GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 5, 2021

Gloria Campbell
Kadima Jewish Support Services For Adults with MI
15999 W Twelve Mile Rd
Southfield, MI 48076

RE: License #: AS630383150
Investigation #: 2021A0465020
Grand 1

Dear Ms. Campbell:

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.

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,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-514-9391
Fax: 517-763-0204
gonzalezs3@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630383150
Investigation #:	2021A0465020
Complaint Receipt Date:	09/10/2021
Investigation Initiation Date:	09/14/2021
Report Due Date:	11/09/2021
Licensee Name:	Kadima Jewish Support Services For Adults with MI
Licensee Address:	15999 W Twelve Mile Rd Southfield, MI 48076
Licensee Telephone #:	(248) 559-8235
Administrator:	Gloria Campbell
Licensee Designee:	Gloria Campbell
Name of Facility:	Grand 1
Facility Address:	28860 Balmoral Way Farmington Hills, MI 48334
Facility Telephone #:	(248) 893-7031
Original Issuance Date:	04/26/2018
License Status:	REGULAR
Effective Date:	10/26/2020
Expiration Date:	10/25/2022
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 9/9/2021, direct care staff, Monica Bubrowski, treated Resident A in a disrespectful manner.	No
On 2/26/2021, direct care staff did not attend to Resident A's safety and protection needs.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/10/2021	Special Investigation Intake 2021A0465020
09/14/2021	Special Investigation Initiated - Letter Spoke to Complainant via phone
10/01/2021	Inspection Completed On-site I reviewed Resident A's record; Interviewed direct care staff, Aaliyah Black and Resident B
10/26/2021	Contact - Document Received Documents received from facility
10/26/2021	Contact – Telephone call made Attempted to contact Guardian A1; Phone number not accepting calls
10/26/2021	Contact – Telephone call made Contacted direct are staff, Monica Bubrowski and LaKimberly Patman
10/29/2021	Inspection Completed-BCAL Sub. Compliance
11/02/2021	Contact – Telephone call made Attempted to contact Guardian A1; Phone number not accepting calls
11/02/2021	Exit Conference Conducted with Ms. Campbell

ALLEGATION:

On 9/9/2021, direct care staff, Monica Bubrowski, treated Resident A in a disrespectful manner.

INVESTIGATION:

On 9/10/2021, a complaint was received, alleging that on 9/9/2021, direct care staff, Monica Bubrowski treated Resident A in a disrespectful manner. The complainant stated that Ms. Bubrowski yelled at Resident A using profane language and that Resident A has a medical condition that can cause her brain to swell when under stress.

On 9/14/2021, I spoke to Complainant, who confirmed that the information contained in the complaint is accurate.

On 10/1/2021, I conducted an onsite investigation at the facility. At the time of my onsite investigation, there were only two residents residing in the home. I interviewed direct care staff, Aaliyah Black, reviewed Resident A's record and interviewed Resident B.

I reviewed Resident A's record. The *Face Sheet* documented that Resident A was admitted to the facility on 8/19/2020 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Schizophrenia (altered mental status) and Hydrocephalus (fluid in the brain). I was unable to locate Resident A's *Assessment Plan for AFC Residents* while onsite at the facility.

I interviewed direct care staff, Aaliyah Black, who stated that she has worked at the facility for six years. Ms. Black stated that she has never observed any staff member, including Ms. Bubrowski, treat Resident A, or any other resident, in a disrespectful manner.

Due to Resident A's medical diagnosis of Schizophrenia and altered mental status, I was unable to interview her for this investigation.

I interviewed Resident B, who stated that she has resided at the facility for one year. Resident B stated that she likes living at the facility. Resident B stated, "The home just got a new roof and I like it here. I don't want to leave to be honest. Staff treat me good. I don't have any problems here. Staff are nice to us all." Resident B denied any concerns related to this allegation.

On 10/26/2021, I interviewed direct care staff, Monica Bubrowski, via telephone. Ms. Bubrowski stated that she has worked at the facility for three years. Ms. Bubrowski stated that she is familiar with Resident A and has provided direct care to her during the time that she has resided at the facility. Ms. Bubrowski stated that Resident A has a history of verbal and physical aggression and altered mental status. Ms. Bubrowksi stated, "I get along well with Resident A. I have never yelled at her or used profanity

when speaking to her. And I have never observed any other staff yell at or treat residents disrespectfully either." Ms. Bubrowski denied that this allegation is true.

On 10/26/2021, I interviewed direct care staff, LaKimberly Patman, via telephone. Ms. Patman stated that she has worked at the facility for several years. Ms. Patman stated that Resident A has a history of confusion, agitation, and verbal/physical aggression. Ms. Patman stated that she has never observed any staff member treat Resident A, or any other resident, in a disrespectful manner.

On 10/26/2021 and 11/2/2021, I attempted to contact Guardian A1. However, Guardian A1's phone number is not currently accepting phone calls as of the date of this report.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.**
ANALYSIS:	According to Ms. Bubrowski, she has never yelled at or used profanity toward Resident A. Ms. Bubrowski denied that this allegation is true. Ms. Black and Ms. Patman have never observed any staff member, including Ms. Bubrowski, treat Resident A, or any other resident, in a disrespectful manner. Resident B likes living at the facility and denied any concerns related to this allegation. Based on the information above, there is not sufficient information to confirm that Ms. Bubrowski has treated Resident A in a disrespectful or degrading manner.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

On 2/26/2021, direct care staff did not attend to Resident A's safety and protection needs.

INVESTIGATION:

On 9/10/2021, a complaint was received, alleging that on 2/26/2021, direct care staff did not attend to Resident A's safety and protection needs. The complaint indicated that on

this date, Resident A was transported to the hospital by law enforcement and staff did not accompany Resident A due to being short-staffed.

During the onsite investigation, I reviewed Resident A's record and was unable to locate an *Incident/Accident Report* for the 2/26/2021 incident.

I interviewed Ms. Patman, who stated that she was the direct care staff on duty on 2/26/2021 when Resident A was transported to the hospital by law enforcement. Ms. Patman stated that on this day, Resident A presented as mentally unstable and in need of emergent medical care. Ms. Patman stated, "In the morning, Resident A was agitated and was threatening staff. We administered medication to her, but it didn't help. I called Easter Seals and requested a petition to have Resident A admitted to the hospital. The police came to the home to transport Resident A to the hospital, but I couldn't go with her. I was the only staff on duty. I called Ms. Campbell to let her know what was going on and then I completed an incident report. No staff ever went to the hospital to stay with Resident A."

I interviewed Ms. Campbell, who stated that on the day that Resident A was transported to the hospital, on 2/26/2021, there were no direct care staff available to follow law enforcement during the transport nor remain with Resident A at the hospital while she awaited admission. Ms. Campbell acknowledged that on 2/26/2021, Resident A was taken to the hospital by law enforcement without staff supervision or assistance to attend to Resident A's protection and safety needs.

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:	According to Ms. Patman, she was the direct care staff on duty on 2/26/2021 when Resident A was transported to the hospital by law enforcement. Resident A presented as mentally unstable, agitated, verbally aggressive and in need of emergent medical care. Ms. Patman observed Resident A's unstable mental state to be significant enough to request Resident A be petitioned for inpatient hospitalization. Due to limited staffing, a staff member was not available to meet Resident A at the hospital to assist with direct care and the hospital admission process. According to Ms. Campbell, on 2/26/2021, the day that Resident A was transported to the hospital, there were no direct care staff available to follow law enforcement during the transport nor remain with Resident A at the hospital while she awaited admission. Ms. Campbell acknowledged Resident A was taken

	to the hospital by law enforcement without staff supervision or assistance to attend to Resident A's protection and safety needs while awaiting admission to the hospital. Based on the information above, on 2/26/2021, the facility did not attend to Resident A's personal needs, including protection and safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

At the time of my onsite investigation on 10/1/2021, I was unable to locate Resident A's *Assessment Plan for AFC Residents*.

On 10/27/2021, Ms. Campbell stated, via an email exchange, that she is unable to locate Resident A's assessment plan. Ms. Campbell stated that she believes the assessment plan is currently in the possession of Guardian A1, awaiting review and signature.

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:	At the time of my onsite investigation, on 10/1/2021, I was unable to locate Resident A's *Assessment Plan for AFC Residents*. On 10/27/2021, Ms. Campbell was unable to locate Resident A's assessment plan. Ms. Campbell believes the assessment plan is currently in the possession of Guardian A1, awaiting review and signature.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

At the time of my onsite investigation, on 10/1/2021, I was unable to locate Resident A's *Incident/Accident Report* for the 2/26/2021 hospitalization. I also reviewed the facility's AFC licensing file and was unable to confirm that the facility sent a written incident report to me within 48 hours of the incident occurrence, as required per licensing rules.

On 10/27/2021, Ms. Campbell stated, via an email exchange, that she is unable to locate the incident report and is unable to provide it for department review nor able to confirm that she sent it to LARA within the time frame required per licensing rules.

On 11/2/2021, I conducted an exit conference with Ms. Campbell. She is in agreement with the findings of this investigation.

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: **(b) Any accident or illness that requires hospitalization** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.**
ANALYSIS:	At the time of my onsite investigation, I was unable to locate Resident A's *Incident/Accident Report* for the 2/26/2021 hospitalization. I also reviewed the facility's AFC licensing file and was unable to confirm that the facility sent a written incident report to me within 48 hours of the incident occurrence, as required per licensing rules. On 10/27/2021, Ms. Campbell stated, via an email exchange, that she is unable to locate the incident report and is unable to confirm that she sent it to LARA within the time frame required per licensing rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

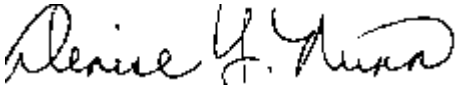
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the license remains unchanged.

11/2/2021

Stephanie Gonzalez — Date
Licensing Consultant

Approved By:



11/05/2021

Denise Y. Nunn — Date
Area Manager