GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 27, 2021

Tamisha Turner
A Caring Home of Michigan, LLC
P.O. Box 81
Walled Lake, MI 48390

RE: License #: AS630298741
Investigation #: 2021A0988026
Chateau of Novi

Dear Ms. Turner:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,

Kenyatta Lewis, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 296-2078

enclosure

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

I.IDENTIFYING INFORMATION

License #:	AS630298741
Investigation #:	2021A0988026
Complaint Receipt Date:	06/23/2021
Investigation Initiation Date:	06/23/2021
Report Due Date:	08/22/2021
Licensee Name:	A Caring Home of Michigan, LLC
Licensee Address:	45750 Eleven Mile Novi, MI 48374
Licensee Telephone #:	(248) 252-8888
Administrator:	Tamisha Turner
Licensee Designee:	Tamisha Turner
Name of Facility:	Chateau of Novi
Facility Address:	45750 Eleven Mile Novi, MI 48374
Facility Telephone #:	(248) 380-4663
Original Issuance Date:	01/22/2009
License Status:	REGULAR
Effective Date:	02/26/2020
Expiration Date:	02/25/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, ALZHEIMERS, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A cannot have private phone calls. The phone is always on speaker mode. The staff ration Resident K's cigarettes. Resident A cannot visit offsite with Relative A.	**No**
There are ongoing issues regarding the scheduling of Resident A's medical appointments.	**No**
Staff were heard taunting Resident A about her hallucinations, during a phone call.	**No**
The home manager placed Resident A at risk by failing to seek psychiatric treatment.	**No**
Resident A's guardians have not been notified of multiple incidents.	**No**
Resident A's guardians have not received incident reports.	**Yes**
Resident A does not receive medications as prescribed.	**No**
It is difficult to determine what medications Resident A needs while away from Chateau of Novi.	**Yes**
Additional Findings	**Yes**

III. METHODOLOGY

06/23/2021	Special Investigation Intake 2021A0988026
06/23/2021	Special Investigation Initiated - Telephone I spoke to Dawn Krull, Office of Recipient Rights (ORR)
06/23/2021	Contact - Document Received Ms. Krull sent Resident A's case management records via email. I reviewed Resident A's Individual Plan of Service (IPOS, crisis plan, and behavioral plan.
06/23/2021	APS Referral Candid Jamerson, Adult Protective Services (APS) is the assigned APS Specialist.

07/10/2021	Contact - Face to Face Virtual staff interviews with Dawn Krull, ORR were canceled due to Ms. Krull being ill.
07/19/2021	Contact - Telephone call made Dawn Krull, ORR
07/28/2021	Inspection Completed On-site I conducted interviews with Resident A and Chateau of Novi staff.
07/28/2021	Contact - Document Sent I sent a text message to Tamisha Kaplan, Licensee Designee.
08/02/2021	Contact - Telephone call made Tamisha Kaplan, Licensee Designee
08/03/2021	Contact - Telephone call made I left a voice message for Akia Williams, Home Manager
08/17/2021	Contact - Telephone call received Candid Jamerson, APS
08/17/2021	Contact - Telephone call received Dawn Krull, ORR
08/17/2021	Contact - Document Sent I sent a text message to Dawn Krull.
08/20/2021	Contact - Document Received I received a text message from Dawn Krull
08/26/2021	Contact - Telephone call made DCW's and home manager
08/26/2021	Contact - Document Sent I sent an email to the home manager and licensee designee.
08/26/2021	Contact - Telephone call made I left messages for the complainants.
08/27/2021	Contact - Telephone call received I interviewed Complainant A1 via telephone.

09/02/2021	Contact - Telephone call made I left a message for Easter Seals case manager, Sherry VanHouten
09/02/2021	Contact - Telephone call made Home manager
09/15/2021	Contact - Telephone call made I spoke to Dawn Krull, ORR and Candid Jamerson, APS.
09/17/2021	Exit Conference I conducted an exit conference via telephone with Ms. Kaplan.

ALLEGATION:

- **Resident A cannot have private phone calls. The phone is always on speaker mode.**
- **The staff ration Resident K's cigarettes.**
- **Resident A cannot visit offsite with Relative A.**

INVESTIGATION:

On 06/23/2021, I received a complaint from BCAL online complaint unit regarding allegations that Resident A is not allowed to use the telephone privately, have access to her cigarettes due to staff rationing them, and staff refusing to allow Relative A to take Resident A offsite for visits.

On 06/23/2021, I initiated my investigation by interviewing Dawn Krull, Office of Recipient Rights (ORR) via telephone. Ms. Krull stated that she is investigating the allegations. The complaint was also assigned to adult protective services (APS) specialist, Candid Jamerson.

On 06/23/2021, Ms. Krull sent Resident A's case management records via email. I reviewed a letter from the complainants, visitation documentation from Guardian A, and Resident A's Easter Seals behavioral plan. I noted that Easter Seals completed a behavioral plan dated 06/24/2020, which documents that "Staff will hold onto Resident A's cigarettes and lighter for her.
a. Resident A can approach staff and get a cigarette when she wants one
b. Staff may assist Resident A with making her cigarettes last as long as possible
  i. Staff may ration Resident A's cigarettes to one per hour when she is in the home
  ii. Staff may counsel Resident A to smoke less and why she should
  iii. Redirect her into activities that are not compatible with smoking."
I also noted that Relative A has permission for unlimited overnight visits with Resident A.

On 07/28/2021, I conducted an unannounced onsite where I interviewed Resident A, the home manager, Akeia Williams, and direct care worker (DCW), Dewonza Boyd.

Resident A stated that she is allowed to use the telephone in a private area. Resident A stated that approximately three months ago, the phone cord was broken so the phone had to be on speaker. The phone is working properly now. Resident A stated that her guardian provides eight to ten packs of cigarettes each month and she is allowed to keep two-three packs at a time. Resident A has to ask staff to light her cigarettes because she was caught smoking in her bedroom last year. Resident A stated that she is able to go offsite with Relative A for visits.

During the onsite, I interviewed home manager Akeia Williams and DCW Dewonza Boyd. They both reported that the telephone is a cordless phone that was never in need of repair. Resident A puts the phone on speaker and walks around the home during her phone conversations. Resident A has been asked to take the phone off of speaker mode but refuses to do so. They also stated that Resident A keeps two-three packs of cigarettes and requests more as needed. Staff light Resident A's cigarettes for her because after she was discovered smoking in her bedroom, she can no longer keep a lighter on her person. They also stated that Resident A is permitted to visit with Relative A offsite. Ms. Boyd stated that she called Ms. Kaplan one time, to verify that Relative A had permission for offsite overnight visits. Ms. Kaplan stated that per Guardian A, offsite visits were permitted and there have been no issues. During the onsite, I observed the cordless phone and noted that it operates on private mode.

On 08/26/2021, I left a voice messages' for DCW's Kalil Harlin and former DCW, Kelilah Bell.

On 08/27/2021, I interviewed Complainant A1 via telephone. The complainant reiterated the allegations and stated that the licensee designee, Tamisha Kaplan, refused to allow Resident A to go offsite with Relative A. Ms. Kaplan told Relative A that she had to make an appointment to have visitation with Resident A, even though the guardian provided written permission when Resident A was admitted. The complainant stated that Resident A has always been permitted to have offsite visitation with Resident A but at times, several phone calls had to be made to verify permission before the visits occurred. According to Complainant A1, Ms. VanHouten from Easter Seals could corroborate the allegations.

On 09/15/2021, I interviewed licensee designee, Tamisha Kaplan via telephone. Ms. Kaplan stated that when Resident A was admitted in September 2020, her guardian was "J. Carney." Shortly after Resident A was admitted Guardian A became Resident A's Guardian and written permission was provided for Relative A to take Resident A on unlimited overnight visits. Relative A has not been denied overnight visitation, but on occasion, as a safety precaution, staff have called to verify that Relative A was permitted to take Resident A out of the home.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: (e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.
ANALYSIS:	Based on the information I received from Resident K, the complainant, Ms. Krull, and Chateau of Novi staff, I determined that Resident A has reasonable access to a telephone for private communications. On 07/28/2021, I observed the cordless phone at Chateau of Novi and noted that it operates on private mode.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: (j) The right of reasonable access to and use of his or her personal clothing and belongings.

ANALYSIS:	Based on the information I received from Resident K, the complainant, Ms. Krull, and Chateau of Novi staff, I determined that Resident A has reasonable access to her cigarettes. Resident A and facility staff stated that Resident A's guardian provides eight to ten packs of cigarettes each month and she is allowed to keep two-three packs at a time
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: (k) The right to have contact with relatives and friends and receive visitors in the home at a reasonable time. Exceptions shall be covered in the resident's assessment plan. Special consideration shall be given to visitors coming from out of town or whose hours of employment warrant deviation from usual visiting hours.
ANALYSIS:	Based on the information I received from Resident K, the complainant, Ms. Krull, and Chateau of Novi staff, I determined that Resident A has reasonable access to visitation with Relative A. Relative A has not been denied overnight visitation with Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

There are ongoing issues regarding the scheduling of Resident A's medical appointments.

INVESTIGATION:

On 06/23/2021, I received a complaint from BCAL online complaint unit regarding allegations that on 05/20/2021, Resident A had a medication review appointment. Ms. Kaplan insisted that the medication review should take place at Chateau of Novi due to an appointment with her Easter Seals case manager the same day. The complainants agreed to come to Chateau of Novi for both appointments, only to learn that that there

was no appointment with Easter Seals scheduled on 05/20/2021. Additionally, in previous months, Complainant A1 has made several attempts to attend Resident A's psychological appointments. In two instances the appointment information provided by the staff was incorrect. The first appointment was cancelled without notifying Complainant A1 and the second appointment occurred at Chateau of Novi, when Complainant A1 was told the appointment was at Dr. Cho's office.

On 07/19/2021, I spoke to Ms. Krull via telephone. Ms. Krull stated that Resident A had a psychological evaluation and medication review on 05/20/2021. A petition was submitted to the court for psychiatric placement on 05/22/2021 and Resident A was admitted to McClaren Hospital. Resident A was discharged on 06/07/2021 and returned to Chateau of Novi.

On 07/28/2021, I conducted an unannounced onsite where I interviewed Resident A, the home manager, Akeia Williams, and direct care worker (DCW), Dewonza Boyd. Resident A stated that she wasn't sure about who staff communicate with regarding her appointments.

During the onsite, I interviewed home manager Akeia Williams and DCW Dewonza Boyd. They both stated that former DCW, Kelilah Bell and former home manager Clarissa Clinton, forgot to inform Guardian A that Resident A's appointment with Easter Seals had been canceled. They both stated that they were not aware of previous psychological appointments that Guardian A was not made aware of and denied the allegations.

On 08/27/2021, I interviewed Complainant A1 via telephone. The complainant reiterated the allegations. I attempted to interview Complainant A2 via telephone. I left a message requesting a return phone call.

On 09/17/2021, I interviewed licensee designee, Tamisha Kaplan via telephone. Ms. Kaplan stated that there was one communication issue with staff and Guardian A regarding Resident A's appointment with Easter Seals. Guardian A has been notified of Resident A's appointments and since May 2021, there have not been any issues.

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:	Based on the information that I gathered from interviews with Resident A, the complainant, and Chateau of Novi staff, I determined that Guardian A was not appropriately notified about the cancellation of one of Resident A's appointments. This appeared to be an isolated incident.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff were heard taunting Resident A about her hallucinations, during a phone call.

INVESTIGATION:

On 06/23/2021, I received a complaint from BCAL online complaint unit regarding allegations that during a voicemail from Resident A, the staff at Chateau of Novi were heard taunting and making fun of Resident A's delusions.

On 07/19/2021, I spoke to Ms. Krull via telephone. Ms. Krull stated that she received a copy of voice recording of someone taunting Resident A from Easter Seals supports coordinator Cherie VanHouten. There was no date stamp, but the complainants sent the recording to Ms. VanHouten, on 10/23/2021. Ms. Krull forwarded the voicemail to my email. I listened to the voicemail. I noted that Resident A was delusional as she attempted to report issues regarding medication. I heard the unidentified person laughing at Resident A and repeating what Resident A said. I heard Resident A say that she was speaking to a lawyer and the unidentified person responded to Resident A and said, "You aren't talking to a lawyer, you are not on a case, you are at a home."

On 07/28/2021, I conducted an unannounced onsite where I interviewed Resident A, the home manager, Akeia Williams, and direct care worker (DCW), Dewonza Boyd. Resident A stated that she has not heard staff taunting her.

I interviewed home manager Akeia Williams and DCW Dewonza Boyd. They both reported that the allegations are false. The staff do not taunt or mistreat the residents.

On 08/26/2021, I sent the recording to the home manager, Akeia Williams and licensee designee, Tamisha Kaplan via email. I asked them to listen and respond to identify the person heard taunting Resident A.

On 08/27/2021, I interviewed Complainant A1 via telephone. The complainant reiterated the allegations and stated that she could not determine who the DCW was on the voice recording. I attempted to interview Complainant A2 via telephone. I left a message requesting a return phone call.

On 09/02/2021, I spoke to home manager, Akeia Williams via telephone. Ms. Williams stated that she did not recognize the voice of the person heard taunting Resident A. Ms. Williams stated that it did not sound like any of the DCW's or residents at Chateau of Novi.

On 09/17/2021, I interviewed licensee designee, Tamisha Kaplan via telephone. Ms. Kaplan stated that she did could not identify the person heard taunting Resident A on the voice recording.

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: (f)(i) mental or emotional cruelty.
ANALYSIS:	Based on the information I gathered from interviews with Resident A, the complainant, and Chateau of Novi staff, I could not determine who taunted Resident A on the voice recording. There is no date stamp or time of the voice recording and the complainant nor Ms. Williams, or Ms. Kaplan could identify the person heard taunting Resident A. It is unknown if another resident taunted Resident A, or when and where the conversation occurred.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The home manager placed Resident A at risk by failing to seek psychiatric treatment.

INVESTIGATION:

On 06/23/2021, I received a complaint from BCAL online complaint unit regarding allegations that on 05/20/2021, Resident A had a medication review appointment attended by Relative A, Guardian A, Resident, home manager, Akeia Williams, and licensee designee, Tamisha Kaplan. Resident A was very agitated and verbally aggressive with her psychiatrist, Dr. Cho. The recommendation was for Resident A to be admitted to the hospital to be stabilized. Later that evening, Resident A talked about running away, using drugs, and committing suicide. Ms. Williams decided it would be a good idea to take Resident A to the park on her own, which put Resident A at risk.

On 07/19/2021, I spoke to Ms. Krull via telephone. Ms. Krull stated that Resident A had a psychological evaluation and medication review on 05/20/2021. A petition was submitted to the court for psychiatric placement on 05/22/2021 and Resident A was admitted to McClaren Hospital. Resident A was discharged on 06/07/2021 and returned to Chateau of Novi.

On 07/28/2021, I conducted an unannounced onsite where I interviewed Resident A, and the home manager, Akeia Williams

Resident A stated that she remembered going to the park alone with Ms. Williams in May. Resident A denied being upset or suicidal and stated that Ms. Williams took her to the gas station to get snacks and took her to the park to get fresh air.

I interviewed home manager Akeia Williams Ms. Williams denied the allegations and stated that she did not put Resident A at risk by taking her to the park. On 05/21/2021, the police came to Chateau of Novi after Guardian A called them to request assistance with transporting Resident A to the psychiatric hospital. The police were not able to transport Resident A because the petition to admit Resident A had not yet been signed. Resident A stated that she needed to get out of the house for awhile and Ms. Williams took her to the gas station to buy chips and pop. Afterward, they went to the park where they sat and talked. Ms. Williams stated that on 05/20/2021 or 05/21/2021, Resident A never expressed that she was suicidal or homicidal. Resident A stated that she wanted to leave Chateau of Novi several times. Ms. Williams stated that there was a low risk of harm to Resident A as she provided 1:1 observation and supervision. The petition to admit Resident A was signed on 05/22/2021 and Resident A was admitted to McClaren Hospital. Resident A was discharged on 06/07/2021 and returned to Chateau of Novi. I noted that Ms. Williams and Ms. Krull, ORR provided the same information regarding Resident A's hospital admission and discharge.

On 08/27/2021, I interviewed Complainant A1 via telephone. The complainant reiterated the allegations. I attempted to interview Complainant A2 via telephone. I left a message requesting a return phone call.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Based on the information that I gathered from interviews with Resident A, the complainant, and the home manager, Ms. Williams, I did not determine that Ms. Williams put Resident A at risk on 05/20/2021. There were plans to admit Resident A to the hospital for stabilization, which occurred on 05/22/2021. Ms. Williams provided 1:1 supervision to Resident A on 05/20/2021 and took Resident A out of the home at her request. Resident A and Ms. Williams deny that Resident A was suicidal or at risk of harm.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **Resident A's guardians have not been notified of multiple incidents.**
- **Resident A's guardians have not received incident reports.**

INVESTIGATION:

On 06/23/2021, I received a complaint from BCAL online complaint unit regarding allegations that incident reports are not provided to Guardian A as requested. There have been at least three incidents that should have been reported. On an unknown date, Resident A assaulted another resident at Chateau of Novi. This information was not shared with Guardian A until Relative A came to the home and asked what happened to Resident A's eye. On an unknown date Resident A called a cab in an attempt to elope. Guardian A was not notified. Resident A has made several attempts to elope, and Guardian A was not notified.

On 07/28/2021, I conducted an unannounced onsite where I interviewed Resident A and the home manager, Akeia Williams. Resident A stated that she did not remember having a fight with another resident. Resident A denied having any injuries to her eye. Resident A stated that there have been times when she wanted to leaved Chateau of Novi, but the staff talk her into staying. Ms. Williams stated that Guardian A has been notified regarding every incident involving Resident A via telephone call or text message. Ms. Williams stated that she was not certain if written incident reports (IR) were sent to Guardian A. Ms. Williams stated that she remembered Resident A being involved in a fight over a year ago. Ms. Williams could not remember who else was involved in the fight with Resident A, but Resident A had never been injured by APS. It should be noted that I queried the Department's SharePoint site to review special investigations. I also queried my email regarding IR's. I did not locate any IR's regarding the allegations or special investigations regarding an altercation between Resident A and another resident. Ms. Williams stated that Resident A has walked away from Chateau of Novi, but staff were aware and convinced Resident A to return.

On 08/27/2021, I interviewed Complainant A1 via telephone. The complainant reiterated the allegations and stated that none of the alleged incident dates were recorded. I

attempted to interview Complainant A2 via telephone. I left a message requesting a return phone call.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(3) If a resident is absent without notice, the licensee or direct care staff shall do both of the following: (a) Make a reasonable attempt to contact the resident's designated representative and responsible agency.
ANALYSIS:	Based on my findings, I could not determine that Ms. Williams did not communicate Resident A's attempts to elope with Guardian A. Resident A has never been absent from the facility without notice.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(5) A licensee shall submit a written report to the resident's designated representative and responsible agency in all instances where a resident is absent without notice. The report shall be submitted within 24 hours of each occurrence.
ANALYSIS:	Based on my findings, the licensee has not submitted any IR's regarding Resident A being absent without notice, because although Resident A has communicated that she will elope and begun to walk away from the home as if she is going to elope, she has always returned.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **Resident A does not receive medications as prescribed.**
- **It is difficult to determine what medications Resident A needs while away from Chateau of Novi.**

INVESTIGATION:

On 06/23/2021, I received a complaint from BCAL online complaint unit regarding allegations that Resident A does not receive all of her medication as prescribed.

On 06/23/2021, Ms. Krull sent a letter from the complainants via email. I reviewed the letter from the complainants and noted allegations that when Resident A goes on overnight visits, the medications are provided in blister packs. The medications are punched out on random dates which makes it difficult to verify if Resident received medications as prescribed. Staff had to be reminded that Resident A takes three medications.

On 07/28/2021, I conducted an unannounced onsite where I interviewed Resident A and the home manager, Akeia Williams, and direct care worker (DCW), Dewonza Boyd. Resident A stated that she receives all of her medications.

I interviewed home manager Akeia Williams and DCW Dewonza Boyd. They both reported that medications are punched out of the pill packs on the corresponding date the medication was administered. Ms. Williams stated there was one occasion (date unknown) when there were not enough medications on site to cover Resident A's offsite visit. Relative A was made aware prior to leaving Chateau of Novi with Resident A. Relative A came back to pick up the medications after the pharmacy delivery. Resident A did not miss any medications. Ms. Williams stated that all DCW's are aware of how many medications Resident A is prescribed and the pill packs are provided when Resident A is offsite.

During the onsite, I observed Resident A's medication administration record (MAR). I noted that Resident A is currently prescribed four medications. I did not note any medication errors. I also observed Resident A's pill packs. I did not observe that the pills were randomly punched out.

On 08/27/2021, I interviewed Complainant A1 via telephone. The complainant reiterated the allegations.

On 09/15/2021, I interviewed licensee designee, Tamisha Kaplan via telephone. Ms. Kaplan stated that she directed the home manager and staff to provide the entire pill pack because of previous issues with Resident A not returning to Chateau of Novi on the date/time that staff expected her, which resulted in phone calls and arrangements being made to meet to provide additional medications. Relative A is allowed unlimited overnight visits, so staff provide the entire pill packet and a form that Relative A is supposed to sign to acknowledge that Resident A's medications were taken offsite.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based on my findings, I did not determine that Resident A did not receive medications as prescribed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	Based on my findings, I did not determine that Resident A, or the person who assumes responsibility for Resident A while she is out of the home, did not receive her medication as required.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/28/2021, during the onsite investigation, I observed and took pictures of the following physical plant deficiencies:

- The August 2021 staff schedule documented the names of staff but did not include the hours scheduled to work.
- There was no lid on the kitchen trash can.
- There was a sticky rod covered with dead gnats on the kitchen counter.
- There was no screen or glass installed at the front screen door. I placed my hand directly through the area where the screen should have been and touched the front door.
- The patio screen door has several tears and holes.
- There was a large bag of rice and two large bottles of cooking oil on the floor of the pantry where vermin could possibly access it. The pantry floor was dirty with black stains.
- There was a towel placed on the kitchen floor in front of the refrigerator to absorb fluid that was leaking. It should be noted that this is a repeated licensing rule violation. In 2020, I completed an LSR and cited the same rule violation due to my observation of pots and pans with scratched non-stick coating.
- The facility was dirty. I observed that the patio screen door had a large amount of lint and cobwebs. I observed a large, abandoned bird nest on the rear patio light. I observed a 3–4-inch hole in the wall in the hallway. I observed two dining room chairs with broken arm rests.

- The ramps at the front and rear of Chateau of Novi have not been stained or resealed in several seasons. I observed missing stain. I observed that bedroom #2 and bedroom #3 have sliding glass doors that lead outside. There is a 4–5-foot drop to the ground and no safe egress. There is an alarm installed on the door, but staff would not be able to prevent injury to a resident if they tried to exit from their bedroom sliding doors. I observed that the lawn has not been maintained. I observed weeds overgrowing the front walkway and a large puddle at the curve of the driveway approximately 4 feet long and 3 feet wide.
- I observed that the surface was discolored on a wood table that the residents use in the kitchen area. I observed several missing window blind slats missing throughout the home.
- The roof and gutters were full of leaves and twigs.
- There is thick layer of dust on the heat exchange in the living room. The heat exchange was bent as if it had been kicked.
- There was a large black welcome mat strewn against the front entrance ramp. Part of the mat was on the ramp, and part of the mat was curled in between the ramp's side slats.
- There were several dirty, worn outdoor furniture cushions stacked on the rear patio and on the ground in the backyard. I observed worn, stained furniture cushions on a wicker loveseat on the rear patio. I observed a rusted grill with no handles on the grill hood. I observed two dirty, rusted glass top patio tables, I observed a rusted iron patio chair with no cushions. I observed a large planter full of dirty rainwater on the patio. I observed piles of leaves and an old patio screen door propped against the side of the home.
- There was a tall bin obstructing the exit from the rear ramp. I observed a water hose strewn about the rear ramp.
- The locks were missing from the patio sliding doors which is used a required means of egress.
- There were large black tape strips on the ramp located at the front of the home. The ramp was not flush to the front door landing and there were multiple side rails that were not attached to the ramp. The ramp was wobbly and in need of repair. There were also side rails missing from the ramp at the rear of the home.

On 07/28/2021, I sent the pictures of the physical plant deficiencies to Ms. Kaplan via text message and requested a return phone call.

On 08/02/2021, I interviewed Ms. Kaplan via telephone. Ms. Kaplan stated that she was appalled when she saw the pictures and that she was working to rectify the physical plant deficiencies. Ms. Kaplan stated that due to the pandemic, she has not been able to visit the home as frequently as she did in the past.

On 09/02/2021, I spoke to Ms. Williams via telephone. Ms. Williams stated that several of the physical plant deficiencies have been fixed. Ms. Williams allowed me to view the home via FaceTime. I observed that the rear deck was stained, and the old, rusted furniture and grill were removed from the patio. I observed that the backyard was

cleaned and most of the debris was removed. I observed that the refrigerator was not leaking, and the paint, charcoal and cords had been removed from the dining room.

On 09/15/2021, I spoke to Dawn Krull, ORR and Candid Jamerson, APS. They both stated that they were not substantiating any of the reported allegations.

On 09/17/2021, I conducted an exit conference via telephone with Ms. Kaplan. I shared my findings and recommendation of a provisional license due to repeat violations and several physical plant deficiencies that to date, were not addressed. Ms. Kaplan stated that all of the violations would be addressed. I requested a corrective action plan and explained that Ms. Kaplan could accept or contest my recommendation of a provisional license via a written statement.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: (c) Hours or shifts worked.
ANALYSIS:	On 07/28/2021. I observed that the July 2021 staff schedule documented the names of staff but did not include the hours scheduled to work.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Licensing Study Renewal (LSR) dated 04/13/2018 and Corrective Action Plan (CAP) signed and dated by licensee designee, Tamisha Kaplan on 04/16/2018.** **Reference LSR dated 03/03/2020, and CAP signed and dated by licensee designee Tamisha Kaplan on 04/06/2020.**

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(4) All garbage and rubbish that contains food wastes shall be kept in leakproof, nonabsorbent containers. The containers shall be kept covered with tight-fitting lids and shall be removed from the home daily and from the premises at least weekly.
ANALYSIS:	On 07/28/2021, There was no lid on the kitchen trash can.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	On 07/28/2021 I observed a sticky rod covered with dead gnats on the kitchen counter.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(7) Each habitable room shall have direct outside ventilation by means of windows, louvers, air-conditioning, or mechanical ventilation. During fly season, from April to November, each door, openable window, or other opening to the outside that is used for ventilation purposes shall be supplied with a standard screen of not less than 16 mesh.
ANALYSIS:	On 07/28/2021, I observed that there was no screen or glass installed at the front screen door. The patio screen door had several tears and holes.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14402	**Food service.**
	(2) All food shall be protected from contamination while being stored, prepared, or served and during transportation to a facility.
ANALYSIS:	On 07/28/2021, I observed a large bag of rice and two large bottles of cooking oil on the floor of the pantry where vermin could possibly access it. The pantry floor was dirty with black stains.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14402	**Food service.**
	(4) All food service equipment and utensils shall be constructed of material and that is nontoxic, easily cleaned and maintained in good repair. All food services equipment and eating and drinking utensils shall be thoroughly cleaned after each use.
ANALYSIS:	On 07/28/2021, I observed a towel placed on the kitchen floor in front of the refrigerator to absorb fluid that was leaking.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference LSR dated 03/03/2020, and CAP signed and dated by licensee designee Tamisha Kaplan on 04/06/2020.**

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:	On 07/28/2021, I observed that the patio screen door had a large amount of lint and cobwebs. I observed a large, abandoned bird nest on the rear patio light. I observed two dining room chairs with broken arm rests. The ramps at the front and rear of Chateau of Novi have not been stained or resealed in several seasons. I observed missing stain patches on the ramps. I observed that bedroom #2 and bedroom #3 have sliding glass doors that lead outside to a 3–4-foot drop to the ground. I observed that the lawn has not been maintained. I observed weeds overgrowing the front walkway and a large puddle at the curve of the driveway approximately 4 feet long and 3 feet wide.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference LSR dated 03/03/2020; CAP signed and dated by licensee designee Tamisha Kaplan on 04/06/2020.**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	On 07/28/2021, I observed that the surface was discolored on a wood table that the residents use in the kitchen area. I observed several missing window blind slats missing throughout the home. I observed Resident A's blue fabric chair leaning as if one of the chair legs was broken or missing. I observed a large bucket of paint and a large bag of grill charcoal in the dining room. I observed several tangled cords on the dining room floor I observed the mirror in bedroom #2 propped on the floor leaning against the wall. The mirror was filthy with handprints and streaks. I observed a walker propped against the wall in the living room. I observed dust and debris on the floors throughout the home. I also observed a mob bucket in the middle of the walkway from the living room to the kitchen area, as if the floor was mopped but not swept.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference LSR dated 03/03/2020; CAP signed and dated by licensee designee Tamisha Kaplan on 04/06/2020.**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(4) A roof, exterior walls, doors, skylights, and windows shall be weathertight and watertight and shall be kept in sound condition and good repair.
ANALYSIS:	On 07/28/2021, I observed the roof and gutters were full of leaves and twigs.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair.

ANALYSIS:	On 07/28/2021, I observed that the laminate floor was not flush against the baseboard molding, causing a large amount of dust and debris collected in the gap between the flooring and the wall. I observed a 3–4-inch hole in the wall in the hallway. I observed a thick layer of dust on the heat exchange in the living room. The heat exchange was bent as if it had been kicked.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference LSR dated 03/03/2020; CAP signed and dated by licensee designee Tamisha Kaplan on 04/06/2020.**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(12) Sidewalks, fire escape routes, and entrances shall be kept reasonably free of hazards, such as ice, snow, and debris.
ANALYSIS:	On 07/28/2021, I observed a large black welcome mat strewn against the front entrance ramp.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(13) A yard area shall be kept reasonably free from all hazards, nuisances, refuse, and litter.
ANALYSIS:	On 07/28/2021, I observed I observed several dirty, worn outdoor furniture cushions stacked on the rear patio and on the ground in the backyard. I observed worn, stained furniture cushions on a wicker loveseat on the rear patio. I observed a rusted grill with no handles on the grill hood. I observed 2 dirty, rusted glass top patio tables, I observed a rusted iron patio chair with no cushions. I observed a large planter full of dirty rainwater on the patio. I observed piles of leaves and an old patio screen door propped against the side of the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14507	**Means of egress generally.**
	(2) A means of egress shall be arranged and maintained to provide free and unobstructed egress from all parts of a small group home.
ANALYSIS:	On 07/28/2021, I observed I observed a tall bin obstructing the exit from the rear ramp. I observed a water hose strewn about the rear ramp.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14507	**Means of egress generally.**
	(5) A door that forms a part of a required means of egress shall be not less than 30 inches wide and shall be equipped with positive-latching, non-locking-against-egress hardware.
ANALYSIS:	On 07/28/2021, I observed that the locks were missing from the patio sliding doors which is used a required means of egress.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14509	**Means of egress; wheelchairs.**
	(2) The slope of ramp shall not be more than 1 foot of rise in 12 feet of run and shall terminate on a firm surface or solid unobstructed ground which will allow the wheelchair occupant to move a safe distance away from the building. Ramps shall have handrails on the open sides and be constructed in accordance with the requirements specified in Section 816.0 of the BOCA National Building Code, 1990, eleventh edition.
ANALYSIS:	On 07/28/2021, I observed large black tape strips on the ramp located at the front of the home. The ramp was not flush to the front door landing and there were multiple side rails that were not attached to the ramp. The ramp was wobbly and in need of repair. There were also side rails missing from the ramp at the rear of the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

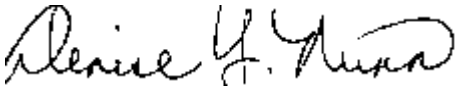
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend modification of the license to provisional.

09/20/2021

Kenyatta Lewis Date
Licensing Consultant

Approved By:



10/27/2021

Denise Y. Nunn Date
Area Manager