



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 11, 2022

Sunil Bhattad
Auburn Fields Assisted Living II, LLC
219 Church Street
Auburn, MI 48611

RE: License #: AL090356074
Investigation #: 2022A0572032
Auburn Fields Assisted Living

Dear Mr. Bhattad:

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 (906) 226-4171.

Sincerely,

A handwritten signature in black ink that reads "Anthony Humphrey". The signature is written in a cursive style with a large, looping flourish at the end.

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL090356074
Investigation #:	2022A0572032
Complaint Receipt Date:	04/11/2022
Investigation Initiation Date:	04/12/2022
Report Due Date:	06/10/2022
Licensee Name:	Auburn Fields Assisted Living II, LLC
Licensee Address:	219 Church Street Auburn, MI 48611
Licensee Telephone #:	(248) 765-5209
Administrator:	Sunil Bhattad
Licensee Designee:	Sunil Bhattad
Name of Facility:	Auburn Fields Assisted Living
Facility Address:	4710 Stephanie Court Auburn, MI 48611
Facility Telephone #:	(248) 765-5209
Original Issuance Date:	09/16/2014
License Status:	REGULAR
Effective Date:	03/16/2021
Expiration Date:	03/15/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility's fire department water access located on the outside of the home was missing the cover.	Yes
There is a tear in the carpet that is a tripping hazard at the entrance of the facility.	No
<ul style="list-style-type: none"> • Resident A's bedroom window blind is broken. • There also is no bedroom door for Resident A. 	No No

III. METHODOLOGY

04/11/2022	Special Investigation Intake 2022A0572032
04/12/2022	Special Investigation Initiated - On Site
04/12/2022	Contact - Face to Face Home Manager, Desire Biggs, and Owner, Kazeem Hodroge.
04/12/2022	Contact - Telephone call made Fire Inspector, Ralph Martin.
05/05/2022	Inspection Completed-BCAL Sub. Compliance
05/05/2022	Exit Conference Licensee, Sunil Bhattad

ALLEGATION:

The facility’s fire department water access located on the outside of the home was missing the cover.

INVESTIGATION:

On 04/11/2022, the local licensing office received a complaint for investigation. There were no other investigative entities involved in this investigation.

On 04/12/2022, an unannounced onsite was made at Auburn Fields Assisted Living, located in Bay County, Michigan. Interviewed were, Home Manager, Desire Biggs, and Owner, Kazeem Hodroge.

On 04/12/2022, I interviewed Home Manager, Desire Biggs. She informed that she noticed the cap fell off and put it to the side. She showed me where the cap was placed. She said that she tried to put it back on, but it just fell back off. She didn’t think it was an issue because it wasn’t mentioned during their most recent fire inspection. I observed the cover and the clamp on the cover appeared to be broken.

On 04/12/2022, I interviewed the Owner, Kazeem Hodroge and he was not aware that it was broken but indicated that he would appreciate it if when people have a problem, to at least let them know what the issue is so they can resolve it.

On 04/12/2022, I spoke with Fire Inspector, Ralph Martin to see if he would consider not having the Fire Department Connection Cap (FDC) a citation. Mr. Martin informed that he would cite the facility if he was aware of this but give them a couple of weeks to resolve the issue. He informed that the facility could contact the Sprinkling System company and they will replace it for free. The reason he would cite the facility is because birds can make a nest in the opening, which would clog the intake. If the intake is clogged, the fire department would not have access to water if there was a fire.

On 04/12/2022, Mr. Hodroge ordered 2 new FDC Connection Caps and it’s scheduled them to be delivered on 04/15/2022.

APPLICABLE RULE	
R 400.15403	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:	During my onsite, I observed the FDC Connection Cap was off. The Home Manager wasn't aware that this was an issue because a recent fire inspection was passed with no mention of the missing cap. In speaking with the Fire Inspector, he informed that this would be a citation if he saw that the cap was off, due to the potential of the intake being clogged by birds building a nest.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

There is a tear in the carpet that is a tripping hazard at the entrance of the facility.

INVESTIGATION:

On 04/12/2022, I interviewed Home Manager, Desire Biggs and she was not sure what tears in the carpet that the complainant is referring to.

On 04/12/2022, I interviewed the Owner, Kazeem Hodroge and he too was not sure what tears in the carpet the complainant is referring to.

On 04/12/2022, I conducted a physical plant inspection of the carpet in every area of the facility. I did not observe any major tears or ruffles in the carpet. There were no tears that would cause a tripping hazard.

APPLICABLE RULE	
R 400.15403	Maintenance of premises.
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	During my onsite inspection, I did not observe any damaged carpet at the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- Resident A's bedroom window blind is broken.
- There is also no bedroom door for Resident A.

INVESTIGATION:

On 04/12/2022, I interviewed Home Manager, Desire Biggs. She informed that they have 4 rooms wear a very small piece of the blinds broke off and Resident A's bedroom does not have a door because the door was damage when it was in the basement.

On 04/12/2022, I interviewed the Owner, Kazeem Hodroge. He informed that there are a few blinds that have a small broken piece because they are very fragile. Two of the blinds were broken when he was cleaning them. He informed that when the blinds are lowered, if you allow them to drop down onto the windowsill, a piece of the blind will break. In regard to the bedroom door, a previous resident was residing in the room with the missing door. There is a door to the main entrance of this room to ensure privacy. The family asked them to remove the door to the bedroom because if she would fall behind the door, staff would have trouble opening the door to get to the resident. The door was then placed in the basement of the facility. When that resident was moved, Resident A was moved into that room. When they went to get the door to put it back up, they found that it was destroyed due to a flood in the basement. A new door was attempted to be ordered, but the style of door that they have throughout the facility has been discontinued, so he ordered a new door of a different style today.

On 4/12/2022, Resident A's room was observed. Resident A's room is equipped with a door. Resident A does have privacy as she has an apartment-style bedroom and to enter, you have to go through the main door of her room.

On 04/12/2022, I observed every room in the facility. Room #4, #5, #20, and #21 had a broken piece of the blind. The blinds appear to be very heavy, and sturdy and the material appear to be made of faux wood. The 4 blinds with the broken pieces were not very noticeable until pointed out to me by the owner of the facility. The blinds had to be closed in order to notice it. While closed, there was no sunlight coming into any of the bedrooms. The part of the blinds that was broken was just one small piece on the corners of each blind. The broken piece on each blinds was maybe 2 inches in length. Regarding Resident A's bedroom door, I observed the bedroom, and it is an apartment-style room inside the facility. There is a door from the hallway to enter into her apartment, where there is a kitchenette, bathroom, living room and a bedroom. The bedroom did not have a door, however; this room has privacy as the main entrance to the bedroom has a door.

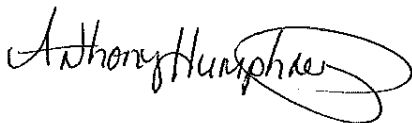
APPLICABLE RULE	
R 400.15403	Maintenance of premises.
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	I observed every window blinds in the facility and there was no major damage to the blinds. There are four blinds in the facility that has a very small piece that were broken.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15408	Bedroom generally.
	(4) Interior doorways of bedrooms that are occupied by residents shall be equipped with a single-hinged, permanently mounted door that is equipped with positive-latching-against-egress hardware.
ANALYSIS:	Resident A's bedroom did not have a bedroom door, however; Resident A does have privacy as she has an apartment-style bedroom and to enter, you have to go through the main door of the apartment. The owner ordered the door and was picking it up today.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 05/05/2022, an Exit Conference was held with Licensee, Sunil Bhattad regarding the investigation. He was informed that there would be a citation issued for one of the allegations and a corrective action plan would be required within 15 days of the receipt of this report.

IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this large adult foster care group home, pending the receipt of an acceptable corrective action plan (Capacity 1-20).

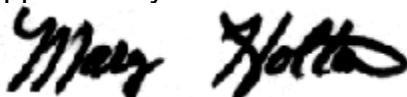


05/10/2022

Anthony Humphrey
Licensing Consultant

Date

Approved By:



05/11/2022

Mary E Holton
Area Manager

Date