GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 2, 2021

Fredrick Hayes
18759 Greenwald
Southfield, MI 48075

RE: License #: AF630313888
Investigation #: 2021A0602031
Good Faith Manor

Dear Mr. Hayes:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A previous recommendation for a provisional license was made in special investigation #2021A0602030, which remains in effect.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF630313888
Investigation #:	2021A0602031
Complaint Receipt Date:	08/12/2021
Investigation Initiation Date:	08/13/2021
Report Due Date:	10/11/2021
Licensee Name:	Fredrick Hayes
Licensee Address:	18759 Greenwald Southfield, MI 48075
Licensee Telephone #:	(248) 632-3778
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Good Faith Manor
Facility Address:	18759 Greenwald Southfield, MI 48075
Facility Telephone #:	(248) 632-3778
Original Issuance Date:	10/26/2012
License Status:	REGULAR
Effective Date:	11/11/2019
Expiration Date:	11/10/2021
Capacity:	6
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident D is not being showered, reeks of urine, clothes are not clean, face is unwashed, and hair is uncut. Resident D's diapers are rarely changed, and he is not properly cleaned when they are changed.	Yes
The facility smells of urine.	Yes

III. METHODOLOGY

08/12/2021	Special Investigation Intake 2021A0602031
08/12/2021	APS Referral Adult Protective Services (APS) referral denied.
08/13/2021	Special Investigation Initiated - Telephone Call made to the home - line busy.
08/17/2021	Contact – Telephone call made Spoke with Resident D's Family Member 1.
09/02/2021	Inspection Completed On-site Interviewed staff member Nathanial Waller, and Resident D.
11/03/2021	Contact – Telephone call made Spoke with Family Member 1.
11/03/2021	Contact – Document sent Email sent to Allysa Hayes requesting a contact number for Fredrick Hayes.
11/05/2021	Exit Conference Message left for Fredrick Hayes.
11/08/2021	Contact – Telephone call received Conducted exit conference with Mr. Hayes

ALLEGATION:

Resident D is not being showered, reeks of urine, clothes are not clean, face is unwashed, and hair is uncut. Resident D's diapers are rarely changed, and he is not properly cleaned when the diapers are changed.

INVESTIGATION:

On 8/12/2021, a complaint was received and assigned for investigation alleging that Resident D is not being showered, reeks of urine, clothes are not clean, face is unwashed, hair is uncut, diapers are rarely changed, and he is not properly cleaned when the diapers are changed.

On 8/17/2021, I interviewed Resident D's family member by telephone. Family Member 1 stated Resident D was residing in his own home with his wife prior to moving into Good Faith Manor. He underwent hip surgery and was placed in the group home. Family Member 1 visited Resident D in August 2021 and was not allowed into the facility due to COVID precautions. The visit took place on the front porch of the home. Resident D did not realize it, but he urinated on himself while sitting on the front porch. Urine began running down his leg soaking his pants despite wearing a depend. Family Member 1 notified the staff member (female name unknown) who was on shift. She informed Family Member 1 that she does not change the male residents. There was no other staff on shift at the time. Family Member 1 had to leave but took a picture of Resident D and sent it to another family member who was on their way to the facility. When the next family member arrived, Resident D had on the same urine-soaked pants. Family Member 1 contacted the home manager, Nathaniel Waller and informed him of the situation. Mr. Waller agreed to go to the home and take care of it. Family Member 1 received a photo from Mr. Waller of Resident D after he had been cleaned and shaved. Family Member 1 stated there should be always a female and male staff on shift if it is the facility's policy to only allow female staff to provide personal care to the female residents and male staff to provide personal care to the male residents. Family Member 1 is looking to place Resident D in another facility.

On 9/02/2021, I conducted an unannounced on-site investigation at which time I interviewed Mr. Waller and Resident D. Mr. Waller stated Resident D does receive showers regularly but has urinated on himself. When this occurs, staff changes his diaper and cleans him up. He went on to state that his clothes are laundered, and he is shaved when needed. Resident D's family visited him in August 2021 on the front porch. Resident D had an accident on himself and the staff on shift took him into the home and cleaned him up. Mr. Waller stated he needed to contact his mother, Christine Hayes. While in the home I spoke with Ms. Hayes by telephone. Ms. Hayes initially stated the female staff provide personal care to the female residents and the male staff provide personal care to the male residents. However, if needed a female staff will provide personal care to a male resident and a male staff will provide care to a female resident.

Ms. Hayes said she was unaware of an incident where a male resident was denied care because there was no male staff on shift.

On 9/02/2021, I interviewed Resident D at the facility. Resident D appeared to be neat, and clean but needed to be shaved. Resident D stated he receives a shower every other day with the assistance of a male staff member. He said he has frequent urination and will try and hold it for as long as he can but, he is not always successful. Resident D could not recall the exact date but remembered when Family Member 1 came to visit him. He said he urinated on himself, and it soaked through to his pants. There was no male staff on shift at the time, and the female staff (name unknown) did not change his diaper or wash him up after his accident. He had to wait until the male staff arrived at the home (exact date and time unknown) before he was changed and cleaned up.

On 11/03/2021 I spoke with Family Member 1 by telephone. Family Member 1 stated although several family members would like Resident D removed from the home, he remains in the facility because he does not want to move, and his wife does not want him moved.

APPLICABLE RULE	
R 400.1420	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity for daily bathing.
ANALYSIS:	Based on the information obtained from Resident D and Family Member 1, Resident D is not bathed daily. Resident D stated he receives a shower every other day and Family Member 1 stated Resident D is not clean when visits are made to the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1420	**Resident hygiene.**
	(5) A licensee shall afford a resident who is capable, opportunities and instructions, when necessary, to routinely launder clothing. Clean clothing shall be available at all times.
ANALYSIS:	Based on the information obtained from Resident D, his clothes are laundered weekly, but he was not given clean pants to put on when he urinated on himself (exact date unknown) until a male staff arrived at the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1420	**Resident hygiene.**
	(6) A licensee shall afford a resident the opportunity to receive assistance in bathing, dressing, or personal hygiene from a member of the same sex, unless otherwise stated in the home's admission policy and written resident care agreement.
ANALYSIS:	Based on the information obtained from Resident D and Family Member 1, a female staff member informed them that she does not change the male residents when Resident D urinated on himself. Resident D had to wait until a male staff arrived at the home (exact date and time unknown).
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility smells of urine.

INVESTIGATION:

On 9/02/2021, I conducted an unannounced on-site investigation at which time staff member Nathaniel Waller answered the door. Mr. Waller stated he could not allow me into the home due to COVID precautions. I identified myself and explained that he could not refuse my entry into the home as I was wearing appropriate personal protection equipment (PPE) and I needed to interview Resident D to address the allegations documented in the complaint. Mr. Waller then allowed me into the home. Upon entering the home, I did not smell urine. Instead, there was an odor mimicking the smell of sewage. Mr. Waller had no explanation for the odor. Mr. Waller then called his mother, Christine Hayes. I spoke with Ms. Hayes by telephone and informed her there was a foul odor in the home that smelled like sewage. She stated there is an issue with the sump pump that is scheduled to be repaired.

On 11/05/2021 I left a message for the licensee, Fredrick Hayes requesting a return call so that an exit conference could be conducted.

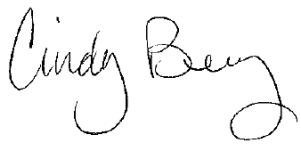
On 11/08/2021 received a return call from Mr. Hayes and was able to conduct an exit conference. I informed Mr. Hayes of the allegations received as well as the investigative findings and recommendation documented in this report. Mr. Hayes stated Resident D's personal care including bathing and grooming is managed by both male and female staff. Resident D has never been told that he would have to wait for a male staff member to arrive to have his diaper and or clothes changed. Mr. Hayes said Mr. Waller has a weekly schedule (usually Friday or Saturday) when he shaves and cuts Resident D's hair. He went on to state that the smell in the home was due to a plumbing issue.

He had three or four different plumbers come to the home to assess the situation and was informed that the sanitation piping was not connected correctly, and this was causing the odor. The piping was repaired about two weeks ago.

APPLICABLE RULE	
R 400.1426	**Maintenance of premises.**
	(1) The premises shall be maintained in a clean and safe condition.
ANALYSIS:	Based on my observation during the investigation, there was no smell of urine in the home. However, there was a smell of sewage that required plumbing work to have the sump pump repaired.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

A recommendation for a provisional license is also being made in special investigation #2021A0602030, which remains in effect.



12/02/2021

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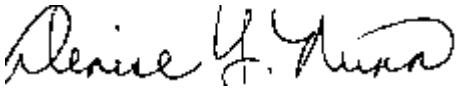
Cindy Berry Date
Licensing Consultant

Approved By:



12/02/2021

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Denise Y. Nunn Date
Area Manager