GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 25, 2022

Zachary Fisher
Randall Residence of Auburn Hills, LLC
310 White Oak Road
Lawton, MI 49065

RE: License #: AL630402684
Investigation #: 2022A0611040
Randall Residence of Auburn Hills II

Dear Mr. Fisher:

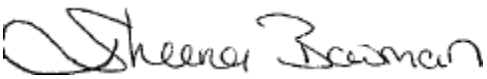
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630402684
Investigation #:	2022A0611040
Complaint Receipt Date:	09/21/2022
Investigation Initiation Date:	09/27/2022
Report Due Date:	11/20/2022
Licensee Name:	Randall Residence of Auburn Hills, LLC
Licensee Address:	310 White Oak Road Lawton, MI 49065
Licensee Telephone #:	(248) 340-9296
Administrator:	Zachary Fisher
Licensee Designee:	Zachary Fisher
Name of Facility:	Randall Residence of Auburn Hills II
Facility Address:	3033 N. Squirrel Rd Auburn Hills, MI 48326
Facility Telephone #:	(248) 340-9296
Original Issuance Date:	09/18/2020
License Status:	REGULAR
Effective Date:	03/18/2021
Expiration Date:	03/17/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident L has been in the VA hospital since 9/12/2022 due to combativeness because the staff where he lived did not give him all of his Seroquel dose for at least 30 days.	Yes
Resident L has open wounds on one arm and his wife found his watch broken in his room.	Yes

III. METHODOLOGY

09/21/2022	Special Investigation Intake 2022A0611040
09/21/2022	APS Referral According to the intake an Adult Protective Services (APS) referral was denied.
09/27/2022	Special Investigation Initiated - Telephone I left a voice message for the reporting source requesting a call back.
09/28/2022	Contact - Telephone call made I made a telephone call to Resident L's guardian. The allegations were discussed.
09/28/2022	Inspection Completed On-site I completed an unannounced onsite. I interviewed the licensee designee, Zachary Fisher. I received copies of Resident L's discharge letter, Resident L's MAR for the month of September 2022, and copies of incident reports.
09/29/2022	Contact - Telephone call received I received a return phone call from the licensee designee, Zachary Fisher. Additional information was discussed regarding Resident L's open wound.
09/29/2022	Contact - Document Received I received a copy of Resident L's MAR for the month of September 2022.
10/04/2022	Contact - Telephone call made I left a voice message for staff member, Yolanda Wellons requesting a call back.

10/04/2022	Contact - Telephone call made I attempted to contact former staff member, Danny Kejbou however; I was informed I have the wrong phone number.
10/04/2022	Contact - Telephone call made I made a telephone call to staff member, Danny Logan. The allegations were discussed.
10/06/2022	Contact - Telephone call received I received a telephone call from Detective Tim Collick. Detective Collick inquired about the details of my investigation. I requested to call Detective Collick back when I was available to provide more details about the case.
10/07/2022	Contact - Face to Face I completed a second unannounced onsite. I spoke with Mr. Fisher regarding Resident L's MAR. I interviewed the Wellness Coordinator, Dematrice Jones, and Resident S.
10/08/2022	Contact - Telephone call made I made a telephone call to Detective Collick. Detective Collick was unable to talk and stated he will give me a call back on Tuesday.
10/11/2022	Contact – Telephone call made I left a voice message for Detective Tim Collick informing him the outcome of my investigation.
10/11/2022	Contact – Telephone call made I attempted to reach staff member Yolanda Wellons however; there was no answer. A voice message was left.
10/11/2022	Contact – Telephone call received I received a return phone call from Detective Collick. Detective Collick stated he will not be pressing charges however; he will document that the AFC group home did not provide proper care regarding Resident L's arm.
10/11/2022	Exit Conference I completed an exit conference with the licensee designee, Zachary Fisher via email as he was not available over the phone.

ALLEGATION:

Resident L has been in the VA hospital since 9/12/2022 due to combativeness because the staff where he lived did not give him all of his Seroquel dose for at least 30 days.

INVESTIGATION:

On 09/21/22, I received an intake regarding the abovementioned allegations. The specific allegations are: Resident is a 71-year-old male Veteran that has advanced dementia and resides at the Randall Residence of Auburn Hills. Resident has been in the VA hospital since 9/12/2022 due to combativeness because the staff where he lived did not give him all of his Seroquel dose for at least 30 days. Resident L also has open wounds on one arm and his wife found his watch broken in his room. There is a staff member named Danny K who works at the Randall Residence, and it is believed that he has abused Resident L. Resident L reported that a man took his finger and pushed his chin and "uses a towel" on him. Resident L's wife and daughter have concerns about Danny K and had a meeting with the director. The director told them that Danny K would no longer work with Larry and be put somewhere else.

On 09/28/22, I made a telephone call to Resident L's guardian. Regarding the allegations, Resident L was admitted into the AFC group home on 08/10/22. Prior to Resident L's admission into the AFC group home, he was at the VA hospital from 06/10/22 to 08/10/22. Resident L went back to the VA hospital on 09/12/22 and returned to the AFC group home on 09/19/22. Resident L was discharged from the AFC group home on 09/23/22. Resident L's guardian stated she received an emergency discharge notice dated 09/23/22. Resident L returned to the VA hospital on 09/23/22. Resident L is currently at the VA hospital located in Detroit, MI. Resident L's guardian stated Resident L was discharged from the AFC group home because he took a fire extinguisher and swung it at a staff member. Resident L's guardian stated there were other instances at the AFC group home involving Resident L being physically aggressive.

Prior to 06/10/22, Resident L was being taking care of by his guardian and an in-home caregiver. However, due to Resident L's aggressive behaviors, the caregiver quit and Resident L's guardian took Resident L to the VA hospital to get his medications adjusted.

Resident L's guardian stated the AFC group home did not administer Resident L's Seroquel for 30 days. Resident L had a meeting with the licensee designee, Zachary Fisher on 09/09/22. Resident L's guardian stated in the meeting that Resident L is prescribed Seroquel four times a day. Resident L should be administered Seroquel at 2:00pm, 8:00pm, 2:00am, and 8:00am. During the meeting, Resident L asked if Resident L is combative at 6:00 am then how is he getting his Seroquel at 2:00 am. Resident L's guardian did not receive a reassuring answer to indicate Resident L was getting his 2:00 am dose of Seroquel. On 09/09/22, Resident L's guardian visited the

AFC group home at 9:00pm. Resident L's guardian asked a staff member if Resident L will receive his 2:00 am dose of Seroquel. The staff member stated Resident L only receives Seroquel during the day, and he does not get it at 2:00 am.

On 09/28/22, I completed an unannounced onsite. I interviewed the licensee designee, Zachary Fisher. I received copies of Resident L's discharge letter, copies of incident reports, and a medication administrative audit report which did not include the MAR information.

On 09/28/22, I interviewed the licensee designee, Zachary Fisher. Regarding the allegations, Mr. Fisher stated Resident L has advanced dementia. Resident L was admitted into the AFC group home on 08/10/22 after being released from the VA hospital. Resident L returned to the VA hospital on 09/12/22 due to being physically aggressive towards staff members and residents at the AFC group home. Mr. Fisher stated he was on vacation during the time Resident L went to the VA hospital. On 09/09/22, Mr. Fisher had a meeting with Resident L's guardian, Resident L's relative, and the lead caregiver Dee Jones regarding Resident L's behaviors. During the meeting, it was decided that if Resident L's behaviors continued, he would have to be sent to a hospital for an evaluation and medication adjustment.

On 09/12/22, Resident L's guardian was contacted by a staff member regarding Resident L's aggressive behaviors. Resident L's guardian transported Resident L to the VA hospital. Resident L returned to the AFC group home on or about 9/19/22. On 09/23/22, an emergency discharge was executed for Resident L. Mr. Fisher stated all of Resident L's belongings have been picked up from the AFC group home with the exception of his medications. Resident L's guardian was asked to retrieve Resident L's medications on 09/26/22. Mr. Fisher will give Resident L's guardian until the end of the week to retrieve the medications before properly disposing the medications. Mr. Fisher stated Resident L was not administered his Seroquel dose at 2:00 am on several occasions. Mr. Fisher stated he thinks staff did not administer Resident L's 2:00 am dose of Seroquel because they did not want to wake him up as he would become combative.

On 09/28/22, I received a copy of nine incident reports, a copy of Resident L's discharge letter and a medication administrative audit report which did not include the MAR information.

According to the incident report dated 08/09/22, a skin assessment was completed for Resident L as he just moved in. It was documented that Resident L had aging red spots on his right and left forearms. There is a body chart on the incident report and both forearms were circled on the body chart. The second incident report was completed on 09/06/22 and signed by Ms. Wellons. The incident report indicates that Resident L punched Ms. Wellons in the face and nose while she was changing him. The third incident report was completed by Sharica Jernagin on 09/07/22. The incident report indicates Resident L kicked Sharica and swung his hands at her.

The fourth incident report dated 09/08/22 is regarding Resident L grabbing plates in the dining room and using profanity. The fifth incident report dated 09/12/22 is regarding Resident L having his hand on another resident's door. Resident L tried to hit a staff member and he hit another resident. The sixth incident report was completed by Lamunel Lewis on 09/21/22. The incident report indicates that Resident L punched a staff member. The seventh incident report was completed by Lamunel Lewis on 09/22/22. The incident report indicates that Resident L pushed and hit Mr. Lewis with a water bottle.

The eighth incident report was completed by Sharica Jernagin on 09/22/22. The incident report indicates that Resident L tried to get out of the building, and he hit Ms. Jernagin because she was trying to stop him. The ninth incident report was completed by Ariel Mosley on 09/22/22. The incident report indicates that Resident L tried to take another residents walker and he hit Ms. Mosley. I also received three handwritten notes from staff regarding combative and aggressive instances involving Resident L towards staff.

The discharge letter is dated 09/23/22 and it indicates a discharge will take place effective immediately on 09/23/22. It was documented that the reason Resident L was discharged was because the welfare and needs of the resident cannot be met in the facility and the safety of individuals in the home are endanger.

On 09/29/22, I received a copy of Resident L's MAR for the month of September 2022. According to the MAR, Resident L is prescribed Quetiapine (Seroquel) every six hours. Regarding the 2:00am dose, Resident L did not receive his Seroquel for twelve days (9/1/22, 9/2/22, 9/3/22, 9/5/22-9/12/22) as there were no staff initials on the MAR. There are four days Resident L did not receive his 2:00pm dose of Seroquel (9/1/22,9/2/22,9/5/22,9/10/22).

On 10/04/22, I interviewed staff member, Danny Logan. Regarding the allegations, Mr. Logan stated he does not administer medications. Mr. Logan stated during his midnight shift, staff member Laresia Avery administered medications. Mr. Logan never saw Ms. Avery administer a 2:00am medication for Resident L.

On 10/07/22, I completed a second unannounced onsite. I spoke with Mr. Fisher regarding Resident L's MAR. Mr. Fisher contacted Nurse Sue Durichko to receive clarification about Resident L's MAR concerning his Seroquel. Mr. Fisher and Nurse Durichko could not provide an explanation as to why there were so many missing staff initials for Resident L's Seroquel. It was concluded that either staff did not administer Resident L's Seroquel or Resident L refused to take it. Nevertheless, it was explained that staff must administer medications as prescribed and/or provide a comment if a resident refuses a medication.

On 10/07/22, I interviewed Resident S. Resident S stated he likes living at the AFC group home. Resident S has resided at the AFC group home for about two months. Resident S stated the staff are nice, they treat him well, and do his laundry. Resident S stated he does not take any medications. Resident S denied any staff member being

mean to him. Resident S denied ever seeing a staff member hit or do anything bad towards a resident. Resident S feels safe at the AFC group home.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident L is prescribed Seroquel every six hours. According to Resident L's MAR, he did not receive his 2:00am dose for twelve days during the month of September 2022. Resident L also did not receive his 2:00pm dose of Seroquel for four days during the month of September 2022. On 09/28/22, Mr. Fisher admitted that Resident L was not administered his Seroquel dose at 2:00 am on several occasions. Mr. Fisher stated he thinks staff did not administer Resident L's 2:00 am dose of Seroquel because they did not want to wake him up as he would become combative.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**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: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	On 10/07/22, neither Mr. Fisher nor Nurse Durichko could provide an explanation as to why there were missing staff initials for Resident L's 2:00pm dose of Seroquel. It is not certain if staff did not administer Resident L's 2:00am dose of Seroquel due to his aggressiveness or due to Resident L's refusal to take it because there was no documentation on the MAR.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

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- **Resident L has open wounds on one arm**
- **Resident L's wife found his watch broken in his room.**

INVESTIGATION:

On 09/28/22, Resident L's guardian stated Resident L has an open wound on his arm and she suspects it came from an altercation between Resident L and Mr. Kejbou. Resident L stated she has no proof or evidence that Mr. Kejbou harmed and/or abused Resident L. When Resident L went to the VA hospital on 09/12/22, the nurse asked Resident L what happened to his arm and Resident L stated he did not know. Resident L has advanced dementia. Resident L saw a young male walk past. Resident L then took his finger and pushed his chin down and said this is what he does to me, and he uses a towel. Resident L's guardian confirmed that the male that walked past was not someone who worked at the AFC group home. Resident L never said anything about Mr. Kejbou.

Resident L's guardian stated she was previously contacted by staff member Yolanda Wellons informing her about an incident where she was helping Resident L in the bathroom at the AFC group home and Mr. Kejbou walked in. At this time, Resident L became aggressive towards Ms. Wellons. Ms. Wellons asked Mr. Kejbou to leave and when he did Resident L calmed down. Resident L's guardian confirmed that she has no reason and/or proof that Mr. Kejbou was abusive towards Resident L. Resident L's guardian was informed by Mr. Fisher that Mr. Kejbou no longer works at the AFC group home.

Resident L's guardian stated Resident L never took his watch off and he slept with it on. Resident L's guardian stated she observed Resident L's watch on his table and the metal band was broken. The staff did not inform Resident L's guardian that the watch was broken, nor did anyone say what happened to it. Resident L's guardian stated Resident L is very strong however; she does not think he ripped it off his arm.

Following my interview with Resident L's guardian, she provided a picture of Resident L's open wound via text message. The size of the open wound appeared to a little bigger than a size of quarter. The open wound was shaped like a triangle and was bloody. There was also bruising behind the open wound which was purplish in color.

On 09/28/22, Mr. Fisher stated staff member, Danny Kejbou provided a two week notice on 09/15/22 however; he did not fulfill his two weeks. Mr. Kejbou decided to quit because there was a lot of drama at the AFC group home. Mr. Kejbou was hired on 08/18/22 and; he did provide care for Resident L. Mr. Fisher stated Mr. Kejbou probably worked with Resident L a hand full of times. Mr. Fisher stated there were no reports or mention of any problems and/or altercations between Mr. Kejbou and Resident L. Resident L's guardian and relative informed Mr. Fisher that they did not care for Mr.

Kejbou. Resident L' guardian and relative stated there was a change in the atmosphere when Mr. Kejbou started working at the AFC group home. Mr. Fisher described Mr. Kejbou as feminine, and it was clear that he lived an alternative lifestyle based on how he carried himself. Resident L's family did not like the way Mr. Kejbou carried himself. There was no evidence that Mr. Kejbou and Resident L did not get along. Mr. Kejbou never complained about Resident L and Resident L never complained about Mr. Kejbou. Mr. Fisher stated Resident L cannot say or remember people's name. Mr. Fisher is not aware of any male staff taking Resident L's finger and pushing his chin or using a towel on him. Mr. Fisher stated Danny Logan is the only other male caregiver at the AFC group home.

Mr. Fisher stated he does not think Resident L was admitted with an open wound on his arm. Mr. Fisher stated he thinks Resident L may have developed the wound from bumping into something and/or picking at his skin. Mr. Fisher stated Resident L's wound was being treated as staff would wrap and dress the wound with gauze. Resident L would pull the gauze and dressing off his wound. I showed Mr. Fisher the picture of Resident L's open wound. Mr. Fisher was not aware of how bad Resident L's wound was.

Mr. Fisher stated he is not aware of Resident L's watch or whether or not if it was broken. Mr. Fisher confirmed that Resident L did have a watch while he was living at the AFC group home. Mr. Fisher stated the AFC group home does not complete a valuables transaction form when a resident is admitted into the home.

On 09/29/22, I received a return phone call from the licensee designee, Zachary Fisher. Regarding Resident L's open wound, Mr. Fisher stated he confirmed that Resident L bumped his arm on a table which created a skin tear. A staff member cleaned the wound and wrapped it up. Mr. Fisher stated whenever Resident L's guardian would visit Resident L, she would remove the wrapping and dressing from Resident L's arm. At the end of each visit Resident L had with his guardian, staff would re-wrap Resident L's arm. I mentioned to Mr. Fisher the severity of the open wound based on the picture that was provided by Resident L's guardian. Mr. Fisher agreed that the wound looked like it may have gotten infected. Mr. Fisher confirmed that Resident L was not seen by a doctor regarding the open wound. Mr. Fisher stated he will contact the in-home nurse to inquire if she treated Resident L's open wound.

On 10/04/22, I made a telephone call to staff member, Danny Logan. Regarding the allegations, Mr. Logan started working at the AFC group home on or about 09/05/22. Mr. Logan primarily works the midnight shift 11:00pm-7:00am. Mr. Logan stated at the beginning of his shift, the majority of the residents are asleep with the exception of two female residents. Mr. Logan stated he briefly met Resident L as Resident L left the AFC group home for about two weeks after Mr. Logan started working at the AFC group home. Mr. Logan does not know where Resident L went for those two weeks. Mr. Logan stated Resident L returned for one night and the next day he left the AFC group home again.

Mr. Logan stated he would check on Resident L every two hours. Mr. Logan never observed Resident L to be aggressive or combative. Mr. Logan stated he would only see Resident L watch football. Mr. Logan denied any altercations or incidents between him, and Resident L. Mr. Logan never witnessed an altercation or incident between Resident L and a staff member or a resident. Mr. Logan stated he is aware of Mr. Kejbou. Mr. Logan does not know if Mr. Kejbou still works at the AFC group home as he has not seen him in a while. Mr. Logan denies witnessing an altercation or incident between Mr. Kejbou and Resident L. Mr. Logan never observed Mr. Kejbou abuse or neglect a resident.

On 10/07/22, Nurse Durichko stated she works remotely, and she is not aware of Resident L's wound on his arm. Mr. Fisher confirmed that no documentation was completed regarding the medical treatment that Resident L received for his wound. Mr. Fisher stated all of the residents in the AFC group home have dementia and are unable to be interviewed with the exception of Resident S.

On 10/07/22, I interviewed the Wellness Coordinator, Dematrice Jones. Regarding Resident L's wound on his arm, Ms. Jones stated she was informed by staff that Resident L scratched his arm on a table which caused a skin tear. Ms. Jones stated the incident happened right before she arrived to work at 7:00am. Ms. Jones observed a small skin tear on Resident L's arm and; there was some bleeding. Ms. Jones used a bandage dressing to wrap Resident L's arm. Ms. Jones stated Resident L's guardian visited Resident L that evening and she took the dressing off Resident L's arm. Ms. Jones stated after Resident L's guardian left the AFC group home, she re-wrapped Resident L's arm. Ms. Jones stated Resident L's arm was healing. I showed Ms. Jones the picture of Resident L's wound that was received by his guardian. Ms. Jones stated she never observed Resident L's wound to look that bad. Ms. Jones confirmed that no documentation was completed regarding the medical treatment that Resident L received for his wound.

On 10/11/22, I completed an exit conference with the licensee designee, Zachary Fisher via email as he was not available over the phone. I informed Mr. Fisher which allegations will be substantiated and that a corrective action plan will be required.

APPLICABLE RULE	
R 400.15305	**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.

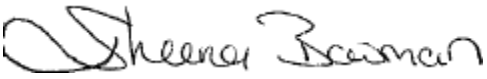
ANALYSIS:	Based on the information above, there is no sufficient information to confirm the allegations pertaining to staff member, Danny Kejbou abusing Resident L. Resident L's guardian admitted that she has no proof, or evidence, or a reason to believe that Mr. Kejbou harmed and/or abused Resident L.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15310	**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:	On 09/28/22, I received a picture of Resident L's open wound via text message from his guardian. The size of the open wound appeared to a little bigger than a size of quarter. The open wound was shaped like a triangle and was bloody. There was also bruising behind the open wound which was purplish in color. On 09/29/22, Mr. Fisher confirmed that Resident L bumped his arm on a table which created a skin tear. A staff member cleaned the wound and wrapped it up. Whenever Resident L's guardian would visit Resident L, she would remove the wrapping and dressing from Resident L's arm. Mr. Fisher confirmed that Resident L was not seen by a doctor regarding the open wound. On 10/07/22, Ms. Jones stated she was informed by staff that Resident L scratched his arm on a table which caused a skin tear. Ms. Jones observed a small skin tear on Resident L's arm and; there was some bleeding. Ms. Jones used a bandage dressing to wrap Resident L's arm. I showed Ms. Jones the picture of Resident L's wound that was received by his guardian. Ms. Jones never observed Resident L's wound to look that bad. Ms. Jones confirmed that no documentation was completed regarding the medical treatment that Resident L received for his wound. Based on the picture of the open wound, it does not appear Resident L's wound was being closely monitored and/or received immediate medical care when the condition worsened.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15315	**Handling of resident funds and valuables.**
	(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	On 09/28/22, Mr. Fisher stated the AFC group home does not complete a valuables transaction form when a resident is admitted into the home. Mr. Fisher confirmed that Resident L did have a watch while he was living at the AFC group home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

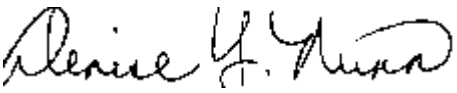


10/11/22

Sheena Bowman
Licensing Consultant

Date

Approved By:



10/25/2022

Denise Y. Nunn
Area Manager

Date