GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 21, 2023

Kimberly Rocca-Riffle
Elder Care Of Michigan, LLC
Suite 400
52188 Van Dyke
Shelby Township, MI 48316

RE: License #: AS350408503
Investigation #: 2023A0360021
Sherman Glen Manor

Dear Ms. Rocca-Riffle:

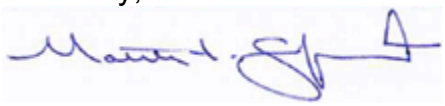
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (866) 865-0006.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
Ste 3
931 S Otsego Ave
Gaylord, MI 49735
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS350408503
Investigation #:	2023A0360021
Complaint Receipt Date:	04/03/2023
Investigation Initiation Date:	04/03/2023
Report Due Date:	06/02/2023
Licensee Name:	Elder Care of Michigan, LLC
Licensee Address:	Suite 400 52188 Van Dyke Shelby Township, MI 48316
Licensee Telephone #:	(586) 997-9401
Administrator:	Kimberly Rocca-Riffle
Licensee Designee:	Kimberly Rocca-Riffle
Name of Facility:	Sherman Glen Manor
Facility Address:	4475 Alabaster Rd National City, MI 48748
Facility Telephone #:	(989) 305-2601
Original Issuance Date:	07/29/2021
License Status:	REGULAR
Effective Date:	01/29/2022
Expiration Date:	01/28/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was forced into the shower and her hand was cut by staff.	Yes

III. METHODOLOGY

04/03/2023	Special Investigation Intake 2023A0360021
04/03/2023	Special Investigation Initiated - Telephone administrator Karen Buzzie
04/03/2023	Contact - Document Received IR from administrator
04/10/2023	Inspection Completed On-site Resident A, Administrator Karen Buzzie
04/10/2023	APS Referral online
04/10/2023	Contact - Document Received Photo from Administrator
04/18/2023	Contact - Telephone call received APS worker Carla Shastal
04/20/2023	Contact - Telephone call made DCS Staci Drollinger
04/21/2023	Exit Conference with administrator Karen Buzzie

ALLEGATION: Resident A was forced into the shower and her hand was cut by staff.

INVESTIGATION: On 4/03/2023 I was assigned a complaint from the LARA online complaint system.

On 4/03/2023 I was contacted by the administrator Karen Buzzie. Ms. Buzzie stated over the weekend one of her direct care staff Staci Drollinger forced Resident A to take a shower and during the shower Resident A's hand was bruised and cut. Ms. Buzzie stated Resident A has not been taking regular showers and the direct care staff have been trying to prompt Resident A to take more showers. She stated Ms. Drollinger has been taken off the schedule and will not be returning to work at the

facility. Ms. Buzzie stated she would send an incident report with the details of the situation.

On 4/03/2023 I received the Incident Report from Ms. Buzzie. The incident report noted that Resident A did not want to take a shower at 7:30 p.m. and told staff that. Staff proceeded to put the resident in the shower chair and roughly took off her clothes. Resident A reportedly said the water was cold like being in a pool and was very angry. Staff grabbed Resident A's left hand to hold her and staff's nails went into Resident A's skin and tore the skin and her hand is all bruised and cut from fingernails. Resident A then grabbed the staff's hair and started to pull it hard. Resident A was screaming for help so loud that all five other residents heard the yelling and came out of their rooms in concerns.

On 4/10/2023 I conducted an unannounced onsite inspection at the facility. Resident A stated she couldn't remember the exact day but over the weekend she went out to the hallway to walk a couple of laps using her wheelchair. She stated she did not want to take a shower. She stated the direct care staff Staci Drollinger started pushing her wheelchair to the shower room. She stated she told Ms. Drollinger she did not want to take a shower. She stated Ms. Drollinger continued to put her into the shower, started the water and started taking off her clothes. She stated she told Ms. Drollinger she did not want to take a shower and when Ms. Drollinger tried lifting her into the shower, Ms. Drollinger dug her nails into her hand. She stated at this point she was yelling for her to stop and Ms. Drollinger forced her to get into the shower. She stated she eventually let Ms. Drollinger wash her hair and complete the shower and noticed that her hand was bleeding. She stated Ms. Drollinger helped her dry off and get pajamas on and kept apologizing for hurting her hand. She stated Ms. Drollinger put a bandage on her hand. She stated she is very upset with Ms. Drollinger for forcing her to take a shower. Resident A's hand was bandaged, and she stated that it is bruised and had a small cut on it.

While at the facility on 4/10/2023 the administrator Karen Buzzie sent me a photo of Resident A's bruised and cut hand. The bruise was purple and the size of a quarter with a centimeter sized cut on her left hand.

On 4/20/2023 I was contacted by adult protective services worker Carla Shastal. Ms. Shastal stated she opened an APS investigation regarding the allegations. She stated another APS worker initially interviewed Resident A and based of her interview they will be substantiating the APS complaint.

On 4/20/2023 I contacted direct care staff Staci Drollinger. Ms. Drollinger stated on Friday 3/31/2023 at about 7:30 p.m. she went to Resident A's room and tried to prompt her to take shower. She stated Resident A hadn't showered in several days. She stated she got Resident A to agree to go down to the shower room and started warming up the water. She stated when she started to take off Resident A's clothes, she "lost it." She stated Resident A started screaming, "help me and that I was trying to kill her". She stated at this point Resident A was still half undressed and her pants

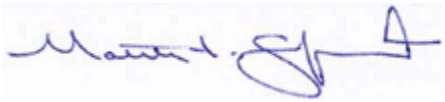
were around her ankles, and she was afraid she might fall in the shower. She stated at this point Resident A started to pull on the braid of her hair and pinched her arm and told her to let her go. She stated she was worried Resident A was going to fall down and all of her clothes were now soaked. She stated she got Resident A to calm down and finished the shower. She stated after the shower was finished she noticed the cut on Resident A's hand. She stated she does not know how Resident A got the cut on her hand. She stated Resident A never told her she did not want to take a shower until after she had her clothes half off. She stated she wrapped Resident A's hand with a bandage and got her ready for bed.

On 4/21/2023 I conducted an exit conference with administrator Karen Buzzie who concurred with the findings of the investigation.

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:	The complaint alleged that Resident A was forced into the shower and her hand was cut by staff. Resident A stated she told direct care staff Staci Drollinger numerous times that she did not want to take a shower. She stated Ms. Drollinger continued to force her into the shower which resulted in an injury to her hand. Ms. Drollinger denied that Resident A refused to take a shower until she was half undressed. She is unsure of how Resident A's hand was bruised and cut. Administrator Karen Buzzie stated Ms. Drollinger has been removed from the schedule and will not be returning to the facility. APS worker Carla Shastal stated she is substantiating the APS complaint. There is a preponderance of evidence that Resident A was not treated with dignity and respect and that her personal needs including protection and safety were not attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

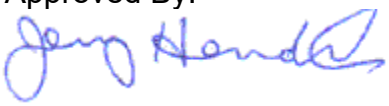
Upon receipt of an acceptable corrective action plan. I recommend no change in the status of the license.



04/21/2023

Matthew Soderquist Date
Licensing Consultant

Approved By:



04/21/2023

Jerry Hendrick Date
Area Manager