



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

April 12, 2024

Karen Harris  
Integrated Living, Inc.  
43133 Schoenherr Road  
Sterling Heights, MI 48313

RE: License #: AS500243286  
Investigation #: 2024A0604002  
Kelly Rd. AFC Home

Dear Ms. Harris:

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,

A handwritten signature in cursive script that reads "Kristine Cilluffo".

Kristine Cilluffo, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Place  
3026 West Grand Blvd Ste 9-100  
Detroit, MI 48202  
(248) 285-1703

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS500243286
<b>Investigation #:</b>	2024A0604002
<b>Complaint Receipt Date:</b>	01/02/2024
<b>Investigation Initiation Date:</b>	01/03/2024
<b>Report Due Date:</b>	03/02/2024
<b>Licensee Name:</b>	Integrated Living, Inc.
<b>Licensee Address:</b>	43133 Schoenherr Road Sterling Heights, MI 48313
<b>Licensee Telephone #:</b>	(586) 731-9800
<b>Administrator:</b>	Karen Harris
<b>Licensee Designee:</b>	Karen Harris
<b>Name of Facility:</b>	Kelly Rd. AFC Home
<b>Facility Address:</b>	Suite # 400 35932 Kelly Road Clinton Township, MI 48035
<b>Facility Telephone #:</b>	(586) 790-8110
<b>Original Issuance Date:</b>	04/04/2002
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	10/04/2023
<b>Expiration Date:</b>	10/03/2025
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Staff, Jacqueline, sleeps on job and Resident A's door is blocked to keep her from getting out.	No
Residents are being mistreated. Residents found with bruises.	Yes
Resident E has bed sores due to not being changed.	No
Resident A has been receiving expired medications. Resident medications are missed.	Yes
The home does not have healthy food or water.	No
Additional Findings	Yes

## III. METHODOLOGY

01/02/2024	Special Investigation Intake 2024A0604002
01/03/2024	Special Investigation Initiated - Telephone TC to Complainant
01/03/2024	APS Referral Referral made to Adult Protective Services (APS)
01/03/2024	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Home Manager, Keunita Whitney, Staff, Chereta Murphy, Shirley Murphy, Resident B and Resident C. I observed Resident A and Resident D. Took pictures of medication logs, menus and wall damage
01/03/2024	Contact - Document Received Emails from Complainant with pictures and video
01/03/2024	Contact - Telephone call made Text messages to and from Complainant
01/04/2024	Contact - Document Received Emails from Complainant with pictures and video
01/04/2024	Contact - Document Sent Email to Complainant

01/04/2024	Contact - Telephone call received Received text messages and picture from Complainant. Sent return text.
01/05/2024	Contact - Telephone call received Received text messages and audio recording from Complainant
01/08/2024	Contact - Telephone call received Text from Complainant. Sent return text.
01/26/2024	Contact - Document Received Email from APS Worker, James Bellamy
01/29/2024	Contact - Document Sent Email to APS Worker, James Bellamy
01/29/2024	Contact - Document Received Email from APS Worker, James Bellamy
02/01/2024	Contact - Telephone call received Received text message from Complainant requesting call
02/02/2024	Contact - Telephone call made Attempted to contact Complainant by phone
02/21/2024	Contact - Document Sent Emails to Sara Harris, Director of Operations. Received copy of staff list from Sara Harris by email.
02/21/2024	Contact- Document Sent Email to Complainant. Received return emails from Complainant and requested call.
02/21/2024	Contact- Telephone call made TC to Complainant. Received text message with picture of bruised finger. Resident B allegedly has bruised finger and black eye. Cause of injuries is unknown.
02/21/2024	Contact- Document Received Received email from Complainant with audio file alleging individuals talking about Resident B having black eye. Unable to open audio file.
02/21/2024	APS Referral Second referral made to APS regarding Resident B

02/22/2024	Contact- Document Sent Email from Sara Harris with Resident A and Resident B's Health Care Chronological (HCC), Crisis Plan and Individual Plan of Service (IPOS). Sent return email.
02/23/2024	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Home Manager, Keunita Whitney. Observed Resident B's eye and hand. Took picture of Resident B prescription dated 01/15/2024.
02/27/2024	Contact- Document Sent Email to and from APS Worker, Emily Poley. APS Worker, Stephanie Howard is assigned investigation.
02/27/2024	Contact- Telephone call received Received message from APS Worker, Stephanie Howard
02/27/2024	Contact- Document Received Email to and from APS Worker, Stephanie Howard
03/01/2024	Contact- Document Sent Email to Sara Harris
03/04/2024	Contact- Document Received Email from Sara Harris with HCC notes. Sent return email.
03/07/2024	Contact- Document Received Received Intake #199963. Dismissed intake and will add allegations to open investigation.
03/07/2024	Contact- Document Sent Email to Sara Harris
03/08/2024	Contact- Telephone call made TC to Staff, Jacqueline Booker. Phone disconnected. Message indicates service restrained or unavailable
03/08/2024	Exit Conference Completed exit conference by phone with Sara Harris and Human Resources, Latoya Goins

## **ALLEGATION:**

- **Staff, Jacqueline, sleeps on the job and Resident A's door is blocked to keep her from getting out.**
- **Residents are being mistreated. Residents found with bruises.**
- **Resident E has bedsores due to not being changed.**

## **INVESTIGATION:**

On 01/02/2024, I received a licensing complaint regarding the Kelly Rd. Home. The Complainant alleged that the facility has expired medication, and Resident A has been receiving them. The facility does not have healthy food or water. Staff, Jacqueline, sleeps on the job and Resident A's door is blocked to keep her from getting out and the manager and assistant manager have been made aware of this. Medication is being missed. Residents are found with bruises. Residents are being verbally abused.

On 03/07/2024, I received a second licensing complaint regarding the Kelly Rd. Home. Staff member, Deana Cole, is sleeping on the night shift. She does not change Resident E's adult brief. Resident E sits in urine/feces all night. As a result, Resident E has skin degradation on her buttocks. The concern has been brought to the attention of management, but they fail to address it. APS completed a face to face with the client at the day center and staff did not observe any breakdowns or wounds on the client. APS was informed by the day center staff that client does have redness between her thighs. Additionally, she has history of breakdowns and they have been treated appropriately. On 03/08/2024, I spoke to Director of Operations, Sara Harris, by phone. Ms. Harris confirmed that staff named in complaint, Deana Cole, resigned and has not worked at home since 02/05/2024.

On 01/03/2024, I interviewed the Complainant by phone. The Complainant stated that there are issues with medications including missed medications, medication logs not being signed and expired narcotics. Resident A was found to have a bruise on her arm. Most of the residents are non-verbal. The Complainant indicated that Resident B fears the dark and staff turn off his bedroom lights to punish him. Staff, Jacquelyn, sleeps, and smokes weed at home. The Complainant stated that residents are being kept in their beds all day. Resident A and Resident B are the only residents that get out.

On 01/03/2024 and 01/04/2024, I received nine emails from Complainant. Emails included Community Living Supports (CLS) Logs, text messages, and medication logs indicating that medications are missed and not documented. The iCloud documents and videos are no longer available due to the attachment expiration date. A video clip was received of wheelchairs in hallway in front of door and video of Resident E in bed. A picture of a bruised right shoulder was received. Face cannot be seen but reported to be Resident A. Bruise is purple and appears to be approximately two inches in length. There also appears to be scratches underneath the bruise. A picture of Lorazepam 1mg pill pack that expired on 10/03/2023 was received. Pictures and video of Resident A in

bed alleged to be pushed up against door by staff was received. Door appears to be open about one foot and Resident A's face can be seen looking out the door and in bed. Also, a note to staff asking staff to clean and organize before inspection was received. Complainant provided pictures of food in refrigerators and freezers. Complainant indicated that she had additional videos and recordings if needed.

On 01/03/2024, I completed an unannounced onsite investigation. I interviewed Home Manager, Keunita Whitney, Staff, Chereta Murphy, Shirley Murphy, Resident B and Resident C. I observed Resident A and Resident D. Residents were observed in the living room and at the kitchen table during the onsite investigation.

On 01/03/2024, I interviewed Home Manager, Keunita Whitney. She stated that she has been the home manager since 2020. She stated that Resident A self-harms and will bruise herself sometimes. Resident A will bite her hands. Resident A is non-verbal and has an unsteady gait. Ms. Whitney stated that staff never moved anything in front of Resident A's door so she could not get out. She stated that they are considering a bed alarm for Resident A. Ms. Whitney stated that Resident C is scared of the dark. She has never seen staff turn his bedroom lights off on purpose to scare him. Ms. Whitney indicated that she was not aware of any residents being verbally abused by staff and that no other residents have bruises. Ms. Whitney stated that Resident E and Resident F go to workshop and get out of bed by 8:00 am. She stated that other residents sleep until about 9:00 am- 9:30 am and are out of bed by 9:30 am- 10:00 am.

On 01/03/2024, I interviewed Staff, Chereta Murphy. She stated that she has worked at the home for one year. Ms. Murphy indicated that she has no concerns regarding the home. She stated that she did see a bruise on Resident A's shoulder the last week before Christmas. The bruise is gone now. She does not know how injury occurred. She stated that Resident A does bite her hands. She has also seen bruises on Resident C's legs. She stated that Resident C hits her legs when she uses her wheelchair. Ms. Murphy stated that she has not seen any staff verbally or physically abuse residents. Ms. Murphy stated that she has not seen anyone block Resident A's bedroom door. Staff may close door but not put something in front of door to block it. Ms. Murphy stated that residents get out of bed around 8:30 am-9:00 am. Sometimes Resident C may not want to get up until 10:00 am-10:30 am. Ms. Murphy stated that she works 6:00 am- 2:00 pm and everyone is up and dressed by the time she leaves. Ms. Murphy has seen midnight shift turn off Resident B's bedroom lights on purpose. He is scared of the dark and she has heard him hollering. She stated that they may do it because they are trying to get him to bed and think turning lights off will make him fall asleep quicker. However, turning the lights off scares him.

On 01/03/2024, I interviewed Staff, Shirley Murphy. She stated that she has worked as a Direct Care Worker for 22 years. She believes they need more staff. Ms. Murphy stated that she has not seen lights turned off in Resident B's room. She works from 6:00 am- 2:00 pm and light is on when she comes in at 6:00 am. She stated that Resident B is scared of the dark. She has not seen Resident A's bed pushed up against door. Ms. Murphy stated that she has not seen any bruises on residents. She has not seen any



staff being verbally abusive to residents. Ms. Murphy stated that residents are out of bed by 10:00 am-11:00 am. Some residents want to sleep in. Resident E and Resident F go to workshop.

On 01/03/2024, I interviewed Resident C. She stated that she likes living at home. She has no problems. She indicated she has lived at home for less than a year. Resident C indicated that she gets all her medications and enough food to eat. The staff talk nice to her. Resident C indicated that a staff punched a resident who moved away. The staff is gone. Resident C stated that she could not tell me their names and that she did not know who they were. No one has done anything to her. Resident C stated that she feels safe in the home. She does not have any bruises. Resident C stated that she wakes up at 5:00 am. She shares a room with Resident A. She indicated that door has been blocked with handle. She later described this as her locking the door. Resident C stated that staff crack door open.

On 01/03/2024, I attempted to interview Resident B. Resident B has limited verbal ability and did not answer any questions related to investigation.

On 01/29/2024, I received an email from APS Worker, James Bellamy. Mr. Bellamy indicated that he did not plan to substantiate the allegations.

On 02/21/2024, I spoke to the Complainant by phone. The Complainant indicated that Licensee Designee is aware that there are concerns about home, however, has not done anything to correct issues. Same staff are working at the home. The Complainant stated that Resident B had a bruised finger about two weeks ago. Staff stated that they do not know how injury occurred and allege he was taken to doctor but there is no documentation. It looks like it could have been slammed in a door. Complainant sent a text with picture of a thumb with brown fingernail. The Complainant also stated that Resident B got a black eye last week and no one knows how the injury occurred.

On 02/21/2024, I made a second referral to APS regarding allegations that Resident B has a bruised finger and black eye.

On 02/21/2024, I received copy of staff list from Sara Harris, Director of Operations. The staff list indicates that Staff, Deana Cole, named in second complaint received on 03/07/2024 is no longer working at the home. Ms. Cole resigned, and her last day was 02/05/2024. Staff, Jacqueline Booker, has been suspended pending investigation.

On 02/23/2024, I completed an unannounced onsite investigation at the home. I interviewed Home Manager, Keunita Whitney, and observed Resident B. Resident B was unable to answer questions regarding eye and finger. I observed Resident B's finger. His thumb nail was brown. I did not observe any bruising on thumb or hand. Resident B did not have a black eye at time of onsite investigation. I did not observe any bruising on Resident B's face. Resident A, Resident C and Resident D were also present during investigation. Residents were out of bed and in the living room/dining area.

On 02/23/2024, I interviewed Home Manager, Keunita Whitney. She stated that APS has been out to the home two times this week. She indicated that APS received a referral regarding Resident B's eye and finger. APS also received a referral alleging that Resident E has bedsores. Ms. Whitney stated that Resident B never had a black eye. She stated that he had what appeared to be bruising or a rug burn in his beard under chin. She stated that Resident B crawls on the floor and that could have caused the injury. Ms. Whitney stated that Resident B's finger is not bruised. He has a history of fungal infection in his nail. He licks his finger and also sticks it in his eye. His nail gets infected, and he has been treated in the past for cellulitis. Ms. Whitney stated that Resident B was seen by doctor for his thumb and received a prescription for Bactrim DS 800mg-160 mg tablet. Ms. Whitney stated that Resident E does have a history of bedsores and receives medical treatment when needed. She indicated that Resident E does not have any sores currently. Ms. Whitney stated that Resident E is seen by Dr. Nichols, every other month at the home. Also, during the onsite investigation Ms. Whitney stated that Resident A currently did have a bruise on her leg. She believed the bruise was caused by Resident A crawling to the living room.

On 02/22/2024, I received a copy of Resident B's HCC. HCC states that Resident B was seen by Dr. Nichols on 01/16/2024 and they were advised to wash his finger daily and add triple antibiotic ointment to finger and wrap a Band-Aid on it. On 02/02/2024 HCC notes, (Resident B) has a bruise on the left side of his face going down to his chin light green and dark part on chin. Staff inform manager." I reviewed Resident B's crisis plan dated 02/08/2024. Plan states that when not in eyesight, visual checks will be completed every 15 minutes due to lack of safety skills, history of taking things that do not belong to him and history of eloping.

On 02/22/2024, I received a copy of Resident A's crisis plan dated 01/31/2024. The plan indicates that Resident A will get up suddenly from a seated position frequently and is at risk of falling or injuring herself; gait belt to be worn during all waking hours. Her plan also lists strategies for physical aggression, self-injury and property destruction. I reviewed Resident A's IPOS addendum dated 11/27/2023. Plan indicates that Resident A is not content to sit and wants to move but this is very difficult for her as she is very off balance. Staff must be attentive to her to prevent falling. Her IPOS also lists interventions for aggression.

I also reviewed Resident A's HCC which indicates the following:

- 02/05/2024- HCC notes, "Came in on shift, changed (Resident A) shift and noticed bruises on her stomach on the right side."
- 02/04/2024- HCC notes, "Staff was passing med and I saw bruises on her left leg".
- 01/06/2024- HCC notes, "I noticed a bruise on (Resident A) left hand when I got her up for breakfast. It's the area she usually bites her hand often."
- 12/10/2023- HCC notes, "(Resident A) had a bruise on her right upper arm when I did her change this morning".

- On 12/11/2023-12/12/2023- HCC notes, "(Resident A) had a bruise on her right side arm."
- 11/09/2023- HCC notes, "(Resident A) left side of lip is busted and bleeding".
- 09/27/2023- HCC notes, "While changing (Resident A) staff noticed a scar on (Resident A) right inner arm area".
- 09/19/2023- HCC notes, "Staff notice mark on (Resident A) left buttock cheek".
- 07/17/2023and 07/31/2023- HCC notes indicate that Resident A was biting herself.
- 07/02/2023- HCC notes, "(Resident A was being checked and changed and staff noticed a bruise on (Resident A's) bottom. Staff observed the bruise while on shift".
- 06/26/2023- HCC notes, "(Resident A) was being checked and changed by staff and staff notice a bruise on (Resident A) right upper thigh".
- 06/05/2023- HCC notes, "Doing hygiene I know (Resident A) had bruises at the site listed above (referring to bite mark on wrist).".
- 06/03/2023- HCC notes, (Resident A) bite into her left wrist because she was upset she couldn't get to another resident".
- On 05/19/2023 HCC noters, "(Resident A) bit her right hand now it's red and a bite mark".
- On 05/07/2023- HCC notes "(Resident A) was getting in bed for the end of shift and (Resident A) hit her head against the wall. Staff checked for redness or bruise there was anything showing".

On 02/27/2024, I received email from APS Worker, Stephanie Howard. Ms. Howard indicated that she did not see a black eye on Resident B. The provider disclosed that the client did have a burn/bruise on his chin area previously. However, she did not observe that. Regarding his finger, it appears that his fingernail is discolored. She did not observe any marks or bruising on them. It appears to Ms. Howard that client has a nail infection as the nail is discolored and oddly shaped. Ms. Howard was informed by staff that his fingernail has been this way for years and he receives antibiotic treatment for it. Additionally, the client is currently on antibiotics for an infection from his primary care physician (PCP).

On 02/27/2024, I received email from APS Worker, Stephanie Howard. She stated that she met with Resident E at her day center. She appeared well and happy. Ms. Howard inquired with staff there regarding any concerns of neglect from the adult foster care home and they denied it. Also, Ms. Howard talked with the staff that provides her personal care and was informed that she has some "redness" in between her thighs, no current bedsores or recent history of them. Also, Ms. Howard was informed that she did not see any signs of neglect with personal care. Additionally, Ms. Howard was informed that the client does have a history of having bedsores and it is usually addressed and cared for.

On 03/04/2027, I received email from Director of Operations, Sara Harris. She stated that Resident E was seen by doctor specifically for sores in July 2023 and November

2023. Ms. Harris stated that Resident E will be seen this week for a follow up appointment. I also received the following notes from Resident E's HCC:

- 03/03/2024- HCC notes that staff noticed a "small round sore on her left cheek". Staff cleaned it and put butt paste and Nystatin 100,000 powder to the affected area and let it air dry. Note states that residents PCP will be called to schedule appointment when they open at 8:00 am.
- 12/14/2023- HCC notes Resident E has a rash on buttocks and inner thigh and cream applied
- 11/21/2023- HCC notes Resident E has an open wound left inner leg area.
- 11/19/2023- HCC notes Resident E has a rash on inner thigh. Cream was applied.
- 07/10/2023- HCC notes that Resident E was taken to doctor concerning sore on her buttocks. PCP suggests to stay off of workshop and be repositioned every two hours. Continue to use the butt paste with every brief change as a barrier cream. PCP refilled all prescriptions and return in four months. Return appointment scheduled for 11/01/2023. Staff asked if PCP suggested wound care. PCP stated that was not necessary. The most important thing at this time is repositioning her often.
- 07/02/2023- HCC notes staff noticed two small openings on Resident E's bottom
- 11/14/2023- HCC notes indicate breakdown. Staff kept (Resident E) home to continue to reposition and keep her dry. Will order "butt paste" and contact PCP.
- 11/01/2023- HCC notes that Resident E was seen by doctor for her blood pressure. She has a small break down in skin. Instructions note to continue using the "butt paste". Next appointment is March 2024.
- 09/16/2023- HCC notes, "Staff notice red mark on (Resident E) left thigh while changing her diaper this morning."

On 03/08/2024, I attempted to interview Staff, Jacqueline Booker, by phone. The phone was disconnected. Message indicates service restrained or unavailable.

On 03/08/2024, I spoke to Director of Operations, Sara Harris, by phone. Human Resources Manager, Latoya Goins, was present during part of the phone call. Ms. Harris stated that Human Resources held a meeting at the home because there has been issues between staff, manager and some staff have left. Ms. Harris confirmed with human resources that there have been no recent reports of staff sleeping or using marijuana during shift. Ms. Harris believed that recipient rights has investigated allegations of sleeping and marijuana use in the past and that the allegations were not substantiated. Ms. Harris stated that Staff, Jacqueline Booker, remains suspended. She does not know at this time if Ms. Booker will be returning. Ms. Harris stated that they did receive a picture alleging to be Resident A's bed pushed up against door by staff. She stated that it was unknown if it was done by staff or if Resident A was able to move the bed. Ms. Goins indicated that she did not discuss the allegation with Ms. Booker.

<b>APPLICABLE RULE</b>	
<b>R 400.14305</b>	<b>Resident protection.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	<p>On 01/03/2024, the Complainant sent a picture of Resident A's bed near the bedroom door. It is alleged that Staff, Jacqueline Booker, moved the bed because she sleeps on shift and blocked the door so Resident A could not get out. Door appears to be open about one foot and Resident A's face can be seen looking out the door while in bed. Ms. Booker has been suspended and her phone was disconnected when an attempt was made to interview her by phone. On 03/08/2024, Sara Harris indicated that it was unknown if resident or staff moved the bed, however, they did receive the picture. Ms. Harris stated that there have been no recent complaints of staff sleeping on shift.</p> <p>The home is not providing adequate supervision and protection to ensure resident safety. On 01/04/2024, I received a picture of a bruised right shoulder from Complainant. On 01/03/2024, Staff, Chereta Murphy stated that she did see a bruise on Resident A's shoulder. She did not know how injury occurred. Home Manager, staff, and Resident A's IPOS indicated that Resident A does self-harm. Resident A's HCC notes incidents of her biting hands and hitting head. However, there are also several notes indicating that Resident A had bruises with no known cause or incident listed. Resident A has had bruises on her stomach, sides, legs, arm, buttocks, and thighs. Resident A's crisis plan dated 01/31/2024 indicates that Resident A will get up suddenly from a seated position frequently and is at risk of falling or injuring herself; gait belt to be worn during all waking hours. Her plan also lists strategies for physical aggression, self-injury and property destruction. Resident A's IPOS addendum dated 11/27/2023 states that Resident A is not content to sit and wants to move but this is very difficult for her as she is very off balance. Staff must be attentive to her to prevent falling.</p> <p>On 02/23/2024, I completed an unannounced onsite investigation regarding an allegation that Resident B had a black eye and a bruised finger. Resident B's injured finger appeared to be an infection and no bruising was observed. Resident B did</p>

	<p>not have a black eye. According to Ms. Whitney, he had what appeared to be bruising or a rug burn in his beard under chin. Resident B crawls on the floor and that could have caused the injury. However, again the cause was unknown by staff.</p> <p>There is not enough information to determine that Resident E has bed sores due to not being changed by Staff, Deana Cole. Resident E has a documented history of sores and treatment while residing at the home. Ms. Cole has not worked at the home since 02/05/2024.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.14308</b>	<b>Resident behavior interventions prohibitions.</b>
	<p><b>(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></p> <p><b>(a) Use any form of punishment.</b></p> <p><b>(b) Use any form of physical force other than physical restraint as defined in these rules.</b></p> <p><b>(f) Subject a resident to any of the following:</b></p> <p><b>(i) Mental or emotional cruelty.</b></p> <p><b>(ii) Verbal abuse.</b></p> <p><b>(iii) Derogatory remarks about the resident or members of his or her family.</b></p> <p><b>(iv) Threats.</b></p>
<b>ANALYSIS:</b>	<p>There is not enough information to determine that residents are being mistreated by being physically or verbally abused. Resident A and Resident B do have documented bruising, however, there is no information to determine that the bruises were the result of physical abuse or punishment. Resident C indicated that a staff punched a resident who moved away. However, was unable to provide any details or names of anyone involved in the incident. Resident C stated that she feels safe in the home and that staff talk nice to her. The other residents present during onsite investigation could not be interviewed due to verbal inability.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

## **ALLEGATION:**

**Resident A has been receiving expired medications. Resident medications are missed.**

## **INVESTIGATION:**

On 01/03/2024, I completed an unannounced onsite investigation. I reviewed December 2023 and January 2024 resident medication administration records.

On 01/03/2024 during the onsite, I reviewed resident medications with Home Manager, Keunita Whitney. I observed that Resident A's Lorazepam 1 mg tabs expired on 10/03/2023. The use by date on medication packs was listed as 10/16/2023.

Resident B's medication log was missing initials for the following medications:

- Terbinafine Hcl 250 mg tablet- 12/01- 12/31, 01/01, 01/02, 01/03
- Ensure Enlive Liquid (8PM)- 12/04- Instructions state to drink 1 carton by mouth twice daily for 14 days. Ensure is initiated by staff twice daily at 10 AM and 8 PM from 12/01-12/31
- Magic Cup Nutrition Snack states to take 1 cup by mouth twice daily for 14 days. Log is not initiated from 12/01-12/31

Resident D's medication log was missing initials for following medications:

- Nystatin 100,000 Unit/Gm Cream- 01/02 (8AM), 01/03 (8AM)
- Prenatal Vitamin Plus Low- 01/03 (8AM)
- Nystatin 100,000 Unit Gm Cream (8AM)- 12/01, 12/04-12/31
- Primidone 50 mg tablet- 12/31 (12PM)
- Ensure Plus- 12/26

Resident E's medication log was missing initials for following medications:

- Lacosamide 200 mg tablet- 01/01 (9PM)
- Levetiracetam 1,000 mg- 01/02 (7PM)
- Levothyroxine 75 Mcg tab- 01/03 (5:30AM)
- Folic Acid 1 Mg tablet- 01/03 (7AM)
- Pravastatin Sodium 40 mg- 01/01
- Zaditor 0.025% drops= 01/01 (9AM, 4PM), 01/02 (9AM), 01/03 (9AM)

Resident F's medication log was missing initials for following medications:

- Bisacodyl 10 mg- 12/01-12/31, 01/01, 01/02- Not initiated for entire month of December. Instructions state to insert one suppository by rectal route every day.
- Mupirocin 2 % ointment- 01/01, 01/02
- Silver Sulfadiazine 1% Cream- 01/01, 01/02
- Docusate Sodium 100 mg- 12/04 (7AM)
- Loratadine 10 mg tablet- 12/04
- Refresh Optive Advanced Drops (8PM)- 12/02, 12/10, 12/12

- Simvastatin 20 mg tablet- 12/10

On 01/03/2024, I interviewed Resident C. Resident C indicated that she gets all her medications.

On 01/03/2024, I interviewed Staff, Chereta Murphy. She stated that there are no issues with resident medications.

On 01/03/2024, I interviewed Staff, Shirley Murphy. Ms. Murphy indicated that medications are being passed appropriately. She has never seen missed or expired medications.

On 01/05/2024, I received a text message with audio recording from Complainant. The audio recording is alleged to be the assistant manager and staff discussing missed seizure medication.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	<b>(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 S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.</b>
<b>ANALYSIS:</b>	Resident B's December 2023 medication log instructions for Ensure indicate to drink 1 carton by mouth twice daily for 14 days. Ensure is initialed by staff twice daily at 10 AM and 8 PM from 12/01-12/31. The medication log indicates for Resident B to have Magic Cup Nutrition Snack, take 1 cup by mouth twice daily for 14 days. Log is not initiated from 12/01-12/31. Resident F's December 2023 medication log lists Bisacodyl 10 mg. The medication is not initialed for entire month of December. Instructions indicate to insert one suppository by rectal route every day. Medication should be discontinued by physician and taken off medication log if no longer needed.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>



<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	<p><b>(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:</b></p> <p><b>(b) Complete an individual medication log that contains all of the following information:</b></p> <p><b>(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.</b></p>
<b>ANALYSIS:</b>	<p>On 01/03/2024, I reviewed December 2023 and January 2024 resident medication administration records. I found staff initials missing and errors on the medication logs for Resident B, Resident D, Resident E and Resident F.</p> <p>Resident B's medication log was missing initials for following medications:</p> <ul style="list-style-type: none"> <li>• Terbinafine Hcl 250 mg tablet- 12/01- 12/31, 01/01, 01/02, 01/03</li> <li>• Ensure Enlive Liquid (8PM)- 12/04- Instructions state to drink 1 carton by mouth twice daily for 14 days. Ensure is initiated by staff twice daily at 10 AM and 8 PM from 12/01-12/31</li> <li>• Magic Cup Nutrition Snack states to take 1 cup by mouth twice daily for 14 days. Log is not initiated from 12/01-12/31</li> </ul> <p>Resident D's medication log was missing initials for following medications:</p> <ul style="list-style-type: none"> <li>• Nystatin 100,000 Unit/Gm Cream- 01/02 (8AM), 01/03 (8AM)</li> <li>• Prenatal Vitamin Plus Low- 01/03 (8AM)</li> <li>• Nystatin 100,000 Unit Gm Cream (8AM)- 12/01, 12/04-12/31</li> <li>• Primidone 50 mg tablet- 12/31 (12PM)</li> <li>• Ensure Plus- 12/26</li> </ul> <p>Resident E's medication log was missing initials for following medications:</p> <ul style="list-style-type: none"> <li>• Lacosamide 200 mg tablet- 01/01 (9PM)</li> <li>• Levetiracetam 1,000 mg- 01/02 (7PM)</li> <li>• Levothyroxine 75 Mcg tab- 01/03 (5:30AM)</li> <li>• Folic Acid 1 Mg tablet- 01/03 (7AM)</li> <li>• Pravastatin Sodium 40 mg- 01/01</li> <li>• Zaditor 0.025% drops= 01/01 (9AM, 4PM), 01/02 (9AM), 01/03 (9AM)</li> </ul> <p>Resident F's medication log was missing initials for following medications:</p>

	<ul style="list-style-type: none"> <li>• Bisacodyl 10 mg- 12/01-12/31, 01/01, 01/02- Not initiated for entire month of December. Instructions state to insert one suppository by rectal route every day.</li> <li>• Mupirocin 2 % ointment- 01/01, 01/02</li> <li>• Silver Sulfadiazine 1% Cream- 01/01, 01/02</li> <li>• Docusate Sodium 100 mg- 12/04 (7AM)</li> <li>• Loratadine 10 mg tablet- 12/04</li> <li>• Refresh Optive Advanced Drops (8PM)- 12/02, 12/10, 12/12</li> <li>• Simvastatin 20 mg tablet- 12/10</li> </ul>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	<b>(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.</b>
<b>ANALYSIS:</b>	On 01/03/2024, I reviewed resident medications with the Home Manager, Keunita Whitney. I observed that Resident A's Lorazepam 1 mg tabs expired on 10/03/2023. The use by date on medication packs was listed as 10/16/2023. The expired medication should be disposed of and new prescriptions should be obtained if Resident A still needs the medication.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**The home does not have healthy food or water.**

**INVESTIGATION:**

On 01/03/2024, I interviewed the Complainant by phone. The Complainant stated that the home has expired food such as moldy lunch meat. She stated that residents are never given water to drink. The home is not following menu.

On 01/03/2024, I received emails from Complainant with pictures of food, refrigerator, and freezer. The Complainant indicated that one week meat was expired, and deep freezer had nothing but junk food such as corn dogs, cinnamon French toast, and a few nutritional items. I also received a picture of moldy hot dog buns. I am unable to determine from the pictures if food was served or discarded once it expired.

On 01/03/2024, I completed an unannounced onsite investigation. The residents were eating lunch. The Home Manager, Keunita Whitney, stated that residents were having turkey sandwiches, pasta salad and grapes for lunch. The posted menu listed chicken salad wrap, garden salad and pineapple for lunch. I observed that there were four weeks of menus posted on the refrigerator. No substitutions were listed on any of the menus. Ms. Whitney stated that they are always doing grocery shopping. However, indicated that they are not writing substitutions on the menu.

During the onsite investigation, I observed the food available in home. I observed items such as milk, eggs, butter, peppers, cheese, pasta salad, and condiments in the refrigerator. The freezer included items such as waffles, sausage, and burritos. The home had a pantry that included cereal, canned goods, Ensure, fruit cups and macaroni and cheese. Also, the home had two additional freezers. One freezer primarily contained frozen vegetables including, corn, green beans, spinach, and mixed vegetables. The second freezer contained packages of meat. The refrigerator was somewhat messy; however, I did not observe moldy food. There was one jar of pickles with a best use by date of 08/28/2023 with the date 10/04/2023 written on it in marker.

On 01/03/2024, I interviewed Staff, Chereta Murphy. She stated that there is enough food in the home for residents. They have plenty of food to cook meals. Ms. Murphy indicated that they home does not follow a set menu. There is no expired food being served.

On 01/03/2024, I interviewed Staff, Shirley Murphy. She stated that they have enough food for residents in the home. She has not seen expired food. Residents drink water and juice. Ms. Murphy stated that they follow the menu but will sometimes substitute when something is not on the menu.

On 01/03/2024, I interviewed Resident C. Resident C indicated that she gets enough food to eat. She likes oranges and water. Resident C stated that she gets enough water to drink. She also likes the spaghetti, meatballs, and coffee.

<b>APPLICABLE RULE</b>	
<b>R 400.14313</b>	<b>Resident nutrition.</b>
	<b>(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.</b>

<b>ANALYSIS:</b>	There is not enough information to determine that residents are not receiving healthy food and water. On 01/03/2024, I completed an unannounced onsite investigation. There was an adequate amount of food in the home. Resident were having turkey sandwiches, pasta salad and grapes for lunch. Staff, Chereta Murphy and Shirley Murphy, indicated that they have enough food for residents. Resident C stated that she gets enough food to eat and water to drink.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.14313</b>	<b>Resident nutrition.</b>
	<b>(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.</b>
<b>ANALYSIS:</b>	The home's posted menu is not being followed. On 01/03/2024, I observed four weeks of menus posted on the refrigerator. No substitutions were listed on any of the menus. Ms. Whitney stated that they are always doing grocery shopping. However, indicated that they are not writing substitutions on the menu. Residents were not eating the lunch posted on the menu at the time of the onsite investigation.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On 01/03/2024, I completed an unannounced onsite investigation. During the onsite investigation, I observed wall damage throughout the home. I observed chipped paint, scratches and damaged drywall.

I completed an exit conference with Director of Operations, Sara Harris, by phone on 03/08/2024. Human Resources Manager, Latoya Goins, was present during part of the phone call. I informed Ms. Harris of the violations found and that a copy of the special investigation would be mailed once approved. I also informed her that a corrective action plan would be requested and that I would contact them if there were any changes to recommendation or if additional information was requested.

<b>APPLICABLE RULE</b>	
<b>R 400.14403</b>	<b>Maintenance of premises.</b>
	<b>(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair.</b>
<b>ANALYSIS:</b>	On 01/03/2024, I observed wall damage throughout the home including chipped paint, scratches, and damaged drywall. The walls need repair and painting.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

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

*Kristine Cilluffo*

03/08/2024

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Kristine Cilluffo  
Licensing Consultant

Date

Approved By:

*Denise Y. Nunn*

04/12/2024

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Denise Y. Nunn  
Area Manager

Date