GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 3, 2022

Laura Esese
Dignified Care LLC
3640 Brambleberry DR Nw
Comstock Park, MI 49321

RE: License #: AS410406418
Investigation #: 2022A0583045
Chalet Home

Dear Ms. Esese:

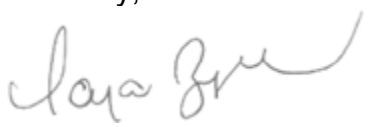
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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, 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 (616) 356-0183.

Sincerely,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410406418
Investigation #:	2022A0583045
Complaint Receipt Date:	09/22/2022
Investigation Initiation Date:	09/22/2022
Report Due Date:	10/22/2022
Licensee Name:	Dignified Care LLC
Licensee Address:	3640 Brambleberry DR Nw Comstock Park, MI 49321
Licensee Telephone #:	(616) 856-9191
Administrator:	Laura Esese
Licensee Designee:	Laura Esese
Name of Facility:	Chalet Home
Facility Address:	4711 Chalet Ln SW Wyoming, MI 49519
Facility Telephone #:	(616) 856-9191
Original Issuance Date:	02/22/2021
License Status:	REGULAR
Effective Date:	08/22/2021
Expiration Date:	08/21/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED, MENTALLY ILL, ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A presents with suspicious bruises on his arms that appear to be “fingerprints”.	No
Additional Findings	Yes

III. METHODOLOGY

09/22/2022	Special Investigation Intake 2022A0583045
09/22/2022	Special Investigation Initiated - Telephone Relative 1, Relative 2
09/22/2022	APS Referral
09/23/2022	Inspection Completed On-site Licensee Designee Laura Esese, Staff Jeff Odhiambo, Staff Beryl Ochieng, Resident B
09/23/2022	Contact - Document Received APS Vicki Pohl
09/25/2022	Contact - Document Received Licensee Designee Laura Esese
09/30/2022	Contact - Document Received Detective Kroschel
10/03/2022	Exit Conference Licensee Designee Laura Esese

ALLEGATION: Resident A presents with suspicious bruises on his arms that appear to be “fingerprints”.

INVESTIGATION: On 09/22/2022 the above-stated complaint allegation was received via the BCAL online reporting system from Adult Protective Services. The complaint allegation stated that the bruised resident is “non-verbal” and “has bruises on his right upper arm”. The complaint alleged that “the bruises appear to be fingermarks” and “there are bruises on his inside of the left forearm that is faded”.

On 09/22/2022 I interviewed Relative 1 and Relative 2 jointly via telephone. Relative 1 and Relative 2 both stated Resident A is non-verbal, and they are his legal

guardians. Relative 1 and Relative 2 stated that on 09/01/2022 they picked Resident A up for a weekend visit at their home and observed a large “fist size” yellowing bruise on Resident A’s left upper arm. Relative 1 and Relative 2 both stated they did not ask facility staff how Resident A may have sustained the injury, but they did photograph the injury on 09/01/2022. Relative 1 and Relative 2 stated that Resident A “appeared happy” to return to the facility following the 09/01/2022 visitation. Relative 1 and Relative 2 stated that on 09/16/2022 they picked Resident A up for a weekend visit and observed multiple small bruises in various stages of healing the size of “fingerprints” on Resident A’s upper “right” arm. Relative 1 and Relative 2 stated they did not ask facility staff if the 09/16/2022 bruises were observed by staff or how the bruises may have originated. Relative 1 and Relative 2 stated they will not be allowing Resident A to return the facility and they photographed the bruises on Resident A’s right upper arm.

On 09/22/2022 I received an email from Relative 1 which contained photographs of Resident A’s right and left upper arms. I observed in the attached photographs a large circular yellowing bruise on Resident A’s left upper arm and multiple small bruises in various stages on Resident A’s right upper arm.

On 09/23/2022 I completed an announced investigation at the facility and privately interviewed Licensee Designee Laura Esese, staff Jeff Odhiambo, Beryl Ochieng, and Resident B.

Licensee Designee Laura Esese stated Resident A has a history of property destruction at the facility and self-abusive behaviors such as picking at parts of his body and striking himself. Ms. Esese stated Resident A is non-verbal and Autistic. Ms. Esese stated she did not know Resident A sustained injuries to his upper arms and Relative 1 and Relative 2 never communicated the existence of these injuries. Ms. Esese stated she did not know how Resident A sustained the bruises to his upper arms but suspected it was due to his self-harm behaviors which Ms. Esese reported were clearly documented by Resident A’s Individual Plan of Service.

Staff Jeff Odhiambo and Beryl Ochieng both reported that Resident A partakes in self harming behaviors such as picking at his fingers, picking at his body, and striking himself. Both staff stated Resident A engages in property destruction of the home which is documented in his Individual Plan of Service. Both staff stated they have not observed Resident A’s upper arm bruises and do know what caused the injuries.

Resident B stated he did not observe Resident A’s upper arm bruises. Resident B stated he has never observed facility staff mistreat Resident B or any other resident of the facility. Resident B stated he happy with the level of care provided by facility staff.

On 09/23/2022 I received an email from Vicki Pohl of Ionia County Adult Protective Services. The email verified that the complaint allegation was communicated to the Wyoming Police Department and assigned to Detective A. Kroschel.

On 09/25/2022 I received via email from Licensee Designee Laura Esese copies of Resident A's Assessment Plan for AFC Residents and "The Right Door" Assessment Plan. Resident A's Assessment Plan was signed 07/28/2022 and states Resident A exhibits self-injurious behaviors and will "scratch himself with any sharp objects around". Resident A's The Right Door Assessment Plan signed 05/18/2022 states Resident A displays a history of becoming "physically aggressive with self and others" and has a history of "trying to pull a filling out of his tooth, uses pins or other sharp objects to prick his fingers, boxing his own ears, hitting his head, or smacking his cheeks".

On 09/30/2022 I received an email from Detective A. Kroschel of the Wyoming Police Department. Detective Kroschel stated she, "did not find any evidence of abuse" after she "interviewed all of the employees, his teacher, and one resident that was verbal" and "they all had no idea how (Resident A) may have gotten the bruises".

On 10/03/2022 I completed an Exit Conference with Licensee Designee Laura Esese. Ms. Esese stated she agreed with the findings.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Resident B stated he has never observed facility staff mistreat Resident B or any other resident of the facility. Licensee Designee Laura Esese, staff Jeff Odhiambo, and Beryl Ochieng each reported that Resident A partakes in self harming behaviors such as picking at his fingers, picking at his body, and striking himself. Licensee Designee Laura Esese, staff Jeff Odhiambo, and Beryl Ochieng each stated they have not observed Resident A's upper arm bruises and do know what may have caused the injuries.

	Resident A's The Right Door Assessment Plan states Resident A displays a history of becoming "physically aggressive with self and others" and has a history of "trying to pull a filling out of his tooth, uses pins or other sharp objects to prick his fingers, boxing his own ears, hitting his head, or smacking his cheeks". A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: The bathroom tile contains "black mold" underneath.

INVESTIGATION: On 09/22/2022 I interviewed Relative 2 via telephone. Relative 2 stated he was at the facility approximately October 2021 repairing bathroom tiles and observed "rotten, wet, back mold" located under the bathroom floor and wall tile. Relative 2 stated he did not notify Licensee Designee Laura Esese of the "rotten, wet, black mold" observed under the floor tiles and instead placed the old tiles over the wet floor and wall. Relative 2 stated he did photograph the wet wooden floor and mold located underneath the bathroom floor and wall tiles.

On 09/22/2022 I received an email from Relative 1 which contained photographs of the facility's bathroom floor and wall. I observed in the photographs what appeared to be wet wooden flooring and wall material. I observed in the photographs what appeared to be mold on the wet flooring and wall material.

While onsite on 09/23/2022 I interviewed Licensee Designee Laura Esese and observed the facility's bathroom. Staff Laura Esese stated Relative 2 did visit the facility last year to fix tiles broken by Resident A. Ms. Esese stated Relative 2 did not inform her of the dampness and possible mold located underneath the tiles but instead reset the tile back into place.

I observed the floor and wall adjacent to the bathtub is covered with tile therefore I could not visually observe the presence of dampness and mold. I did observe that the bathroom floor appeared soft in spots adjacent to the bathtub.

On 10/03/2022 I completed an Exit Conference with Licensee Designee Laura Esese. Ms. Esese stated she agreed with the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**

	(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair.
ANALYSIS:	I received an email from Relative 1 which contained photographs of the facility's bathroom floor and wall. The photographs appeared to show wet wooden flooring and wall material as well as what appeared to be mold on the wet flooring and wall material. While onsite on 09/23/2022 I observed the facility's bathroom floor and wall adjacent to the bathtub are covered with tile therefore I could not visually observe the presence of dampness and mold. The bathroom floor appeared soft in spots adjacent to the bathtub. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: The stairway leading from the main floor to the basement of the facility lacks a handrail on the open side.

INVESTIGATION: On 09/22/2022 I interviewed Relative 1 and Relative 2 jointly via telephone. Relative 1 and Relative 2 stated that the stairway leading from the main floor of the facility to the basement contains an open side with no handrail.

While onsite on 09/23/2022 I observed that the facility contains a self-latching door leading to a stairway to the basement. I observed that there is a handrail located to the right of the stairway which is closed by a wall but there is no handrail located to the left of the stairway which is not closed by a wall.

On 10/03/2022 I completed an Exit Conference with Licensee Designee Laura Esese. Ms. Esese stated she agreed with the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(8) Stairways shall have sturdy and securely fastened handrails. The handrails shall be not less than 30, nor more than 34, inches above the upper surface of the tread. All exterior and interior stairways and ramps shall have handrails on the open sides. All porches and decks that

	are 8 inches or more above grade shall also have handrails on the open sides.
ANALYSIS:	While onsite on 09/23/2022 I observed that the facility contains a self-latching door leading to a stairway to the basement. I observed that there is a handrail located to the right of the stairway which is closed by a wall but there is no handrail located to the left of the stairway which is not closed by a wall. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

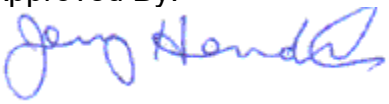
Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.

10/03/2022

Toya Zylstra
Licensing Consultant

Date

Approved By:



10/03/2022

Jerry Hendrick
Area Manager

Date