RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

November 27, 2018

Mary Black
Scotland Manor Enterprises, LLC
1357 N. River Road
St. Clair, MI 48079

RE: License #: AS740282833
Investigation #: 2018A0604009
River's Edge Assisted Living

Dear Mrs. Black:

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) 975-5053.

Sincerely,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 285-1703

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS740282833
Investigation #:	2018A0604009
Complaint Receipt Date:	04/25/2018
Investigation Initiation Date:	04/26/2018
Report Due Date:	06/24/2018
Licensee Name:	Scotland Manor Enterprises, LLC
Licensee Address:	1357 N. River Road St. Clair, MI 48079
Licensee Telephone #:	(810) 650-5902
Administrator:	Mary Black
Licensee Designee:	Mary Black
Name of Facility:	River's Edge Assisted Living
Facility Address:	1427 Oakland St. Clair, MI 48079
Facility Telephone #:	(810) 329-1112
Original Issuance Date:	10/26/2006
License Status:	REGULAR
Effective Date:	11/04/2016
Expiration Date:	11/03/2018
Capacity:	6
Program Type:	MENTALLY ILL AGED

ALLEGATION(S)

	Violation Established?
Facility was over capacity with over six residents in care.	No
Staff, Erika Ramsey, was found to have a felony and a past substance abuse problem.	No
Staff were asking for refills of Resident A's Xanax too soon and there was a discrepancy with pill count.	No
Additional Findings	Yes

II. METHODOLOGY

04/25/2018	Special Investigation Intake 2018A0604009
04/26/2018	Special Investigation Initiated - Telephone TC to Complainant
04/26/2018	Contact - Document Received Received email with text messages from Complainant.
04/30/2018	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Staff, Sherry Smith and Alexis Alexander. Observed six residents and completed walk through of home.
04/30/2018	Contact - Telephone call made TC to and from Mary Black
05/01/2018	Contact - Document Received Email from Mary Black
05/01/2018	Contact - Document Sent Email to Mary Black
05/17/2018	Contact - Document Sent Email to Mary Black
05/20/2018	Contact - Document Received Received Resident A's medication log by email from Mary Black
05/20/2018	Contact - Document Received Received copy of resident register by email from Mary Black

05/21/2018	Contact - Document Sent Email to Mary Black
05/22/2018	Contact - Document Received Received email with staff phone numbers from Mary Black
05/25/2018	Contact - Document Received Received email from Mary Black
05/29/2018	Contact - Document Received Received copies of Resident A's medication logs by email from Mary Black
05/29/2018	Contact - Document Sent Email to Mary Black
05/30/2018	Contact- Telephone call Received Received text message from Mary Black
05/31/2018	Contact - Document Received Received email from Complainant with Facebook Messenger conversation.
07/09/2018	Contact- Document Received Email from Complainant
07/10/2018	Contact- Document Sent Email to Complainant
08/16/2018	Contact - Telephone call made TC to Staff, Erika Ramsey. Told I have wrong phone number.
08/16/2018	Contact- Telephone call made Left message for Staff, Sarah Harshman
08/16/2018	Contact- Telephone call made Left message for Staff, Val Harris
08/16/2018	Contact- Telephone call made Left message for Staff, Ashley Dean
08/16/2018	Contact- Telephone call made Left message for Staff, Sherry Smith. Received return call.
08/20/2018	Contact- Face to Face Face to Face meeting with Mary Black at Scotland Manor

09/07/2018	Contact- Face to Face Face to Face Meeting with Mary Black and Attorney Greg Bator at Pontiac Office.
09/17/2018	Contact- Document Received Email from Complainant
09/17/2018	Contact- Telephone call received Received message from Staff, Sarah Harshman and returned call
09/18/2018	Contact- Document Sent Email to Complainant
09/18/2018	Contact- Telephone call received Received message from Staff, Ashley Dean and returned call
09/24/2018	Exit conference Completed exit conference by phone and email with Mary Black

ALLEGATION:

Facility was over capacity with over six residents in care.

INVESTIGATION:

I received a complaint regarding River's Edge Assisted Living on 04/25/2018. It was alleged that in January 2018 there was a discrepancy regarding Resident F's Xanax medication. Staff were asking for the medication refills too soon. The owner, Mary Black, did confirm there had been a problem and had confirmed that the staff person was no longer there. On 01/12/2018 Ms. Black left for a cruise. During the time she was gone the Complainant and her sister went to the facility to visit their mother (Resident F) and witnessed a new staff person, Erica Dare Ramsey there alone with the residents. Complainant was not informed of any new staff so they went onto Ms. Ramsey's Facebook page and found she was celebrating a year sobriety and also found that she was a felon. The Complainant and her sister removed Resident F from the home on 01/18/2018 because they were concerned for her safety. Staff notified Ms. Black while she was on her cruise and Ms. Black began sending text messages to Complainant's sister questioning why they were removing their mother. They have record of all the text messages with Ms. Black regarding the issue. It was also witnessed that Ms. Black had over six residents in the home at one time.

I received a complaint regarding River's Edge Assisted Living on 02/01/2018 alleging that there was a felon working in the home and that medication was missing from the home, however, the resident and staff member were not listed on complaint. I

completed Special Investigation #2018A0604005 dated 03/27/2018. No violations were found regarding these allegations.

I interviewed the Complainant by phone on 04/26/2018. She stated that in December 2017 she saw seven residents living in the home.

I completed an unannounced onsite investigation on 04/30/2018. During the onsite investigation I completed a walk through and observed six residents in the home. I only observed six beds in the home.

I interviewed Staff, Sherry Smith during the onsite investigation and by phone. Ms. Smith stated that she has worked at the home for approximately three years. She stated that there have never been more than six residents residing in the home.

I interviewed license designee, Mary Black, by phone. She stated that she does not recall more than six residents ever residing in the home.

I interviewed Staff, Sarah Harshman by phone. Ms. Harshman stated that she has worked for Ms. Black for seven and a half to eight years. Ms. Harshman stated that there have never been more than six residents residing at the home. There are currently six residents living in the home.

I interviewed Staff, Ashley Dean. She stated that she has worked at River's Edge since January 2018, however, worked on and off for Ms. Black doing odds and ends before. Ms. Dean stated that there have never been more than six residents residing in the home. There are currently six residents living in the home.

I reviewed the resident register for the home. The resister register does not indicate that there were ever seven residents residing at River's Edge Assisted Living at one time.

APPLICABLE RULE	
R 400.14105	**Licensed capacity.**
	(1) The number of residents cared for in a home and the number of resident beds shall not be more than the capacity that is authorized by the license.
ANALYSIS:	There is not enough information at this time to determine that more than six residents have lived in the home. According to Ms. Black and staff interviewed, there have not been more than six residents residing in the home. I completed an unannounced onsite investigation on 04/30/2018 and observed six beds and six residents at River's Edge Assisted Living.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff, Erika Ramsey, was found to have a felony and a past substance abuse problem.

INVESTIGATION:

I received a complaint regarding River's Edge Assisted Living on 02/01/2018 alleging that there was a felon working in the home. I completed Special Investigation #2018A0604005 dated 03/27/2018. There was not enough information to determine that Mary Black had a felon working in the home. The Complainant did not provide the name of employee alleged to have a felony. Ms. Black provided Michigan Workforce Background Check letters to verify that her current staff have been fingerprinted and were eligible for employment. Ms. Blacked stated that Erika Ramsey had shadowed at River's Edge but was never left alone or hired. Ms. Black provided a copy of Registry Exclusion Results for Erika Ramsey dated 01/19/2018 which confirmed that a clearance was completed for Ms. Ramsey.

I reviewed conversation from Facebook Messenger between Complainant and Ms. Black regarding Resident F being moved from the home. On 01/18/2018 the Complainant wrote, "I found out that you hired an employee that was celebrating one-year sobriety. So we did some research and found out that after speaking to you about the pills being missing, you hired a felon. So obviously you neglected to do a background check. She has been incarcerated and in drug abuse counseling". Ms. Black questions Complainant as to who she is referring too. Ms. Black then stated that staff were too train her to see if she was a good fit and states she was not to be on the schedule alone. Ms. Black stated that she runs background checks and that would be done when she returned home if she was a good fit. The Complainant requests to pick up television and complete refund of unused rent. On 02/05/2018 the Complainant sent Ms. Black a message stating that she has not received refund check. On 02/06/2018 Ms. Black responds and states that she is sending through her personal accountant. She requests Complainants address and indicates that check will come from Chase bank.

I interviewed Ms. Black. She stated that River's Edge was short of help and she asked staff if anyone knew someone to work at home. She stated that all her staff know rules regarding requirements to work at home. Ms. Black believed that staff, Val Harris found Erika Ramsey. Ms. Black stated that Ms. Ramsey never worked alone and only shadowed staff to see if job was a fit. She believes Ms. Ramsey shadowed over a period of two days, two to three hours per shift. Ms. Black stated that she believes residents family found Ms. Ramsey though Val's Facebook. Ms. Black stated that she initially agreed to give family refund because she was on a cruise and did not have the facts about what was going on. Once she returned from cruise she determined that they did nothing wrong and decided that a refund was not required.

I interviewed Staff, Valerie Harris during the onsite investigation on 02/06/2018. She stated that the only other staff that work at the home are Sarah, Sherry and Ashley. Ms. Harris was not aware of any other individuals who have recently worked at the home. She stated that she did just come back from a recent vacation. Ms. Harris did not return phone call for additional information. Ms. Black stated that Ms. Harris is no longer working at home.

I interviewed Staff, Sherry Smith during the onsite investigation. She stated that there was an Erika that worked at the home for about one month. Ms. Smith stated that Ms. Ramsey never worked by herself. Ms. Smith stated that she helped train Ms. Ramsey and she worked three to four times with her. I interviewed Ms. Smith a second time by phone on 08/16/2018. Ms. Smith stated that Ms. Ramsey only worked at the home for a few hours. She stated that Ms. Ramsey came in one day for training and never came back. Ms. Smith stated that she did not train Ms. Ramsey and she was not sure who did. Ms. Smith denied that anyone asked her to change her previous statement and indicated that she provided incorrect information in initial interview because she was working a lot of hours.

I interviewed Staff, Sarah Harshman by phone. She stated that Erika Ramsey was trained on each shift for a couple hours each shift. Ms. Harshman stated that Ms. Ramsey never worked by herself. Ms. Harshman stated that she trained Ms. Ramsey one to two times and they “showed her the ropes” for about one week. Ms. Ramsey was never hired. Ms. Harshman stated that Ms. Black will at times ask if they know anyone who would like to work at the home if they are looking to hire an employee.

I interviewed Staff, Ashley Dean by phone. Ms. Dean stated that Erika Ramsey never worked at the home and was only shadowing. Ms. Dean stated that she was leaving her afternoon shift and Ms. Ramsey arrived at the home to shadow Sherry Smith on the midnight shift. Ms. Dean stated that she knows Ms. Dean was shadowing on shifts for about two hours, however, she never trained Ms. Ramsey.

I attempted to contact Erika Ramsey by phone on 08/16/2018, however, was told I had the wrong number.

I reviewed Resident F’s medication logs from May 2017- January 2018. It does not appear that Erika Ramsey passed medications while at the home. Staff, Erika Ramsey’s name or initials were not found on medication logs.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: (a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.

ANALYSIS:	There is not enough information to determine that Erika Ramsey worked at the home alone despite having a felony and past substance abuse problem. Ms. Black and staff stated that Erika Ramsey shadowed at River's Edge Assisted Living but was never left alone or hired. Ms. Black provided a copy of Registry Exclusion Results for Ericka Ramsey dated 01/19/2018 which confirmed that a clearance was completed. I attempted to contact Ms. Ramsey by phone, however, was told I had wrong number.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff were asking for refills of Resident A's Xanax too soon and there was a discrepancy with pill count.

INVESTIGATION:

I received a complaint regarding River's Edge Assisted Living on 02/01/2018 alleging that resident medications are missing. I completed Special Investigation #2018A0604005 dated 03/27/2018. There was not enough information to determine that resident medications were missing at River's Edge. The Complainant did not report which resident had missing medications. Ms. Black stated that Resident F's family believed that Xanax was missing, however, later found the medication they thought they brought to the home. This was confirmed in a text message Ms. Black provided. During the onsite investigation on 02/06/2018, I reviewed resident medications and medication logs and did not identify any missing medications.

I interviewed Staff, Valerie Harris, during the investigation on 02/06/2018. Ms. Harris stated that she was not aware of any missing resident medications. She stated that they did call pharmacy to get Resident F's Xanax refilled and were told she was not due for a refill. Ms. Harris stated that Resident F's family later found bottle of Xanax they though they brought.

I interviewed Staff, Sherry Smith by phone. Ms. Smith was not aware of medications ever missing in the home.

I interviewed Staff, Sarah Harshman by phone. She stated that she is not aware of any residents missing medications in the home. She stated that one family believed that resident was missing medications, however, later family realized that the error was on their part. She stated that the family would hold onto resident's pills until they were completely out. Ms. Harshman stated that family realized that they had bottle of bills they thought they were missing.

I interviewed Staff, Ashley Dean, by phone. Ms. Dean stated that she was not aware of any residents missing Xanax or any other medication in the home.

I reviewed Resident F's medication logs from May 2017- January 2018. Resident A was prescribed PRN Xanax (Alprazolam) up to three times per day while at the home. Medication logs were initialed by staff when medication was distributed.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	There is not enough information to determine that Resident F had Xanax pills that went missing in the home. Ms. Black stated that Resident F's family believed that Xanax was missing, however, later found the medication they thought they brought to the home. Both the Complainant and Ms. Black provided text messages that indicated there was confusion regarding the number of Xanax pills Resident F should have remaining. Resident F is no longer placed in the home in order for current medications and medication logs to be reviewed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the investigation of Ms. Black's two homes River's Edge and Scotland Manor, I was provided with information that I determined to be inaccurate and/or untruthful. A meeting was held with Mary Black and Attorney Greg Bator on 09/07/2018 to address these concerns. Specially in regard to River's Edge, Staff Sherry Smith initially reported on 04/30/2018 that she helped train Ms. Ramsey and she worked three to four times with her. I interviewed Ms. Smith a second time by phone on 08/16/2018. Ms. Smith stated that Ms. Ramsey only worked at the home for a few hours. She stated that Ms. Ramsey came in one day for training and never came back. Ms. Smith stated that she did not train Ms. Ramsey and she was not sure who did. Ms. Smith denied that anyone asked her to change her previous statement and indicated that she provided incorrect information in initial interview because she was working a lot of hours. Ms. Black reported during an interview on 08/20/2018 that Ms. Smith did in fact train Ms. Ramsey. She stated that Ms. Smith was worried she was going to get fired.

I completed an exit conference with Mary Black by phone and email on 09/24/2018. I informed her of the violation found and that a copy of the special investigation report

would be mailed once approved. I also informed her that a corrective action plan would be requested.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	During the investigation, Staff Sherry Smith initially stated that she trained Erika Ramsey three to four times. She later stated that she never trained Ms. Ramsey and was not sure who did. Ms. Smith indicated that she provided incorrect information because she was working a lot of hours. There is concern that staff is either being untruthful or is unable to recall important information. A meeting was held with Ms. Black and Attorney Greg Bator to address concerns regarding untruthful information being provided to licensing.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change in the license status is recommended.

Kristine Cilluffo 09/24/2018

Kristine Cilluffo Date
Licensing Consultant

Approved By:

Denise Y. Nunn 11/27/2018

Denise Y. Nunn Date
Area Manager