GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 24, 2023

Colleen Burke
Lourdes Alz Special Care Ctr Inc
2400 Watkins Lake Rd
Waterford, MI 48328

RE: License #: AL630007360
Investigation #: 2023A0605034
Clausen Manor

Dear Colleen Burke:

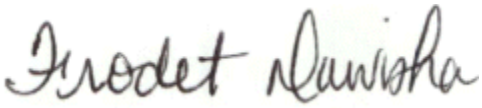
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630007360
Investigation #:	2023A0605034
Complaint Receipt Date:	06/20/2023
Investigation Initiation Date:	06/20/2023
Report Due Date:	08/19/2023
Licensee Name:	Lourdes Alz Special Care Ctr Inc
Licensee Address:	2400 Watkins Lake Rd Waterford, MI 48328
Licensee Telephone #:	(248) 674-4732
Administrator:	Maureen Comer
Licensee Designee:	Colleen Burke
Name of Facility:	Clausen Manor
Facility Address:	2400 Watkins Lake Road Waterford, MI 48328
Facility Telephone #:	(248) 674-4732
Original Issuance Date:	01/13/1995
License Status:	REGULAR
Effective Date:	02/01/2022
Expiration Date:	01/31/2024
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident B is inappropriately touching Resident A. Licensee Designee Colleen Burke does nothing about Resident B' action. Resident B was caught with his pants down in Resident A's room. Resident A may not be able to consent due to her condition.	Yes
Cameras are in residents' rooms.	No

III. METHODOLOGY

06/20/2023	Special Investigation Intake 2023A0605034
06/20/2023	Special Investigation Initiated - Telephone Discussed allegations with reporting person (RP)
06/22/2023	Inspection Completed On-site Conducted an unannounced on-site investigation
06/29/2023	Contact - Telephone call received Call from Natalie Barman with Regulatory Affairs Manager with SafelyYou
08/01/2023	Contact - Telephone call made Interviewed DCS 8 regarding the allegations. Left messages for DCS 9 and DCS 10
08/03/2023	APS Referral Adult Protective Services (APS) referral made
08/07/2023	Contact - Document Received Email from APS worker Tiffany Pitts
08/09/2023	Contact - Telephone call made Left second messages for DCS 9 and DCS 10
08/09/2023	Contact - Telephone call received Discussed allegations with DCS 9
08/09/2023	Contact - Telephone call received Discussed allegations with DCS 10

08/09/2023	Exit Conference Left detailed message for licensee designee Colleen Burke conducting exit conference with my findings

ALLEGATION:

Resident B is inappropriately touching Resident A. Licensee Designee Colleen Burke does nothing about Resident B' action. Resident B was caught with his pants down in Resident A's room. Resident A may not be able to consent due to her condition.

INVESTIGATION:

On 06/20/2023, intake #195939 was assigned for investigation. I initiated the special investigation by contacting the reporting person (RP) and discussing the allegations. The RP stated that Resident B is his own guardian and is higher functioning than Resident A. Resident B has stated to RP, "Resident A is 12 years old in her mind and I like that." Resident B is ambulatory but uses a walker to ambulate. Resident B does not leave Resident A alone. Resident B has been observed trying to inappropriately touch Resident A and continuously goes into Resident A's bedroom. A direct care staff (DCS) at this facility found Resident B naked in Resident A's bedroom while Resident A was lying in bed with her underwear off. Resident B makes all the female staff uncomfortable with his inappropriate sexual remarks. The licensee designee Colleen Burke advises staff not to write an incident report regarding the issues with Resident B and tells staff, "I'll take care of it." Ms. Burke has not addressed the issue because Resident B continues to make sexual advances towards Resident A.

On 06/22/2023, I conducted an unannounced on-site investigation at this facility. During this visit, there was a shift change so additional staff arrived at the facility. I interviewed the registered nurse (RN) Janet Burns regarding the allegations. Resident A and Resident B are not married. Resident A has dementia and Resident B is high functioning and is his own guardian. Resident B is extremely infatuated with Resident A. He is extremely friendly with Resident A, but Resident A does not tell Resident B to stop when Resident B is trying to hold Resident A's hand. The RN has not heard about Resident A lying in bed without her underwear and Resident B sitting on Resident A's bed naked. The RN stated that management has added extra staffing during all the shifts to ensure that Resident A and Resident B are separated. In addition, the RN stated that there are cameras throughout the facility for monitoring. She has no additional information to offer.

I interviewed DCS 1 regarding the allegations. DCS 1 has witnessed inappropriate behaviors by Resident B towards Resident A. DCS 1 has seen Resident B kiss Resident A in the mouth when DCS 1 began their shift. Another DCS observed what happened and immediately redirected Resident B. DCS 1 has observed Resident B in Resident A's bedroom however, they have never found Resident A or Resident B naked

in Resident A's bedroom. When asked about safety measures in place for Resident A, DCS 1 did not know what they were if any have been placed to ensure Resident A's safety and protection from Resident B.

I interviewed DCS 2 regarding the allegations. DCS 2 reported that a few weeks ago, they observed Resident B knocking on Resident A's door and Resident A opened her door and let Resident B into her bedroom. DCS 2 immediately redirected Resident B out of the bedroom but then later that day, DCS 2 caught Resident B back in Resident A's bedroom and both were only wearing their adult briefs. Again, DSC 2 redirected Resident B out of Resident A's bedroom, which he did and then a telephone call was made to Colleen Burke and an incident report was made. DCS 2 asked Resident B what he was doing in Resident A's bedroom and Resident B stated, "I was kissing her." Resident B continued to try to get into Resident A's bedroom. The safety plan was to keep an eye on Resident A and to make sure Resident B does not go into her room. There was no specific staff assigned to Resident A or Resident B to ensure Resident A's safety. DCS 2 found Resident B again in Resident A's legs sitting on her bed next to her legs. DCS 2 does not know what Resident B was doing but Resident B stated he was rubbing Resident A's legs. These issues began soon after Resident B was admitted to this facility which was about three months ago. Management is aware of the concerns but only say to "keep an eye on them."

I interviewed DCS 3 regarding the allegations. DCS 3 stated that Resident B makes sexual comments towards the female staff. DCS 3 has witnessed Resident B take Resident A's feet and "put them on him." DCS 3 immediately redirected Resident B which usually works. Resident B is very persistent in trying to get Resident A as he believes Resident A is his "girlfriend." DCS 3 has never observed Resident B in Resident A's bedroom.

I interviewed DCS 4 regarding the allegations. DCS 4 also observed Resident B take Resident A's legs and put them on him and then Resident B begins rubbing Resident A's feet. Resident A's family is aware of these concerns and has informed staff and management to "keep Resident A away from Resident B." However, Resident B continues to follow Resident A to the bathroom and to her bedroom. DCS 4 never observed Resident A or Resident B naked in Resident A's bedroom.

I interviewed DCS 5 regarding the allegations. DCS 5 heard that Resident B follows Resident A to her room as "he seemed obsessed with her." DCS 5 has observed Resident B put his hand on Resident A's let and tries to hold her. Staff intervene, but it is a constant challenge as Resident B tries to be with Resident A every chance he gets. DCS 5 has witnessed Resident B at Resident A's door trying to get into her room when staff are assisting other residents. Resident B is high functioning, but Resident A has dementia and is often confused. These concerns were reported to management Colleen Burke who stated, "We will talk with Resident B and notify Resident A's family." DCS 5 does not know if a safety plan was put in place to ensure Resident A's safety because if there was, she was never informed.

I interviewed DCS 6 regarding the allegations. DCS 5 heard from a previous staff member that used to work at this facility that “Resident B does not belong here.” A DCS (name unknown) said that they found Resident B in Resident A’s room undressed. DCS 5 has never witnessed Resident B inappropriate with Resident A, but Resident B does like to sit with Resident A in the dining room. Resident B has never been inappropriate with DCS 5. DCS 5 has observed Resident B knocking on Resident A’s bedroom door, but DCS 5 immediately redirects him. According to DCS 5, the concerns with Resident B occur during the afternoon and midnight shifts. DCS 5 feels that the allegations are “exaggerated,” because DCS 5 “Resident B is a nice person,” and that “Resident A has never complained about Resident B.” Resident A has dementia and Resident B is high functioning.

I interviewed DCS 7 regarding the allegations. Resident A is friendly with all the residents at this facility. Resident B is nice but has certain residents he talks too. DCS 7 has never seen Resident B touch Resident A, but DCS 7 has seen Resident B look for Resident A throughout the facility. DCS 7 has never observed Resident B in Resident A’s bedroom and has never observed them naked or only wearing their briefs. DCS 7 stated, “staff know that when they (staff) do not see Resident A and Resident B, then staff immediately begin looking for them.” Resident B is ambulatory but uses a wheelchair because he wants to use it. Staff always find him near Resident A’s bedroom but stop him before he goes inside.

I attempted to interview Resident A but was unsuccessful as she did not know who Resident B was and was unable to answer my questions. Resident A did state that she “loves it here.”

I interviewed Resident B regarding the allegations. Resident B stated, “I’m infatuated with her (Resident A) because she’s bright, cheerful and smiles.” Resident B was very guarded when asked if he has been inappropriate with Resident A and stated, “I don’t want to answer that.” Resident B denied he and Resident A were naked in Resident A’s bedroom but did admit to kissing Resident A on her lips. He stated, “Staff were down the hall, so I kissed her (Resident A).” Then Resident B whispered, “We have a relationship, but I never had sex with her.”

I interviewed Resident C regarding the allegations. Resident C does not know what the relationship is between Resident A and Resident B. Resident C denied seeing any inappropriate touching between Resident A and Resident B. Resident C did not have any additional information to offer.

I interviewed Resident D and Resident E who are married regarding the allegations, Resident D and Resident E appeared confused and Resident D stated, “I don’t know Resident A or Resident B,” but then said, “I’m not sure if they’re married.” Resident D and Resident E could not offer anything additional regarding the allegations.

I attempted to interview Resident F, but she was extremely confused as she was talking about working at this facility. Resident E was unable to provide any additional information to the allegations.

I interviewed licensee designee Colleen Burke regarding the allegations. Ms. Burke denied she received any report from any DCS that Resident B was found in Resident A's room naked. Ms. Burke was informed that DCS found Resident B trying to kiss and rub Resident A's legs in the dining room. Ms. Burke advised all DCS that Resident B must be separated from Resident A as Resident A has dementia and cannot give consent. Ms. Burke advised that DCS reported to her that Resident B was found sitting on Resident A's bed who was lying in bed, but they were both fully dressed. Ms. Burke stated it has been challenging to keep Resident B away from Resident A so Resident B has been provided with a 30-day discharge on 06/08/2023 and will be moving in a couple of weeks. There was no specific safety plan put in place regarding Resident A other than staff told to keep Resident A and Resident B separated.

On 07/10/2023, I reviewed Resident B's assessment plan completed on 05/01/2023 and the timeline of shift report regarding Resident B from 05/02/2023-06/28/2023. The assessment plan did not have any statements regarding Resident B's inappropriate sexual behaviors and how staff will be addressing these behaviors. In addition, the shift report showed a pattern of inappropriate sexual behaviors by Resident B towards Resident A and towards another female resident who is no longer at this facility. Colleen Burke had several communications with Resident B regarding his inappropriate behaviors, but no safety plan appeared to be put in place according to this shift report. Ms. Burke provided Resident B's family with a 30-discharge notice on 06/08/2023 due to Resident B's behaviors.

On 08/01/2023, I interviewed DCS 8 via telephone regarding the allegations. Resident B was infatuated with Resident A. He would go into her bedroom and each time DCS would redirect him, he was back in there. These concerns were expressed to Colleen Burke several times, but the issue remained, Resident B continued to go into Resident A's bedroom. Ms. Burke advised DCS 8, "I'm taking care of it," but Ms. Burke was not because Resident B continued to go into her bedroom. DCS 8 was informed by other DCS that Resident B was found naked in Resident A's bedroom who was also naked. DCS 8 stated they kept an extra eye on Resident B because he was high functioning and knew what he was doing whereas Resident A has dementia and is almost always confused. No safety plan was put in place regarding Resident A's safety.

On 08/01/2023, I interviewed DCS 9 via telephone regarding the allegations. DCS 9 stated that Resident B is very inappropriate with the female staff. Resident B grabbed his private parts and attempted to show DCS 9 porn on his cellphone. DCS 9 has never observed Resident B go into Resident A's bedroom but was informed by other DCS that they have witnessed Resident B in Resident A's bedroom on multiple occasions and one-time Resident B had his pants down while in Resident A's bedroom. These concerns were written in the shift report, but no safety plan was put in place. DCS 9 was never advised to "keep an extra eye," on Resident B regarding these concerns.

However, DCS 9 was checking on Resident B and making sure he was not in Resident A's room because of these concerns. DCS 9 stated, "Resident A does not know any better because of her dementia, but Resident B does, and, in his head, he believes she's, his girlfriend." DCS 9 stated that Resident B has since been discharged from this facility.

On 08/01/2023, I interviewed DCS 10 via telephone regarding the allegations. DCS 10 heard from other DCS that they had observed Resident B in Resident A's bedroom several times and that one of those incidents, Resident B was putting his hands up Resident A's gown. DCS 10 never observed or witnessed Resident B in Resident A's bedroom or anything inappropriate from Resident B during their shift. DCS 10 was never advised of any safety plan in place for Resident A regarding these concerns.

On 08/07/2023, I received an email from APS worker Tiffany Pitts indicating that she is investigating these allegations.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on my review of Resident A's assessment plan dated 05/01/2023, the assessment plan did not have any statements regarding Resident B's inappropriate sexual behaviors and how staff will be addressing these behaviors. The assessment plan should have been updated to reflect Resident B's inappropriate sexual behaviors and how these behaviors will be addressed by staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15305	**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 my investigation and information gathered, Resident A's safety and protection was not attended to at all times. Resident A has dementia and cannot give consent. Resident B was infatuated with Resident A. Resident B has been observed by several DCS make inappropriate sexual advancements towards Resident A; going into Resident A's bedroom, kissing, and touching her legs and feet and trying to put his hands up her gown. There was no safety plan put in place to ensure Resident A's protection and safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	Based on my investigation and review of Resident B's staff report, Resident B's unacceptable behaviors were not specified in his assessment plan nor were interventions put in place to ensure Resident A's safety and protection. Licensee designee Colleen Burke had several communications with Resident B regarding his inappropriate sexual behaviors towards Resident A; however, this did not stop Resident B's behaviors. Resident B was discharged from the facility as the facility was unable to ensure Resident A's safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Cameras are in residents' rooms.

INVESTIGATION:

On 06/20/2023, I discussed the allegations with the RP who stated there are two-way cameras in all the residents' bedrooms. DCS have access to speak to the resident when the resident is in their bedroom through the camera. The families of the residents have not been informed that the facility installed the cameras.

On 06/22/2023, I interviewed the RN Janet Burns regarding the allegations. The RN stated, "there are no cameras in residents' bedrooms. We are looking to get cameras for fall risk and the camera only records when person falls on the floor." The RN stated that the facility will get approval from residents and/or their guardians before the camera's are installed.

On 06/22/2023, I interviewed DCS 1, DCS 2, DCS 3, DCS 4, DCS 5, DCS 6, and DCS 7 who all stated that the cameras were installed last week in all the residents' bedrooms. Some staff did not know why the cameras were installed, but other staff stated the purpose of the cameras was to record when a resident falls in their bedroom. DCS 1 stated that when a resident falls, the phone to the front desk rings and tells the staff who answers the phone which room the fall took place. DCS 6 stated that some of the residents' families attended a Zoom meeting at this facility about the cameras. Families were told that the cameras were "livestream," and that consent must be given before the cameras are turned on.

On 06/22/2023, I walked through the entire facility and there were cameras installed in all 20 bedrooms. I discussed these cameras with the licensee designee Colleen Burke. The cameras were installed last week but have yet to be turned on. The camera system is through SafelyYou, and the purpose of the cameras is to capture recording of a fall in a residents' bedroom. The camera system only records 10 minutes before the fall and 10 minutes after the fall. When a resident falls in their bedroom, the camera sees the fall, then makes a phone call at the front desk. The staff answers the phone and is told the room number where the resident has fallen. The recording is then saved to return to view to obtain information about the fall. Ms. Burke stated she has received consent from guardians already but there are guardians and residents that are not consenting to turn on the cameras in their bedrooms. Ms. Burke stated only the consented residents' cameras will be turned on. I advised Ms. Burke that the cameras cannot be turned on as the facility will be in violation of residents' rights pertaining to the need for privacy. Ms. Burke stated she will not turn the cameras on but that she will reach out to SafelyYou regarding the cameras.

On 06/29/2023, I received a telephone call from Colleen Burke. Ms. Burke stated she spoke with SafelyYou who informed Ms. Burke that SafelyYou received approval from

the state prior to installing the cameras. Ms. Burke stated she will turn the cameras off and will send me documentation showing that the state approved the cameras.

On 06/29/2023, I received a telephone call from Natalie Barman, Regulatory Affairs Manager with SafelyYou. SafelyYou is currently operational in 31 states. Ms. Barman explained on the camera system works and stated, “it’s not a surveillance camera.” While the camera is on Artificial Intelligence (AI) tries to detect with the feed if the resident is on the floor. When the feed detects a fall, it will contact the front desk and alert staff. The feed will begin recording 10 minutes before the fall and 10 minutes after the fall. Ms. Barman stated SafelyYou, and the facility will only view the feed when a fall has been recorded. The purpose of the cameras is to learn how someone falls and to be notified when they fall. Ms. Barman then began stating rules that I was not familiar with regarding the cameras. I advised Ms. Barman the rule I was referring to with regards to “residents rights,” and the “need for privacy.” The rules Ms. Barman was referencing were Home for the Aged rules. I advised Ms. Barman that Clausen Manor is an adult foster care facility (AFC), not home for the aged; therefore, this facility must be compliant with the AFC rules, not the Home for the Aged. Ms. Barman then stated she spoke with AFC licensing consultants regarding the cameras prior to having them installed at Clausen Manor. After Ms. Barman provided the names of the licensing consultants, they were consultants or area managers for home for the aged, not AFC. I advised Ms. Barman that if the cameras are turned on, then Clausen Manor would be in violation of the AFC rules regarding “resident rights,” and the “need for privacy.”

On 07/05/2023, Ms. Barman emailed me a brochure and a “quick video,” regarding SafelyYou and how it works. The brochure discusses the technology regarding SafelyYou and that it detects falls, provides the ability to see and understand how the falls occur, reducing unnecessary emergency room visits and reducing fall risks. The video shares a story of how SafelyYou works in a memory care facility.

On 07/25/2023, Clausen Manor submitted a variance request for the cameras to be allowed in the residents’ bedrooms and turned on only when consent is given by the resident and/or designated representative. The variance request was granted.

On 08/01/2023, I interviewed DCS 8 regarding the allegations. There are cameras in all the residents’ bedrooms. The cameras were turned off but now they are on. Staff have not been trained on the cameras, but the families had the opportunity to see how SafelyYou works at a Zoom meeting at this facility. Staff do not have access to view the cameras.

On 08/01/2023, I interviewed DCS 9 regarding the allegations. The cameras in the residents’ rooms are there to see how a fall happened. When a resident falls, staff is alerted to the residents’ room and can assist a resident immediately after their fall. Staff do not have access to view the cameras.

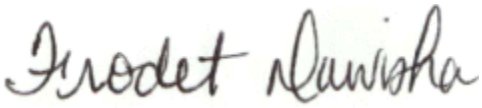
On 08/01/2023, I interviewed DCS 10 regarding the allegations. DCS 10 stated that staff were never informed of the cameras and never explained what the purpose of the cameras were for. One day DCS 10 arrived at their shift and the cameras were installed in all the residents' bedrooms. DCS 10 had no other information.

On 08/09/2023, I conducted the exit conference with licensee designee Colleen Burke with my findings. Ms. Burke stated that Resident B has been discharged from the facility and she will submit a corrective action plan.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**
ANALYSIS:	During my on-site investigation on 06/22/2023, I observed cameras in all the residents' bedrooms. The cameras were installed through SafelyYou, and the purpose of the cameras is to detect falls. Cameras are not allowed in residents' bedrooms as it would be in violation of the residents' rights and the need for privacy. SafelyYou provided information through a brochure and a video explaining how the cameras work and the purpose of the cameras in this facility. The cameras are not surveillance monitoring. This technology is through AI, and it only records the feed when there is a fall. Staff at Clausen Manor are alerted to the residents' room to assist. On 07/25/2023, Clausen Manor submitted a variance request, requesting the cameras to be allowed in residents' bedrooms with resident and/or designated representative consent. The variance request was granted on 07/25/2023.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

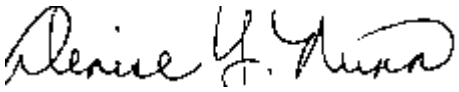
Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



08/16/2023

Frodet Dawisha — Date
Licensing Consultant

Approved By:



08/24/2023

Denise Y. Nunn — Date
Area Manager