GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 5, 2022

Mary Black
Scotland Manor Enterprises, LLC
1357 N. River Road
St. Clair, MI 48079

RE: License #: AS740282833
Investigation #: 2022A0604030
River's Edge Assisted Living

Dear Mrs. Black:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. A previous recommendation of revocation was made in confirming letter dated 07/22/2021, which remains in effect. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Kristine Cilluffo

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 West Grand Blvd Ste 9-100
Detroit, MI 48202
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS740282833
Investigation #:	2022A0604030
Complaint Receipt Date:	07/25/2022
Investigation Initiation Date:	07/25/2022
Report Due Date:	09/23/2022
Licensee Name:	Scotland Manor Enterprises, LLC
Licensee Address:	1357 N. River Road St. Clair, MI 48079
Licensee Telephone #:	(810) 329-1112
Administrator:	Mary Black
Licensee Designee:	Mary Black
Name of Facility:	River's Edge Assisted Living
Facility Address:	1427 Oakland St. Clair, MI 48079
Facility Telephone #:	(810) 329-1112
Original Issuance Date:	10/26/2006
License Status:	1ST PROVISIONAL
Effective Date:	02/16/2021
Expiration Date:	08/15/2021
Capacity:	6
Program Type:	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Untrained staff are administering medications and caring for residents.	Yes
Unsanitary medical treatment of residents. No alcohol pads or necessary sanitary medical supplies for diabetic resident needing insulin shots	No
Residents are missing medications that are supposed to be given.	Yes
There are times when residents are left unattended.	No
Additional Findings	Yes

III. METHODOLOGY

07/20/2022	Contact- Face to Face Zoom Hearing with Administrative Law Judge, Aaron McClintic re: Notice of Intent to revoke license
07/21/2022	Contact- Face to Face Zoom Hearing with Administrative Law Judge, Aaron McClintic re: Notice of Intent to revoke license
07/25/2022	Special Investigation Intake 2022A0604030
07/25/2022	Special Investigation Initiated - Telephone Email to and from Adult Protective Services (APS) Supervisor, Jennifer Perrin.
07/25/2022	Contact - Document Sent Email to APS Supervisor, Jennifer Perrin.
07/26/2022	APS Referral Referral to APS
07/26/2022	Contact - Document Sent Email to Jennifer Perrin and Marnie Debell. Received return email from Marnie Debell.
07/26/2022	Inspection Completed On-site Completed unannounced onsite investigation with Adult Foster Care (AFC) Licensing Consultant Eric Johnson, APS Supervisor Jennifer Perrin and APS Worker Marnie DeBell. Interviewed David

	and Mary Black, Staff, Anna Swinson, Resident A, Resident B and Resident D.
07/27/2022	Contact - Document Sent Email to Mary Black and Attorney, Eric Naslund requesting documents for special investigation
07/28/2022	Contact - Telephone call received TC from Attorney, Eric Naslund. Returned call and referred him to Manager.
09/15/2022	Contact- Document Received Received Proposal for Decision supporting Notice of Intent to revoke license.
10/03/2022	Exit Conference Completed exit conference with Mary Black by phone.

ALLEGATION:

- **Untrained staff are administering medications and caring for residents.**
- **Unsanitary medical treatment of residents. No alcohol pads or necessary sanitary medical supplies for diabetic resident needing insulin shots.**
- **Residents are missing medications that are supposed to be given.**

INVESTIGATION:

I received a complaint regarding River's Edge Assisted Living on 07/25/2022. It was alleged that untrained staff are administering medications and caring for residents. There is unsanitary medical treatment of residents. Residents are missing medications that are supposed to be given. There are no alcohol pads or necessary sanitary medical supplies for diabetic resident needing insulin shots. There are times when residents are left unattended.

I completed an unannounced onsite investigation at River's Edge Assisted Living and Scotland Manor on 07/26/2022 along with AFC Licensing Consultant Eric Johnson, APS Supervisor, Jennifer Perrin and APS Worker, Marnie DeBell. Mary and David Black were present during investigation. A licensing complaint was also received for Scotland Manor on 07/22/2022. I interviewed Staff, Anna Swinson, Resident A, Resident B and Resident D.

On 07/26/2022, I interviewed Staff, Anna Swinson at the home. She stated that she has worked at River's Edge Assisted Living for a couple months. She stated that she also previously worked at the home a couple years ago. There are four residents who live in the home. She stated that Resident C has been in the hospital since last week. Ms.

Swinson stated that she has not been fingerprinted. Ms. Swinson stated that she has never completed First Aid/CPR training, fire safety or bloodborne pathogen training. She stated that a manager did train her on passing medications. Ms. Swinson stated that there have been times that Resident A and Resident B's Xanax has not been available in the home. She stated that she is unsure why the medications were not available. The residents did have Xanax available in the home at the time of investigation. Ms. Swinson stated that diabetic supplies and alcohol swabs are available in the home. She showed the alcohol swabs that were kept in the cupboard.

On 07/26/2022, I interviewed David Black who was present at the home. He stated that he is not involved with home and was working in the yard. He stated that he was getting ready for boat races. Mr. Black contacted Mary Black's attorney, Eric Naslund, by phone during the inspection. I informed Mr. Naslund that additional complaints were received after the administrative hearing for revocation.

On 07/26/2022. I interviewed Resident A. She does not know how long she has lived at River's Edge Assisted Living. She stated that she receives her medications. She did not know what medications she takes. She stated that she sees a doctor but does not know their name. Resident A did not report any concerns. She stated that her daughter comes to visit her.

On 07/26/2022, I interviewed Resident B. She stated that she always gets her medications and takes what she needs. She stated that she sees a doctor when needed. She did not report any concerns regarding the home.

On 07/26/2022, AFC Licensing Consultant, Eric Johnson reviewed Resident B and Resident D's medications and medication logs. The label for Resident B's Hydralazine 50 mg stated to take one tablet by mouth four times daily (hold if systolic BP is below 120). Resident B's medication log stated Hydralazine tab 50 mg take one tablet by mouth three times daily (hold if BP less than 110).

Resident B's medication log had missing staff initials and boxes where there was only a slash symbol with no explanation or staff initials. Resident B's July 2022 medication log was missing staff initials for the following medications:

- Furosemide tab 40 mg- 7/23-8am, 7/24-8am, 7/25-8am, 7/26-8am
- Escitalopram tab 20 mg- 7/23-8am, 7/24-8am, 7/25-8am, 7/26-8am
- Metoprolol tab 50 mg- 7/22-5pm, 7/23-8am, 5pm, 7/24-5pm, 7/25-5pm
- Divalproex 250 mg- 7/22-5pm, 7/23-8am, 5pm, 7/24-5pm, 7/25-5pm
- Eliquis 2.5mg- 7/22-5pm, 7/23-8am, 5pm, 7/24-5pm, 7/25-5pm
- Hydralazine tab 50 mg- 7/16-8pm, 7/18-8pm, 7/21-5pm, 7/22-5pm, 8pm, 7/23- 8am, 5pm, 8pm, 7/24-5pm, 8pm, 07/25- 5pm, 8pm – Benazepril 40mg- 7/23-8am
- Atorvastatin tab 20mg- 7/22-8pm, 7/23-8pm, 7/24-8pm, 7/25-8pm
- Melatonin 5 mg- 7/22-8pm, 7/23-8pm, 7/24-8pm, 7/25-8pm

Resident D's July 2022 medication log was missing staff initials for the following medications:

- Buspirone 10 mg- 7/25 8pm
- Hydro/papa 10-325 mg- 7/24-8pm, 7/25-4pm, 8pm
- Seroquel 50mg- 7/24-8pm, 7/25-8pm
- Doxepin 50mg- 7/25-8pm
- Atarax 25mg- 7/25- 5pm,8 pm

Resident D's pill pack label for Ropinirole (Requip) 2 mg stated to take 4 tablets (8mg) by mouth at 8 am, 2 tablets (4mg) by mouth a noon, 8PM and 4AM (discontinue Ropinirole ER 8 MG). Requip 2 mg was listed on medication log. The times were crossed out and the word "correct" was written. The medication log indicates that the medication has been given by staff 3 times per day, however, times are unknown. The medication log indicates that the Requip was only given twice on 07/09 and one time on 07/25. Resident D's Acetaminophen tab 500 mg was not listed on the medication log.

There were no reasons recorded for the administration of Resident D's PRN medications including Xanax, Atarax and Ondansetron HCL.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	On 07/26/2022, Staff Anna Swinson stated that she has not been trained in First Aid/CPR, fire safety or bloodborne pathogens (prevention and containment of communicable diseases). Licensee, Mary Black, stated that records could be requested from her attorney. On 07/27/2022, I sent an email to Mary Black and her attorney, Eric Naslund, requesting records. No training records have been provided as of 10/03/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 not enough information to determine that there is unsanitary medical treatment of residents. During the onsite, alcohol pads were available in the home. A staff list was not provided to interview additional staff regarding conditions.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident B and Resident D's medication has not been given pursuant to label instructions. The label for Resident B's Hydralazine 50 mg stated to take one tablet by mouth four times daily (hold if systolic BP is below 120). Resident B's medication log stated Hydralazine tab 50 mg take one tablet by mouth three times daily (hold if BP less than 110). Resident D's pill pack for Ropinirole (Requip) 2 mg indicated to take 4 tablets (8mg) by mouth at 8 am, 2 tablets (4mg) by mouth a noon, 8PM and 4AM (discontinue Ropinirole ER 8 MG). Requip 2 mg was listed on medication log. The times were crossed out and the word "correct" was written. The medication log indicates that the medication has been given by staff 3 times per day, however, times are unknown.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference confirming letter dated 07/22/2021**

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.** **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.**
ANALYSIS:	It is unknown if current staff are trained in the proper handling and administration of medication. Ms. Black did not provide staff list and phone numbers in order to interview staff or any staff training records. Staff, Anna Swinson, stated that she did receive medication training from a manager, however, no verification was provided. Resident B and Resident D's medication logs were missing staff initials. Resident B's medication log was missing staff initials for the following medications: - Furosemide tab 40 mg- 7/23-8am, /24-8am, 7/25-8am, 7/26-8am - Escitalopram tab 20 mg- 7/23-8am, 7/24-8am, 7/25-8am, 7/26-8am - Metoprolol tab 50 mg- 7/22-5pm, 7/23-8am, 5pm, 7/24-5pm, 7/25-5pm - Divalproex 250 mg- 7/22-5pm, 7/23-8am, 5pm, 7/24-5pm, 7/25-5pm - Eliquis 2.5mg- 7/22-5pm, 7/23-8am, 5pm, 7/24-5pm, 7/25-5pm - Hydralazine tab 50 mg- 7/16-8pm, 7/18-8pm, 7/21-5pm, 7/22-5pm, 8pm, 7/23- 8am, 5pm, 8pm, 7/24-5pm, 8pm, 7/25- 5pm, 8pm - Benazepril 40mg- 7/23-8am - Atorvastatin tab 20mg- 7/22-8pm, 7/23-8pm, 7/24-8pm, 7/25-8pm

	- Melatonin 5 mg- 7/22-8pm, 7/23-8pm, 7/24-8pm, 7/25-8pm Resident D's medication log was missing staff initials for the following medications: - Buspirone 10 mg- 7/25 8pm - Hydro/papa 10-325 mg- 7/24-8pm, 7/25-4pm, 8pm - Seroquel 50mg- 7/24-8pm, 7/25-8pm - Doxepin 50mg- 7/25-8pm - Atarax 25mg- 7/25- 5pm,8 pm Resident D's Acetaminophen tab 500 mg was not listed on medication log There were no reasons recorded for the administration of Resident D's PRN medications including Xanax, Atarax and Ondansetron HCL.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference confirming letter dated 07/22/2021**

ALLEGATION:

There are times when residents are left unattended.

INVESTIGATION:

On 07/26/2022, I interviewed Licensee, Mary Black, at Scotland Manor regarding allegations at River's Edge Assisted Living and Scotland Manor. She stated that all records should be requested from her Attorney, Eric Nasland. Ms. Black stated that there are always staff present at both of her homes. Residents are never left alone. She stated that staff always pass medications.

On 07/26/2022. I interviewed Resident A. She stated that there are always staff at the home. Resident A stated that she does not know the names of staff at the home.

On 07/26/2022, I interviewed Resident B. She stated that there is always staff at the home.

On 07/26/2022, I observed Resident D. She was participating in music therapy. She indicated that there is always staff at the home.

On 07/27/2022, I sent email to Mary Black and her attorney, Eric Naslund, requesting records. No records have been received to date.

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:	There is not enough information at this time to determine that residents are left alone. Licensee, Mary Black, stated that there are always staff at the home. A current staff list was not provided to interview additional staff who work at home. Resident A, Resident B and Resident D all stated that there are always staff at the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/26/2022, Staff Anna Swinson stated that she has not been fingerprinted. On 07/26/2022, Mary Black was interviewed at Scotland Manor and said all records should be requested from her Attorney, Eric Naslund. On 07/27/2022, I sent an email to Attorney, Eric Naslund and Mary Black requesting Ms. Swinson’s fingerprinting clearance. No clearances have been provided.

APPLICABLE RULE	
MCL 400.713	**License required; application; forms; investigation; on-site evaluation; issuance or renewal of license; disclosures; maximum number of persons; stating type of specialized program; issuance of license to specific person at specific location; transferability of license; sale of facility; notice; items of noncompliance; refusal by department to issue or renew license; conditions; unlicensed facility; violation as misdemeanor; penalty; receipt of completed application; issuance of license within certain time period; inspections; report; criminal history and records check; storage of fingerprints in automated fingerprint identification system database; convictions; "completed application" defined.**
	(3) Before issuing or renewing a license, the department shall investigate the activities and standards of care of the applicant and shall make an on-site evaluation of the

	facility. On-site inspections conducted in response to the application may be conducted without prior notice to the applicant. On-site inspections conducted for renewing a license may be conducted within 12 months before the expiration date of the current license without impact on the license renewal date or the license fee. Subject to subsections (9), (10), and (11), the department shall issue or renew a license if satisfied as to all of the following: **(e) The good moral character of the licensee or licensee designee, owner, partner, director, and person responsible for the daily operation of the facility. The applicant is responsible for assessing the good moral character of the employees of the facility. The person responsible for the daily operation of the facility shall be not less than 18 years of age.**
ANALYSIS:	On 07/26/2022, Staff Anna Swinson stated that she has not been fingerprinted. On 07/27/2022, I sent email to Mary Black and her attorney, Eric Naslund, requesting clearances. No clearances have been provided by Mary Black or her attorney.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 07/26/2022, I completed an unannounced onsite investigation at River's Edge Assisted Living and Scotland Manor. During the investigation, Licensee Mary Black directed licensing to request all needed records from her Attorney, Eric Naslund. On 07/27/2022, I sent an email to Attorney, Eric Naslund and Mary Black requesting the following records:

- Current staff list and phone numbers
- Fingerprinting clearance and training records for Staff, Bret Thurman, at Scotland Manor
- Fingerprinting clearance and training records for Staff, Anna Swinson, at River's Edge Assisted Living
- Incident reports for (Resident A and Resident B) deaths- Scotland Manor
- Incident report for (Resident C) hospitalization- River's Edge Assisted Living
- Order discontinuing (Resident D) Divalproex- Scotland Manor

As of 10/03/2022, Ms. Black and Mr. Naslund have not provided any of the requested records to licensing.

APPLICABLE RULE	
R 400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(3) The failure of an applicant or licensee to cooperate with the department in connection with an inspection or investigation shall be grounds for denying, suspending, revoking, or refusing to renew a license.
ANALYSIS:	Licensee, Mary Black, has not cooperated with providing records/documents needed for this special investigation to licensing. During the onsite investigation, Mary Black told licensing to request all records from her attorney. On 07/27/2022, I sent email to Mary Black and her attorney, Eric Naslund, requesting records. As of 10/03/2022, no records have been provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 07/26/2022, I completed an unannounced onsite investigation at River's Edge Assisted Living. During the investigation, Staff Anna Swinson stated that Resident C was in the hospital since last week. An incident report had not been provided to licensing. Ms. Black indicated that incident reports could be requested from her attorney. On 07/27/2022, I sent email to Attorney Eric Naslund and Mary Black requesting incident reports for Resident C's hospitalization. As of 10/03/2022, the incident report was not provided to licensing.

I completed an exit conference with Licensee Designee, Mary Black on 10/03/2022. I informed her of the findings and recommendation. I also informed her that a copy of the special investigation report would be mailed once approved.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.**

ANALYSIS:	On 07/26/2022, Staff Anna Swinson stated that Resident C was hospitalized. An incident report was not provided to licensing.
CONCLUSION:	**VIOLATION ESTABLISHED**

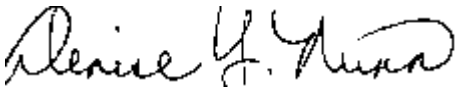
IV. RECOMMENDATION

A recommendation of revocation of the license was made in confirming letter dated 07/22/2021, which remains in effect.

10/03/2022

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



10/05/2022

Denise Y. Nunn — Date
Area Manager