GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 1, 2021

Nichole Landers
Landers & Landers Home for the Aged, Inc.
PO Box 33202
Bloomfield Hills, MI 48303

RE: License #: AS820400269
Investigation #: 2021A0992030
Mayfield Home #3

Dear Mrs. Landers:

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 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 (313) 456-0380.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820400269
Investigation #:	2021A0992030
Complaint Receipt Date:	08/17/2021
Investigation Initiation Date:	08/17/2021
Report Due Date:	10/16/2021
Licensee Name:	Landers & Landers Home for the Aged, Inc.
Licensee Address:	Suite 503 East, 15565 Northland Dr Southfield, MI 48075
Licensee Telephone #:	(313) 213-2722
Administrator:	Nichole Landers
Licensee Designee:	Nichole Landers
Name of Facility:	Mayfield Home #3
Facility Address:	15324 Mayfield St., Livonia, MI 48154
Facility Telephone #:	(734) 237-4663
Original Issuance Date:	12/03/2019
License Status:	REGULAR
Effective Date:	05/20/2020
Expiration Date:	05/19/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 8/11/2021, Resident A tried to leave the home in a cab but was physically pulled out by staff and slammed on the floor in the home.	Yes

III. METHODOLOGY

08/17/2021	Special Investigation Intake 2021A0992030
08/17/2021	Special Investigation Initiated - Telephone Complainant
08/18/2021	Inspection Completed On-site Terrell Marsh, home manager and Resident B
08/19/2021	Contact - Telephone call made Nicole Landers, licensee designee
08/19/2021	Contact - Telephone call made Arthur Pitts, Area Manager
08/23/2021	Contact - Document Received Resident A's adult foster care assessment
08/24/2021	Inspection Completed On-site Markita Brooks, direct care staff
08/24/2021	Contact - Telephone call made Mr. Marsh
08/24/2021	Contact - Telephone call made Catina Hayes, Office Manager
08/26/2021	Contact - Telephone call made Kenyatta Sabir, adult protective services (APS)
08/26/2021	Contact - Telephone call made Eryn Sherman, APS
08/27/2021	Contact - Telephone call made Relative A and Resident A

08/31/2021	Contact - Telephone call made Ms. Sherman
08/31/2021	Contact - Document Received Resident A's incident reports
08/31/2021	Exit conference Ms. Landers

ALLEGATION: On 8/11/2021, Resident A tried to leave the home in a cab but was physically pulled out by staff and slammed on the floor in the home.

INVESTIGATION: On 8/17/2021, I contacted the complainant and proceeded to discuss the allegations. The complainant identified Resident A as a resident in the Mayfield Home #3. The complainant further stated that Terrell Marsh, direct care staff was observed physically removing Resident A from a cab to prevent her from leaving. The complainant said Resident A stated Mr. Marsh also slammed her to the floor in the home, but the complainant denied witnessing Mr. Marsh slam Resident A to the floor. The complainant said after speaking with Mr. Marsh, he expressed concerns regarding Resident A leaving the home because she threatened to elope. The complainant said Mr. Marsh expressed additional concerns regarding Resident A’s behaviors, including prank calling Livonia Police stating she’s fearful, and when they arrived, she said it was a prank.

On 8/18/2021, I completed an onsite inspection and interviewed Terrell Marsh, home manager and Resident B regarding the allegations. Mr. Marsh explained that prior to the cab arriving to transport Resident A to therapy, she (Resident A) threatened to elope from therapy. Mr. Marsh said he immediately contacted Arthur Pitts, area manager and made him aware of Resident A’s threats. He said Mr. Pitts instructed him to cancel Resident A’s therapy appointment and not allow her to leave the home. Mr. Marsh said he proceeded to cancel Resident A’s appointment, however the cab arrived anyway. He said when the cab arrived Resident A proceeded out the door with a bag and got in the cab. He said he verbally directed her to get out the cab and she refused. He said he reached for her, and she kicked towards him and waved him away. Mr. Marsh said he grabbed her wrist and she proceeded to come with him. He said she physically walked back into the house and he didn’t pick her up or slam her to the ground. I asked Mr. Marsh if Resident A has a guardian that agreed to cancel her therapy appointment and he said no, she doesn’t have a guardian. I asked him if Resident A wanted to go to therapy and he said yes.

I asked him for a copy of Resident A’s individual plan of service (IPOS) or behavior plan. Mr. Marsh said he doesn’t have access to either of those documents and suggested I contact Mr. Pitts. He said Resident A is relatively new to the home and was admitted on 08/02/2021. I suggested that if this situation occurs in the future that he should contact the therapist and express his concerns regarding Resident A

threatening to elope, so that it could be addressed in treatment. Also, I suggested making the transporter aware, so he/she can keep an eye out for signs but at no time should staff physically redirect her unless it’s outlined in the resident’s IPOS or behavior plan. Mr. Marsh explained that after further discussion with Mr. Pitts and Psygenics; Resident A did attend the scheduled therapy session.

Resident B regarding the allegations. Resident B denied having any knowledge on this incident. Resident B said Mr. Marsh has never grabbed her or touched her in an aggressive manner. She denied she has ever witnessed Mr. Marsh grab or mistreat any of the residents. She said the staff takes good care of all the residents.

On 8/19/2021, I contact Nicole Landers, licensee designee and interviewed her regarding the allegations. Ms. Landers stated that she was previously made aware of the allegations but denied having any knowledge of Mr. Marsh physically redirecting Resident A in an attempt to prevent her from going to therapy. I explained that based on my interview with Mr. Marsh he was instructed by Mr. Pitts to stop Resident A from attending therapy. I asked for contact information for Mr. Pitts and Ms. Landers agreed to have Mr. Pitts contact me. I made Ms. Landers aware that once the investigation is complete, I will contact her to conduct an exit conference.

On 8/19/2021, I received a call from Mr. Pitts and interviewed him regarding the allegations. Mr. Pitts confirmed that once he was made aware Resident A was threatening to elope from therapy, he instructed Mr. Marsh to cancel her therapy appoint and not allow her to leave the home. Mr. Pitts said it’s not clear why the transporter arrived. I made Mr. Pitts aware that Mr. Marsh grabbed Resident A’s wrist and asked her to get out the cab to prevent her from leaving. Mr. Pits said he was not aware Mr. Marsh physically grabbed Resident A. He said the staff are not supposed to physically redirect the residents at all. I suggested that if this situation occurs in the future that he should contact the therapist and express his concerns regarding Resident A threatening to elope, so that it could be addressed in treatment. I also suggested making the transporter aware, so he/she can keep an eye out for signs but at no time should staff physically redirect a resident unless it’s outlined in their IPOS or behavior plan which is typically as a result of physical behaviors for restraining purposes only. I requested a copy of Resident A’s IPOS, and Mr. Pitts said they have not received a copy of her IPOS, but an AFC assessment plan was completed at the time of admission, he agreed to provide me with a copy.

On 8/23/2021, I received a copy of Resident A's AFC assessment plan. As it pertains to Resident A’s aggressive behaviors, her assessment plan indicates, “she has anxiety and will work with staff on coping skills”. As far as moving independently in the community, “moves independently, must be monitored for wellness and safety (elopement risk).”

On 8/24/2021, I completed an onsite inspection in an attempt to interview Resident A. Markita Brooks, direct care staff made me aware that Resident A has not returned to the home since 8/12/2021. She was uncertain of Resident A's whereabouts.

On 8/24/2021, I contacted Mr. Marsh regarding Resident A's whereabouts. Mr. Marsh explained that on 8/12/2021 once Resident A returned from therapy Kenyatta Sabir, adult protective services (APS) arrived, and arrangements were made with Resident A's relatives to come get her pending the investigation. Mr. Marsh suggested I contact Mr. Pits or Catina Hayes, office manager for additional information.

On 8/24/2021, I contacted Ms. Hayes and interviewed her regarding the allegations. Ms. Hayes said she was not aware Mr. Marsh grabbed Resident A's wrist or physically redirected her. She said the staff are not supposed to physically redirect the residents. I asked about Resident A's current whereabouts and she said she is with her relatives. Ms. Hayes further stated that Mr. Sabir arrived at the home and a plan was put in place pending the investigation. She said Resident A's relatives picked her up and they have been calling daily asking when she can return. Ms. Hayes said her staff would never intentionally hurt any of the residents. She said she has a good working relationship with Resident A's family, and it is their intentions to return Resident A to the home. She said Mr. Marsh will be removed from the home.

On 8/26/2021, I contacted Mr. Sabir, regarding the allegations. Mr. Sabir explained that on the day in question he was working on the APS Strike Team and made initial contact with Resident A. He said when he arrived Resident A was standing outside the facility crying. He said she stated she was afraid to go into the home. He said she stated that she was terrified of Mr. Marsh and that he physically removed her from the cab and was putting his fingers in her face in a threatening manner. Mr. Sabir said arrangements were made with her relatives to come get her and he remained onsite until they picked her up. He said the investigation has been assigned to Eryn Sherman, APS.

On 8/26/2021, I contacted Ms. Sherman regarding the investigation. Ms. Sherman confirmed Resident A is currently with her relatives pending the investigation. She said she intends to interview Resident A while in her relative's care. She said based on the information she received, Resident A was agitated and threatened to elope from the home and Mr. Marsh prevented her from doing so. I asked her if she was aware Mr. Marsh physically grabbed Resident A's wrist to get her out of the cab and escorted her back into the home and she said no. She said from what she understands, Resident A was agitated, and Mr. Marsh didn't think it was a good idea for Resident A to be transported in such of an emotional state. I explained to Ms. Sherman that it appears as though the information was communicated to her differently. I further stated that I intend on interviewing Resident A and would follow-up with her regarding the status of her investigation.
On 8/27/2021, I contacted Relative A and Resident A regarding the allegations. Prior to addressing the allegations, Relative A explained that Resident A has been in her

care for 15 years. She said prior to 2020, she did have guardianship of her but due to Covid and the court closing, the guardianship expired and has not been renewed. She said she is in the process of trying to get it reinstated. Relative A said recently it was decided that an AFC home would be appropriate for Resident A because her behaviors were getting "out of hand". Relative A said at the time Resident A was admitted into the Mayfield Home she was not on any psychotropic medications and was a bit uneasy. She said the transition from home to a new setting had her agitated and she would constantly call saying she wanted to come home. As far as the allegations Relative A said they received a call requesting Resident A be picked up from the home pending an investigation. Relative A said Resident A initially said Mr. Marsh grabbed her out of the cab and slammed her on the floor in the home, but she later recanted and said he grabbed her out the cab, but he didn't slam her to the floor. Relative A said Resident A was also upset because Mr. Marsh was putting his finger in her face. Relative A said she's very familiar with Resident A and her behaviors. She said she didn't believe she was being honest about him slamming her to the floor, in fact she said Resident A said it wasn't true. Relative A said at the time Resident A said whatever she needed to say to get back home. Relative A said therapy has always been a part of Resident A's life so she didn't understand why they would cancel her therapy session. However, Relative A said Resident A knows she wasn't totally truthful, and she wants to return to the home. Relative A said she has been in contact with Ms. Landers and Ms. Hayes because Resident A wants to return to the home. She said Ms. Hayes assured her that Mr. Marsh will no longer be at the home. Relative A said she would never put Resident A in a setting where she is uncomfortable or unsafe.

On 8/31/2021, I received a copy of the incident report authored by Mr. Marsh, which states that "he grabbed Resident A's arm and she walked into the home."

On 8/31/2021, I made follow-up contact with Ms. Sherman and made her aware of the findings. Ms. Sherman said she is still actively investigating the case.

On 8/31/2021, I completed an exit conference with Ms. Landers regarding the findings. I explained to Ms. Landers that based on the investigation there is evidence to support the allegations regarding Mr. Marsh grabbing Resident A and physically removing her from the cab. However, I was unable to determine that he slammed her on the floor in the home. I explained to Ms. Landers that the staff cannot use any form of physical force with the Residents unless it is physical restraint as defined in the rules, their IPOS or behavior plan. Ms. Landers said she understands and agreed to submit a corrective action plan.

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: **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.** **(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.** **(e) Withhold food, water, clothing, rest, or toilet use.** **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.** **(g) Refuse the resident entrance to the home.** **(h) Isolation of a resident as defined in R400.14102(1)(m).** **(i) Any electrical shock device.**
ANALYSIS:	During this investigation I interviewed Licensee Designee, Nicole Landers; Area Manager, Arthur Pits; Office Manager, Catina Hayes; Direct Care Staff, Terrell Marsh; Relative A; Resident A and the Complainant regarding the allegations and it was determined that Mr. Marsh physically removed Resident A from the cab. I also reviewed the incident report authored by Mr. Marsh, which states that “he grabbed (Resident A’s) arm and she walked into the home.” Based on the investigative findings, there is sufficient to support the allegations that Mr. Marsh used physical force with Resident A. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend the status of the license remain unchanged.

09/01/2021

Denasha Walker — Date
Licensing Consultant

Approved By:

09/01/2021

Jerry Hendrick — Date
Area Manager