



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 5, 2023

Colleen Cassidy
Essence Memory Care II LLC
3910 Athens Ave
Waterford, MI 48329

RE: License #: AS630405613
Investigation #: 2023A0611020
Essence Memory Care II

Dear Ms. Cassidy:

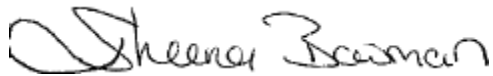
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,

A handwritten signature in black ink that reads "Sheena Bowman". The signature is fluid and cursive, with the first name "Sheena" and last name "Bowman" clearly legible.

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
CAUTION: THIS REPORT CONTAINS QUOTED PROFANITY**

I. IDENTIFYING INFORMATION

| | |
|---------------------------------------|--|
| License #: | AS630405613 |
| Investigation #: | 2023A0611020 |
| Complaint Receipt Date: | 04/24/2023 |
| Investigation Initiation Date: | 04/27/2023 |
| Report Due Date: | 06/23/2023 |
| Licensee Name: | Essence Memory Care II LLC |
| Licensee Address: | 3910 Athens Ave Waterford, MI 48329 |
| Licensee Telephone #: | (248) 308-9607 |
| Administrator: | Caroline Anderson |
| Licensee Designee: | Collen Cassidy |
| Name of Facility: | Essence Memory Care II |
| Facility Address: | 22208 Wingate Ct Farmington Hills, MI 48335 |
| Facility Telephone #: | (248) 308-9607 |
| Original Issuance Date: | 12/21/2020 |
| License Status: | REGULAR |
| Effective Date: | 06/21/2021 |
| Expiration Date: | 06/20/2023 |
| Capacity: | 6 |
| Program Type: | ALZHEIMERS AGED |

II. ALLEGATION(S)

| | Violation Established? |
|--|---------------------------|
| Staff are physically abusing the elderly dementia residents. Two women have been previously injured by staff. Resident L was hit by staff and was bruised. Staff admitted to hitting Resident L and calling her a "bitch". Staff lie to cover up how they treat residents. | No |
| Additional Findings | Yes |

III. METHODOLOGY

| | |
|------------|---|
| 04/24/2023 | Special Investigation Intake 2023A0611020 |
| 04/27/2023 | APS Referral Adult Protective Services (APS) referral, denied to investigate. |
| 04/27/2023 | Special Investigation Initiated - On Site I completed an unannounced onsite. I interviewed the home manager, Jessica Sims and staff member, Jasmine Wheeler. I observed Resident B's arms and I attempted to interview Resident L. |
| 05/03/2023 | Contact - Telephone call made I made a telephone call to the licensee designee, Colleen Cassidy. The allegations were discussed. |
| 05/03/2023 | Contact - Telephone call made I made a telephone call to a former employee by the name of Andrea Harrison. The allegations were discussed. |
| 05/04/2023 | Contact - Face to Face I made an unannounced onsite to Essence Memory Care located in Northville, MI. I observed Resident M and I interviewed the Administrator, Drita Aliatim. |
| 05/04/2023 | Exit Conference I completed an exit conference with the licensee designee, Colleen Cassidy via email. |

ALLEGATION:

Staff are physically abusing the elderly dementia residents. Two women have been previously injured by staff. Resident L was hit by staff and was bruised. Staff admitted to hitting Resident L and calling her a "bitch". Staff lie to cover up how they treat residents.

INVESTIGATION:

On 04/25/23, I received an intake regarding the abovementioned allegations. The allegations were reported by an anonymous source. The specific allegations are as follows: There are at least two women in the facility that have previously been injured by staff. One of the women is Resident L and the other is Resident M. Resident L was hit by a staff member and obtained a bruise. Resident L did not know how the bruise appeared due to her dementia. A staff member admitted to hitting Resident L and then calling Resident L a "bitch". On another occasion, staff failed to verbally direct Resident M to her room, instead, they just grab her and put her where she needs to be. Rather than communicate with the clients, staff often physically grab the clients and move them to where they need to go. If clients are bruised as a result of getting grabbed by staff, staff tell the clients they must have hit their hand (or other body part) on something which resulted in the bruising.

On 04/27/23, I completed an unannounced onsite. I interviewed the home manager, Jessica Sims and staff member, Jasmine Wheeler. I observed Resident B's arms and I attempted to interview Resident L.

On 04/24/23, I interviewed the home manager, Jessica Sims. Regarding the allegations, Ms. Sims denied any knowledge of any resident being abused. Ms. Sims has not observed any marks or bruises on any of the residents. There are no cameras in the AFC group home. Ms. Sims stated Resident L walks well however, she uses a walker. Resident L is not a fall risk. Ms. Sims is not aware of any staff member calling a resident any names and/or using any profane language. Ms. Sims stated all of the residents in the home have dementia. Ms. Sims denied any staff member grabbing a resident to move them. Ms. Sims stated Resident T is the only resident staff have to assist with walking. Resident T does use a walker. The staff will assist residents with getting up from a chair by lifting them up from the back of their pants.

On 04/27/23, I interviewed staff member Jasmine Wheeler. Ms. Wheeler has worked at the AFC group home on and off for two years. Regarding the allegations, Ms. Wheeler stated she has no knowledge of any staff member abusing a resident physically or verbally. Ms. Wheeler denied ever grabbing or causing a mark on a resident. Ms. Wheeler denied ever witnessing a staff member grabbing a resident, or harassing a resident, or causing a bruise on a resident. Ms. Wheeler stated Resident B has a bruise on one of her arms due to being on blood thinners which causes her skin to be overly sensitive. Ms. Wheeler stated the staff will assist residents with getting up from a chair

by grabbing the back of their pants or by lifting their arms. Ms. Wheeler stated the staff do not use any force when assisting a resident with getting up. Ms. Wheeler stated the staff will count to three and then assist with lifting the resident.

On 04/27/23, I observed Resident B sleeping in a chair in the living area along with the other residents. I observed Resident B's lower arms and did not see any marks or bruises. Ms. Wheeler stated Resident B's bruises come and go quickly. There were three other residents sleeping in the living area. I attempted to interview Resident L who was also sitting in the living area. Resident L stated she likes living at the AFC group home and the staff are nice people. Resident L could not remember what she ate for breakfast, and she stated she was 39 years old. The residents appeared cleaned, dressed appropriately and comfortable in the AFC group home.

On 05/03/23, I made a telephone call to the licensee designee, Colleen Cassidy. Regarding the allegations, Ms. Cassidy stated she has no idea where the allegations are coming from. Ms. Cassidy stated no staff member has reported any abuse concerning the residents. Ms. Cassidy stated she has recently terminated two employees in the beginning of April 2023. The first employee was fired for not receiving her fingerprints in a timely manner. The second employee was fired for having a history of calling off work on a monthly basis and not showing up to work without calling off. Ms. Cassidy denied having any issues with disgruntled employees.

Ms. Cassidy has not witnessed any marks or bruises on the residents. Resident L is capable walking on her own. Resident M uses a walker, and the staff walks behind her to ensure she doesn't fall backwards. Ms. Cassidy denied any knowledge of staff moving and/or forcing residents to move from one place to another. Ms. Cassidy stated her staff members are really good. Ms. Cassidy denied any knowledge of staff using profane language or calling the residents any names.

On 05/03/23, I made a telephone call to former staff member, Andrea Harrison. Regarding the allegations, Ms. Harrison stated she worked for the AFC group home for one week. Ms. Harrison was fired. Ms. Harrison stated she thinks she was fired due to Resident B eloping from the AFC group home. Ms. Harrison stated the police were called and Resident B was found. Ms. Harrison stated this incident occurred in April 2023. Ms. Harrison denied any other issues while she was working at the AFC group home. Ms. Harrison stated none of the residents were being abused by the staff members. Ms. Harrison stated the staff were nice to the residents. Ms. Harrison denied any staff member using profanity or calling any resident names. Ms. Harrison denied abusing or using profanity towards the residents as well.

On 05/04/23, I made an unannounced onsite to Essence Memory Care located in Northville, MI. I observed Resident M and I interviewed the Administrator, Drita Aliatim. There are residents in the home who are positive with COVID-19. Resident M was observed sitting outside in the backyard. Resident M is currently recovering from COVID-19. Resident M has dementia and was unresponsive to me. Resident M

appeared well-groomed and comfortable. There were no marks or bruises observed on Resident M.

On 05/04/23, I interviewed the Administrator Drita Aliatim. Ms. Aliatim became the Administrator on 05/01/23. Prior to Ms. Aliatim promotion, she was a direct care staff. Regarding the allegations, Ms. Aliatim stated Resident M was ambulatory with the use of a walker. However, since Resident M tested positive for COVID-19, her health has declined and now she is no longer ambulatory. The staff have to count to three to lift Resident M up from one spot and sit her back down in another spot. Resident M has a consultation with hospice today.

Ms. Aliatim stated she never worked at Essence Memory Care II when she was a direct care staff. However, Ms. Aliatim visited this home yesterday and her goal is to visit 3-4 times a week. Ms. Aliatim denied knowledge of any staff member at this home physically abusing the residents, using profanity, or displaying any inappropriate behavior towards the residents.

| 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: | Based on the information above, there is not sufficient information to confirm any resident at the AFC group home has been physically abused or not protected. There were no marks or bruises observed on Resident L or Resident M. Resident L stated she likes living at the AFC group home and the staff are nice. |
| CONCLUSION: | VIOLATION NOT ESTABLISHED |

ADDITIONAL FINDINGS:

INVESTIGATION:

On 04/24/23, I interviewed the home manager, Jessica Sims. Regarding the allegations, Ms. Sims stated Resident M was discharged from the AFC group home in the beginning of April 2023. Ms. Sims stated there was no specific reason as to why Resident M was discharged from the AFC group home. Resident M has dementia, and she is not capable of being interviewed. Ms. Sims was unsure of Resident M's exact discharge date. The resident register in the home was not accurate as it was not current nor was it being maintained in chronological order. Ms. Sims had to contact someone on the

phone to obtain Resident M's discharge date which was 03/19/23. Resident M was admitted into another AFC group home located in Northville, MI (Essence Memory Care) within the same corporation. Ms. Sims stated Resident M's file was transferred to the new AFC group home and none of her records were kept in the home she was discharged from. I explained to Ms. Sims the requirement of maintaining a resident register. I also explained to Ms. Sims that each AFC group home is assigned an individual license and you cannot transfer records assigned to one license AFC group home to another license AFC group home.

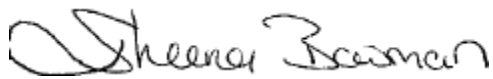
On 05/04/23, I completed an exit conference with the licensee designee, Colleen Cassidy via email. Ms. Cassidy was informed the allegations will not be substantiated but the additional information gathered during the investigation will be substantiated.

| APPLICABLE RULE | |
|------------------------|--|
| R 400.14210 | Resident register. |
| | A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident: (a) Date of admission. (b) Date of discharge. (c) Place and address to which the resident moved, if known. |
| ANALYSIS: | During the onsite on 04/24/23, it was discovered that the AFC group home is not maintaining a chronological register of the residents who are admitted and discharged from the home. |
| CONCLUSION: | VIOLATION ESTABLISHED |

| APPLICABLE RULE | |
|------------------------|--|
| R 400.14316 | Resident records. |
| | (2) Resident records shall be kept on file in the home for 2 years after the date of a resident's discharge from a home. |
| ANALYSIS: | During the onsite on 04/24/23, it was discovered that Resident M was discharged from the AFC group home on 03/19/23 however; her file is not being kept in the home. |
| CONCLUSION: | VIOLATION ESTABLISHED |

IV. RECOMMENDATION

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

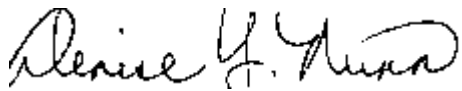


Sheena Bowman
Licensing Consultant

05/04/23

Date

Approved By:



06/05/2023

Denise Y. Nunn
Area Manager

Date