



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

May 12, 2023

Jasween Jagjit-Webb  
Auburn Heights Senior Care, Inc.  
110 Auburn Road  
Auburn, MI 48611

RE: License #: AL090260028  
Investigation #: 2023A0572027  
Auburn Heights Senior Care, Inc.

Dear Ms. Jagjit-Webb:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (517) 643-7960.

Sincerely,

A handwritten signature in cursive script that reads "Anthony Humphrey".

Anthony Humphrey, Licensing Consultant  
Bureau of Community and Health Systems  
411 Genesee  
P.O. Box 5070  
Saginaw, MI 48605  
(810) 280-7718

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AL090260028
<b>Investigation #:</b>	2023A0572027
<b>Complaint Receipt Date:</b>	03/14/2023
<b>Investigation Initiation Date:</b>	03/14/2023
<b>Report Due Date:</b>	05/13/2023
<b>Licensee Name:</b>	Auburn Heights Senior Care, Inc.
<b>Licensee Address:</b>	110 Auburn Road Auburn, MI 48611
<b>Licensee Telephone #:</b>	(989) 662-2099
<b>Administrator:</b>	Jasween Jagjit-Webb
<b>Licensee Designee:</b>	Jasween Jagjit-Webb
<b>Name of Facility:</b>	Auburn Heights Senior Care, Inc.
<b>Facility Address:</b>	110 Auburn Road Auburn, MI 48611
<b>Facility Telephone #:</b>	(989) 545-9462
<b>Original Issuance Date:</b>	01/27/2004
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	06/13/2022
<b>Expiration Date:</b>	06/12/2024
<b>Capacity:</b>	20
<b>Program Type:</b>	AGED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Resident A has concerns about the care he is being given, has not had a shower in over a week because he does not have any bandages for his bed sores.	No
Workers at the home have stolen video games, food, and drinks from Resident A.	No

## III. METHODOLOGY

03/14/2023	Special Investigation Intake 2023A0572027
03/14/2023	APS Referral Referral made from APS.
03/14/2023	Special Investigation Initiated - Letter
03/21/2023	Inspection Completed On-site Resident Care Coordinator, Johanna Rueda; Staff, Misty Warczynski; Staff, Briana Wallace and Resident A.
05/01/2023	Contact - Telephone call made Wound Care Nurse Jeff.
05/03/2023	Contact - Telephone call made A&D Nurse, Julie Alerie.
05/05/2023	Contact - Telephone call made Licensee, Jasween Jagjit-Webb, asked if there is another number for Wound Care Nurse.
05/05/2023	Exit Conference Licensee, Jasween Jagjit-Webb
05/10/2023	Contact - Telephone call made Licensee, Jasween Jagjit-Webb, asked for wound care nurse number or Resident A had a new wound care nurse. Also asked for Weight Record and Assessment Plan.
05/11/2023	Contact - Telephone call made

	Licensee, Jasween Jagjit-Webb, reminder that wound care nurse contact, Weight Record and Assessment Plan is needed.
05/11/2023	Contact – Document Received Received Resident A's Weight Record, Assessment Plan and Care Plan.
05/11/2023	Contact – Document Sent Licensee, Jasween Jagjit-Webb, emailed that wound care nurse info is needed if available.

**ALLEGATION:**

Resident A has concerns about the care he is being given, has not had a shower in over a week because he does not have any bandages for his bed sores.

**INVESTIGATION:**

On 03/14/2023, the local licensing office received a complaint for investigation. Adult Protective Services (APS) made the referral to Licensing.

On 03/21/2023, I made an unannounced onsite at Auburn Heights Senior Care, located in Bay County Michigan. Interviewed were Resident Care Coordinator, Johanna Rueda; Staff, Misty Warczynski; Staff, Briana Wallace and Resident A.

On 03/21/2023, I interviewed Resident Care Coordinator, Johanna Rueda regarding the allegation. When Resident A was accepted to their home on 01/31/2023, they were not aware of his sexual inappropriate comments and his history of making allegations that people are stealing from him. Resident A constantly is refusing services. He had a Wound Care Nurse that he fired. They made a Log for when he refuses showers and a log for when he refuses meals. He often tells staff who are trying to assist him to get out of his room. Because he has a right to refuse, they will leave his room, but then he will complaint that no one is helping him. When he accepts staff providing care, they will have 2 staff to assist because of his inappropriate comments and to also have a witness if he tries to make up allegations.

On 03/21/2023, I reviewed a stack of incident reports from 02/02/2023 to 03/06/2023 where Resident A has made inappropriate comments to staff, complained that staff don't know what they are doing and made allegations that some of his belongings had been stolen.

On 03/21/2023, I reviewed a meal refusal log, and it indicates that date of refusal, shift and reasonings. From 02/22/2023 to 03/20/2023, Resident A refused 19 meals for reasons such as; 'They don't have good food', 'He just don't want to eat', or "He doesn't like the portion size".

On 03/21/2023, I interviewed Staff, Misty Warczynski regarding the allegation. Ms. Warczynski informed that Resident A refuses to be taken care of and that he refused to take a shower yesterday and refused dinner last night. Resident A fired his wound care nurse, and he accused a staff member of hitting him on his day off.

On 03/21/2023, I interviewed Staff Briana Wallace regarding the allegation. Ms. Wallace informed that staff are taking care of Resident A as much as he allows them to. She gave Resident A a shower last week, washed his face and provided wound care. This Monday, Resident A refused a shower, and every time staff asks him if he wants to eat, he says, "No." Ms. Wallace goes in Resident A's room about 3 times a day to empty his catheter, give him snacks, assist him with his cellphone and adjust his heating pad. Ms. Wallace stated, "Most of the care that they try to give him, he refuses. He even fired his wound care nurse."

On 03/21/2023, I interviewed Resident A regarding the allegation. Resident A informed that the allegation is true, and that staff are not feeding or bathing him. Staff are assisting everyone else except for him. Resident A informed that he had to fire his wound care nurse because he was not doing anything for him. In my observation of Resident A, he was clean and did not smell of urine.

On 05/01/2023, I attempted to contact the wound care nurse, but the number was not working. Contacted the facility on two different occasions to obtain the correct number and they did not have any other number as of 05/11/2023.

On 05/03/2023, I interviewed A&D Waiver Staff, Julie Alerie regarding the allegation. Ms. Alerie informed that it is very difficult to determine if any of the allegations are true or not because Resident A is very manipulative. He is currently at Covenant Hospital, and they are trying to obtain a better placement for him, however; he is very difficult to place because of his behaviors. Ms. Alerie informed that there could be some truth to what he is saying because she has come to the facility after he called her to complain about room is dirty and he needed his face washed so he could see and be able to call people on his phone, and the room wasn't kept and his face wasn't washed, but because of his history of manipulation, he could of refused and then called someone to say that it wasn't being done. Resident A fired his most recent wound care nurse, and he has fired several of them in the past.

On 05/11/2023, I reviewed care plan for Resident A. It indicates that Resident A is to receive total care for personal hygiene and is a 2 person assist, with bathing being two times per week.

On 05/11/2023, I reviewed Resident A's Weight Record. Resident A moved in on 01/31/2023 and weighed 190 pounds. He weighed in at 190.04 on 02/04/2023. Resident A refused to weigh in March 2023. Resident A was discharged on 03/22/2023.

<b>APPLICABLE RULE</b>	
<b>R 400.15303</b>	<b>Resident care; licensee responsibilities.</b>
	<b>(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.</b>
<b>ANALYSIS:</b>	During my investigation, there was not enough evidence to establish a violation as Resident A has a history of manipulation. Everyone that works with him, he claims does not assist him with any of his needs. Staff have indicated that he refuses care and then make complaints that he is not being cared for. Resident A indicates that the allegations are true and that there aren't any competent workers available to assist him.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

Workers at the home have stolen video games, food, and drinks from Resident A.

**INVESTIGATION:**

On 03/21/2023, I interviewed Resident Care Coordinator, Johanna Rueda regarding the allegation. When Resident A was accepted to their home on 01/31/2023, they were not aware of his sexual inappropriate comments and his history of making allegations that people are stealing from him. Resident A has made several allegations that various items had been stolen out of his room. They are not aware of anyone stealing anything out of his room. Resident A had some friends that came to his room, and they moved a lot of items into his storage unit. She does not know if any of those items that he claims to be stolen are the items that were moved into the shed. She denies that staff are stealing food and snacks from Resident A as he often times refuses food.

On 03/21/2023, I interviewed Staff, Misty Warczynski regarding the allegation. Ms. Warczynski does not believe that are stealing anything out of his room. Resident A is very manipulative and will say things that are not true.

On 03/21/2023, I interviewed Staff Briana Wallace regarding the allegation. Ms. Wallace denied that staff are stealing food and other items out of his room. She often goes in his room to assist him and bring him snacks because he refuses a lot of meals. She was not aware that Resident A had a video game because he's a paraplegic and has very limited use of his hands to play a video game.

On 03/21/2023, I interviewed Resident A regarding the allegation. Resident A informed that his Nintendo Switch and 9 games were stolen out of his room, he had two cans of peanuts and now he only has one can, and similar things were going on in his previous home.

On 05/03/2023, I interviewed A&D Waiver Staff, Julie Alerie regarding the allegation. Ms. Alerie is not sure if any of his belongings have been stolen. She knows that his friends had came to his room and put a lot of his belongings in the storage unit.

On 05/03/2023, I received a copy of the police report. It indicates that the manager, Johanna Rueda provided the officer with an inventory form with all of Resident A's belongings. Also on the form, it states that Resident A had other belongings, but would not allow employees to go through them. Ms. Rueda denied stealing any of Resident A's belongings. There were 3 pages of inventory and Resident A is the only one with a key to his storage unit. A Nintendo Switch was listed on the Inventory Sheet. It is indicated on the inventory sheet that Resident A has 2 storage units that the facility does not have access to and per Resident A, staff were not able to go through those items and add them to his inventory sheet.

<b>APPLICABLE RULE</b>	
<b>R 400.15315</b>	<b>Handling of resident funds and valuables.</b>
	<b>(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.</b>
<b>ANALYSIS:</b>	During my investigation, I interviewed staff, Resident A and received a copy of the police report. Resident A had a Nintendo Switch on his Inventory Sheet. The facility indicated that Resident A had friends who moved many of his items in a storage unit that they do not have access to. Based on my interviews, there is no substantial evidence that any of Resident A's items were stolen from him.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

On 05/05/2023, an Exit Conference was held with Licensee, Jasween Jagjit-Webb regarding the allegations. She was informed that there would be no citations issued.

**IV. RECOMMENDATION**

I recommend that no changes be made to the licensing status of this large adult foster care group home (Capacity 1-20).



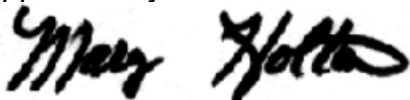
05/12/2023

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Anthony Humphrey  
Licensing Consultant

Date

Approved By:



05/12/2023

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Mary E. Holton  
Area Manager

Date