GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 24, 2023

Ronda Freeman-McDonald
Altum Care Homes, LLC
23408 Plum Hollow
Southfield, MI 48033

RE: License #: AS630332450
Investigation #: 2023A0993030
Plum Hollow House

Dear Ms. Freeman-McDonald:

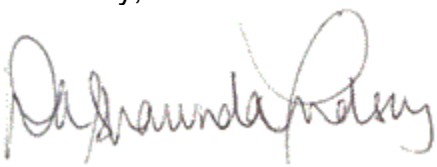
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste. 9-100
Detroit, MI 48202
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630332450
Investigation #:	2023A0993030
Complaint Receipt Date:	06/15/2023
Investigation Initiation Date:	06/21/2023
Report Due Date:	08/14/2023
Licensee Name:	Altum Care Homes, LLC
Licensee Address:	23408 Plum Hollow Southfield, MI 48033
Licensee Telephone #:	(313) 377-3776
Administrator:	Ronda Freeman-McDonald
Licensee Designee:	Ronda Freeman-McDonald
Name of Facility:	Plum Hollow House
Facility Address:	23408 Plum Hollow Southfield, MI 48033
Facility Telephone #:	(313) 377-3776
Original Issuance Date:	04/30/2013
License Status:	REGULAR
Effective Date:	01/31/2022
Expiration Date:	01/30/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
• Staff are physically abusive and neglectful to the residents. • Staff call the residents names, swear at them as well as hit them. • Staff sleep at work when they are supposed to be awake.	No
Staff was supposed to give Resident A $200 for her Bridge Card but did not.	Yes

III. METHODOLOGY

06/15/2023	Special Investigation Intake 2023A0993030
06/21/2023	Referral - Recipient Rights Forward allegations to recipient rights advocate Darlita Paulding
06/21/2023	Special Investigation Initiated - Telephone Telephone call made to former staff Shontia Anderson. Left a message.
06/26/2023	Contact - Telephone call made Telephone call made to former staff Shontia Anderson. Left a message. Sent a text message.
06/28/2023	Inspection Completed On-site Conducted an unannounced onsite investigation. No answer at the door.
06/28/2023	Contact - Telephone call made Telephone call made to licensee designee Ronda Freeman-McDonald
06/29/2023	Contact - Document Sent Requested documentation
07/11/2023	Contact - Telephone call made Telephone call made to staff Shontia Anderson. Left a message.
07/11/2023	Contact - Telephone call received Telephone call received from staff Shontia Anderson

07/11/2023	Contact - Telephone call made Telephone call made to staff Unique Austin
07/11/2023	Contact - Telephone call made Telephone call made to staff Yeteive Currie
07/11/2023	Contact - Telephone call made Telephone call made to staff Briahna Mason
07/11/2023	Contact - Telephone call made Telephone call made to staff Sommer McGhee Harrison
07/11/2023	Contact - Telephone call made Telephone call made to staff Michaela Montgomery
07/11/2023	Contact - Telephone call made Telephone call made to staff Marla Pulliam
07/11/2023	Contact - Telephone call made Telephone call made to staff Osheka Ramsey
07/11/2023	Contact - Telephone call made Telephone call made to staff Paula Tsoungui-Mbessa. Mailbox was not set up. Sent a text message.
07/11/2023	Contact - Telephone call made Telephone call made to staff Shana Walker. Left a message.
07/11/2023	Contact - Telephone call made Telephone call made to staff Leah Walker
07/11/2023	Contact - Telephone call made Telephone call made to licensee designee Ronda Freeman-McDonald
07/11/2023	Contact - Telephone call received Telephone call received from staff Shana Walker
07/11/2023	Contact - Document Received Received documentation
07/16/2023	APS Referral Forwarded allegations to adult protective services (APS)
07/26/2023	Inspection Completed On-site Conducted an unannounced onsite investigation

07/26/2023	Inspection Completed On-site Conducted an announced onsite investigation
08/08/2023	Exit Conference Attempted to hold with licensee designee Ronda Freeman-McDonald. Left a message.

ALLEGATION:

- Staff are physically abusive and neglectful to the residents.
- Staff call the residents names, swear at them as well as hit them.
- Staff sleep at work when they are supposed to be awake.

INVESTIGATION:

On 06/16/2023, I received the allegations from Bureau of Child and Adult Licensing (BCAL) Online Complaints.

On 07/11/2023, I conducted a telephone interview with staff Shontia Anderson. Ms. Anderson stated staff Shana Walker, staff Leah Walker as well as other staff are physically abusive and neglectful towards the residents. She stated they call the residents names and swear at them. Ms. Anderson did not state any specific incidents where she observed staff being physically and verbally abusive towards the residents. Ms. Anderson also mention that staff sleep at work when they are supposed to be awake. Ms. Anderson did not staff which staff sleeps on shift and/or state anu specific incidents when this occurred.

On 07/11/2023, I conducted a telephone interview with staff Unique Austin. Ms. Austin denied knowledge of staff being physically or verbally abusive towards the residents. She denied knowledge of staff calling residents out of their names or swearing at them. She also denied knowledge of staff sleeping at work when they are supposed to be awake.

On 07/11/2023, I conducted a telephone interview with staff Yeteive Currie. Ms. Currie denied knowledge of staff being physically or verbally abusive towards the residents. She denied knowledge of staff calling residents out of their names or swearing at them. She also denied knowledge of staff sleeping at work when they are supposed to be awake.

On 07/11/2023, I conducted a telephone interview with staff Briahna Mason. Ms. Mason denied knowledge of staff being physically or verbally abusive towards the residents. She denied knowledge of staff calling residents out of their names or swearing at them. She also denied knowledge of staff sleeping at work when they are supposed to be awake.

On 07/11/2023, I attempted to conduct a telephone interview with staff Sommer McGhee Harrison. Ms. Harrison stated she was just rehired with the agency. She has not worked in the facility yet.

On 07/11/2023, I conducted a telephone interview with staff Michaela Montgomery. Ms. Montgomery denied knowledge of staff being physically or verbally abusive towards the residents. She denied knowledge of staff calling residents out of their names or swearing at them. She stated she has observed staff sleep on shift, but she could not recall their names.

I conducted a telephone interview with staff Marla Pulliam. Ms. Pulliam denied knowledge of staff being physically or verbally abusive towards the residents. She denied knowledge of staff calling residents out of their names or swearing at them. She also denied knowledge of staff sleeping at work when they are supposed to be awake.

On 07/11/2023, I conducted a telephone interview with staff Osheka Ramsey. Ms. Ramsey denied knowledge of staff being physically or verbally abusive towards the residents. She denied knowledge of staff calling residents out of their names or swearing at them. She also denied knowledge of staff sleeping at work when they are supposed to be awake.

On 07/11/2023, I conducted a telephone interview with staff Leah Walker. Ms. L. Walker denied knowledge of staff being physically or verbally abusive towards the residents. She denied knowledge of staff calling residents out of their names or swearing at them. She also denied knowledge of staff sleeping at work when they are supposed to be awake.

On 07/11/2023, I conducted a telephone interview with licensee designee Ronda Freeman-McDonald. Ms. Freeman- McDonald denied knowledge of staff being physically or verbally abusive towards the residents. She denied knowledge of staff calling residents out of their names or swearing at them. She also denied knowledge of staff sleeping at work when they are supposed to be awake. Per Ms. Freeman-McDonald, “we don’t beat our residents. We have a good situation. We don’t allow that”.

On 07/11/2023, I conducted a telephone interview with staff Shana Walker. Ms. S. Walker denied knowledge of staff being physically or verbally abusive towards the residents. She denied knowledge of staff calling residents out of their names or swearing at them. She also denied knowledge of staff sleeping at work when they are supposed to be awake.

On 07/26/2023, I conducted an unannounced onsite investigation. I interviewed staff Felicia Pugh as well as Resident B.

Ms. Pugh denied knowledge of staff being physically or verbally abusive towards the residents. She denied knowledge of staff calling residents out of their names or

swearing at them. She also denied knowledge of staff sleeping at work when they are supposed to be awake.

Resident B denied knowledge of staff being physically or verbally abusive towards the residents. She denied knowledge of staff calling residents out of their names or swearing at them. Resident B stated there has been times when Ms. Ramsey has fallen asleep in a chair. However, Resident B stated Ms. Ramsey still does her job.

On 07/26/2023, I conducted an announced onsite investigation. I interviewed staff Auctavia Johnson as well as Resident A, Resident C, Resident D, and Resident E.

Ms. Johnson denied knowledge of staff being physically or verbally abusive towards the residents. She denied knowledge of staff calling residents out of their names or swearing at them. She also denied knowledge of staff sleeping at work when they are supposed to be awake.

Resident A denied knowledge of staff being physically or verbally abusive towards the residents. She denied knowledge of staff calling residents out of their names or swearing at them. She also denied knowledge of staff sleeping at work when they are supposed to be awake.

Resident C denied knowledge of staff being physically or verbally abusive towards the residents. She denied knowledge of staff calling residents out of their names or swearing at them. She also denied knowledge of staff sleeping at work when they are supposed to be awake.

Resident D denied knowledge of staff being physically or verbally abusive towards the residents. She denied knowledge of staff calling residents out of their names or swearing at them. She also denied knowledge of staff sleeping at work when they are supposed to be awake.

Resident E denied knowledge of staff being physically or verbally abusive towards the residents. She denied knowledge of staff calling residents out of their names or swearing at them. Resident E stated there has been times when staff are sleeping when they are supposed to be awake. Resident E stated it has been more than one staff. Resident E could not recall the names of those staff. In addition, she did not state any specify incident when it occurred.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Except Ms. Anderson, all staff interviewed, Ms. Freeman-McDonald as well as all residents denied knowledge of staff being physically or verbally abusive towards the residents. She denied knowledge of staff calling residents out of their names or swearing at them. Except Ms. Anderson, Ms. Montgomery, and Resident B and Resident C, all staff interviewed, Ms. Freeman-McDonald as well as Resident A, Resident C, and Resident D denied knowledge of staff sleeping at work when they are supposed to be awake.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Except Ms. Anderson, all staff interviewed, Ms. Freeman-McDonald as well as all residents denied knowledge of staff being physically or verbally abusive towards the residents. She denied knowledge of staff calling residents out of their names or swearing at them.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATIONS:

Staff was supposed to give Resident A $200 for her Bridge Card but did not.

INVESTIGATION:

On 07/11/2023, I conducted a telephone interview with staff Shontia Anderson. Ms. Anderson stated staff bought Resident A's Bridge Card from her for $200. Staff then sold the card to other people.

On 07/11/2023, I conducted a telephone interview with staff Unique Austin. Ms. Austin denied knowledge of staff allegedly purchasing Resident A's Bridge Card from her for $200 but not giving her the money. Ms. Austin stated she believes Resident A controlled her own card.

On 07/11/2023, I conducted a telephone interview with staff Yeteive Currie. Ms. Currie denied knowledge of staff allegedly purchasing Resident A's Bridge Card from her for $200 but not giving her the money.

On 07/11/2023, I conducted a telephone interview with staff Briahna Mason. Ms. Mason denied knowledge of staff allegedly purchasing Resident A's Bridge Card from her for $200 but not giving her the money.

On 07/11/2023, I conducted a telephone interview with staff Michaela Montgomery. Ms. Montgomery denied knowledge of staff allegedly purchasing Resident A's Bridge Card from her for $200 but not giving her the money.

On 07/11/2023, I conducted a telephone interview with staff Marla Pulliam. Ms. Pulliam denied knowledge of staff allegedly purchasing Resident A's Bridge Card from her for $200 but not giving her the money.

On 07/11/2023, I conducted a telephone interview with staff Osheka Ramsey. Ms. Ramsey denied knowledge of staff allegedly purchasing Resident A's Bridge Card from her for $200 but not giving her the money.

On 07/11/2023, I conducted a telephone interview with staff Leah Walker. Ms. L. Walker stated she was terminated after it was learned that staff purchased Resident A's Bridge Card. Ms. L. Walker denied purchasing Resident A's Bridge Card from her. Per Ms. L. Walker, Resident A gave her the card to purchase items for her. Ms. L. Walker stated she purchased the items for Resident A, gave her the items and returned the card to Resident A.

On 07/11/2023, I conducted a telephone interview with licensee designee Ronda Freeman-McDonald. Ms. Freeman-McDonald stated when she learned of the incident she sent a report to her licensing consultant, Oakland Community Health Network (OCHN) as well as others. She conducted an internal investigation. Staff Shana Walker and staff Leah Walker were terminated. A police report was filed as well. Ms. Freeman-McDonald stated she does not believe Resident A received any money for her card, and several thousands of dollars was taken off her card. Charges were not filed as Resident A willingly gave staff her card.

On 07/11/2023, I conducted a telephone interview with staff Shana Walker. Ms. S. Walker denied the allegations. She stated Resident A informed her staff was not taking her shopping. Ms. S. Walker took Resident A's card and went shopping for her. She gave Resident A her items, the receipt as well as her card when she finished. Ms. S. Walker denied taking Resident A's card and/or selling it to other people.

On 07/11/2023, I reviewed written verification dated 05/30/2023 that staff Shana Walker and staff Leah Walker were terminated due to financial exploitation (utilization of a resident's Bridge Card).

On 07/26/2023, I conducted an unannounced onsite investigation. I interviewed staff Felicia Pugh. Ms. Pugh stated Resident A had a large amount on her Bridge Card. Ms. S. Walker bought some of the food assistance from Resident A, but later did not give Resident A the money. Ms. S. Walker and Ms. L. Walker were terminated.
On 07/26/2023, I conducted an announced onsite investigation. I interviewed staff Auctavia Johnson and Resident A.

Ms. Johnson stated all she knows is there was an issue with Ms. S. Walker and another staff (Ms. Johnson could not recall her name) spending money off of Resident A's Bridge Card.

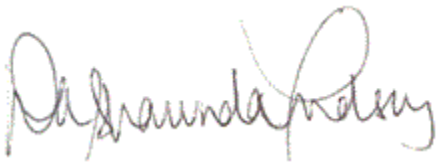
Resident A stated she felt sorry for Ms. S. Walker after she stated her son's girlfriend left him, and they did not have food. Resident A gave her Bridge Card to Ms. S. Walker, and Ms. S. Walker spent over $2,000. Ms. S. Walker tried to give Resident A $10, but she did not take it.

On 08/08/2023, I attempted to conduct an exit conference with licensee designee Ronda Freeman-McDonald. I left a message.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	Resident A stated she felt sorry for Ms. S. Walker after she stated her son's girlfriend left him, and they did not have food. Resident A gave her Bridge Card to Ms. S. Walker, and she spent over $2,000. Ms. Freeman-McDonald conducted an internal investigation and Ms. S. Walker and Ms. L. Walker were terminated effective 05/30/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

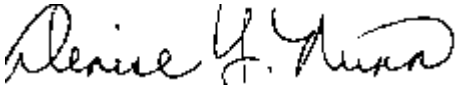
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



08/08/2023

DaShawnda Lindsey Date
Licensing Consultant

Approved By:



08/24/2023

Denise Y. Nunn Date
Area Manager