GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 4, 2024

Colleen Cassidy and Caroline Anderson
22467 Paddington Ct
Novi, MI 48374

RE: License #: AS630390815
Investigation #: 2024A0605038
Essence Memory Care LLC

Dear Colleen Cassidy and Caroline Anderson:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (248) 975-5053.

Sincerely,

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd.
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630390815
Investigation #:	2024A0605038
Complaint Receipt Date:	07/29/2024
Investigation Initiation Date:	07/30/2024
Report Due Date:	09/27/2024
Licensee Name:	Colleen Cassidy AND Caroline Anderson
Licensee Address:	22467 Paddington Ct Novi, MI 48374
Licensee Telephone #:	(248) 506-1634
Administrator:	Colleen Cassidy
Licensee Designee:	Caroline Anderson
Name of Facility:	Essence Memory Care LLC
Facility Address:	20800 Chigwidden St Northville, MI 48167
Facility Telephone #:	(248) 308-9607
Original Issuance Date:	02/01/2018
License Status:	REGULAR
Effective Date:	08/01/2022
Expiration Date:	07/31/2024
Capacity:	6
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was neglected in his transition to death and dying. The resident is now dying unmedicated and without skilled care as the current owner Micheal Kruckeberg brought on unqualified staff.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/29/2024	Special Investigation Intake 2024A0605038
07/30/2024	Special Investigation Initiated - On Site An unannounced on-site was conducted
07/30/2024	Contact - Telephone call received Discussed allegations with Michael Kruckeberg, currently licensee designee
07/31/2024	Contact - Document Received Email from Michael Kruckeberg
08/01/2024	Contact - Document Received Emails from Michael Kruckeberg
08/05/2024	Contact - Telephone call received Follow-up with Michael Kruckeberg
08/08/2024	Contact - Document Received Emails to and from Michael Kruckeberg
08/14/2024	Contact - Document Received Emails from Michael Kruckeberg
08/15/2024	Contact - Telephone call made Discussed allegations with home manager Drita Aliatim, direct care staff, Mychella Scott, Andrea Whitaker and Berline Saint Jean
08/19/2024	Contact - Telephone call made Discussed allegations with Misty Novakowski, previous DCS Alyssa Hayes and Paige Gardner

	Left message for previous DCS Samantha Brettle
08/19/2024	Contact - Telephone call made Left message for Open Arms Hospice Nurse regarding Resident A
08/20/2024	Contact - Telephone call received Discussed allegations with Open Arms hospice nurse Tracy Carr and Open Arms social worker Deborah Rogers
08/22/2024	Contact – Telephone call made Call with previous owner Caroline Anderson
08/28/2024	Exit Conference Conducted exit conference via telephone with licensee designee Carolyn Anderson and current provider Michael Kruckeberg.

ALLEGATION:

Resident A was neglected in his transition to death and dying. The resident is now dying unmedicated and without skilled care as the current owner Micheal Kruckeberg brought on unqualified staff.

INVESTIGATION:

On 07/29/2024, intake #201841 was assigned for investigation regarding current owner and licensee designee Michael Kruckeberg. The previous staff that was trained were let go and Mr. Kruckeberg brought in untrained staff to provide care to Resident A who was in hospice and transitioning to death and dying.

Note: On 07/23/2023, the purchase and sale agreement of this corporation was made by Michael Kruckeberg and Misty Novakowski from Caroline Anderson and Colleen Cassidy. On 10/13/2023, a management agreement was made and entered into by and between Caroline Anderson and Colleen Cassidy with purchaser Michael Kruckeberg and Misty Novakowski for Essence Memory Care LLC until Mr. Kruckeberg is issued a license under the new application. Mr. Kruckeberg submitted an application on 12/29/2023 for Essence Memory Care LLC to change licensee type from "Group," to "LLC" for Essence Memory Care LLC. The issuance of the license is currently pending.

On 07/30/2024, I conducted an unannounced on-site investigation. I interviewed direct care staff (DCS) Erykah Kouayara, Resident A's wife, and Resident B and his niece and nephew who were also present.

I interviewed DCS Ms. Kouayara regarding the allegations. She was working for about eight months at Essence Memory Care II, the Farmington Hills location also owned by

Michael Kruckeberg and Misty Novakowski before she began working at this home. She was terminated by Ms. Novakowski from Essence Memory Care II due to “lack of residents.” She has only been working here for three days. Ms. Kouayara completed her training and background checks. She was not present during the incident on 07/26/2024, heard that Ms. Novakowski was supposed to work at this home, but Mr. Kruckeberg flew in from Florida and called the police on Ms. Novakowski who served her with a “no trespassing notice.” Resident A’s wife was extremely upset about this because Resident A was on hospice and transitioning to death and dying. Ms. Kouayara stated that DCS Samantha Brettle was working that shift, but then left her shift when she saw the new home manager (HM) Drita Aliatim was now in charge. The new staff are Mychella Scott, Andrea Whitaker and Berline Saint Jean. She believes they are all fully trained except for Ms. Saint Jean whose first day working was on 07/29/2024. Ms. Saint Jean was initially working with the HM but then the HM left Ms. Jean alone during her shift. There is only one DCS per shift and there are two shifts: 7AM-7PM and 7PM-7AM. Ms. Kouayara believes that both Resident A and Resident B are a two-person assist.

I did not interview Resident A as she was in bed sleeping. I interviewed Resident A’s wife regarding the allegations. Resident A has Parkinson’s Disease. He was admitted into this home on 06/10/2024. Resident A’s wife stated, “I signed the contract with Misty Novakowski and her daughter Savannah Novakowski as Ms. Novakowski is also a hospice nurse. The previous staff took “really good care of Resident A.” He was ambulating with a walker but was then hospitalized two weeks ago for pneumonia. He was discharged home and then began declining. Ms. Novakowski suggested Open Arms Hospice. Resident A qualified for hospice services and began receiving all services, social worker, nurses, aides and a case manager. These services were provided at this home and all medications were being administered by the nurse except for the morphine which was administered every six hours or as needed. Morphine was being administered by DCS working at this home.

Last Friday, 07/26/2024, when Resident A’s wife arrived, the code lock was removed from the outside door. She had to knock on the door to get inside instead of using the code. There were two individuals inside the home she did not recognize. The individuals asked her, “Who are you?” She identified herself as Resident A’s wife and asked the male, who she found out was part owner Michael Kruckeberg. Mr. Kruckeberg advised her that there is a “restraining order against Misty Novakowski.” Resident A’s wife became upset and asked for Ms. Novakowski to return because she only wanted Ms. Novakowski and her staff to provide care to Resident A. Mr. Kruckeberg said, “no,” and then they went outside and began arguing. Mr. Kruckeberg had called 911 without Resident A wife’s knowledge so when they were outside, two police cars arrived at the home. That upset Resident A’s wife even more since she has been sitting by her husband’s bedside daily because he was transitioning to death and dying. One of the officer’s advised Resident A’s wife to go inside, which she did. She called the social worker (SW) with Open Arms who arrived at the home shortly after and calmed her down.

Resident A's wife stated she is concerned that the new staff brought in by Mr. Kruckeberg are untrained and unskilled to provide the care Resident A requires. Resident A is a two-person assist when changing him and there is only one DCS per shift. Last night, there was a staff that did not speak English and Resident A's wife was unable to communicate Resident A's needs to this staff. She does not know the staff's name. Resident A's wife expressed her dissatisfaction with how Mr. Kruckeberg had no regard for Resident A's condition and that there was no communication from Mr. Kruckeberg about his intentions of firing the trained staff and hiring new staff who are unaware of Resident A's needs.

I interviewed Resident B and his niece and nephew-in-law who were sitting at his bedside. Resident B was admitted to this home on 07/18/2024 for respite. Resident B's wife is away for work for about three weeks so Resident B will be returning home on 08/07/2024. Resident B requires care with all his activities of daily living (ADL) and sometimes requires assistance with feeding. He wears an adult brief and requires two-persons to change him, but there is only one DCS per shift, so the niece stated, "one day I had to help the staff roll him over." Resident B is a one person assist with transfers using the Hoyer lift. She does not know what occurred on 07/26/2024 but stated that there were new staff at the home after that date when the "split happened." She arrived at the home on that day and saw a young gentleman, Michael Kruckeberg sitting at the table doing paperwork. She did not recognize any of the staff at the home and was told that the "old staff were gone." The niece reported that her only concern was there being only one DCS on shift to provide care to Resident B.

I reviewed Resident A's assessment plan on file. Resident A's assessment plan was incomplete as many of the boxes were unchecked and the boxes that were checked regarding Resident A "having needs," describing the needs and how they will be met were left blank. Resident A's assessment plan was signed by Resident A's wife, but not by the licensee designee and there was no date as to when this assessment plan was signed or completed. I also reviewed Resident A's resident care agreement (RCA) that was incomplete and signed by Resident A's wife, but there is no date and no signature of the licensee designee.

I reviewed Resident B's assessment plan on file. Resident B's assessment plan was also incomplete as many of the boxes were checked regarding Resident B "having needs," but describing the needs and how they will be met were left blank. However, the assessment plan did state one-two person assist bed change, for toileting and to use thickener in drinks for eating/feeding. Resident B's assessment plan was signed by Resident B's wife dated 05/08/2024, but not by the licensee designee. I also reviewed Resident B's RCA that was incomplete and signed by Resident B's wife on 07/18/2024, with DCS Savannah Novakowski's signature but not the licensee designee.

On 07/30/2024, I received a telephone call from Michael Kruckeberg regarding the allegations. Mr. Kruckeberg received several text messages from Ms. Novakowski stating her intent to permanently cease her duties from this home. She gave Mr. Kruckeberg 48 hours to take over via text message. He flew down from Florida after

receiving this information from Ms. Novakowski and stated he did not want to leave the residents without staff, so he hired home manager (HM) Drita Aliatim. Ms. Aliatim had previously managed the location in Farmington Hills, Essence Memory Care II and has extensive experience with adult foster care (AFC) management, so he hired her to continue as the HM and the administrator of this home. He believed that Ms. Novakowski became increasingly irrational upon learning that Ms. Aliatim was hired as the HM to provide care to the residents. He received threats both verbally and by text from Ms. Novakowski and based on those threats, he contacted the police because he owns this home, so police issued a "no trespassing order." The HM hired new staff that began providing care to Residents A and B. I advised Mr. Kruckeberg of my concerns regarding the new staff he hired have not been trained and that there is only one DCS per shift when both Residents A and B require two-person assist when being changed. Mr. Kruckeberg stated that the staff are trained and will email me all their trainings, medicals, TBs, and their background checks. He will also send me the staff schedules along with the staff contact list.

On 07/31/2024, I received an email from Michael Kruckeberg with the text messages between him and Misty Novakowski. On 07/19/2024, Misty Novakowski sent a text message to Mr. Kruckeberg stating that "all Northville (this home) staff are leaving. You will have to come up and work shifts. I cannot work them all. There are two residents, both males. Your house is your license, and I quit physically working your part. I will give you 48 hours to be on shift. It's your Comfort Keepers respite (Resident B) you insisted on so you can come take care of him. This is not a joke. You are legally for those two men. Since our staff are leaving related to you, I'm done. I will let the families know. Drita was the last straw."

On 08/01/2024, I received emails from Michael Kruckeberg regarding employee records. I reviewed the following records:

- **Drita Aliatim** hire date was 07/29/2024. Her fingerprints were completed in 2022 under Blossom Hill and not Essence Memory Care LLC. She was missing the following trainings: protection and safety, reporting requirements, Safety and fire prevention and medication administration.
- **Erykah Kouayara** hire date was 07/28/2024. No criminal background/fingerprints were completed, her first aid and cardiopulmonary resuscitation (CPR) expired on 03/2024. She was missing the following trainings, protection and safety, reporting requirements, safety and fire prevention, and medication administration. She also did not have documentation that her TB was completed and up to date prior to working at this facility.
- **Mychella Scott** hire date was 07/28/2024. No criminal background/fingerprints were completed. There was no documentation that her TB was completed or up to date prior to working at this facility and the following trainings were missing, protection and safety, safety and fire prevention and medication administration.
- **Andrea Whitaker** hire date was 07/26/2024. Her fingerprints were completed on 02/08/2023 for Blossom Hill and not for Essence Memory Care LLC. She was missing the following trainings: protection and safety, safety and fire prevention,

and medication administration. She too did not have documentation that her TB was completed prior to working at this facility.

- **Berline Saint Jean** hire date was 07/29/2024. No criminal background/ fingerprints were completed. There was no documentation that her TB was completed or up to date prior to working at this facility and the following trainings were missing, protection and safety, safety and fire prevention and medication administration.

I received July and August 2024 staff schedules. According to July 2024 and August 2024 staff schedules, there is only one DCS working per shift. All the staff above were on the schedules beginning 07/25/2024 to present working unsupervised, prior to having all their trainings completed, any background/fingerprint checks completed, or documentation that their TB was completed and/or up to date.

I received 2023 and 2023 fire drills. A fire drill was missing for July 2024.

On 08/05/2024, I received a telephone call from Michael Kruckeberg. Mr. Kruckeberg stated that two DCS have been hired from Blossom Hill where Drita Aliatim is the licensee designee, Andrea Whitaker and Berlin Saint Jean. These two staff members have completed all their training and their background checks. However, he cannot submit another background check for any of the staff members because the AFC license has yet to be issued to him. Therefore, he had the HM provide the fingerprint eligibility letters for Ms. Whitaker and Ms. Saint Jean with Blossom Hill's information. He stated, "something is better than nothing." He will continue working to ensure that this home is following all licensing requirements.

On 08/08/2024, I sent and received emails from Michael Kruckeberg regarding missing documents from the employee files. Mr. Kruckeberg stated, "we will get this completed and sent to you." Also included in the email were "Partnership Dissolution Agreement," between him and Ms. Novakowski. They dissolved the partnership within Essence Memory Care II and Essence Memory Care LLC. Mr. Kruckeberg retains sole ownership of Essence Memory Care LLC and Ms. Novakowski retains sole ownership of Essence Memory Care II. This is effective on 07/24/2024.

On 08/14/2024, I received emails from Michael Kruckeberg regarding additional documents for the employee files. Medication administration training, TB and some physicals were completed by the following DCS on the following dates:

- **Drita Aliatim**: Med training 08/09/2024, TB and physical on 10/14/2022
- **Erykah Kouayara**: Med training 08/03/2024, physical on 08/14/2024; the TB date was 08/07/2024 on the medical clearance form, but the form was not signed by any medical practitioner. TB results were not included.
- **Mychella Scott**: Med training 08/10/2024 and TB on 07/20/2023
- **Andrea Whitaker:** Med training 08/07/2024, TB on 08/07/2024 and physical completed on 08/14/2024. TB results were not included.

- **Berline Saint Jean**: Med training 08/03/2024, physical completed on 08/14/2024, the TB date was 08/07/2024 on the medical clearance form, but the form was not signed by any medical practitioner. TB results were not included.

On 08/15/2024, I interviewed the HM Drita Aliatim via telephone regarding the allegations. The HM is a licensee designee at Blossom Hill, an AFC facility. She began her employment at this home on 07/25/2024. She stated she had previously managed Essence Memory Care II in Farmington Hills prior to Mr. Kruckeberg and Ms. Novakowski purchased this corporation. Due to conflict between Mr. Kruckeberg and Ms. Novakowski, there was a dissolution of the purchase agreement. Mr. Kruckeberg is responsible for this home and Ms. Novakowski has the home in Farmington Hills. The staff that were working at this home were contacted by Ms. Novakowski asking them to come to work at the Farmington Hills location, so the staff decided to leave. DCS Samantha Brettle was working on 07/26/2024 when HM arrived but then Ms. Brettle received a phone call, asked to take a lunch, the HM said, “Ok,” but Ms. Brettle never returned. The HM moved staff from her Blossom Hill location Andrea Whitaker and Berlin Saint Jean to this home. DCS Erykah Kouayara and Michella Scott completed their trainings and background checks as they have been working at the Farmington Hills location, but Ms. Novakowski locked the HM and Mr. Kruckeberg out of the system, so they are unable to gain access to the employee records. She acknowledges that staff have been working at this home without TBs completed nor medication training nor background checks. The HM is working with Mr. Kruckeberg to get all staff trained, TBs and medicals and background checks completed. The HM stated that Resident A passed away on hospice on 08/05/2024 and Resident B was discharged on 08/11/2024. There are currently no residents at this home.

On 08/15/2024, I interviewed DCS Andrea Whitaker via telephone regarding the allegations. Ms. Whitaker began employment at this home on 07/26/2024 when the HM moved her from Blossom Hill where she had worked for two years as a DCS. Her first day on shift was 07/26/2024 and stated that when she arrived, the HM, Michael Kruckeberg and the HM’s sister, Linda were present and informed her of what happened. Resident A and Resident B were present as were their families. Ms. Whitaker stated that the HM from Blossom Hill, Danielle was also present and worked with Ms. Whitaker her first day, but then the days after, Ms. Whitaker was working alone on day shift from 7AM-7PM. Ms. Whitaker stated that both Resident A and Resident B are total assist, with their personal care needs; which means two-person, but the assessment plans do not reflect that; however, she stated, “I was able to provide care to both Resident A and Resident B all by herself.” Ms. Whitaker did not complete any training when she began working at this home nor did she complete her TB or any background checks. There is only one DCS per shift to provide for the needs of the residents.

On 08/15/2024, I interviewed DCS Mychella Scott via telephone regarding the allegations. Ms. Scott began working at this home in 01/2024-04/2024, quit but then was called back by Mr. Kruckeberg to work, which she agreed after learning that

leadership changed. Her first day was on 07/28/2024, but then stated she quit on 08/03/2024. She completed all her trainings, TB, and fingerprints at the time of her hire. Ms. Scott quit because, “Misty lied on me.” Ms. Scott did not provide details but stated that she (Ms. Scott) always follows rules and never gets into trouble. Her shift was from 7PM-8AM and there was only one DCS per shift. Resident A and Resident B were the two residents she provided care to. Resident A was completely bedbound, had a catheter and one DCS can provide care to him, which Ms. Scott stated she did. However, Resident B was a total assist during day shift because he required two-person to roll him over to be changed, but only one-person during the midnight shift because he did not require changing during that shift. Ms. Scott quit because she did not agree with how the HM and Mr. Kruckeberg were “running,” this home. Ms. Novakowski and Mr. Kruckeberg allowed DCS to pop medications, place them in the cup for the next shift to administer. Ms. Scott did not agree with this method because she did not feel comfortable not knowing what medications were in the cup she was administering. In addition, she stated, “Mike was in charge, but he was only the money man and outside of that, he was hands off.” Therefore, she quit.

On 08/15/2024, I interviewed DCS Berline Saint Jean via telephone regarding the allegations. Ms. Saint Jean was working at Blossom Hill with the HM Drita Aliatim when she was asked to move to this home. Her first day working was on 07/29/2024. She stated, “there was a lady (name unknown) who worked with her for one hour showing me what to do and then she left me alone.” Ms. Saint Jean did not complete any training at this home, nor did she have a background check completed on her. She was administering morphine to Resident A and providing care to both Resident A and Resident B. She is unsure of their needs as she quit working at this home on 07/31/2024 as her schedule did not work well for her to work at this home and at Blossom Hill.

On 08/19/2024, I interviewed Misty Novakowski via telephone regarding the allegations. On 07/26/2024, she was heading to this home to assist DCS Samantha Brettle in showering one of the residents. Ms. Novakowski received a text message from Mr. Kruckeberg stating, “you’re not allowed here.” She texted back saying, "that’s absolutely ridiculous, let me come and take care of the client.” She then received a “no trespassing letter,” from police that were called to the home. Ms. Novakowski stated that she reached out to Mr. Kruckeberg asking for help and then he shows up on 07/26/2024, calls the police and then leaves 48 hours to Florida where he lives. The family was extremely upset when they found out that she would not be providing services to their loved ones and that new management had taken over. When she and Mr. Kruckeberg purchased this company, Drita Aliatim was the HM of both locations, but Ms. Novakowski and Mr. Kruckeberg terminated her employment because there was a resident with a broken arm in two places and the HM never took her to the hospital. Ms. Novakowski believes that the HM is unqualified to work at this home. The staff that worked at this home, Samantha Brettle, Alyssa Hayes and Paige Gardner quit after learning that Ms. Aliatim was now the HM.

On 08/19/2024, I interviewed DCS Alyssa Hayes via telephone regarding the allegations. Ms. Hayes began working at this home 01/2023 but quit about two months later. She was part-time working two days a week from 7PM-7AM. There were only Residents A and B at this home and only one DCS per shift. Both Residents A and B were “technically,” a two-person assist with transfers, but only one DCS was available to provide for their care. Ms. Hayes quit working at this home because, “Mike didn’t want to pay us and was not paying us on time.” Also, any questions they had about the residents, they had to contact Ms. Novakowski because Mr. Kruckeberg “did not know anything about them and didn’t know anything at all.” She stated she also left because the HM Drita Aliatim who was terminated from this corporation was “hired back.” Ms. Novakowski texted Ms. Hayes giving her an option to work at the Farmington Hills location or to stay at this home, so Ms. Hayes decided to leave.

On 08/19/2024, I interviewed via telephone DCS Samantha Brettle regarding the allegations. Ms. Brettle began working for this corporation since 12/25/2023 and quit on 07/25/2024. She was full-time and worked 7AM-7PM. There was only one DCS per shift. Resident A was a “complicated,” case according to Ms. Brettle. He was initially a one-person assist, but towards the end of the day, during sundowning, he required two persons to provide his care. He was walking with a walker until he became bedbound. Resident B in her opening is a one-person assist with changing, but during transfers and showering, he is a two-person assist. Whenever Ms. Brettle needed to transfer and/or shower the residents, she would call Ms. Novakowski or her daughter Savannah who would come to the home to help. Ms. Brettle stated that there were a lot of issues with Mr. Kruckeberg when he came into town. She was informed by Ms. Novakowski that she (Ms. Brettle) had to “train him.” When she arrived on shift, he was present, then went into the house and sat on the dining room table doing paperwork. Then Drita Aliatim and her sister Linda arrived and “took over.” Ms. Brettle went into Resident A’s bedroom to comfort Resident A’s wife who was visiting Resident A who was transitioning from death to dying when she saw the HM and her sister put Resident B in a Hoyer lift to visit with his niece outside. Around lunch time, Ms. Brettle received a call from Ms. Novakowski who advised her to “get out of there,” because she was on her way to the home. Ms. Brettle told them she was going out to lunch and never returned. She did not want to work for Mr. Kruckeberg or the HM, so she left and now works only at the Farmington Hills location with Ms. Novakowski.

On 08/19/2024, I interviewed DCS Paige Gardner regarding the allegations via telephone. Ms. Gardner began working for this corporation from 10/02/2023-07/25/2024 when she quit. She was hired by the previous owners, Caroline Anderson and Colleen Cassidy. Drita Aliatim was the administrator of both Essence Memory Care homes. Ms. Gardner never had contact with the HM as she began reporting to Ms. Novakowski after she and Mr. Kruckeberg purchased this corporation. She has had a good relationship with Ms. Novakowski who is “hands on.” Mr. Kruckeberg was “supposed to be the boss,” but he was “never involved.” Any issues staff had; they would address these issues with Ms. Novakowski. Ms. Garnder never thought of leaving but when she received a text message from Ms. Aliatim requesting her schedule, she quit. She stated, “there were a lot of carelessness that occurred by Drita who was fired for neglecting

residents." She reported that a resident had a skin tear but then later it was discovered she had a broken arm and the HM never sought treatment. Resident A was initially a one-person assist until he became bedbound and required two-persons for transfers. Resident B was a one-person assist but also required two-persons for transfers and showers. She called Ms. Novakowski or Savannah to assist whenever she needed to transfer the residents. She was not present during the incident on 07/26/2024 so she does not have any information.

On 08/20/2024, I contacted Open Arms Hospice nurse, Tracey Carr. Ms. Carr reported that she was providing hospice services to Resident A. Initially, Ms. Novakowski was working at the home, but then she left and Resident A's wife was extremely upset. Ms. Carr does not have any information regarding the incident on 07/26/2024 but stated that after Open Arms social worker Deborah Rogers met with the wife, the wife was better. Resident A's wife had no complaints about the current staff providing care to her husband.

On 08/20/2024, I received a call from Open Arms social worker Deborah Rogers. Ms. Rogers was contacted by Resident A's wife regarding the incident on 07/26/2024. She was upset that the old staff left and now there was new staff at the home who were unskilled to provide the care Resident A required as he was transitioning from death to dying. Ms. Rogers arrived at the home and calmed Resident A's wife down. Ms. Rogers stated that she questioned the owner, Michael Kruckeberg's judgement of calling police and not allowing Ms. Novakowski at the home while Resident A was transitioning. Mr. Kruckeberg never provided any information to the wife as to what was happening and why he did what he did.

On 08/22/2024, I contacted previous owner Caroline Anderson. Ms. Anderson stated that Drita Aliatim was hired as the HM by her to manage both locations sometime in 06/2023. As a HM, she was very involved in the care of the residents and very involved with staff. She was compassionate and caring and all the families loved her. The HM provided excellent care and Ms. Anderson did not have any concerns. In fact, Ms. Anderson was happy to hear that Mr. Kruckeberg hired Ms. Aliatim as the HM of this home. Ms. Anderson reported that she is unsure about Ms. Novakowski's state of mind. At the closing of the purchase of the corporation, Ms. Novakowski arrived wearing a onesie. Ms. Novakowski told them, "I forgot about this." Also, when Ms. Novakowski took over the Farmington Hills location, she immediately fired Ms. Aliatim. Ms. Anderson does not know about any concerns of a residents' arm being broken and Ms. Aliatim not seeking medical treatment. She stated that Ms. Novakowski requested an X-ray agency which Ms. Anderson provided, and that the resident was under Ms. Novakowski's care at the time. She stated that Ms. Novakowski was making "fast changes," and staff and

family members were unhappy about that. Ms. Anderson believes that the residents are safe with Ms. Aliatim providing the care.

On 08/28/2024, I conducted the exit conference via telephone with current provider Michael Kruckeberg with my findings and recommendation. Mr. Kruckeberg stated that he believes these concerns were due to Misty Novakowski mismanagement of this group home and because of her mismanagement, he brought in currently HM Drita Aliatim. He understands that the home must always be in full compliance with the licensing requirements and knows that at the time of this investigation, it was not, he and the HM made many changes including all staff are not fully trained. He expressed concerns about this impacting his current AFC application and wants consideration that he and Ms. Novakowski are no longer partners of Essence Memory Care and that he should be provided an opportunity to show that he can maintain compliance with the licensing requirements moving forward.

On 08/28/2024, I conducted the exit conference with licensee designee Carolyn Anderson with my findings and recommendations. Ms. Anderson requested an administrative closure without a five year ban due to her not having any disciplinary actions taken on the license prior to the selling of her corporation to both Mr. Kruckeberg and Ms. Novakowski.

On 09/04/2024, I contacted licensee designee Carolyn Anderson regarding our recommendation of a six-month provisional license. Ms. Anderson acknowledged and stated she will submit a corrective action plan requesting to voluntarily close the license due to no residents currently residing at this home.

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:	Based on my investigation and information gathered, the HM Drita Aliatim, DCS Andrea Whitaker, Berline Saint Jean, Erykah Kouayara and Mychella Scott did not have documentation that their criminal background/fingerprints were completed at the time of their hire for this home before they began providing care to Resident A and Resident B.
CONCLUSION:	**VIOLATION 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: **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(f) Safety and fire prevention.**

ANALYSIS:	Based on my investigation and review of employee records, I found that DCS were missing the following trainings: • **Drita Aliatim** hire date was 07/29/2024 was missing, protection and safety, reporting requirements, safety and fire prevention. • **Erykah Kouayara** hire date was 07/28/2024 was missing protection and safety, reporting requirements, safety and fire prevention. Her first aid and cardiopulmonary resuscitation (CPR) expired on 03/2024. • **Mychella Scott** hire date was 07/28/2024 was missing, protection and safety, safety and fire prevention. • **Andrea Whitaker** hire date was 07/26/2024 was missing protection and safety, safety and fire prevention. • **Berline Saint Jean** hire date was 07/29/2024 was missing, protection and safety, safety and fire prevention.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.

ANALYSIS:	Based on my investigation and review of employee records, I found that DCS were missing their communicable tuberculosis (TB) before assumption of their duties in the home. • **Erykah Kouayara**: hire date was 07/28/2024, and TB was completed on 08/07/2024 according to the medical clearance form, but the form was not signed by any medical practitioner. TB was negative according to the medical form, but the TB reading showing a negative was not included. • **Andrea Whitaker:** hire date was 07/26/2024, and TB was completed on 08/07/2024 according to the medical clearance form, which was negative, but TB reading showing a negative was not included. • **Berline Saint Jean**: hire date 07/29/2024 and the TB was completed on 08/07/2024 on the medical clearance form which stated negative, but the form was not signed by any medical practitioner. TB reading showing a negative were not included.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Based on my investigation and information gathered, there was insufficient DCS on shift to provide for the supervision, personal care, and protection of Residents A and B. According to all the DCS I interviewed that previously worked or were currently working at this home reported that both Residents A and B are a two-person assist with transfers and when Resident B requires showering or changing his adult brief in bed. However, there is only one DCS per shift which is evident by the review of the July 2024-August 2024 staff schedules.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**
ANALYSIS:	Based on my investigation and information gathered, Residents A and B were not suitable for this home due to the amount of personal care, supervision, and protection required by both residents who were a two-person assist available in the home. Both Resident A and Resident B required two DCS to assist with transfers and Resident B required two DCS with showers and being changed in bed. According to Resident B's niece, she had to assist one of the DCS in rolling Resident B when he needed his adult brief changed, because there was only one DCS during that shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.

ANALYSIS:	Based on my review of Resident A's and Resident B's assessment plans, they were incomplete and not signed by the licensee designee. Resident A's assessment plan was incomplete as many of the boxes were checked regarding Resident A "having needs," but describing the needs and how they will be met were left blank. Resident B's assessment plan was also incomplete as many of the boxes were unchecked and the boxes that were checked regarding Resident B "having needs," describing the needs and how they will be met were left blank.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.** **(b) A description of services to be provided and the fee for the service.** **(c) A description of additional costs in addition to the basic fee that is charged.** **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.** **(e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission.** **(f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule.**

	(g) An agreement by the resident to follow the house rules that are provided to him or her. **(h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident.** **(i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures.** **(j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.14315.** **(k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met.** **(l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.**
ANALYSIS:	I reviewed Resident A's resident care agreement (RCA) that was incomplete and signed by Resident A's wife, but there is no date and no signature of the licensee designee. I reviewed Resident B's RCA that was also incomplete and signed by Resident B's wife on 07/18/2024, with DCS Savannah Novakowski's signature instead of the licensee designee.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	According to Resident B's assessment plan on 05/08/2024 Resident B was a one-two person assist during bed changes. There is only one DCS per shift; therefore, Resident B's assessment plan was not being followed to provide for the protection, safety, and personal care of Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 my investigation and information gathered, Resident A's and Resident B's personal needs, including protection and safety were not attended to at all times due to insufficient staffing. Resident A and Resident B required two-persons for transfers and Resident B required two persons for showering and changing of his adult briefs, but due to only having one DCS per shift, Resident A and Resident B were placed at risk of harm.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**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: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Based on my investigation and review of employee records, the HM Drita Aliatim and DCS Erykah Kouayara, Mychella Scott, Andrea Whitaker, and Berline Saint Jean were administering medications to Resident A and Resident B prior to being trained in the proper handling and administration of medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14318	**Emergency preparedness; evacuation plan; emergency transportation.**
	(5) A licensee shall practice emergency and evacuation procedures during daytime, evening, and sleeping hours at least once per quarter. A record of the practices shall be maintained and be available for department review

ANALYSIS:	I reviewed the fire drills for 2023-2024 and found that a fire drill was not conducted during the third quarter (July) of 2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site investigation on 07/30/2024, while I was interviewing Resident B in his bedroom, the bedroom door was not closing properly.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(4) Interior doorways of bedrooms that are occupied by residents shall be equipped with a side-hinged, permanently mounted door that is equipped with positive-latching, non-locking-against-egress hardware.
ANALYSIS:	During the on-site investigation on 07/30/2024, while I was interviewing Resident B in his bedroom, the bedroom door was not closing properly.
CONCLUSION:	**VIOLATION ESTABLISHED**

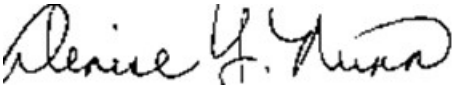
IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend modification of the license to a six-month provisional license.

08/28/2024

Frodet Dawisha Date
Licensing Consultant

Approved By:



08/29/2024

Denise Y. Nunn Date
Area Manager