GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 13, 2025

Tonya Carter
Encore McHenry
Suite 710
230 West Monroe
Chicago, IL 60606

RE: License #: AL630417060
Investigation #: 2025A0605014
The Courtyard At Auburn Hills 4

Dear Tonya Carter:

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 (248) 972-9136.

Sincerely,

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

## I. IDENTIFYING INFORMATION

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| **License #:** | AL630417060 |
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| **Investigation #:** | 2025A0605014 |
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| **Complaint Receipt Date:** | 06/12/2025 |
| | |
| **Investigation Initiation Date:** | 06/12/2025 |
| | |
| **Report Due Date:** | 08/11/2025 |
| | |
| **Licensee Name:** | Encore McHenry |
| | |
| **Licensee Address:** | Suite 710<br>230 West Monroe<br>Chicago, IL 60606 |
| | |
| **Licensee Telephone #:** | (248) 340-9296 |
| | |
| **Administrator/ Licensee Designee:** | Tonya Carter |
| | |
| **Name of Facility:** | The Courtyard At Auburn Hills 4 |
| | |
| **Facility Address:** | 3033 N. Squirrel Rd.<br>Auburn Hills, MI 48326 |
| | |
| **Facility Telephone #:** | (248) 340-9296 |
| | |
| **Original Issuance Date:** | 08/01/2024 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 02/01/2025 |
| | |
| **Expiration Date:** | 01/31/2027 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A was found soiled after an unattended bathroom accident. | Yes |
| Resident A is on a questionable medication causing hallucinations. | No |
| There are ants present in some rooms at the facility. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

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|---|---|
| 06/12/2025 | Special Investigation Intake<br>2025A0605014 |
| 06/12/2025 | Special Investigation Initiated - Letter<br>Email to Adult Protective Services (APS) |
| 06/12/2025 | APS Referral<br>Adult Protective Services (APS) made referral |
| 06/16/2025 | Inspection Completed On-site<br>Conducted unannounced on-site investigation |
| 07/16/2025 | Contact - Telephone call made<br>Discussed allegations with direct care staff (DCS) |
| 07/17/2025 | Contact - Telephone call received<br>Discussed allegations with DCS |
| 08/05/2025 | Contact - Telephone call made<br>Discussed fire drills with Bureau of Fire Safety Paul Mullett and licensee designee Tonya Carter |
| 08/06/2025 | Contact - Telephone call made<br>Follow-up with Resident A's friend |
| 08/12/2025 | Contact - Face to Face<br>Conducted surprise fire drill at Cottage 4 with Paul Mullett |

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| 08/13/2025 | Exit Conference<br>I left a detailed voice mail message for licensee designee Tonya Carter with my findings. |

**ALLEGATION:**

**Resident A was found soiled after an unattended bathroom accident.**

**INVESTIGATION:**

On 06/12/2025, intake #205956 was referred by Adult Protective Services (APS) regarding Resident A being in an altercation with another resident, put on medications resulting in hallucinations.

On 06/16/2025, I conducted an unannounced on-site investigation. I learned that these allegations were pertaining to Cottage 4. Present were licensee designee Tonya Carter, Assistant Wellness Director Amber Carmicheal and direct care staff (DCS) Isreal Williams. Also present were Residents A, B, C, D, E, F, G, H, I, and J.

On 06/16/2025, I interviewed licensee designee Tonya Carter regarding these allegations. Resident A is incontinent but there has never been a time when there were feces in the hallway due to him having an accident. Staff check and change residents every two hours and there has not been a time when residents are left soiled for long periods of time. Again, Ms. Carter reported that one DCS is sufficient in providing care to all 13 residents because there were no residents at Cottage 4 who required two DCS for transfers or changing.

On 06/16/2025, I interviewed Amber Carmichael regarding these allegations. Resident A is incontinent and has refused to be changed by staff. However, there have not been any incidents of feces on the floor, nor have there been any issues with Resident A being soiled for long periods of time. She has not received any complaints from staff finding Resident A or any other resident soiled. Ms. Carmichael also stated that one DCS is sufficient to provide for the care and needs of all 13 residents because there were no residents, that was a two-person assistance with changing or transferring.
On 06/16/2025, I interviewed DCS 1 regarding the allegations. About a week ago, when DCS 1 began their shift, they discovered that Resident A was soiled because he had a bowel movement. DCS 1 changed him and the sheets that were also soiled. This was an isolated incident.

On 06/16/2025, I attempted to interview Resident A regarding the allegations, but Resident A was unable to provide any information regarding the allegations. He was lying on the bed, and he did not appear to be soiled.

On 06/16/2025, I interviewed Resident A's friend regarding the allegations via telephone. There have been times when the friend found Resident A soiled. He smelled

strongly of urine this past week when she found him soiled. Last weekend, Resident A's friend arrived at the facility to visit with Resident A. He had a bowel movement and there were feces on the floor of his bedroom. She tried calling staff but due to only one DCS working, and that staff was assisting another resident, Resident A's friend mopped the floor. The feces were in the bathroom and the path in his bedroom. The DCS that was working during this time was filling in for the DCS that was on break. The friend does not know the staff names. The friend does not believe there is enough staff on shift to care for all the residents and their needs.

On 07/16/2025, I interviewed DCS 2 regarding the allegations via telephone. DCS 2 found Resident A soiled along with his sheets when they arrived at their shift. They cannot recall which staff was working, but it has occurred more than once. They did not report this to anyone. DCS 2 stated that sometimes when Resident A, Resident D, and Resident G are having a "bad day," they need two DCS to assist with transferring to and from the bed to their wheelchair and vice versa. There are other DCS that have stated that they would staff from other cottages to assist them in transferring.

On 07/16/2025, I interviewed DCS 3 regarding these allegations via telephone. DCS 3 has never found Resident A soiled or any other resident. They check residents every two hours and change them if they are soiled. DCS 3 stated they are unaware of any resident who is a two-person assist because they have not worked at Cottage 4 for long.

On 07/16/2025, I interviewed DCS 4 regarding these allegations via telephone. DCS 4 has never seen feces on the floor of Resident A's bedroom, nor have they seen Resident A soiled. DCS 4 stated that management is big on ensuring that all residents are checked and changed every two hours. There have not been any residents left unchanged by another staff. DCS 4 works midnight and does not know of residents who are two-person assistance because they have not worked long at Cottage 4.

On 07/16/2025, I interviewed DCS 5 regarding these allegations via telephone. DCS 5 has not found Resident A soiled or any other resident soiled but stated that sometimes DCS 5 needs help from another staff member at Cottage 3 for transfers. Resident G needs two DCS to help them transfer from the wheelchair to the toilet and vice versa and needs two DCS to transfer from wheelchair to his bed.

On 07/17/2025, I interviewed DCS 6 regarding these allegations via telephone. DCS 6 stated that there have been a few times when they began their shift that they found Resident G soiled through their pants. This occurs whenever DCS 1 is working. DCS 6 stated, "it's hard for one staff to get everything done for all these residents." DCS 6 has asked management for additional staffing, but management say, "there's no one here that is a two-person assist." DCS 6 stated that Resident A, Resident G, and Resident I require two DCS to assist with changing their briefs and transferring.

On 07/17/2025, I interviewed DCS 7 regarding these allegations via telephone. DCS 7 stated that Resident A will refuse to be changed by staff because he only allows certain

staff to change him. DCS 7 has found Resident A soiled and believes it is because he refused to be changed. Resident A is incontinent and sometimes can require two DCS to change him when “he’s in his mood.” DCS 7 stated that sometimes Resident A will refuse care and when there is a “newer staff,” working, that “new staff,” will call staff from Cottage 3 to assist. In addition to Resident A, Resident G can also be a two person assist with transfers even though DCS 7 can provide care by themselves. DCS 7 has seen again “newer staff,” requiring additional help with the residents. DCS 7 stated, “it’s usually the midnight staff that need the additional help.”

On 07/28/2025, I interviewed DPOA-I regarding the allegations. DPOA-I visits Resident I several times a week depending on his needs. There was one time when she visited him and observed feces on his sheets where she brought it immediately to the staff’s attention and they changed the sheets. This was an isolated incident. Resident I had a stroke and after that stroke, he began having spasms. DPOA-I stated that one DCS can provide care to Resident I; however, there are some days due to Resident I’s spasms being “out of control,” he can require two staff for care; changing briefs and transfers.
On 07/28/2025, I contacted Resident D’s DPOA-D regarding the allegations. DPOA-D primarily visits in the afternoon and during the visits, DPOA-D has never observed him being soiled. The DPOA-D stated, “I can transfer him on my own as staff does.” Resident D is not a two person assist. He can be transferred with only one staff member. DPOA-D stated, even though Resident D is not a two person assist, there should be more than one DCS on shift. One time a resident pulled their cord into their bedroom and made the light on above their room come on and there was no staff around to help. She cannot recall which staff were on shift, but it was during second shift. Another time, DPOA-D needed to leave the visit and there was no staff to let them out of the building since the code was no longer provided to visitors. DPOA-D walked the indoor parameter of Cottage 4 four times and could not locate a staff member. Finally, they went into the kitchen and the DCS was there with other staff members having a meeting. DPOA-D was then let out of the building.

On 08/01/2025, Tonya Carter emailed the fire drills; however, I requested the last six months to determine if one DCS per shift was sufficient staffing for 13 residents and received the following:

- 06/13/2024- Cottage 3 and Cottage 4, 2:45PM, five staff initials on log with evacuation time 3minutes 10 seconds.
- 10/15/2024- Cottage 4, 3:15PM, three staff initials on log with no evacuation time on log.
- 10/16/2024- Cottage 4, 6:08AM, two staff initials on log with no evacuation time on log.
- 11/15/2024- Cottage 3 and Cottage 4, unknown time, 10 staff initials on log with no evacuation time on log.
- 01/24/2025- Cottage 4, unknown time, five staff initials on log with no evacuation time on log.
- 03/03/2025- Cottage 4, 4:30 (unknown AM or PM), no staff initials and no evacuation time on log.

- 03/07/2025- Cottage 4, 6:30 (unknown AM or PM), three staff initials on log and no evacuation time on log.
- 04/24/2025- Cottage 4, 2:11 (unknown AM or PM), five staff initials on log and no evacuation time on log.
- 06/27/2025- Cottage 3 and Cottage 4, 6AM, five staff initials on log and evacuation time 3minutes 7seconds.

On 08/05/2025, I contacted the Bureau of Fire Safety Fire Marshal Paul Mullett regarding the fire drills. I emailed the fire drills to Mr. Mullett's attention. Mr. Mullett and I reviewed the fire drills, and he agreed that the fire drills were incomplete, and that there were no fire drills with only one DCS conducting the drill to determine the accurate evacuation time. In addition, there were several missing drills. Mr. Mullett agreed to conduct a surprise fire drill at Cottage 4 on 08/12/2025.

On 08/05/2025, I followed up with licensee designee Tonya Carter. Ms. Carter stated that Cottage 4 has never conducted a fire drill with only one DCS to determine evacuation time because there are multiple administrative staff in the building, so they are all included in the drill. Ms. Carter stated that the fire drill completed on 10/16/2024 at 6:08AM was with two DCS during the midnight shift because at that time, there was two DCS per shift. However, currently there is only one DCS per shift, but a fire drill was never conducted when there was a decrease in staffing. I advised Ms. Carter that I have been advised that Residents A, G, and I can be a two-person assist with transfers and changing. She stated there is no one that is a two-person assist even though this was being reported to me. I also advised Ms. Carter that there have been times when there were no staff found in Cottage 4 after a resident pulled their cord in their bedroom and when a family member wanted to leave the building. Ms. Carter stated that there have been no complaints from anyone about not locating staff and that the longest it has taken staff to let anyone in the building after ringing the doorbell was six minutes. Ms. Carter stated that regarding the pull-cords, the response time has been less than 15 minutes for staff to get to residents who pull their cords. Again, she stated there have not been any complaints made to her or to Amber Carmichael about response times. Ms. Carter advised that one DCS is sufficient to provide for the care of the residents as there is an ample amount of time for one DCS to change residents because residents are checked and changed every 2 hours. According to Ms. Carter, there are five residents who are incontinent, and she again stated that one DCS can attend to all the residents without assistance from other staff.

On 08/06/2025, I followed up with Resident A's friend via telephone regarding the allegations. Resident A's friend stated that since Resident A had been discharged from the hospital within the last couple of months, his health had declined. Resident A uses a wheelchair to ambulate requiring two DCS to assist him with transfers and with changing his briefs. Resident A stated that another resident, Resident D, is also a two-person transfer as Resident A's friend has observed Resident D requiring two DCS to assist.

On 08/12/2025, I along with Paul Mullett with BFS conducted a surprise onsite at this facility to conduct a fire drill with only one DCS. Tonya Carter, Amber Carmichael, Amanda Azar, DCS Barbara Blackmon and Andre Garrison, the maintenance person was present. There were also three family members visiting at this time. Ms. Carmichael stated that there was a total of 12 residents at the facility as Resident L was in rehab. I advised Ms. Carter that we were here to conduct a fire drill with only Ms. Blackmon to participate in the evacuation drill to determine the evacuation time with only one DCS since there is only one DCS working during the midnight shift. Ms. Carter advised Mr. Garrison to call the alarm company which he did to advise that a simulated drill was being performed. I began the stopwatch once the alarm went off and stopped when the last resident along with Ms. Blackmon were outside the facility. The total time was *seven minutes and seven seconds*. I counted the residents outside and there were only 11 residents. Ms. Carter stated that another resident was out with their family.

I observed the following during the fire drill, Ms. Carter and one of the family members held the doors open, while another family member assisted in pushing Resident I in his wheelchair assisting Ms. Blackmon with evacuating the residents. I advised Ms. Carter that based on the evacuation time of 11 residents with the assistance of her and the family members, there was insufficient staff during the midnight shift to ensure the safety of all 13 residents. Ms. Carter stated that she has additional staff in the other cottages that can assist with evacuation. Ms. Carter was advised that additional and/or floating staff cannot be counted towards resident to staff ratio; therefore, she is understaffed.

Mr. Mullett advised Ms. Carter that based on his observations and the evacuation time, if it were midnight, it would have been around 15 minutes for one DCS to evacuate all 13 residents. Ms. Carter insisted that only one DCS would be sufficient to evacuate all 13 residents in under 8 minutes. I advised Ms. Carter that she will need to re-evaluate her staffing to resident ratio, based on the residents' needs, especially during the midnight shifts since there are no other staff in the facility to assist during an emergency. Ms. Carter again stated that Cottage 3 has an additional staff that can assist Cottage 4, but Mr. Mullett advised Ms. Carter that the additional staff would need to help Cottage 3 evacuate since both cottages are only separated by the kitchen and that again, she cannot depend on other staff to assist in evacuating since they are not working at this building. I advised Ms. Carter that based on this fire drill, I will be substantiating my findings regarding insufficient staffing. Ms. Carter stated that she does not agree with my findings and believes that one DCS during the midnight shift to meet the needs of all 13 residents is sufficient.

| **APPLICABLE RULE** | |
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| **R 400.15206** | **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** |

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| | **specified in the resident's resident care agreement and assessment plan.** |
| **ANALYSIS:** | Based on my investigation and information gathered, there is insufficient staff during the midnight shifts. There are a total of 13 residents and only one DCS working per shift; however, during the day shift and part of the afternoon shift, there is administration working in Cottage 4 that will participate if there is an actual emergency. However, there is no administration working during the midnight shift leaving only one DCS to assist all 13 residents during an emergency.<br><br>On 08/12/2025, I along with BFS Paul Mullett conducted a surprise fire drill onsite with only one DCS, Barbara Blackmon. Ms. Blackmon is an experienced staff, and it took her 7 minutes and 7 seconds to evacuate 11 residents with the assistance of licensee designee Tonya Carter and other family members either holding open the doors or pushing residents outside. Ms. Mullett advised Ms. Carter that if this drill was during midnight hours, it would have taken one DCS around 15 minutes to evacuate, which is more than the 8 minutes or less that is required for an evacuation time.<br><br>In addition, there are five residents who are incontinent, and Resident A has been observed several times soiled in his briefs by Resident A's friend and several DCS. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| **APPLICABLE RULE** | |
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| **R 400.15305** | **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 my investigation and information gathered, Resident A's personal needs were not attended to at all times when Resident A's friend and DCS 2, DCS 6, and DCS 7 have observed Resident A soiled.<br><br>In addition, there is one DCS working per shift. However, administration work at Cottage 4 during the day shift and most of the afternoon shift, but no other staff other than one DCS is |

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| | working during the midnight shift caring for all 13 residents. Residents A, B, C, D, E, F, G, H, I, J, K, L, and M protection and safety are not attended to at all times with one DCS working per shift as evident by the surprise drill that was conducted on 08/12/2025. The evacuation time during the day shift with only one DCS participating was 7 minutes and 7 seconds with 11 residents and the assistance of Ms. Carter and other family members present holding the doors or pushing the residents out of the building. One DCS would not be able to evacuate all 13 residents safely during the midnight shift during an emergency. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| **APPLICABLE RULE** | |
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| **R 400.15318** | **Emergency preparedness; evacuation plan; emergency transportation.** |
| | **(5) A licensee shall practice emergency and evacuation procedures during daytime, evening, and sleeping hours at least once per quarter. A record of the practices shall be maintained and be available for department review.** |
| **ANALYSIS:** | I reviewed the emergency and evacuation procedures submitted by licensee designee Tonya Carter and according to the fire drills conducted, they were incomplete and missing drills. A sleep drill was missing for the first quarter of 2025, and an evening drill was missing during the second quarter of 2025. In addition, the fire drills were incomplete with no evacuation times documented. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**Resident A is on a questionable medication causing hallucinations.**

**INVESTIGATION:**

I interviewed licensee designee Tonya Carter regarding the allegations. Resident A recently moved from Cottage 3 to Cottage 4 on 03/2025, because Resident A's level of care decreased. Ms. Carter denied an altercation between Resident A and another resident. Resident A was put on psychotropic medications not because of an altercation but because he was attempting to elope from this facility multiple times. Resident A's Seroquel increased on 05/22/2025, Risperidone was prescribed as a scheduled medication, and Ativan was prescribed as needed by his primary care physician (PCP),

Dr. Priti. Resident A has “moments of confusion,” but she denied he reported any hallucinations. Both times Resident A tried to elope, the door alarm went off and staff intervened, resulting in Resident A not leaving this facility. There were no protective measures put in place other than the alarms on the doors. Ms. Carter stated that there is only one DCS per shift for 13 residents. She stated that no resident at Cottage 4 is a “two-person assist,” and that “these residents had no needs that would require two DCS per shift.” Resident A attempted to elope on 05/22/2025 when DCS Barbara Blackman was working during the morning shift when all management were in a staff meeting. The door alarm went off and Ms. Blackman attempted to redirect Resident A but was unsuccessful as he continued to try to leave. Ms. Blackman then contacted management and Amber Carmichael and Ms. Carter were able to redirect him from leaving. Resident A never left the building. Resident A wanted to leave because he believed his car was parked outside and he wanted to go somewhere. Ms. Carter stated that whenever Resident A has these types of episodes, they contact his friend who seems to be able to calm him down and get Resident A to cooperate with staff.

I interviewed Amber Carmichael, Assistant Wellness Director, regarding the allegations. Ms. Carmichael also denied Resident A having an altercation with any other resident. She too reported that Resident A attempted to elope from the facility; therefore, his medications were changed to calm him down. He has never reported any hallucinations to her nor has any other staff. On 05/22/2025, during a staff meeting, Ms. Carmichael was contacted by DCS Barbara Blackman advising her that Resident A is trying to elope. The door alarm went off and Ms. Blackman tried to redirect Resident A, but Resident A was still trying to leave. Ms. Carmichael and Ms. Carter both went to assist and were able to redirect Resident A. Resident A believed his car was outside, so he wanted to go somewhere. Ms. Carmichael advised Resident A that they would call his friend Lisa Gerling who would be able to take him where he wanted to go. This calmed him down.

I interviewed DCS 1 regarding the allegations. DCS 1 has been working for this corporation since February 2024. He works first shift from 7AM-3PM. There is only one DCS per shift. He does not know of any altercations between Resident A and another resident. He heard that Resident A tried to elope but that is all he knows. He denied Resident A trying to elope during his shifts. He also denied Resident A hallucinating and reported that his medications were changed but that no concerns were reported.

I interviewed Resident A regarding the allegations in his bedroom. Resident A was lying in bed facing the wall. He was not forthcoming with his responses. I asked him if he was in a fight with anyone and he stated, “hardly.” I asked him if he tried to leave this building he stated, “yes, I don’t like it here.” He was unable to provide any further information.

I interviewed Resident B in their bedroom. Resident B does not know who Resident A is nor have they seen or heard about anyone fighting or trying to leave this building. They reported no concerns.

I interviewed Resident C in their bedroom along with the occupational therapist, Makenzie, with John Paul Home Health Care. Resident B does not know who Resident A is nor has she seen nor heard about any fights between anyone here. She does not know about anyone trying to leave the building. Makenzie is working with Resident B's cognition and visits twice a week.

I interviewed Resident D regarding the allegations in their bedroom. Resident D likes it here and does not know who Resident A is. He reported no concerns.

I attempted to interview Resident E regarding the allegations, but I was unsuccessful. I was unable to understand Resident E as they were mumbling when answering my questions.

I interviewed Resident F regarding the allegations in their bedroom. Resident F has not lived here for long. They have not heard anyone fighting or arguing. They reported no concerns.

I interviewed Resident G regarding the allegations in the common area. Resident G was visiting with family members. Resident G stated everything was "fine," and there had not been anyone fighting or arguing here. Resident G's daughter-in-law knows who Resident A is as they see Resident A in the dining room. No one here has been aggressive, nor have there been any concerns about fighting.

I was unable to interview Resident H who was out of the facility.

I interviewed Resident I regarding the allegations in their bedroom. Resident I reported no one had been fighting or arguing here. Their only concern was that the "food was not appetizing." They were unable to provide any details.

I interviewed Resident J and Resident K regarding the allegations in their bedroom. Both like it here and reported no one fighting or arguing here. Their biggest complaint was the food not having flavor but then stated, "the older we get, the more we lose our taste and smell. Everyone here will have different ideas of what tastes good, so we eat what they give us."

**Note**: I reviewed Resident A's medications and scripts, and Resident A was prescribed with Risperidone, and his Seroquel was increased by Dr. Priti.

I interviewed Jeff Parrish, the chef at Cottage 4, regarding the concerns expressed by several residents regarding the food. It was lunchtime so I observed fresh green beans, rice, and chuck roast stir fry. Everything appeared fresh and nutritional. Mr. Parrish stated that he has received no complaints about the food from any residents. He meets with the residents periodically for feedback and during these meetings, the residents have not reported many issues other than "too much seasoning," so he has been

adding less seasonings to food.  Mr. Parish stated that families have given many compliments about the food and have not reported any complaints to him.

On 06/16/2025, I interviewed Resident A's friend regarding the allegations via telephone. The friend is Resident A's durable power of attorney for finances only. There was an incident between Resident A and Resident I. According to staff (name unknown) Resident A pushed Resident I out of his wheelchair. Resident A was also trying to elope from the facility. Because of these incidents Resident A was then put on medication. The medication was causing Resident A to hallucinate believing his car was in the parking lot, so he was trying to leave. The friend stated that Resident A's agitation occurs more during the evening because he is up all night and sleeps during the day. The friend stated that their issues are with Dr. Priti and because the friend is not the DPOA for medical reasons, Dr. Priti cannot share any information with them.

On 07/16/2025, I interviewed DCS 2 regarding the allegations. DCS 2 wanted to remain anonymous. DCS 2 works second shift from 3PM-11PM. They heard about a fight between Resident A and Resident I from another staff (name unknown) as DCS 2 was not present. Resident A has had behavioral issues and outbursts resulting in hospitalization. While at the hospital, his medication was adjusted, which caused hallucinations. Resident A was talking about cats in his bedroom when there were no cats.  Resident A is given his medication as prescribed. DCS 2 heard that Resident A tried to leave the facility and that this only occurs during the first shift from 7AM-3PM.

On 07/16/2025, I interviewed DCS 3 regarding the allegations via telephone. DCS 3 works second shift from 3PM-11PM. They have not worked at Cottage 4 for long. They do not know anything about an incident between Resident A and Resident I. However, DCS 3 has heard that Resident A tried eloping two-three times. DCS 3 stated that alarms on the doors are the protective measure in place and to administer Resident A's medication when he is agitated. DCS 3 reported that Resident A's medications are given as prescribed.

On 07/16/2025, I interviewed DCS 4 regarding the allegations via telephone. DCS 4 has not worked at Cottage 4 for long. They have not heard anything about an incident between Resident A and Resident I nor have they heard anything about Resident A eloping from Cottage 4. DCS 4 does not administer medications, so they do not know anything about what medications Resident A is taking.

On 07/16/2025, I interviewed DCS 5 regarding the allegations via telephone. DCS 5 works the second shift from 3PM-11PM. Resident A has been in and out of the hospital due to his behaviors. The last time he was in the hospital was June 2025. They have never observed any incidents between Resident A and Resident I. They have not heard anything about Resident A eloping or having any hallucinations. DCS 5 did not have any further information.

On 07/16/2025, I interviewed DCS 6 regarding the allegations via telephone. DCS 6 works second shift 3PM-11PM at Cottage 4. Resident A has not had an altercation with

anyone at Cottage 4. There were some issues with his medication initially when he was hallucinating seeing cats in his bedroom. Resident A then went into the hospital in June 2025, then the medication was adjusted and now he is doing better. DCS 6 passes medications and stated that Resident A is only given medication as prescribed.

On 07/17/2025, I interviewed DCS 7 regarding the allegations via telephone. DCS 7 works the day shift from 7AM-3PM. Resident A and Resident I do not get along. There have been verbal alterations between them but there was no physical altercation between them at Cottage 4. Resident A was reporting seeing cats outside the window while he was in the dining room, but when DCS 7 looked outside, there was no cat. Prior to June 2025, there was an incident during DCS 7 dayshift where Resident A tried to leave this facility. Whenever, Resident A "gets in a mood," and is "in the dining room or TV room," he tries to get out. Resident A tried to open the door, but the alarm sounded alerting DCS 7 who was assisting another resident. DCS 7 tried to redirect Resident A but was unsuccessful, so they contacted management. Amber Carmichael arrived and redirected Resident A back to his bedroom. This was an isolated incident during DCS 7 shift. There was another incident during the second shift when Resident A attempted to elope. DCS 6 was working that shift. Again, the door alarm sounded off and DCS 6 redirected Resident A from the door. Both times, Resident A never left the building. The protective measures in place are the alarms on the doors and Resident A's medications were adjusted, which have made him calmer.

On 07/28/2025, I contacted Resident I's DPOA-I via telephone regarding the allegations. Resident A was residing at Cottage 2 before moving to Cottage 4. Over a year ago, not at Cottage 4, but at Cottage 2 there was a resident that was provoking Resident I and it was observed by staff that Resident I was pulled out of his wheelchair. DPOA-I was contacted regarding that incident and since moving to Cottage 4, there have not been any other issues. Resident I is doing better in Cottage 4 since moving from Cottage 2.

On 08/06/2025, I followed up with Resident A's friend who stated that Resident A was referred to Optimal for psychiatric support and since seeing the nurse he has been taken off the medications that were causing hallucinations and is much calmer and doing better.

| **APPLICABLE RULE** | |
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| **R 400.15312** | **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** |

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| | **Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.** |
| **ANALYSIS:** | Based on my investigation and information gathered, Resident A was prescribed with Seroquel, Risperdal, and Ativan by his PCP Dr. Priti. I verified this by reviewing Resident A's medications. These medications were prescribed due to Resident A's behaviors of him trying to elope this facility more than once as reported by Resident A's friend and staff. Resident A attempted to elope on 05/22/2025 and again after the first incident (date unknown). Both times, he tried to push the door, and the door alarm went off alerting staff to prevent him from leaving Cottage 4. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ALLEGATION:**

**There are ants present in some rooms at the facility.**

**INVESTIGATION:**

On 06/16/2025, I interviewed licensee designee Tonya Carter regarding the allegations. Ms. Carter stated that she has not observed ants in any of the residents' bedrooms due to this facility having a preventative pest control monthly. There have not been any staff or family members reporting seeing ants in this facility.

On 06/16/2025, I interviewed Amber Carmichael regarding the allegations. Ms. Carmichael has not seen ants in residents' bedrooms, nor have they received complaints from residents, staff or family members about seeing ants in this facility. Ms. Carmichael stated that there is a preventative pest control monthly that addresses any insects in this facility.

On 06/16/2025, I interviewed DCS 1 regarding the allegations. DCS 1 has not seen any ants in any of the residents' bedrooms, nor have there been any complaints made by the residents, their families, or other DCS.

On 06/16/2025, I interviewed Resident A regarding the allegations. Resident A stated there are no ants in their bedroom. I did not observe any ants in Resident A's room. The room was clean.

On 06/16/2025, I interviewed Resident B regarding the allegations. Resident B has not seen any ants in their bedroom or anywhere else in this building. I too did not observe any ants in Resident B's bedroom. This bedroom was clean.

On 06/16/2025, I interviewed Resident C in their bedroom regarding the allegation. Resident C has not seen any ants in their bedroom or anywhere else in this building. The OT denied seeing any ants in this bedroom or building. I too did not observe any ants in Resident C's bedroom. The bedroom was clean.

On 06/16/2025, I interviewed Resident D in their bedroom regarding the allegations. Resident D denied any ants in their bedroom or anywhere else in the building. I observed no ants in their bedroom, and it was clean.

On 06/16/2025, I interviewed Resident E in their bedroom regarding the allegations. Resident E has never seen any ants in their bedroom or in this building. I observed no ants in their bedroom, and it was clean.

On 06/16/2025, I interviewed Resident F in their bedroom regarding the allegations. Resident F denied any ants in their bedroom or in this building. I observed the bedroom clean, and no ants were present.

On 06/16/2025, I interviewed Resident G in their bedroom regarding the allegations. Resident G denied having ants in their bedroom and I did not observe any ants in this room. The room was clean.

On 06/16/2025, I interviewed Resident H regarding the allegations in the common area. She denied any ants in her bedroom and denied seeing any ants in this building. While I was in the common area, I did not observe any ants.

On 06/16/2025, I interviewed Resident I in his bedroom regarding the allegations. Resident I has never seen any ants in his bedroom. I observed no ants in his bedroom, and it was clean.

On 06/16/2025, I interviewed Resident J in her bedroom regarding the allegations. Resident J denied seeing any ants in their bedroom. I did not observe any ants in her bedroom, and it was clean.

On 06/16/2025, I interviewed Resident K and Resident L in their bedroom. They both denied seeing any ants in their bedroom. Their bedroom was observed to be clean, and I did not see any ants.

On 06/16/2025, I interviewed Resident A's friend regarding the allegations via telephone. The friend stated they observed ants on the floor last week in Resident A's bedroom. The friend tried calling out to the staff but because they were assisting another resident, the friend decided to mop the floor and get rid of the ants. Since then, they have not seen any more ants.

On 07/16/2025, I interviewed DCS 2 regarding the allegations via telephone. DCS 2 has not seen ants in residents' bedrooms but has seen beetles and moths in the hallway but

have been taken care of by maintenance. Since maintenance has addressed the issue, she has not seen any insects since.

On 07/16/2025, I interviewed DCS 3 regarding the allegations via telephone. DCS 3 has not seen any ants in any of the residents' bedrooms. There have not been any complaints by residents, staff, or families about ants.

On 07/16/2025, I interviewed DCS 4 regarding the allegations via telephone. DCS 4 has not seen any ants in any of the residents' bedrooms. There have not been any complaints by staff, residents, or families about ants.

On 07/16/2025, I interviewed DCS 5 regarding the allegations via telephone. DCS 5 has not seen ants in any of the residents' bedrooms, nor have they received any complaints from anyone about ants.

On 07/16/2025, I interviewed DCS 6 regarding the allegations via telephone. DCS 6 had seen ants in residents' bedrooms in the past, but since the building has been receiving preventative pest control maintenance, there have not been any ants observed in the bedrooms or in the common area.

On 07/17/2025, I interviewed DCS 7 regarding the allegations via telephone. DCS 7 has not seen any ants in any of the residents' bedrooms. There have not been any complaints from staff, residents, or their families regarding ants.

| **APPLICABLE RULE** | |
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| **R 400.15401** | **Environmental health.** |
| | **(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.** |
| **ANALYSIS:** | During the unannounced on-site investigation on 06/16/2025, I did not observe ants in any of the residents' bedrooms nor in the common areas of Cottage 4. All the residents denied having ants in their bedrooms and Tonya Carter stated that the facility is sprayed for ants monthly as a preventative measure. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

During the on-site investigation on 06/16/2025, I observed in Resident A's bedroom a cup full of pills. I asked Resident A if the pills belonged to him and he stated that the staff brought them for him to take but that he refused to take them.

On 06/16/2025, I interviewed DCS 1 regarding the cup of medication sitting in Resident A's bedroom. DCS 1 stated that he went into Resident A's bedroom to pass his medications, but Resident A refused. While he was encouraging Resident A to take the medication, another resident pulled their cord in their bedroom. DCS 1 set the cup down on the table near Resident A's bed and left to assist the other resident. He stated that this was an isolated incident and that he has never left a cup of medications in Resident A's or any other residents' bedroom.

On 06/16/2025, I interviewed Resident B regarding the allegations. Resident B stated that DCS bring her the medication in a cup and watch her take it. She stated that there was never a time when DCS left the cup with the medication in her bedroom. I did not observe any medication in her bedroom.

On 06/16/2025, I interviewed Resident C and the OT with John Paul HHC regarding the allegations. Resident B was unable to provide any details regarding the allegations; however, the OT stated that there has been at least one time she arrived to see Resident B and observed pills in a cup sitting on the table. There was no DCS in the bedroom when she saw the pills on the table. I did not observe any medication in her bedroom.

On 06/16/2025, I interviewed Resident D regarding the allegations. Resident D stated that DCS came into his bedroom with pills in a cup and put the pills in his mouth and watch him take them. He does not recall a time when DCS left pills in a cup in his bedroom. I did not observe any medication in his bedroom.

On 06/16/2025, I attempted to interview Resident E regarding the allegations but due to her speech, I was unable to understand her. I did not observe any medication in her bedroom.

On 06/16/2025, I interviewed Resident F regarding the allegations. Resident F stated that DCS always watch him when he takes his medications. There has never been a time when DCS left medications in his bedroom. I did not observe any medication in his bedroom.

On 06/16/2025, I interviewed Resident G regarding the allegations. Resident G stated that DCS always watch her take her medication and have never left the medication in her bedroom. I did not observe any medication in her bedroom.

On 06/16/2025, I interviewed Resident H regarding the allegations. Resident H stated that DCS always watches her when she takes her medication. They have never left medication in her bedroom.

On 06/16/2025, I interviewed Resident I regarding the allegations. Resident I stated that DCS always watches him take his medications and that they have never left medication in his bedroom. I did not observe any medication in his bedroom.

On 06/16/2025, I interviewed Resident J regarding the allegations. Resident J stated sometimes DCS watch her take her medications but other times they do not watch her. The staff (name unknown) hands her the cup and leaves her bedroom.

On 06/16/2025, I interviewed Residents K and L who stated that staff always watch them both when they take their medications and then leave. They reported that staff have never left a cup full of their pills in the bedroom and left.

On 07/16/2025, I interviewed DCS 2, DCS 3, DCS 4, DCS 5, and DCS 6 who all reported that they have never left a cup of pills in any of the residents' bedrooms. All the staff stated that they supervise the residents take their medications and then initial on their medication logs that the medication was taken. They have never observed in any residents' bedrooms a cup of pills left by another staff member.

On 07/16/2025, I interviewed DCS 7 regarding the allegations. DCS 7 has never left a cup of pills in a residents' bedroom and stated that they always supervise the residents taking their medications. DCS 7 has never been in a residents' bedroom and found a cup of medications sitting in there.

On 08/13/2025, I left a detailed voice mail message for licensee designee Tonya Carter conducting the exit conference with my findings.

| **APPLICABLE RULE** | |
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| **R 400.15312** | **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:**<br>**(a) Be trained in the proper handling and administration of medication.** |
| **ANALYSIS:** | Based on my investigation, DCS 1 did not properly handle and administer Resident A's medication properly as DCS 1 left Resident A's medications in a cup next to Resident A's bed. DCS 1 did not supervise Resident A taking his medications. According to DCS 1, he was in the process of administering Resident A's medications when another resident pulled their cord, so DCS 1 left the cup with the pills on the table to go and assist another resident leaving the mediation unattended. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| APPLICABLE RULE | |
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| **R 400.15312** | **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:**<br>**(c) Record the reason for each administration of medication that is prescribed on an as needed basis.** |
| **ANALYSIS:** | On 06/16/2025, I reviewed Resident A's medication logs and found the following errors:<br>• Lorazepam Tab 1MG: take one tablet by mouth every six hours as needed was administered on 06/02/2025, 06/05/2025-06/07/2025, 06/09/2025 and 06/10/2025, but the reason for this as needed medication was not recorded.<br>• Haloperidol Tab 5MG: take one tablet by mouth three times daily as needed was given on 06/09/2025, but the reason for this as needed medication was not recorded. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

Frodet Dawisha 08/13/2025

Frodet Dawisha Date
Licensing Consultant

Approved By:

Denise Y. Nunn 08/13/2025

Denise Y. Nunn Date
Area Manager