



STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

GRETCHEN WHITMER  
GOVERNOR

MARLON I. BROWN, DPA  
DIRECTOR

May 10, 2024

Drew Doubleday  
Doubleday Hill LLC  
25307 Ivanhoe Ave  
Redford, MI 48239

RE: License #:	AL790412771
Investigation #:	2024A0872029 Doubleday Hill LLC

Dear Drew Doubleday:

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 (517) 284-9730.

Sincerely,

A handwritten signature in cursive script that reads "Susan Hutchinson".

Susan Hutchinson, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909  
(989) 293-5222

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AL790412771
<b>Investigation #:</b>	2024A0872029
<b>Complaint Receipt Date:</b>	03/25/2024
<b>Investigation Initiation Date:</b>	03/26/2024
<b>Report Due Date:</b>	05/24/2024
<b>Licensee Name:</b>	Doubleday Hill LLC
<b>Licensee Address:</b>	616 W Gilford Rd Caro, MI 48723
<b>Licensee Telephone #:</b>	(708) 990-1449
<b>Administrator:</b>	Drew Doubleday
<b>Licensee Designee:</b>	Drew Doubleday
<b>Name of Facility:</b>	Doubleday Hill LLC
<b>Facility Address:</b>	616 W Gilford Rd Caro, MI 48723
<b>Facility Telephone #:</b>	(989) 673-7406
<b>Original Issuance Date:</b>	03/06/2024
<b>License Status:</b>	TEMPORARY
<b>Effective Date:</b>	03/06/2024
<b>Expiration Date:</b>	09/05/2024
<b>Capacity:</b>	17
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

	TRAUMATICALLY BRAIN INJURED ALZHEIMERS
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**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A was not provided with a proper 30-day discharge notice.	No
Resident A has fallen 6 times in the last month and staff has not sought medical attention for him. Resident A has missed doctor's appointments due to staff refusing to take him.	No
The residents are not getting enough food during mealtimes.	No
The downstairs shower is broken so the male residents must walk through a shared women's bedroom to use their attached bathroom shower.	Yes

**III. METHODOLOGY**

03/25/2024	Special Investigation Intake 2024A0872029
03/25/2024	APS Referral This complaint was referred by APS. Gerald Edwards is the APS Worker
03/26/2024	Special Investigation Initiated - On Site Unannounced
05/08/2024	Exit Conference I conducted an exit conference with the licensee designee, Drew Doubleday
05/08/2024	Inspection Completed-BCAL Sub. Compliance
05/10/2024	Contact – Document received I received a reviewed a copy of Resident A's Assessment Plan
05/10/2024	Contact – Telephone call made AFC Licensing Consultant, Christopher Holvey spoke to the referral source about this complaint

**ALLEGATION: Resident A was not provided with a proper 30-day discharge notice.**

**INVESTIGATION:** On 03/26/24, I conducted an unannounced onsite inspection of Doubleday Hill Adult Foster Care facility. I interviewed the home manager (HM), Paula Boadway and Residents A-E.

According to HM Boadway, the facility gave Resident A a 30-day discharge notice due to non-payment, and it expired on 03/16/24. Resident A asked to stay until 03/30/24 and the licensee designee agreed. HM Boadway provided me with a copy of the 30-day notice.

Resident A said that he has resided at this facility since 10/30/23. Resident A said that since he has lived at this facility, he has not paid any payments and the licensee designee has let him stay, "out of the goodness of her heart." Resident A confirmed that he received a written 30-day notice dated 02/16/24 due to non-payment and said that the licensee designee agreed to let him stay until 03/30/24.

I reviewed the 30-day discharge notice dated 02/16/24 signed by the licensee designee (LD), Drew Doubleday, and Resident A. The notice states that if Resident A does not pay the licensee designee \$1350.00 by 03/16/24, he will be discharged from the facility.

On 05/10/24, AFC Licensing Consultant, Christopher Holvey spoke to the referral source (RS.) The RS confirmed that Resident A was given a 30-day discharge notice by the licensee designee in March 2024. According to the RS, he received a copy of the 30-day discharge notice as well as Resident A. The RS stated that sometime in the middle of April 2024, LD Doubleday paid for Resident A to stay in a hotel, and she then began helping him plan to move into his own apartment. The RS told AFC Consultant, Christopher Holvey that Adult Protective Services confirmed that Resident A is now living in his own apartment, and he is not in need of AFC services. He is capable of living on his own.

<b>APPLICABLE RULE</b>	
<b>R 400.15302</b>	<b>Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.</b>
<b>ANALYSIS:</b>	<b>(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.</b>

	<p>According to HM Boadway, the facility gave Resident A a 30-day discharge notice due to non-payment, and it expired on 03/16/24. Resident A asked to stay until 03/30/24 and the licensee designee agreed.</p> <p>Resident A said that he has resided at this facility since 10/30/23. Resident A said that since he has lived at this facility, he has not paid any payments and the licensee designee has let him stay, "out of the goodness of her heart." Resident A confirmed that he received a written 30-day notice dated 02/16/24 due to non-payment and said that the licensee designee agreed to let him stay until 03/30/24.</p> <p>On 05/10/24, AFC Licensing Consultant, Christopher Holvey spoke to the referral source (RS.) The RS confirmed that Resident A was given a 30-day discharge notice by the licensee designee in March 2024.</p> <p>The RS told AFC Consultant, Christopher Holvey that Adult Protective Services confirmed that Resident A is now living in his own apartment, and he is not in need of AFC services. He is capable of living on his own.</p> <p>I conclude that there is insufficient evidence to substantiate this rule violation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:** Resident A has fallen 6 times in the last month and staff has not sought medical attention for him. Resident A has missed doctor's appointments due to staff refusing to take him.

**INVESTIGATION:** On 03/26/24, I conducted an unannounced onsite inspection of Doubleday Hill Adult Foster Care facility. I interviewed the home manager (HM), Paula Boadway and Residents A-E. I reviewed the allegations with HM Boadway, and she said that although the first-floor shower is broken and not being used, the other allegations are not true.

HM Boadway said that Resident A is his own guardian. She said that he does not always tell staff when he falls and sometimes tells them days or weeks later. HM Boadway said that to her knowledge, Resident A has never fallen and injured himself, needing medical attention. She also said that staff is not required to provide transportation for Resident A, and he typically makes his own arrangements. On one occasion, Resident A missed a medical appointment because he did not notify staff until

the day before the appointment, and nobody was available to take him. On another occasion, Resident A's ride cancelled on him 45 minutes before the appointment. According to HM Boadway, the facility gave Resident A a 30-day discharge notice due to non-payment, and it expired on 03/16/24. Resident A asked to stay until 03/30/24 and the licensee designee agreed.

Resident A said that he has resided at this facility since 10/30/23. He said that he has poor balance and will fall on occasion, but he has never told staff because he has not needed medical attention. According to Resident A, staff is not responsible for providing him with transportation and he has never missed medical appointments or treatment due to staff negligence or staff refusing to provide transportation to him.

I reviewed Resident A's Resident Care Agreement dated 10/30/23. The facility did not state that they would provide transportation for Resident A. I reviewed Resident A's Health Care Appraisal dated 11/01/23. According to this document, he is diagnosed with hypertension, peripheral vascular disease, gastroesophageal reflux disease, coronary artery disease, and congestive heart failure. He uses a cane and walker for ambulation. The document does not state that he has a history of falls.

On 05/10/24, I received a reviewed a copy of Resident A's Assessment Plan dated 10/30/24. According to this document, Resident A uses a walker and a cane for mobility, and he is unable to climb stairs. He does not require assistance with transferring, bathing, toileting, dressing, or personal hygiene. His assessment plan does not state that he has a history of falls.

<b>APPLICABLE RULE</b>	
<b>R 400.15310</b>	<b>Resident health care.</b>
<b>ANALYSIS:</b>	<b>(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.</b>
	<p>HM Paula Boadway said to her knowledge, Resident A has never fallen and injured himself, needing medical attention. She also said that Resident A has never missed doctor's appointments due to staff refusing to take him.</p> <p>Resident A said that he has "poor balance", and he will fall on occasion, but he has never injured himself or needed medical attention. He said that he has never told staff if he falls because he does not need medical attention. According to Resident A, staff is not responsible for providing him with transportation and he has never missed medical appointments or treatment due to staff negligence or staff refusing to provide transportation to him.</p>

	<p>I reviewed Resident A’s Resident Care Agreement dated 10/30/23. The facility did not state that they would provide transportation for Resident A.</p> <p>Resident A uses a walker and a cane for mobility, and he is unable to climb stairs. He does not require assistance with transferring, bathing, toileting, dressing, or personal hygiene.</p> <p>I conclude that there is insufficient evidence to substantiate this rule violation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION: The residents are not getting enough food during mealtimes.**

**INVESTIGATION:** On 03/26/24, I conducted an unannounced onsite inspection of Doubleday Hill Adult Foster Care facility. I interviewed the home manager (HM), Paula Boadway and Residents A-E. I reviewed the allegations with HM Boadway, and she said that although the first-floor shower is broken and not being used, the other allegations are not true.

According to HM Boadway, the residents are given three meals a day plus snacks. She said that none of the residents have ever told her that they are not getting enough food to eat. She said that residents are all given the same amount of food at each meal and if they request a second helping, they are given it unless it is unhealthy food. She said that she oversees creating the menus and shopping list and the licensee designee does the grocery shopping at least once per week. I examined the refrigerator, freezer, and cabinets and noted an ample amount of food. I also observed fresh and canned fruits and vegetables that are available for the residents. I examined the posted menu and found it to be acceptable.

Resident A stated that he is a “big eater,” and he chooses to buy and make a lot of his meals himself. He said that sometimes, he does not like what the facility is serving for meals so he will eat his own food but said that he is always offered three meals a day plus snacks. Resident A said that there is always enough food in the facility, and he never goes hungry.

Resident B said that he has lived at this facility “a long time” and said that the food is “excellent.” Resident B said that he always gets enough food to eat and there is always food in the facility.

Resident C said that she has lived at this facility since 2002. She said that she and the other residents are given three meals a day plus snacks and said that the meals are good. She told me that she always gets enough food to eat and there is always food in the facility.

Resident D said that she has lived at this facility for approximately five months. She said that the meals are “ok” but said that sometimes she does not like the food that is being served. Resident D stated that she is provided three meals a day plus snacks and there is always enough food in the facility.

Resident E said that she has lived at this facility for approximately ten years. She said that her favorite food is pizza, and she always gets enough food to eat. Resident E stated that the facility provides her with three meals a day plus snacks and she never feels hungry.

<b>APPLICABLE RULE</b>	
<b>R 400.15313</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>	<p>According to HM Boadway, the residents are given three meals a day plus snacks. She said that none of the residents have ever told her that they are not getting enough food to eat and there is always food in the facility.</p> <p>I examined the refrigerator, freezer, and cabinets and noted an ample amount of food. I also observed fresh and canned fruits and vegetables that are available for the residents. I examined the posted menu and found it to be acceptable.</p> <p>Residents A, B, C, D, and E said that they are provided with three meals a day plus snacks. They all said that they always get enough food to eat and there is always food available at this facility.</p> <p>I conclude that there is insufficient evidence to substantiate this rule violation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:** The downstairs shower is broken so the male residents must walk through a shared women’s bedroom to use their attached bathroom shower.

**INVESTIGATION:** On 03/26/24, I conducted an unannounced onsite inspection of Doubleday Hill Adult Foster Care facility. I interviewed the home manager (HM), Paula Boadway and Residents A-E. I reviewed the allegations with HM Boadway, and she

said that although the first-floor shower is broken and not being used, the other allegations are not true.

According to HM Boadway, this facility is licensed for 17 residents. She said that there are 7 residents on the first floor and 10 residents on the second floor. She stated that there are two full bathrooms on the first floor of the facility and a full bathroom on the second floor of the facility. One of the bathrooms on the first floor is located off one of the multi-occupancy bedrooms which houses three female residents and is intended for their use. The other first floor bathroom is intended to be used by the remaining 4 residents but currently, the shower enclosure in that bathroom is broken and since water will seep into the walls and cause mold, it has not been used for approximately 4 months. Therefore, all the first-floor residents must use the female residents' bathroom and to get to that bathroom, they must go through the female resident's bedroom. The male residents must knock before entering the female resident's bedroom and bathroom and the female residents must give their permission for the male residents to use it.

Resident A confirmed that the first-floor resident bathroom shower is not usable. He said that since he is not able to navigate the stairs, he must use the bathroom attached to the multi-occupancy women's bedroom to shower. He confirmed that the other residents on the first floor also use the women's bathroom to shower because the residents' shower cannot be used.

Resident C said that she, Resident E, and one other female resident share the multi-occupancy bedroom on the first floor. She confirmed that the main first floor shower does not work so all first-floor residents use the shower in the bathroom attached to her bedroom. Resident C said that if someone needs to use the shower, they will knock on the bedroom door and all the ladies will leave until the resident is finished showering.

<b>APPLICABLE RULE</b>	
<b>R 400.15403</b>	<b>Maintenance of premises.</b>
	<b>(7) All water closet compartments, bathrooms, and kitchen floor surfaces shall be constructed and maintained so as to be reasonably impervious to water and to permit the floor to be easily kept in a clean condition.</b>

<b>ANALYSIS:</b>	HM Boadway and Residents A, C, and E all said that the first-floor bathroom shower is broken and unusable. They all said that the first-floor residents use the shower in the bathroom that is attached and only accessible through the multi-occupancy women's bedroom.  I conclude that there is sufficient evidence to substantiate this rule violation.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 05/08/24, I conducted an exit conference with the licensee designee (LD), Drew Doubleday. I discussed my investigation and explained which rule violation I am substantiating. LD Doubleday agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

**IV. RECOMMENDATION**

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

*Susan Hutchinson*

May 10, 2024

Susan Hutchinson Licensing Consultant	Date
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Approved By:

*Mary Holton*

May 10, 2024

Mary E. Holton Area Manager	Date
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