GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 31, 2022

Paula Ott
Central State Community Services, Inc.
Suite 201
2603 W Wackerly Rd
Midland, MI 48640

RE: License #: AS500404109
Investigation #: 2021A0990024
Brandenburg

Dear Ms. Ott:

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,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500404109
Investigation #:	2021A0990024
Complaint Receipt Date:	09/29/2021
Investigation Initiation Date:	09/30/2021
Report Due Date:	11/28/2021
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 - 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Paula Ott
Licensee Designee:	Eva Hemphill
Name of Facility:	Brandenburg
Facility Address:	50351 Jefferson Chesterfield, MI 48047
Facility Telephone #:	(586) 273-7015
Original Issuance Date:	01/19/2021
License Status:	REGULAR
Effective Date:	07/19/2021
Expiration Date:	07/18/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff Michelle Burmistrzak, Breonia Standiefor and Charlene Goldenbogen were sleeping on their shift on 09/04/2021 at 3:30PM.	Yes
Staff were unaware that Resident A left the home. Staff refused to install an alarm system after several requests.	No
Staff neglected to take Resident A to physical therapy (PT), occupational therapy (OT), and baseball practice on 09/07/2021 and in August.	Yes
Resident A was given his prescribed medications twice improperly resulting in an overdose.	Yes
Medications were observed to be in disarray in the office on 09/26/2021.	No
Resident A is not given a proper diet as prescribed by his doctor.	No
Resident A was sent to school on 09/09/2021 and 09/26/2021 unshaved and unbathed.	No
Additional Findings	Yes

III. METHODOLOGY

09/29/2021	Special Investigation Intake 2021A0990024
09/30/2021	APS Referral Adult Protective Services (APS) referral complaint sent via email.
09/30/2021	Special Investigation Initiated - Letter I emailed Relative A requesting information regarding Resident A. Relative A response via email on 09/30/2021.
10/07/2021	Contact - Telephone call received I received a phone call from Relative A and conducted a phone interview.
10/14/2021	Contact - Telephone call received

	I conducted a phone interview with Jim Bellamy, APS investigator.
10/18/2021	Contact - Document Sent I emailed Relative A. No response received to date.
11/02/2021	Inspection Completed On-site I conducted an onsite. I was not able to enter due to active COVID-19 cases in the home. conducted a brief interview with Megan Kruczynski, home manager outside.
12/06/2021	Contact - Telephone call made I conducted a phone interview with Michelle Burmistrzak, direct care staff.
12/06/2021	Contact - Telephone call made I left a detailed message for Corin Delay, direct care staff.
12/06/2021	Contact - Telephone call made I conducted a phone interview with Melissa Gray, Behaviorist
12/06/2021	Contact - Telephone call made I left a detailed message with Susan Polkowski, supports coordinator. Ms. Polkowski returned call and said that Resident A is a new client, and she is not familiar with the allegations.
12/06/2021	Contact - Telephone call made I conducted a phone interview with Marquise Little, direct care staff.
12/06/2021	Contact - Telephone call made I conducted a phone interview with direct care staff Breonia Standiefor.
12/06/2021	Contact - Telephone call made I conducted a phone interview with Amber Matejowsky.
12/06/2021	Contact - Document Received I reviewed documents requested at an earlier date.
12/06/2021	Contact - Telephone call made Left detailed message for Charlene Goldenbogen. No return call received to date.
12/21/2021	Contact - Telephone call made I contacted Lutz School to conduct a phone interview with Resident A.

12/21/2021	Contact - Telephone call made I conducted phone interviews with Resident B, and Resident C.
12/21/2021	Contact - Telephone call made I conducted a phone interview with Meagan Kraczynski- home manager.
01/18/2022	Exit conference I conducted an exit conference with Eva Hemphill.

ALLEGATION:

Direct care staff Michelle Burmistrzak, Breonia Standiefor and Charlene Goldenbogen were sleeping on their shift on 09/04/2021 at 3:30PM.

INVESTIGATION:

On 09/29/2021, I received the online complaint via email. The complaint was received as a written fax from the reporting person.

On 10/07/2021, I received a phone call from Relative A and conducted a phone interview. Relative A said that Resident A is currently hospitalized. Relative A said that Brandenburg is Resident A's first placement outside of the family home. Relative A mentioned that there is concern that there have been many police calls to the home by another resident for unknown reasons. Relative A said that the home manager Charlene Goldenbogen recently quit, and Megan Kruczynski is the new home manager. Relative A said that there is a lot of unprofessionalism occurring in the home. Relative A said that her spouse, Relative A1 observed the staff asleep during a shift. Relative A said that her Relative A1 was not available to discuss the allegations.

On 12/06/2021, I conducted a phone interview with Michelle Burmistrzak, direct care staff. Ms. Burmistrzak said that she was not present when the situation occurred but heard about it through her colleagues. Ms. Burmistrzak said that she was told that direct care staff Breonia Standiefor and Charlene Goldenbogen were the two staff that were caught sleeping on the shift. Ms. Burmistrzak said that she was not working on 09/04/2021 and could not attest to staff sleeping on the shift. Ms. Burmistrzak said that in the past it was reported that she was sleeping during a midnight shift, but this was untrue. Ms. Burmistrzak said that on the day she was accused of sleeping on shift, she was sitting on the sofa in which, the back of the sofa faces the living room door and Relative A entered the home. Ms. Burmistrzak said that she was looking down at her phone when Relative A entered and was not sleeping as it appeared based on her sitting position. Ms. Burmistrzak said that she had observed one staff person sleeping in the office (name disclosed but will not be documented in the report).

On 12/06/2021, I conducted a phone interview with Marquise Little, direct care staff. Mr. Little said that he could not attest to the validity of this allegation because he does not work the midnight shift. Mr. Little denied having knowledge or observing Ms. Burmistrzak or Ms. Standiefor sleeping during work. Mr. Little said that he did observe Charlene Goldenbogen sleeping on shift and he documented this. Mr. Little did not provide specific dates or other information regarding Ms. Goldenbogen sleeping on shift.

On 12/06/2021, I conducted a phone interview with direct care staff Breonia Standiefor. Ms. Standiefor denied that she sleeps on her shift. Ms. Standiefor said that she works the day shift. Ms. Standiefor denied observing any staff sleeping on their shift.

On 12/06/2021, I conducted a phone interview with Amber Matejowsky. Ms. Matejowsky said that she worked the midnight shift from 11PM to 11AM and has never worked the same shift as Ms. Burmistrzak. Ms. Matejowsky said that she and Ms. Burmistrzak are roommates and do not work the same shift. Ms. Matejowsky has only observed Charlene Goldenbogen always being on her phone video chatting and not doing her job.

On 12/06/2021, I reviewed the staff schedule and observed that on 09/04/2021 Meagan Kruczynski, Marquis Little and Michelle Burmistrzak were on schedule at 3:30PM.

On 12/21/2021, I contacted Lutz School to conduct a phone interview with Resident A. I was transferred to the social work department. I left a detailed message. I received a phone call back from the social worker, Tony Woznicki who stated that he conferenced with staff as well as Resident A's guardians and it was determined that a phone or face to face interview at school could not be granted. Mr. Woznicki worker said that due to Resident A's disability, he could not handle being interviewed as it would be extremely emotionally upsetting and staff would have a challenging time calming him down. Mr. Woznicki said that more than likely when Resident A is upset or pulled from his routine, he will elope from the building.

On 12/21/2021, I conducted phone interviews with Resident B and Resident C. Resident B denied observing staff sleeping on shift. Resident C did not understand the question and only repeated the question back to me.

On 12/21/2021, I conducted a phone interview with Meagan Kruczynski - home manager. Ms. Kruczynski said that she was not present during the shift that afternoon shift on 09/26/2021 and did not observe staff sleeping. Ms. Kruczynski said that Michelle Burmistrzak and Charlene Goldenbogen both worked the day shift. Ms. Kruczynski became aware of the allegation through the APS investigation. Ms. Kruczynski said that she has observed both sleeping on their shift when they both worked 36 hours straight.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	According to the staff schedules reviewed, on 09/04/2021 Meagan Kruczynski, Marquis Little and Michelle Burmistrzak were on schedule and worked at 3:30PM. Ms. Burmistrzak denied sleeping on shift but reported that she observed at least one staff person sleeping on shift. Mr. Little observed Charlene Goldenbogen sleeping on shift, but no specific date was provided. Ms. Matejowsky has observed Charlene Goldenbogen always on her phone video chatting and not doing her job. Ms. Kruczynski has observed both Michelle Burmistrzak and Charlene Goldenbogen sleeping on their shift when they both worked 36 hours straight. Based on the above interviews there is sufficient information to support that there have been multiple times that staff were not properly supervising Resident A because they were sleeping during shift. Further, Resident A's IPOS documents that he requires 24/7 specialized care.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff were unaware that Resident A left the home. Staff refused to install alarm system after several requests.

INVESTIGATION:

On 09/29/2021, I emailed Relative A requesting information regarding Resident A. Relative A responded via email on 09/30/2021. Relative A said that Resident A left Brandenburg on Saturday evening at approximately 7:20 pm on September 11, 2021 unsupervised. According to Relative A, there was only one staff present at that time. Relative A said it was direct care staff person Michelle Burmistrzak, and she was not aware that Resident A took the house phone and left the home unsupervised.

Relative A said that Resident A's behavior plan addresses the necessity of an alarm system due to his elopement issues. Relative A said that this plan will be revised during the next meeting with the behaviorist, Melissa Gray. Relative A said that the alarm

system was installed earlier this summer however, it was removed without notification. Relative A said that Resident A ran away from the home shortly after the alarm system was removed. Relative A said that this elopement incident resulted in Resident A being hospitalized at Pontiac General Hospital. Relative A did not provide a specific date as to when Resident A was hospitalized or when the alarms were removed from the home.

On 10/07/2021, I received a phone call from Relative A. Relative A said that while direct care staff Michelle Burmistrzak was working, Resident A took the phone around 7:30PM and called her from outside alone. Relative A said that Resident A was in the backyard when he called her. When Relative A asked Resident A where he was going, he said that he was going to the park next door. Relative A said there is concern that Resident A was outside unsupervised. Relative A did not provide additional information pertaining to this allegation.

Relative A said that door alarms were installed at one point however, the exact timeframe was not mentioned. Relative A said that the door alarms were removed because another resident did not like the alarms. Relative A was told this by staff however, she did not provide a date or name of when and who informed her of this.

On 12/06/2021, I conducted a phone interview with Michelle Burmistrzak, direct care staff. Ms. Burmistrzak said that she was present when Resident A left the home on 09/11/2021. Ms. Burmistrzak was showering a resident and Resident A asked if he could go to the park and she told him that he had to wait until later. Resident A came back two seconds later and asked if he could use the phone to call his mother. Ms. Burmistrzak said that Resident A called his mother, and she could hear him talking on the phone. Ms. Burmistrzak went into the bathroom to assist the resident to exit the shower and she no longer heard Resident A talking on the phone. Ms. Burmistrzak said that she went to look for Resident A and observed him standing on the backyard porch talking on the phone still. Ms. Burmistrzak told Resident A to come back inside. Ms. Burmistrzak said that Resident A was outside less than one minute alone. Ms. Burmistrzak had heard that Resident A had gotten outside before during a shift with Charlene Goldenbogen. Ms. Burmistrzak said that she heard that Resident A went outside and across the street. Ms. Burmistrzak was told that a police report was made regarding that incident. Ms. Burmistrzak said that the family requested door alarms but is unsure as to why they were not installed.

On 12/06/2021, I conducted a phone interview with Melissa Gray, Behaviorist. Ms. Gray said that door alarms were in discussion but had not been implemented to the home for Resident A. Relative A requested that this be added to his behavioral plan because he has a history of elopement. Ms. Gray said that before the alarms could be placed in the plan, Resident A moved back to his family home. Ms. Gray said that prior to Resident A being discharged from the home, the staff were informed that alarms may be put on the doors, and they were all in agreement. Ms. Gray said that Resident A had elopement issues prior to being placed into the home. Resident A is diagnosed with intermediate explosive disorder, OCD and autism disorder. To Ms. Gray's knowledge, Resident A only had one elopement issue in the home, in which he went down the

street away from the home but did not recall the specific dates or time. Ms. Gray said that when Resident A does not get his way, he will elope, and interventions are placed in his plan to reduce this reaction. Ms. Gray said that before door alarms could be placed on the home, it would also have to be mentioned in the other residents' plan which takes time.

On 12/06/2021, I conducted a phone interview with Marquise Little, direct care staff. Mr. Little said that he recalls hearing from one of his colleagues that Resident A ran out during a shift that Charlene Goldenbogen worked. Mr. Little was told that Ms. Goldenbogen told Resident A to put on his shoes in an aggressive tone and therefore Resident A ran outside and away from the home. Mr. Little said that there were door alarms placed on the doors at one point, but they were removed because another resident had an issue with the noise it made. To Mr. Little's knowledge, the door alarms were installed for Resident A but were removed because the alarms endangered a different resident, Resident D.

On 12/06/2021, I conducted a phone interview with direct care staff Breonia Standiefor. Ms. Standiefor said she is unaware of the Resident A leaving the home unsupervised or door alarms needing to be installed.

On 12/06/2021, I conducted a phone interview with Amber Matejowsky. Ms. Matejowsky began working at the home on 08/18/2021. Ms. Matejowsky said that she is not aware of door alarms placed on the home. Ms. Matejowsky said that door alarms are restrictive. Ms. Matejowsky was only aware of one incident in which Resident A got out of the home and was standing in the driveway.

On 12/06/2021, I reviewed Resident A's Individual Plan of Service (IPOS) dated 06/30/2021. The IPOS indicates that Resident A is to receive 24/7 specialized care. There are no door alarms documented in the IPOS. I observed in Resident A's crisis plan that his behavioral challenges are elopement and that he does like loud noises and commotion. The crisis plan documents that Resident A lacks impulse control.

On 12/21/2021, I conducted phone interviews with Resident B and Resident C. Resident B or Resident C were not asked questions due to their limited cognitive abilities.

On 12/21/2021, I conducted a phone interview with Meagan Kruczynski - home manager. Ms. Kruczynski said that there were conversations about installing door alarms for Resident A by his Supports Coordinator. Ms. Kruczynski said that door alarms were not part of his plan. Resident A had elopement issues. Ms. Kruczynski recalls that one-time Resident A eloped once and the police were called. He was found very close to the home and unharmed.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the investigation there is insufficient information that staff improperly supervised Resident A. According to direct care staff person Michelle Burmistrzak, on 09/11/2021, Resident A stepped out of the home to the backyard. Resident A was not out of her eyesight for less than one minute and was already using the phone speaking to Relative A. There are no door alarms documented in Resident A's IPOS. In Resident A's crisis plan, his behavioral challenges are elopement. The crisis plan documents that Resident A lacks impulse control. Further, Resident A's Behaviorist confirmed that there were no door alarms in his plan. Ms. Gray said that there were conversations about installing this, but Resident A was discharged from the home. Additionally, direct care staff, Ms. Burmistrzak, Mr. Little, Ms. Matejowsky and Ms. Kruczynski-home manager all deny that there were door alarms to be installed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff neglected to take Resident A to physical therapy (PT), occupational therapy (OT), and baseball practice on 09/07/2021 and in August.

INVESTIGATION:

On 09/29/2021, I emailed Relative A requesting information regarding Resident A. Relative A responded via email on 09/30/2021. Relative A said that Resident A attends Quality Care Rehab/Autism Center on Tuesdays, 4-6pm and on Saturdays, 9:45 to 11:45am. Resident A's baseball schedule is as follows: Wednesdays 6:30pm, September 15 and 22; Saturdays September 11, 16, 18, 25 and 29, 2021.

On 10/07/2021, I received a phone call from Relative A. Relative A said that Resident A missed a baseball game on 09/11/2021 because the staff neglected to take him to the game. Relative A said that there is no communication between the staff. Relative A said that Resident A missed baseball practice three times.

On 12/06/2021, I conducted a phone interview with Michelle Burmistrzak, direct care staff. Ms. Burmistrzak said that she was made aware of Resident A missing baseball practice because someone forgot to put it on the home's calendar. Ms. Burmistrzak recalls asking direct care staff Marquis Little during shift change (specific date not provided), if Resident A had any appointments and he told her that he did not. Ms. Burmistrzak said that she received a phone call around 11:30AM from Relative A informing her that Resident A was supposed to be at baseball practice. Ms. Burmistrzak told Relative A she could not take him because she was working alone with six residents. Ms. Burmistrzak said from what she recalls, Resident A attended physical therapy and occupational therapy on Thursdays and she only took him twice.

On 12/06/2021, I conducted a phone interview with Marquise Little, direct care staff. Mr. Little denied not getting Resident A to his appointments during his shifts. Mr. Little said that there is one staff person that does not have a driver's license and is not able to transport Resident A to and from appointments.

On 12/06/2021, I conducted a phone interview with direct care staff Breonia Standiefor. Ms. Standiefor said during that timeframe, mid September to late September, she worked the night shift and was unaware of the day activities.

On 12/06/2021, I conducted a phone interview with Amber Matejowsky. Ms. Matejowsky said that from what she recalled, Resident A was always taken to all these activities such as OT, PT, baseball and swimming. Ms. Matejowsky or Megan Kruczynski would transport him. Ms. Matejowsky said that Charlene Goldenbogen was the only staff person that did not transport because she did not have a driver's license.

On 12/06/2021, I reviewed Resident A's IPOS which documents that Quality Care will provide his OT two times per week and PT three times per week. I observed that Resident A's *Resident Care Agreement* documented that transportation is deemed necessary by his IPOS with a limitation of 56 miles. I observed on the staff schedule for 09/07/2021, Charlene Goldenbogen worked and Amber Matejowsky.

On 12/21/2021, I conducted a phone interview with Meagan Kruczynski - home manager. Ms. Kruczynski had no information about Resident A missing appointments. Ms. Kruczynski said that the previous manager (Charlene Goldenbogen) was not keeping up the schedules.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(4) A licensee shall provide all of the following: (c) An opportunity for community-based recreational activities.

ANALYSIS:	According to Relative A, Resident A missed a baseball game on 09/11/2021 because the staff neglected to take him to the game and Resident A missed baseball practice at least three times. Ms. Burmistrzak was made aware of Resident A missing baseball practice because someone forgot to put it on the home's calendar. Due to Ms. Burmistrzak working alone on the day of the incident (specific date not recalled), Resident A missed practice. Charlene Goldenbogen was the only staff person that did not transport because she did not have a driver' license. Further, Resident A's IPOS documents that Quality Care will provide his OT two times per week and PT three times per week. Resident A's *Resident Care Agreement* documented that transportation is deemed necessary by his IPOS. There is sufficient evidence to support that Resident A was not transported to his community-based recreational activities per his IPOS.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **Resident A was given his prescribed medications twice improperly resulting in an overdose.**
- **Medications were observed to be in disarray in the office on 09/26/2021.**

INVESTIGATION:

On 10/07/2021, I received a phone call from Relative A. Relative A said that on 09/12/2021, during the second shift, the former home manager Charlene Goldenbogen, gave Resident A his medications twice. Relative A said Ms. Goldenbogen told her that the first shift's staff did not document that Resident A's medications were passed therefore, she passed them to Resident A which resulted in him received double doses. Relative A did not specify which medications were passed twice. No additional information was provided from Relative A regarding this allegation. Relative A said that her spouse observed the medications in disarray on 09/26/2021 at 10:30AM (the spouse could be heard in the background answering questions and is reference as Relative A1).

Relative A1 said that when he arrived at the home on 09/26/2021, Resident A was still in bed. There was a new staff person present named Corin Delay who was in the office where the medications were all over the desk. Relative A1 said that he asked Ms. Delay for Resident A's medications because he was leaving the home with him, and Ms. Delay

told him that she needed to find them. Relative A1 said Ms. Delay had no knowledge that Resident A was going to be picked up and this had been communicated to direct care staff Brian. Relative A1 said that Resident A's medications were never located.

On 10/14/2021, I conducted a phone interview with Jim Bellamy, APS investigator. Mr. Bellamy said that he was informed by the regional manager (name not provided) that the staff person Charlene Goldenbogen was terminated due to the medication error. Mr. Bellamy interviewed Ms. Goldenbogen and she admitted to accidentally giving Resident A his medications twice. Mr. Bellamy said that the family is not happy with the care Resident A received and Resident A is not returning to the home. Mr. Bellamy said that Resident A is still hospitalized, and the family attributes the hospitalization to the poor care that they alleged Resident A received at the home. Mr. Bellamy will be substantiating his investigation against Ms. Goldenbogen for the medication error.

On 12/06/2021, I conducted a phone interview with Michelle Burmistrzak, direct care staff. Ms. Burmistrzak said that she was not present when Resident A was given his medications twice. Ms. Burmistrzak said that she heard about this from Charlene Goldenbogen who admitted to giving Resident A his medications twice. Ms. Burmistrzak said that Ms. Goldenbogen told her that she gave Resident A two doses of his medications because she was tired. Ms. Burmistrzak said that Ms. Goldenbogen told her that she gave Resident A his morning meds and nighttime meds at the same time.

Ms. Burmistrzak said that she heard that the office was found in disarray because the staff pulled the meds to do the end of the month count. Ms. Burmistrzak said that at the end of each month staff count meds and dispose of old meds. Ms. Burmistrzak said that is the only reason the office would have medications throughout.

On 12/06/2021, I conducted a phone interview with Marquise Little, direct care staff. Mr. Little said that he was aware of the incident in which, Resident A was given too much medication. Mr. Little said that Charlene Goldenbogen admitted to doing this. Mr. Little does remember an incident in which there was a complaint made about the medications in disarray in the staff office. Mr. Little said that the only time this could have been witnessed is at the end of the month, they do a medication count and change out medications for the new month.

On 12/06/2021, I conducted a phone interview with direct care staff Breonia Standiefor. Ms. Standiefor said that she does not recall exactly what occurred with the medication errors but heard that Charlene Goldenbogen overdosed Resident A. Ms. Goldenbogen did not tell staff and she became aware of this by Relative A when Resident A was discharged. Ms. Standiefor said that she has no knowledge of the staff office having medications in disarray.

On 12/06/2021, I conducted a phone interview with Amber Matejowsky. Ms. Matejowsky said that during the allegation period she was not medication trained. Ms. Matejowsky was just trained in November 2021. Ms. Matejowsky said that she has

never observed the medications anywhere except for the medication cart. Ms. Matejowsky denied observing medications out anywhere.

On 12/06/2021, I reviewed Resident A's medication administration record (MAR) for September 2021 which documents that he is prescribed seven medications and one PRN. It is documented on the MAR that on 09/12/2021 at 8:28AM, that Resident A's Diazepam 5mg that the staff forgot to list Resident A as being out of the facility on a family visit at 3PM. Therefore, the family did not receive the 3PM medication to take home. On 09/26/2021, the Diazepam 5mg could not be located by staff person Corin Delay therefore, Relative A1 could not administer the 3PM dosed during an outing.

On 12/21/2021, I conducted a phone interview with Meagan Kruczynski - home manager. Ms. Kruczynski said that she became aware of the medication error from the APS investigation. Ms. Kruczynski believes there was no incident report made about it because the only person that was aware this occurred was Charlene Goldenbogen since she was the person that made the error.

Ms. Kruczynski said that at the end of each month, a large medication order comes from the pharmacy. Ms. Kruczynski said that when the new orders arrive, the staff are to remove the old medications from prior month and add the new medications. Ms. Kruczynski said that based on the dates this was observed, the staff person was doing the medication change from September to October. Ms. Kruczynski was not working that day but was informed that Relative A1 walked into the staff office unannounced.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on interviews and documents review, former home manager Charlene Goldenbogen administered Resident A's medications twice on 09/12/2021. According to Relative A, on 09/12/2021 during the second shift the former home manager Charlene Goldenbogen gave Resident A his medications twice. Mr. Bellamy, APS interviewed Charlene Goldenbogen and she admitted to accidentally giving Resident A his medications twice. Charlene Goldenbogen told Ms. Burmistrzak that she gave Resident A his morning meds and nighttime meds at the same time. According to Mr. Little, Charlene Goldenbogen admitted to doing this as well. Additionally, it is documented on the MAR that direct care staff Corin Delay failed to provide Relative A1 with Resident A's

	Diazepam 5mg 3PM dose on 09/26/2021. It was also documented on the MAR that staff failed to provide the Diazepam 3PM dose for an outing on 09/12/2021 for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	There is insufficient information that Resident A's medications were not locked and stored properly. According to Ms. Burmistrzak, Mr. Little and Ms. Kruczynski, at the end of each month staff count meds and dispose of old meds. Apparently on 09/26/2021, Relative A1 observed the staff doing a medication count and organizing.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A is not given a proper diet as prescribed by his doctor.

INVESTIGATION:

On 10/07/2021, I received a phone call from Relative A. Relative A said that Resident A is prescribed a low calorie and low-fat diet by his nutritionist, name not provided. Relative A said that Resident A had a physical recently and his cholesterol levels were high, and that he has gained weight since living in the home. Relative A said that the staff allows Resident A to drink pop, and he is at risk of a heart attack due to his poor diet.

On 12/06/2021, I conducted a phone interview with Michelle Burmistrzak, direct care staff. Ms. Burmistrzak said that Resident A was provided a healthy diet. Ms.

Burmistrzak said the only eating concern she observed with Resident A is that he eats fast. Resident A would chug his food and drink liquids fast. Ms. Burmistrzak said staff would monitor his eating pace so that he would not choke. Ms. Burmistrzak is not aware of Resident A being prescribed a special diet.

On 12/06/2021, I conducted a phone interview with Melissa Gray, Behaviorist. Ms. Gray said that Resident A was not prescribed a special diet to her knowledge. Ms. Gray said that the special diet would be in his behavioral plan if it was related to compulsive behaviors disorder. Ms. Gray said that redirecting Resident A from food was sufficient for his behavioral plan.

On 12/06/2021, I conducted a phone interview with Marquise Little, direct care staff. Mr. Little heard from Charlene Goldenbogen that Relative A complained that Resident A was overeating. Mr. Little said that there was no special diet plan in effect for Resident A. Mr. Little said that Ms. Goldenbogen told him they needed to keep an eye on Resident A's weight gain. Mr. Little was trained to redirect Resident A when eating too fast but there was nothing in the plan that limited his intake or portion sizes.

On 12/06/2021, I conducted a phone interview with direct care staff Briona Standiefor. Ms. Standiefor said that Resident A did not have a special diet prescribed but Relative A wanted him to only eat certain foods. Ms. Standiefor said that Relative A ~~derived~~ develop? her own eating plan for Resident A. Ms. Standiefor said that Relative A requested that Resident A eat no sugars.

On 12/06/2021, I conducted a phone interview with Amber Matejowsky. Ms. Matejowsky was not aware of a special diet prescribed for Resident A. Ms. Matejowsky said that Resident A spoke about having a nutritionist. However, she was only made aware of dietary needs by Relative A. Relative A told her that Resident A needs to eat more fruits, veggies, have no salt and portion control.

On 12/06/2021, I reviewed Resident A's *Assessment Plan* which indicates that he needs reminders to eat slowly. I observed that there was no special diet documented on Resident A's *Health Care Appraisal* or IPOS. The IPOS documented that staff should manage food distribution. I observed on Resident A's *Resident Weight Record* that his weight at admission was 213.6 pounds and at discharge 205.6 pounds. Resident A lost eight pounds from May 2021 until October 2021.

On 12/21/2021, I conducted phone interviews with Resident B and Resident C. Resident C said that he gets enough to eat. Resident B said that he had cereal for breakfast and the food is "cooked good." Resident C said that he gets enough to eat. Resident C could not describe or recall recent meals.

On 12/21/2021, I conducted a phone interview with Meagan Kruczynski - home manager. Ms. Kruczynski said that Resident A is not prescribed a special diet. Ms. Kruczynski said that Resident A did not gain or lose any weight while living in the home.

Ms. Kruczynski said that there were no doctors' orders or orders from a nutritionist prescribing a special diet for Resident A.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: (b) Special diets.
ANALYSIS:	Based on the investigation conducted, there is insufficient information to support that Resident A was prescribed a special diet. According to Ms. Gray, Resident A was not prescribed a special diet to her knowledge. According to Ms. Burmistrzak, Mr. Little, Ms. Standiefor, Ms. Matejowsky and Ms. Kruczynski-home manager, Resident A was not prescribed a special diet. Relative A expressed concerns about weight gain and health however, there was no special diet received. Resident A's *Assessment Plan* indicates that he needs reminders to eat slowly. There was no special diet documented in Resident A's *Health Care Appraisal* or IPOS. Additionally, according to the *Resident Weight Record*, Resident A loss eight pounds from his admission in May 2021 until his discharge in October 2021.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A was sent to school on 09/09/2021 and 09/26/2021 unshaved, unbathed.

INVESTIGATION:

On 10/07/2021, I received a phone call from Relative A. Relative A said that Charlene Goldenbogen primarily gave Resident A his showers. Relative A said that Ms. Goldenbogen told her that on 09/26/2021, Resident A was not showered or shaved because the midnight staff slept the entire shift.

On 12/06/2021, I conducted a phone interview with Michelle Burmistrzak, direct care staff. Ms. Burmistrzak said that Resident A is diagnosed with obsessive compulsive disorder (OCD) and he is preoccupied with cleanliness. Ms. Burmistrzak said that

Resident A would shower himself every night and each morning before school. Staff assisted Resident A with shaving, and this was done every two days.

On 12/06/2021, I conducted a phone interview with Marquise Little, direct care staff. Mr. Little said that in the past he had a conversation with Relative A about Resident A's hygiene. Mr. Little said that he was the staff person that shaved Resident A. Mr. Little said that he has observed Megan Kruczynski shave Resident A. Mr. Little said that there were no issues with Resident A showering because he showered frequently.

On 12/06/2021, I conducted a phone interview with direct care staff Breonia Standiefor. Ms. Standiefor said that Resident A is showered every morning and at 1PM daily because he is diagnosed with OCD. Resident A is very routine. Ms. Standiefor said that Resident A was shaven frequently and only recalls that his shaving was skipped for a while because when he had returned from a hospital stay and he had a scar on his face that needed to heal.

On 12/06/2021, I conducted a phone interview with Amber Matejowsky. Ms. Matejowsky said that Resident A bathed twice per day. Ms. Matejowsky said that Resident A would not go to bed without showering and each morning. Ms. Matejowsky said that Resident A was very clean and would never wear dirty clothes.

On 12/06/2021, I reviewed Resident A's *Assessment Plan* which documents that there are no bathing requirements, but that staff are to monitor. The *Assessment Plan* documents that staff are to assist with hair crew and nail clipping.

On 12/21/2021, I conducted phone interviews with Resident B and Resident C. Resident B said he takes a shower daily. Resident C answered "yes" when asked if he is showered. Neither Resident B nor Resident C have the cognitive abilities to verbalize more detailed information.

On 12/21/2021, I conducted a phone interview with Meagan Kruczynski- home manager. Ms. Kruczynski said that this allegation is "completely false." Ms. Kruczynski said that Resident A took two showers per day and as frequent as possible. Resident A is diagnosed with OCD. Ms. Kruczynski said that she helped shave him daily.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary. (2) A licensee shall afford a resident facilities, and instructions, when necessary, for daily shaving.

ANALYSIS:	There is insufficient information to support that Resident A was unshaved and unbathed on 09/09/2021 and 09/26/2021. According to Ms. Burmistrzak, Resident A is diagnosed with obsessive compulsive disorder (OCD) and he is preoccupied with cleanliness. Resident A would shower himself every night and each morning before school. Additionally, according to direct care staff Mr. Little, Ms. Standiefor, Ms. Matejowsky and Ms. Kruczynski-home manager, Resident A showered twice a day due to his OCD diagnosis. The staff also denies that Resident A was not shaved. Resident B and Resident C both stated that they are showered daily.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 11/02/2021, I conducted an onsite. I was not able to enter due to active COVID-19 cases in the home. I conducted a brief interview with Megan Kruczynski, home manager outside. Ms. Kruczynski said that Resident A is no longer living at the home and was discharged to his family. Ms. Kruczynski said that currently one resident is hospitalized due to COVID-19, one resident recently came home from being hospitalized due to COVID-19/quarantined, one resident positive for COVID-19/quarantined and one resident quarantined due to exposure to COVID-19. Ms. Kruczynski said that she just returned from being out from COVID-19 illness. Ms. Kruczynski said that incident reports were not done due to the staff being ill. I advised Ms. Kruczynski that incident reports were required for hospitalization. To date, I have not received any incident reports. Ms. Kruczynski said that the last she heard, Charlene Goldenbogen is now working at a different adult foster care home.

On 12/06/2021, I reviewed documents requested. I observed that there were two incident reports written that were not submitted to licensing. observed that Resident D was hospitalized for aggressive behavior on 09/19/2021. Resident C was hospitalized for aggressive behaviors on 10/04/2021 and licensing was not notified.

On 01/19/2021, I conducted an exit conference with Eva Hemphill. I informed Ms. Hemphill of the violations established. Ms. Hemphill responded to one of the rule violations regarding Resident A missing baseball practice. Ms. Hemphill said that Relative A contacted her as well to express her concerns regarding the missed practice. Ms. Hemphill agreed to submit a corrective action plan once the report is received.

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: (c) Incidents that involve any of the following: (ii) Hospitalization.
ANALYSIS:	On 11/02/2021, during an unannounced onsite investigation, I was informed that one resident was hospitalized, one resident was recently released from the hospital due to COVID-19 virus. I requested incident reports from Megan Kruczynski and have not received them to date. Further, on 12/06/2021, I observed two incident reports written for Resident C (10/04/2021) and Resident D (09/19/2021) due to their hospitalizations were required to be sent to licensing within 48 hours, but were not received.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

L. Reed 01/18/2022

LaShonda Reed Date
Licensing Consultant

Approved By:

Denise Y. Nunn 01/31/2022

Denise Y. Nunn Date
Area Manager