GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 8, 2024

Milton Kennedy
K & K Assisted Living LLC
P.O.BOX 27560
Detroit, MI 48227

RE: License #: AS820343351
Investigation #: 2025A0901005
K & K Assisted Living 4

Dear Milton Kennedy:

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,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820343351
Investigation #:	2025A0901005
Complaint Receipt Date:	11/12/2024
Investigation Initiation Date:	11/13/2024
Report Due Date:	01/11/2025
Licensee Name:	K & K Assisted Living LLC
Licensee Address:	16530 Warwick Detroit, MI 48219
Licensee Telephone #:	(313) 231-3605
Administrator:	Milton Kennedy
Licensee Designee:	Milton Kennedy
Name of Facility:	K & K Assisted Living 4
Facility Address:	16114 Sunderland Detroit, MI 48219
Facility Telephone #:	(313) 231-3605
Original Issuance Date:	10/29/2013
License Status:	REGULAR
Effective Date:	05/01/2024
Expiration Date:	04/30/2026
Capacity:	6

Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

I. ALLEGATION(S)

	Violation Established?
On 11/01/2024, Resident A was in an altercation with Resident B. Staff was not near and did not intervene.	Yes

II. METHODOLOGY

11/12/2024	Special Investigation Intake 2025A0901005
11/12/2024	Adult Protective Services Referral
11/12/2024	Referral - Recipient Rights
11/13/2024	Special Investigation Initiated - Telephone Home Manager, Carolyn Bonner
11/13/2024	Contact - Document Received Email
11/15/2024	Contact - Telephone call made Staff, Myra Bryant
11/15/2024	Contact - Telephone call made Staff, Martha Jones
11/19/2024	Contact - Telephone call made Home Manager, Carolyn Bonner
11/19/2024	Contact - Telephone call made Case Manager, Teju Mowawale
11/21/2024	Inspection Completed On-site
11/21/2024	Contact - Telephone call received Sister B
11/22/2024	Contact - Telephone call made Staff, Jerry Bedford

11/22/2024	Contact - Telephone call made Staff, Martha Jones
12/04/2024	Contact - Telephone call made Case Manager, Teju Mowawale
12/19/2024	Exit Conference Licensee Designee, Milton Kennedy

ALLEGATION:

On 11/01/2024, Resident A was in an altercation with Resident B. Staff was not near and did not intervene.

INVESTIGATION:

On 11/13/2024, I made a telephone call to the home manager, Carolyn Bonner. She confirmed Resident A attacked Resident B and that staff, Martha Jones and Myra Bryant, were working at the time. She explained that the facility is a high behavioral home and the residents there have behavior issues and behavior plans. Carolyn reported Resident A is very aggressive and his attacks are unpredictable. She said Resident B has limited verbal skills and tends to repeat himself a lot and is not able to physically defend himself. On 11/01/2024, Resident B kept repeating Resident A's name, which irritated him. Resident A was already upset, since earlier that day, do to not getting his way. Resident A does not like being told no. This along with Resident B constantly repeating Resident A's name triggered the attack. It happened in the living room. Resident B was sitting in his recliner and Resident A started biting him. Resident A bit Resident B on the arms and bit through the gristle of his ear. Martha was sitting at the dining room table at the time, writing progress notes, and Myra was in the kitchen getting dinner ready. Carolyn said Martha tried to intervene but got knocked down. Myra also tried to help but could not get Resident A off Resident B, so she ran next door to their other licensed facility for help (K & K Assisted Living 3). Staff called the police and petitioned Resident A into the hospital. Resident B was also taken to the hospital, by ambulance, and was treated and released that same day. She said both residents were taken to Sinai Grace hospital and Resident B will require surgery on his ear. Resident A was discharged the next day but taken to K & K Assisted Living 3 for safety reasons and since it consists of male staff. Carolyn said there is always male staff on duty at that home and that Resident A did better with male staff than with females. She indicated neither resident required 1:1 supervision, but both are required to be within eyesight of staff. Carolyn further stated Martha no longer works for them. She said Martha is elderly and that due to her age, health issues, and safety concerns, she felt she could no longer handle the demands of the job so discharged her of her

duties. Since then, they have not been able to contact her, and she doubted Martha would return my calls.

On 11/13/2024, I received an email from Carolyn. The email consisted of incident reports, hospital discharge paperwork, Carolyn's investigative findings, and Resident A's behavior plan. On 11/01/2024, Martha completed an incident report. The incident report indicated that at 5:30 p.m., Resident B was sitting in the living room in his recliner calling Resident A's name. Resident A attacked Resident B and started biting him really bad on multiple areas of his body. Martha ran from the dining room and tried getting Resident A off Resident B and Myra ran from the kitchen to help. Myra called for a male staff from next door to assist. Myra called the police and EMS and Resident B was taken to Sinai Grace Hospital. On 11/01/2024 at 5:30 p.m., Myra completed an incident report. The incident report indicated that Resident A was in behavior mode all day and staff, Myra and Martha, had been redirecting him for verbal aggression. It further stated Myra was in the kitchen preparing dinner and Martha was sitting in eye view of the residents, who were in the living room. Resident A attacked Resident B for talking, biting him in several locations. Myra and Martha tried to get Resident A off Resident B, but he was too aggressive and strong. Myra called for assistance from the male staff next door and Resident A started biting him. Myra called the police, and Resident A was petitioned into the hospital. Neither of the incident reports completed by Myra and Martha indicated who the male staff was that assisted them. On 11/01/2024 at 11:30 p.m., Myra completed an incident report. The incident report indicated Resident B was discharged from the hospital with some prescriptions and that Resident B's sister (Sister B), who is also his guardian, met staff at the hospital and stayed with them until he was discharged. On 11/2/2024 at 4:00 p.m., Carolyn completed an incident report. The incident report indicated Resident A was discharged from the hospital and was still in behavior mode when he arrived at the facility. He attacked the licensee designee, Milton Kennedy, hitting and biting him. Staff, Brian Bazel, called the police, but they never arrived. Milton eventually got him calm.

The residents' discharge paperwork verified they were seen at Sinai Grace hospital on 11/01/2024. The paperwork confirmed Resident A was discharged on 11/02/2024 with instructions to follow-up with Wayne Center for mental health services. Resident B's paperwork confirmed he was treated on 11/01/2024 for human bite wound.

Carolyn also sent a statement detailing her investigative findings, which was signed and dated for 11/03/2024. The statement indicated that Martha and Myra should have moved Resident B to another location, due to Resident A's aggressive behaviors and for safety precautions. She indicated the severity of the injuries, and the strength of Resident A required help from law enforcement. Therefore, she released Martha from her duties. Due to her age and illness, she feels Martha can no longer handle the severity of behaviors that occur with the residents and is considered unsuitable to meet the needs of residents.

Resident A's behavior plan is dated for 10/25/2024 and was completed by Wayne Center. The plan describes Resident A having impulse control issues, being physically and verbally aggressive, and self-injurious. The behavior plan indicates he hits, bites, kicks, is inciting and intimidating. It documents that when showing signs of agitation, staff should engage him and help or redirect him into an activity. It also indicated that when Resident A becomes disruptive, physically aggressive, or otherwise exhibits difficulties, staff should clear the area of other persons to ensure safety, while decreasing the attention Resident A receives for his exhibited behaviors. Staff should also attempt to direct him to a less stimulating area to provide him with the opportunity to calm down and regain control of his behaviors.

On 11/15/2024, I made a telephone call to Myra. She said Resident A was aggravated all day because Resident B kept talking. She explained Resident B repeats himself a lot and that this is a behavior he cannot control. She was in the kitchen when she heard Resident B holler. She rushed to see what was wrong. Resident A was biting Resident B. Myra tried to help but was knocked down. Martha tried to help too but Resident A was too strong. Myra went next door for help and called the police. Myra described Resident A as being very aggressive and unpredictable when he attacks and that he attacks residents and staff. Myra reported they usually take the other residents to another room when Resident A is agitated or having behavior issues, and someone will remain with Resident A and have him color or something until he calms down. When asked if that was done on 11/01/2024, she replied "no."

On 11/15/2024, I attempted to contact Martha. I left a voice message, but the call was not returned.

On 11/19/2024, I made a telephone call to Carolyn. She identified the male staff that assisted on 11/01/2024 as Jerry Bedford and gave me his contact information. She also stated I could come to the home whenever I liked, but said I needed to be careful when talking to Resident A. She said if I discussed the incident or said something he did not like, he would become agitated and go into a behavior.

On 11/19/2024, I made a telephone call to Teju Mowawale, the residents' case manager from Wayne Center. She verified that the residents did not require 1:1 supervision but should be within staff's eyesight and staff should be aware of their whereabouts. She stated Resident A has been at the facility a long time and that all the staff know him. She spoke highly of Carolyn and the staff. She said it was a great facility and that staff treats the residents like family and does a good job of implementing their treatment plans. Her concern was that staff did not do enough during this situation to deescalate Resident A. She felt had they followed the behavior plan and removed him or the other residents sooner, the incident may not have happened. She also felt that due to the injuries, staff may not have intervened quick enough. She suggested that when I go to the facility to see the residents, that I do not discuss the incident with Resident A because it will trigger him.

On 11/21/2024, I conducted an onsite inspection at the facility and observed Resident B. His right ear was bitten, there were two bite marks on his lower right arm, two bite marks on his upper left arm, one on his lower left arm, and one the lower back of his of his head.

On 11/21/2024, I observed Resident A at K & K Assisted Living 3. He seemed to be in a good mood. He said he was doing good at the facility and that he liked it. During this onsite inspection, he was watching television with the other residents, with staff present.

On 11/21/2024, Milton was present during this onsite inspection. He stated Resident A attacked staff, Brian Bazel, yesterday and bit him on the arm. Brain called the police. They came and took Resident A to Sinai Grace hospital, but he was discharged four hours later and returned to the facility. Milton stated despite this incident, he felt this home was a better fit for Resident A due to the strong male presence. He also said Resident A's medications were just adjusted by the psychiatrist. Milton stated they were waiting to see if the change was effective before they proceeded with discharging him.

On 11/21/2024, I received a telephone call from Sister B. She was very upset about the incident and stated she wanted to press criminal charges against Resident A and Martha because she felt Martha did not do enough to prevent the incident from happening. I informed her that I could not assist with that, and she would have to contact law enforcement to see if legal action could be taken. Sister B also said Resident B had been in the home several years and that she had always been completely satisfied with the care and staff. Sister B indicated nothing like this had ever happened before. She expressed concern that Resident A was allowed to remain in the same room as the other residents and no one intervened sooner to separate him. She also sent me pictures she took of Resident B's injuries while at the hospital.

On11/22/2024, I made a telephone call to Jerry. He confirmed he was working at K & K Assisted Living 3 when the incident happened. He said Myra came and got him. When he entered the facility, Resident B was bleeding badly, and Resident A ran upstairs as soon as he saw him. Martha was in the kitchen and Myra was attending to Resident B. He remained there with them until the police came.

On 11/22/2024, I made another telephone call to Martha but there was no answer. I left a voice message, but the call was not returned.

On 12/19/2024, I made a telephone call to Milton for an exit conference. I informed him of my investigative findings. He had no questions or comments and agreed to send a correction action plan when he received the report. He also stated that the medication change was helpful. Although Resident A continues to have behavior issues, Milton said he has been more manageable, and they held off on discharging him.

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:	Based on the information obtained during this investigation, the supervision and protection that was required based on Resident A's behavior plan assessment was not implemented. As reported by Myra and Carolyn, Resident A was agitated all day and was verbally aggressive. His behavior plan specified that when exhibiting that type of behavior, he should be separated from the other residents. Myra and Martha failed to separate Resident A or the other residents from him before his behaviors intensified, resulting in the attack on Resident B. The case manager also confirmed that the behavior plan was not adhered to during this incident. In addition to this, there was not adequate supervision. Carolyn indicated that Resident A did better with male staff and that due to Martha's age and health, she could not handle the behaviors of the residents. Despite knowing this, Martha was still working in the home and there was no male staff on duty.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

_____12/20/2024

Regina Buchanan Date
Licensing Consultant

Approved By:

01/08/2025

_____

Ardra Hunter Date
Area Manager