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 #: AM500408396
Investigation #: 2024A0617019
Sandalwood Valley II

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 #:	AM500408396
Investigation #:	2024A0617019
Complaint Receipt Date:	03/07/2024
Investigation Initiation Date:	03/12/2024
Report Due Date:	04/06/2024
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 II
Facility Address:	33255 26 Mile Rd Lenox, MI 48048
Facility Telephone #:	(586) 270-6784
Original Issuance Date:	11/15/2021
License Status:	REGULAR
Effective Date:	05/15/2022
Expiration Date:	05/14/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 2/25 and 2/29, Resident A went over 10 hours without a brief change.	**No**
Resident A's emergency cord was taped.	**Yes**
On 2/25, Resident A did not get her scheduled medications.	**No**
Facility's exterior door is broken.	**No**

III. METHODOLOGY

03/07/2024	Special Investigation Intake 2024A0617019
03/12/2024	Special Investigation Initiated – Letter Email Sent to Complainant
03/12/2024	APS Referral Adult Protective Services (APS) referral received - denied
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. I also interviewed Resident A's Daughter via telephone.
03/14/2024	Contact - Telephone call made I interviewed staff Dawn Castellano.
03/14/2024	Contact - Document Received I received an email from Resident A's granddaughter with several pictures and videos from Resident A's bedroom.
03/14/2024	Contact - Telephone call made TC to Hospice Nurse Dana Zuccaro
03/14/2024	Contact- Document Sent Email sent to Workforce Background

03/15/2024	Contact - Telephone call made TC to Hospice Nurse Dana Zuccaro
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

ALLEGATION:

- **On 2/25 and 2/29, Resident A went over 10 hours without a brief change.**
- **Resident A's emergency cord was taped.**

INVESTIGATION:

On 03/07/24, a complaint was received regarding Sandalwood Valley II. The complaint indicated the following: "At the urging of employees to hospice, Resident A received a Broda chair. After not being out of her room since 04/06/23, the employees decided on 02/25/24, to take Resident A from her room, for over 10 hours using the Broda chair. In that 10-hour period, facility manager admitted to me as well as hospice nurse Dana Zuccaro that Resident A did not get her brief changed or her medications that she is prescribed to get every four hours. On 02/28/24, my niece went to visit Resident A in the evening. My niece contacted me with photos showing a handwritten sign stating door system was broken. We knew there to be an issue for about two weeks. Their "security" was chairs strategically, piled against the door (photos are available). On Thursday 02/29/24 at 6:40 pm, Resident A was checked on by staff. This was the last time she was checked on or would see anyone until 8:28 am the next day. When Resident A pulled her cord at 8:57am, the cleaning lady, not a care worker came to check on her. That's over 12 hours with no checks at all. There is video camera proof that at 9am the cook comes into Resident A's room. At 10:57 am facility manager Cindy finally tends to Resident A by changing her brief. That is over 14 hours with no brief change. There are things going on there every single day. Rayann is now allegedly the administrator of all the facilities. We were informed yesterday that they intend to discharge Resident A on the basis of lies they have stated in the email. I believe this is in retaliation of providing evidence via photos and videos from previous investigation and incidents. As well as for calling them out with proof that they are negligent. At the time of this writing, I am witnessing on video care worker Dawn taping the emergency pull cord, so it cannot be

used by Resident A. Resident A has her days and nights completely mixed up, is unaware of what time she pulls cord. she just knows that most times no one will come because they are and always have been understaffed."

On 03/13/24, I completed an unannounced onsite investigation at the facility. During my onsite investigation, I interviewed licensee designee Ms. Rayann McCoy, facility manager Cindy Shelly, Resident A and Resident B. Staff Mary Simonds 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.

According to Ms. Shelly, on 02/25/24, Resident A was not in her room due to her receiving a Broda chair and being able to get out of her room to sit in various locations throughout the facility.

Ms. Shelly stated that Resident A had her briefs changed several times throughout the day. Staff changed Resident A in the facility bathrooms and not in her room. Ms. Shelly stated the facility does not chart when residents are changed. Ms. Shelly denied the allegations that Resident A was not checked on or changed for 14 hours on 02/29/24. Ms. Shelly stated that Resident A is constantly checked on due to her constant requests. Ms. Shelly stated that Resident A is a difficult resident to work with and constantly pulls on her call cord for staff assistance, even his assistance is not needed. According to Ms. Shelly, there is no tape on Resident A's pull cord. Ms. Shelly stated that staff Dawn attempted to tape Resident A's pull cord but was unsuccessful due to the tape not sticking well enough. Ms. Shelly stated that Resident A is constantly calling for staff for unnecessary reasons and that frustrated staff.

During the onsite investigation, Resident A's daughter called the facility and requested to speak with me. According to Resident A's daughter, the facility manager admitted to her as well as hospice nurse Dana Zuccaro that Resident A did not get her briefs changed or her medications that she is prescribed to get every four hours on 02/25/24. On 02/28/24, Resident A's daughter's niece went to visit Resident A in the evening. Her niece observed a handwritten sign stating door system was broken. At that time the facility's "security" was chairs strategically piled against the door. On Thursday, 02/29/24, at 6:40 pm Resident A was checked on by staff. This was the last time she was checked on or would see anyone until 8:28 am the next day. When Resident A pulled her cord at 8:57am, the cleaning lady, not a care worker came to check on her which is over 12 hours with no checks at all. Resident A was not changed until 10:57 am when facility manager Cindy finally tends to Resident A by changing her briefs.

According to Resident A's daughter, the facility is discharging Resident A based on lies. According to Ms. McCoy, Resident A is being discharged due to her care needs changing and the facility no longer being able to meet her care needs.

Ms. McCoy was not able to provide the requested resident files for me to review. Ms. McCoy stated that the files are incomplete and all over the place. She has been working on correcting the files, but it is taking longer than expected.

During the onsite investigation, I interviewed Resident A in her bedroom. According to Resident A, she is well taken care of at the facility. Staff checks on her regularly during the day and night shifts. Resident A stated that staff did not tape her pull cord and she always have access to it. Resident A stated that her briefs are changed regularly.

During the interview with Resident A, I observed that Resident A's room had an egregious pungent foul smell. I had a tightly fitted mask on and could vividly smell it through the mask. Ms. McCoy was present during the interview and smelled the smell as well. Ms. McCoy stated that she received a headache from it and agreed that the smell was unacceptable. Resident A was observed laying down in bed, the room was dirty with food crumbs/spills and stains on the floor. Ms. Shelly was questioned on why Resident A's room smelled like that. According to Ms. Shelly, Resident A received a bath that morning approximately three hours prior to my arrival by the Hospice Nurse. Ms. Shelly stated that Resident A's room is routinely cleaned and believes the source of the smell is Resident A's mattress. According to Ms. Shelly, Resident A was offered a new bed multiple times, but Resident A's family refused. Prior to leaving the facility, Ms. McCoy stated that she had two staff members thoroughly clean Resident A's room and staff found that Resident A had dropped feces on the floor and that was the source of the smell.

On 03/14/24, I interviewed staff Dawn Castellano. According to Ms. Castellano, she put the tape loosely over the call button to deter Resident A from continuously calling staff for assistance. Ms. Castellano stated she told Resident A that the call button was broken and needed to be fixed because Resident A had been calling staff for assistance every five minutes or so but did not actually need anything. Ms. Castello stated that Resident A was disturbing the other residents with her constant use of the call button. Ms. Castello stated that Resident A is very difficult to work with and requires a lot of attention. Ms. Castello stated that Resident A briefs are always changed timely and she does not go hours without it being changed.

On 03/13/24, I received an email from Resident A's granddaughter with several pictures and videos from Resident A's bedroom. I observed in the pictures and video, a staff member placing tape over Resident A's call button. In the video, Resident A's TV was extremely loud and staff and Resident A could barely hear each other. With the call button obstructed and the TV extremely loud, staff would not be able to hear Resident A if she called for assistance. Also in the video, staff can be seen moving a table between the side bedrails to prevent Resident A from getting out of bed.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Ms. Castellano admitted that she put tape loosely over the call button to deter Resident A from continuously calling staff for assistance. I observed in the pictures and video, a staff member placing tape over Resident A's call button. In the video, Resident A's TV was extremely loud and staff and Resident A could barely hear each other. With the call button obstructed and the TV extremely loud, staff would not be able to hear Resident A if she called for assistance. I observed Resident A's room had and egregious pungent foul smell. I had a tightly fitted mask on and could vividly smell it through the mask. Ms. McCoy was present during the interview and smelled the smell as well. Ms. McCoy stated that she received a headache from it and agreed that the smell was unacceptable. I was unable to determine if Resident A went 10 hours without being changed per the allegations.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 2/25/24, Resident A did not get her scheduled medications.

INVESTIGATION:

During the onsite investigation, Ms. Shelly stated that she worked on 02/25/24 and Resident A received her medications. I reviewed Resident A's medication logs for 02/25/24, and according to the log, she received all prescribed scheduled medications.

During the onsite investigation, I conducted a medication review for Resident A and Resident B. The following medication errors were found for Resident A:

- The medication ABHR Gel 1ML was not given every 4 hours on 3/2, 3/4, 3/5, 3/6, 3/7, 3/8, 3/9, 3/11, 3/12.
- The medication Nystatin Pow 100000 was not given on 3/1 8pm, 3/2 8am and 8pm, 3/3 8pm, 3/6 8am and 8pm, 3/7 8am, 3/8 8pm, 3/9 8am and 8pm, 3/10 8am, 3/11 8am.
- The medication Meclizine 25mg did not have a discontinue order from a medical professional.
- The medication Quetiapine 25MH did not have a discontinue order from a medical professional.
- The medication Acetaminophen tab 325mg did not have a discontinue order from a medical professional.
- The medication Diclofanac gel 1% Medication log stated that the medication is prescribed as needed. The label on the medication stated that it is prescribed for 4 times a day/daily.

- The medication Haloperidol 5mg expired on 9/29/23 and was still being given to Resident A.

The following medication errors were found for Resident B:
- The medication Docusate Sod Liq 50mg/5ml was not given on 3/2 and 3/6.
- The medication Famotidine 20mg was not given on 3/4 - 7pm, 3/5 - 7pm, 3/7 7pm, 3/8 - 7pm, 3/10 - 7pm, 3/11 - 7pm
- The medications Acetaminophen 650 MG Sup 600 MG and Bisacodyl 10 MG Sup 10MG were missing.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	During the onsite investigation, I conducted a medication review for Resident A and Resident B. The following medication errors were found for Resident A: • The medication ABHR Gel 1ML was not given every 4 hours on 3/2, 3/4, 3/5, 3/6, 3/7, 3/8, 3/9, 3/11, 3/12 • The medication Nystatin Pow 100000 was not given on 3/1 8pm, 3/2 8am and 8pm, 3/3 8pm, 3/6 8am and 8pm, 3/7 8am, 3/8 8pm, 3/9 8am and 8pm, 3/10 8am, 3/11 8am. • The medication Meclizine 25mg did not have a discontinue order from a medical professional. • The medication Quetiapine 25MH did not have a discontinue order from a medical professional. • The medication Acetaminophen tab 325mg did not have a discontinue order from a medical professional. • The medication Diclofanac gel 1% medication log stated that the medication is prescribed as needed. The label on the medication stated that it is prescribed for 4 times a day/daily. • The medication Haloperidol 5mg expired on 9/29/23 and was still being given to Resident A. The following medication errors were found for Resident B: • The medication Docusate Sod Liq 50mg/5ml was not given on 3/2, 3/6. • The medication Famotidine 20mg was not given on 3/4 7pm, 3/5 7pm, 3/7 7pm, 3/8 7pm, 3/10 7pm, 3/11 7pm. • The medications Acetaminophen 650 MG Sup 600 MG and Bisacodyl 10 MG Sup 10MG were missing.

CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(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) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given**
ANALYSIS:	During the onsite investigation, I conducted a medication review for Resident A and Resident B. The following medication errors were found for Resident A: • The medication ABHR Gel 1ML was not given every 4 hours on 3/2, 3/4, 3/5, 3/6, 3/7, 3/8, 3/9, 3/11, 3/12 • The medication Nystatin Pow 100000 was not given on 3/1 8pm, 3/2 8am and 8pm, 3/3 8pm, 3/6 8am and 8pm, 3/7 8am, 3/8 8pm, 3/9 8am and 8pm, 3/10 8am, 3/11 8am. The following medication errors were found for Resident B: • The medication Nystatin Pow 100000 was not given on 3/1 8pm, 3/2 8am and 8pm, 3/3 8pm, 3/6 8am and 8pm, 3/7 • The medication Docusate Sod Liq 50mg/5ml was not given on 3/2, 3/6 • The medication Famotidine 20mg was not given on 3/4 7pm, 3/5 7pm, 3/7 7pm, 3/8 7pm, 3/10 7pm, 3/11 7pm
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility's exterior door is broken.

INVESTIGATION:

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.

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.”

On 3/14/24, I observed pictures of chairs being used to keep the exterior doors shut. There is also a picture of a sign on the door that says, “use side door, not resetting”. There is no date on when the pictures were taken.

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.

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 that 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.

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 me with a paid invoice from Audio Sentry Corporation with a service date on 2/29/24.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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 on 3/13/24, 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 03/18/24, 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 400.14208	**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 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	
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 3/14/24, 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 indicate that each of those individuals were listed on the schedules to work. 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

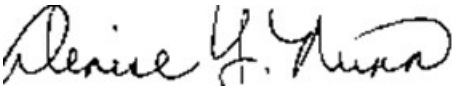
Based on continual quality of care violations, including lack of staff to meet the resident's needs, summary suspension is recommended. Revocation of the license was previously recommended in Special Investigation Report #2024A0617014, which remains in effect.

03/18/24

_____

Eric Johnson Date
Licensing Consultant

Approved By:



03/18/2024

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Denise Y. Nunn Date
Area Manager