GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 18, 2024

Rayann Burge
RSR Valley LLC
33255 26 Mile Road
Lenox, MI 48048

RE: License #: AM500408293
Investigation #: 2024A0617020
Sandalwood Valley I

Dear Ms. Burge:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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 #:	AM500408293
Investigation #:	2024A0617020
Complaint Receipt Date:	03/13/2024
Investigation Initiation Date:	03/13/2024
Report Due Date:	05/12/2024
Licensee Name:	RSR Valley LLC
Licensee Address:	33255 26 Mile Road Lenox, MI 48048
Licensee Telephone #:	(586) 383-2802
Administrator:	Rayann Burge
Licensee Designee:	Rayann Burge
Name of Facility:	Sandalwood Valley I
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 TRAUMATICALLY BRAIN INJURED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Upon leaving the hospital and returning to the AFC home, Resident A could not get anyone to open the door for 10 minutes of knocking. There is suspicion staff were asleep.	Yes

III. METHODOLOGY

03/13/2024	Special Investigation Intake 2024A0617020
03/13/2024	APS Referral Adult Protective Services (APS) referral - denied
03/13/2024	Special Investigation Initiated - Face to Face Initiated the investigation by conducting an unannounced investigation
03/13/2024	Inspection Completed On-site I completed an unannounced onsite investigation of the facility. During my onsite inspection I interviewed Licensee Designee Ms. Rayann McCoy, facility manager Cindy Shelly, Residents A, and Resident B.
03/14/2024	Contact - Telephone call made TC with complainant
03/14/2024	Contact - Telephone call made TC with Dawn Castellano
03/14/2024	Contact - Telephone call made TC with Danielle Nasser
03/14/2024	Contact- Document Sent Email sent to Workforce Background
03/15/2024	Exit Conference I conducted an exit conference with Licensee Designee Rayann McCoy to discuss the findings of this report
03/18/2024	Contact- Document Received Email received from Workforce Background

03/18/2024	Contact- Telephone call received TC with Ms. Danielle Nasser
03/18/2024	Contact- Document Received Received a video that included Ms. Nasser, Ms. Shelly and Ms. McCoy
03/18/2024	Contact- Telephone call received Interview with Resident C's daughter
03/18/2024	Contact- Document Received Received Pictures from Resident C's daughter

ALLEGATION:

Upon leaving the hospital and returning to the AFC home, Resident A could not get anyone to open the door for 10 minutes of knocking. There is suspicion staff were asleep.

INVESTIGATION:

On 03/13/24, a complaint was received regarding Sandalwood Valley I. The complaint indicated the following: Resident A lives in Sandalwood Valley I Assisted Living. Resident A has dementia, but no other health issues are known. Resident A was picked up from Henry Ford Macomb where she had been for a couple hours today for problems urinating. Once Resident A arrived back at Sandalwood, the transport team were not able to get anyone inside to come to the door after 10 minutes of knocking on doors and windows. Finally, after about 15 minutes an alarm was set off when the transport team tried opening the door. Law enforcement was called, and Resident A was able to get inside. There were only two employees inside, Danielle and Dawn. Both employees said they could not hear the alarm going off from where they were on the other side of the building and the front door is broken. The land line is out, and the phone goes straight to voicemail, so staff only use their cell phones in the building. There was a TV blaring inside and could be heard all over the facility. There was a blanket and pillow in the common room near where Danielle came from, and she said she was helping Dawn who is older and not able to do this job on her own anymore. Dawn uses a walker to get around. Once Resident A was in her room, Danielle said they were not expecting her until the next day so that is why they were not up-front waiting for her. Danielle only recently obtained her CPR certification and Dawn has some other type of technician certificate, but it is unknown what that certification is.

On 03/13/24, I completed an unannounced onsite investigation of the facility. During my onsite inspection I interviewed licensee designee Ms. Rayann McCoy, facility manager Cindy Shelly, Resident A and Resident B. Staff Star Dominguez was working as a care worker, Ms. Cindy Shelly was working as the med technician, and licensee designee Rayann McCoy was upstairs in the staff office.

During the onsite investigation, I observed the exterior doors of the facility to be in good working order. Staff was able to open the door and let me in without issue. The alarms on the door were also in good working order. I tested the facility phones by calling the facility and also by making outgoing calls. The phones were working with no issues.

According to Ms. Shelly, the front door was broken a few weeks ago but it was repaired on 02/29/24. Ms. Shelly provided me with a paid invoice from Audio Sentry Corporation with a service date of 2/29/24. According to the invoice, “the front door contact was missing screw for proper terminal and would make contact work reverse (when door closed would sound); adjusted Maglock to enable less sensitive egress; also moved door plate to tighten up door; door is functional now.”

I reviewed an Incident Report dated 3/11/24. The incident report stated that Resident A had blood in her urine earlier in the day around noon. Resident A’s behavior continued to be combative, confused and defiant. Staff called Resident B’s doctor and it was suggested that Resident B be sent to the hospital. Staff contacted Resident A’s guardian on 3/11/24 at 6:15pm. I reviewed the posted staff schedules from 3/10/24 to 3/16/24. According to the staff schedules, staff Eugina worked (Sandalwood Valley 1) on 3/11/24 from 3pm to 11pm, Dawn (Sandalwood Valley 2) from 11pm to 7am, and Danielle (Sandalwood Valley 1) from 11pm to 7am.

According to Ms. McCoy, staff Danielle and Dawn have proper trainings and qualifications. Ms. McCoy was not able to provide the requested staff files for me to review. Ms. McCoy stated that Dawn does not use a walker and is able to move freely without restrictions.

According to Resident A, she enjoys the facility and has no issues to complain about. Resident A was seen affectionately interacting with staff.

According to Resident B, she is well taken care of at the facility. Staff checks on her regularly during the day and night shifts. Resident B did not have any concerns to report.

On 03/14/24, I interviewed the Complainant. According to the Complainant, Resident A was picked up from Henry Ford Macomb where she had been for a couple hours that day for problems urinating. Once Resident A arrived back at Sandalwood, the transport team were not able to get staff inside to come to the door. After about 5 to10 minutes of knocking on doors and windows, the transport team tried entering codes to enter the building. This set an alarm off that went on for over 15 minutes. The transport team called law enforcement and when the police arrived, they easily opened the door and entered the building. There were only two employees inside, Danielle and Dawn. Both employees said they could not hear the alarm going off from where they were on the other side of the building and the front door is broken. According to the complainant, the land line was not working, and when the transport team and police tried calling the facility, the phone went straight to voicemail. There was a TV blaring inside and could

be heard all over the facility. There was a blanket and pillow in the common room near where Danielle came from, and she said she was helping Dawn who is older and not able to do this job on her own anymore. The complainant stated that she observed Dawn using a walker to get around the facility.

On 03/14/24, I interviewed staff Dawn Castellano. According to Ms. Castellano, she was working in Sandalwood Valley II on 03/11/24. It was only Ms. Castellano and Ms. Danielle Nasser working both facilities. Ms. Castellano stated that she needed assistance working with a resident in Sandalwood Valley II and Ms. Nasser came over to help. During that time the transportation team brought Resident A back to the facility and staff was unaware. According to Ms. Castellano, there was only one phone for both facilities and the phone was in a part of the building where staff was unable to hear it. Ms. Castellano stated that while staff was working in the other part of the building, the police was able to gain access to the building without staff knowledge. Ms. Castellano stated the police told her that they just pulled the door open without issue and that caused the alarm to go off. She stated it scared her, and it is also frightening to know that the facility can be so easily penetrated. Ms. Castellano stated that she does not use a walker and can get around without restrictions.

On 03/14/24, I interviewed staff Danielle Nasser. According to Ms. Nasser, she and Ms. Castellano were the only two individuals working both facilities. Ms. Nasser stated that she went to the other building where Ms. Castellano was working because she was trying not to fall asleep. While in the other building, they watched television for a few minutes before going back to do their rounds. When Ms. Nasser went to conduct her rounds, she found Resident C scooting across the kitchen floor. Ms. Nasser asked Ms. Castellano to assist her because Resident C is a large male and deaf. The two staff worked together to get Resident C back in bed. Afterward, the staff went to the other building to work together to assist another resident who required two people. While the other building, the staff heard a male voice, and it scared them because they could not recognize the voice. Eventually the male yelled out and identified himself as the Sherif from the Sherif's department. Ms. Nasser stated that the Sherif pulled extremely hard on the door to get it to open. Ms. Nasser stated that staff was not expecting Resident A back at the facility because it was 3:40AM and no one notified them that she would be back at that time. Ms. Nasser stated that she did not hear the facility phone ringing while working. Ms. Nasser denied sleeping on shift. She stated when she arrived at the facility that day around 9 PM, she found staff Eugina sleeping and the cover and pillow observed by the complainant, was Eugina's. Ms. Nasser stated that Ms. Castellano does not use a walker. The walker that she was seen using belonged to Resident A and Ms. Castellano was taking it back to Resident A's room.

On 03/14/24, I contacted Workforce Background received notification that the following workers were not cleared to work at the facility: Dawn Castellano, Stacy Schokora, Monika Schward, Nehemie Solomon, Mary Simonds, and Starly Dominguez. Staff schedules reviewed indicate that each of those individuals were listed on the schedules.

On 03/15/24, I conducted an exit conference with Licensee Designee Rayann McCoy to discuss the findings of this report. Ms. McCoy understood the violations and stated she is actively interviewing to hire more staff and is addressing all of the concerns as quickly as possible.

On 03/18/24, I received a video of staff Danielle Nasser, Cindy Shelly and Rayann McCoy having a discussion. In the video, Ms. McCoy stated that she did not know which staff were trained or when training was completed. Also in the video, Ms. Shelly and Ms. McCoy and Ms. Nasser, reviewed footage of Resident C leaving his room, falling on the floor, and scooting across the kitchen floor for over an hour before Ms. Nasser found him.

On 03/18/24, I conducted an interview with Resident C's daughter. According to Resident C's daughter, Resident C is deaf but can speak. He relies on reading lips because he can't read or write very well. He can understand and write small words. He has severe dementia, and he does have some behavioral issues. He does know sign language and he has a video phone with an app that you speak to, and it will display the signs for the resident. Resident C's daughter is unaware if staff is aware of the phone or knows how to use it. With regards to Resident C falling on 03/11/24, she was unaware and have not been contacted by staff. Resident C's friends went to visit him on Saturday, and they noticed a bruise on him. The friends are deaf and Resident C told them via sign language that he fell. Resident C's daughter sent me a picture of Resident C with a big bruise on the side of his face near his eye. I also observed a screenshot of a text message exchange from Resident C's friends and Resident C's daughter that stated Resident C had a big bruise on his face along with scratches on his wrist.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**

ANALYSIS:	During the onsite investigation Ms. McCoy stated staff Danielle Nasser and Dawn Castellano have proper trainings and qualifications. However, Ms. McCoy was not able to provide the requested staff files for me to review. On 03/18/24, I received a video of staff Danielle Nasser, Cindy Shelly and Rayann McCoy having a discussion. In the video, Ms. McCoy stated that she did not know which staff were trained or when training was completed.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	During the onsite investigation, I observed multiple two-person assist residents in this facility. I reviewed the posted staff schedules from 3/10/24 to 3/16/24. According to the staff schedules, staff Eugina worked (Sandalwood Valley 1) on 3/11/24 from 3pm to 11pm, Dawn (Sandalwood Valley 2) from 11pm to 7am, and Danielle (Sandalwood Valley 1) from 11pm to 7am. By only having one direct care staff per building from 11pm to 7am, the facility was not properly staffed. If staff needed assistance, staff from the other facility would have to come assist and that would leave a facility unstaffed.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(a) Name, address, telephone number, and social security number.** **(b) The professional or vocational license, certification, or registration number, if applicable.** **(c) A copy of the employee's driver license if a direct care staff member or employee provides transportation to residents.**

	(d) Verification of the age requirement. **(e) Verification of experience, education, and training.** **(f) Verification of reference checks.** **(g) Beginning and ending dates of employment.** **(h) Medical information, as required.** **(i) Required verification of the receipt of personnel policies and job descriptions.**
ANALYSIS:	During the onsite investigation Ms. McCoy stated staff Danielle Nasser and Dawn Castellano have proper trainings and qualifications. However, Ms. McCoy was not able to provide the requested staff files for me to review.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	During the onsite investigation, I observed the exterior doors of the facility to be in good working order. Staff were able to open the door and let me in without any issue. The alarms on the door were also in good working order. Ms. Shelly provided a paid invoice from Audio Sentry Corporation with a service date of 2/29/24.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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: **(e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable**

	amount of change shall be available in the group home to enable residents to make change for calling purposes.
ANALYSIS:	During the onsite, I tested the facility phones by calling the facility and by also making outgoing calls. The phones were working with no issues.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under

	subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	During the onsite investigation Ms. McCoy stated staff have proper trainings and qualifications. However, Ms. McCoy was not able to provide the requested staff files for me to review. On 03/14/24, Workforce Background was contacted, and I received notification that the following workers were not cleared to work at the facility: Dawn Castellano, Stacy Schokora, Monika Schward, Nehemie Solomon, Mary Simonds, and Starly Dominguez. Staff schedules reviewed indicate that each of those individuals were listed on the schedules. The facility was not able to provide conditional employment paperwork per MCL 400.734b (6) since they were not able to provide any staff files.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Based on continual quality of care violations, including lack of staff to meet the resident's needs, summary suspension is recommended. Revocation of the license was previously recommended in Special Investigation Report #2024A0617013, which remains in effect.

03/18/24

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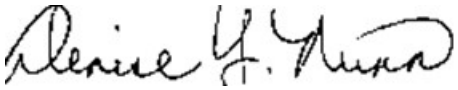
Eric Johnson Date
Licensing Consultant

Approved By:



03/18/2024

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Denise Y. Nunn Date
Area Manager