/11/22, I interviewed direct care worker, Katherine Horton, via telephone. Ms. Horton stated that she occasionally covers shifts at the Oakland home. She stated that she never got into a verbal altercation with Resident A, as she does not feed into it when Resident A is escalated. She stated that she never made a comment such as, “The Mexican doesn’t eat.” She never yelled, swore, or cussed out Resident A or any of the residents in the home. Ms. Horton stated that they typically only have one staff on shift, so she never witnessed any other staff being verbally aggressive towards Resident A. She stated that Cathy Mayer can be outspoken and called the police on Resident A at least once. Ms. Horton stated that Kathy Gliniecki is very nice, maybe too nice. On one occasion, Resident A “called her out her name” and Ms. Gliniecki’s feelings were hurt.

On 05/11/22, I interviewed direct care worker, Kathryn Gliniecki. Ms. Gliniecki stated that she typically works the midnight shift two or three days a week. Ms. Gliniecki stated that she was never verbally aggressive towards Resident A. She never swore at him or made any derogatory remarks. She denied making any comments such as, “The Mexican doesn’t eat.” Ms. Gliniecki stated that on one occasion Resident A called her “a

white trash bitch." She did not swear or yell at him in return. Ms. Gliniecki stated that she never witnessed any staff being verbally aggressive towards Resident A, but they typically only have one staff on shift.

On 05/11/22, I interviewed direct care worker, Harold Cloud, via telephone. Mr. Cloud indicated that he does not typically work at the Oakland home, but he covers shifts there when they need him. Mr. Cloud stated that on one occasion Resident A was demanding his medications. Mr. Cloud was passing medications to someone else and Resident A got upset. When Mr. Cloud asked Resident A to come get his medications, Resident A did not come. Mr. Cloud stated that he did not cuss at Resident A and was not verbally aggressive towards him. He told Resident A, "If you don't want your medications, I am not going to argue with you." Mr. Cloud stated that he does not get angry with the residents. He tries to joke and laugh with them. He did not have any concerns about the other staff in the home.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (f) Subject a resident to any of the following: (ii) Verbal abuse. (iii) Derogatory remarks about the resident or members of his or her family.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that staff were verbally abusive or made derogatory remarks about Resident A. None of the staff or other residents who were interviewed witnessed staff yelling, swearing, or making negative remarks towards Resident A. The staff who were interviewed denied making any comments such as, "The Mexican doesn't eat."
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff do not follow the posted menu. Staff only cook dinner and do not prepare breakfast or lunch. There is not enough food in the home, because they do not have staff to get groceries.

INVESTIGATION:

On 03/17/22, I interviewed Resident A, via telephone. Resident A stated that the home has a menu that shows breakfast, lunch, and dinner, but staff only cook dinner. They never cook breakfast or lunch. Staff do not follow the menu. There is food in the refrigerator, but sometimes it is low. Resident A stated that there is cereal in the home, but it has other residents' names on it. Staff cook dinner every night, but they do not follow the menu that is posted. Staff state that the menu is just for licensing.

On 03/22/22, I conducted an unannounced onsite inspection and interviewed direct care worker, Bashar Mutammara. Mr. Mutammara stated that he typically works from 7:00am-3:00pm and 3:00pm-11:00pm. Mr. Mutammara stated that he cooks three meals a day for the residents. For breakfast, they can eat waffles, French toast, pancakes, eggs, or cereal. The residents usually decide what they want. They can ask Mr. Mutammara to make breakfast, or they can get it themselves. He stated that they usually have sandwiches for lunch, and today it would be tuna sandwiches or meat sandwiches. Most of the time, he follows the menu for dinner. The company provides a menu, and he completes a shopping list every Tuesday. He sends the shopping list to the program manager, Stephen Slaght. Mr. Slaght does the shopping or has it delivered. There is always food in the home. Mr. Mutammara stated that he is not sure what happens when other staff are working in the home, but he always cooks. He stated that sometimes other staff will serve leftovers from what he prepared.

On 03/22/22, I interviewed the program manager, Stephen Slaght. Mr. Slaght indicated that staff are supposed to prepare breakfast, lunch, and dinner. Some of the residents in the home have the ability to prepare their own breakfast and lunch with supervision. Resident A is capable of making his own meals. This should be included in his care plan upon admission to the home. Mr. Slaght stated that Mr. Mutammara provides a shopping list and shopping is completed weekly. Staff should be following the menu.

On 03/22/22, I interviewed Resident B. Resident B stated that one staff person, Bashar Mutammara, cooks three meals a day. He will serve cereal or waffles for breakfast and tuna or lunch meat sandwiches for lunch. Most of the other staff do not prepare breakfast or lunch. The residents must handle it on their own, but staff cook dinner. Resident B stated that he typically eats cereal and sandwiches with lunch meat. He did not know if the other residents ate when staff did not prepare their meals. He stated that Resident D does not cook for himself at all and orders pizza every day. Resident B stated that the home has menus, but staff do not follow the menu. They have never followed the menu in all the years he has lived there. Resident B stated that Mr. Mutammara is the best staff in the home, and he typically follows the menu. Mr. Mutammara puts a grocery list together for the manager to do the shopping. For the most part, there is always food in the home.

On 03/22/22, I interviewed Resident C. Resident C stated that they, "don't do breakfast, lunch, and dinner" in the home. There is usually food available, but she chooses not to

eat breakfast. The residents just eat what is in the house or they get takeout or pizza. There is usually lunch meat, bread, cheese, and eggs. She stated, “If you want it, you make it.” Resident C stated that staff do cook dinner every day. Bashar Mutammara is the best cook, and he follows the menu. Otherwise, they do not “do menus” in the home. It is a laid-back house.

On 03/22/22, I interviewed Resident D. Resident D stated that lately there is no food in the house for anything. He stated that they have to scrape up stuff if they want to make a meal. They can usually make something skimpy, like a sandwich. Resident D stated that they have a menu, but staff do not follow it. Resident D stated that staff do not cook breakfast. He chooses not to eat breakfast, but he could eat cereal if he wanted to. Resident D stated that if staff do not cook, he typically orders Jet’s Pizza. Resident D stated that some staff cook more than others. Bashar Mutammara always cooks. Staff cook dinner when they can, but they do not always have the groceries they need. Resident D stated that he buys pizza when this happens.

On 05/11/22, I interviewed staff Catherine Mayer, Katherine Horton, Kathryn Gliniecki, and Harold Cloud via telephone. All of the staff who were interviewed indicated that there is always food available in the home. Ms. Mayer stated that the purpose of the program is to encourage the residents to be more independent, so they are supposed to do for themselves as much as they can, which includes making breakfast and lunch. There are options available for them if they want to eat. Ms. Horton stated that she will ask the residents what they want for breakfast, because there is no sense in preparing a large breakfast if nobody is going to eat it. Ms. Gliniecki stated that none of the residents like to eat breakfast, but she would prepare something if they asked. All of the staff indicated that they prepare dinner for the residents. They try to follow the menu, but sometimes make substitutions if items are not available. They do not typically write substitutions on the menu.

During the onsite inspection, I observed that there was adequate food in the refrigerator, freezer, and cupboards. There were menus and a shopping list posted in the home. There were no substitutions written on the menus.

I reviewed a copy of Resident A’s assessment plan dated 08/12/21. The assessment plan does not indicate that Resident A is responsible for preparing his own breakfast or lunch.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff are not preparing 3 regular, nutritious meals daily. I observed that there was adequate food in the home; however, the staff and residents reported that staff do not always prepare breakfast or lunch. The residents can make food if they want it, but sometimes choose to skip these meals or order pizza. Resident A's assessment plan did not indicate that he was responsible for preparing meals.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	During the onsite inspection, I observed that a menu was written in advance and posted; however, the residents and staff who were interviewed indicated that staff do not always follow the menu, especially for breakfast and lunch, and they do not write in substitutions.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the investigation, I received and reviewed a copy of Resident A's resident care agreement that was completed on 08/21/21. The resident care agreement was not updated when Resident A transferred to Estates of Oakland in February 2022. The resident care agreement form was not fully completed. Several of the check boxes were not marked, and the care agreement did not include the description of services provided and the fee for service.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the

	resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: (a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal. (b) A description of services to be provided and the fee for the service. (c) A description of additional costs in addition to the basic fee that is charged. (d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost. (e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission. (f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule. (g) An agreement by the resident to follow the house rules that are provided to him or her. (h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident. (i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures. (j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.14315. (k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met. (l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A’s resident care agreement was not updated when he changed placements and moved to Estates of Oakland in February 2022. The resident care agreement form was not fully completed and did not include the description or fee for services provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the investigation, I received and reviewed a copy of an incident report regarding the altercation that took place between Resident A and staff, Catherine Mayer, on 03/20/22. The report notes that Resident A was being verbally aggressive, calling staff filthy names, and was threatening to punch staff in the face. Ms. Mayer called 911 and the sheriff's department responded to the call. The incident report was not completed on a licensing form. The program manager, Stephen Slaght, indicated that it was not sent to the adult foster care licensing division.

On 05/13/22, I conducted an exit conference via telephone with the licensee designee, Paul Semian. Mr. Semian indicated that the facility is in the process of changing ownership and is operating under a management agreement. He felt that some things were falling through the cracks during this process. Mr. Semian stated that he would share the findings with the new owners and would submit a corrective action plan to address the issues identified during the investigation.

APPLICABLE RULE	
R 400.14311	**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: (c) Incidents that involve any of the following: (i) Displays of serious hostility. (iii) Attempts at self-inflicted harm or harm to others.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that an incident report was not completed on a licensing form and sent to the licensing division within 48 hours of Resident A showing serious hostility and threatening staff on 03/20/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/13/2022

Kristen Donnay Date
Licensing Consultant

Approved By:

05/18/2022

Denise Y. Nunn Date
Area Manager