GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 18, 2022

Brenda Ice
Loving Care Residential Assisted Living, LLC
27852 Starling Lane
Flat Rock, MI 48134

RE: License #: AS820292538
Investigation #: 2022A0116048
Loving Care Residential Assisted Living

Dear Ms. Ice:

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,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820292538
Investigation #:	2022A0116048
Complaint Receipt Date:	09/23/2022
Investigation Initiation Date:	09/23/2022
Report Due Date:	11/22/2022
Licensee Name:	Loving Care Residential Assisted Living, LLC
Licensee Address:	31704 Marigold Dr. Brownstown, MI 48173
Licensee Telephone #:	(734) 348-6006
Administrator:	Brenda Ice
Licensee Designee:	Brenda Ice
Name of Facility:	Loving Care Residential Assisted Living
Facility Address:	31704 Marigold Dr. Brownstown, MI 48173
Facility Telephone #:	(734) 379-2601
Original Issuance Date:	02/07/2008
License Status:	REGULAR
Effective Date:	09/07/2022
Expiration Date:	09/06/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Complainant reported that he observed an unknown male along with the female staff smoking marijuana in front of the home. Complainant reported smelling the marijuana while assisting Resident A into the home.	Yes

III. METHODOLOGY

09/23/2022	Special Investigation Intake 2022A0116048
09/23/2022	Special Investigation Initiated - Telephone Spoke with licensee designee, Brenda Ice.
09/23/2022	APS Referral Made by ORR.
09/29/2022	Inspection Completed On-site Interviewed staff, Sade Lindsay and Resident A.
09/29/2022	Contact - Telephone call made Interviewed staff, Danielle Farnham.
09/29/2022	Contact - Document Received Received a screen shot of text messages between staff, Danielle Farnham and former staff, Caresse Milete.
09/30/2022	Contact - Telephone call made Interviewed Guardian (1).
09/30/2022	Contact - Telephone call made Interviewed Guardian (2).
09/30/2022	Contact - Telephone call made Interviewed Witness (1).
09/30/2022	Inspection Completed-BCAL Sub. Compliance
10/03/2022	Contact - Telephone call received Received verification of former staff, Caresse Milete direct care training, from licensee designee, Brenda Ice.
10/12/2022	Exit Conference

	With licensee designee, Brenda Ice.

ALLEGATION:

Complainant reported that he observed an unknown male along with the female staff smoking marijuana in front of the home. Complainant reported smelling the marijuana while assisting Resident A into the home.

INVESTIGATION:

On 09/23/22, I interviewed licensee designee, Brenda Ice, and she reported that the staff person she believes was observed smoking marijuana is Caresse Milete. Ms. Ice reported that she terminated Ms. Milete on 09/22/22, for failing to complete her job responsibilities. Ms. Ice reported that she is going to make some calls and try to determine if the allegation is true and confirm who the staff person is.

On 09/29/22, I conducted an unscheduled onsite inspection and interviewed staff, Sade Lindsay and Resident A. Ms. Lindsay reported that she was off work for the past week or so but reported hearing about the incident. Ms. Lindsay reported that I needed to talk with staff, Danielle Farnham, as she was an actual witness to the incident.

I interviewed Resident A, but she was unable to distinguish between marijuana and cigarette smoke but reported that some of the staff smoke out in the back of the house. Resident A was nicely dressed and groomed.

On 09/29/22, I interviewed staff, Danielle Farnham, and she reported that on Tuesday 09/20/22, she was scheduled to work the afternoon shift which starts at 3:00 p. m. she reported that she was having car trouble, so she texted staff, Caresse Milete who was the day shift staff, to let her know that she was running late, but was on her way. Ms. Farnham reported that Ms. Milete texted her back and stated that she would be outside. Ms. Farnham reported that she arrived at the home at about 4:02 p.m. and walked up the driveway. She reported she observed Resident B's guardians in their vehicle, and she observed Ms. Milete's boyfriend's car also in the driveway. Ms. Farnham reported observing him and Ms. Milete smoking marijuana and she could smell it as she walked past the car. Ms. Farnham reported that she went in the house as the residents were in there alone and she wanted to make sure they were all okay. Ms. Farnham reported that Ms. Milete got out of her boyfriend's car and came in the house to punch out and she left. Ms. Farnham reported that she waved at Resident B's guardians and reported when they saw her enter the house they left. Ms. Farnham reported later learning that they had been at the house for about 45 minutes and did not want to leave the house while no staff was inside. Ms. Farnham reported that Ms. Milete knows better and reported she was glad that the residents were unharmed when she arrived. Ms. Farnham reported that Resident B's guardians called and informed Ms. Ice of what they had observed.

On 09/29/22, Ms. Farnham sent a screenshot of the text messages between she and Ms. Milete. Ms. Milete was continually texting Ms. Farnham inquiring where she was and asking how long until she would arrive. Ms. Milete also stated she was outside and once Ms. Farnham informed her she was coming down the street, Ms. Milete responded at 3:56 p.m. stating she was going to go back inside and clock out.

On 09/30/22, I interviewed Guardian (1) and she reported that she was not aware of the incident and reported Ms. Ice had not called her. Guardian (1) reported she had

talked to Resident A but reported she does not have the capacity to know the difference between marijuana and cigarette smoke smells, and she has not mentioned anything concerning to her. Guardian (1) reported that this is unacceptable and that she hopes the staff is terminated and that Ms. Ice reiterates with her staff the inappropriateness of this. Guardian (1) reported that prior to this she has had no real concerns regarding the care provided at the home. Guardian (1) reported she will be contacting Ms. Ice to discuss further.

On 09/30/22, I interviewed Guardian (2) and she reported that on 09/20/22, she and her sister went to the home to gather some of Resident B's belongings as she was sent to a rehabilitation facility from the hospital, for some physical therapy. Guardian (2) reported when they arrived staff Caresse Milete was outside with a male inside his vehicle. Guardian (2) reported she and her sister went into the home and were getting the items that Resident B needed. She reported they were at the home for almost an hour and Ms. Milete remained outside. Guardian (2) reported she was there when Resident A was dropped off from her program and reported observing Ms. Milete meet the driver of the van in the driveway to assist Resident A into the home. Guardian (2) reported that Ms. Milete took Resident A in the home and then immediately went back outside with her boyfriend. Guardian (2) reported that she did not observe Ms. Milete smoking as she was inside of the home for the most part. Guardian (2) reported once she was finished in the house she and her sister went outside and got in her car. She reported that she was not going to leave until she saw another staff person come. She reported that at about 4:00 p. m. staff Danielle Farnham arrived and reported that is when she left. Guardian (2) reported that she called and texted Ms. Ice and informed her of what had occurred. Guardian (2) reported that she could not believe that Ms. Milete left the residents unsupervised for an hour and that she had the audacity to do in front of her and her sister. Guardian (2) reported that when she arrived there were four residents in the home, and when Resident A arrived from her program, she made five.

On 09/30/22, I interviewed Witness (1) and he reported that on or about 09/20/22, he was at the home doing a drop off and while getting Resident A out of the vehicle he observed a "female staff" and an unknown male in the driveway smoking, he reported observing them in the car, "passing the joint back and forth". Witness (1) reported as he proceeded up the driveway, he walked into a cloud of marijuana smoke. Witness (1) reported the female staff got out of the vehicle and met him in the middle of the driveway and assisted Resident A into the home. Witness (1) reported before he could pull off, the "female staff" was back outside and heading to the vehicle with the male in it. Witness (1) reported that he was shocked at what he was seeing happening at a licensed group home.

On 10/03/22, I received verification of staff, Caresse Milete's, direct care training and confirmed that she was fully trained in all required areas.

On 10/12/22, I conducted the exit conference with licensee designee, Brenda Ice and informed her of the findings of the investigation as well as the rules that were

cited. Ms. Ice reported an understanding and reported that she terminated Ms. Milete.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on the findings of the investigation, which included interviews of Ms. Farnham and Witness (1) I am able to corroborate the allegations. Ms. Farnham observed Ms. Milete outside of the home smoking marijuana, while she was still on shift and responsible for the care of the residents. Ms. Farnham reported that when she arrived at the home and walked up the driveway, she could smell the marijuana smoke. Witness (1) reported when he arrived at the home, he observed Ms. Milete and an unknown male in a vehicle in the driveway, "passing a joint back and forth." Witness (1) also reported while assisting Resident A out of the vehicle and up the driveway to the home, he walked through a cloud of marijuana smoke. This violation is established as Ms. Milete, while still on shift, and responsible for the care of the residents, was observed to be smoking marijuana outside of the home, while the residents were left alone inside. Based on her actions, Ms. Milete is not suitable to meet the physical, emotional, intellectual, and social needs of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 findings of the investigation, which included interviews of Ms. Farnham, Guardian (2) and Witness (1) I am able to corroborate the allegations. Ms. Farnham reported prior to her arrival to the home, Ms. Milete texted and informed her that she was outside, as she was waiting for her to get there to relieve her. Ms. Farnham reported when she arrived, Ms. Milete was outside in a vehicle with her boyfriend smoking marijuana and had left the Residents inside of the home unattended. Guardian (2) reported when she arrived at the home, Ms. Milete was outside in a vehicle with a male, and four residents were inside left unsupervised. Guardian (2) reported she was at the home for almost and hour and reported during that time Ms. Milete remained outside. Guardian (2) reported that Ms. Milete came inside for a maybe a minute while assisting Resident A into the home after she was dropped off from her program. Guardian (2) reported she then immediately returned outside. Guardian (2) reported she stayed at the home until another staff showed up, and once she saw her enter the home, she felt comfortable leaving. Witness (1) reported when he dropped Resident A off, he observed Ms. Milete and an unknown male outside in a vehicle, “passing a joint back and forth”. Witness (1) reported Ms. Milete walked Resident A into the home, and before he could pull off, she was back outside and heading back into the vehicle. This violation is established as there was not sufficient staff on duty for the supervision, personal care and protection of the residents, as evidenced by Ms. Milete’s decision to engage in inappropriate activities, outside of the home, while on shift and still responsible for the care of these residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Pandrea Robinson
Licensing Consultant

10/17/22
Date

Approved By:

Ardra Hunter
Area Manager

10/18/22
Date