GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 6, 2022

Kenneth Jordan
Samaritan Homes, Inc.
22610 Rosewood
Oak Park, MI 48237

RE: License #: AS820068075
Investigation #: 2022A0101020
Vreeland Home

Dear Mr. Jordan:

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 (313) 456-0380.

Sincerely,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820068075
Investigation #:	2022A0101020
Complaint Receipt Date:	04/14/2022
Investigation Initiation Date:	04/15/2022
Report Due Date:	06/13/2022
Licensee Name:	Samaritan Homes, Inc.
Licensee Address:	22610 Rosewood Oak Park, MI 48237
Licensee Telephone #:	(248) 399-8115
Administrator:	Kenneth Jordan
Licensee Designee:	Kenneth Jordan
Name of Facility:	Vreeland Home
Facility Address:	17090 Ray Riverview, MI 48194
Facility Telephone #:	(734) 282-0230
Original Issuance Date:	10/01/1995
License **Status:**	REGULAR
Effective Date:	05/15/2022
Expiration Date:	05/14/2024
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
There is physical abuse, two male residents. One male resident had bruises on him.	No
• Resident A lost a substantial amount of weight for some unknown reason and staff did not obtain medical care for at least two months. • Resident A's weight loss was due to not being fed enough food.	Yes No
Resident B's breathing machine is missing, along with some clothes and medications.	No
Additional Findings	Yes

III. METHODOLOGY

04/14/2022	Special Investigation Intake 2022A0101020
04/15/2022	Special Investigation Initiated - Telephone Kenneth Jordan, Licensee Designee
04/19/2022	Contact - Telephone call made Home manger Brianne Jones
04/19/2022	APS & ORR referral made
04/25/2022	Contact - Document received
05/08/2022	Contact - Telephone call made Ms. Jones
06/08/2022	Contact - Telephone call made Resident A's guardian
06/08/2022	Contact - Telephone call made Resident B's guardian
06/09/2022	Inspection Completed On-site
06/17/2022	Contact - Document received

06/17/2022	Virtual inspection of food supply
06/23/2022	Exit Conference with Licensee Designee Mr. Jordan

ALLEGATION: There is physical abuse, two male residents. One male resident had bruises on him.

INVESTIGATION: On 04/15/2022, I spoke with the licensee designee, Kenneth Jordan. Mr. Jordan stated he was onsite because he received the complaint allegations and went directly to the home. Mr. Jordan stated there had been some problems with the staff, "Things were not being done." He had to dismiss all of the staff and hired all new staff. Mr. Jordan stated no one in the home has bruises on them.

On 04/19/2022, I spoke with the new home manager Brianne Jones. Ms. Jones stated the new staff took over on 03/28/2022. Ms. Jones stated prior to that date no documentation was being done. Ms. Jones stated no one in the home has bruises on them.

On 06/08/2022, I spoke with Resident A's and Resident B's guardian. Resident A and Resident B are the two male residents residing in the home. Resident A's and Resident B's guardians are relatives who are very involved with their care. They both stated there were problems with the previous staff. They stated the new staff are wonderful. Resident A's and Resident B's guardian both stated they have never observed bruises on any of the residents.

On 06/09/2022, I conducted an onsite investigation. I interviewed Residents C, D and E. Residents C, D, and E stated they are treated well, and they feel safe in their home.

APPLICABLE RULE	
R 400.14305	**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:	There is no evidence to determine one male resident had bruises. Resident A's and Resident B's guardians stated they have never seen bruises on any of the residents. Mr. Jordan and Ms. Jones also stated they did not observe bruises on any of the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Resident A lost a substantial amount of weight for some unknown reason and staff did not obtain medical care for at least two months.**
- **Resident A's weight loss was due to not being fed enough food.**

INVESTIGATION: On 06/08/2022, I spoke with Resident A's guardian. He stated Resident A has lost weight. Resident A's guardian stated he noticed Resident A did not eat the foods prepared by the former staff. Resident A's guardian stated since the new staff started Resident A is eating a lot more.

On 06/17/2022, I received two pictures of Resident A. One was before his weight loss and the other was after his weight loss. The pictures showed a sudden adverse change in his physical condition. There was a substantial reduction in muscle mass.

According to Resident A's weight chart, in January 2022 he weighed 143 pounds and in March 2022 he weighed 116 pounds. For at least 2 months there had been a sudden adverse change in Resident A's physical condition. On 03/28/2022, the new staff took over they noticed Resident A loss 27 pounds. A doctor's appointment was immediately scheduled.

On 04/13/2022, Resident A had an appointment with his primary care physician. The doctor prescribed Ensure three times a day with each meal. On 04/18/2022, Resident A was diagnosed with Dysphagia, difficulty in swallowing. Resident A was prescribed Thick–It Food and Beverage, "a nutrition solution for people with Dysphagia."

On 04/15/2022 I spoke with the licensee designee Mr. Jordan and on 04/19/2022 I spoke with the home manager Ms. Jones. They both stated prior to the new staff taking over the former staff were not doing their job. Resident A's rapid and drastic weight lost should have not been ignored.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home

	shall obtain needed care immediately.
ANALYSIS:	According to Resident A's weight chart, in January 2022 he weighed 143 pounds and in March 2022 he weighed 116 pounds. For at least 2 months there had been a sudden adverse change in Resident A's physical condition. Resident A loss 27 pounds for some unknown reason and the home did not obtain care immediately. Resident A's rapid and drastic weight lost should have not been ignored.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Resident A's weight loss was not due to a lack of food. On 04/18/2022, Resident A was diagnosed with Dysphagia, difficulty in swallowing. On 06/17/2022, I conducted a virtual inspection of the food supply. There was an abundant amount of food in the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident B's breathing machine is missing, along with some clothes and medications.

INVESTIGATION: On 04/15/2022, I spoke with the licensee designee, Mr. Jordan. Mr. Jordan stated he was willing to replace any missing items.

On 04/19/2022, I spoke with the home manager Ms. Jones. Ms. Jones stated Resident B does not have a breathing machine. Ms. Jones stated Resident B's airway clearance vest was missing, it helps remove mucus. Ms. Jones stated the home was in the process of getting a new vest, a doctor's appointment had been scheduled. On 04/25/2022, Ms. Jones sent me a text and photos of Resident B's missing items. They were found in a trunk inside of the home. Ms. Jones stated there were no missing medications.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(2) The care of any resident funds and valuables that have been accepted by a licensee for safekeeping shall be treated by the licensee as a trust obligation.
ANALYSIS:	On 04/15/2022, Mr. Jordan expressed a willingness to replace all of Resident B's missing items. On 04/25/2022, Resident B's missing items were found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 06/08/2022, I reviewed Resident A's weight record. From February 2021 thru June 2021 no weight was recorded. No weight was recorded in February 2022 and was not recorded until 03/28/2022 when the new staff took over.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.

ANALYSIS:	The licensee failed to record weight monthly. From February 2021 thru June 2021 no weight was recorded. No weight was recorded in February 2022 and was not recorded until 03/28/2022 when the new staff took over.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 06/17/2022, I requested the residents' medication logs from January 2022 until June 2022. According to Ms. Jones, there are no medication logs prior to 03/28/2022.

APPLICABLE RULE	
R 400.14312	**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.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.** **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.** **(d) Initiate a review process to evaluate a resident's condition if a resident requires the repeated and prolonged use of a medication that is prescribed on an as needed basis.** **The review process shall include the resident's prescribing physician, the resident or his or her designated representative, and the responsible agency.** **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the**

	resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication. **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuse prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	The licensee failed to complete an individual medication log that contains all of the following information: (i) The medication. (ii) The dosage. (iii) Label instructions for use. (iv) Time to be administered. (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. (vi) A resident's refusal to accept prescribed medication or procedure. On 06/17/2022, I requested the residents' medication logs from January 2022 until June 2022. According to Ms. Jones, there are no medication logs prior to 03/28/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: Based upon the findings of this investigation the administrator failed to oversee the daily operation and management of this adult foster care small group home. Weights were not being recorded monthly. Medication logs were missing or had not been completed. Resident A's medical need was not being addressed. He had lost a substantial amount of weight. Resident B's airway clearance vest was missing.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(2) A licensee shall have the financial and administrative capability to operate a home to provide the level of care and program stipulated in the application.

ANALYSIS:	Based upon the findings of this investigation the administrator failed to oversee the daily operation and management of this adult foster care small group home. Weights were not being recorded monthly. Medication logs were missing or had not been completed. Resident A's medical need was not being addressed. He had lost a substantial amount of weight. Resident B's airway clearance vest was missing.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon submission of an acceptable corrective action plan I recommend the status of the license remains unchanged.

06/29/2022
Edith Richardson Date
Licensing Consultant

Approved By:

07/06/2022
Ardra Hunter Date
Area Manager