GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 18, 2025

Kenneth Rice, II
9825 Lyon Drive
Brighton, MI 48114

RE: License #: AF470407146
Investigation #: 2025A0466031
Rice's House

Dear Mr. Rice, II:

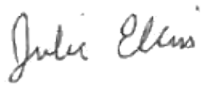
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 335-5985.

Sincerely,



Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF470407146
Investigation #:	2025A0466031
Complaint Receipt Date:	05/07/2025
Investigation Initiation Date:	05/09/2025
Report Due Date:	07/06/2025
Licensee Name:	Kenneth Rice, II
Licensee Address:	9825 Lyon Drive Brighton, MI 48114
Licensee Telephone #:	(313) 304-9515
Administrator:	N/A
Name of Facility:	Rice's House
Facility Address:	9825 Lyon Drive Brighton, MI 48114
Facility Telephone #:	(313) 304-9515
Original Issuance Date:	06/15/2021
License Status:	REGULAR
Effective Date:	12/15/2023
Expiration Date:	12/14/2025
Capacity:	6
Program Type:	AGED

II. ALLEGATIONS:

	Violation Established?
Facility is not appropriately staffed.	No
Resident C has a hospital bed with an overhead trapeze bar that was not attached properly.	No
Additional Findings	Yes

III. METHODOLOGY

05/07/2025	Special Investigation Intake 2025A0466031.
05/09/2025	Special Investigation Initiated - On Site.
05/12/2025	Contact- Document recevied- additional complaint #205523
05/12/2025	APS Referral Jim Lynch Assigned.
05/12/2025	Contact - Telephone call made APS Lynch interviewed.
06/10/2025	Contact - Telephone call received APS Lynch.
06/16/2025	Contact- Telephone call to VA Therapist Lindsay Mitchell interviewed.
06/16/2025	Contact- Telephone call to VA PT Lynn Kujawski, message left.
06/17/2025	Contact- Telephone call to licensee Kenneth Rice interviewed/Exit Conference
06/17/2025	Contact- Documents recevied from licensee Kenneth Rice.

ALLEGATION: Facility is not appropriately staffed.

INVESTIGATION:
On 05/05/2025, Anonymous Complainant reported that licensee Kenneth Rice was unable to properly staff a home of six vulnerable adults as there have been incidents where lack of staffing resulting in reduced supervision that has led to potentially harmful situations [ex: resident becoming aggressive with another resident and no one able to intervene]. Complainant reported that another instance was when a resident was left alone at emergency department as licensee Rice needed to return to the home to care for the five other residents; there should have been another staff called so the resident could have a companion. Complainant was anonymous, so no

additional information including the name of the resident or details regarding the allegation could be gathered.

Complainant reported that on 4/21/25, Resident B struck a Resident A. Complainant reported concerns that Resident B's cognitive issues are too involved for the level of care that the home can provide. Complainant reported concerns for the safety of the other residents due to these conditions.

On 05/09/2025, I conducted an unannounced investigation and responsible person Angie Lauich reported that Resident A was hospitalized for an obstructed bowel last week. Responsible person Lauich reported that licensee Rice took Resident A to the hospital and she was gone prior to him returning home. Responsible person Lauich was unaware if Resident A was left at the hospital alone. Responsible person Lauich reported that Resident A told her about Resident B hitting him. Responsible person Lauich reported that Resident B has become more aggressive with the other residents actually hitting them and also acting like he was going to hit them. Responsible person Lauich reported that due to Resident B's dementia advancing he is becoming more difficult to redirect and his behavior is unpredictable. Responsible person Lauich reported that there has only been one physical altercation between Resident A and Resident B. Responsible person Lauich reported that none of the residents require two-person assistance for showers or transfers.

Resident A reported that he was hospitalized recently and that licensee Kenneth Rice took him to the hospital. Resident A did not recall being at the hospital alone. Resident A reported that Resident B hit him once on the side of the head/face and licensee Rice saw it on the camera. Resident A reported that he was not injured as a result of being hit. Resident A reported that Resident B has dementia and has recently started to be more aggressive.

Resident B was asleep in the chair for the entire time I was at the facility and therefore he was not able to be interviewed.

On 06/10/2025, APS Lynch reported that he talked with Guardian B1 who reported that Resident B's needs were being met at the facility and that she did not have any concerns about this facility nor was she looking for another placement at this time. APS Lynch reported that he did not find any substations with his inviestgaiton and that he was going to close his case.

On 06/16/2025, I interviewed Lindsey Mitchell Physical Therapist (PT) home based primary care with the U.S. Department of Veteran Affairs (VA) who reported Resident A was hospitalized and his Relative A1 was supposed to go to the hospital to sit with him but never showed up so Resident A was at the hospital alone. PT Mitchell reported that licensee Rice left Resident A at the hospital alone prior to the Relative A1 arriving to sit with him. PT Mitchell reported that she witnessed Resident B hit Resident A completely out of the blue and unprovoked. PT Mitchell reported

that she does not believe that responsible person Lauich observed the altercation as she was in another part of the home at the time. PT Michell reported that she, PT Kujawski and another person from Visiting Angles (does not recall her name) observed the interaction. PT Mitchell is concerned as Resident B's dementia has progressed and she is concerned if this home can continue to meet Resident B's needs. PT Mitchell reported that she believes that licensee Rice is doing a good job but that Resident B's behavior may be more that this home can handle. PT Mitchell reported that she believes that Resident B would benefit from a specialized memory care unit but she is not sure how placement changes are made though the VA.

On 06/17/2025, licensee Rice reported that Resident A was sent to the hospital via emergency medical service (EMS) because it was an emergency and he was the only staff member on duty. Licensee Rice reported that Guardian A1 was supposed to meet Resident A at the hospital but never showed up. Licensee Rice reported that Resident A was not admitted, he was brought back to the facility via EMS the same day. Licensee Rice reported that Resident A does go to the community center unsupervised and is able to supervise himself alone in the community. Licensee Rice reported that he was informed of the time that Resident B hit Resident A. Licensee Rice reported that it was an isolated incident and that Resident B receives nursing and medical care through the VA. Licensee Rice reported that this incident was reported and being addressed. Licensee Rice acknowledged that Resident B is diagnosed with dementia but reported that he is still able to meet his needs.

On 06/17/2025, I reviewed Resident A's written *Assessment Plan for Adult Foster Care (AFC) Residents* which was completed on 06/15/2021 and documented that Resident A moves independently in the community.

I reviewed Resident B's written *Assessment Plan for AFC Residents* which was completed on 6/28/2022 and documented that Resident B controls his aggression and gets along with others.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until a resident assessment plan is made and it is determined that the resident is suitable pursuant to the following provisions: (a) The amount of personal care, supervision, and protection required by the resident is available in the home.

ANALYSIS:	Based on interviews with responsible person Lauich, Resident A and licensee Rice, Resident A was at the hospital independently. Resident A's written *Assessment Plan for AFC Residents* documented that Resident A moves independently in the community and therefore can be in the hospital independently. Responsible person Lauich, Resident A and licensee Rice all reported that Resident B hitting Resident A was an isolated incident. Licensee Rice reported Resident B receives nursing and medical care through the VA and this incident was reported and this behavioral change is being addressed. Licensee Rice acknowledged that Resident B is diagnosed with dementia but reported that he is still able to meet Resident B needs therefore there is not enough evidence to establish a violation at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident C has a hospital bed with an overhead trapeze bar that was not attached properly.

INVESTIGATION:
On 05/05/2025, Anonymous Complainant reported that a resident had a hospital bed with an overhead trapeze bar that was not attached properly. Complainant reported that the trapeze bar was incompatible with the bed to which it is attached, and it is not safe as it is not secure. Complainant reported that the trapeze bar was propped up on the wall with a wooden block and could seriously injure a resident. Complainant reported that that the bar was removed by clinicians to prevent injury. Complainant was anonymous, so no additional information including the name of the resident or details regarding the allegation could be gathered.

On 05/09/2025, I conducted an unannounced investigation and I interviewed responsible person Lauich who admitted that Resident C had an older trapeze that did not go with his bed, so they ordered a new one that was compatible with the bed. Responsible person Lauich reported that when the physical therapist (PT) identified the problem she took the trapeze off so that it could not be used. Responsible person Lauich reported that no injury resulted from the trapeze being in properly attached.

On 06/16/2025, PT Mitchell reported that she and PT Linda Kujawski both observed the overhead trapeze bar that was not attached properly in Resident C's bedroom. PT Mitchell reported that the trapeze bar was incompatible with the bed and was not safe as it was not secure. PT Mitchell reported that the trapeze bar was propped up on the wall with a wooden block and that could have seriously injured Resident C. PT Mitchell reported that she and PT Kujawski removed the bar to prevent injury.

PT Mitchell reported that this has been resolved as the new bar compatible with Resident C's bed has been ordered and installed.
On 06/17/2025, licensee Rice reported that Resident C was admitted four months ago and brought the trapeze with him that was installed by his family member. Licensee Rice reported that per the advisement of PT Mitchell and PT Kujawski the trapeze was removed and the correct one was ordered and installed by the VA.

APPLICABLE RULE	
R 400.1426	**Maintenance of premises.**
	(1) The premises shall be maintained in a clean and safe condition.
ANALYSIS:	Responsible person Lauich, PT Mitchell and PT Linda Kujawski all observed the overhead trapeze bar that was not attached properly to Resident C's bed. Responsible person Lauich, and PT Mitchell reported that the trapeze bar was incompatible with the bed and was not safe as it was not secure. Responsible person Lauich and PT Mitchell reported that the trapeze bar was propped up on the wall with a wooden block and that could have seriously injured Resident C. Responsible person Lauich. PT Mitchell and licensee Rice reported that PT Mitchell and PT Kujawski removed the bar to prevent injury. Responsible person Lauich, PT Mitchell and licensee Rice reported that this has been resolved as the new bar has been ordered, installed and is compatible with Resident C's bed. At the time of the inspection there was no safety risk therefore therefor there is not enough evidence to establish a violation as the trapeze was corrected and properly installed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 05/12/2025, I conducted an unannounced investigation and I observed that there were cameras in Resident A and Resident C's bedrooms. Additional cameras were observed in the family room and kitchen.

I interviewed responsible person Lauich who reported that the facility had cameras in the kitchen, family room, and Resident A and Resident C's bedrooms. Responsible person Lauich reported that she did not have any knowledge about the cameras meaning if they were a live feed or if the cameras recorded. Responsible person Lauich reported that she was not aware of why they were being used or who had access to them.

Resident A reported that the facility has cameras for licensee Rice to watch them and it's another way for them to communicate with him while licensee Rice is in the upper level of the facility.
Resident B was asleep in the chair for the entire time I was at the facility and therefore he was not able to be interviewed.

APPLICABLE RULE	
R 400.1409	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, the licensee shall inform and explain to the resident or the resident's designated representative all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall provide the resident and the resident's designated representative with a written copy of the rights outlined in subrule (1) of this rule upon a resident's admission to the home.**
ANALYSIS:	Cameras located in Resident A and Resident C's personal bedroom space do no provide personal dignity, individuality, and the need for privacy therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 05/12/2025, I conducted an unannounced investigation and I observed that Resident B has a bedroom on the upper level of the home while four of the other residents have bedrooms in lower level of the home. Responsible person Lauich reported that Resident B can no longer ambulate the stairs so licensee Rice drives Resident B down to the lower level in the morning and then drives him back up to the upper level before bed so Resident B can enjoy the company of other residents. While I was at the facility, Resident B was sleeping at the dining room table chair. Responsible person Lauich reported that Resident B spends a lot of time sleeping during the day especially now with his medications being adjusted. Responsible person Lauich reported that unless licensee Rice comes home to drive Resident B back upstairs, Resident B does not have access to his bedroom while she is on duty as she is not comfortable helping him ambulate the stairs. Responsible person Lauich reported that there is a responsible person to assist with residents typically from 7:30am-12:30pm Monday through Friday. Responsible person Lauich reported that during this time Resident B is typically with the other residents on the main level of the home without access to his bedroom.

Resident B was asleep in the chair for the entire time I was at the facility and therefore he was not able to be interviewed.

On 06/16/2025, PT Mitchell reported that she has observed Resident B sleeping at the dining table. PT Mitchell reported that she would have concerns with Resident B ambulating the stairs.

On 06/17/2025, licensee Rice reported that Resident B can ambulate the stairs but that he feels better driving Resident B to be safe. Licensee Rice reported that he has offered for Resident B to sit on a couch or to sleep somewhere else during the day, but he prefers to sit by the table.

I reviewed Resident B's written *Assessment Plan for AFC Residents* which was completed on 6/28/2022 and documented that Resident B

"has dementia, needs to be told when to eat, shower, drink water. Will help himself to food in the fridge, overdrink ensure. Has no filter, may say inappropriate things. Can be lazy. Gets up a lot at night and naps a lot."

APPLICABLE RULE	
R 400.1409	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, the licensee shall inform and explain to the resident or the resident's designated representative all of the following resident rights: **(p) The right of access to his or her room at his or her own discretion.** **(2) A licensee shall provide the resident and the resident's designated representative with a written copy of the rights outlined in subrule (1) of this rule upon a resident's admission to the home.**

ANALYSIS:	Resident B has a bedroom on the upper level of the home while most residents have bedrooms in lower level of the home. Responsible person Lauich reported that Resident B can no longer safely ambulate the stairs so licensee Rice drives Resident B down to the lower level in the morning and then drives him back up to the upper level before bed so Resident B can enjoy the company of the other residents. While I was at the facility, Resident B was sleeping in the chair at the dining table. Responsible person Lauich reported that he spends a lot of time sleeping there during the day. Resident B back does not have access to his bedroom as he cannot ambulate the stairs and he is dependent on licensee Rice to drive him to the upper floor where his bedroom is located. Therefore he does not have access to his bedroom at his own discretion and a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 05/12/2025, I conducted an unannounced investigation and responsible person Lauich reported that she administers medications however she does not take the medication out of the container provided by the pharmacy, nor does she sign for the medications on the medication administration record (MAR). Responsible person Lauich reported that she does not know where the MARs are stored and therefore cannot provide them for department review. Responsible person Lauich reported that licensee Rice pre-sets the medications in a daily pill container for each resident therefore responsible person Lauich reported that she is not completely sure which medications she is administering to each resident. Responsible person Lauich reported that she receives verbal direction from licensee Rice about medication administration and she follows his instruction. Responsible person Lauich reported that the cabinet used to store the medications is not locked and that she is not provided with a medication key. At the time of the unannounced investigation, I observed medications in pre-set pill cases unsecured, medicated lotions and creams in resident bedrooms, prescribed medications on top of the medication cabinet unsecured and medications unsecured in the cabinet.

On 06/17/2025, licensee Rice reported that he is the only person that administers medications and that is why he pre-sets them.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions:

	(a) Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years. **(5) Prescription medication shall be kept in the original pharmacy supplied and pharmacy-labeled container, stored in a locked cabinet or drawer, refrigerated if required, and labeled for the specific resident.**
ANALYSIS:	At the time of the unannounced investigation the MARs were not available for department review, all prescription medication was not stored in the original pharmacy supplied container, as medications were being pre-set, and medications are not being stored in a locked drawer/cabinet therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 05/09/2025, I conducted an unannounced investigation and at the time of the investigation the responsible person on duty, Lauich did not have access to the resident records for department review. Responsible person Lauich contacted licensee Rice but he did not return to the facility, nor did he provide her instruction as to where the records were kept so that they could be reviewed. Responsible person Lauich reported that she receives verbal instructions from licensee Rice regarding the care that the residents need and she follows his instructions.

APPLICABLE RULE	
R 400.1422	**Resident records.**
	(1) A licensee shall complete and maintain a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number.** **(iii) Home address.** **(iv) Name, address, and telephone number of the next of kin or designated representative.** **(v) Name, address, and telephone number of person or agency responsible for the resident's placement in the home.**

	(vi) Name, address, and telephone number of the preferred physician and hospital. **(b) Date of admission.** **(c) Date of discharge and place to which resident was discharged.** **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication.** **(iv) Instructions for emergency care.** **(e) Resident care agreement.** **(f) Assessment plan.** **(g) Weight record.** **(h) Incident and accident reports.** **(i) Resident funds and valuables record.** **(j) Resident grievances and complaint record.** **(2) Resident records shall be kept on file in the home for 2 years after the date of a resident's discharge from a home.**
ANALYSIS:	At the time of the unannounced investigation responsible person Lauich reported that she did not have access to the resident records and therefore they were not available for department review.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Julie Elkins

06/18/2025

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Julie Elkins Date
Licensing Consultant

Approved By:

Dawn Timm

06/18/2025

_____

Dawn N. Timm Date
Area Manager