GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 26, 2024

Sherman Taylor
Taylor's Special Care Services, Inc.
Ste 210
23800 West Ten Mile Rd
Southfield, MI 48034

RE: License #: AS630282992
Investigation #: 2024A0602004
Somerset Home

Dear Mr. Taylor:

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,

Cindy Berry, Licensing Consultant
3026 West Grand Blvd
Cadilac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630282992
Investigation #:	2024A0602004
Complaint Receipt Date:	11/08/2023
Investigation Initiation Date:	11/09/2023
Report Due Date:	01/07/2024
Licensee Name:	Taylor's Special Care Services, Inc.
Licensee Address:	Ste 210 23800 West Ten Mile Rd Southfield, MI 48034
Licensee Telephone #:	(248) 350-0357
Administrator:	Sherman Taylor
Licensee Designee:	Sherman Taylor
Name of Facility:	Somerset Home
Facility Address:	29434 Somerset Southfield, MI 48076
Facility Telephone #:	(248) 395-1508
Original Issuance Date:	09/19/2006
License Status:	REGULAR
Effective Date:	06/28/2023
Expiration Date:	06/27/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 11/6/2023, Resident A was locked out of her room and staff would not open the door.	Yes
Staff member Lisa Rutland would come into Resident A's room and hit her when trying to wake her up.	No

III. METHODOLOGY

11/08/2023	Special Investigation Intake 2024A0602004
11/09/2023	Special Investigation Initiated - Telephone Call made to the complainant.
11/15/2023	Inspection Completed On-site No response.
11/28/2023	Inspection Completed On-site Interviewed the home manager, Quania Adkins. Resident A not home.
11/29/2023	Contact – Telephone call m ade Call made to staff member Chanta Gaither, number no longer in service.
12/13/2023	Contact – Telephone call made Call made to Resident A. No answer, unable to leave a message.
01/29/2024	Contact – Telephone call made Call made to Ms. Adkins, received correct number for Ms. Gaither.
01/29/2024	Contact – Telephone call made Interviewed staff member Chanta Gaither.
01/29/2024	Contact – Telephone call made Interviewed staff member LaShawn Favors.
01/29/2024	Contact – Telephone call made Spoke with Office of Recipient Rights (ORR) worker, Natalie Hall
01/29/2024	Contact – Telephone call made Interviewed Resident A.

02/20/2024	Contact – Telephone call made Interviewed staff member, Lisa Rutland.
02/20/2024	Exit Conference Call made to the licensee designee, Sherman Taylor, not available. Spoke with Chasity Ellis.

ALLEGATION:

- **On 11/6/2023, Resident A was locked out of her room and staff would not open the door.**
- **Staff member Lisa Rutland would come into Resident A's room and hit her when trying to wake her up.**

INVESTIGATION:

On 11/08/2023, a complaint was received and assigned for investigation alleging that on 11/06/2023 Resident A was locked out of her room and staff would not open the door. Staff member Lisa Rutland would come into Resident A's room and hit her when trying to wake her up.

On 11/28/2023, I conducted an unannounced on-site investigation at which time I interviewed the home manager, Quania Adkins. Ms. Adkins stated Resident A moved into the home on 9/20/2023 and was issued an emergency discharge about three weeks ago due to her abusive and destructive behaviors. Resident A works two part-time jobs and locks her bedroom door before she leaves the home. Ms. Adkins said she could not recall the exact date, but Resident A came home from work and asked staff member Chanta Gaither to unlock her bedroom door. Ms. Gaither asked Resident A to wait a minute and she became angry and started throwing things. Ms. Adkins said she does not know why Resident A does not have a key to her room. She went on to state that she had no knowledge of Ms. Rutland ever hitting Resident A. Ms. Rutland now works in another home (name unknown) operated under Taylor's Special Care Services Inc.

I was unable to interview any other residents as they were not home at the time the on-site investigation was conducted.

On 1/29/2024, I interviewed staff member Chanta Gaither by telephone. Ms. Gaither stated Resident A can be very demanding if she does not get what she wants when she wants it, she becomes angry and will lash out at staff. Ms. Gaither said one evening, Resident A came into the home after work and asked her to unlock her bedroom door. Ms. Gaither was completing some paperwork and asked Resident A to give her a few minutes. Resident A went into the den, retrieved a book, threw it across the room, repeatedly opened and slammed doors and called her a "bitch". Another staff member, Katy (last name unknown) unlocked Resident A's bedroom door. The police arrived at the home and spoke with Resident A. They asked her to calm down and instructed her

to stay away from Ms. Gaither. Resident A agreed and there were no other incidents for the remainder of that shift. Ms. Gaither said she did not know why Resident A does not have a key to her room. She never witnessed Ms. Rutland hit Resident A when attempting to wake her. She may have tapped her on her arm when she fell asleep on the couch.

On 1/29/2024, I spoke with ORR worker Natalie Hall who covers the City of Southfield. Ms. Hall stated she recalls receiving similar allegations, but a complaint was not opened, and the allegations were not investigated. She stated that Resident A did not have a key to her room but was unable to recall the reason why.

On 1/29/2024, I interviewed Resident A by telephone. Resident A stated she moved into the home on 9/20/2023 from a room and board facility and works two part-time jobs in Lathrup Village. She said one day when she returned to the home from work, she asked staff member Chanta Gaither to unlock her bedroom door, but she refused. Ms. Gaither told her, “That’s why I’m not opening your door because you didn’t get up when I asked you to.” Another staff member, Katy (last name unknown) unlocked the door, and she was able to enter her bedroom. Resident A said she likes for her bedroom door to be locked when she is not home to keep others out of her room. She was never given a key to her room and must ask staff to lock and unlock her door. Resident A was unaware if anyone else witnessed the incident. She went on to state that one evening (exact date unknown) she was sitting on the couch in the living room on her phone when Ms. Rutland hit her on her arm, told her to get up and go to her room. Resident A responded by saying, “Get your fucking hands off of me.” Ms. Rutland accused Resident A of attacking her and threatened to write an incident report. Resident A said she never put her hands on Ms. Rutland and there have been no other issues between the two as Ms. Rutland no longer works in the home. According to Resident A, she was issued a discharge notice (exact date unknown) but will remain in the home until another placement is obtained.

On 2/20/2024, I called the licensee designee, Sherman Taylor to conduct an exit conference, but he was unavailable. I spoke with Chasity Ellis who stated she could speak on his behalf. I informed Ms. Ellis of the investigative findings and recommendation documented in this report. Ms. Ellis stated Resident A was issued a discharge notice due to her aggressive behaviors. She will remain in the home until her case manager secures another placement. Ms. Ellis does not know why Resident A does not have a key to her room. I informed Ms. Ellis that Resident A stated she never received a key to her room and must ask staff to lock and unlock her door daily. Ms. Adkins and Ms. Gaither both indicated that they had no explanation as to why Resident A did not have a key to her room. I also informed Ms. Ellis that Ms. Adkins did not have a contact number for Ms. Rutland and that I needed to interview her regarding the allegations. Ms. Ellis provided the contact information for Ms. Rutland.

On 2/20/2024, I interviewed staff member, Lisa Rutland by telephone. Ms. Rutland stated she no longer works at the Somerset home due to Resident A’s physical and verbal abuse. On 10/13/2023 Resident A physically attacked her. The police were called

and transported Resident A to the hospital. Ms. Rutland said she put her hands and arms up to her own face as a shield to protect herself from Resident A. She said she never hit her. She denied going into Resident A's bedroom and hitting her to wake her. Ms. Rutland stated there was an incident where Resident A fell asleep on the couch, and she tapped her on her arm and told her to go to bed. Ms. Rutland said it was a soft tap, not a hit. She went on to state that she had no knowledge as to why Resident A does not have a key to her room.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: (p) The right of access to his or her room at his or her own discretion.
ANALYSIS:	Based on the information obtained during the investigation, there is sufficient information to determine that Resident A does not have a key to her bedroom, preventing her of access to her room at her own discretion. According to Ms. Adkins, Ms. Gaither, and Ms. Hall, Resident A does not have a key to her bedroom and must ask staff to lock and/or unlock the door. According to Resident A, she likes to lock her bedroom door when she is out of the home but was never given a key of her own. She must ask staff to lock the door when she leaves and unlock it when she returns.
CONCLUSION:	**VIOLATION 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:

	(b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Based on the information obtained during the investigation, there is insufficient information to determine that Ms. Rutland hit Resident A. According to Ms. Gaither and Ms. Rutland, Ms. Rutland tapped Resident A on the arm when she fell asleep on the couch and asked her to go to her room. According to Resident A, Ms. Rutland hit her on her arm but there were no known witnesses.
CONCLUSION:	VIOLATION NOT ESTABLISHED

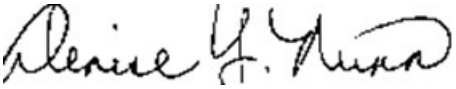
IV. RECOMMENDATION

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

02/22/2024

Cindy Berry — Date
Licensing Consultant

Approved By:



02/26/2024

Denise Y. Nunn — Date
Area Manager