GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 13, 2024

Sherman Taylor
Taylor's Special Care Services, Inc.
Ste 210
23800 West Ten Mile Rd
Southfield, MI 48034

RE: License #: AS630405301
Investigation #: 2024A0612024
Winchester Home

Dear Mr. Taylor:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630405301
Investigation #:	2024A0612024
Complaint Receipt Date:	05/21/2024
Investigation Initiation Date:	05/21/2024
Report Due Date:	06/20/2024
Licensee Name:	Taylor's Special Care Services, Inc.
Licensee Address:	Ste 210 23800 West Ten Mile Rd Southfield, MI 48034
Licensee Telephone #:	(248) 350-0357
Administrator:	Sherman Taylor
Licensee Designee:	Sherman Taylor
Name of Facility:	Winchester Home
Facility Address:	21001 Winchester Street Southfield, MI 48076
Facility Telephone #:	(248) 350-0357
Original Issuance Date:	01/26/2021
License Status:	REGULAR
Effective Date:	07/26/2023
Expiration Date:	07/25/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
• Resident A's cell phone was taken away. • Someone stole Resident A's teeth.	Yes
Resident A's summer clothes were replaced with winter clothes.	No
Resident A is not getting her allowance.	No

III. METHODOLOGY

05/21/2024	Special Investigation Intake 2024A0612024
05/21/2024	APS Referral Referral received from Adult Protective Services (APS).
05/21/2024	Special Investigation Initiated - Letter I made a referral to Oakland Community Health Network (OCHN) - Office of Recipient Rights (ORR) via email.
05/22/2024	Inspection Completed On-site I completed an unannounced onsite investigation. I interviewed Resident A, Resident B, home manager Roxanne Turner, and direct care staff Briana Chamberlain.
05/23/2024	Contact - Telephone call made Telephone interview completed with Resident A’s daughter.
05/23/2024	Contact - Document Received Facility documentation received via email.
05/31/2024	Contact - Document Received Facility documentation received via email.
06/03/2024	Exit Conference I placed a telephone call to licensee designee, Sherman Taylor to hold an exit conference.

ALLEGATION:

- **Resident A's cell phone was taken away.**
- **Someone stole Resident A's teeth.**

INVESTIGATION:

On 05/21/24, I received a referral from Adult Protective Services (APS). APS denied the referral for investigation. The complaint alleged for the past sixteen weeks Resident A has been living at the Winchester AFC home. Resident A has not received any allowance since she began staying there. All Resident A's money is going to the group home. Resident A needs money for clothes, shampoo, underwear, snacks, coffee, and flavored drinks. Resident A would like to move out, but her important numbers are on her cell phone. Three weeks ago, Resident A's cell phone was taken away. Resident A was on Facetime with a friend. Resident A's friend wanted to ask the manager some questions. The manager got upset. Resident A apologized for the incident. Resident A's phone was taken away and she has not been allowed access to the phone numbers stored on the phone. Two weeks ago, staff member, Lisa, took Resident A's summer clothes and replaced them with winter clothes. Resident A only has a few summer dresses. Resident A's underwear has been getting stolen since she moved in. She had 10 to 12 pairs when she moved in and now, she has two pairs. There is concern another resident is stealing the underwear. Someone took Resident A's shampoo bottles leaving her with three bottles of V05. Someone put something in Resident A's conditioner making her hair greasy. The first day she moved in, someone stole Resident A's teeth. She has not gotten them back. She has not had any teeth since they were stolen. Resident A has been asking the manager to help her get teeth and nothing has been done about it. On 05/21/24, I initiated my investigation by making a referral to Oakland Community Health Network (OCHN) - Office of Recipient Rights (ORR) via email.

On 05/22/24, I completed an unannounced onsite investigation. I interviewed Resident A, Resident B, home manager Roxanne Turner, and direct care staff Briana Chamberlain. While onsite I observed Resident A's bedroom. Resident A had a drawer full of underwear and a closet full of clothes. I observed multiple summer dresses and shorts outfits. Resident A had several bottles of shampoo and conditioner in her bedroom. Resident A was dressed appropriately for the weather wearing a sleeveless casual dress, she was well kept and observed with good hygiene. Resident A was not wearing dentures.

On 05/22/24, I interviewed Resident A. Resident A stated when she moved into the home her dentures were stolen, she had both the top and the bottom teeth. Resident A stated the home manager took her cellphone and will not give it back. Resident A said that she was on Facetime with a friend. Resident A's friend wanted to ask the manager some questions. The manager got upset and took her cell phone.

On 05/22/24, I interviewed home manager Roxanne Turner. Ms. Turner stated she has been employed with this company for 12 years. She works the day shift. Ms. Turner stated Resident A has psychoaffective disorder. Resident A has a history of making false allegations as she believes that someone stole her belongings. Ms. Turner stated when Resident A moved into the home, she did not have dentures. Ms. Turner denied

that Resident A's dentures were stolen while living in the home. Ms. Turner stated Resident A has a history of calling the police and making complaints. One day when Resident A called 911 to make a complaint Resident A's daughter asked that Ms. Turner take Resident A's cell phone away from her. Ms. Turner stated she took Resident A's cellphone away approximately three weeks ago and she has not given it back. Resident A continues to have access to the home phone. Ms. Turner stated Resident A eloped from the home on 05/01/24. On 05/03/24, she was found when she called her daughter from a CVS. Police picked her up and brought her back to the group home.

On 05/22/24, I interviewed direct care staff, Briana Chamberlain. Ms. Chamberlain has been employed at this home for one year she works the day shift. Ms. Chamberlain stated she has never seen any staff and/or any resident take any of Resident A's personal belongings. However, Resident A goes into other resident's bedrooms and takes their belongings. Resident A must be consistently redirected from taking other residents belongings. Ms. Chamberlain stated when Resident A moved into the home, she did not have dentures. Ms. Chamberlain has never observed Resident A's dentures and denied that they have been stolen. Ms. Chamberlain stated Resident A has a history of calling 911 and making complaints. As such, her personal cell phone was taken away by the home manager. Resident A has access to the home phone.

On 05/22/24, I interviewed B. Resident B stated she receives $44 a month in allowance, and she uses that to purchase personal items and hygiene products. Resident B stated the staff treat her well and all her needs are met. Resident B stated Resident A often asks her for things like her clothes. She has given Resident A her robe and pairs of socks.

On 05/23/24, I interviewed Resident A's daughter via telephone. Resident A's daughter stated Resident A has a history of calling the police and/or crisis lines and making complaints. She did this when she lived at her daughter's home too. Resident A's daughter stated Resident A moved into this group home on a Wednesday, she had her dentures. Resident A's daughter informed staff that Resident A wraps her dentures up in napkins, so they have to be careful not to throw them away. Resident A's daughter stated by Saturday, Resident A's dentures were missing. They have never been found. Resident A's daughter stated the home has not taken Resident A to the dentist to explore any options about replacing the dentures. Resident A's daughter stated Resident A had a cell phone. She called 911 and home manager, Ms. Turner took her cell phone away. Ms. Turned called Resident A's daughter and told her that she took Resident A's cellphone because she was making false reports to 911. Resident A's daughter stated the home will not return the cell phone to Resident A. Resident A's daughter stated Resident A recently eloped from the home and they were unable to locate her because she did not have her cellphone. If Resident A would have had her cell phone with her when she eloped form the home, they could have used the tracking feature on the phone to find her. Resident A's daughter stated she has offered suggestions on how to monitor Resident A's cellphone use. Such as, having her use the phone with staff supervision as opposed to taking it away from her.

During my onsite investigation I observed Resident C and Resident D. They were appropriately dressed and well groomed. Resident C and Resident D both declined to be interviewed.

I reviewed Resident A's AFC Assessment Plan dated 04/26/24, which indicates Resident A has dentures.

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: (j) The right of reasonable access to and use of his or her personal clothing and belongings.
ANALYSIS:	Based on the information gathered through my investigation there is sufficient information to conclude Resident A's cell phone was taken away and her dentures are missing. Home manager Roxanne Turner stated Resident A called 911 to make a complaint. Resident A's daughter asked her to take Resident A's cell phone away from her. Ms. Turner took Resident A's cell phone away approximately three weeks ago and she has not given it back. Resident A's daughter denied that she told Ms. Turner to take Resident A's cell phone away. Resident A's daughter stated Resident A called 911 and Ms. Turner took her cell phone away because she was making a false report. During the unannounced onsite investigation completed on 05/22/24, Resident A confirmed that he does not have her cell phone. Furthermore, although Ms. Turner and direct care staff, Briana Chamberlain consistently stated when Resident A moved into the home, she did not have dentures. Resident A's AFC Assessment Plan dated 04/26/24, indicates Resident A has dentures. Resident A's daughter stated Resident A moved into this group home on a Wednesday, she had her dentures. By Saturday they were missing. Both staff interviewed were unable to provide an explanation as to what happened to Resident A's dentures.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's summer clothes were replaced with winter clothes.

INVESTIGATION:

On 05/22/24, I interviewed Resident A. Resident A stated she has underwear however, they do not fit because they are not hers. They belonged to someone who lived in the home before her. Resident A stated she has clothes, but they were donated so they do not fit her properly. Resident A stated that she wants more dresses and dresses made of a lighter material. Resident A stated someone mixed her shampoo and conditioner together and now when she uses them it makes her hair greasy. Resident A stated when she runs out of personal hygiene products, or she needs new clothes her daughter buys her more.

On 05/22/24, I interviewed home manager Roxanne Turner. Ms. Turner stated Resident A has summer clothes however she prefers to wear specific things and therefore she feels like she does not have enough summer clothes. Resident A has been known to bag up her belongings and throw them away because she wants new or different clothes. Ms. Turner stated Resident A's daughter recently purchased her new underwear and in addition Ms. Turner gave her five new pair of underwear. Ms. Turner stated Resident A had four big bottles of shampoo however she mixed then together. Resident A has done this in the past when she wants a different brand of shampoo or conditioner. Ms. Turner stated the home does not oversee Resident A’s finances; her finances are handled by her daughter. Resident A’s daughter gives Resident A spending money regularly and buys her any personal items she needs.

On 05/22/24, I interviewed direct care staff, Briana Chamberlain. Ms. Chamberlain stated Resident A has a lot of clothing. Resident A has weather appropriate clothing for summer.

On 05/22/24, I interviewed B. Resident B stated she receives $44 a month in allowance, and she uses that to purchase personal items and hygiene products. Resident B stated the staff treat her well and all her needs are met. Resident B stated Resident A often asks her for things like her clothes. She has given Resident A her robe and pairs of socks.

On 05/22/24, I completed an unannounced onsite investigation. I interviewed Resident A, Resident B, home manager Roxanne Turner, and direct care staff Briana Chamberlain. While onsite I observed Resident A’s bedroom. Resident A had a drawer full of underwear and a closet full of clothes. I observed multiple summer dresses and shorts outfits. Resident A had several bottles of shampoo and conditioner in her bedroom. Resident A was dressed appropriately for the weather wearing a sleeveless casual dress, she was well kept and observed with good hygiene. Resident A was not wearing dentures.

On 05/23/24, I interviewed Resident A's daughter via telephone. Resident A's daughter stated she is Resident A's Representative Payee. Every weekend she gives Resident A $100 and takes her shopping and to purchase personal items such as cigarettes. Resident A's daughter stated Resident A has a distorted reality, she believes that she is running out of things or that someone is stealing her personal belongings. Resident A's daughter stated Resident A has appropriate summer clothing.

During my onsite investigation I observed Resident C and Resident D. They were appropriately dressed and well groomed. Resident C and Resident D both declined to be interviewed.

I reviewed the following relevant information:

- Resident A's Individual Plan of Service (IPOS) and Crisis Plan. Resident A's Crisis Plan identifies "running out of stuff, not having stuff come in," and hoarding behavior with clothes and food as crisis prevent strategies.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(4) A licensee shall afford a resident opportunities, and instruction when necessary, to dress as fashion, fit, cleanliness, and season warrant.
ANALYSIS:	Based on the information gathered through my investigation there is insufficient information to conclude that Resident A does not have access to weather appropriate clothing. On 05/22/24, I observed multiple summer dresses and shorts outfits in Resident A's closet. Resident A was dressed appropriately for the weather wearing a sleeveless casual dress. Resident A's daughter, home manager Roxanne Turner, and direct care staff Briana Chamberlain consistently stated that Resident A has sufficient summer clothing, and her summer clothes were not replaced with winter clothes.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A is not getting her allowance.

INVESTIGATION:

On 05/22/24, I interviewed Resident A. Resident A stated her social security check is $1,700.00 a month and she does not get any allowance. Resident A stated when she runs out of personal hygiene products her daughter buys her more.

On 05/22/24, I interviewed home manager Roxanne Turner and direct care staff, Briana Chamberlain. Ms. Turner and Ms. Chamberlain consistently stated the home does not oversee Resident A's finances; her finances are handled by her daughter. Resident A's daughter gives Resident A spending money regularly.

On 05/22/24, I interviewed B. Resident B stated she receives $44 a month in allowance, and she uses that to purchase personal items and hygiene products.

On 05/23/24, I interviewed Resident A's daughter via telephone. Resident A's daughter stated she is Resident A's Representative Payee. Every weekend she gives Resident A $100 and takes her shopping and to purchase personal items such as cigarettes.

During my onsite investigation I observed Resident C and Resident D. They were appropriately dressed and well groomed. Resident C and Resident D both declined to be interviewed.

I reviewed Resident A's Crisis Plan which identifies her daughter as the person who pays her bills.

On 06/03/24, I placed a telephone call to licensee designee, Sherman Taylor to hold an exit conference and review my findings. Mr. Taylor acknowledge the rule violation and verbally agreed to complete a corrective action plan.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(7) A resident shall have access to and use of personal funds that belong to him or her in reasonable amounts, including immediate access to not less than $20.00 of his or her personal funds. A resident shall receive up to his or her full amount of personal funds at a time designated by the resident, but not more than 5 days after the request for the funds. Exceptions to this requirement shall be subject to the provisions of the resident's assessment plan and the plan of services.
ANALYSIS:	Based on the information gathered through my investigation there is insufficient information to conclude that Resident A does not have access to and use of her personal funds. Resident A's daughter is Resident A's Representative Payee. It was consistently reported by Resident A's daughter, home manager Roxanne Turner, and direct care staff Briana Chamberlain that Resident A's daughter regularly provides Resident A with

	spending money and ensures that Resident A has personal items and hygiene products as needed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

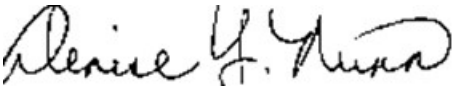
IV. RECOMMENDATION

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

06/03/2024

Johnna Cade — Date
Licensing Consultant

Approved By:



06/13/2024

Denise Y. Nunn — Date
Area Manager