GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 14, 2019

Kingsley Matthew
Preferred Optimal Care
Po Box 947
Garden City, MI 48136

RE: License #: AS820388043
Investigation #: 2019A0116020
Colbert House

Dear Mr. Matthew:

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.

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820388043
Investigation #:	2019A0116020
Complaint Receipt Date:	04/08/2019
Investigation Initiation Date:	04/11/2019
Report Due Date:	06/07/2019
Licensee Name:	Preferred Optimal Care
Licensee Address:	1011 Mitchell Drive Westland, MI 48185
Licensee Telephone #:	(347) 599-3801
Administrator:	Kingsley Matthew
Licensee Designee:	Kingsley Matthew
Name of Facility:	Colbert House
Facility Address:	15515 Colbert St. Romulus, MI 48174
Facility Telephone #:	(734) 629-3652
Original Issuance Date:	02/12/2019
License **Status:**	TEMPORARY
Effective Date:	02/12/2019
Expiration Date:	08/11/2019
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Complainant alleged that Resident A is not being fed properly on a regular basis.	Yes
Resident A reported there are medication errors.	No
Additional Findings	Yes

III. METHODOLOGY

04/08/2019	Special Investigation Intake 2019A0116020
04/08/2019	APS Referral Referral made by Office of Recipient Rights
04/11/2019	Special Investigation Initiated - On Site Interviewed staff Chiome Okafur and Residents B-D.
04/11/2019	Contact-Telephone call made Spoke to Mr. King.
04/17/2019	Inspection Completed On-site Interviewed Resident's A, E and F staff Jacqueline Green, observed food supply, and medication.
04/17/2019	Contact - Telephone call made Interviewed licensee designee Kingsley Matthew
04/17/2019	Inspection Completed-BCAL Sub. Compliance
04/24/2019	Contact - Telephone call made Spoke with Mr. Matthew.

05/02/2019	Contact - Telephone call made Left a message for assigned APS worker, Jawana Kelly.
05/02/2019	Contact - Telephone call made Left a message for Mr. Matthew requesting a return call.
05/02/2019	Contact - Telephone call received Interviewed Ms. Kelly.
05/13/2019	Contact - Telephone call made Spoke with Mr. King regarding status of investigation.
05/20/2019	Exit Conference With licensee designee Kingsley Matthew

ALLEGATION:

Complainant alleged that Resident A is not being fed properly on a regular basis.

INVESTIGATION:

On 04/11/19, I conducted an unscheduled onsite inspection and interviewed Residents B-D and staff Ms. Okafur. Residents B-D all reported that the food in the home is scarce and that they do not get enough to eat. They reported that they eat a lot of frozen meals and that there is not enough prepared for a second serving. Resident B reported that if they had more nutritious choices and larger servings they would not be as hungry between meals. Resident C reported most days after they finish one meal they are already waiting on the next because they are still hungry. Resident D reported that the meals aren't "complete" and do not include foods from all of the food groups. Resident D reported a typical breakfast maybe 2 sausage links and 2 slices of bread. He reported that lunch is a ham or turkey sandwich and chips, dinner is chicken and a canned vegetable. Resident D reported that he is a grown man and that lack of adequate food has been an ongoing issue.

I interviewed Ms. Okafur and she reported that she is not staff and is at the home helping her cousin, Mr. Matthew. She reported that she has been cooking foods that are available in the home and that is all she can do. Ms. Okafur reported that I needed to speak to Mr. Matthew for additional information. I looked in the home's refrigerator, freezer and cabinets and observed that the food supply was inadequate

for 6 adults. I also observed that there were no fresh fruits or vegetables available for the residents.

Ms. Okafur contacted Mr. King while I was at the home and I spoke with him briefly. I informed him of my observations and informed him that he needed to purchase additional food for the home as the food supply was inadequate. Mr. King reported that he would do so. I informed him that I would contact him later to address the other concerns.

On 04/17/19, I completed an unscheduled onsite inspection and interviewed Resident A, E, F and staff Jacqueline Green.

Resident A reported that he and his roommates are not being fed properly. He reported that there is never enough food in the home and that they are always hungry. Resident A reported that the meals are not nutritious and that he can not remember a time where there was fresh fruit in the home. Resident A reported that most meals are “quick fixes,” such as ramen noodles, frozen dinners, canned vegetables and that nothing is fresh or requires time and effort to prepare. Resident E and F reported that the food is always scarce and that they rarely get full after meals. Resident F reported he eats good at his workshop program and that helps him.

I interviewed Ms. Green and she reported that she just started working in the home on 04/16/19. Ms. Green reported that she can not speak to what has occurred in the past. Ms. Green reported that there is enough food in the home for a couple days and reports that Mr. Matthew will be bringing more. I observed the food supply and there was enough food in the home to prepare meals for at least 3 days.

I interviewed and conducted the exit conference with Mr. Matthew regarding the food supply and lack of nutritious food on 04/17/19. Mr. Matthew reported that he believes that there is and has been an adequate food supply in the home and that the food is nutritious. I informed him that based on my observations at the onsite inspection on 04/17/19, and interviews with the residents, nutritious meals are not being provided and the residents are not getting enough to eat. I informed Mr. King that I would send him the “Basic Nutrition Facts” publication cited in administrative rule 400.14313(2) so that he could see what a nutritious meal consists of. Mr. Matthew reported that he would purchase additional more nutritious food and take it to the home.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	Resident A reported that he was not being fed properly and that the meals are not nutritious. Based on the information obtained during the course of the investigation, which included interviews of Residents A-F and personal observation, I am able to corroborate the allegations. Residents A-F all reported that the food supply is scarce, they are not full after meals and that they are not provided three nutritional meals per day as required by the rules. I also observed the food supply and found it to be inadequate for 6 adult males.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A reported there are medication errors.

INVESTIGATION:

On 04/11/19, I conducted an unscheduled onsite inspection and interviewed Residents B-D and Ms. Okafur. Residents B-D reported being unaware of any medication errors. They reported that their medication is given to them by Mr. Matthew or the staff on shift. Ms. Okafur reported that she is unaware of any medication errors and reported that she has administered the resident's medication as instructed by Mr. Matthew.

On 04/17/19, I conducted an unscheduled onsite and interviewed Residents A, E and F. Resident A reported that on one occasion he was given the wrong medication and on another occasion one of his medications were not administered. Resident A could not provide any additional details relating to dates, times, or the specific medications. Residents E and F reported to their knowledge they are administered all of their prescribed medications and reported no concerns. I requested to review medication logs to match with the medication labels and was informed by Ms. Okafur that she was not aware of any medication logs being in the home.

On 04/17/19, I interviewed Mr. Matthew and he denied any knowledge of any medication errors. Mr. Matthew reported that all Residents are given their medications according to the label instructions.

On 05/02/19, I interviewed APS investigator Ms. Kelly and she reported that her investigation is still active. Ms. Kelly reported that she attempted to see if there were discrepancies with the medications, however, reported that the home didn't have any

medication logs for her to review to be able to determine if any medications were missed or not administered as required.

On 05/20/19, I conducted the exit conference with Mr. Matthew. I informed him that there was insufficient evidence to corroborate the allegations and that the violation would not be established. Mr. Matthew agreed with the finding.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A reported that there were medication errors, however, was unable to provide specific dates, times, or medications that he believed he was given in error or not given as required. Residents B-F all reported that to their knowledge they are given their medications as prescribed and stated no concerns. Based on insufficient evidence to substantiate the allegations this violation is not established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 04/11/19 and 04/17/19, I conducted an unscheduled onsite inspection and interviewed Ms. Okafur and Ms. Green respectively. Ms. Okafur reported that she was not staff and was helping her cousin, Mr. King, until he was able to hire staff. Ms. Okafur reported that she had not signed any consent and disclosures relating to a criminal history/background check and is unaware if Mr. Matthew requested one. Ms. Okafur also reported that she had not submitted a set of fingerprints and therefore, was not aware if she was cleared or eligible to work in a licensed adult foster care home.

I interviewed Ms. Green on 04/17/19 and she also reported that she had not completed or signed a consent and disclosure form prior to working in the home and is unaware if Mr. Matthew had completed a background check on her. Ms. Green reported that she had not submitted her fingerprints and reported that Mr. Matthew may not have gotten around to speaking with her regarding this requirement. Ms.

Green reported her belief that she had been fingerprinted in the past for another corporation, however, was unable to provide any verification of that.

I interviewed Mr. Matthew on 04/17/19 and he reported that he is still working on completing the employee files. Mr. Matthew reported that neither Ms. Okafur or Ms. Green had completed the required consent and disclosure forms, had not completed the fingerprinting process, and therefore he had not received any documentation attesting to their suitability to work in the home. I informed Mr. Matthew that completion of the form was required prior to sending the employees to be fingerprinted and reminded him that I had provided all of this information to him during the enrollment process and had emailed him a copy of the consent and disclosure form.

I conducted the exit conference with Mr. Matthew on 05/20/19 and informed him that the violations are established as he is not in compliance with the background check requirements. Mr. Matthew reported that he was unaware of the background check requirements and reported that he would contact Lansing to see if they could provide him log in information to access the system. I informed Mr. Matthew that the information is emailed and mailed to the licensee designee shortly after issuance of the license.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(3) An individual who applies for employment either as an employee or as an independent contractor with an adult foster care facility or staffing agency and who has not been the subject of a criminal history check conducted in compliance with this section shall give written consent at the time of application for the department of state police to conduct a criminal history check under this section, along with identification acceptable to the department of state police. If the individual has been the subject of a criminal history check conducted in compliance with this section, the individual shall give written consent at the time of application for the adult foster care facility or staffing agency to obtain the criminal history record information as prescribed in subsection (4) or (5) from the relevant licensing or regulatory department and for the department of state police to conduct a criminal history check under

	this section if the requirements of subsection (11) are not met and a request to the federal bureau of investigation to make a determination of the existence of any national criminal history pertaining to the individual is necessary, along with identification acceptable to the department of state police. Upon receipt of the written consent to obtain the criminal history record information and identification required under this subsection, the adult foster care facility or staffing agency that has made a good faith offer of employment or an independent contract to the individual shall request the criminal history record information from the relevant licensing or regulatory department and shall make a request regarding that individual to the relevant licensing or regulatory department to conduct a check of all relevant registries in the manner required in subsection (4). If the requirements of subsection (11) are not met and a request to the federal bureau of investigation to make a subsequent determination of the existence of any national criminal history pertaining to the individual is necessary, the adult foster care facility or staffing agency shall proceed in the manner required in subsection (5). A staffing agency that employs an individual who regularly has direct access to or provides direct services to residents under an independent contract with an adult foster care facility shall submit information regarding the criminal history check conducted by the staffing agency to the adult foster care facility that has made a good faith offer of independent contract to that applicant.
ANALYSIS:	Mr. Matthew has employed Ms. Okafur and Ms. Green and failed to ensure that they have provided written consent at the time of application to conduct a criminal history check as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(4) Upon receipt of the written consent to conduct a criminal history check and identification required under subsection (3), the adult foster care facility or staffing agency that has made a good faith offer of employment or independent contract to the individual shall make a request to the department of state police to conduct a criminal history check on the individual and input the individual's fingerprints into the automated fingerprint identification system database, and shall make a request to the relevant licensing or regulatory department to perform a check of all relevant registries established according to federal and state law and regulations for any substantiated findings of abuse, neglect, or misappropriation of property. The request shall be made in a manner prescribed by the department of state police and the relevant licensing or regulatory department or agency. The adult foster care facility or staffing agency shall make the written consent and identification available to the department of state police and the relevant licensing or regulatory department or agency. If the department of state police or the federal bureau of investigation charges a fee for conducting the criminal history check, the charge shall be paid by or reimbursed by the department. The adult foster care facility or staffing agency shall not seek reimbursement for a charge imposed by the department of state police or the federal bureau of investigation from the individual who is the subject of the criminal history check. The department of state police shall conduct a criminal history check on the individual named in the request. The department of state police shall provide the department with a written report of the criminal history check conducted under this subsection. The report shall contain any criminal history record information on the individual maintained by the department of state police.

ANALYSIS:	Mr. Matthew employed Ms. Okafur and Ms. Green and failed to ensure that they submitted their fingerprints for the purpose of completion of the criminal history/background check as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(5) Upon receipt of the written consent to conduct a criminal history check and identification required under subsection (3), if the individual has applied for employment either as an employee or as an independent contractor with an adult foster care facility or staffing agency, the adult foster care facility or staffing agency that has made a good faith offer of employment or independent contract shall comply with subsection (4) and shall make a request to the department of state police to forward the individual's fingerprints to the federal bureau of investigation. The department of state police shall request the federal bureau of investigation to make a determination of the existence of any national criminal history pertaining to the individual. An individual described in this subsection shall provide the department of state police with a set of fingerprints. The department of state police shall complete the criminal history check under subsection (4) and, except as otherwise provided in this subsection, provide the results of its determination under subsection (4) and the results of the federal bureau of investigation determination to the department within 30 days after the request is made. If the requesting adult foster care facility or staffing agency is not a state department or agency and if criminal history record information is disclosed on the written report of the criminal history check or the federal bureau of investigation determination that resulted in a conviction, the department shall notify the adult foster care facility or staffing agency

	and the individual in writing of the type of crime disclosed on the written report of the criminal history check or the federal bureau of investigation determination without disclosing the details of the crime. The notification shall inform the adult foster care facility or staffing agency and the applicant regarding the appeal process in section 34c and shall include a statement that the individual has a right to appeal the information relied upon by the adult foster care facility or staffing agency in making its decision regarding his or her employment eligibility based on the criminal history check. Any charges imposed by the department of state police or the federal bureau of investigation for conducting a criminal history check or making a determination under this subsection shall be paid in the manner required under subsection (4).
ANALYSIS:	Mr. Matthew employed Ms. Okafur and Ms. Green and failed to comply with the criminal history/background check requirements and allowed them direct access to the residents without knowing if they were suitable. Proper notification could not be provided to Mr. Matthew because he failed to require submission of Ms. Okafur and Ms. Green's fingerprints.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I conducted unscheduled onsite inspections on 04/11/19 and 04/17/19 and requested to review employee records. On both occasions I was informed that there were no records.

On 04/17/19, I interviewed Mr. Matthew and he admitted that he was still working on the employee records and stated that they were not complete. I provided Mr. Matthew the specific rule pertaining to employee records and recommended he review the rule to ensure that the records contained all of the required documents.

On 05/20/19, I conducted the exit conference with Mr. Matthew and informed him that the violation is established due to the fact that there were no employee records onsite at neither of my onsite inspections, coupled with his own admission that he had not completed them.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(a) Name, address, telephone number, and social security number.** **(b) The professional or vocational license, certification, or registration number, if applicable.** **(c)A copy of the employee's driver license if a direct care staff member or employee provides transportation to residents.** **(d) Verification of the age requirement.** **(e) Verification of experience, education, and training.** **(f) Verification of reference checks.** **(g) Beginning and ending dates of employment.** **(h) Medical information, as required.** **(i) Required verification of the receipt of personnel policies and job descriptions.**
ANALYSIS:	Mr. Matthew has failed to complete and maintain a record for each employee that contains all of the information required above. On 04/11/19 and 04/17/19 employee records were not onsite or readily available for department review. Mr. Matthew admitted that he is still working on completing employee records.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I conducted unscheduled onsite inspections on 04/11/19 and 04/1/719 and observed resident medications pre-organized and in weekly pill containers. Ms. Okafur and Ms. Green reported that Mr. Matthew has all the resident's medication set up for the week and reported that they administer it according to the day on the pill container.

I interviewed Mr. Matthew on 04/17/19 and he admitted that he is aware that it is wrong to pre-organize medication and store it in weekly pill containers. Mr. Matthew reported that he is working with a pharmacy to switch from medication bottles to bubble packs. I informed Mr. Matthew that regardless of bottle or bubble packs the

rule is clear that all medications are to be stored in the pharmacy supplied container until administration.

On 05/20/19, I conducted the exit conference with Mr. Matthew and informed him of the findings of the investigation. Mr. Matthew reported an understanding of the violation and reported he is working to correct it.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	I completed onsite inspections on 04/11/19 and 04/17/19 and observed prescription medications pre-organized and stored in weekly pill containers. Both Ms. Okafur and Ms. Green reported that Mr. Matthew prepares the medication and they administer it to the residents. Mr. Matthew admitted to pre-organizing the medication and reported being aware that this is wrong. Mr. Matthew reported working to rectify this deficiency.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I conducted unscheduled onsite inspections on 04/11/19 and 04/17/19 and observed that individual medication logs were not completed as required. I interviewed Ms. Okafur and she reported that she was not aware of any medication logs being used in the home and reported that she administers the pre-organized medication that Mr. Matthew prepares.

Ms. Green reported that she administered medications on 04/16/19 and 04/17/19 and did not review or initial a medication log for the residents. Ms. Green reported the medication was prepared by Mr. Matthew and she gave it to each resident based

on his instruction. Ms. Green reported being aware of what a medication log is, however, denies that there are any in the home.

I interviewed Mr. Matthew on 04/17/19 and he admitted being aware that staff were not reviewing or signing medication logs. Mr. Matthew reported that he is working on completing medication logs for each of the residents.

I conducted the exit conference on 05/20/19 and informed Mr. Matthew of the findings of the investigation. Mr. Matthew reported an understanding of the rule violation.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Mr. Matthew failed to complete or ensure that staff complete individual medication logs that contain all of the above required information. Ms. Okafur, Ms. Green and Mr. Matthew all reported that medication logs are not being used in the home. Mr. Matthew reported he is working on completing the medication logs for each resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I conducted unscheduled onsite inspections on 04/11/19 and 04/17/19 and did not observe written and posted menus. I interviewed Ms. Okafur and Ms. Green and

they both reported being unaware if there were any menus completed or in the home. They both reported that they prepare food that is available in the home and were never instructed to follow a menu.

I interviewed Residents B-D on 04/11/19 and they reported that the home has never had menus and they never know what they are going to eat until they are at the table.

I interviewed Mr. Matthew on 04/17/19 and he reported that he was unaware of the menu requirement. I informed Mr. Matthew that all of this information is contained in the rule book and reminded him that I has also shared this information with him during the enrollment process.

I conducted the exit conference with Mr. Matthew on 05/20/19 and informed him of the findings of the investigation. Mr. Matthew reported an understanding of the violation.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.

ANALYSIS:	Mr. Matthew failed to complete written menus at least 1 week in advance and post as required. Ms. Okafur, Ms. Green and Residents B-D all reported that menus are not being used in the home. Mr. Matthew reported that he was unaware that menus are required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I completed unscheduled onsite inspections on 04/11/19 and 04/17/19 and requested to review each of the resident records. Both Ms. Okafur and Ms. Green were unaware of the whereabouts of the records and requested that I speak to Mr. Matthew.

I interviewed Mr. Matthew on 04/17/19 and he admitted that he had not completed the resident records and was working on them. I reminded Mr. Matthew that I had emailed him all of the required resident forms during the enrollment process. Mr. Matthew reported that he had received them, however, was still working to complete the records.

I conducted the exit conference with Mr. Matthew on 05/20/19 and informed him of the findings of the investigation. Mr. Matthew reported an understanding of the violation.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, 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, date of birth, case number, and marital status.** **(iii) Former address.** **(iv) Name, address, and telephone number of the next of kin or the designated representative.**

	(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home. **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.** **(ix) Resident's religious preference information.** **(b) Date of admission.** **(c) Date of discharge and the place to which the 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, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.** **(e) Resident care agreement.** **(f) Assessment plan.** **(g) Weight record.** **(h) Incident reports and accident records.** **(i) Resident funds and valuables record and resident refund agreement.** **(j) Resident grievances and complaints.**
ANALYSIS:	Mr. Matthew failed to complete and maintain in the home, a separate record for each resident that contains all of the information listed above. Mr. Matthew admitted that the resident records were not complete and that is why they were not available for consultant review on 04/11/19 and 04/17/19.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I conducted unscheduled onsite inspections on 04/11/19 and 04/17/19 and observed the front window of the home busted out. The window was observed to have sharp pieces of glass still attached in the corners. The window had cardboard and a thin film of plastic taped to frame, however, cold winds could be felt blowing into the home.

I interviewed Ms. Okafur on 04/11/19 and she reported that she was told that Resident A became upset and broke the window, tore his bedroom door off the frame, and broke the bathroom door. Ms. Okafur reported she was not present when the incident occurred.

I interviewed Ms. Green on 04/17/19 and she reported that she was told that Resident A broke the front window as well as the bathroom and his bedroom door. Ms. Green reported that she was not employed at the time the incident occurred.

I completed a walk-through of the home and observed the bathroom door and Resident A's (west) bedroom door to be off of the hinges preventing the doors from closing.

I interviewed Resident's B-D on 04/11/19 and they all reported that Resident A got upset and started destroying the home. They reported that the damage to the home occurred about two weeks ago.

I interviewed Mr. Matthew on 04/17/19 and he reported that he had contacted several window companies and is waiting on a date for the window to be installed. Mr. Matthew reported that he will go back to the home a create a better seal and remove any remaining glass from the window. Mr. Matthew also reported that the maintenance man will be completing the other repairs to the bathroom and bedroom doors as soon as possible.

I conducted the exit conference on 05/20/19 and informed Mr. Matthew of the findings of the investigation. Mr. Matthew reported an understanding and stated that he is working to get the repairs completed.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	It was alleged that Resident A became upset and broke the front window of the home, the bathroom and his bedroom door after becoming upset. On 04/11/19 and 04/17/19 I observed the front window of the home busted out and covered with cardboard and plastic. The window had sharp pieces of glass still attached to the frame presenting a safety risk to the residents. I also observed the bathroom and Resident A's (west) bedroom door to be broken preventing them from closing. Residents B-D reported that the windows and doors had been broken for at least two weeks.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/13/19 and 05/20/19 I spoke at length with Mr. Matthew and he reported that he wishes to voluntarily close the license. Mr. Matthew reported that he can not afford to staff the home and needs additional funding. Mr. Matthew reported that he has contacted Detroit Wayne Mental Health Authority and was informed that they are not contracting with any new homes at the present. Mr. Matthew reported that he will contact the guardian of the one Resident in the home that requires AFC and have him moved. Mr. Matthew reported that the other five residents do not require 24-hour supervision and are only in need of room and board.

On 05/21/19, I received a closure letter from Mr. Matthew requesting to close the license.

IV. RECOMMENDATION

I recommend closure of the license based on the voluntary written request submitted by Mr. Matthew on 05/21/19. The written closure letter will serve as the corrective action plan and the license will be closed.

05/28/19

Pandrea Robinson
Licensing Consultant

Date

Approved By:

06/14/19

Ardra Hunter
Area Manager

Date