GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 7, 2022

Hemant Shah
Cranberry Park Of Milford
801 Whitlow Drive
Milford, MI 48381

RE: License #: AH630392068
Investigation #: 2022A1021054
Cranberry Park Of Milford

Dear Mr. Shah:

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 authorized representative and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action. Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630392068
Investigation #:	2022A1021054
Complaint Receipt Date:	08/19/2022
Investigation Initiation Date:	08/19/2022
Report Due Date:	10/18/2022
Licensee Name:	CRANBERRY PARK MILFORD LLC
Licensee Address:	26900 FRANKLIN RD Southfield, MI 48033
Licensee Telephone #:	(248) 210-5981
Administrator:	Gary Kosten
Authorized Representative:	Hemant Shah
Name of Facility:	Cranberry Park Of Milford
Facility Address:	801 Whitlow Drive Milford, MI 48381
Facility Telephone #:	(248) 329-0750
Original Issuance Date:	11/29/2018
License Status:	REGULAR
Effective Date:	05/29/2022
Expiration Date:	05/28/2023
Capacity:	61
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A treated inappropriately.	Yes
Facility smells like urine and call buttons do not work.	No
Additional Findings	No

III. METHODOLOGY

08/19/2022	Special Investigation Intake 2022A1021054
08/19/2022	Special Investigation Initiated - Letter referral sent to APS
08/22/2022	Inspection Completed On-site
08/23/2022	Contact-telephone call made Interviewed SP3
08/23/2022	Contact-Telephone call made Interviewed SP2
09/01/2022	Inspection completed on site
09/02/2022	Contact-Telephone call made Interviewed SP4
09/07/2022	Exit Conference Exit conference with Hemant Shah

ALLEGATION:

Resident A treated inappropriately.

INVESTIGATION:

On 8/19/22, the licensing department received an anonymous complaint with allegations the administrator told caregivers to use racial slurs with a resident. Due

to the anonymous nature of the complaint, I was unable to obtain additional information.

On 8/19/22, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 8/22/22, I interviewed facility nurse Debra Huff at the facility. Ms. Huff reported Resident A calls staff person 1 (SP1) and SP2 “niggers.” Ms. Huff reported there have been concerns with the care SP1 and SP2 provides to Resident A. Ms. Huff reported it has been reported that the caregiver has flipped off Resident A and left him on the toilet. Ms. Huff reported SP1 has given her 10-day notice and SP2 will be moved to third shift. Ms. Huff reported it has not been reported to her that management told the caregivers to call Resident A racial names.

On 8/22/22, I interviewed SP1 at the facility. SP1 reported Resident A uses racial slurs with her and has thrown things at her. SP1 reported she was told by the SP5, to call Resident A a “white honkey.” SP1 reported she always treats Resident A with respect.

On 8/22/22, I interviewed Resident A at the facility. Resident A reported caregivers are disrespectful to him because he is white. Resident A reported caregivers will not assist him with care.

On 8/22/22, I interviewed administrator Gary Kosten at the facility. Mr. Kosten reported there have been concerns about the care SP1 and SP2 provides. Mr. Kosten reported he was told by SP1 and SP2 that they were told by SP5 to call Resident A a white honky. Mr. Kosten reported he would be speaking with SP5 on appropriate behavior.

On 8/23/22, I interviewed SP3 by telephone. SP3 reported she has witnessed Resident A not receiving the care he needs by caregivers not responding to call light and not going into Resident A’s room. SP3 reported he has heard Resident A call caregivers’ names but has never heard management tell caregivers to call him names. SP3 reported she has observed SP1 and SP2 swearing and laughing at Resident A when providing care to him.

On 8/23/22, I interviewed SP2 by telephone. SP2 reported Resident A has used racial slurs towards her and has thrown urine at her. SP2 reported SP5 told her to call Resident A “white honky.” SP2 reported she always treats Resident A respectfully.

On 9/1/22, I interviewed Mr. Kosten at the facility. Mr. Kosten reported he spoke with SP5 regarding the allegations. Mr. Kosten reported SP5 denied the allegations and reported she said she has been called a white honky but did not tell caregivers to call Resident A that. Mr. Kosten reported since this licensing consult initial on site

investigation on 8/22/22, SP1 has resigned and is no longer employed at the facility. Mr. Kosten reported SP2 was influenced by SP1 and her behavior has improved.

On 9/1/22, I interviewed SP5 at the facility. SP5 reported she did not tell caregivers to call Resident A a white honky. SP5 reported that she told them she has been called that but that they still need to provide care to Resident A.

On 9/2/22, I interviewed SP4 by telephone. SP4 reported SP1 and SP2 will leave Resident A in the bathroom and will not respond to his call lights. SP4 reported SP1 and SP2 will provoke him, such as touching him on the back, and this will upset Resident A. SP4 reported SP1 did flip off Resident A. SP4 reported he has never heard Resident A call caregivers names. SP4 reported he reported the behaviors of SP1 and SP2 to Ms. Huff. SP4 reported for one week, African-American caregivers were not allowed to provide care to Resident A but then the sit-stand device was obtained and African-American caregivers were then able to provide care to Resident A.

I reviewed SP1 and SP2 employee record. The record revealed SP1 and SP2 were trained in resident rights and abuse. There was no discipline record for SP1 and SP2.

I reviewed Resident A's service plan. The service plan omitted information on the behaviors of Resident A.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: R 325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's

	service plan states that the resident needs continuous supervision.
ANALYSIS:	Interviews with management, caregivers, and residents revealed concerning care provided by SP1 and SP2 to Resident A. Management was made aware of the said behavior but did not put measures of protective in place to ensure Resident A was treated appropriately.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility smells like urine and call buttons do not work.

INVESTIGATION:

The complainant alleged the facility smells like urine and call buttons do not work.

Ms. Huff reported the facility has a full-time housekeeper that cleans the facility. Ms. Huff reported the housekeeper is responsible for cleaning resident rooms and common areas. Ms. Huff reported if a resident room or common area is dirty, the caregiver is expected to clean the area. Ms. Huff reported she has not received any complaints about the facility not being clean.

Mr. Kosten reported residents in assisted living have a call button that is to go to staff telephones. Mr. Kosten reported at times the system goes down, but he can re-start the system. Mr. Kosten reported if the system does go down, it is resolved within a few hours. Mr. Kosten reported he has ordered new phones that will work better. Mr. Kosten reported there are computers located by each medication cart that show when a call button is activated.

On 8/22/22, I interviewed SP6 at the facility. SP6 reported she is responsible for cleaning the facility. SP6 reported she cleans resident rooms, resident bathrooms, and common areas. SP6 reported she keeps the facility very clean and has had no complaints about the cleanliness of the facility.

I interviewed SP7 at the facility. SP7 reported the housekeeper cleans the facility and caregivers assist as needed. SP7 reported no concerns with cleanliness at the facility. SP7 reported at times the call buttons do not go to the telephones worn by the caregivers. SP7 reported if this occurs, caregivers are to check the computer by each medication cart to respond to call alerts.

I interviewed Resident B at the facility. Resident B reported she wears a call pendent around her neck. Resident B reported when she pushes for assistance, a caregiver responds in an appropriate timeframe.

I interviewed Resident C at the facility. Resident C's statements were consistent with those made by Resident B.

I observed the common areas of the facility including the living area, dining area, hallways, and bathrooms. The common areas of the facility were clean as observed by the floors were vacuumed, there was no litter on the floor, and the facility smelt clean.

I observed multiple resident rooms and bathrooms. The rooms were tidy and clean. The bathrooms were also clean.

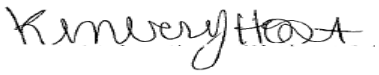
I observed two medication carts on the assisted living unit. The medication carts had a computer that showed activated call lights. The computers were easily accessible for caregivers to access and respond to call lights.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Interviews conducted and observations made at the facility revealed the facility is kept clean and call buttons are in working condition. There is lack of evidence to support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 9/17/22, I conducted an exit conference with authorized representative Hemant Shah by telephone. Mr. Shah had no questions about the findings in this report.

IV. RECOMMENDATION

Contingent upon receipt of a corrective action plan, I recommend no change in the status of the license.



9/2/22

Kimberly Horst Date
Licensing Staff

Approved By:

09/07/2022

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section