GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN
ACTING DIRECTOR

August 9, 2023

Shannon White-Schellenberger
Angels' Place
Suite 2
29299 Franklin Road
Southfield, MI 48034

RE: License #: AS630072584
Investigation #: 2023A0611025
Lopez Family Home

Dear Mrs. White-Schellenberger:

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,

Sheena Worthy, 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

I. IDENTIFYING INFORMATION

License #:	AS630072584
Investigation #:	2023A0611025
Complaint Receipt Date:	06/30/2023
Investigation Initiation Date:	07/05/2023
Report Due Date:	08/29/2023
Licensee Name:	Angels' Place
Licensee Address:	Suite 2 29299 Franklin Road Southfield, MI 48034
Licensee Telephone #:	(248) 350-2203
Administrator:	Shannon White-Schellenberger
Licensee Designee:	Shannon White-Schellenberger
Name of Facility:	Lopez Family Home
Facility Address:	16022 Webster Ave Southfield, MI 48076
Facility Telephone #:	(248) 594-6794
Original Issuance Date:	02/14/1997
License Status:	REGULAR
Effective Date:	11/29/2021
Expiration Date:	11/28/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Former employee has concerns over the facility not properly taking care of medications. They reported a medication incident to the manager and were told that an incident report (IR) would be done, and nothing was done.	Yes

III. METHODOLOGY

06/30/2023	Special Investigation Intake 2023A0611025
07/05/2023	Contact - Telephone call made I left a voice message for the reporting source requesting a call back.
07/05/2023	Contact - Telephone call made I made a return phone call to the reporting source. The allegations were discussed.
07/05/2023	Special Investigation Initiated - On Site I completed an unannounced onsite. I interviewed the Home Manager Evelyn Steward and the program director Berlinda Wilcox. I received copies of the MAR for all residents for the month of June and July. I also received a copy of Resident M's health care chronological log sheet.
07/13/2023	Contact - Telephone call made I left a voice message for Resident M's guardian requesting a call back.
07/13/2023	Contact - Telephone call received I received a return phone call from Resident M's guardian. The allegations were discussed.
07/13/2023	Contact - Face to Face I completed a second unannounced onsite. I spoke with the Home Manager, Evelyn Steward and the program director, Berlinda Wilcox regarding the MAR and Resident M's Prilosec.
07/13/2023	Contact - Telephone call made I made a telephone call to someone who has requested to remain anonymous. The allegations were discussed.

07/13/2023	Exit Conference I completed an exit conference with the licensee designee, Shannon White-Schellenberger via telephone.

ALLEGATION:

Former employee has concerns over the facility not properly taking care of medications. They reported a medication incident to the manager and were told that an incident report (IR) would be done, and nothing was done.

INVESTIGATION:

On 07/03/23, a complaint was received and assigned for investigation alleging that an incident was reported to the owner of the facility, and they said they would write an IR but they never did and never sent it regarding a resident missing their medication. The manager of the facility is wrong and abusive to the staff and the residents. The manager makes a lot of mistakes, but it just gets covered up by the company.

On 07/05/23, I made a return phone call to the reporting source. The allegations were discussed. The reporting source stated Resident M was prescribed Prilosec once a day however; following a recent doctor's appointment, her doctor wrote a new prescription for Resident M to receive Prilosec twice a day. The reporting source stated the Home Manager, Evelyn Steward did not write the medication change for Resident M's Prilosec on the MAR. Ms. Steward did not look at the new medication and she placed it on a shelf in the medication room. As a result, Resident M did not receive this medication as prescribed on 06/18/23 or on 06/19/23. The reporting source stated on 06/20/23 she noticed the medication error. The reporting source contacted the pharmacy and confirmed that Ms. Steward signed for Resident M's new prescription for Prilosec.

The reporting source contacted Ms. Steward and received no response. Therefore, the reporting source contacted the program director, Berlinda Wilcox. The reporting source explained the medication error to Ms. Wilcox. Ms. Wilcox informed the reporting source that she will write an incident report. Ms. Wilcox advised the reporting source to finish checking and transcribing the medications. The reporting source thought it was odd for Ms. Wilcox to write an incident report instead of her. The reporting source stated she never saw the incident report that Ms. Wilcox said she would write. The reporting source thinks that Ms. Wilcox did not want to report the incident because Ms. Steward has had recipient rights complaints against her in the past. Ms. Steward has said before that she cannot receive another complaint against her.

The reporting source stated after she spoke with Ms. Wilcox about the medication error. Ms. Steward became hostile towards her and created a hostile work environment. Ms. Steward used bullying tactics by reporting to Ms. Wilcox about her regarding there not being any prescriptions in the medication book when there was. Ms. Wilcox would also slam binders on the tables and close drawers aggressively. As a result, the reporting

source resigned. Resident M's guardian became upset that the reporting source was no longer at the AFC group home. The reporting source informed Resident M's guardian about the medication error. Resident M's guardian was advised to get a copy of the incident report however; the guardian never received it. The reporting source stated she documented the medication error in Resident M's health care chronological.

The reporting source stated Ms. Steward is not aggressive towards the residents. Ms. Steward is hands off with the residents. The reporting source stated she contacted the Vice President of the company regarding Ms. Steward's hostile behaviors towards her. The information that was given to the Vice President by the reporting source was reported back to Ms. Steward. The reporting source believes the company will not terminate Ms. Steward because the company has a high turnover rate in the AFC group home because the majority of the residents are non-verbal and; Ms. Steward does not mind working in this AFC group home.

On 07/05/23, I completed an unannounced onsite. I interviewed the Home Manager Evelyn Steward and the Program Director Berlinda Wilcox. I received copies of the MAR for all residents for the month of June and July. I also received a copy of Resident M's health care chronological log sheet. I was not able to interview the residents since Resident M has Dementia, Resident B is blind and cannot comprehend well, and the other residents in the home are non-verbal.

On 07/05/23, I interviewed the Home Manager, Evelyn Steward. Regarding the allegations, Ms. Steward stated she didn't know anything about the allegations. Ms. Steward stated when the medications arrived to the AFC group home at the end of June for the month of July, a prescription was needed for Resident M's medication change for Prilosec. Resident M's Prilosec was increased from once a day to twice a day. Resident M did not receive her Prilosec for two days. Ms. Steward does not know when Resident M's prescription for Prilosec was received. Ms. Steward stated it was the medication coordinator responsibility to follow up on obtaining Resident M's prescription for Prilosec. The medication coordinator was Kyanna Stephens however; she no longer works at the AFC group home.

Ms. Steward denied being abusive towards staff or the residents. Ms. Steward does not know why anyone would accuse her of being abusive. Ms. Steward stated she and Ms. Stephens use to butt heads over job related issues. Ms. Steward did not agree on how Ms. Stephens completed her job duties; which resulted in Ms. Steward getting the program manager involved to ensure things were done correctly. Ms. Stephens would be unhappy if she had to cover a staff shift if they called off. Ms. Steward denied witnessing any staff member being abusive towards other staff members or the residents. Ms. Steward stated Resident M has Dementia, Resident B is blind, and she cannot comprehend well, and the other residents in the home are non-verbal. Ms. Steward stated an incident report was not completed because Ms. Stephens did not complete one when she discovered Resident M's Prilosec was not in the home.

On 07/05/23, I interviewed the Program Director, Berlinda Wilcox. Regarding the allegations, Ms. Wilcox stated she does not know anything about the allegations. Ms. Wilcox denied any staff reporting to her that Ms. Steward creates a hostile work environment. Ms. Wilcox stated in June a medication came to the AFC group home, but it was not transcribed on the MAR. As a result, Resident M was not administered her medication. Ms. Wilcox does not know how many days Resident M did not receive her medication. Ms. Wilcox thinks Ms. Steward signed off on the medication but she was not responsible for transcribing the medication. Ms. Steward stated the medication coordinator, Ms. Stephens was responsible for transcribing the medication but, she does not know if Ms. Stephens was present when the medication was received. Ms. Wilcox stated if Ms. Stephens wasn't present when the medication was received then Ms. Steward would have been responsible to transcribe the medication on the MAR. When asked again if she knew anything about Ms. Steward creating a hostile environment, Ms. Wilcox stated she received one complaint from staff member, Chasity Bridges. Ms. Bridges complained about the manner in which Ms. Steward spoke to her. Ms. Wilcox spoke to Ms. Steward about the complaint. Ms. Wilcox has not received any more complaints from Ms. Bridges. Ms. Wilcox has not witnessed Ms. Steward be hostile towards staff or the residents.

On 07/05/23, I received a copy of the MAR for every resident for the month of June and July. I also received a copy of Resident M's health care chorological (HCC). Resident M's HCC has three notes dated for 06/20/23. The first note is about Resident M receiving a PRN. The second note was about Resident M receiving an ointment for her chin. The third note was about Resident M's appointment information being placed in the medication book. A note regarding the allegations was not found in Resident M's HCC.

According to Resident M's MAR for the month of June, she was administered Omeprazole 20mg (Prilosec) once a day at 8:00am until 06/22/23. There is a note written on the MAR which states Omeprazole 20mg was discontinued on 06/22/23 at 4:00pm. The initials K.S was written by this note. At the end of Resident M's MAR, it was handwritten for Resident M to receive Omeprazole 20mg twice a day at 8:00am and 4:00pm. According to the initials on the MAR for this new prescription, Resident M started receiving this medication at 4:00pm on 06/22/23. Therefore, Resident M was not given Omeprazole 20mg twice a day until 06/22/23 which means she was not administered this medication as prescribed for approximately four days. The following medications were missing staff initials on Resident M's MAR for the month of June:

Quetiapine 25mg on 06/04/23, 06/26/23
Temazepam 30mg on 06/25/23, 06/27/23, 06/29/23
Trazodone 100mg on 06/25/23, 06/27/23, 06/29/23
Clonazepam 0.5mg on 06/30/23
Diclofenac on 06/26/23
Mupirocin on 06/02/23, 06/11/23, 06/13/23, 06/25/23
Ensure on 06/02/23, 06/05/23, 06/07/23-06/09/23, 06/12/23, 06/14/23, 06/15/23, 06/18/23-06/25/23, 06/27/23-06/30/23.

Pepto Bismol is handwritten on Resident M's MAR for the month of June however; there are no label instructions included for this medication. Resident M was administered this medication on 06/09/23. There were missing staff initials on Resident M's MAR for the month of July for Ensure on 07/02/23, 07/03/23, and 07/04/23.

I reviewed the MAR's for the other residents in the AFC group home for the month of June and July. The following medications were missing staff initials on the MAR for the month of June:

Resident A - Fluticasone on 06/02/23

Resident B – Adult Multivitamin on 06/29/23, Famotidine 40 mg on 06/25/23, Loratadine 10mg on 06/25/23, Pantoprazole on 06/29/23, Econazole on 06/25/23

Resident C - check for residuals every four hours on 06/08/23, 06/11/23, 06/18/23, 06/29/23, Zeasorb powder on 06/29/23

The following medications were missing staff initials on the MAR for Resident D for the month of July:

Phenobarbital 30mg on 07/02/23
Check blood pressure on 07/02/23
Metronidazole on 07/02/23

On 07/13/23, I received a return phone call from Resident M's guardian. Regarding the allegations, the guardian stated she transported Resident M to see Dr. Serge Sorcer for her gastrologist appointment on 06/15/23. The guardian stated Resident M's new prescription for Prilosec was sent to Clarkston pharmacy however; there was an issue regarding the insurance not wanting to pay for the medication increase. The pharmacy contacted Dr. Sorcer requesting an explanation for the medication increase to be sent to the insurance company. The guardian stated after 1-2 days passed, the pharmacy had not received a response from Dr. Sorcer. The guardian contacted the pharmacy and informed them that she would pay out of pocket for the medication. The guardian stated Resident M's Prilosec was delivered to the AFC group home 2-3 days later after Resident M's doctor's appointment. The guardian stated the staff did not document Resident M's medication on her medication record for two days. Resident M was not administered her Prilosec as prescribed for at least two days. The guardian thinks it took two days to receive Resident M's Prilosec and it took two days for the staff to administer the medication. The guardian stated she is not aware of an issue like this happening before.

The guardian stated she was made aware of an argument between a staff member and the manager. The manager wanted the staff member to write an incident report regarding Resident M's Prilosec however; the staff refused because she was not working when the incident happened. The guardian stated she is concerned about the

staffing issues at the AFC group home as there is currently a high turnover rate. The guardian thinks there is a high turnover rate due to a staff member that is overwhelmed and unhappy with working at the AFC group home and she takes it out on the other staff members. The guardian did not want to provide any staff members names. The guardian stated the new staff members appear to be nice. The staff document Resident M's behavioral issues however; the guardian would like for the staff to document Resident M's sleeping habits so that she can report it to her doctor.

On 07/13/23, I completed a second unannounced onsite. I spoke to the Home Manager, Evelyn Steward and the Program Director, Berlinda Wilcox. I observed Resident M's Prilosec bubble packet and confirmed she was prescribed this medication on 06/19/23. Ms. Steward confirmed Resident M's doctor's appointment with Dr. Sorcer was on 06/15/23. I informed Ms. Steward and Ms. Wilcox that I observed several circle's, lines, and missing staff initials on the resident's MAR. Ms. Steward explained that a circle means that a resident was not in the home as they may be at a doctor's appointment and; the staff notates that on the back of the MAR. Ms. Steward stated a line means the resident did not need the medication. Ms. Steward described an instance where a dietician stated Resident M did not need her Ensure for every meal because she didn't want her to be dependent on it. I explained to Ms. Steward and Ms. Wilcox that staff must administer every medication as it is prescribed and if changes are made to the medication, they must receive a new prescription from a doctor before changes are made.

On 07/13/23, I made a telephone call to someone who requested to be anonymous. The anonymous person has witnessed Ms. Steward being verbally aggressive and hostile towards staff members including the anonymous person. The anonymous person described an instance where Ms. Steward was in the bathroom assisting a resident, when the anonymous person walked in the bathroom to talk to Ms. Steward. Ms. Steward was upset and had an attitude and spoke in an aggressive and hostile manner towards the anonymous person. The anonymous person and Ms. Steward exchanged words in front of the resident who is non-verbal. The anonymous person reported the incident to Ms. Wilcox however; she didn't do anything about it. Ms. Wilcox informed the anonymous person that she would speak to Ms. Steward but, she does not believe that she did.

The anonymous person stated a similar situation happened again between her and Ms. Steward. The anonymous person stated she ignored Ms. Steward. This second incident occurred 3-4 months ago. There were no residents present during the second incident. Ms. Steward does not speak aggressively nor is hostile towards the residents. The anonymous person stated she witnessed Ms. Steward arguing with another staff member. Ms. Steward was yelling and using profanity towards the staff member. This incident occurred in the kitchen and the residents were in the back of the AFC group home.

On 07/13/23, I completed an exit conference with the licensee designee, Shannon White-Schellenberger. Mrs. Schellenberger was familiar with the allegations. Mrs.

Schellenberger stated the staff were waiting to receive a prescription for Resident M's medication change. Mrs. Schellenberger stated sometimes Resident M's guardian transports Resident M to her doctor's appointment and; sometimes there is a delay between when the guardian conveys any changes to the staff. Mrs. Schellenberger does not know if that is what happened regarding this incident. Mrs. Schellenberger is not aware of Ms. Steward being aggressive or hostile towards staff or the residents. Mrs. Schellenberger suspects that allegations came from Ms. Stephens as she walked off the job because Ms. Steward asked her to make changes to the staff schedule.

Mrs. Schellenberger stated there is tension in the AFC group home due to Resident M as she has dementia, and she screams for long periods of time on a regular basis. Resident M is assigned 1:1 staffing for 84 hours a week. Mrs. Schellenberger denied any staff member complaining to her about how Ms. Steward treats or talks to them. Mrs. Schellenberger confirmed that an incident report was not completed regarding the allegations, and she is unsure as to why. Mrs. Schellenberger was informed that the allegations pertaining to the medication error will be substantiated and she will be notified via email what is required once the investigation report is completed.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on the information gathered, there is sufficient evidence to support the allegations pertaining to the Home Manager, Evelyn Steward being aggressive and/or hostile towards staff members. The Program Director, Berlinda Wilcox confirmed that a staff member has complained to her about the manner in which Ms. Steward spoke to her. The reporting source and an anonymous person confirmed that Ms. Steward has been verbally aggressive and/or hostile towards them. The anonymous person described an instance where Ms. Steward spoke to her in a verbally aggressive manner in front of one of the residents. The anonymous person also described an instance where Ms. Steward had an argument involving the use of profanity while the residents were present in the AFC group home. The residents are non-verbal, has Dementia or cannot comprehend.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 06/15/23, Resident M's doctor wrote a prescription increasing Resident M's Prilosec from once a day to twice a day. The AFC group home had a delay with receiving the medication due to the insurance not wanting to pay for it. As a result, Resident M's guardian agreed to pay for the medication. The AFC group home received the medication on 06/19/23 however; the staff did not administer the medication as prescribed until 06/22/23. Therefore, Resident M did not receive her medication as prescribed for three days.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:** **(iii) Label instructions for use.**
ANALYSIS:	According to Resident M's MAR for the month of June, Pepto Bismol was handwritten on the MAR. However, there were no label instructions documented for use.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**

ANALYSIS:	I reviewed the MAR for the month of June and July for all of the residents. I found several missing staff initials for Resident M, Resident A, Resident B, Resident C, and Resident D. I also observed circles and lines on the MAR for different residents. Ms. Steward explained that a circle means that a resident was not in the home as they may be at a doctor's appointment. Ms. Steward stated a line means that a staff member determined that the resident did not need the medication. Therefore, staff are not administering the medications as prescribed to the other residents in the AFC group home as well.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

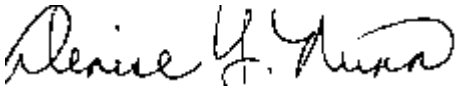
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

07/13/23

Sheena Worthy
Licensing Consultant

Date

Approved By:



08/09/2023

Denise Y. Nunn
Area Manager

Date