GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 17, 2023

Saundra Williams-Sulaiman
Golden Residential Facility LLC
1912 Cambridge Drive
Kalamazoo, MI 49001

RE: License #: AS390394619
Investigation #: 2023A0581038
Golden Residential Facility LLC

Dear Mrs. Williams-Sulaiman:

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) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390394619
Investigation #:	2023A0581038
Complaint Receipt Date:	05/25/2023
Investigation Initiation Date:	05/26/2023
Report Due Date:	07/24/2023
Licensee Name:	Golden Residential Facility LLC
Licensee Address:	1912 Cambridge Drive Kalamazoo, MI 49001
Licensee Telephone #:	(269) 365-0002
Administrator:	Saundra Williams-Sulaiman
Licensee Designee:	Saundra Williams-Sulaiman
Name of Facility:	Golden Residential Facility LLC
Facility Address:	1912 Cambridge Drive Kalamazoo, MI 49001
Facility Telephone #:	(269) 365-0002
Original Issuance Date:	05/15/2020
License Status:	REGULAR
Effective Date:	11/15/2022
Expiration Date:	11/14/2024
Capacity:	2
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff, Donna Nix, brings her husband to work with her.	No
Resident A's medications, vitamins and over the counter medications are not being secured.	Yes
Initials of direct care staff who administer medications are not entered at the time medication is administered.	Yes
Direct care staff are not safeguarding resident medications.	Yes
Resident A is not offered breakfast and there is no fruit, vegetables, or milk in the facility.	No
Menus are not being updated.	Yes
The licensee is not providing hand soap or toilet paper to Resident A.	Yes
There are chemicals in the facility bathroom accessible to Resident A.	Yes
A window screen on the front of the facility was popped out of the window and broken.	Yes
The facility is keeping spoiled food and not properly storing food.	Yes
The facility's refrigerator is uncleaned and unkempt.	Yes
The facility was in disarray and uncleaned.	Yes
Facility staff are not providing Resident A with the supervision required by his Individual Plan of Service.	No

III. METHODOLOGY

05/25/2023	Special Investigation Intake 2023A0581038
05/26/2023	Contact – Telephone call made Interview with Complainant.
05/26/2023	Referral - Recipient Rights ISK is already investigating; therefore, no referral is necessary.
05/26/2023	Special Investigation Initiated - Telephone Interviewed Integrated Services of Kalamazoo, Recipient Rights Officer, Suzie Suchyta.
05/26/2023	Contact – Document Received Email from Complainant.
05/26/2023	Contact - Document Received

	Emails from Ms. Suchyta
05/26/2023	APS Referral Made via email
05/30/2023	Contact - Document Received Received email indicating APS denied complaint for investigation.
05/31/2023	Inspection Completed On-site Interviewed staff, Resident A, observed facility and obtained resident documentation.
05/31/2023	Contact - Telephone call made Interview with licensee designee, Saundra Williams-Sulaiman.
05/31/2023	Contact - Telephone call made Interview with Ms. Suchyta.
05/31/2023	Inspection Completed-BCAL Sub. Compliance
05/31/2023	Exit Conference with licensee designee, Saundra Williams - Sulaiman via telephone.
06/08/2023	Contact – Document Received Received additional allegations.
06/08/2023	Contact – Document Sent Email correspondence with Ms. Suchyta.
06/22/2023	Contact – Document Received Received additional allegations.
06/22/2023	Contact – Document Sent Email correspondence with Ms. Suchyta.
06/23/2023	Inspection Completed On-site No one was home, unable to enter facility.
06/26/2023	Inspection Completed On-site- Interviewed staff and Resident A.
06/26/2023	Contact – Document Sent Email correspondence with Ms. Suchyta.
07/14/2023	Exit conference with Licensee Designee, Saundra Williams-Sulaiman, via telephone.

ALLEGATION:

Direct care staff, Donna Nix, brings her husband to work with her.

INVESTIGATION:

On 06/22/2023, Complainant alleged on 06/22/2023 direct care staff, Ms. Nix's husband, who is not a staff, came into the facility and was in the living room with Resident A.

On 06/22/2023, I confirmed with Integrated Services of Kalamazoo (ISK) Recipient Rights Officer (RRO), Suzie Suchtya, she was aware of the allegations. Ms. Suchyta report to me was consistent with the allegations.

On 06/26/2023, I conducted an unannounced inspection at the facility and interviewed direct care staff, Chandra Williams, and Resident A. Ms. Williams stated Ms. Nix's husband was not a direct care staff. She stated Ms. Nix's husband drops Ms. Nix off at the facility for her shifts and picks her back up, but he also often sits in the vehicle during pickups and drop offs. Ms. Williams stated if Ms. Nix's husband does come in, he's not accessing resident records or completing any direct care work.

Resident A stated he may talk briefly with Ms. Nix's husband, but he primarily stays in his room. Resident A did not express or report any concerns with Ms. Nix's husband. He also did not report Ms. Nix's husband was acting in the capacity of a staff.

On 07/13/2023, I interviewed direct care staff, Donna Nix. Ms. Nix's statement to me was consistent with Ms. Williams' statement to me. Ms. Nix stated her husband has also occasionally mowed the facility's lawn. She denied her husband spending significant time around any residents or having direct access to resident records or personal information. She stated her husband was not a direct care staff.

Ms. Williams-Sulaiman's statement to me was consistent with Ms. Williams' and Ms. Nix's statements to me.

APPLICABLE RULE	
R 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.

ANALYSIS:	Based on my interviews with direct care staff, Chandra Williams and Donna Nix, Resident A, and the licensee designee, Ms. Williams-Sulaiman, there is no evidence direct care staff, Donna Nix's, husband is acting in the capacity of a direct care staff. Subsequently, due to Ms. Nix's husband not acting in the capacity of a direct care staff or having direct access to resident records, there is no need for him to obtain fingerprints. At the conclusion of my investigation, all my interviews were consistent in that Ms. Nix's husband is providing Ms. Nix with transportation to and from work and is spending minimal time within the facility around Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's medications, vitamins and over the counter medications are not being secured.

INVESTIGATION:

On 05/22/2023, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged on or around 05/25/2022, there had been a single use packet of Theraflu on a living room table.

On 05/25/2023, I interviewed Complainant. Complainant's statement to me was consistent with the allegations. Complainant stated forwarded me a picture taken of a single use packet of Over the Counter (OTC) Theraflu, nighttime severe cold and cough medicine that was observable on the facility's living room table.

On 05/31/2023, I conducted an unannounced inspection and observed an empty single use packet of Theraflu on the living room table.

On 06/08/2023, I received additional allegations alleging over the counter (OTC) medications and vitamins were being kept in Resident A's bedroom rather than being secured.

On 06/08/2023, Complainant confirmed the allegations and provided picture documentation showing OTC Acetaminophen and Melatonin in Resident A's bedroom.

On 06/26/2023, I conducted an unannounced inspection at the facility. I observed a bottle of OTC Acetaminophen 500 mg, multiple bottles of dietary supplements including Magnesium 500 mg, Super B Complex with Vitamin C, Zinc 50 mg, Melatonin 5 mg, a bottle of Saline Nasal Spray, and a bottle of Antacid Tablets unsecured throughout Resident A's bedroom.

Direct care staff, Chandra Williams, stated Resident A purchases vitamins and OTC medications while he's out in the community and then brings them back to the facility. She stated his relatives use the cell phone application, Cash App, to give him money, which he uses to purchase the medications. Ms. Williams stated staff removed similar medications from his bedroom a couple of weeks ago, but stated he must have purchased more. She stated she would remove the medications from his bedroom and acknowledged understanding the need for them to be secured and only administered by direct care staff.

Resident A's statement to me was consistent with Ms. Williams' statement to me.

On 07/14/2023, I interviewed Ms. Williams-Sulaiman, via telephone. I discussed with Ms. Williams-Sulaiman about potentially getting a physician's order or statement approving Resident A to administer his medication. I informed her the order/statement must be available in Resident A's record, and approval must be addressed in Resident A's assessment plan. I also discussed that although Resident A may administer his medications unsupervised, she has a responsibility to safeguard the medication and to remind Resident A to maintain his medication schedule, as directed by Resident A's physician.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	Facility direct care staff are not securing over the counter medication and dietary supplements as a single use packet of Theraflu medicine, Acetaminophen 500 mg, Magnesium 500 mg, Super B Complex with Vitamin C, Zinc 50 mg, Melatonin 5 mg, a bottle of Saline Nasal Spray, and a bottle of Antacid Tablets were observed in both the facility's living room and in Resident A's bedroom on multiple occasions in May and June 2023. OTC medications and dietary supplements are required to be in a locked cabinet or drawer.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Initials of direct care staff who administer medications are not entered at the time medication is given.

INVESTIGATION:

The complaint alleged Resident A's Medication Administration Record (MAR) was not being initialed by direct care staff, Abdulsamad Sulaiman, after he passes Resident A's morning medications. The complaint alleged Mr. Sulaiman completes the MAR at the end of his shift.

Complainant's statement to me was consistent with the allegations. I reviewed pictures provided by Complainant showing on or around 05/25/2023, Mr. Sulaiman did not initial Resident A's MAR indicating his morning medications had been administered.

During my unannounced inspection, I interviewed Mr. Sulaiman. Mr. Sulaiman stated he passed Resident A's morning medications, which were administered at approximately 8 am. He stated that despite administering the medications that morning, he doesn't initial or complete the MAR until the end of his shift. I instructed Mr. Sulaiman he needs to initial a resident's MAR after he administers a resident's medication instead of waiting until the end of his shift.

I reviewed Resident A's MAR during my unannounced inspection, which took place at approximately 8:45 am. According to my review of the MAR, Mr. Sulaiman did not initial for any of Resident A's morning medications including Eliquis 5 mg, Escitalopram Oxalate 10 mg, and Vitamin D High Potency 1000unit.

Resident A did not indicate any concerns with not receiving his medication, as required.

Ms. Williams-Sulaiman stated she would inform direct care staff to initial the MARs after they administered resident medication.

On 06/08/2023, Complainant stated Resident A's evening medications were not initialed and signed for on 06/05 and 06/07. Complainant again stated direct care staff were reporting the medications had been administered despite staff initials not being on the MAR. Complainant provided picture documentation of the MAR showing staff missing staff initials.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Direct care staff, Abdulsamad Sulaiman, stated he waits until the end of his shift to initial Resident A's Medication Administration Record (MAR) rather than at the time the medication is administered, which is required. Resident A's May and June MAR were reviewed on multiple occasions after medications were administered; however, they were not initialed documenting they had been administered, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Direct care staff are not safeguarding resident medications.

INVESTIGATION:

The complaint alleged on or around 05/25/2023, the facility's medication cabinet was observed with the medication cabinet keys in the lock. It was also alleged direct care

staff are keeping the facility's medication cabinet keys in an unlocked box directly under the medication cabinet when the keys are not being utilized.

Complainant's statement to me was consistent with the allegations. Complainant forwarded me a picture of the medication keys in the keyhole of the medication cabinet.

Direct care staff, Donna Nix, and Mr. Sulaiman, both stated the facility's medication cabinet keys are kept in an unlocked pull-out drawer beneath the medication cabinet. Ms. Nix stated she stored the keys this way since she started in the middle of April 2023. I explained to both Ms. Nix and Mr. Sulaiman they needed to safeguard the medications by keeping the medication keys on their persons as anyone, including the residents, could access the unlocked drawer with the medication cabinet keys.

Ms. Williams-Sulaiman stated direct care staff are now expected to always keep the key to the medication cabinet on his or her person rather than in the cabinet or in a place easily accessible to Resident A or someone else.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	The facility's medication cabinet keys were being stored in an unlocked and unsecured pull-out drawer beneath the medication cabinet, allowing anyone, including residents, with direct access to resident medication. Consequently, the licensee was not taking reasonable precautions to ensure resident medications were safeguarded and used or accessed by anyone.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **Direct care staff are not feeding Resident A.**
- **There are no fruit or vegetables in the facility.**
- **Resident A is not offered breakfast.**
- **There is no milk in the facility.**

INVESTIGATION:

Aside from the aforementioned allegations, the complaint also alleged Resident A was receiving food from a local pantry, Loaves and Fishes, because direct care staff were not feeding him.

I reviewed pictures taken by Complainant of the facility's refrigerator contents and countertops. According to my review of these pictures, the facility had vegetables like onions and sweet potatoes for consumption.

During my inspections, I observed canned vegetables in the facility's pantry consisting of corn, mixed greens, and tomatoes. I also observed an orange in the facility's refrigerator and milk; however, there were no additional fruits or vegetables in the facility. I also observed grains and milk products such as milk, yogurt, and cheese as well as bread and pasta. Ms. Williams stated additional fruit and vegetables are purchased when staff or the licensee designee, Saundra Williams, go grocery shopping.

Ms. Williams stated facility staff provide meals to Resident A, including breakfast; however, he often complains he does not like what they make. Ms. Williams stated Resident A may not be awake when breakfast is served, but it will be available for him to eat at the time he gets up.

Ms. Williams also stated Resident A has gotten meals delivered from Loaves and Fishes, a local grocery pantry program that provides meals to those in need. Ms. Williams stated while Resident A is out in the community he will stop at Loaves and Fishes or calls them and request the meals, which they deliver to the facility. She stated 4-5 prepared meals are delivered at a time, which Resident A consumes over a couple of days.

Though there was no current menu in the facility, I reviewed past menus, which documented a variety of foods being served to Resident A, including fruits, vegetables, meats, grain products and milk products, as required by the food pyramid.

Ms. Williams stated milk is provided to Resident A; however, she stated staff will make his milk using powdered milk so that he's not accessing an entire gallon at one time. Ms. Williams stated Resident A will consume an entire gallon of milk within a couple of hours and become sick. Ms. Williams showed me the powdered milk in the pantry. I also observed a small container of milk that had been created using powdered milk, which was available to Resident A for cereal.

Resident A confirmed he requests meals through Loaves and Fishes while in the community. He stated that while staff do cook for him, he often doesn't like what they cook and prefers the food from Loaves and Fishes. Resident A was unable to provide specifics in terms of what he didn't like about the food staff were making him. Resident A reported he had "some sort of meat and green beans" for dinner the night before. He stated he has had fruits and vegetables served to him for various meals. Resident A stated he often sleeps in and may not eat breakfast or doesn't want breakfast.

Ms. Nix's statement to me was consistent with Ms. Williams' statement to me. She stated there is food in the facility. She stated fresh fruit and vegetables are in the home, but Resident A will eat all of them right away. She stated Resident A requests food from Loaves and Fishes when he's experiencing delusions as he will accuse staff of feeding him dog food and trying to poison him.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on my interviews with Resident A and direct care staff, there is no evidence supporting the licensee is not providing Resident A with 3 regular meals a day, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(2) Meals shall meet the nutritional allowances recommended pursuant to the provisions of "Appendix I: Recommended Dietary Allowances, Revised 1980" contained in the publication entitled "Basic Nutrition Facts: A Nutrition Reference," Michigan Department of Public Health publication no. 11-808, 1/89. This publication may be

	obtained at cost from the Division of Research and Development, Michigan Department of Public Health, P.O. Box 30195, Lansing, Michigan 48909.
ANALYSIS:	Based on my interviews with direct care staff, Resident A, my review of pictures taken by Complainant and my own observations, the licensee has the required dietary allowances available to Resident A, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Menus are not being updated.

INVESTIGATION:

The complaint alleged menus are not being updated or reflecting what is being served.

During my 06/26/2023 inspection, I observed menus; however, there was no menu for the current week. Ms. Williams was unable to provide an explanation why there was no menu for the week. She stated if there aren't items in the facility to create the meals on the menu then she will make meals based on what is in the refrigerator and then update the menu to reflect this change. Of the menus Ms. Williams provided to me, which some had dates, and some did not, there were meals that had been updated to reflect the meal that served.

Ms. Nix stated menus are kept on refrigerator and are updated, as required.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	At the time of my 06/26/2023 inspection, there was no menu available for the upcoming week, as required. Upon my review of the previous menus direct care staff, Chandra Williams, provided, it appeared they were being updated to reflect what was actually served.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The licensee is not providing hand soap or toilet paper to Resident A.

INVESTIGATION:

Complainant stated toilet paper and hand soap were not observed in the facility on 06/08/2023.

During both my unannounced inspections at the facility I observed toilet paper and hand soap available to Resident A.

Ms. Williams and Ms. Nix both stated hand soap and toilet paper are available in the home and if either item runs out then it's replenished as soon as possible.

Ms. Williams-Sulaiman stated she has reminded and instructed staff to contact her if the facility is running low on toilet paper or hand soap.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	At the time of my onsite inspections, toilet paper and hand soap were available for Resident A's personal hygiene needs, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There are chemicals in the facility bathroom accessible to residents.

INVESTIGATION:

The complaint alleged there were bathroom chemicals accessible to residents.

On 06/08/2023, Complainant provided a picture of the chemical accessible to residents, which was identified as "Comet Ultra Bathroom Spray Lavender".

On 06/08/2023, I reviewed this cleaner's product details, product usage, warnings, storage and disposal, and ingredient list on www.cometcleaner.com. According to my review of this information, the cleaner presents "HAZARDS TO HUMANS AND

DOMESTIC ANIMALS CAUTION: KEEP OUT OF REACH OF CHILDREN AND PETS". It also identified "mild eye irritation" if contact was made with the eyes. Additional warnings included, "MAY BE HARMFUL IF SWALLOWED" and to not mix with household products containing chlorine-type bleaches or with mildew stain removers because "dangerous fumes may result".

During my 06/26/2023 inspection, I did not observe any chemicals accessible to residents within the facility, including the bathroom. Direct care staff, Ms. Williams, stated all chemicals were kept in the facility's basement.

On 07/13/2023, direct care staff, Donna Nix, also stated chemicals are kept in the facility's basement. She stated there had been on incident where chemicals were accessible in the facility's bathroom because she had forgotten to put them away after she was finished cleaning.

APPLICABLE RULE	
R 400.1401	**Environmental health.**
	(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.
ANALYSIS:	Based on my review of the pictures sent by Complainant and my own observations, confirmed a bathroom cleaner, Comet Ultra Bathroom Spray Lavender, was in the facility's bathroom accessible to residents. Consequently, the caustic cleaner was not being stored and safeguarded in non-resident and non-food preparation storage areas, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

A window screen on the front of the facility was popped out of the window and broken.

INVESTIGATION:

Complainant provided a picture of the facility's front window. Upon my review of the picture, it was evident the screen was popped out of the window and the bottom of the screen frame was broken. The picture also showed the screen was being used for ventilation as the window was open.

On 06/23/2023, I conducted an unannounced inspection at the facility; however, no one was home to answer the door. I observed the left front window screen to have a hole in the bottom left side of the screen, which was approximately two inch wide by

one inch in height. I also observed the screen to the right of the front steps to have an approximate four-inch gash in the center of the screen.

On 07/13/2023, Ms. Nix stated the screens had been repaired.

APPLICABLE RULE	
R 400.1401	**Environmental health.**
	(7) Each habitable room shall have direct outside ventilation by means of windows, louvers, air-conditioning, or mechanical ventilation. During fly season, from April to November, each door, openable window, or other opening to the outside that is used for ventilation purposes shall be supplied with a standard screen of not less than 16 mesh.
ANALYSIS:	Based on my review of the pictures sent by Complainant and my own observations, the facility utilizes the front windows for ventilation, however, the screens on the front of the facility were broken, in disrepair and had observable holes and gashes in them.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **Take out food is being left out overnight.**
- **There are rotting sweet potatoes on top of the refrigerator.**
- **Leftovers in the fridge are uncovered and undated.**

INVESTIGATION:

The complaint alleged facility direct care staff are leaving food in old takeout containers on the living room table overnight, there is rotting sweet potatoes on top of the refrigerator, and leftovers are being kept in the refrigerator uncovered and undated.

On 05/26/2023, Complainant forwarded me pictures of the takeout containers on the living room table.

During my 05/31/2023 inspection, I observed pizza take out boxes on the living room table with food still in them. Direct care staff, Jaylen Jones, stated they were his pizza boxes and upon leaving the home he planned to take the leftovers with him. At

the time of the inspection, I informed Mr. Jones and Ms. Nix any leftover food needed to covered and placed in the refrigerator to prevent contamination.

On 06/08/2023, Complainant forwarded me pictures of rotting sweet potatoes observed at the facility. The sweet potatoes, which were still in their produce bag, appeared shriveled and soft looking. Additionally, Complainant provided a picture of an uncovered cooked pork chop in a storage container within the refrigerator.

During my 06/26/2023 inspection, I observed regular potatoes on top of the refrigerator that were soft and appeared not suitable for eating; despite, Ms. Williams stating food that is spoiled or rotten is thrown away. Upon looking in the refrigerator, I observed an opened package of hotdogs, exposing the hotdogs to contamination.

Ms. Nix stated she checks fruit and vegetables regularly. She stated if Resident A doesn't like a fruit or vegetable then he won't eat it, or she'll throw it away. Ms. Nix stated she wasn't aware of leftovers being put away uncovered, undated, or left out. She stated she usually prepares the food, so she makes sure the leftovers are taken care of properly.

APPLICABLE RULE	
R 400.1402	**Food service.**
	(1) All food shall be from sources that are approved or considered satisfactory by the department and shall be safe for human consumption, clean, wholesome and free from spoilage, adulteration, and misbranding.
ANALYSIS:	Based on my review of the pictures sent by Complainant and my own observations, facility direct care staff were leaving leftovers out instead of refrigerating them, which does not protect them against spoilage. Additionally, potatoes in the facility appeared rotten due to their soft and wrinkled appearance. Subsequently, there was food observed in the home on multiple occasions that that did not appear safe for human consumption.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1402	**Food service.**
	(2) All food shall be protected from contamination while being stored, prepared, or served and during transportation to a facility.

ANALYSIS:	Leftover food was not being stored in covered containers, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility's refrigerator is uncleaned and unkempt.

INVESTIGATION:

Complainant provided a picture of the facility's refrigerator showing the refrigerator's shelves were not cleaned as there was observable grime indicating a liquid had spilled and hardened on the shelves.

When I conducted my 06/26/2023, there appeared to an improvement of the condition of the inside of the refrigerator as the majority of the grime and hardened liquid had been removed from the shelves; however, some hardened liquid remained on the front of the shelves and near the back of the shelves.

Ms. Nix stated she wipes the inside of the refrigerator out every Sunday and "deep cleans" it once a month.

In my review of the facility record, I determined this is a repeat violation of Adult Foster Care (AFC) licensing rule, R 400.1402(4). According to Renewal Licensing Study Report, 10/31/2022, the facility was in violation of AFC rule 400.1402(4) when it was established the facility's refrigerator needed to be cleaned due to observable encrusted food/liquid and debris on the shelves. The facility's approved Corrective Action Plan (CAP), dated 11/2022, stated the licensee designee would clean the refrigerator out every couple weeks to ensure it stayed clean.

APPLICABLE RULE	
R 400.1402	**Food service.**
	(4) All food service equipment and utensils shall be constructed of material that is nontoxic, easily cleaned and maintained in good repair. All food services equipment and eating and drinking utensils shall be thoroughly cleaned after each use.

ANALYSIS:	Based on my review of the pictures provided by Complainant and my own observations of the refrigerator from 06/26/2023, there is evidence the facility's refrigerator was not clean, as required.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[SEE RENEWAL LICENSING STUDY REPORT, DATED 10/31/2022, CAP DATED 11/2022]**

ALLEGATION:

The facility was in disarray and uncleaned.

INVESTIGATION:

The complaint alleged on or around 05/25/2023, the facility was "filthy." The complaint alleged the floors were covered in significant debris, the bathroom sink was covered in hair, there was garbage on the bathroom floor, the tub had observable dirt in it, the kitchen had dirty pots and pans on the stove with hardened food in them, the sink was overflowing with dirty dishes, there was a bowel of chicken bones in the kitchen counter and there were old take-out boxes on the living room table.

Complainant provided pictures, which were consistent with the allegations.

During my inspection, I observed observable dirt and debris on the facility's kitchen, living, and bathroom floors. The facility's kitchen sink was empty with clean dishes drying on a drying rack. I did not observe any pots and pans on the facility's kitchen stove; however, the top of the stove had observable debris on it. The bathroom toilet also had a rust ring in the toilet bowl. The bathroom sink and tub appeared to have been recently clean. Additionally, there were two leftover pizza boxes on the living room table, which Mr. Sulaiman indicated was from overnight direct care staff, Jaylen Jones', dinner the night before. I informed Mr. Sulaiman that leftovers should be dated and refrigerated.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.

ANALYSIS:	On 05/25/2023 and 05/23/2023, multiple rooms within the facility were observed to be dirty and in need of cleaning. The facility's floors had observable dirty and debris on them, the bathroom sink and tub had observable dirt and loose hair on them while the toilet had a rust ring in it. Dirty pots and pans, with hardened food, as well as leftover take out boxes were also observed. The facility's housekeeping standards did not present in a comfortable, clean, and orderly appearance, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility staff are not providing Resident A with the supervision required by his Individual Plan of Service.

INVESTIGATION:

Complainant stated Resident A's Individual Plan of Service (IPOS) states Resident A is to have enhanced staffing and that the staff is to accompany Resident A in the community. Complainant stated the enhanced staff member, Donna Nix, reported she does not go out with Resident A in the community because she does not like to.

At the time of my 06/26/2023 inspeciton, Resident A was not intially in the facility because Ms. Williams stated he went to the store. Ms. Williams stated Resident A was allowed to be in the community by himself without staff supervision. She stated he requires 1:1 supervision while he is in the home. She stated staff do not go with him while he's out in the community.

Resident A stated he's allowed to be out in the community by himself without staff supervision. He stated he often goes to the store in the morning by himself. Resident A stated staff are always in the facility with him.

Ms. Nix stated Resident A doesn't have any specific supervision requirments while he's in the community. She stated he has "full access to community" without staff supervision. She stated he's always had the same level of supervision while in the community. She stated Resident A requries the assistance of staff while in the facilty because he needs redirection, monitoring, and assistance from staff.

I reviewed Resident A's Integrated Services of Kalamazoo (ISK) IPOS Addendum, dated 06/13/2023, which identified the IPOS "effective date" as 05/01/2023 and the IPOS "expiration date" as 04/30/2024. The reason for the addendum as identified as "To extend AFC enhanced staffing authorization".

Resident A's IPOS Addendum identified Resident A as receiving "Community Living Supports (CLS) including 8 hours of enhanced staffing per day". According to the

IPOS Addendum, effective 06/15/2023 through 09/30/2023, Resident A would received “8 hours of enhanced staffing per day to assist with safety, redirecting inappropriate behaviors, and managing mental health symptoms”. The IPOS Addendum further documented facility staff would document details of service provided during the enhanced staffing time as well as other CLS serivces they provide including the following:

> -Redirection from calling police, 911 reporting things that he believes are happening in the home or community.
> -Prompting/redirection when he becomes verbally aggression[*sic*], redirection that others are not stealing from him.
> -Extra Monitoring for safety of others (Staff, housemates, community members)
> -Staff going out with him into the community during enhanced staffing times (1 unit per day)

On 07/14/2023, I interviewed the licensee designee, Saundra Williams-Sulaiman, via telephone. Ms. Williams-Sulaiman stated Resident A has enhanced supervision; however, there are no specifications on the time frames of this enhanced supervision. She stated the enhanced supervision “means to protect [Resident A] from himself and staff”. She stated the staff assigned as his enhanced staff person is to monitor him and prompt him if she’s exhibiting maladpative behaviors. Ms. Williams-Sulaiman stated that while his IPOS documents Resident A requires 8 hours of enhanced supervision per day, she stated it is up to her and staff to determine those 8 hours. She stated when Resident A goes out within the community, he often goes to concerning parts of town that could endanger her staff. She stated that as a result, her staff do not provide enhanced supervision to Resident A when he’s on his independent access within the community. Ms. Williams-Sulaiman stated if her staff are providing the enhanced supervision to Resident A while, he’s in the home and then he decides to leave, she stated then her staff are “off the clock” and no longer providing that enhanced supervision until Resident A returns to the facility. Ms. Williams-Sulaiman stated she discussed her rationale with ISK personnel; however, she did not receive this specific instruction or clarification in writing.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(2) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.

ANALYSIS:	Based on my review of Resident A's ISK Addendum to his Individual Plan of Service (IPOS), dated 06/13/2023, Resident A receives "8 hours of enhanced staffing per day to assist with safety, redirecting inappropriate behaviors, and managing mental health symptoms", which includes staff providing Resident A with redirection from calling police and 911, prompting and redirecting him when he becomes verbally aggressive or accusing others of stealing from him, monitoring for safety of others (e.g. staff, housemates, community members), and going out with him into the community during enhanced staffing times. Despite Resident A's IPOS documenting Resident A's need for 8 hours of enhanced staffing per day there is no documentation identifying the *specific* hours of enhanced supervision; therefore, I am unable to establish the licensee wasn't implementing Resident A's IPOS, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 05/31/2023, I conducted my exit conference with the licensee designee, Saundra Williams-Sulaiman, via telephone. Ms. Williams-Sulaiman acknowledged my findings and indicated she would correct the issues.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

Cathy Cushman

07/17/2023

_____

Cathy Cushman Date
Licensing Consultant

Approved By:

Dawn Timm

07/17/2023

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Dawn N. Timm Date
Area Manager