GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 20, 2019

Ronda Kuzmanovich
Adams House Inc.
26900 Franklin Rd.
Southfield, MI 48034

RE: License #: AS630015668
Investigation #: 2019A0986017
Adams House

Dear Ms. Kuzmanovich:

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,

Roeiah Epps, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(586) 256-1776

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630015668
Investigation #:	2019A0986017
Complaint Receipt Date:	05/17/2019
Investigation Initiation Date:	05/17/2019
Report Due Date:	07/16/2019
Licensee Name:	Adams House Inc.
Licensee Address:	26900 Franklin Rd. Southfield, MI 48034
Licensee Telephone #:	(248) 350-8070
Administrator:	Kimberly Taylor
Licensee Designee:	Gary Romanelli
Name of Facility:	Adams House
Facility Address:	4094 Rouge Circle Troy, MI 48098
Facility Telephone #:	(248) 540-1450
Original Issuance Date:	09/06/1994
License Status:	REGULAR
Effective Date:	12/12/2017
Expiration Date:	12/11/2019
Capacity:	6
Program Type:	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
• Siding is falling off the home, and the home smells of urine. • There is also very little food inside the home, which makes it hard for staff members to create meals. • The residents are also left home alone on a semi-regular basis.	No
• Resident A is not getting showers regularly, even when he requests them. Consequently, he smells of urine. • Resident A also has drawers missing from his dresser.	No
The residents' medical charts are not organized or up to date.	Yes
Residents B and C are confined to their bedrooms, and staff members take Resident C's walker.	No
Resident D's blood sugar is not monitored and his blood pressure was low, and nothing was done.	No

III. METHODOLOGY

05/17/2019	Special Investigation Intake 2019A0986017
05/17/2019	Inspection Completed On-site
05/17/2019	Special Investigation Initiated - On Site Interviewed Residents A, B, C, D, and E; and interviewed staff members Takeya Bell and Alisa Morehouse
05/17/2019	APS Referral Adult Protective Services (APS) referral from Centralized Intake
08/06/2019	Contact - Document Sent Email to Adult Protective Services (APS) worker Tiffany Pitts
08/12/2019	Contact - Telephone call received Voicemail from corporation's main office

08/16/2019	Contact - Telephone call made Left voicemail messages for Residents A and C's legal guardians (LG); interviewed Residents B, D, and E's LG's; and left voicemail and text for Resident D's adult daughter ("AD")
08/16/2019	Exit Conference Email to licensee designee Ronda Kuzmanovich and administrator Kimberly Taylor

ALLEGATION:

- **Siding is falling off the home, and the home smells of urine.**
- **There is also very little food inside the home, which makes it hard for staff members to create meals.**
- **The residents are also left home alone on a semi-regular basis.**

INVESTIGATION:

On 5/17/19, I conducted an unannounced inspection at the facility and interviewed Residents A, B, C, D, and E; and interviewed staff members Takeya Bell and Alisa Morehouse. Due to Resident A and Resident B being non-verbal, I was unable to interview them both. However, I was able to observe both residents, and did not see any signs or indications of licensing concerns.

On 5/17/19, I observed the exterior sides of the home and did not observe any siding fall off the home. Upon my entrance inside the home and complete walk through of the home, I did not smell the presence of urine, or any other signs of human waste. I also observed the home's food supply in the refrigerator and cabinets, in unison with the facility's posted menu, and did not see a disparity in food supply or meal variety.

On 5/17/19, staff member Takeya Bell stated she has worked at the facility for approximately three and half years. Since Ms. Bell's employment, she has never had any issues or safety concerns regarding any of the residents' care. Further, Ms. Bell stated that the allegations are not true, and believes the complaint was made out of retaliation by a disgruntle employee. Ms. Bell stated residents are never left alone inside the facility or unsupervised. Additionally, there is always a sufficient food supply and the home does not smell of urine. Ms. Bell stated the facility has undergone some renovations, and some updates are continuing. However, siding has never been observed falling off the home, or posing a risk to residents at the facility.

On 5/17/19, staff member Alisa Morehouse stated that she has been employed at the facility for approximately 10 years and has never had any issues or safety concerns regarding the residents' care. Ms. Morehouse also corroborated Ms. Bell's account of the allegations and provided a similar account regarding the allegations. Ms. Morehouse emphasized the allegations were not true, and echoed Ms. Bell's sentiments

regarding the complaint being made by a disgruntle employee that was recently terminated.

On 5/17/19, I interviewed Resident C. Resident C has resided at the facility since 12/21/16 and has never had any issues or safety concerns for himself or the other residents. Resident C stated he works outside of the facility and believes staff members do a good job in caring for the residents. Resident C stated the allegations are not true and a staff member is always on the premises 24 hours a day.

On 5/17/19, I interviewed Resident D. Resident D has resided at the facility since 11/8/04 and has never had any issues or safety concerns for himself or the other residents at the facility. Resident D stated he is incontinent, and staff members check him for diaper changing, etc. as required. Resident D stated the facility is always staffed with direct care workers, and none of the allegations are true.

On 5/17/19, I interviewed Resident E. Resident E has resided at the facility since 5/31/07 and has never had any issues or safety concerns for her care or any other resident at the facility. Resident E stated the allegations are not true, and stated her only concern is that staff members control her cigarettes too much because they try to ensure she remains cancer free.

On 8/16/19, I interviewed the administrator Kimberly Taylor. Ms. Taylor apologized for being on vacation at the time of my inspection in May but was adamant that the allegations were not true. Ms. Taylor also stated the staff member that was terminated threatened to make a licensing complaint during the month of May, so she was not surprised. Ms. Taylor stated she has been at the facility for over 10 years and has never had any issues or safety concerns for the residents' care and she always ensures sufficient food is always available in the home, because she grocery shops for the facility.

On 8/16/19, Resident D's LG1 stated he has been Resident D's LG and conservator for almost eight years and has never had any issues or concerns regarding his care at the facility. LG1 also stated that Resident D's adult daughter was appointed as his LG in July, but he remains Resident D's conservator. Further, as Resident D's conservator, LG1 is pleased with Resident D's care.

On 8/16/19, Resident B's LG2 stated she visits Resident B at the facility at a minimum three times a month, to once a week at times. Resident B has been a resident at the facility for over 20 years, and she has been pleased with his care. LG2 stated Resident B is her brother so she takes the allegations very seriously and can adamantly say that the allegations are not true. LG2 stated if at any point she believed the allegations to be true, she would have removed her brother from the home. Further, LG2 stated that her brother always appears happy and well cared for every time she visits the home.

On 8/16/19, Resident E's LG3 stated she has been involved with Resident E for the past six months and she has never had any issues or safety concerns regarding her care at the facility; and has never observed any of the above allegations.

On 8/16/19, Oakland County APS intake confirmed that none of the above allegations were substantiated.

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:	During my onsite inspection on 5/17/19, no signs of physical plant issues with siding fall off the home, or the smell of urine was observed. Moreover, all staff members, LG's, and residents interviewed stated the allegations were not true.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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:	At the time of my onsite inspection on 5/17/19, sufficient amounts of food were observed; and all residents and staff members interviewed stated the allegations of inadequate food supply was not true.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	On 5/17/19, Residents C, D, and E stated a staff member is always at the facility to supervise the residents, and no resident is ever left unsupervised.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **Resident A is not getting showers regularly, even when he requests them. Consequently, he smells of urine.**
- **Resident A also has drawers missing from his dresser.**

INVESTIGATION:

On 5/17/19, I observed Resident A sitting on his bed in his bedroom. Resident A did not smell of urine, nor did he appear to have poor hygiene. No drawers were observed to be missing out of his dresser as well.

On 5/17/19, staff members Ms. Bell and Ms. Morehouse stated the allegations were not true, and again emphasized a disgruntle employee made the complaint in retaliation as a means to get revenge against the facility, because she was fired.

On 8/16/19, administrator Kimberly Taylor stated the allegations were not true, corroborated Ms. Bell and Ms. Morehouse explanation regarding the allegations. Further, Resident A is bathed and well-groomed at all times, and she does not believe staff members are not providing him showers as required.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	During an unannounced onsite inspection on 5/17/19, I observed Resident A to be appropriately dressed, with no signs of poor hygiene nor did he smell of urine.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	On 5/17/19, I conducted an unannounced inspection, and did not observe any missing drawers in Resident A's bedroom dresser.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The resident's medical charts are not organized or up to date.

INVESTIGATION:

On 5/17/19, staff members Ms. Bell and Ms. Morehouse stated that the residents do not have medical charts; rather, all residents' are kept in a file for each resident. Consequently, I reviewed each residents' file. All residents' files were appropriately organized with all relevant required licensing forms. However, all residents' health care appraisals are expired, with the exception of Resident B. Specifically:

- Resident A's health care appraisal is dated 5/11/18
- Resident C's health care appraisal is dated 5/11/18
- Resident D's health care appraisal is dated 5/11/18
- Resident E's health care appraisal is dated 5/11/18

Additionally, all resident's assessment plans are expired:

- Resident A's is dated for 4/12/18
- Resident B's health care appraisal is dated for 5/4/17
- Resident C's is not signed or dated
- Resident D's is dated for 4/28/18
- Resident E's is dated for 4/28/18

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an

	emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Residents A, C, D, and E's health care appraisals dated 5/11/18, are not current and need to be updated.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	All residents' assessment plans are not current and need to be updated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B and Resident C are confined to their bedrooms and staff members take Resident C's walker.

INVESTIGATION:

On 5/17/19, I observed Resident B sitting his wheelchair in his bedroom watching television. Because Resident B is a quadriplegic and non-verbal, I was unable to interview him. However, staff members Ms. Bell and Ms. Morehouse stated in their years of experience at the facility, they have never witnessed or observe any staff member confine Resident B to his bedroom.

On 5/17/19, Resident C stated the allegations are not true. Resident C stated he works outside the facility, so staff are not able to confine him to his bedroom or take his walker from him.

On 8/16/19, LG2 stated the allegations are not true. At a minimum, LG2 has visited her brother (Resident B) at the facility for the past 20 years on a monthly basis. During

each visit, LG2 has not witnessed or observed staff members confining him to his bedroom only. Moreover, LG2 stated she would remove Resident B immediately from the facility if she ever believed he was mistreated.

On 8/16/19, administrator Kimberly Taylor stated that no resident is confined to their bedroom nor does any staff member take residents' assistive devices as a means of restraining them to a confined area.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident. (d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.
ANALYSIS:	According to LG2, she has never witnessed or observed any staff member confine Resident B to his bedroom or any area of the home in the 20 years he has ever been a resident at the facility. In addition, Resident C also reported staff members do not take his walker or confine him to his bedroom.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident D's blood sugar is not monitored and his blood pressure was low, and nothing was done.

INVESTIGATION:

On 5/17/19, Resident D stated that staff members check his blood pressure at a minimum three times a day. Additionally, he is aware of when his blood pressure gets extremely low and may need to seek medical attention. Resident D stated he has not had an episode recently that required him to obtain medical attention. I also reviewed Resident D's blood pressure logs at the time of inspection, which evidenced his account of staff members monitoring his blood pressure as he indicated.

On 5/17/19, staff members Ms. Bell and Ms. Morehouse stated the allegations are not true. Staff members stated that they are required to monitor Resident D's blood pressure and record it at all time to ensure his blood pressure is stable.

On 8/16/19, administrator Kimberly Taylor stated that all staff members are trained to check Resident D's blood pressure and record it to ensure his blood pressure level does not get extremely low. Further, Ms. Taylor stated that staff members are required to log his blood pressure levels and take him to the hospital if his blood pressure becomes too low, and submitted copies of his blood pressure logs to evidence this for my review.

On 8/16/19, LG1 stated since Resident D has been his ward the past 7 years at the facility, and he has never had any issues or safety concerns about the facility not properly monitoring his blood pressure and does not believe the allegations are true.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: (d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.
ANALYSIS:	According to Resident D, staff members check his blood pressure at a minimum three times a day as required. Further, blood pressure logs evidence at the facility and LG1 reported no signs or indications exist that the facility is not monitoring Resident D's blood pressure as required.
CONCLUSION:	VIOLATION NOT ESTABLISHED

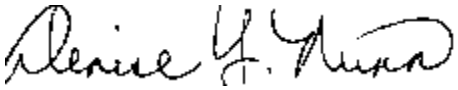
IV. RECOMMENDATION

Contingent upon the licensee submitting an acceptable corrective action plan, I recommend that the special investigation be closed with no change to the license.

8/16/19

Roeiah Epps — Date
Licensing Consultant

Approved By:



08/20/2019

Denise Y. Nunn — Date
Area Manager