GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 8, 2023

Donitia Strickland
RSR Valley LLC
33255 26 Mile Road
Lenox, MI 48048

RE: License #: AM500408396
Investigation #: 2023A0617029
Sandalwood Valley II

Dear Ms. Strickland:

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,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd.
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM500408396
Investigation #:	2023A0617029
Complaint Receipt Date:	06/08/2023
Investigation Initiation Date:	06/08/2023
Report Due Date:	07/08/2023
Licensee Name:	RSR Valley LLC
Licensee Address:	33255 26 Mile Road Lenox, MI 48048
Licensee Telephone #:	(586) 383-2802
Administrator:	Donitia Strickland
Licensee Designee:	Donitia Strickland
Name of Facility:	Sandalwood Valley II
Facility Address:	33255 26 Mile Rd Lenox, MI 48048
Facility Telephone #:	(586) 270-6784
Original Issuance Date:	11/15/2021
License Status:	REGULAR
Effective Date:	05/15/2022
Expiration Date:	05/14/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED; AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A is not being properly cared for.	Yes

III. METHODOLOGY

06/08/2023	Special Investigation Intake 2023A0617029
06/08/2023	Special Investigation Initiated - Telephone TC with complainant
06/08/2023	Contact - Document Sent Email sent to Ms. Strickland
06/09/2023	Contact - Document Received Email rec from Ms. Strickland
06/12/2023	Contact - Document Received Email from Complainant that included pictures of Resident A and Resident A room
06/13/2023	Contact - Telephone call received TC with Complainant
06/13/2023	Contact - Document Received Email from Ms. Strickland
06/20/2023	Contact - Document Sent Email to Ms. Strickland
06/21/2023	Contact - Document Received Email received from Ms. Strickland
08/07/2023	Exit Conference I conducted an exit conference with Licensee Designee Donitia Strickland to discuss the findings of this report

ALLEGATION:

Resident A is not being properly cared for.

INVESTIGATION:

On 06/08/23, a complaint was received regarding The Sandalwood Valley II facility. The complaint stated that Resident A has never received consistent and proper care even on the lowest level. Resident A has never had a toileting program in place. She is too unstable to walk on her own. Staff is not and has not been available to assist her in a reasonable time frame. Often Resident A has refused to wear an incontinence brief. Staff has been aware of this yet still does not come in to diaper her or offer her a restroom trip. We have photos of feces all over the bed and her at many different times. There are not regularly scheduled hygiene practices, as the facility has let her go months without any actual bathing. They do not change her clothes every day, do not assist her in grooming or offer. Resident A has had strokes and does have shaking of her hands, she cannot eat easily on her own. Again, she cannot get up on her own. They do not offer to help her eat, they do not offer to wipe her hands or face after eating either. We have a camera in her room, that everyone is aware of. We have regularly monitored sheer negligence. No one comes to check on her at all for 8, 10, 12 or 14 hours. No one changing her brief, offering assistance or food, snacks etc. We provide most of the nutrition she receives. I can go into more detail and have video clips as proof if necessary. We have tried every avenue with them. Resolutions last mere days then revert. They do not have enough staff at any given time for support of number of residents. Often, we can't find staff to let us out of the locked building.

On 06/12/23, I conducted an interview with the complainant. According to the complainant, Resident A's family have had numerous meetings, both in person and on the phone, and zoom with the administrator, managers owners, etc. Each time, the family is told that the problems will be fixed, and the remedy is always very short-live, a few days at best. The complainant stated that often the family have gone to the facility to find feces or urine stains on Resident A's bed and even on the walls. Resident A is not very coordinated and spills things. There's constantly a mess on the floor and on her bed. The complainant sent me several photos that included pictures of feces on the resident and on the floor. Some of the photos show stains that are dark brown on her floor, which is her nutrition drink that she consumes. It's a boost drink milk-based and she will spill it and staff will barely help to clean up. So, it just rots to the floor or tray table, according to the complainant. According to the complainant staff does not handle Resident A's hygiene on a daily basis. Staff does not offer to wipe her hands, help her eat, or change her clothes daily. There has been many times Resident A has called the complainant saying that she's pulled her buzzer to get help in her room and it's been such a long time that she's calling and begging us for help.

The complainant stated that Resident A has fallen in the facility and staff never contacted them. The complainant only knew because she saw it on camera. According

to the complainant, the facility has notified the family that they don't have enough help to do properly care for the residents. Staff are spread very thin. The complainant stated that they have gotten additional hospice services to service Resident A to check on her more often. Hospice now handle Resident A's bathing, and that's only once a week. According to the complainant, there has never been a toileting program in place for Resident A. Staff does not come in regularly and assist Resident A. Resident A will often refuse services and staff stopped helping. Resident A is diagnosed with Dementia and staff should still assist Resident A. According to the complaint, she has addressed this issue with staff. Staff were informed that the complainant is the power of attorney on Resident A's behalf and staff was directed to do what needs to be done with regards to Resident A's care, regardless of her dismay.

According to the complainant, the facility is often so short staffed that family members at one time or another have had to search for a staff member to get let out of the facility. Sometimes even relying on calling the facility so they will answer the phone and then come to a door to let us leave. Most times the entire facility smells so bad of urine and feces. According to the complainant, there have been many times staff have left the soiled, bedding or clothing in her room, rather than taking it directly to laundry, so it just stenches the entire place then they will come into her room and say that it stinks and wildly spray room freshener to the point where Resident A has been coughing and choking.

On 06/13/23, I completed an unannounced onsite inspection of the facility. During my onsite inspection I interviewed Licensee Designee Ms. Strickland, staff Isabella Hunter, Cindy Shelly and Monica Swartz. I also interviewed Resident A.

According to Ms. Isabella Hunter, the facility does not have enough staff consistently to properly care for the residents at the facility. Sandalwood Valley II's building is connected to AFC Sandalwood Valley I. Sandalwood Valley I has eight residents and Sandalwood Valley II has seven residents. Ms. Hunter reported that there is usually one staff member working at each building, a medication technician who serves both facilities simultaneously and a cook who prepares meals for both facilities. According to Ms. Hunter, when one of the facilities is short staffed, the med tech will step in and cover direct care duties for one of the facilities, as well as pass meds for both facilities. There are times where there is no cook and staff will have to cover those responsibilities as well.

At the time of my onsite investigation, there was no cook and staff Cindy Shelly had to prepare the meals for both facilities as well as pass medications. Ms. Hunter stated that Resident A can feed herself but needs assistance with toileting and hygiene. Resident A wears briefs and requires assistance changing. Ms. Hunter stated that there is no set schedule for checking on Resident A. Ms. Hunter stated that Resident A will often take her briefs off during the night and will urinate and defecate in the bed. Ms. Hunter stated that Resident A will often refuse services when staff attempts to assist. If Resident A refuses services, then staff will just leave and document that she refused services.

Resident A's clothes are not changed daily nor is she bathed often according to Ms. Hunter.

According to Ms. Monica Swartz, the facility does not have enough staff consistently to properly care for the residents at the facility. Ms. Swartz reported that there is usually one staff member working at each building, a medication technician who serves both facilities simultaneously and a cook who prepares meals for both facilities. According to Ms. Swartz, when one of the facilities is short staffed, the med tech will step in and cover direct care duties for one of the facilities, as well as pass meds for both facilities. There are times where there is no cook and staff will have to cover those responsibilities as well. Ms. Swartz stated that the facility could use more staff, but they do the best they can.

According to Ms. Cindy Shelly, staff offers Resident A baths on Wednesdays, but she almost always refuses. Hospice provides Resident A baths on Fridays. Ms. Shelly stated that staff will often check on Resident A and offer assistance, but she will refuse or be combative. Ms. Shelly believes that Resident A is cognitive enough to know what she is doing and believes that Resident A is doing things on purpose such as taking her briefs off and using the bathroom in bed. According to Ms. Shelly, when Resident A refuses care, staff will document it and move on to the next resident.

During the onsite investigation, I reviewed Resident A's Assessment plan and care logs from 03/24/23 to 05/17/23. Logs observed indicated that Resident A often refuses services. Resident A's assessment plan indicates that Resident A needs assistance with eating/feeding, toileting, bathing, dressing, and personal hygiene.

According to Licensee Designee Ms. Strickland, Resident A does not require a special menu as her diet is just to have food blended so that it is soft due to her not having teeth. I observed and reviewed Resident A's health care appraisal. According to the appraisal, Resident A's diet should include ground/mechanical/soft foods. Ms. Strickland stated that she has had several meetings with the family of Resident A to review her care plan. The last meeting was held on 03/13/23. At that meeting, Ms. Strickland stated it was decided that due to Resident A consistently refusing care, staff should continually prompt Resident A to allow them to assist her. If attempts fail, staff are expected to contact the family for assistance. At no point are staff allowed to leave Resident A without assisting. Staff are only attempting to assist her once. Ms. Strickland stated that there is no documentation of staff attempting to assist multiple times. Ms. Strickland stated that she is at the facility 2-3 times a week and staff have never made her aware that there were any issues with Resident A.

During the onsite investigation, I interviewed Resident A in her room. Resident A was observed laying down in bed, the room was dirty with food crumbs/spills and stains on the floor. Resident A's room had a horrendous foul smell. Staff Ms. Hunter stated that Resident A's room always smells this way due to her refusal of care and baths. Ms. Hunter stated that she was able to do a bedside wash up of Resident A that morning and she had a fresh set of clothes put on her for the first time in a long time however,

the smell was still strong and horrific. According to Resident A, she is well taken care of at the facility. Staff checks on her regularly during the day and night shifts. Resident A stated that she does indeed take off her briefs but doesn't know why. Resident A stated that she is able to feed herself and receives enough food. Ms. Strickland observed Resident A's foul smell and agreed that is unacceptable.

During the onsite investigation, I inspected the facility. The facility was clean and there were no concerns to report. I observed residents from both Sandalwood Valley I and II in the dining room preparing for lunch. I interviewed the residents and they all reported that they enjoy residing in the facility and staff there are wonderful. Residents did not have any concerns to report. Residents appeared to be clean and did not have a noticeable odor.

On 08/07/23, I conducted an exit conference with Licensee Designee Donitia Strickland to discuss the findings of this report.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	During the onsite investigation, I reviewed Resident A's Assessment plan and care logs from 03/24/23 to 05/17/23. Logs observed indicated that Resident A often refuses services. Resident A's assessment plan dated 03/13/23, indicates that Resident A needs assistance with eating/feeding, toileting, bathing, dressing, and personal hygiene. Ms. Strickland stated at the meeting on 03/13/23, and it was decided that due to Resident A consistently refusing care, staff should continually prompt Resident A to allow them to assist her. If attempts fail, staff are expected to contact the family for assistance. At no point are staff allowed to leave Resident A without assisting. However, staff are only attempting to assist her once. Ms. Strickland stated that there is no documentation of staff attempting to assist multiple times. During the onsite, I observed Resident A laying down in bed. The room was dirty with food crumbs/spills and stains on the floor. Resident A's room had a horrendous foul smell. Staff Ms. Hunter stated that Resident A's room always smells this way due to her refusal of care and baths. Ms. Hunter was able to do a bedside wash up of Resident A that morning and she had a fresh set of clothes put on her for the first time in a long time

	however, the smell was still strong and horrific. Staff are not following Resident A's assessment plan nor are they properly caring for Resident A's personal care needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	During the onsite investigation, I reviewed Resident A's Assessment plan and care logs from 03/24/23 to 05/17/23. Logs observed indicated that Resident A often refuses services. Resident A's assessment plan dated 03/13/23, indicates that Resident A needs assistance with eating/feeding, toileting, bathing, dressing, and personal hygiene. Ms. Strickland stated at the meeting on 03/13/23, and it was decided that due to Resident A consistently refusing care, staff should continually prompt Resident A to allow them to assist her. If attempts fail, staff is expected to contact the family for assistance. At no point is staff allowed to leave Resident A without assisting. However, staff are only attempting to assist her once. During the onsite, I observed Resident A laying down in bed, the room was dirty with food crumbs/spills and stains on the floor. Resident A's room had a horrendous foul smell. Staff Ms. Hunter stated that Resident A's room always smells this way due to her refusal of care and baths. Ms. Hunter was able to do a bedside wash up of Resident A that morning and she had a fresh set of clothes put on her for the first time in a long time however, the smell was still strong and horrific. Staff are not following Resident A's assessment plan nor are they properly caring for her personal care needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Resident A was observed laying down in bed, the room was dirty with food crumbs/spills and stains on the floor. Resident A's room had a horrendous foul smell. According to staff Ms. Hunter, Resident A's room always smells this way due to her refusal of care and baths. Ms. Hunter was able to do a bedside wash up of Resident A in the morning of the onsite and she had a fresh set of clothes put on her for the first time in a long time. However, the smell was still strong and horrific. Staff are not properly caring for Resident A personal care needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

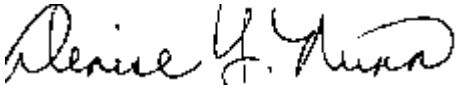
IV. RECOMMENDATION

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

08/07/23

Eric Johnson — Date
Licensing Consultant

Approved By:



09/08/2023

Denise Y. Nunn — Date
Area Manager