GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 27, 2025

Karen Harris
Integrated Living, Inc.
43133 Schoenherr Road
Sterling Heights, MI 48313

RE: License #: AS500015839
Investigation #: 2025A0617013
Garbor Group Home

Dear Mrs. Harris:

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.

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) 972-9136.

Sincerely,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd.
Detroit, MI 48202

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500015839
Investigation #:	2025A0617013
Complaint Receipt Date:	04/28/2025
Investigation Initiation Date:	04/29/2025
Report Due Date:	06/27/2025
Licensee Name:	Integrated Living, Inc.
Licensee Address:	43133 Schoenherr Road Sterling Heights, MI 48313
Licensee Telephone #:	(586) 731-9800
Administrator:	Karen Harris
Licensee Designee:	Karen Harris
Name of Facility:	Garbor Group Home
Facility Address:	27630 Ryan Road Warren, MI 48091
Facility Telephone #:	(586) 731-9800
Original Issuance Date:	08/15/1994
License **Status:**	REGULAR
Effective Date:	04/24/2023
Expiration Date:	04/23/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
• Residents are not being cared for properly. Resident A has bed sores and a rash because staff, Tina and Kalen, are refusing to change his briefs. • Resident B has dried feces on him. Staff Tina and Kalen leave all of the residents in soaked/soiled briefs and fall asleep on shift. • Tina grabs and shoves Resident B. Tina also yells and curses at Resident B. • Resident D, is left in his bed and is never turned by staff, leaving him susceptible to bed sores. Residents are not being cared for properly.	No
Staff Tina Chamberlin is stealing Resident C's Lorazepam medication. Tina tried to have staff Antonio Winston sign his name on the med sheet even though Antonio did not pass medications.	Yes

III. METHODOLOGY

04/28/2025	Special Investigation Intake 2025A0617013
04/28/2025	Contact - Document Received Email from Ms. Amber Sultes
04/28/2025	Referral - Recipient Rights Referral to Recipient Rights made
04/29/2025	Special Investigation Initiated – Telephone TC with Complainant
05/05/2025	Inspection Completed On-site I conducted an unannounced onsite investigation at the Garbor Group Home. I interviewed staff Kalen Dayley, Tina Chamberlin, Erika Anderson and Resident D. I attempted to interview Residents A, B, and C but all were nonverbal and unable to answer questions.
06/25/2025	Exit Conference I held an exit conference with licensee designee informing her of the findings of the investigation.

ALLEGATION:

- **Residents are not being cared for properly. Resident A has bed sores and a rash because staff, Tina and Kalen, are refusing to change his briefs.**
- **Resident B has dried feces on him. Staff Tina and Kalen leave all of the residents in soaked/soiled briefs and fall asleep on shift.**
- **Tina grabs and shoves Resident B. Tina also yells and curses at Resident B.**
- **Resident D, is left in his bed and is never turned by staff, leaving him susceptible to bed sores.**

INVESTIGATION:

On 04/28/25, I received a complaint regarding the Garbor Group home. The complaint indicated that on unknown dates in since 4/10/25, the following has been observed: 1. Resident A has bed sores and a rash because staff, such as Tina and Kalen, are refusing to change his briefs. Resident B has dried feces on him. It was alleged that staff Tina and Kalen leave all of the residents in soaked/soiled briefs and fall asleep on shift. 2. Staff Tina is taking Resident C, Lorazepam for herself. Tina tried to have staff Antonio Winston sign his name on the med sheet even though Antonio did not pass medications. 3. Tina grabs and shoves Resident B. Tina also yells and curses at Resident B. 4. Resident D, is left in his bed and is never turned by staff, leaving him susceptible to bed sores.

On 04/28/25, I interviewed office of Recipient Rights worker Amber Sultes. According to Ms. Sultes, Resident A has bed sores and a rash because staff, Tina Chamberlin and Kalen Dayley, are refusing to change his briefs. Resident B has dried feces on him. Ms. Sultes stated that it was alleged that staff Tina and Kalen leave all of the residents in soaked/soiled briefs and fall asleep on shift. According to Ms. Sultes it is alleged that staff Tina grabs and shoves Resident B. Tina also yells and curses at Resident B. Resident D, is left in his bed and is never turned by staff, leaving him susceptible to bed sores.

On 05/05/25, I conducted an unannounced onsite investigation at the Garbor Group Home. I interviewed staff Kalen Dayley, Tina Chamberlin, Erika Anderson and Resident D. I attempted to interview Residents A, B, and C but all were nonverbal and unable to answer questions. I observed Resident A laying in a recliner chair in the living room of the home. He appeared to be clean and neat with no noticeable odor. I observed Resident B being taken to McDonalds by staff Erika Anderson. Resident B was clean, and neat with no noticeable odor. Resident B smiled and appeared to be happy and in good spirits. I observed Resident C sitting in the living room watching television. He smiled, waved and appeared to be in a good mood. Resident C was clean and neat with no noticeable odor. During the onsite investigation, I reviewed several resident files, and the facility appears to be properly caring for the residents.

During the onsite investigation, I interviewed staff Erika Anderson. According to Ms. Anderson, Resident A has one bedsore that he recently developed. She is unsure on how Resident A developed the bedsore but stated that his nurse is aware of it. Ms. Anderson denied that Resident B has or had dried feces on him. Ms. Anderson stated that the residents are bathed regularly, however there home does not keep a shower log. Ms. Anderson stated that she has not witnessed nor been made aware of Tina or Kalen hitting, grabbing, shoving or yelling at any of the residents. According to Ms. Anderson, she has not witnessed staff Tina or Kalen leave residents in soiled briefs. Ms. Anderson stated that the residents are changed regularly. Ms. Anderson stated that Resident D is not left in bed, but he refuses to get out of bed. Ms. Anderson stated that she is the only staff that can convince Resident D to get out of bed and she tries to get him out of bed twice a week.

During the onsite investigation, I interviewed staff Tina Chamberlin. According to Ms. Chamberlin, Resident A does not have bedsores however she has been off work and has not changed or checked Resident A recently. Ms. Chamberlin stated that Resident A is turned every two hours. Ms. Chamberlin stated that when residents develop bedsores the doctor is contacted. Resident A has a nurse who comes to the home to check on him. She stated that if Resident A has a bedsore, it would be in Resident A's file. Ms. Chamberlin went through Resident A's file and provided me with notes from his nurse indicating that on 4/29/25, Resident A was observed by the nurse with a bedsore. Ms. Chamberlin stated that Resident B does not have dried feces on him. Residents are showered very often but at least once a week. Ms. Chamberlin stated that Resident B get showers more often than the others because he often has large bowel movements that require a shower to properly clean him. Ms. Chamberlin showed me a posting in the home with the shower schedule. The men are showered on Monday, Wednesday and Fridays (two males are showered in the morning and two males in the afternoon). The women are showered on Tuesdays, Thursdays and Saturdays (one female is showered in the morning and one in the afternoon). Ms. Chamberlin denied not changing the resident briefs timely or allowing them to sit in soiled briefs. Ms. Chamberlin stated that residents are checked every half hour to an hour and changed as needed. Ms. Chamberlin denied pushing or grabbing Resident B. She stated that this complaint came from a former disgruntle employee whom she had to call the police on for harassment. Ms. Chamberlin stated that Resident D stays in bed often because he refuses to get out of bed. Ms. Chamberlin stated that Resident D only allows staff Erika Anderson to get him out of bed. However, he is rotated every two hours.

During the onsite investigation, I interviewed staff Kalen Dayley. According to Mr. Dayley, he checks and change resident briefs every hour or as needed. Mr. Dayley denied leaving residents in soiled briefs. Mr. Dayley stated that Resident D stays in bed often because he refuses to get out of bed. Mr. Dayley stated that Resident D only allows staff Erika Anderson to get him out of bed. However, he is rotated every two hours. Mr. Dayley stated that residents are showered multiple times a week. Mr. Kalen denied seeing Ms. Chamberlin push or grab Resident B. Mr. Dayley stated that Resident B will often grab staff and scratch them, but staff will just redirect him.

During the onsite investigation, I interviewed Resident D. According to Resident D, staff tries to get him out of bed, but he refuses because he doesn't like getting out of bed. Resident D stated that staff does rotate him very often. Resident D was observed in bed watching television. Resident D stated that he had no concerns or issues to report.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information gathered through my interviews and documentation reviews, the facility has treated residents with dignity and his or her personal needs, including protection and safety, have been attended to at all times in accordance with the provisions of the act. Staff denied all allegations. The home was clean and there were no concerns to report. I attempted to interview Residents A, B, and C but all were nonverbal and unable to answer questions. I observed Resident A laying in a recliner chair in the living room of the home. He appeared to be clean and neat with no noticeable odor. I observed Resident B being taken to McDonalds by staff Erika Anderson. Resident B was clean, and neat with no noticeable odor. Resident B smiled and appeared to be happy and in good spirits. I observed Resident C sitting in the living room watching television. He smiled, waved and appeared to be in a good mood. Resident C was clean and neat with no noticeable odor. Resident D reported that he had no concerns or issues to report. During the onsite investigation, I reviewed several resident files, and the facility appears to be properly caring for the residents. According to Resident A's file, Resident A does have a bedsore but there is no evidence of how he obtained it. Staff Tina and Kalen denied not changing residents timely. Both staff stated that the residents are checked and changed every 30 minutes to an hour and changed as needed. Staff denied that Resident B has dried feces on him. Staff report that he is bathed multiple times a week. Staff Tina denied grabbing or shoving Resident B. Staff Kalen and Erika also denied witnessing it happening.

	According to Resident D, he doesn't get out of bed often because he refuses. He stated that he does not like getting out of bed. Resident D stated that staff move him within the bed often.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	I attempted to interview Residents A, B, and C but all were nonverbal and unable to answer questions. I observed Residents A, B and C to be clean and neat with no noticeable odor. Multiple staff stated that Resident B does not have dried feces on him. Residents are showered very often but at least once a week. Ms. Chamberlin stated that Resident B get showers more often than the others because he often has large bowel movements that require a shower to properly clean him. Ms. Chamberlin showed me a posting in the home with the shower schedule. The men are showered on Monday, Wednesday and Fridays (two males are showered in the morning and two males in the afternoon). The women are showered on Tuesdays, Thursdays and Saturdays (one female is showered in the morning and one in the afternoon).
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff Tina Chamberlin is stealing Resident C's Lorazepam medication

INVESTIGATION:

According to Ms. Sultes, it is alleged that staff Tina is taking Resident C, Lorazepam for herself. Tina tried to have staff Antonio Winston sign his name on the med sheet even

though Antonio did not pass medications. According to Ms. Sultes, she reached out to Rx Specialties on the missing medications at Garbor AFC and the representative, Heather, gave her some information as follows that would be helpful to know:

- Resident C's medication Lorazepam is a PRN, not on an auto-refill; staff called and have this filled as needed. It was filled on 2/20/25 and recently on 4/23/25.
- Resident C's Hydroxyzine was last filled on September 2024 and is PRN medication.
- Resident B's Loperamide was last filled 5/2/24; there has been no additional refills for this medication. It is a PRN that is not an auto-refill.
- Resident D's cream was a 1x fill on 9/4/24; no additional refills remain.
- Resident D's Tylenol was a 1x fill on 9/4/24; no additional refills remain.

During the onsite investigation on 05/05/25, I conducted a medication audit for all residents. I observed that Resident C's medication Lorazepam is prescribed twice a day as needed for agitation. The medication is provided by the pharmacy with a 30day supply for the AM and a 30day supply for the PM. According to the medication logs for January 2025, Resident C received this medication twice a day for the entire month. For the month of February 2025, Resident C did not receive the medication from 2/1-2/20. Staff stated that Resident C had ran out of the medication and the new medication did not arrive until 2/20/25. According to the medication logs, Resident C received the medication in the AM on 2/21-2/24, 2/28 and in the PM on 2/20-2/28. Resident C did not receive this medication at all during the months of March or April 2025, but it is unknown where the rest of the medication went. On 04/22/25 (6 days prior to Special investigation) I conducted an onsite renewal inspection and observed multiple medication errors. The medication errors included serval resident medications missing including Resident C's Lorazepam 0.5mg. If the medication was only given 5 times in the AM and 9 times in the PM, there should've been 25 pills left for the AM supply and 21 pills for the PM supply.

The medication was refiled on 4/23/25 and the facility was supplied with a new 30-day supply for the AM and a new 30-day supply for the PM. According to May 2025 medication logs Resident C received the Lorazepam medication in the AM on 5/1-5/4. However, only 3 of the AM pills were missing from the pack and an additional 3 pills from the PM pack were missing that were not initialed for. Staff could not provide an explanation for the missing pills.

Staff Ms. Erika Anderson denied any knowledge of Resident C's missing medication.

Staff Kalen Dayley denied any knowledge of Resident C's missing medication.

Staff Tina Chamberlin denied stealing Resident C's medication.

On 06/25/25, I held an exit conference with licensee designee Karen Harris informing her of the findings of the investigation. She did not answer, and a voicemail was left for her.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Resident C's medication Lorazepam is provided by the pharmacy with a 30day supply for the AM and a 30day supply for the PM. According to the medication logs for January 2025, Resident C received this medication twice a day for the entire month. For the month of February 2025, Resident C did not receive the medication from 2/1-2/20. Staff stated that Resident C had ran out of the medication and the new medication did not arrive until 2/20/25. According to the medication logs, Resident C received the medication in the AM on 2/21-2/24, 2/28 and in the PM on 2/20-2/28. Resident C did not receive this medication at all during the months of March or April 2025, but it is unknown where the rest of the medication went. On 04/22/25 (6 days prior to this special investigation) I conducted an onsite renewal inspection and observed multiple medication errors. The medication errors included several resident medications missing including Resident C's Lorazepam 0.5mg. On 02/20/25, Resident C received a 30-day supply of the medication Lorazepam for the AM and a 30day supply for the PM. Between February 20 and April 22, 2025, Resident C only received 5 doses of the medication Lorazepam in the AM, and he received 9 doses in the PM. Therefore, there are 25 pills from the AM supply and 21 pills from the PM supply missing. The medication was refilled on 4/23/25 and the facility was supplied with a new 30-day supply for the AM and a new 30-day

	supply for the PM. According to May 2025 medication logs, Resident C received the Lorazepam medication in the AM on 5/1-5/4. However, only 3 of the AM pills were missing from the pack but 4 dates were initialed. According to the med logs Resident C did not receive any doses for the PM. However, there were 3 pills from the PM pack missing. Staff could not provide an explanation for the missing pills.
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: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(d) Initiate a review process to evaluate a resident's condition if a resident requires the repeated and prolonged use of a medication that is prescribed on an as needed basis. The review process shall include the resident's prescribing physician, the resident or his or her designated representative, and the responsible agency.**
ANALYSIS:	Resident C's medication Lorazepam is prescribed twice a day as needed for agitation. Resident C's medication Lorazepam was refilled on 4/23/25 and the facility was supplied with a new 30-day supply for the AM and a new 30-day supply for the PM. According to May 2025 medication logs, Resident C received the Lorazepam medication in the AM on 5/1-5/4. However, only 3 of the AM pills were missing from the pack and an additional 3 pills from the PM pack were missing that were not initialed for. Staff could not provide an explanation for the missing pills. According to the medication logs for January 2025, Resident C received his Lorazepam medication twice a day for the entire month. The facility could not provide documentation of initiating a review process to evaluate Resident C's condition since he required the repeated and prolonged use of the as needed medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

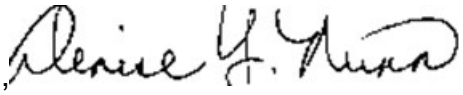
IV. RECOMMENDATION

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

06/25/25

Eric Johnson — Date
Licensing Consultant

Approved By:



06/27/2025

Denise Y. Nunn — Date
Area Manager