

GRETCHEN WHITMER GOVERNOR STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

MARLON I. BROWN, DPA DIRECTOR

July 18, 2024

Vini Voggu Elderly Solutions, Inc. 100 Santure Road Monroe, MI 48162

> RE: License #: AS580291609 Investigation #: 2024A0116035 Elderly Solutions Inc - II

Dear Ms. Voggu:

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 (313) 456-0380.

Sincerely,

naan

Pandrea Robinson, Licensing Consultant Bureau of Community and Health Systems Cadillac PI. Ste 9-100 3026 W. Grand Blvd Detroit, MI 48202 (313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

1:00000 #	4050004000
License #:	AS580291609
	000440440005
Investigation #:	2024A0116035
Complaint Receipt Date:	06/17/2024
Investigation Initiation Date:	06/17/2024
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Report Due Date:	08/16/2024
Licensee Name:	Elderly Solutions, Inc.
Licensee Name.	
Licensee Address:	100 Santure Road
	Monroe, MI 48162
Licensee Telephone #:	(734) 240-2374
Administrator:	Vini Voggu
Licensee Designee:	Vini Voggu
Name of Facility:	Elderly Solutions Inc - II
Name of Facility.	
Facility Address	100 Conturo Dd #2
Facility Address:	100 Santure Rd #2
	Monroe, MI 48162
Facility Telephone #:	(734) 240-2374
Original Issuance Date:	09/12/2007
License Status:	REGULAR
Effective Date:	04/09/2024
Expiration Date:	04/08/2026
Conceitur	
Capacity:	0
Program Type:	
	AGED
Original Issuance Date:	09/12/2007 REGULAR 04/09/2024 04/08/2026 6 PHYSICALLY HANDICAPPED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
One of the staff is allegedly on drugs and stealing resident's medication.	No
One of the staff slapped a resident on the arm.	No
Staff, Amberlyn Mosher, is borrowing money from a resident.	Yes
Additional Findings	Yes
Note: All allegations were not addressed because they were regarding a resident who resides at another licensed facility.	

III. METHODOLOGY

06/17/2024	Special Investigation Intake 2024A0116035
06/17/2024	Special Investigation Initiated - On Site Interviewed staff, Anne Rockey and Sarah Heinzerling, Relative B1, Residents A and B, visually observed Resident C, reviewed Residents A-C medications and medication administration records (MARs).
06/17/2024	Contact - Telephone call received Interviewed staff, Sarah Heinzerling.
06/17/2024	Contact - Telephone call made Interviewed licensee designee, Vini Voggu.
06/17/2024	Adult Protective Services (APS) Referral Made.
06/17/2024	Inspection Completed-BCAL Sub. Compliance
06/21/2024	Contact - Telephone call made Left a message for staff, Amberlyn Mosher, requesting a return call.
06/21/2024	Contact - Telephone call made

	Interviewed home manager, Brandy Bray.
07/03/2024	Contact-Telephone call made Left a message for staff, Amberlyn Mosher, requesting a return call.
07/12/2024	Contact - Telephone call made Left a message for assigned APS investigator, Tria Sparks, requesting a return call.
07/12/2024	Exit Conference With licensee designee, Vini Voggu.
07/15/2024	Contact-Telephone call received. Interviewed assigned APS investigator, Tria Sparks.

ALLEGATION:

One of the staff is allegedly on drugs and stealing resident's medication.

INVESTIGATION:

On 06/17/24, I conducted an unscheduled on-site inspection and interviewed staff Anne Rockey (assigned to adjoining licensed facility for today #AS5800255782) staff, Sarah Heinzerling, Residents A-C and reviewed the medications and MARs.

Staff, Anne Rockey, reported that to her knowledge none of the staff are on drugs and no one is stealing resident medications. Ms. Rockey reported that these allegations are likely coming from a disgruntled employee that quit prior to being terminated and have no merit. Ms. Rockey added that although she is assigned to work in the adjoining licensed facility today, she reported that all staff are scheduled and can work in both facilities.

I interviewed staff, Sarah Heinzerling, and she denied the allegations. Ms. Heinzerling reported that she has worked in the facility for a little over a month and has not observed any of the other staff exhibit any behaviors associated with drug use/abuse and reported that since she has worked there no medications have come up missing.

I interviewed Residents A and B separately and they both reported that they do not believe any of the staff are on drugs and reported that they all are very nice and provide good care to them. They also reported that their medications are always available in the home for them to take and do not believe that anyone has stolen any of their medications. I attempted to interview Resident C but due to her diagnosed Alzheimer's disease, the interview was unsuccessful. Resident C would repeat the questions that I asked or would provide a response that was not relevant to my questions.

I reviewed the medications and MARs for the three residents who currently reside in the facility. All the medications in the medication cart matched the MARs and appeared to be administered as prescribed. No concerns noted.

On 06/17/24, I interviewed licensee designee, Vini Voggu, and she reported that the allegations are not true. Ms. Voggu reported that she is sure they came from a disgruntled employee, that was counseled for her poor work performance, and was upset and terminated her employment. Ms. Voggu reported that none of her staff, to her knowledge, is using or abusing drugs and reported she knows for certain that medications are not being stolen as she regularly audits the medication cart.

On 06/21/2024, I interviewed home manager, Brandy Bray, and she reported that the allegations are not true. Ms. Bray reported that she has not observed any staff appear to be using/abusing drugs and reported no medications are being stolen. Ms. Bray reported that the residents are receiving their medications as prescribed and reported that she along with Ms. Voggu monitor the medication counts.

On 07/12/24, I conducted the exit conference with licensee designee, Vini Voggu, and informed her of the findings of the investigation. Ms. Voggu agreed with the findings.

On 07/15/2024, I interviewed assigned APS investigator, Tria Sparks, and she reported that there was insufficient evidence to substantiate this allegation.

APPLICABLE RULE	
R 400.14204	Direct care staff; qualifications and training.
	(2) Direct care staff shall possess all of the following qualifications:
	(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.

ANALYSIS:	 Based on the findings of the investigation, which included interviews of Ms. Rockey, Ms. Heinzerling, Residents A and B, Ms. Bray and Ms. Voggu, I am unable to corroborate the allegations, that the staff is not suitable to meet the needs of the residents. Ms. Rockey, Ms. Heinzerling, Ms. Voggu and Ms. Bray all denied that any of the staff is using drugs or stealing medications. Residents A and B denied the allegations and reported that to their knowledge none of the staff are using drugs or stealing their medications.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

One of the staff slapped a resident on the arm.

INVESTIGATION:

On 06/17/24, I conducted an unscheduled on-site inspection and interviewed staff, Anne Rockey and Sarah Heinzerling, and Residents A and B. Ms. Rockey and Ms. Heinzerling both reported that they have not observed any staff slap any of the residents on the arm. They also both reported that none of the residents had verbalized to them that a staff had slapped them on the arm.

I interviewed Residents A and B and they both denied that they have ever been slapped on the arm or anywhere else by staff. They also both denied observing any staff slap or become physical in any way with Resident C. Resident A added that she would tell her family members if anyone was hitting or mistreating her.

On 06/17/24, I interviewed licensee designee, Vini Voggu, and she reported her belief that this allegation is not true and is retaliatory due the recent termination of an employee. Ms. Voggu reported that none of the residents has expressed to her or any of the other staff, that they were hit or slapped.

On 06/21/24, I interviewed home manager, Brandy Bray, and she reported that the allegation is not true and that none of the staff would hit or slap a resident. Ms. Bray reported that she has never observed any staff get physical with a resident nor has a resident expressed to her that they were hit or slapped by staff.

On 07/12/24, I conducted the exit conference with licensee designee, Vini Voggu, and informed her of the findings of the investigation. Ms. Voggu agreed with the findings.

On 07/15/2024, I interviewed assigned APS investigator, Tria Sparks, and she reported that there was insufficient evidence substantiate this allegation.

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 findings of the investigation, which included interviews of Ms. Rockey, Ms. Heinzerling, Residents A and B, Ms. Voggu and Ms. Bray, I am unable to corroborate that the residents personal needs, including protection and safety, are not being attended to at all times.
	Ms. Rockey, Ms. Heinzerling, Ms. Voggu and Ms. Bray all denied observing or being aware of any staff slapping any of the residents on the arm as alleged.
	Residents A and B both denied being slapped on the arm by staff or observing any staff slap Resident C on the arm.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff, Amberlyn Mosher, is borrowing money from a resident.

INVESTIGATION:

On 06/17/24, I conducted an unscheduled on-site inspection and interviewed staff, Anne Rockey, Sarah Heinzerling, Residents A and B and Relative B1. Ms. Rockey and Ms. Heinzerling both denied any knowledge of any staff borrowing money from any of the residents.

I interviewed Resident A and she reported that none of the staff has ever asked her to borrow money.

I interviewed Resident B in the presence of Relative B1 and she reported that she gave staff, Amberlyn Mosher, a total of \$90. Resident B reported that Ms. Mosher initially asked her for \$40 and she gave it to her. Resident B reported that Ms. Mosher came back to her a little later and asked her for another \$50 after explaining that someone had taken the \$40, she had recently given her, out of her pocket. Resident B reported she does not remember the exact day that Ms. Mosher asked her for the money but reported that it wasn't that long ago. Resident B reported that this was the first time any staff had asked her for money. Resident B reported that she is not to give anyone in the home any money moving forward and that if anyone asks her for money, he wants her to call and inform him. Resident B reported that she would and reported she will not give anyone money moving forward.

I interviewed Relative B1, and he reported that this is the first time he has heard of this incident and reported that he will speak with his family to make sure they are limiting the amount of cash they give Resident B as they do not want a reoccurrence. Relative B1 reported that this is a really good facility and reported the staff take very good care of Resident B. Relative B1 reported that he has no other concerns.

On 06/17/24, I interviewed licensee designee, Vini Voggu, and she reported that she was not aware of the allegation, but reported in the past speaking to Resident B's family about limiting the amount of cash and valuables they provide her because she didn't want her to misplace it or it to create an issue. Ms. Voggu reported she is not making an excuse, because at the end of the day, Ms. Mosher is wrong if she asked Resident B for money. Ms. Voggu reported that she just didn't see the need for Resident B to keep all of the additional cash, credit, and debit cards in the home. Ms. Voggu reported that Resident B's family members are the ones who take her on outings and shopping for things she wants and needs, so she thought it would make more sense for them to provide her the monies while she is out with them, instead of allowing her to keep it all in the home. Ms. Voggu reported that if the family desires to continue to allow her to keep in her room to secure it. Ms. Voggu reported that she would be conducting an internal investigation into the matter.

On 06/21/24, I interviewed home manager, Brandy Bray, and she reported that after speaking with Ms. Voggu about the allegation, she also spoke with Resident B who provided the exact account of events, that she provided to me. Ms. Bray reported that Resident B has been consistent in her account of what occurred, and she believes that Ms. Mosher asked her for the money as alleged. Ms. Bray reported that Ms. Voggu has given Resident B the \$90 back and has purchased a small lock box for Resident B to keep her cash and other valuable in. Ms. Bray reported that she, Ms. Voggu and Resident B's family have reiterated to Resident B not to give the residents or staff any of her money, and to report to the staff and family if anyone asks her for money again. Ms. Bray reported that Resident B reported an understanding.

On 07/12/24, I conducted the exit conference with licensee designee, Vini Voggu, and informed her of the findings of the investigation. Ms. Voggu reported an understanding. Ms. Voggu reported that she conducted an internal investigation regarding the matter and concluded that staff, Ms. Mosher, likely asked and received the \$90 from Resident B. Ms. Voggu reported that Ms. Mosher denied the allegation and would cry each time she spoke with her regarding the matter. Ms. Voggu reported that she has re-educated all of the staff regarding the rule and has reduced Ms. Mosher's work hours. Ms. Voggu reported that Ms. Mosher will be seeking employment elsewhere. Ms. Voggu added that she has reimbursed the \$90 to Resident B and has purchased a lock box for her to keep her cash and other valuables in.

On 07/15/2024, I interviewed assigned APS investigator, Tria Sparks, and she reported that based upon the findings of her investigation and Resident B's

credibility, she is substantiating the allegation of financial exploitation and has referred the matter to law enforcement. Ms. Sparks further reported that she interviewed staff, Amberlyn Mosher, and she adamantly denied that she borrowed any money from Resident B.

APPLICABLE RULE	
R 400.14315	Handling of resident funds and valuables.
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	
	Based on the findings of the investigation, which included interviews with Residents A and B, Ms. Voggu, Ms. Bray and APS investigator, Ms. Sparks, I am able to corroborate that staff, Amberlyn Mosher borrowed \$90 from Resident B.
	Resident B was consistent in her reporting and stated that staff, Amberlyn Mosher, asked her to borrow money and she provided it to her.
	Ms. Bray reported that Resident B was credible in her reporting of what occurred and believes that Ms. Mosher asked her for the \$90.
	Ms. Voggu reported that after completion of her internal investigation, her belief is that Ms. Mosher asked and received \$90 from Resident B. Ms. Voggu has since reimbursed Resident B with the \$90.
	Ms. Sparks reported that based on the credibility of Resident B, and her statements during the course of her investigation, she is substantiating financial exploitation and has referred the matter to law enforcement.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/17/2024, I conducted an unscheduled on-site inspection and observed staff, Sarah Heinzerling, leave out of the facility and go to her vehicle where she remained for about 20-25 minutes. Ms. Heinzerling was the staff on duty and responsible for the three residents who reside in the facility.

On 06/17/24, I interviewed staff, Anne Rockey, who was the staff assigned to the adjoining licensed facility. Ms. Rockey reported that Ms. Heinzerling was dealing with a personal matter, and she needed to be on the phone for what she believed may be a court hearing. Ms. Rockey reported that Ms. Heinzerling asked her if she would assist in keeping an eye out on the three residents, she was responsible for so that she could complete her personal matter. Ms. Rockey reported that she agreed to do so because three of her four residents were asleep, none require 1:1 staffing, and it was not a problem for her to walk down the hallway to the other facility to keep check on the other residents. I explained to Ms. Rockey, that although I can appreciate her willingness to help, Ms. Heinzerling is the staff assigned and responsible for the care of the residents in this facility. Ms. Rockey reported an understanding, however, continued to walk over to the facility to make sure the residents were good until Ms. Heinzerling completed her call.

Ms. Heinzerling was walking back into the facility while I was exiting and I requested that she call me, as I had another appointment and was unable to speak with her at that time.

On 06/17/24, I interviewed staff, Sarah Heinzerling, regarding my observations during the on-site inspection. Ms. Heinzerling apologized for her action's and reported that this is the first time she had done this. She reported that she had to appear on zoom for a court hearing and she had to be present. I informed Ms. Heinzerling that she should have informed her manager or the licensee designee, Ms. Voggu, so that arrangements could have been made to ensure proper staffing. Ms. Heinzerling reported an understanding.

On 06/17/24, I spoke to licensee designee, Vini Voggu and informed her of my observations. Ms. Voggu was shocked and reported that staff know that they are scheduled and assigned to each separate licensed facility and are solely responsible for the care of those residents. Ms. Voggu reported that she would have felt a little better if Ms. Heinzerling stayed inside the facility in view of the residents, while participating in the zoom call. Ms. Voggu reported that she would be having a conversation with Ms. Heinzerling regarding her actions today and re-educating her on her role and responsibilities as a direct care staff.

On 07/12/24, I conducted the exit conference with licensee designee, Vini Voggu, and informed her of the findings of the investigation. Ms. Voggu reported an understanding and reported that she has re-educated Ms. Heinzerling on her role

and responsibilities as a direct care staff and reminded her that the residents are always the priority while at work.

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 the findings of the investigation, which included my observation and interviews of Ms. Heinzerling and Ms. Voggu, I am able to establish that on 06/17/24, there was not sufficient direct care staff on duty at all times for the supervision, personal care and protection of the residents.
	Although, staff Anne Rockey, who was responsible for the care of the residents at the adjoining licensed facility, frequented the facility to check in on the residents, Ms. Heinzerling was the staff assigned to the facility and was ultimately responsible for their care.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

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Pandrea Robinson Licensing Consultant

07/15/24 Date

Approved By:

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07/18/24

Ardra Hunter Area Manager Date