GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 11, 2021

Julie Wiley
23845 Lee Baker Drive
Southfield, MI 48075

RE: License #: AS630086106
Investigation #: 2021A0605037
L & W Adult Foster Care Home

Dear Ms. Wiley:

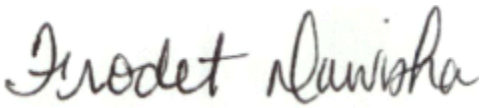
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Frodet Dawisha, Licensing Consultant
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51111 Woodward Avenue
Pontiac, MI 48342
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630086106
Investigation #:	2021A0605037
Complaint Receipt Date:	06/22/2021
Investigation Initiation Date:	06/22/2021
Report Due Date:	08/21/2021
Licensee Name:	Julie Wiley
Licensee Address:	23845 Lee Baker Drive Southfield, MI 48075
Licensee Telephone #:	(313) 790-4327
Administrator:	Maurice Latham
Licensee Designee:	Julie Wiley
Name of Facility:	L & W Adult Foster Care Home
Facility Address:	23845 Lee Baker Southfield, MI 48075
Facility Telephone #:	(248) 355-2294
Original Issuance Date:	09/28/1999
License Status:	REGULAR
Effective Date:	11/20/2020
Expiration Date:	11/19/2022
Capacity:	6
Program Type:	MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided his 1:1 timely, as his care plan was not complete. Resident A was not given the care he requires for his and others safety.	Yes
Resident A was not being provided his medication injection timely.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/22/2021	Special Investigation Intake 2021A0605037
06/22/2021	Special Investigation Initiated - Telephone Left message for reporting person (RP) requesting a return call to discuss the allegations.
06/24/2021	Contact - Telephone call made Left another message for RP requesting a return call to discuss allegations.
06/24/2021	Contact - Telephone call received I interviewed the RP regarding the allegations.
06/28/2021	Inspection Completed On-site I conducted an unannounced on-site investigation. I interviewed acting home manager DeShawn Barry and Residents B, C, and D. I reviewed Resident A's medication logs.
07/08/2021	Contact - Telephone call made I interviewed licensee Julie Wiley and administrator Maurice Latham regarding the allegations.
08/03/2021	Contact - Telephone call made I left a voice mail message for Resident A's supports coordinator Jeanine Peck with Team Wellness. I followed up with licensee Julie Wiley via telephone.

08/05/2021	Contact - Telephone call made I left a message with receptionist Kim at Team Wellness who stated she will send an email to Resident A's supports coordinator Jeanine Peck to return my call.
08/09/2021	Contact - Telephone call made I left for supports coordinator Jeannine Peck advising her that I was still in receipt of Resident A's individual plan of service (IPOS) and a return call from her direct supervisor regarding Resident A.
08/09/2021	Contact - Document Received Jeannine Peck emailed Resident A's IPOS completed by Team Wellness for my review.
08/11/2021	Exit Conference I conducted the exit conference via telephone with licensee Julie Wiley with my findings.

ALLEGATION:

Resident A was not provided his 1:1 timely, as his care plan was not complete. Resident A was not given the care he requires for his and others safety.

INVESTIGATION:

On 06/22/2021, intake #180331 was assigned for investigation regarding L & W Adult Foster Care Home failed to provide proper care to Resident A by not administering his medications properly or updating Resident A's individual plan of service (IPOS) completed by Team Wellness.

On 06/24/2021, I contacted the reporting person (RP) via telephone regarding the allegations. The RP stated that Resident A moved into this group home as an emergency placement in 02/2021 by Resident A's supports coordinator, Darlene Jones with Team Wellness. According to the RP, after Resident A was admitted into this group home, it was agreed upon by Ms. Jones that Resident A would receive a 1:1 staff and that the IPOS would be updated to reflect the 1:1. However, the RP stated that the IPOS was never updated, and Resident A never received a 1:1 staff at this home. On 05/03/2021, Resident A assaulted a staff with a knife at this group home and was arrested. The RP was contacted and informed that Resident A was taken to the hospital and then to jail. The staff never told police that Resident A had a mental illness. The RP stated the staff was not injured and this incident occurred because Resident A was not given his medication or his injections. The RP was told by licensee Julie Wiley that Resident A refused his medications and the injections. The RP stated that a 1:1 staff was again attempted on 04/01/2021 but disapproved. The RP stated that the 1:1 staff was approved after Resident A was arrested and placed in jail.

On 06/28/2021, I conducted an on-site investigation and interviewed the acting home manager DeShawn Barry, Resident B, C and D and reviewed Resident A's medication logs. Mr. Barry has worked for this corporation for 10 years. There is only one DCS per shift. Mr. Barry stated Resident A moved in sometime in 02/2021. At first, it was unclear to Mr. Barry if Resident A required a 1:1 staff, but then when Resident A was trying to elope from this group home to pan handle for money to purchase "weed," it was determined that Resident A should have a 1:1 staff. Mr. Barry was unable to provide information as to Resident A's needs or his diagnosis.

On the afternoon/evening of 05/03/2021, Mr. Barry was writing an incident report (IR) regarding Resident D because Resident D was not feeling well and had to go to the hospital. The ambulance arrived and took Resident D. Mr. Barry continued writing the IR in his office and then asked Resident A to see if the garage door was opened and if it was to close the garage door. Mr. Barry stated Resident A did not appear agitated when Mr. Barry asked him to do this, but then Mr. Barry felt a hand on the back of his head and then he saw a knife come around and then placed across his neck. Mr. Barry turned around and saw Resident A holding the knife in his hand. Mr. Barry stated the knife scratched his neck, but he did not require medical treatment. He stated Resident A ran outside with the knife in his hand. Mr. Barry called 911 and went outside to look which way Resident A ran. Resident A was on the front lawn. Resident A told Mr. Barry, "I know you're not calling on me." Resident A began walking towards Mr. Barry while the knife was still in his hand and then the police arrived. The police took the knife from Resident A, took pictures of Mr. Barry's neck, and then arrested Resident A. Mr. Barry

stated there was no precursor that would indicate Resident A was going to become aggressive and pull a knife on him. He stated Resident A had no suspicious behaviors and was cooperative and calm on this day. Mr. Barry stated Resident B and Resident C were present but were in their bedrooms during the incident.

I requested to review Resident A's IPOS completed by Team Wellness, medications, and health care chronological regarding Resident A's appointments for his injections. Mr. Barry stated he cannot locate the records; therefore, the records were not available for my review.

Mr. Barry called licensee Julie Wiley via telephone and put her on speaker phone. Ms. Wiley stated she had the keys to the cabinet where all the residents' records were locked up. Ms. Wiley stated she was an hour away. I advised Ms. Wiley that staff should always have access to resident records to ensure they are reviewing their IPOS' to provide care according to their plans. Ms. Wiley stated she will email the documents to me.

I attempted to interview Resident B in their bedroom but was unsuccessful as Resident B was unable to answer my questions regarding Resident A. Resident B stated, "there is no electricity here," but the lights were on in her bedroom. The Resident B stated, "Resident A is the guy who was selling crack cocaine and he attacked me here and was put in jail for it. People from the hospital are coming in here."

I interviewed Resident C upstairs in his bedroom regarding the allegations. Resident C shares a bedroom with Resident E who was in the hospital during this visit. Resident C has lived in this group home for 10 years. Resident C stated he knew Resident A, but that he never witnessed Resident A become aggressive or pull a knife on any staff or any resident. Resident C recalls the police coming to this group home and saw that the police took Resident A with them, but Resident C does not know why.

I attempted to interview Resident D in their bedroom but was unsuccessful as I was unable to understand what Resident D was saying. Resident D's bedroom was full of papers that Resident D was on their bed looking through these papers.

Mr. Barry stated Resident D does not allow anyone in their bedroom and it is very difficult for staff to clean Resident D's bedroom. When staff do assist Resident D in cleaning the bedroom, Resident D messes it up again.

On 07/08/2021, I interviewed licensee Julie Wiley via telephone regarding the allegations. Ms. Wiley stated that Resident A has medical problems; sickle cell and is medically fragile. Ms. Wiley stated it was "out of the blue," that Resident A attacked Mr. Barry. She stated the knife was taken from the kitchen and it was dull. Ms. Wiley reported that Resident A was an emergency placement and there was no indication that Resident A was aggressive or had aggressive behaviors. She stated the IPOS completed by Team Wellness did not indicate that knives needed to be locked up or that Resident A required a 1:1 staff. Ms. Wiley stated around the end of April 2021, Resident

A began requesting to go be taken to a marijuana home to purchase marijuana. Ms. Wiley explained to Resident A that although marijuana was legal, she has house rules and that this was a drug free home and she would not tolerate drugs in her home. She reported that Resident A began leaving the home and that is when she reached out to Team Wellness to get his IPOS updated to include a 1:1 staff. Ms. Wiley stated the day after the incident on 05/03/2021 is when Team Wellness approved the 1:1 staff, but it was too late since Resident A was in jail.

Ms. Wiley stated that Resident A's records were at the home, but they were locked in a cabinet, and she had the keys. She now understands that the records must be available for the departments review upon request and that staff must also have access to the IPOS to ensure they are providing the care as written in the residents' IPOS.

On 07/08/2021, I interviewed Mrs. Wiley's husband Gregory Wiley who stated he is a staff at this group home. Mr. Wiley stated there was no indication of any aggressive behaviors that would indicate that Resident A would pull a knife on Mr. Barry. Mr. Wiley stated that Resident A began eloping to go and smoke marijuana. Due to Resident A being medically fragile and his elopement, he, and Mrs. Wiley reached out via Zoom to Team Wellness. Team Wellness initially stated that these concerns regarding Resident A did not require a 1:1 staff, but then agreed to review the 1:1 staff on 04/30/2021. However, the 1:1 staff was approved the day after Resident A assaulted Mr. Barry and was arrested.

On 07/08/2021, Mrs. Wiley emailed Resident A's Crisis Plan dated 12/01/2020 completed by Team Wellness, Resident A's assessment plan completed by Mrs. Wiley with Resident A's signature, Resident A's resident care agreement signed by Mrs. Wiley and Resident A on 01/22/2021 and Resident A's record of physician contacts. I reviewed the IPOS and there was no information on the IPOS other than Resident A requesting to go to Kingswood Hospital for psychiatric and Henry Ford Hospital for physical health. I reviewed the assessment plan completed by Mrs. Wiley and according to the assessment plan, the only need that Resident A had was for staff to administer medication and that Resident A "does not exhibit injurious behaviors." This assessment plan does not provide any information as to what Resident A's needs are and how staff are to meet these needs. I reviewed the resident care agreement which specifies that the group home will transport Resident A to and from medical and psychiatric appointments. I reviewed the physician contacts and according to the contacts, Resident A was taken for his injections on 03/19/2021 and 04/19/2021 by Mrs. Wiley.

On 08/03/2021, I contacted Mrs. Wiley via telephone as a follow-up to the allegations. Mrs. Wiley stated she recalled other incidents that occurred with Resident A in March 2021. She stated that on two different occasions, Resident A went into Resident B's bedroom one night but did not do anything to Resident B. Resident B reported this to Mrs. Wiley. Mrs. Wiley stated another night Resident B reported to Mrs. Wiley that Resident A went into Resident B's bedroom and Resident B pulled their pants down. Resident B told Mrs. Wiley that is the only thing that happened. Mrs. Wiley asked Resident A about these incidents and Resident A stated, "I don't remember."

On 08/05/2021, I contacted Resident A's supports coordinator Jeannine Peck, with Team Wellness. Ms. Peck stated that Resident A was new on her case, and she did not know much about him or his IPOS that was completed by Darlene Jones. Ms. Peck stated she will email me the IPOS and have her supervisor call me to discuss Resident A. Ms. Peck stated that Resident A is currently in their Jail Diversion Program.

On 08/09/2021 and 08/10/2021, I left messages with the receptionist at Team Wellness to have Ms. Peck's supervisor call me regarding Resident A but I never received any return calls.

On 08/09/2021, I received an email from Jeannine Peck with Resident A's IPOS. I reviewed the IPOS dated 12/20/2020, but all the information within the IPOS had information regarding Resident A residing with his mother who was at that time his legal guardian. There was no information about Resident A moving into L & W Adult Foster Care Home and what needs and/or services staff were going to provide to Resident A.

APPLICABLE RULE	
R 400.14301	**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 the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.

ANALYSIS:	Based on my investigation and information gathered, the assessment plan that was completed on 01/22/2021 was incomplete as there was insufficient information to determine Resident A's needs and how staff were going to meet/address those needs. In addition, the assessment plan should have been updated in March 2021 after the incidents involving Resident A going into Resident B's bedroom and Resident A pulling their pants down. A copy of Resident A's assessment plan and IPOS were not available for my review during my on-site investigation on 06/28/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on my investigation and information gathered, Resident A's assessment plan dated 01/22/2021 did not have enough information regarding Resident A's needs and how staff were going to meet those needs. Also, licensee Julie Wiley did not update the assessment plan in March 2021, regarding Resident A going into Resident B's bedroom and pulling their pants down to indicate an increase in supervising Resident A. Therefore, Resident A was not provided with the supervision and protection required to ensure the safety of Resident A and Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following:

	(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.
ANALYSIS:	During the on-site investigation on 06/28/2021, I requested to review the incident report regarding Resident A's arrest on 05/03/2021, but Mr. Barry did not have the incident report available for my review.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: (d) Health care information, including all of the following: (iv) A record of physician contacts. (e) Resident care agreement. (f) Assessment plan. (h) Incident reports and accident records.
ANALYSIS:	During the on-site investigation on 06/28/2021, this group home did not have Resident A's physician contacts, resident care agreement, assessment plan, or the incident report dated 05/03/2021, when Resident A pulled a knife on Mr. Barry and was arrested available for my review.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was not being provided his medication injection timely.

INVESTIGATION:

On 06/28/2021, Mr. Barry was able to locate Resident A's medication log for the month of April 2021. Resident A was prescribed with only one medication Trazodone HCL 50MG PO TAB: take one tablet by mouth at bedtime was not given on 04/09/2021,

04/12/2021-04/15/2021 as staff put a line in the boxes. Staff administered the medication on 04/11/2021 but did not initial the medication log.

Mr. Barry stated that staff should have put an "R," where the lines are for 04/09/2021, 04/12/2021-04/15/2021 because Resident A refused the medication on those dates. Mr. Barry stated there is no documentation to reflect that Resident A refused the medication and no documentation to reflect that Resident A's physician was contacted when Resident A refused the medication.

On 07/08/2021, Mrs. Wiley stated she had not reviewed Resident A's medication log prior to me coming out to the home but that Resident A was receiving his medications. I advised Mrs. Wiley that according to Mr. Barry, Resident A refused his medications, but that no one contacted Resident A's physician regarding the refusal of the medication. Mrs. Wiley acknowledged.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my review of Resident A's medication log, Resident A was not given his medications pursuant to label instructions. According to the medication log for April 2021, Resident A's Trazodone 50MG was not given on 04/09/2021, 04/12/2021-04/15/2021 as staff put a line through the boxes for those days.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:

	(vi) A resident's refusal to accept prescribed medication or procedures.
ANALYSIS:	Based on my review of Resident A's medication log for April 2021, Resident A refused Trazodone 50MG on 04/09/2021, 04/12/2021-04/15/2021 and staff did not initial an "R," for refuse but instead put a line in the box.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: (f) Contact the appropriate health care professional if a medication error occurs or when a resident refuse prescribed medication or procedures and follow and record the instructions given.
ANALYSIS:	Based on my review of Resident A's medication log for April 2021, Resident A refused Trazodone 50MG on 04/09/2021, 04/12/2021-04/15/2021, but staff did not contact Resident A's health care professional and follow and record the instructions given.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/28/2021, I observed a broken dresser door in Resident B's bedroom.

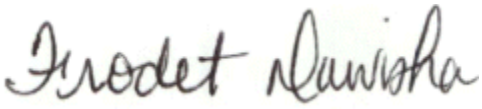
I observed the bathroom in Resident C's bedroom to be extremely cluttered and unclean. The bathroom sink was dirty as was the toilet. The garbage can in the bathroom was overflowing with garbage.

On 08/11/2021, I conducted the exit conference via telephone with licensee Julie Wiley regarding my findings. Ms. Wiley stated she will submit an acceptable corrective action plan as she has already began addressing many of the concerns reported to her during this investigation.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	During the on-site investigation on 06/28/2021, Resident B's dresser had a broken door and the bathroom in Resident C's bedroom was not clean or orderly.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

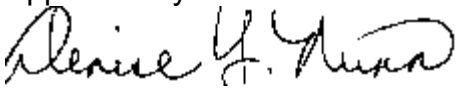
Contingent upon receiving an acceptable corrective action plan, I recommend closing this special investigation and no change to the status of the license.



08/11/2021

Frodet Dawisha Date
Licensing Consultant

Approved By:



08/11/2021

Denise Y. Nunn Date
Area Manager