GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 21, 2023

Matthew Sufnar
Randall Residence of Sterling Heights, LLC
13400 19 Mile Rd
Sterling Heights, MI 48313

RE: License #: AL500402690
Investigation #: 2023A0990011
Randall Residence of Sterling Heights IV

Dear Mr. Sufnar:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500402690
Investigation #:	2023A0990011
Complaint Receipt Date:	08/07/2023
Investigation Initiation Date:	08/07/2023
Report Due Date:	10/06/2023
Licensee Name:	Randall Residence of Sterling Heights, LLC
Licensee Address:	13400 19 Mile Rd Sterling Heights, MI 48313
Licensee Telephone #:	(586) 254-5719
Administrator:	Matthew Sufnar
Licensee Designee:	Matthew Sufnar
Name of Facility:	Randall Residence of Sterling Heights IV
Facility Address:	13400 19 Mile Rd Sterling Heights, MI 48313
Facility Telephone #:	(586) 254-5719
Original Issuance Date:	08/11/2020
License Status:	REGULAR
Effective Date:	02/11/2023
Expiration Date:	02/10/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 08/03/2023, Ahjanae Wade pushed Resident A and punched him on his left shoulder.	Yes

III. METHODOLOGY

08/07/2023	Special Investigation Intake 2023A0990011
08/07/2023	APS Referral Adult Protective Services (APS) complaint assigned at intake.
08/07/2023	Special Investigation Initiated – Letter I emailed Matt Sufnar, licensee designee (LD) and requested documents related to the investigation.
08/07/2023	Contact - Document Sent I emailed Emily Poley, APS investigator informing of the assignment of the complaint.
08/10/2023	Contact - Face to Face I conducted an unannounced onsite investigation. I interviewed Mr. Sufnar and Resident A.
08/29/2023	Contact - Document Received I reviewed direct care staff Ahjanae Wade’ s employee record and Resident A's resident record.
08/29/2023	Contact – Telephone call to I conducted an interview with Ahjanae Wade.
08/30/2023	Contact - Telephone call received I conducted a phone interview with Detective Jobe after he returned my phone call.
09/18/2023	Contact - Telephone call made I called direct care staff Ronnetria Barnes, I left a detailed message. No phone call received to date.

09/18/2023	Contact - Telephone call made I called Relative A, which also Resident A's first line of contact. Relative A requested that I speak with Relative A1 as she was dealing with a tragedy.
09/18/2023	Contact - Telephone call made I conducted an interview with Relative A1.
09/18/2023	Contact - Telephone call made I made a follow-up phone call with Detective Jobe. I left a brief message.
09/18/2023	Contact - Document Sent I emailed Emily Poley, APS investigator. Ms. Poley said that her investigation was substantiated and closed. Ms. Poley was informed by Detective Jobe that he issued a warrant and was waiting to hear back from the prosecutor's office.
09/19/2023	Contact- Telephone call received Detective Jobe returned call. Ms. Wade was charged with elder abuse. Detective Jobe said that he has not received a response from the prosecutor's office.
09/19/2023	Exit Conference I conducted an exit conference with the LD Matt Sufnar.

ALLEGATION:

On 08/03/2023, Ahjanae Wade pushed Resident A and punched him on his left shoulder.

INVESTIGATION:

On 08/07/2023, the complaint was received via email. In addition to the allegations, it was reported that the incident occurred at 6:35am on 08/03/2023. Resident A had an argument with direct care staff Ahjanae Wade. Ms. Wade pushed Resident A causing him to fall backwards flipping over a chair. When Resident A stood up off the floor, Ms. Wade punched him on the left shoulder. Resident A has no marks, bruises, or injuries currently.

On 08/10/2023, I conducted an unannounced onsite investigation. I interviewed Matthew Sufnar, licensee designee (LD) and Resident A. Mr. Sufnar said that he was not present when the incident occurred. Mr. Sufnar was informed of the incident by direct care staff Ronnetria Barnes. Mr. Sufnar was informed that direct care staff Ahjanae Wade pushed and punched Resident A. The incident occurred in Resident A's

private suite. Mr. Sufnar said that Resident A was not taken to the emergency room after the incident because he said that he was ok. Mr. Sufnar said that the incident occurred around 6:30AM. Resident A was assessed by the nurse on shift and there were no injuries. Mr. Sufnar said that Ahjanae Wade was terminated.

I interviewed Resident A. Resident A said that “staff pushed me”. Resident A said that he does not recall the staff person’s name but described the staff as female with “a bad attitude”. Resident A went on to say that the staff person that pushed him, had a “bad disposition” when caring for him. Resident A said that the staff person pushed him, and he fell to the floor. Resident A said that no other staff were present or residents. Resident A denied that he had been physically assaulted by this staff person before or any other staff. Resident A denied observing staff physically assault other residents. Resident A said that he was not hurt by the staff person and did not want to be seen at the hospital.

On 08/29/2023, I reviewed direct care staff Ahjanae Wade’s employee record and Resident A's resident record. Ms. Wade was fully trained on 06/22/2023. Ms. Wade’s *Workforce Background Check* results were received on 06/19/2023. Ms. Wade had one disciplinary action in her file which was a written counseling for absenteeism and tardiness on 07/28/2023.

On 08/29/2023, I reviewed Resident A’s resident record. Resident A’s admission date was 04/18/2023. Resident A’s *Health Care Appraisal* listed his diagnosis as dementia. On Resident A’s *Assessment Plan* the following questions were answered “yes” in terms of Resident A not needing assistance or aide for the following social/behavioral assessments: Controls aggressive behavior; gets along with others; exhibits self-injurious behavior. Randall Residence internal document called *Custom Level of Care* documents that Resident A need reminders for activities of daily living (ADL’s), assistance needed because of confusion with some unpredictable behaviors and requires medication management.

On 08/29/2023, I conducted an interview with direct care staff Ahjanae Wade. Ms. Wade said that she had been interviewed by APS and Detective Jobe from Warren Police Department regarding the allegations. Ms. Wade said that on the day of the incident, she was training another staff person whose name she did not recall. Ms. Wade said the incident occurred because there was a female resident crying in the hallway. Ms. Wade asked the resident what was wrong with her and told her nicely that she should not cry. Resident A came out of his bedroom and asked her “Why can’t she cry?” in reference to the other resident. Resident A then got into her face and began yelling at her because he was upset that she was addressing the other resident crying. Resident A became hysterical, and he pushed her. Ms. Wade said that at this point, the two of them were in Resident A’s doorway to his bedroom. Resident A then grabbed her and restrained her against the wall. Ms. Wade said that the other staff person who she was training came near the room as this was occurring but did not enter. Ms. Wade said that she had to push Resident A off her. When she pushed Resident A, he fell to the floor, but jumped back up and charged at her with his fist balled up and punched her

near her shoulder area and she only shielded herself. Ms. Wade said that she eventually got away from Resident A. Ms. Wade said that prior to this incident she never had any issues with Resident A. Resident A had attacked another resident before, and she has seen him punch a different resident twice but could not provide names or specific dates of these incidents. Ms. Wade said that she had bruises because of the incident. Ms. Wade denied punching Resident A but admits to pushing him because he had her pinned to the wall. Ms. Wade added that after she got away from Resident A, he was still shaking and hysterical.

On 08/30/2023, I conducted a phone interview with Detective Jobe after he returned my phone call. Detective Jobe said that he was unsure if charges are going to be pressed against Ms. Wade, Detective Jobe said that he sent the information to the prosecutor's office last week.

On 09/18/2023, I conducted an interview with Relative A1. Relative A1 was aware of the allegations. Relative A1 was told that the staff person punched and pushed Resident A to the floor. Relative A1 has spoken to Detective Jobe and he told him that there will be criminal charges pressed against the staff person. Relative A1 said that he had no other concerns regarding Resident A's safety and feels that the management handled the incident appropriately.

On 09/19/2023, I conducted an exit conference with Mr. Sufnar Matt Sufnar. Mr. Sufnar was informed of the findings. Mr. Sufnar said that after the incident, staff were in-serviced about appropriate responses to behavior management with residents. Mr. Sufnar said that he would document this in the corrective action plan once the report is received.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	On August 3, 2023, there was an argument between Resident A and direct care staff Ahjanae Wade. Resident A said that Ms. Wade pushed him and he fell to the floor. Resident A described Ms. Wade as having a "bad disposition." Ms. Wade admitted to pushing Resident A because he restrained her against the wall. Ms. Wade denies punching Resident A but said that he punched her. Ms. Wade confirmed that there was an argument between she and Resident A.

	Ms. Wade was terminated immediately. The Warren Police Department, Detective Jobe reported that Ms. Wade is being charged with elder abuse. Based on the information obtained, there is sufficient information to support that Ms. Wade used inappropriate behavior interventions that could have caused serious physical harm or pain to Resident A who is diagnosed with dementia. Based on Resident A's *Assessment Plan* he does not have a history of aggressive behaviors.
CONCLUSION:	**VIOLATION ESTABLISHED**

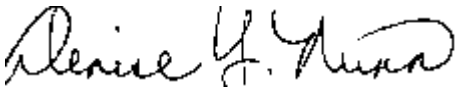
IV. RECOMMENDATION

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

09/21/2023

LaShonda Reed — Date
Licensing Consultant

Approved By:



09/21/2023

Denise Y. Nunn — Date
Area Manager