GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 2, 2025

Charles Kelly
R & B Living Supports, Inc.
130 45th Street
Bloomingdale, MI 49026

RE: License #: AS030390275
Investigation #: 2025A0579039
Blue Sky AFC

Dear Mr. Kelly:

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 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 (616) 356-0100.

Sincerely,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W., Unit 13
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS030390275
Investigation #:	2025A0579039
Complaint Receipt Date:	05/19/2025
Investigation Initiation Date:	05/22/2025
Report Due Date:	07/18/2025
Licensee Name:	R & B Living Supports, Inc.
Licensee Address:	130 45th Street Bloomingdale, MI 49026
Licensee Telephone #:	(269) 521-4500
Administrator:	Charles Kelly
Licensee Designee:	Charles Kelly
Name of Facility:	Blue Sky AFC
Facility Address:	331 49th Street Grand Junction, MI 49056
Facility Telephone #:	(269) 521-6789
Original Issuance Date:	06/27/2018
License Status:	REGULAR
Effective Date:	12/27/2024
Expiration Date:	12/26/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED/ MENTALLY ILL/ DEVELOPMENTALLY DISABLED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Direct care worker, Cheri Klifman called Resident A worthless.	No
Additional Findings	Yes

III. METHODOLOGY

05/19/2025	Special Investigation Intake 2025A0579039
05/22/2025	Special Investigation Initiated - Face to Face Resident A, Resident B, Resident C, and Cheri Klifman (Direct Care Worker)
05/23/2025	Exit Conference Charles Kelly, Licensee Designee

ALLEGATION: Direct care worker, Cheri Klifman called Resident A worthless.

INVESTIGATION: On 5/19/25, I received this referral which alleged direct care worker ("DCW") Cheri Klifman called Resident A worthless.

On 5/22/25, I completed an unannounced on-site investigation. Interviews were completed privately with Resident A, Resident B, Resident C, and Ms. Klifman (DCW/Home Manager).

Resident A reported he does not want to live at this home, he wants to live with his fiancée. He reported he feels Ms. Klifman targets him. He began discussing a previous investigation that relates to his finances being misused but did not state Ms. Klifman was involved in those allegations. He then reported he did not receive his medication in the evening on 5/18/25. He denied further concern about his treatment in the home. When I inquired if Ms. Klifman ever said hurtful comments to him, he said that Ms. Klifman has told him that he is a "screw up." He stated Resident B and Resident C have witnessed Ms. Klifman saying this to him.

Resident B denied Ms. Klifman saying hurtful things to Resident A or any resident. He denied that Ms. Klifman called anyone worthless or a "screw up." He denied concerns regarding his care.

Resident C reported that sometimes Ms. Klifman is mean to residents. He stated she will say, "You guys are a waste of time." He stated he is also concerned that Ms. Klifman will not allow him to get the mail and that she keeps his mail from him because now he does not get mail.

Ms. Klifman stated residents pick on her by repeatedly making comments such as saying, “You’re blonde” over and over. She stated the comments are not hurtful comments and no one in the home says means comments to each other. She denied calling anyone worthless, a waste of time, or a “screw up.” She stated if she gets overwhelmed by residents, she walks away to a quieter area to calm down and does not say hurtful things to them.

Ms. Klifman denied getting the mail. She stated she ensures Resident A is holding his mail due to previous allegations relating to debt collectors contacting him, but it is the residents who go to the mailbox and bring the mail in. She stated Resident C was upset because a package was delivered this week and she brought it inside because it was something for the home, not for residents. She stated Resident C thought the package was for him and that she was not allowing him to have it. She stated once it was in the home, she allowed him to see the label to confirm that it was not for him.

Resident C overheard my conversation with Ms. Klifman. He stated it is true that residents “pick on” Ms. Klifman and that she walks away and does not say hurtful things. He stated they only joke with each other. He stated it is true that he recently thought a package that was delivered was for him, because his brother sometimes sends him things, and he was initially upset that Ms. Klifman brought the package inside. He stated she let him see that it was addressed to the home and not to him or other residents. He stated residents take turns getting the mail.

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:	Resident A initially reported concern relating to allegations that have already been investigated involving his finances and not receiving his medication. With prompting, he reported Ms. Klifman has said he is a “screw up.” Resident C initially stated Ms. Klifman stated, ”You guys are a waste of space.” When he overheard me speaking to Ms. Klifman. He then stated she does not say hurtful things and they all joke with each other. Resident B denied Ms. Klifman stating hurtful comments to residents.

	Ms. Klifman denied stating residents are “a waste of space”, or a “screw up.” She stated that when she is overwhelmed by residents, she goes to a quiet place to calm down and does not say hurtful things. Based on the interviews completed, there is insufficient evidence that residents are not treated with dignity and their needs are not attended to at all times by Ms. Klifman.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

On 5/22/25, Resident A reported he did not receive his evening medication on 5/18/25 because the DCW could not find it and it was in the wrong place. He stated Ms. Klifman fixed this on 5/19/25 and it only occurred once.

Ms. Klifman stated it is true that Resident A did not receive his evening medication on 5/18/25. She stated the DCW working that day did not call her to tell her that they could not find the medication. She stated had someone called her, she would have come in and found the medications because she lives close to the home. She stated she learned on 5/19/25 that Resident A was not given his evening medications on 5/18/25 and immediately addressed it.

Ms. Klifman stated on 5/19/25, she found Resident A’s evening medications were put pill pack face down in the drawer above where Resident A’s medications are kept. She stated she does not know who put them there or why the DCW did not search the medication cart to find them when they were not in Resident A’s drawer. She stated she immediately changed the home’s policy so that DCWs cannot have headphones in while preparing medications to ensure they are better focused. She stated she is now having DCWs initial the bubble packs to ensure they are checking the packs and initialing that they passed them. She stated she is also going to provide additional training to DCWs about how to check for medications in the medication cart (such as knowing where the overflow medications go) and respond appropriately when they cannot find the medications. She presented the memo regarding the new medication policy which was signed by multiple DCWs. She agreed these steps would be added to a Corrective Action Plan (“CAP”) because she understands that Resident A not receiving his medication is a rule violation.

On 5/23/25, I sent an email to licensee designee, Charles Kelly, I discussed that Ms. Klifman had already implemented a CAP regarding Resident A not receiving his evening medications on 5/18/25, I requested a formal CAP with the necessary components be sent prior to this report disposition if possible due to the CAP already being implemented.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**
ANALYSIS:	Resident A reported he did not receive his evening medications on 5/18/25 due to the DCW in the home not knowing where they were. Ms. Klifman confirmed this occurred. She reported she immediately implemented a corrective action plan to prevent this from occurring. Based on the interviews completed, I found sufficient evidence the instructions and recommendations of Resident A's physician were not followed regarding his medication when he was not given his evening medication on 5/18/25.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/23/25, I completed an exit conference with Mr. Kelly discussing my findings and requesting a CAP. He did not dispute my findings or recommendations.

IV. RECOMMENDATION

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

Cassandra Duursma 05/23/2025

Cassandra Duursma Date
Licensing Consultant

Approved By:

Jerry Hendrick 06/02/2025

Jerry Hendrick Date
Area Manager