GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 22, 2022

Robert McDaniel
Lakeshore Caring Corp.
4851 Lakeshore, Bldg A
Fort Gratiot, MI 48059

RE: License #: AL740007431
Investigation #: 2022A0604013
Lakeshore Woods II

Dear Mr. McDaniel:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Suite 9-100
3026 W. Grand Blvd.
Detroit, MI 48202
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL740007431
Investigation #:	2022A0604013
Complaint Receipt Date:	02/25/2022
Investigation Initiation Date:	02/25/2022
Report Due Date:	04/26/2022
Licensee Name:	Lakeshore Caring Corp.
Licensee Address:	4851 Lakeshore, Bldg A Fort Gratiot, MI 48059
Licensee Telephone #:	(810) 385-3185
Administrator:	Robert McDaniel
Licensee Designee:	Robert McDaniel
Name of Facility:	Lakeshore Woods II
Facility Address:	4851 Lakeshore Bldg B Fort Gratiot, MI 48059
Facility Telephone #:	(810) 385-3185
Original Issuance Date:	09/29/1995
License Status:	REGULAR
Effective Date:	03/14/2020
Expiration Date:	03/13/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Two staff were changing Resident A. Resident A slapped staff and staff hit Resident A's bottom. Staff admitted to hitting resident and was terminated.	Yes

III. METHODOLOGY

02/25/2022	Special Investigation Intake 2022A0604013
02/25/2022	Special Investigation Initiated - On Site Completed onsite investigation. Interviewed Rob McDaniel, Darlene Mason, Cheyenne Keys and observed Resident A.
02/25/2022	Contact - Document Received Email from Robert McDaniel with employee records. Sent return email.
02/28/2022	APS Referral Adult Protective Services (APS) referral denied.
04/22/2022	Exit Conference Completed exit conference by email with Licensee Designee, Robert McDaniel.

ALLEGATION:

Two staff were changing Resident A. Resident A slapped staff and staff hit Resident A's bottom. Staff admitted to hitting resident and was terminated.

INVESTIGATION:

On 02/23/2022, I received an email from Licensee Designee, Robert McDaniel. Mr. McDaniel stated that an incident occurred between a resident and staff while he was on leave. He stated that the incident was investigated by Wellness Director and the staff was terminated. I informed Mr. McDaniel to submit an incident report and to contact APS if the incident involved abuse and/or neglect of a resident. I received a copy of incident report on 02/23/2022. The incident report indicated on 02/14/2022 it was brought to Wellness Director, Darlene Mason's attention that on 02/13/2022 staff, Desiree Pearson smacked Resident A on the bottom after the resident had smacked

Ms. Pearson across the face, while two staff members were attempting to change the resident's brief. An investigation was completed by Ms. Mason on 02/15/2022, before Ms. Pearson's next scheduled shift. Ms. Pearson openly admitted to hitting the resident on the bottom. The staff member was terminated at the end of the interview. I opened a special investigation atter reviewing the incident report.

I completed an onsite investigation on 02/25/2022. I Interviewed Rob McDaniel, Darlene Mason, Cheyenne Keys and observed Resident A.

On 02/25/2022, I interviewed Licensee Designee, Robert McDaniel. Mr. McDaniel stated that staff, Desiree Pearson admitted to hitting Resident A after resident smacked her in the face. Mr. McDaniel stated that Resident A has dementia. Ms. Pearson has been terminated. Mr. McDaniel stated that there were no prior complaints regarding Ms. Pearson and she did not have any disciplinary action. He described her as a good employee. She worked for Lakeshore Woods since 06/21/2017.

On 02/25/2022, I interviewed Wellness Director, Darlene Mason. Ms. Mason stated that caregivers were talking about the incident. Ms. Mason stated that Resident A has dementia and can be physically aggressive. Ms. Mason interviewed Desiree Pearson about the incident. Ms. Pearson stated that she "accidentally" smacked Resident A and that she will never do it again. Ms. Mason terminated Ms. Pearson on the spot and Ms. Pearson agreed to leave. Ms. Mason stated that she also notified Resident A's family regarding the incident. Ms. Pearson stated that she interviewed a few other staff who said that Ms. Pearson gets angry and loses her patience. Staff, Cheyenne Keys reported that Ms. Pearson had hit residents before. Ms. Mason stated that Resident A was observed to have bruising on left hand. She completed a full head to toe assessment.

On 02/25/2022, I interviewed Staff, Cheyenne Keys. She stated that she and Ms. Pearson were getting Resident A up to change her brief. She went to get brief, and she heard a loud slap. Resident A told Ms. Pearson to get out of her room now. Ms. Pearson said that she was allowed to hit back if a resident hit her first. Ms. Keys stated that she never saw or heard of Ms. Pearson hitting another resident before. Ms. Keys stated that Darlene Mason found out about the incident and asked her about it. She stated that she did not tell someone immediately because there was no one to tell and Darlene asked her about incident the next day.

On 02/25/2022, I observed Resident A. Resident A was participating in group activity with pool noodles. I observed that Resident A had a bruise on her hand.

On 02/25/2022, I received employee records for Desiree Pearson from Robert McDaniel. Ms. Pearson was fingerprinted and had a clearance completed on 06/20/2017. Ms. Pearson also completed required licensing training including reporting requirements, resident rights and personal care, supervision and protection.

I completed an exit conference by email with Licensee Designee, Robert McDaniel on 04/22/2022. I informed him of the violations found and that a copy of the special investigation report would be mailed once approved. I also informed him that a corrective action plan would be requested.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	On 02/13/2022, Staff Desiree Pearson and Cheyenne Keys were attempting to change Resident A's brief. Resident A slapped Ms. Pearson in the face. Ms. Pearson admitted to hitting Resident A back on the bottom. An investigation was completed by Wellness Director, Darlene Mason, and Ms. Pearson was terminated on 02/15/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15311	**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:** **(i) Displays of serious hostility.** **(iii) Attempts at self-inflicted harm or harm to others.**

ANALYSIS:	On 02/13/2022, Resident A slapped Staff, Desiree Pearson. In response, Ms. Pearson hit Resident A back on the bottom. The incident was not reported to licensing until 02/23/2022. In addition, the physical abuse was not reported to APS until after the Licensee Designee was advised to do so on 02/23/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

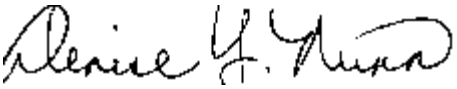
IV. RECOMMENDATION

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

04/22/2022

Kristine Cilluffo Date
Licensing Consultant

Approved By:



04/22/2022

Denise Y. Nunn Date
Area Manager