GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 17, 2024

Diane Jackson
Sunshine Care
28180 Danvers Drive
Farmington Hills, MI 48334

RE: License #: AS630379574
Investigation #: 2024A0602025
Sunshine Care

Dear Ms. Jackson:

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,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630379574
Investigation #:	2024A0602025
Complaint Receipt Date:	05/03/2024
Investigation Initiation Date:	05/06/2024
Report Due Date:	07/02/2024
Licensee Name:	Sunshine Care
Licensee Address:	22318 Berg Road Southfield, MI 48033
Licensee Telephone #:	(248) 229-2028
Administrator:	Diane Jackson
Licensee Designee:	Diane Jackson
Name of Facility:	Sunshine Care
Facility Address:	22318 Berg Road Southfield, MI 48033
Facility Telephone #:	(248) 229-2028
Original Issuance Date:	02/09/2016
License Status:	REGULAR
Effective Date:	08/09/2024
Expiration Date:	08/08/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff are belittling Resident A and calling her names.	No
On 8/07/2024, Resident B wanted to use the phone, but staff member Bianca Wilson refused. Resident B became angry and flipped over the kitchen table. Ms. Wilson pulled Resident B's hair and used cussed words.	Yes

III. METHODOLOGY

05/03/2024	Special Investigation Intake 2024A0602025
05/06/2024	Special Investigation Initiated - Telephone Call made to Resident A.
05/13/2024	Inspection Completed On-site No response.
05/29/2024	Inspection Completed On-site Interviewed the home manager, Quinshell Wasson.
06/03/2024	Contact – Telephone call made Message left for Resident A.
08/08/2024	Inspection Completed On-site Interviewed the home manager, Quinshell Wasson.
08/09/2024	Contact – Telephone call made Interviewed Resident B.
08/09/2024	Contact – Telephone call made Message left for Resident C.
08/09/2024	Contact – Telephone call made Message left for staff member Bianca Wilson.
09/13/2024	Contact – Telephone call made Spoke with Ms. Wasson.

09/13/2024	Contact – Telephone call made Message left for Bianca (last name unknown) who is the home manager of Resident C's new placement.
09/13/2024	Exit Conference Message left for the licensee designee, Diane Jackson.

ALLEGATION:

Staff are belittling Resident A and calling her names.

INVESTIGATION:

On 5/03/2024, a complaint was received and assigned for investigation alleging that staff are belittling Resident A and calling her names.

On 5/29/2024, I conducted an unannounced on-site investigation at which time I interviewed the home manager, Quinshell Wasson. Ms. Wasson stated she had no knowledge of any staff member belittling Resident A or calling her names. Resident A no longer resides in the home as she moved into a semi-independent home. There were no residents home at the time the on-site was conducted.

On 8/09/2024, I interviewed Resident B by telephone. Resident B stated she did not witness any staff member belittling Resident A or calling her names. Resident B had no further information to report regarding Resident A.

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:	Based on the information obtained during the investigation, there is insufficient information to determine that Resident A was belittled or yelled at by any staff member. According to the home manager, Ms. Wasson, she had no knowledge of Resident A being belittled or yelled at by any staff member. Resident A no longer resides at the home. She currently resides in a semi-independent facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL ALLEGATIONS:

INVESTIGATION:

On 8/07/2024, additional allegations were received alleging that Resident B wanted to use the phone, but staff member Bianca Wilson refused. Resident B became angry and flipped over the kitchen table. Ms. Wilson pulled Resident B's hair and said, "Pick up the fucking table." Resident C said, "Don't swear at her." Ms. Wilson replied, "Mind your own fucking business."

On 8/08/2024, I conducted an unannounced on-site investigation at which time I interviewed the home manager, Quinsell Wasson. Ms. Wasson stated on 8/05/2024 she met with Ms. Wilson (while human resources was on speaker phone) to discuss the allegations. Ms. Wilson denied cursing at Resident B or Resident C. She stated Resident B flipped over the kitchen table and started walking out of the kitchen. Ms. Wilson pulled Resident B by her shoulder and told her to come and pick the table up. Ms. Wilson demonstrated how she pulled Resident B's shoulder (forcefully). Ms. Wilson was given a deficiency notice (write up) and asked to write a statement with her account of what happened. Once her statement was written, she was instructed to clock out and was informed that she was suspended pending the outcome of the investigation (as documented in the deficiency notice). Ms. Wasson went on to state that Resident B has been in crisis (throwing things, upset, and hearing voices that tell her to do things when she is angry) and was hospitalized at Harbor Oaks around the end of July 2024 for 7 days.

On 8/08/2024, I received and reviewed a copy of Resident B's discharge paperwork from Harbor Oaks Hospital. According to the paperwork, Resident B was admitted on 7/24/2024 and discharged on 8/01/2024. She was admitted for inpatient psychiatric treatment due to danger to self and danger to others. No other information regarding treatment was documented in the discharge paperwork. I also received and reviewed a copy of Resident B's crisis plan dated 4/18/2024 – completed by CNS Healthcare. According to the plan, Resident B has a history of hearing voices, throwing things, and breaking things.

I was unable to interview any residents at the time the on-site was conducted as they were not home.

On 08/09/2024, I interviewed Resident B by telephone. Resident B stated does not recall why she flipped over the kitchen table, but she remembers being upset about something. She said Ms. Wilson cursed at her and pulled her hair. The police were called, and she was transported to Ascension Providence Hospital in Southfield. Resident B went on to state that she does not know if Ms. Wilson was fired but has not returned to the home since the incident occurred. This is all the information Resident B had regarding the incident.

On 9/13/2024, I spoke with Ms. Wasson by telephone. I informed her that I have been unable to reach Resident C. Ms. Wasson stated Resident C no longer resides at the home and provided the contact information for the home manager of the facility where she currently resides. Ms. Wasson stated that Bianca Wilson was terminated.

On 9/13/2024, I left a message for the licensee designee, Diane Jackson requesting a return call to discuss the investigative findings and recommendation documented in this report.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (b) Use any form of physical force other than physical restraint as defined in these rules. (f) Subject a resident to any of the following: (ii) Verbal abuse.
ANALYSIS:	Based on the information obtained during the investigation, there is sufficient information to determine that Ms. Wilson did in fact use physical force and verbal abuse when attempting to have Resident B return to the kitchen after flipping over the kitchen table. Ms. Wasson stated Ms. Wilson admitted to pulling Resident B on the shoulder and told her to come and pick the table up. Resident B stated she flipped the kitchen table over and Ms. Wilson pulled her hair and cursed at her.
CONCLUSION:	**VIOLATION ESTABLISHED**

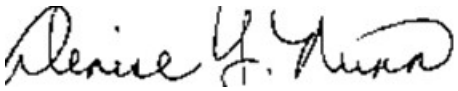
IV. RECOMMENDATION

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

9/13/2024

Cindy Berry — Date
Licensing Consultant

Approved By:



09/17/2024

Denise Y. Nunn — Date
Area Manager