GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 27, 2023

Sally Londry
S & D Senior Living Home
1359 S. Colling Rd.
Caro, MI 48723

RE: License #: AM790388202
Investigation #: 2023A0572038
S&D Senior Living Home

Dear Sally Londry:

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 (517) 643-7960.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM790388202
Investigation #:	2023A0572038
Complaint Receipt Date:	05/02/2023
Investigation Initiation Date:	05/02/2023
Report Due Date:	07/01/2023
Licensee Name:	S & D Senior Living Home
Licensee Address:	1359 S. Colling Rd. Caro, MI 48723
Licensee Telephone #:	(989) 286-3711
Administrator:	Brooke Londry
Licensee Designee:	Sally Londry
Name of Facility:	S&D Senior Living Home
Facility Address:	1359 S. Colling Rd. Caro, MI 48723
Facility Telephone #:	(989) 286-3711
Original Issuance Date:	10/18/2018
License **Status:**	REGULAR
Effective Date:	04/18/2023
Expiration Date:	04/17/2025
Capacity:	10
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
On 5/01/23, Resident A reported that on 04/30/2023 @ 1:14 am, she inserted an object in her rectum. The object was currently still inserted and was causing her significant pain. Resident A indicated that she requested medical attention from her guardian and home staff but was denied and was told that she was lying about inserting.	Yes
Additional findings	Yes

III. METHODOLOGY

05/02/2023	Special Investigation Intake 2023A0572038
05/02/2023	Special Investigation Initiated - Telephone
05/02/2023	APS Referral Open to Tuscola County MDHHS
05/17/2023	Inspection Completed On-site Licensee Designee, Sally Londry, and various residents.
06/26/2023	Exit Conference Face to face exit conference with Licensee Sally Londry
06/27/2023	Inspection Completed On-site Interviewed Licensee Sally Londry, observed residents in the facility.
06/27/2023	Contact - Telephone call made Telephone call to Guardian A1, left message
06/27/2023	Contact - Telephone call made Telephone call to Case Manager Allison Learman
06/27/2023	Contact -Telephone call made Telephone call to Licensee Sally Londry

ALLEGATION:
Resident A reported that on 05/01/2023 that on 04/30/2023 @ 1:14 am, she inserted an object in her rectum. The object was currently still inserted and was causing her significant pain. Resident A indicated that she requested medical attention from her guardian and home staff but was denied and was told that she was lying about inserting.

INVESTIGATION:
On June 26, 2023, I conducted an unannounced onsite investigation and interviewed Licensee Sally Londry. Licensee Londry indicated Licensing Consultant Anthony Humphrey along with Adult Protective Service Worker Tyler Earl previously conducted an onsite investigation regarding this allegation. Upon review of the licensing file for this facility, the previous special investigation with Anthony Humphrey did not include the above allegation.

Licensee Londry indicated Resident A is no longer living in the facility. Licensee Londry reported that on May 1, 2023, she knew nothing about Resident A inserting an object in her rectum. Resident A handed her a letter and that is how she found out about her possibly inserting something in her rectum. Licensee Londry provided me a copy of the letter and it indicates "I just want to confess to you that I did south harm in the middle of the night. I was wonder if either you or I call her. I really to tell her everything it take the emotional pain away for a long time today. I was deeply down in depression last night. I was having all kinds of thought, so I finally snapped then the self-harm happened. When I was telling it was an emergency, I was being serious. I was all run tell you guys the truth." Licensee Londry said Guardian A1 does not want Resident A "always going to the hospital." Licensee Londry indicated Resident A told her that she "felt like doing something" but did not self-harm herself. Guardian A1 told Licensee Londry not to take Resident A to the emergency room.

Licensee Londry said she immediately called Guardian A1 and advised her of what Resident A had said. Guardian A1 came over within ten minutes and Resident A told her that she was fine. When Resident A got up Monday, she used the phone and called Case Manager Allison. Resident A told Case Manger Allison that she inserted something into her rectum and Case Manager took her to the emergency room. The examining doctor wrote a report dated 05/10/2023, "Regarding [Resident A], perforation through the rectal mucosa would cause a wound that would take weeks if not months to heal. It is not known how long the needle has been in her perineum, but it was not inserted the day before she was taken to the emergency room as evidence any the surgeon's report."

On June 26, 2023, I observed several residents in the facility. They were all clean and appeared to be receiving adequate care.

On June 27, 2023, I telephoned Resident A's Case Manager Allison Learman. Ms. Learman indicated Resident A told her that she inserted the object on April 29th. Ms. Learman stated she did take Resident A to the emergency room and the doctor

reported the object had been inserted in her rectum “longer than a day.” Ms. Learman stated Resident A “was frustrated with the home.” Ms. Learman did not know if it was the facility putting restrictions on Resident A or if it was the guardian. Ms. Learman indicated Resident A is going to be placed in a more restrictive AFC home.

As of this typing, I have not received a return telephone call from Guardian A1.

Licensee Londry indicated Resident A would not shower for 8-9 days and Guardian A1 told her she could not leave the facility unless she showered. Guardian A1 did not take Resident A to the emergency room because she had not showered. Sally Londry reported Resident A was sponge bathing daily.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Resident A advised Licensee Sally Londry that she did self- harm herself. Licensee Londry did not take Resident A to the emergency room. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On June 27, 2023, I telephone Licensee Sally Londry and asked if an *AFC Licensing Division – Incident/Accident Report* had been completed regarding Resident A going to the emergency room. Licensee Londry indicated she did not know that she had to complete one.

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:	Licensee Sally Londry said she did not complete an *AFC Licensing Division – Incident/Accident Report* regarding the emergency room visit Resident A had on May 1, 2023. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On June 27, 2023, I conducted a telephone exit conference with License Sally Londry. Sally Londry was informed of the findings of this investigation.

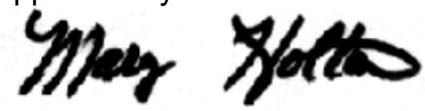
IV. RECOMMENDATION

Continent upon receipt of an acceptable plan of correction, I recommend continuation of the current status of the license of this AFC adult medium group home (capacity 7-12).

06/27/2023

Kathryn A. Huber Date
Licensing Consultant

Approved By:



06/27/2023

Mary E. Holton Date
Area Manager