GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 24, 2024

Rayann Burge
RSR Creek LLC
5485 Smiths Creek
Kimball, MI 48074

RE: License #: AS740408305
Investigation #: 2024A0580026
Sandalwood Creek II

Dear Rayann Burge:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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 (517) 643-7960.

Sincerely,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS740408305
Investigation #:	2024A0580026
Complaint Receipt Date:	03/01/2024
Investigation Initiation Date:	03/06/2024
Report Due Date:	04/30/2024
Licensee Name:	RSR Creek LLC
Licensee Address:	5485 Smiths Creek Kimball TWP, MI 48074
Licensee Telephone #:	(810) 204-0577
Administrator:	Rayann Burge
Licensee Designee:	Rayann Burge
Name of Facility:	Sandalwood Creek II
Facility Address:	5485 Smiths Creek Kimball TWP, MI 48074
Facility Telephone #:	(810) 367-7192
Original Issuance Date:	11/16/2021
License Status:	REGULAR
Effective Date:	05/16/2022
Expiration Date:	05/15/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility is short-staffed.	No
Showers are given but Residents are not cleaned.	No
Resident B has 2 black eyes after falling, having been left alone in the shower.	No
Resident A has a large bruise on the bottom of his lip. It is suspected that staff Jason Wasyck caused the bruise.	No
The food lacks nutrition and small portions are provided.	No
Additional Findings	Yes

III. METHODOLOGY

03/01/2024	Special Investigation Intake 2024A0580026
03/06/2024	Special Investigation Initiated - Telephone Call to Dan Schiver of APS.
03/06/2024	APS Referral Opened by APS for investigation.
03/11/2024	Inspection Completed On-site Inspection completed onsite.
03/11/2024	Contact - Face to Face Interview with Resident A.
03/11/2024	Contact - Face to Face Interview with Relative Guardian A.
03/11/2024	Contact - Face to Face Interview with LD Burge.
03/11/2024	Contact - Document Received Review of Assessment Plan and Incident Report.
03/19/2024	Inspection Completed On-site Onsite inspection. Interview with LD Burge.
03/19/2024	Contact - Face to Face Interview with Resident B.

03/19/2024	Contact - Face to Face
03/19/2024	Contact - Face to Face Interview with Resident C.
03/19/2024	Contact - Face to Face Interview with Resident D.
03/19/2024	Contact - Face to Face Interview with Resident D.
03/20/2024	Contact - Document Received Documents requested were received.
03/27/2024	Inspection Completed On-site Unannounced onsite. Observed and interviewed Resident B.
03/27/2024	Contact - Face to Face Spoke with LD Burge while onsite.
04/15/2024	Contact - Telephone call made Spoke with LD Burge.
04/17/2024	Contact - Document Received Documents requested were received.
04/18/2024	Contact - Telephone call made Call to Relative B.
04/19/2024	Contact - Telephone call made Call to direct staff, Nicole Convery.
04/19/2024	Contact - Telephone call made Call to former direct staff, Mary Simmonds.
04/19/2024	Contact - Telephone call made Call to former direct staff, Jason Wasyck.
04/22/2024	Inspection Completed On-site In person interview with direct staff, Alfred Davis.
04/23/2024	Contact - Telephone call made Call to Public Guardian C.
04/23/2024	Contact - Telephone call made Call to Relative Guardian D.

04/23/2024	Contact - Telephone call made Call to Relative Guardian E.
04/24/2024	Exit Conference Exit Conference with the Rayann Burge, licensee Designee.

ALLEGATION:

The facility is short-staffed.

INVESTIGATION:

On 03/11/2024, intake #199990 was received and combined with this investigation.

On 03/19/2024, I conducted an unannounced onsite inspection at Sandalwood Creek II spoke with the LD Burge regarding the allegations, which she denied. She adds that due to the firing of several staff, she anticipated complaints being made. LD Burgess states that there are currently 5 residents in the home. There is 1 staff each shift. Resident A was not available at the time of the visit.

The assessment plan reviewed for Resident A indicates that he requires staff assistance with toileting, bathing, and mobility. He uses both a wheelchair and a walker as assistive devices.

On 03/19/2024, While onsite, I conduced an interview with Resident B. Resident B is blind and was observed in her room, sitting in her chair, listening to a book. Resident B stated that she requires assistance with mobility and toileting. Resident B denied waiting long periods of time for staff assistance. She has a call button and estimates that it takes about a 5-minute wait for staff. Resident B was observed as being adequately dressed and groomed. Resident B appeared to be receiving proper care.

The assessment plan for Resident B indicates that she requires staff assistance getting to and from the bathroom. Resident B uses both a wheelchair and a walker as assistive devices. Due to being blind she requires verbal cueing and direction.

On 03/19/2024, while onsite, I interviewed Resident C while in his room. Trash in the room was observed overflown with disposed diapers and his room reeked of urine. Resident C was observed lying in his bed while watching TV. Resident C was adequately dressed and no concerns with his care were noted. Resident C stated that he does not wait a long time for staff assistance.

The assessment plan for Resident C indicates that he requires staff assistance with toileting, bathing, grooming, hygiene, and mobility. Resident C requires the use a wheelchair for transfers and mobility.

On 03/19/2024, while onsite, I interviewed Resident D in his room. The room was observed nice and clean. Resident D stated that staff cleans his room. Resident D was adequately dressed and groomed. Resident D stated that he does not wait long for assistance. Staff help him when needed.

The assessment plan for Resident D indicates that he requires assistance with toileting, grooming, bathing, dressing and personal hygiene. Resident A is able to walk with staff assistance to determine balance/gait. He also uses both a walker and wheelchair for mobility.

On 03/19/2024, while onsite, I interviewed Resident E in his room, which was observed to be clean. Resident E was dressed and groomed adequately. Resident E appeared to be receiving proper care. Resident E stated that he does not wait long periods of time for staff assistance. Staff assist him as needed and are easy to locate.

The assessment plan for Resident E indicated that he requires staff assistance with toileting, bathing, grooming, dressing, personal hygiene, and mobility. Resident E also uses both a walker and wheelchair for mobility.

On 03/20/2024, I reviewed a copy of the March 2024 staff schedule for Sandalwood Creek II. The schedule indicates that there is 1 direct care worker staffed each shift, 7am-3pm, 3pm-11pm and 11pm-7am. In addition, there is a day cook scheduled daily from 7am-2pm and an afternoon cook scheduled 2pm-7pm.

Fire drill reviewed indicate in December 2023, the 5 residents were evacuated by 1 staff in 1 min, 30 seconds. In January 2024 1 staff evacuated 4 residents in 2 minutes. In February 2024, 5 residents were evacuated by 1 staff, in 2 minutes and 20 seconds.

On 04/18/2024, I spoke with Relative B, who stated that she believes that the facility is short staffed. One person is not able to meet the needs of the residents.

On 04/19/2024, I spoke with direct staff Marie Carrier, who denied that the facility is short staffed. Staff Carrier stated that she can meet the needs of the residents when working alone.

On 04/19/2024, I placed a call to direct staff, Nicole Convery who denied that they are short-staffed at Sandalwood Creek Side 2. Staff Convery also stated that she can handle the needs of all the residents when working alone.

On 04/19/2024, I placed a call to Mary Simmonds, former employee. A voice mail message was left requesting a return call.

On 04/22/2024, I conducted an onsite inspection at Sandalwood Creek II. I spoke with direct staff, Alfred Davis. Staff Davis stated that he can handle the needs of the residents when working alone at the facility. Residents were observed sitting at the dinette table visiting with family while other residents were watching TV in the living

room. The residents were adequately dressed, groomed, and appeared to be receiving proper care.

On 04/23/2024, I spoke with Public Guardian C, representative for Resident C, who denied any concerns. Resident C has not expressed any concerns regarding lack of staffing.

On 04/23/2024, I spoke with Relative E, who stated that Resident E has not expressed any concerns regarding not being able to reach staff to assist with his needs when asked. Resident C has not expressed any concerns regarding lack of staffing.

On 04/23/2024, I placed a call to Relative D, leaving a voice mail requesting a return call.

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:	It was alleged that the facility is short-staffed. Licensee Designee, Rayann Burge and her direct staff members, Marie Carrier, Nicole Convery and Alfred Davis denied the allegations. The assessment plans for Residents A-E were reviewed. Residents B-E were interviewed, and all denied waiting long periods of time for staff assistance. The March 2024 staff schedule was reviewed. Relative B stated that she believes 1-person is not enough for the 5 residents and the facility is short-staffed. Public Guardian C stated that Resident C has not expressed any concerns regarding lack of staffing.

	Relative E stated that Resident E has not expressed any concerns regarding not being able to reach staff to assist with his needs when asked.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Showers are given but Residents are not cleaned.

INVESTIGATION:

On 03/19/2024 Resident B denied the allegations that she is not cleaned during showers. Although she is blind Resident B stated that she can smell soap. Resident A was observed adequately cleaned and groomed, with no hygiene concerns.

The assessment plan for Resident B states that she requires assistance with being handed soaps, shampoos while bathing and uses both a wheelchair and a walker as assistive devices. Due to being blind she requires verbal cueing and direction.

On 03/19/2024, Resident C denied the allegations. Resident C was observed lying in his bed while watching TV. Although the room reeked of urine, Resident C did not appear to be wet. Resident C was adequately dressed and groomed.

The assessment plan for Resident C indicates that he requires staff assistance with bathing.

On 03/19/2024, Resident D denied the allegations. Staff help him with showers when needed. Resident D was observed adequately cleaned and groomed, with no hygiene concerns.

The assessment plan for Resident D indicated that he requires staff assistance with giving him a washcloth and prompts for bathing.

On 03/19/2024, Resident E denied the allegations that he is not cleaned while showered. Resident E was dressed and groomed adequately, with no hygiene concerns. He appeared to be receiving proper care.

The assessment plan for Resident E indicates that he requires staff assistance with bathing.

On 04/18/2024, Relative B stated that Resident B is very particular about her hot showers. Resident B has never complained that she was not being showered.

On 04/19/2024, staff Carrier denied the allegations, stating that she always uses good smelling body washes and soaps when she showers the residents.

On 04/19/2024, staff Convery denied the allegations, stating that she provides the residents with full body washes when giving showers.

On 04/22/2024, I spoke with staff Davis, who stated that he provides the residents with full body washes when assisting with resident showers.

On 04/23/2024, I spoke with Public Guardian C, representative for Resident C, who denied any concerns. Resident C has not expressed any concerns regarding his hygiene or not receiving showers.

On 04/23/2024, I placed a call to Relative D, leaving a voice mail requesting a return call.

On 04/23/2024, I spoke with Relative E, who stated that Resident E has not expressed that he is not receiving showers. Resident E has complained that he has to get up early for showers. Relative Guardian E has no concerns regarding Resident E's hygiene.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	It was alleged that showers are given but Residents are not cleaned. Licensee Designee, Rayann Burge and her direct staff members, Marie Carrier, Nicole Convery and Alfred Davis denied the allegations. The assessment plans for Residents A-E were reviewed. Residents B-E were interviewed, and all denied not being cleaned during showers. Relative B stated that Resident B has never complained that she was not being showered. Public Guardian C stated that Resident C has not expressed any concerns regarding his hygiene or not receiving showers.

	Relative E stated that Resident E has complained that he has to get up early for showers. Relative Guardian E has no concerns regarding Resident E's hygiene. Based on the interviews conducted and a review of the assessment plans for Residents A-E, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B has two black eyes after falling, having been left alone in the shower.

INVESTIGATION:

On 03/27/2024, I made an unannounced onsite inspection at Sandalwood Creek II. While onsite I observed that Resident B had sustained two black eyes, with significant purple bruising under both eyes. The left eye is completely shut. A photo was taken. Resident B stated that she fell out of her chair. Resident B was observed in her room, sitting in her chair, listening to a book. Resident B was observed as being adequately dressed and groomed. Resident B appeared to be receiving proper care.

On 03/27/2024, while onsite, LD Burge shared that Resident B sustained the injuries by falling from her chair.

On 03/29/2024, intake #200264 was combined with this investigation.

On 04/15/2024, I spoke with LD Burge requesting a copy of the incident report related to Resident B's fall and medical discharge documentation.

The incident report, dated 03/21/2024, indicates that staff Nicole Convery and Mary Simonds were on duty. Resident B was in the bathroom sitting in her wheelchair and fell forward. Staff called 911 management staff and Relative Guardian B. Staff will follow instructions from the hospital/physician upon discharge.

The assessment plan for Resident B states that she requires assistance with being handed soaps, shampoos while bathing and uses both a wheelchair and a walker as assistive devices. Due to being blind she requires verbal cueing and direction. The assessment plan only states that Resident B requires assistance giving soaps and shampoos.

The Lake Huron Medical Center After Visit Summary for Resident B indicates that Resident B was seen due to a fall/facial hematoma on 03/21/2024. Treatment included

CT Cervical spine without contrast, CT Head without contrast, CT Maxillofacial Bones without contrast and a knee x-ray. Discharge instructions include follow-up with family physician and continue Tylenol, ibuprofen. Ice the areas as needed.

On 04/18/2024, I spoke with Relative B, who stated that Resident B has resided at the facility for a number of years, however, the care there has declined. Due to physical limitations, she has not been able to visit with Resident B for some time, however, her other siblings have. Relative B stated that this is Resident B's second fall at the facility. The 1st one having occurred in November of 2023. Relative B states that she was given 2 different stories regarding Resident B's fall. Originally, she was told that staff on duty left Resident B standing in the shower while tending to another resident. LD Burgess told her that staff working left Resident B to go get a drying towel to dry her off when she fell. However, Resident B was already dressed in her bra and panties. Staff leaving her alone to go get a drying towel does not make sense. She also expressed concern that Resident B was sent to the hospital in her bra and panties and had to return in a hospital gown. She chose to move Resident B abruptly due to safety concerns.

On 04/19/2024, I spoke with direct staff, Nicole Convery who recalled that she'd just finished giving Resident B a shower. When asked, staff Convery confirmed that Resident B was being showered on the other side of the facility, at Sandalwood Creek I. She could not provide a reason why she was showering the resident on that side. Staff Conery went on to state that she'd dried Resident B off, gotten her dressed in her bra and panties and sat her down in her chair. Staff Connvery stated that she reached to get an additional towel to place on the floor, when Resident B just fell forward, hitting her face on the tile floor. Staff Convery denied leaving Resident B alone, stating that the linens are within reach in the bathroom. Staff Convery stated that she showered Resident B alone with no assistance from any other staff, however, staff Mary Simmonds had stepped in the bathroom to ask her a question and witnessed the incident as well.

On 04/19/2024, I placed a call to former staff, Mary Simmonds. Ther was no answer. A voice mail message was left requesting a return call.

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:	It was alleged that Resident B has 2 black eyes after falling, having been left alone in the shower. LD Burge shared that Resident B sustained the injuries by falling from her chair.

	I observed that Resident B had sustained 2 black eyes, with significant purple bruising under both eyes. The left eye is completely shut. A photo was taken. Resident B stated that she fell out of her chair. The incident report dated 03/21/2024 was reviewed. The assessment plan for Resident B states that she requires assistance with being handed soaps, shampoos while bathing and uses both a wheelchair and a walker as assistive devices. Due to being blind she requires verbal cueing and direction. The 03/21/2024 Lake Huron Medical Center After Visit Summary for Resident B was reviewed. Relative B stated that this is Resident B's second fall at the facility. Relative B states that she was given 2 different stories regarding Resident B's fall. She chose to move Resident B abruptly due to safety concerns. Direct staff, Nicole Convery stated that she'd just finished giving Resident B a shower and sat her down in her chair. Staff Convery stated that she reached to get an additional towel to place on the floor, when Resident B just forward, hitting her face on the tile floor. Staff Convery denies leaving Resident B alone, stating that the linens are within reach, in the bathroom. Staff Convery stated that she showered Resident B alone with no assistance from any other staff Based on the interviews conducted with Licensee Designee, Rayann Burge, direct staff Nicole Convery, Resident B, Relative B, a review of the assessment plan for Resident B, the incident report and Lake Huron Medical Center After Visit Summary dated 03/21/2024, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A has a large bruise on the bottom of his lip. It is suspected that staff Jason Wasyck caused the bruise.

INVESTIGATION:

On 03/01/2024, I received a complaint via BCAL Online Complaints. This complaint was opened by APS for investigation.

On 03/06/2024, I spoke with Dan Schave, APS Investigator in St. Clair County, who shared that Resident A is still quite sharp, although he has dementia. He observed the bruising on his lip which did not require medical attention. Resident A refused to speak with him about the allegations. Resident A stated that he feels safe in the home. Investigator Schave added that when he spoke with the licensee designee, Rayann Burge, regarding the allegations, she stated that no one saw what occurred, however, in theory it is believed that Resident A was attempting to get out of bed on his own. Staff Wasyck is no longer allowed to care for Resident A when working. He will be closing the case with no substantiation.

On 03/11/2024, I conducted an unannounced onsite inspection at Sandalwood Creek II. While onsite I interviewed Resident A, who stated that he fell due to some equipment being in his way, near his bed when he tried to get up. Resident A denied being hit by staff. While in Resident A's room I observed a tray table and walker next to his bed. Resident A was observed sitting in his wheelchair while in his bedroom. Resident A was adequately clothed and groomed. Resident A appeared to be receiving proper care. Resident A's left lower lip was slightly purple in color with some scabbing, appearing to be in the final stages of healing.

While onsite, I observed one resident sitting at the dining table finishing her meal, while two others were in the living room watching television. Everyone was adequately dressed and groomed. They appeared to be receiving proper care. No concerns were noted.

On 03/11/2024, while onsite, I spoke with Relative Guardian A, who was visiting with Resident A at the time of the onsite, stated "turns out it was nothing". He adds that to his knowledge, Resident A slipped on his walker. The staff was assisting another resident so Resident A tried to get up himself. Relative A stated that he spoke with the license designee Rayann about the incident. Relative A stated that "he doesn't see anything to it."

On 03/11/2024, while onsite, I spoke with LD Burge, who denied the allegations. She stated that she does not believe that staff Jason Wasyck harmed Resident A. LD Burge added that it not his mannerisms. LD Burge shared that staff Wasych no longer works for the corporation. Staff Wasych had put in his 2-week notice prior to this alleged incident, preparing to leave for a factory job that pays more.

On 03/11/2024, I reviewed the assessment plan for Resident A, which indicates that he requires staff assistance with toileting, bathing, and mobility. Resident A uses both a wheelchair and a walker as assistive devices.

The incident report, dated 02/27/2024, states that staff, Jason Wasyck, had just left Resident A's room after finishing helping him out. Staff Wasyck then heard Resident A yell out. Staff Wasyck went back to the room and Resident A had hit his lip. Staff Wasyck wrote that he believes that Resident A hit his lip on his walker while trying to get up on his own. Actions taken included washing Resident A's mouth out with cold water and providing ice to help stop the bleeding. Day staff notified family. Staff will continue to monitor Resident A, is written as the corrective measures taken.

On 04/19/2024, I placed a call to former direct staff, Jason Wasyck. A voice mail message was left requesting a return call.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Resident A has a large bruise on the bottom of his lip. It is suspected that staff Jason Wasyck caused the bruise. Dan Schave, APS Investigator in St. Clair County stated that Resident A refused to speak with him about the allegations. Resident A stated that he feels safe in the home. He will be closing the case with no substantiation. Resident A denied being hit by staff. His lower left lower lip was slightly purple in color with some scabbing, appearing to be in the final stages of healing. Relative Guardian A stated that to his knowledge, Resident A slipped on his walker. The staff was assisting another resident so Resident A tried to get up himself. Licensee Designee Rayann Burge denied the allegations. She stated that she does not believe that staff Jason Wasyck harmed Resident A.

	The assessment plan for Resident A was reviewed. The incident report dated 02/27/2024 was reviewed. Based on the interviews conducted with APS Investigator, Dan Schave, Licensee Designee Rayann Burge, Resident A, Relative A, and a review of the assessment plan for Resident A and incident report dated 02/27/2024, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The food lacks nutrition and small portions are provided.

INVESTIGATION:

On 03/19/2024, while onsite Resident B stated that she gets enough food to eat. Sloppy Joes, vegetables, baked beans and pie were served for lunch.

On 03/19/2024, while onsite, Resident C, D and E all stated that they receive enough food to eat in the home.

The weight log for Resident A indicates that he moved in the facility on 04/06/2023, weighing 162.5 lbs. Resident A peaked at 167 lbs. in both June and July 2023. Resident A weighs 165 lbs. effective March 1, 2024.

Resident A entered the facility in January 2021 weighing 142 lbs. She maintained the same weight, give, or take a 1-2 lbs. throughout 2022 and 2023, peaking at 145 lbs. in May of 2023. Resident B has lost weight monthly since then. Her weight, effective March 1, 2024, is recorded as 135 lbs.

Resident C entered the facility weighing 174 lbs. in October 2022. He has steadily gained weight since being at the facility. Effective March 1, 2024, Resident C weighs 203 lbs.

Resident D entered the facility in November of 2023 weighing 134 lbs. His weight remained the same in December of 2023. Beginning January 2024, Resident A has lost 2 lbs. a month. Resident A weighs 128 lbs. as of March1, 2024.

Resident E entered the facility in October of 2023, weighing 177 lbs. He has lost weight each month since being at the facility. He currently weighs 167.5 lbs., effective March 1, 2024.

On 03/19/2024, while onsite, I spoke with the LD Burge regarding the allegations, which she denied. She adds that due to the firing of several staff, she anticipated complaints being made. While onsite, the food supply in the home was observed. Due to this smaller facility being attached to the larger facility the majority of the food and all meals are cooked on the larger side. Resident snacks and drinks were observed in the cupboards and Frigidaire. The larger food supply, also housed in the attached facility contains a pantry closet adequately stocked with non-perishable items and canned goods. The freezer contained several packages of frozen meat and microwaveable items and the Frigidaire contained drinks, cold cuts, yogurts, and other items, deemed sufficient to meet the nutritional needs of the residents.

On 03/20/2024, I received a copy of the March 2024 menu for the facility. Upon review, I determined that the menu meets the nutritional allowances recommended, per the Recommended Dietary Allowances.

On 04/18/2024, Relative B stated that towards the end of Resident B's stay, in her opinion, the food in the home has declined. Residents are being served things like corn dogs and tater tots. Relative B adds that Resident B is always concerned with her weight, citing she needs to lose pounds. Resident B was overweight in the past; however, her weight has not been a concern.

On 04/23/2024, I spoke with Public Guardian C, representative for Resident C, who denied any concerns. Resident C has not expressed any concerns regarding food at the facility.

On 04/23/2024, I placed a call to Relative D, leaving a voice mail requesting a return call.

On 04/23/2024, I spoke with Relative E who stated that Resident E has complained to him that he does not get enough food to eat. Resident E is losing weight as a result. Relative Guardian has not addressed this concern with LD Burge because Resident E asked him not too.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(2) Meals shall meet the nutritional allowances recommended pursuant to the provisions of "Appendix I: Recommended Dietary Allowances, Revised 1980" contained in the publication entitled "Basic Nutrition Facts: A Nutrition Reference," Michigan Department of Public Health publication no. H-808, 1/89. This publication may be obtained at cost from The Division of Research and Development, Michigan Department of Public Health, P.O. Box 30195, Lansing, Michigan 48909.

ANALYSIS:	It was alleged that the food lacks nutrition and small portions are provided. Residents B-E all stated that they enough food to eat. The weight log for Resident A indicates that he has been in the home for 1 year and has gained 2.5 lbs. Resident B entered the facility in January 2021 weighing 142 lbs. and currently weighs 135 lbs. effective March 1, 2024. Resident C entered the facility weighing 174 lbs. in October 2022. Resident C weighs 203 lbs. effective March 1, 2024. Resident D entered the facility in November of 2023 weighing 134 lbs. His weight remained the same in December of 2023. Beginning January 2024, Resident A has lost 2 lbs. a month. Resident A weighs 128 lbs. as of March 1, 2024. Resident E entered the facility in October of 2023, weighing 177 lbs. He has lost weight each month since being at the facility. He currently weighs 167.5 lbs., effective March 1, 2024. Licensee Designee Rayann Burge denied the allegations. Food supply in the home was observed. The pantry, Frigidaire and freezer contained an adequate food supply, deemed sufficient to meet the nutritional needs of the residents. The March 2023 menu reviewed meets the nutritional allowances recommended, per the Recommended Dietary Allowances. Relative B stated that the food in the home has declined. Resident B's weight has not been a concern. Public Guardian C stated that Resident C has not expressed any concerns regarding food at the facility. Relative E who stated that Resident E has complained to him that he does not get enough food to eat. Resident E is losing weight as a result.

	Based on the interviews conducted, a review of the home's food supply, a review of the March 2023 menu and weight logs for residents A-E, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

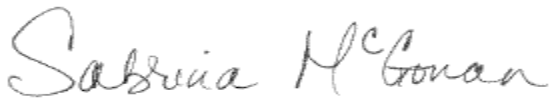
On 03/19/2024, while onsite, Resident C's bedroom trash in the room was observed overflown with disposed diapers and his room reeked of urine.

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:	Resident C's bedroom trash in the room was observed overflown with disposed diapers and his room reeked of urine. Based on this observation, there is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 04/24/2024, I conducted an exit conference with the Licensee Designee, Raynn Burge. LD Burge was informed of the findings of this investigation.

IV. RECOMMENDATION

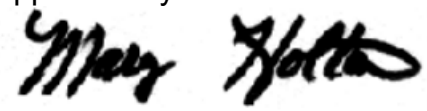
Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.



04/24/2024

Sabrina McGowan Date
Licensing Consultant

Approved By:



04/24/2024

Mary E. Holton Date
Area Manager