GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 8, 2021

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

RE: License #: AS630293956
Investigation #: 2021A0465019
Pitt Home

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.

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,

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
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630293956
Investigation #:	2021A0465019
Complaint Receipt Date:	09/09/2021
Investigation Initiation Date:	09/09/2021
Report Due Date:	11/08/2021
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:	Pitt Home
Facility Address:	32735 Olde Franklin Farmington, MI 48334
Facility Telephone #:	(248) 663-4337
Original Issuance Date:	04/10/2008
License Status:	REGULAR
Effective Date:	07/22/2021
Expiration Date:	07/21/2023
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 9/7/2021, Resident A was found wandering the streets, disoriented and without staff supervision.	Yes
Direct care staff are confining Resident A to his bedroom at night.	No
Resident A is not being provided his prescribed special diet.	Yes
The facility is dirty.	No
Additional Findings	Yes

III. METHODOLOGY

09/09/2021	Special Investigation Intake 2021A0465019
09/09/2021	Special Investigation Initiated - Letter Email exchange with Complainant
09/24/2021	Inspection Completed On-site Interviewed direct care staff, Geoffrey Ogholo; Interviewed Resident B and Resident C. Attempted to review Resident A's record, informed by Ms. Campbell that a record is unable to be located for review.
10/20/2021	Contact – Telephone call made Interviewed direct care staff, Dallas Sweeney
10/28/2021	Inspection Completed-BCAL Sub. Non-Compliance
11/01/2021	Contact – Telephone call received Spoke to CNS State Hospital Liaison, Mary Ann Bucalos
11/02/2021	Exit Conference Conducted Exit Conference with Ms. Campbell

ALLEGATION:

On 9/7/2021, Resident A was found wandering the streets, disoriented and without staff supervision.

INVESTIGATION:

On 9/7/2021, an *Incident Report* was received, which indicated that Resident A was found wandering the streets on 9/6/2021 by an off-duty employee. The incident report indicated the following:

- 09/6/2021 at 8:10am: When the manager (LaMonica Glover) arrived to the home, the midnight staff (Brooke Ferguson) notified the mgr. that Resident A left the home without signing out. The second morning staff (Dallas Sweeney) saw Resident A standing on Middlebelt street while she was coming to work and picked him up. Midnight staff called 911 and contacted the home manager. The home manager tried to explain to Resident A the importance of signing out when he wants to leave. Also told Resident A he should never leave the home alone during a midnight shift.

On 09/24/2021, I conducted an onsite investigation at the facility. I interviewed direct care staff, Geoffrey Ogholo, Resident B and Resident C.

I reviewed the *Resident Registrar*, which listed Resident A's admission date to the facility as 8/30/2021. I attempted to review Resident A's record but direct care staff, Godfrey Ogholo, was unable to locate the file.

During the onsite investigation on 09/24/2021, I interviewed Mr. Godfrey, who stated that Resident A has a history of delusions and hallucinations and does not have a legal guardian. At the time of the onsite investigation, Resident A was admitted to the hospital, and it is unknown if, and when, he will be returning to the facility.

On 10/20/2021, I interviewed direct care staff, Dallas Sweeney, via telephone. Ms. Sweeney stated that she has been working at the facility for seven months. Ms. Sweeney stated that she is familiar with Resident A and has provided direct care to him during the time that he has resided at the facility. Ms. Sweeney stated that Resident A has a history of delusions, confusion, agitation, aggressive behavior and wandering. Ms. Sweeney stated, "On 9/6/2021, I was driving to work at approximately 7:45am, and I saw someone walking down the street. I looked closer and I saw that it was Resident A. I stopped and offered him a ride. He got into my car but was very confused. He kept saying he was God and saying things that didn't make any sense. He was very upset, and I was trying to keep him calm until I was able to get him back to the facility. When I got him back to the facility, the staff knew that he was missing and didn't know where he was. I am not sure how long he was missing from the facility before I found him in the street." Ms. Sweeney acknowledged that, based on Resident A's level of cognitive functioning, he requires supervision in the community. Ms. Sweeney stated, "When he

was first admitted, we didn't know anything about him. We didn't know if he could go out in the community unsupervised. But now we know he can't."

I attempted to interview Ms. Ferguson and Ms. Glover via telephone, but I have not received a return call as of the date of this report.

I interviewed licensee designee, Gloria Campbell, via telephone while onsite at the facility. Ms. Campbell confirmed that Resident A was admitted to the facility on 8/30/2021. Ms. Campbell stated that the facility has not obtained or completed any AFC/resident documents for Resident A as of yet, due to staffing issues. Ms. Campbell stated that is unknown exactly what time Resident A eloped from the facility prior to being found by Ms. Sweeney.

On 11/1/2021, I interviewed Mary Ann Bucalos, the CNS state hospital liaison for Resident A. Ms. Bucalos stated that Resident A has a medical diagnosis of Schizoaffective Disorder with Bipolar Type, and has a history of manic episodes, verbal and physical aggression, alcohol use, and wandering/elopement. Ms. Bucalos stated that, prior to Resident A's admission to the facility on 8/30/2021, she informed Ms. Campbell of Resident A's medical diagnosis and behavioral history. Ms. Bucalos stated that Resident A presented as mentally stable at the time he was admitted to the facility, but immediately after admission, began to have manic episodes and his mental state deteriorated quickly. Ms. Bucalos stated that Resident A is currently hospitalized and has been discharged from the facility.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	On 9/6/2021, Resident A was found wandering the streets at 7:45am, confused, disoriented and agitated, by Ms. Sweeney. It is unknown exactly how long Resident A was missing from the facility prior to be found by Ms. Sweeney. Ms. Sweeney acknowledged that, based on Resident A's altered mental state, he required supervision in the community. At the time of admission, the facility failed to properly assess Resident A's personal needs, including protection and safety needs. The failure to properly assess Resident A's protection and safety needs, allowed Resident A to elope from the facility without staff awareness, as well as inappropriate corrective measures being implemented by staff upon Resident A's return to the facility.

	Based on the information above, on 9/6/2021, the facility did not attend to Resident A's personal needs of protection and safety. At the time of Resident A's elopement from the facility, he had been residing at the facility for seven days, during which time he displayed altered mental status, including delusional and hallucinatory thinking. Despite Resident A's altered mental status, he was able to wander away from the facility on 9/6/2021 without staff being aware. When Resident A was found by Ms. Sweeney at 7:45am, he was disoriented and confused. Upon returning to the facility, while in an altered mental state, Resident A was advised by staff of the importance of signing out before leaving the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Direct care staff are confining Resident A to his bedroom.

INVESTIGATION:

On 9/9/2021, a complaint was received, alleging that direct care staff are confining Resident A to his bedroom. The complaint indicated that direct care staff are preventing Resident A was staying up past curfew time, which is 10:00pm. The complaint indicated that direct care staff are not allowing Resident A to leave his bedroom to go outside for a cigarette break after 10:00pm.

On 9/9/2021, I spoke to Complainant, who confirmed the information in the complaint as accurate.

On 09/24/2021, I conducted an onsite investigation at the facility. I interviewed direct care staff, Geoffrey Ogholo, Resident B and Resident C.

On 9/24/2021, during the onsite investigation, I interviewed Mr. Godfrey, who stated that the facility has a curfew of 10:00pm for all residents. Mr. Godfrey stated, "We do have a 10pm curfew for all residents, but residents are still allowed to come out of their rooms after 10pm and go outside to smoke if they want to. I have never confined a resident in their room and have never heard of another staff doing that either." Mr. Godfrey denied any knowledge of Resident A ever being confined to his room.

I interviewed Resident B, who stated that he has been residing at the facility for almost two years. Resident B stated, "It's good living here. We do have a curfew at 10pm, but we can still go outside after 10pm and smoke whenever we want. Staff don't stop us, and we can come out of our rooms and go outside if we want to smoke. Staff don't make us stay in our rooms."

I interviewed Resident C, who stated that he has been residing at the facility for three years. Resident C stated that he is allowed to go outside and smoke at any time, even after the 10:00pm curfew time. Resident C stated, “We never get locked in our rooms or told we can’t come out of our rooms. Staff let us go outside to smoke at night. I have never seen anyone get locked in their room by staff.”

Due to Resident A’s medical diagnosis and current hospitalization, he was unable to be interviewed for this investigation.

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 other person who lives in the home shall not do any of the following: **(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 any manner.**
ANALYSIS:	According to Mr. Godfrey, the facility has a curfew of 10:00pm, but residents are still allowed to come out of their rooms after 10:00pm and go outside to smoke. Mr. Godfrey denied any knowledge of Resident A ever being confined to his room. According to Resident B and Resident C, they have been residing at the facility for several years. Although there is a curfew of 10:00pm, residents are still allowed to leave their rooms throughout the night to go outside and smoke cigarettes. Resident B and Resident C denied any knowledge of a time when any resident, including Resident C, was confined to their room against their will. Based on the information above, there is not sufficient information to confirm that direct care staff have confined Resident A to his bedroom.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A is not being provided his prescribed special diet.

INVESTIGATION:

On 9/9/2021, a complaint was received, alleging that the facility is not providing Resident A with his prescribed special diet. The complaint indicated that Resident A is not being provided a Kosher food diet.

During my onsite investigation, there were no resident records for Resident A available for review.

I interviewed Mr. Godfrey, who stated that Resident A has requested a special Kosher diet. Mr. Godfrey stated that Resident A does not have any documents at the facility to confirm or deny that he is prescribed a special diet by a physician.

I interviewed Ms. Sweeney, who stated that Resident A demanded a Kosher food diet. Ms. Sweeney stated that she has not reviewed Resident A's health care appraisal or other documents and is unsure if Resident A is prescribed a special diet by a physician.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	During my onsite investigation, I was unable to review Resident A's *Health Care Appraisal*, as well as other resident records, to determine if he is prescribed a special diet. Resident A has requested a special Kosher diet. Resident A does not have any documents at the facility to confirm or deny that he is prescribed a special diet by a physician. According to Ms. Campbell, Resident A's file, and all required paperwork, have not yet been completed and were unavailable for review during my onsite investigation. Based on the information above, the facility does not have the necessary documents available to determine whether or not Resident A has been prescribed a special diet by a physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility is dirty.

INVESTIGATION:

On 9/9/2021, a complaint was received, alleging that the facility is dirty. The complaint did not provide additional details.

On 09/24/2021, I conducted an onsite investigation at the facility and completed a walk-through of the entire facility. I observed all the of the resident bedrooms and common areas of the home. I observed the home to be well organized, free from clutter and in a clean and orderly condition. I did not observe any concerns related to the health, safety and well-being of residents.

I interviewed Mr. Godfrey, who stated that the facility is cleaned and sanitized multiple times throughout the day on a continuous basis. Mr. Godfrey denied any knowledge of a time when the facility was dirty or a health risk to residents.

I interviewed Ms. Sweeney, who stated that the facility is cleaned and sanitized multiple times throughout the day on a continuous basis. Ms. Sweeney denied any knowledge of a time when the facility was dirty or a health risk to residents.

I interviewed Resident B, who stated that he does not have any concerns related to the cleanliness of the facility. Resident B stated that the facility is kept in a clean condition. Resident B did not vocalize any concerns related to this allegation.

I interviewed Resident C, who stated that he does not have any concerns related to the cleanliness of the facility. Resident C did not vocalize any concerns related to this allegation.

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 09/24/2021, I completed a thorough walk-through of the entire facility. I observed all the of the resident bedrooms and common areas of the home. I observed the home to be well organized, free from clutter and in a clean and orderly condition. I did not observe any concerns related to the health, safety and well-being of residents. Based on the information above, the facility is being maintained adequately for the health, safety and well-being of residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 09/24/2021, I conducted an onsite investigation at the facility. I reviewed the Resident Registrar, which listed Resident A's admission date to the facility as 8/30/2021. I attempted to review Resident A's record but direct care staff, Godfrey Ogholo, was unable to locate the file. While at the facility, I contacted licensee designee, Gloria Campbell, via telephone. Ms. Campbell stated that Resident A's file, and all paperwork, has not yet been completed and is unavailable for review.

On 11/2/2021, I conducted an exit conference with licensee designee, Gloria Campbell. Ms. Campbell is in agreement with the provisional license issuance.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Based on the information above, the facility did not obtain a written health care appraisal for Resident A prior to his admission to the facility on 8/30/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.** **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.** **(c) The resident appears to be compatible with other residents and members of the household.**
ANALYSIS:	Based on the information above, the facility did not complete a written assessment of Resident A prior to his admission to the facility on 8/30/2021, to determine his suitability for admission to the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 the information above, the facility did not complete a written assessment plan with Resident A and Ms. Bucalos prior to his admission to the facility on 8/30/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.** **(b) A description of services to be provided and the fee for the service.** **(c) A description of additional costs in addition to the basic fee that is charged.** **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.** **(e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission.** **(f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule.** **(g) An agreement by the resident to follow the house rules that are provided to him or her.** **(h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident.** **(i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures.** **(j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.14315.** **(k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met.** **(l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.**

ANALYSIS:	Based on the information above, the facility did not complete a written resident care agreement with Resident A and Ms. Bucalos prior to Resident A's admission to the facility on 8/30/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Based on the information above, the facility has not completed funds and valuables transaction forms for Resident A.
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: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number, date of birth, case number, and marital status.** **(iii) Former address.** **(iv) Name, address, and telephone number of the next of kin or the designated representative.** **(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.**

	(ix) Resident's religious preference information. **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.**
ANALYSIS:	Based on the information above, the facility has not completed and maintained in the home, a record for Resident A with the information listed above, as required by the department.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that a six-month provisional license be issued.

Stephanie Gonzalez

11/2/2021

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Stephanie Gonzalez — Date
Licensing Consultant

Approved By:

Denise Y. Nunn

11/08/2021

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Denise Y. Nunn — Date
Area Manager