GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 3, 2023

Judith Alemnjuh
Five Star Residential, Inc.
22190 Sussex Street
Oak Park, MI 48237

RE: License #: AS630407499
Investigation #: 2024A0611001
Golfview Home

Dear Ms. Alemnjuh:

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 #:	AS630407499
Investigation #:	2024A0611001
Complaint Receipt Date:	10/06/2023
Investigation Initiation Date:	10/10/2023
Report Due Date:	12/05/2023
Licensee Name:	Five Star Residential, Inc.
Licensee Address:	22190 Sussex Street Oak Park, MI 48237
Licensee Telephone #:	(248) 421-2735
Administrator:	Judith Alemnjuh
Licensee Designee:	Judith Alemnjuh
Name of Facility:	Golfview Home
Facility Address:	23010 Golfview Dr Southfield, MI 48033
Facility Telephone #:	(248) 809-6353
Original Issuance Date:	04/29/2021
License Status:	REGULAR
Effective Date:	10/29/2023
Expiration Date:	10/28/2025
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
The facility was paid for two months while Resident E was not living at the facility and now the facility is saying they can't hold his bed anymore. The guardian is denied the resident's file.	No
Staff are giving Resident E medication that he does not need.	No
Resident E claims he is not getting his spending money from the facility. Resident E had a bridge card that the facility had been using while he was in the hospital.	Yes

III. METHODOLOGY

10/06/2023	Special Investigation Intake 2024A0611001
10/10/2023	Special Investigation Initiated - Telephone A voice message was left for the reporting source requesting a call back.
10/10/2023	Contact - Telephone call received I received a return phone call from the reporting source. The allegations were discussed.
10/11/2023	Contact - Face to Face I completed an unannounced onsite (Five Star Residential) however; no one was home. I contacted the licensee designee, Cynthia Nkeng and she agreed to meet me at the home tomorrow.
10/12/2023	Contact - Face to Face I made an announced visit to Five Star Residential. The licensee designee, Cynthia Nkeng confirmed that Resident E does not reside at her AFC group home. I was informed that Resident E resides at Golfview Home.
10/12/2023	Inspection Completed On-site I completed an onsite. The staff member present did not have access to Resident E's file as it was locked up in the staff office. I observed Resident E's bedroom.

10/13/2023	Inspection Completed On-site I completed another onsite. I interviewed the home manager, Boris Lienge. I received copies of Resident E's MAR for the month of August, and his funds part II forms.
10/18/2023	Contact - Telephone call made I made a telephone call to Resident E's case manager at Easter Seals, Miranda Lapan. The allegations were discussed.
10/20/2023	Contact - Telephone call made I made a telephone call to Resident E's guardian. The allegations were discussed.
10/20/2023	Exit Conference I completed an exit conference with the licensee designee, Judith Alemnjuh via telephone.

ALLEGATION:

The facility was paid for two months while Resident E was not living at the facility and now the facility is saying they can't hold his bed anymore. The guardian is denied the resident's file.

INVESTIGATION:

On 10/06/23, a complaint was received and assigned for investigation alleging that the facility is mistreating a resident by giving him medication that he does not need which has led the resident to get worse. The facility is refusing to change the resident's medication or to stop giving the resident the medication since they only listen to the psychiatrist. On 10/05/2023 the guardian was supposed to have a conference call with the facility and other staff members, but the psychiatrist wasn't present who is refusing to change the resident's medication. The facility was paid for two months despite the resident not being there and; now the facility is saying they can't hold his bed anymore. The resident was also being given $50-60 for spending money but the resident said that he was never receiving any of his spending money. The guardian wants access to the residents file but has not been able to get it. The resident had a bridge card that the facility had been using while the resident was in the hospital.

On 10/10/23, I received a return phone call from the reporting source. Regarding the allegations, Resident E was admitted into the hospital on 08/03/23. Resident E was admitted into the hospital because he could not move his body. Resident E spent approximately three weeks in the hospital. When Resident E was discharged from the hospital, he was sent to a rehab facility during the month of September. The reporting source stated Resident E was placed in a wheelchair for one day while he was at the rehab facility, because he fell to his knees. The reporting source stated on 09/01/23,

they were informed by the licensee designee, Judith Alemnjuh that Resident E is being immediately discharged from the AFC group home because he is in a wheelchair and the home is not wheelchair accessible. The reporting source explained to Ms. Alemnjuh that Resident E was only placed in a wheelchair on a temporary basis for safety. Ms. Alemnjuh also accused the reporting source for not allowing Resident E's case manager from Easter Seals to visit him at the rehab facility.

The reporting source stated they never received a discharge notice from Ms. Alemnjuh. However, Ms. Alemnjuh sent the reporting source a text message stating Resident E is being discharged from the home. The reporting source stated they paid Resident E's monthly rent for the AFC group home for the month of August and September in order to hold his bed while he was in the hospital and the rehab facility. The reporting source stated they did not pay Resident E's monthly rent for October because Ms. Alemnjuh stated there was no need to because Resident E cannot return to the AFC group home. On 09/13/23, the reporting source was informed by Ms. Alemnjuh that Resident E can return to the AFC group home. The reporting source stated Resident E is expected to be discharged from the rehab facility on 10/14/23. According to the reporting source, the home manager, Boris Lienge stated he will provide Resident E's file on 10/02/23.

On 10/12/23, I made an announced visit to Five Star Residential. The licensee designee, Cynthia Nkeng confirmed that Resident E does not reside at her AFC group home. I was informed that Resident E resides at Golfview Home. I contacted the licensee designee at Golfview Home, Judith Alemnjuh. Ms. Alemnjuh confirmed that Resident E is currently at a rehab facility, and he will return to the AFC group home on Monday 10/16/23. Ms. Alemnjuh stated the reason Resident E is not returning to the AFC group home on 10/14/23, is because she wants to wait for a new authorization from Easter Seals to resume Resident E's per diem payments. Ms. Alemnjuh also stated that the rehab facility did not contact Resident E's case manager from Easter Seals, Miranda Lapan for discharge planning therefore; she did not know that he was ready to be discharged.

Ms. Alemnjuh admitted that she wrote a 24-hour discharge notice for Resident E and provided it to Ms. Lapan. Ms. Alemnjuh confirmed that she did not provide a copy of the 24-hour discharge notice to Resident E's guardian. Ms. Alemnjuh stated she issued the 24- hour discharge notice because Resident E was in a wheelchair and the AFC group home is not wheelchair accessible. Resident E was placed in a wheelchair because his gait was unsteady. Ms. Alemnjuh stated after Resident E was placed in a wheelchair, she checked on him a few days later and found that he was still in a wheelchair. Ms. Alemnjuh stated she was informed by Ms. Lapan to hold off on discharging Resident E to see how he does at the rehab facility. Ms. Alemnjuh agreed to hold off on the immediate discharge but, she did not put anything in writing withdrawing her initial 24-hour discharge notice. Ms. Alemnjuh was informed by Ms. Lapan to contact Resident E's guardian and inform her that Resident E is very sick and request authorization to complete an OBRA screening to see if Resident E is eligible to go to a nursing home. The guardian's response was no.

Ms. Alemnjuh stated on Monday (10/9/23) she went to the rehab facility with Ms. Lapan and, they saw Resident E walking but, he sat down in a wheelchair. Ms. Alemnjuh was informed that Resident E would be ready for discharge from the rehab facility on 10/14/23.

Ms. Alemnjuh stated the reason why Resident E was admitted into the hospital in August was because his feet were swollen, and he was physically weak. Resident E was transferred from the hospital to the rehab facility in September because he couldn't walk, and his gait was unsteady. Ms. Alemnjuh stated she received Resident E's AFC payment for the month of August and September. Ms. Alemnjuh stated she has not received Resident E's AFC payment for October because she told his guardian that if he does not get better or if he is in a wheelchair then he cannot return to the AFC group home. The guardian told Ms. Alemnjuh that Resident E can walk. Ms. Alemnjuh stated she cannot remember if she told the guardian if Resident E was discharged from the home. The guardian is aware that Resident E will be returning to the AFC group home on 10/16/23.

Resident E's guardian sent a text message to Mr. Lienge requesting a copy of his entire file. Ms. Alemnjuh advised Mr. Lienge to make copies of the documents that the guardian does not already have. Ms. Alemnjuh stated the guardian never came to the AFC group home to pick up the documents. Ms. Alemnjuh stated Mr. Lienge is not at the AFC group home today as he has the day off.

On 10/12/23, I arrived to Golfview Home. The staff member present did not have access to Resident E's file as it was locked up in the staff office. I observed Resident E's bedroom. Resident E's bed was made, and his clothes were seen in his closet. The home manager, Boris Lienge was contacted, and he agreed to meet me at the home tomorrow.

On 10/13/23, I completed another onsite to Golfview Home. I interviewed the home manager, Boris Lienge. I received copies of Resident E's MAR for the month of August, and his funds part II forms. Regarding the allegations, Mr. Lienge stated Resident E was admitted into the hospital because he was not feeling good, his feet were swollen, and he could not stand up on his own. Mr. Lienge stated Resident E was never discharged from the AFC group home as he still have his bed and clothes in the home.

Mr. Lienge stated Resident E's guardian requested a copy of his file last Friday (10/6/23) and she was supposed to come to the home to pick up her copies, but she never showed up. Mr. Lienge provided text messages between him and Resident E's guardian regarding Resident E's file. According to the text messages on 10/02/23, Mr. Lienge informed the guardian that he will give her the documents she requested but, he also needs her to come to the home to sign paperwork. Mr. Lienge also stated his boss said no need to pay rent for Resident E this month since they are not sure when he will be coming home. The guardian response was Resident E is supposed to be discharged 10/14/23. The guardian also stated she will stop by Friday and asked Mr. Lienge what

hours will he be at the home. Mr. Lienge informed the guardian he will be at the home from 8:00am until 8:00pm.

According to the text messages, on 10/05/23, the guardian said “I still need the file”. Mr. Lienge response was “I will get it for you tomorrow when you come in”. The guardian stated “I do not need to come by and sign papers if Judith will not take him back right?! She told me he could return so I paid his rent”.

On 10/18/23, I made a telephone call to Resident E’s case manager from Easter Seals, Miranda Lapan. Regarding the allegations, Ms. Lapan stated Ms. Alemnjuh gave her a 30-day discharge notice for Resident E however; the discharge notice was not formally filed as she asked Ms. Alemnjuh to hold off on discharging Resident E to see if it would be appropriate for him to return to the AFC group home. Ms. Lapan stated the discharge notice was not effective as a copy was never given to Resident E’s guardian. Ms. Lapan stated since November 2022 Resident E had been receiving 4 to 6 hours of 1:1 supervision at the AFC group home because he required hands on assistance. Resident E required assistance with eating, getting on and off the toilet, in and out of bed, bathing, dressing, and he wore adult diapers. During this time, Resident E received a screening which recommended Resident E to be placed in a nursing home. At the time, Resident E’s guardian was through a guardianship company who did not locate a nursing home. In January 2023, Resident E was assigned to his current guardian who ultimately did not agree with Resident E being placed in a nursing home. Resident E’s guardian does not believe a nursing home is the right placement for Resident E.

Ms. Lapan stated Resident E was hospitalized in August 2023 due to circulation issues and having trouble standing up. When Resident E was placed in a rehab facility, the guardian did not disclose the location to Ms. Lapan for two weeks, because she thinks Ms. Lapan is going to place him in a nursing home. The guardian told Ms. Lapan that she will never approve Resident E to receive a OBRA screening in order to determine if he qualifies for a nursing home. Ms. Lapan stated there was concerns regarding Resident E using a wheelchair because the AFC group home is not wheelchair accessible. Ms. Lapan stated before Resident E was discharged from the hospital, she and Ms. Alemnjuh completed a re-evaluation at the rehab facility and determined it was safe for Resident E to return to the AFC group home. Ms. Lapan witnessed Resident E walking and not being dependent on a wheelchair. Ms. Lapan submitted a request for Resident E to resume receiving 4 hours of 1:1 supervision. Ms. Lapan has submitted an application to locate another group home that is better suitable to meet Resident E’s physical needs on a long-term basis.

On 10/20/23, I made a telephone call to the guardian. The guardian confirmed she did not show up to the AFC group home after she was texting Mr. Lienge to receive copies of Resident E’s file because she felt there was no need to if Resident E was going to be discharged from the home. On 10/17/23, the guardian reviewed Resident E’s file and took pictures of certain documents. The guardian stated she was informed by Mr. Lienge that she would have to receive a copy of Resident E’s file from Easter Seals.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.**
ANALYSIS:	Although the licensee designee Judith Alemnjuh, stated she provided a discharge letter to Resident E's case manager, she did not provide a copy of the discharge letter to the guardian and/or the licensing consultant as she agreed to hold off from discharging Resident E.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(8) At the time of discharge, a licensee shall provide copies of resident records to the resident and his or her designated representative when requested, and as determined appropriate, by the resident or his or her designated representative. A fee that is charged for copies of resident records shall not be more than the cost to the licensee of making the copies available.

ANALYSIS:	Based on the information gathered, there is no sufficient evidence to support the allegation as Resident E was never officially discharged from the AFC group home. On 10/16/23, when Resident E was discharged from the rehab facility, he returned to the AFC group home. Therefore, the licensee designee Judith Alemnjuh was not required to provide a copy of Resident E's entire file to his guardian.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff giving Resident E medication that he does not need.

INVESTIGATION:

On 10/10/23, the reporting source confirmed that the medication Resident E is being administered at the AFC group home is prescribed by a doctor. The reporting source believes that Resident E should not be prescribed Risperidone because it causes him to have tremors.

On 10/12/23, Ms. Alemnjuh stated all of the medications administered to Resident E was prescribed by a doctor.

On 10/12/23, I arrived to Golfview Home. There was no current MAR to review for Resident E as he has not lived in the home since August.

On 10/13/23, I completed another onsite to Golfview Home. According to Resident E's MAR for the month of August he is prescribed the following medications:

- Bentropine three times a day
- Docusate Sodium two times a day
- Omeprazole one times a day
- Risperidone two times a day
- Tamsulosin one times a day
- Vitamin D3 one times a day
- Ferosul one times a day
- Nicorette two times a day
- Ventolin as a PRN

On 10/18/23, Ms. Lapan stated Resident E had an appointment yesterday with his neurologist. Resident E's guardian was present during the appointment. The neurologist would like to discontinue Resident E's Risperidone and try a different medication. Resident E's guardian is in agreement with discontinuing Risperidone. Resident E's psychiatrist does not agree with stopping Resident E's Risperidone. Resident E's

guardian would like for Resident E to be prescribed Clozaril however; the side effects from Clozaril could affect his heart. Resident E has a follow up appointment with his psychiatrist on Monday.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on my investigation and the information gathered, there is no evidence to support the allegation. It was confirmed that the AFC group home was only administering medications to Resident E that were prescribed by a doctor.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident E claims he is not getting his spending money from the facility. Resident E had a bridge card that the facility had been using while he was in the hospital.

INVESTIGATION:

On 10/10/23, the reporting source stated the AFC group home has been using Resident E's bridge card while he has been in the hospital/rehab. The reporting source stated they would write one check for Resident E's rent and another check for $50 or $60 for Resident E's spending money. The reporting source stated the staff would cash Resident E's check for his spending money and not give it to him. The reporting source stated they know that the staff is not giving Resident E his spending money because Resident E denied receiving any money. The reporting source stated when she asked Mr. Lienge about Resident E not getting his spending money, Mr. Lienge explained to Resident E and the reporting source that whenever staff takes him to McDonald's or out to eat, they use his spending money.

On 10/12/23, Ms. Alemnjuh confirmed that Resident E has a bridge card. Ms. Alemnjuh stated only she and Mr. Lienge have access to Resident E's bridge card. Ms. Alemnjuh stated currently Resident E is the only resident at the AFC group home who has a bridge card however; in the past there was three residents who had a bridge card. When there was multiple residents who had a bridge card, the staff would rotate each bridge card each week and use a bridge card to buy food for every resident in the AFC group home. Ms. Alemnjuh confirmed that Resident E's bridge card was being used for the AFC group home while he was not living at the home. Ms. Alemnjuh was informed that she is not allowed to use a resident's bridge card to purchase food for other residents. Ms. Alemnjuh was also informed that Resident E's bridge card should not have been used while he was at the hospital or in the rehab facility. Ms. Alemnjuh stated she will take the heat for misusing Resident E's bridge card. Ms. Alemnjuh stated she is not sure but, she thinks Resident E's guardian was giving him spending money.

On 10/13/23, Mr. Lienge confirmed that Resident E was admitted into the hospital on August 4, 2023. Mr. Lienge stated he has used Resident E's bridge card to purchase food for the house. Mr. Lienge admitted to using Resident E's bridge card once during the month of September. Mr. Lienge stated Ms. Alemnjuh used Resident E's bridge card either in August or September. I observed Resident E's bridge card in his file. Mr. Lienge called the number on the bridge card to obtain a balance. Resident E currently has a balance of $437.25 for food and $20.01 for cash.

On 10/13/23, I observed Resident E's spending money in his file. According to Resident E's funds part II pertaining to his cash, he has a balance of $202.52. Mr. Lienge counted the money that was in Resident E's file and, it was the exact amount of $202.52. I saw the following copies of AFC payment checks for Resident E:

- 03/03/23 rent $1027.50 and a separate check 03/03/23 for $60 for allowance
- 05/04/23 $1027.50 rent for the month of April
- 06/05/23 $1027.50 rent for June
- 08/03/23 $1077.50 for his rent and $50 for allowance for the month of July

I also observed a personal check dated 03/20/23 for $50 for spending money that was not cashed. Mr. Lienge explained that he does not have copies of the checks for the missing months above because sometimes Resident E's guardian would drop her check off at Sussex Home and a copy would not be made for the file.

According to Resident E funds part II pertaining to his cash, there was four deposits made from April 2023 through August 2023. On 04/01/23, a deposit of $44 was made, On 06/15/23, a deposit of $50 was made, On 07/11/23, a deposit of $50 was made, and on 08/17/23, a deposit of $50 was made. The other listed transactions were for haircuts, pizza, and McDonald's. According to Resident E's funds part II pertaining to his AFC payments, payments have been received in the amount of $1027.50 from January 2023 until August 3, 2023.

On 10/20/23, I completed an exit conference with the licensee designee, Judith Alemnjuh. Ms. Alemnjuh was informed of which allegations will be substantiated. Ms. Alemnjuh was informed that a corrective action plan will be requested.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(2) The care of any resident funds and valuables that have been accepted by a licensee for safekeeping shall be treated by the licensee as a trust obligation.
ANALYSIS:	According to Resident E's funds part II pertaining to his cash, it appears the AFC group home was properly documenting each deposit that was received for Resident E's spending money as well as his transactions. However, the licensee designee Judith Alemnjuh and the home manager Boris Lienge confirmed that they were using Resident E's bridge card to purchase food for every resident at the AFC group home. Furthermore, Resident E's bridge card was being used by the AFC group home while Resident E was in the hospital and/or rehab facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(6) Except for bank accounts, a licensee shall not accept resident funds of more than $200.00 for any resident of the home after receiving payment of charges owed.
ANALYSIS:	As of 10/13/23, Resident E had a cash balance of $202.52 in his file for spending money. Resident E's last deposit for spending money was received on 08/17/23 for $50 which was after he was admitted into the hospital.
CONCLUSION:	**VIOLATION ESTABLISHED**

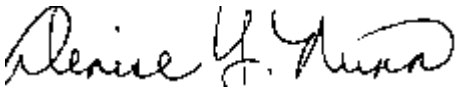
IV. RECOMMENDATION

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

Sheena Worthy
Licensing Consultant

10/25/23
Date

Approved By:



11/03/2023
Date

Denise Y. Nunn
Area Manager