GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 11, 2022

Iemelif Julian
1635 Millard Ave
Madison Heights, MI 48071

RE: License #: AS500407573
Investigation #: 2022A0604023
Genesis Adult Foster Care Home V

Dear Ms. Julian:

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,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 West Grand Blvd Ste 9-100
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 #:	AS500407573
Investigation #:	2022A0604023
Complaint Receipt Date:	05/24/2022
Investigation Initiation Date:	05/26/2022
Report Due Date:	07/23/2022
Licensee Name:	Iemelif Julian
Licensee Address:	1635 Millard Ave Madison Heights, MI 48071
Licensee Telephone #:	(248) 635-7685
Administrator:	Iemelif Julian
Licensee Designee:	Iemelif Julian
Name of Facility:	Genesis Adult Foster Care Home V
Facility Address:	16211 Chatham Dr Clinton Township, MI 48035
Facility Telephone #:	(248) 635-7685
Original Issuance Date:	08/11/2021
License Status:	REGULAR
Effective Date:	02/11/2022
Expiration Date:	02/10/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff told 911 operator that they were not trained in CPR/First Aid.	Yes
There is a resident with dementia in the home that is not compatible with other residents.	No
The home does not have menus posted.	Yes
Staff is setting up resident medications in advance and using weekly containers.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/24/2022	Special Investigation Intake 2022A0604023
05/26/2022	Special Investigation Initiated - Telephone Text and telephone call to Complainant
05/26/2022	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Staff, Haidee Cruz and Jhon Giuagiw, Resident A and Resident B. Spoke to Licensee, Iemelif “Meng” Julian on staff's phone while onsite.
05/26/2022	Contact - Document Sent Email to Ms. Julian, regarding licensing concerns and requested staff records. Advised that she immediately address staffing and sleeping arrangements.
05/27/2022	Contact - Telephone call received Text message to and from Complainant
05/31/2022	Contact - Document Sent Email to Alex Smith and Eddie Ibarra. Requested staff records.
05/31/2022	APS Referral Referral to Adult Protective Services (APS)
05/31/2022	Contact - Document Received Received staff information and meal plan from Alexandria Smith by email.

06/03/2022	Contact - Telephone call received Text messages to and from Complainant
06/15/2022	Inspection Completed On-site Completed unannounced onsite investigation to check resident medications. Interviewed Licensee, Ms. Julian and Staff, Haidee Cruz.
06/15/2022	Contact - Document Received Email from Alexandria Smith
06/16/2022	Contact - Document Received Email to and from Alexandria Smith.
06/22/2022	Contact - Document Sent Received APS referral denial letters dated 05/31/2022
06/29/2022	Contact- Face to Face Face to Face contact with Alexandria Smith and Eddie Ibarra at Genesis II renewal. Discussed special investigation.
07/11/2022	Contact- Document Sent Email to Alexandria Smith
07/12/2022	Contact- Document Sent Email to Meng Julian, Eddie Ibarra and Alexandria Smith. Received return email from Ms. Smith with additional information.
07/13/2022	Exit Conference Email to Meng Julian, Eddie Ibarra and Alexandria Smith. Completed exit conference by phone with designated person/Administrator, Eddie Ibarra.
08/03/2022	Contact- Document Sent Email to Eddie Ibarra and Alexandria Smith. Received return email from Ms. Smith.
08/05/2022	Contact- Document Received Received email from Alexandria Smith with resident assessment plans and health care appraisals.

ALLEGATION:

Staff told 911 operator that they were not trained in CPR First/Aid.

INVESTIGATION:

I opened a special investigation for Genesis Adult Foster Care Home V on 05/24/2022. I received previous phone calls/text messages from Complainant who wished to remain anonymous and did not want to disclose name of home. I provided Complainant with information on making a licensing complaint through LARA and APS referral phone number. I contacted Complainant on 05/26/2022 by phone/text and indicated that I would need to move forward with completing a special investigation as the name of home was reported and their complaint had not been received. Complainant stated that some of their issues had been addressed with licensee. The Complainant had initially reported to licensing that staff called 911 and was asked by the operator if they knew how to do CPR. The staff stated that they were not CPR trained and were instructed by the operator. The Complainant also stated that she has not seen menus posted in the home. They also had concerns regarding confidentiality and medical services. The Complainant alleged that there is a resident with dementia in the home that is aggressive and not compatible with other residents. In addition, it was reported that medications were being set up in advance by staff.

On 05/26/2022, I completed an unannounced onsite investigation. I interviewed Staff, Haidee Cruz and John Giuagiw, Resident A and Resident B. I spoke to Licensee, Meng Julian on staff's phone while onsite.

On 05/26/2022, I interviewed Staff, Haidee Cruz and Jhon Giuagiw, during the onsite investigation. Ms. Cruz and Mr. Giuagiw stated that they are live in caregivers and have worked at the home for six months. Ms. Cruz and Mr. Giuagiw stated that they work from 7:00 am-7:00 pm. There are no other caregivers that work at the home. I observed that there was a small female child at the home during the investigation. Ms. Cruz confirmed it was her daughter. Ms. Cruz and Mr. Giuagiw indicated that they sleep in the living room when they are not working. They do not have a bedroom. Ms. Cruz and Mr. Giuagiw indicated that they have not completed CPR/First Aid training, however, the 911 operator instructed them on CPR during a recent call. Ms. Cruz stated they did have past training when living in the Philippines.

On 05/31/2022, I received training records for Staff Haidee Cruz and Jhon Giuagiw from Genesis Secretary, Alexandria Smith, by email. Training records indicated that Mr. Giuagiw and Ms. Cruz did not complete reporting requirements, First Aid/CPR, personal care supervision, and protection, resident rights, safety and fire prevention and prevention and containment of communicable diseases training until 05/31/2022. Ms. Smith indicated their date of hire was 01/16/2022.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Training records provided by Genesis Secretary, Alexandria Smith, on 05/31/2022 indicated that Jhon Giuagiw and Haidee Cruz did not complete reporting requirements, First Aid/CPR, personal care supervision, and protection, resident rights, safety and fire prevention and prevention and containment of communicable diseases training until 05/31/2022. On 05/26/2022, during the onsite investigation Mr. Giuagiw and Ms. Cruz indicated that they are live in caregivers and have worked at the home for six months. Alexandria Smith indicated their date of hire was 01/16/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There is a resident with dementia in home that is not compatible with other residents.

INVESTIGATION:

On 05/26/2022, during the onsite investigation, Staff Haidee Cruz indicated that four out of the six residents at the home have dementia. In addition, all the residents at the home are seniors. The Complainant reported concern that there is a resident in the home that has dementia that is not compatible with other residents. The Complainant indicated that the resident can be aggressive.

On 07/12/2022, Alexandria Smith stated that they have one resident (Resident F) who gets agitated easily. Ms. Smith stated that the caregivers usually can catch her in time, however they did have an instance where she pushed her walker at someone in the hallway. However, Resident F has not attacked or harmed anyone to Ms. Smith's knowledge.

On 07/13/2022, I interviewed Assistant Administrator, Eddie Ibarra. He stated that there was one incident at the home where Resident F was agitated and pushed her walker towards a resident's family member. He stated that no one was hit. Mr. Ibarra stated that staff typically accompany Resident F with walking. Mr. Ibarra stated that Resident F was seen by the doctor after the incident as she seemed more agitated than normal. It was found that Resident F had a urinary tract infection, and she was prescribed an antibiotic. Mr. Ibarra stated that no staff or residents have been assaulted by Resident F.

On 08/05/2022, I received resident assessment plans and health care appraisals from Alexandria Smith by email. Resident B's health care appraisal indicates that she is diagnosed with dementia/memory loss. Resident C's health care appraisal indicates she is diagnosed with dementia and has memory deficits. Resident D's health care appraisal states she has a confused status post stroke. Resident F's health care appraisal indicates she is diagnosed with Alzheimer's.

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: **(c) The resident appears to be compatible with other residents and members of the household.**
ANALYSIS:	There is not enough information to determine that Resident F is not compatible with other residents in the home. Genesis Adult Foster Care Home V's program indicates that they provide care for residents who are aged and/or have Alzheimer's and dementia. Staff, Haidee Cruz, indicated that four out six residents in the home have dementia. Ms. Smith and Mr. Ibarra indicated that there was one incident where Resident F was agitated and pushed her walker towards another resident's family member. No one was injured during the incident.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The home does not have menus posted.

INVESTIGATION:

I interviewed Complainant by phone on 05/26/2022. They stated that toast is served for breakfast nearly every morning. A couple times bagels were served. Residents get sandwiches every day for lunch and maybe some soup. The Complainant stated that dinner is usually better than breakfast and lunch and something like chicken with a vegetable is served.

I completed an onsite investigation on 05/26/2022. Staff, Haidee Cruz, stated that the home did have menus posted in the kitchen that were followed. I observed two menus posted to the right of the refrigerator. The first menu was titled “Breakfast & Lunch Weekly Plan”. The second menu was titled “Dinner Combinations” and listed various dinners, salads, veggies, fruits and side dishes without any dates. Ms. Cruz stated that they planned to make the Salisbury Steak for dinner which was one of the dinner combinations listed. Ms. Cruz showed me a frozen Salisbury Steak dinner in the freezer they planned to make for dinner. The weekly menu listed various sandwiches or hotdog, soup and desert for lunches. The breakfasts varied and included options such as pancakes, eggs and corned beef hash, cereal with fruit and omelets. Ms. Cruz stated that they offer breakfast on menu, however, some residents do not want what is on the menu and get toast and jelly instead.

On 05/26/2022, I interviewed Resident A at the home. She stated that the home does not follow a menu and the food is not good. She stated that they have made one watered down can of soup for lunch and added some chicken. She stated that soup is not watered down anymore after a complaint was made. For breakfast she received a bowl of Wheaties and milk. Resident A believed that the food provided should be better for the cost of living at the home.

On 05/26/2022, I interviewed Resident B at the home. She stated that there is no menu posted. She stated that she receives toast for breakfast and a half a sandwich for lunch. Resident B stated she gets the same thing every day. She stated that an example of dinner served is spaghetti, sweet potatoes, and apples.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	The home only had a weekly menu posted for breakfast and lunch. The dinner menu was a list of possible dinner combinations and was not dated. Resident A and Resident B stated that the home does not follow a menu. Resident B was not aware that a menu was posted. In addition, substitutions were not noted on menu.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff is setting up resident medications in advance and using weekly containers.

INVESTIGATION:

On 06/15/2022, I completed an unannounced onsite investigation to observe medications. Licensee, Meng Julian, showed me a locked cabinet in kitchen area where medications were kept. I also observed medication log that was up to date with initials from staff.

On 06/15/2022, I interviewed Staff, Haidee Cruz. I asked Ms. Cruz if any weekly pill containers were being used in the home. Ms. Cruz said containers were being used and showed me an unlocked drawer in kitchen where each resident had a weekly pill container with pills inside. Ms. Julian then reported that she or her son, Jerome, set up medications each week. She stated that she was told this was allowed by Oakland County Consultants. I informed Ms. Julian that medications must always be kept in the pharmacy supplied container in a locked location. I also advised Ms. Julian that she should remove weekly pill containers from all her homes.

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 {333.1101 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:	On 06/15/2022, I observed that medications were not being kept in their pharmacy supplied containers in a locked location. Medications were being set up on a weekly basis for each resident and kept in a weekly pill container. The containers were being kept in an unlocked drawer in the kitchen.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 05/26/2022, During the onsite investigation, I observed a camera in Resident B and Resident C's bedroom. The camera was pointed toward Resident C's side of the room. Resident B was not aware that there was a camera in the bedroom. I informed Staff, Haidee Cruz, that a camera should not be allowed in resident's bedroom due to privacy. On 05/26/2022, I spoke to Ms. Julian on the phone during the investigation. Ms. Julian stated that Resident C is a new resident and the family approved a camera in bedroom for safety. I informed Ms. Julian that cameras were not allowed in bedrooms.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**

ANALYSIS:	During the onsite investigation, I observed a camera in Resident B and Resident C's bedroom. Resident B was not aware that there was a camera in the bedroom.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 05/26/2022, During the onsite investigation, Staff, Jhon Giuagiw and Haidee Cruz indicated they have worked in the home for six months. On 05/31/2022, I received fingerprinting clearances for Staff Haidee Cruz and Jhon Giuagiw from Genesis Secretary, Alexandria Smith, by email. Mr. Giuagiw's clearance letter is dated 03/23/2022. Ms. Cruz's letter is dated 03/22/2022.

APPLICABLE RULE	
MCL 400.713	**License required; application; forms; investigation; on-site evaluation; issuance or renewal of license; disclosures; maximum number of persons; stating type of specialized program; issuance of license to specific person at specific location; transferability of license; sale of facility; notice; items of noncompliance; refusal by department to issue or renew license; conditions; unlicensed facility; violation as misdemeanor; penalty; receipt of completed application; issuance of license within certain time period; inspections; report; criminal history and records check; storage of fingerprints in automated fingerprint identification system database; convictions; "completed application" defined.**
	(3) Before issuing or renewing a license, the department shall investigate the activities and standards of care of the applicant and shall make an on-site evaluation of the facility. On-site inspections conducted in response to the application may be conducted without prior notice to the applicant. On-site inspections conducted for renewing a license may be conducted within 12 months before the expiration date of the current license without impact on the license renewal date or the license fee. Subject to subsections (9), (10), and (11), the department shall issue or renew a license if satisfied as to all of the following: **(e) The good moral character of the licensee or licensee designee, owner, partner, director, and person responsible for the daily operation of the facility. The applicant is responsible for assessing the good moral character of the employees of the facility. The person responsible for the daily operation of the facility shall be not less than 18 years of age.**

ANALYSIS:	On 05/26/2022, Jhon Giuagiw and Haidee Cruz indicated that they have worked at Genesis for six months. Ms. Giuagiw and Ms. Cruz were not fingerprinted at the time of hire. Mr. Giuagiw's clearance letter is dated 03/23/2022 and Ms. Cruz's letter is dated 03/22/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 05/26/2022, during the onsite investigation, Staff, Jhon Giuagiw and Heidi Cruz stated that they are live in caregivers. They both indicated that they work 7:00 am-7:00 pm and that there are no other staff who work at the home. They stay in the living room when they are not working.

On 05/26/2022, I interviewed Resident A. She stated that staff help her, but she tries to do what she can by herself. Staff do help her shower. She stated that residents who urinate on their clothes and linens get their laundry done more than she does. Resident A stated that staff are not supposed to help after 7:00 pm. She stated that she tries to ask for anything she needs such as refill on her water before 7:00 pm.

On 05/26/2022, I interviewed Resident B. She stated that staff work from 7:00 am-7:00 pm. She has a bell to ring if she needs something.

On 05/26/2022, I spoke to Licensee, Ms. Julian when she called during the onsite investigation. I also sent an email to Ms. Julian regarding licensing concerns and requested staff records. I advised that she immediately address staffing and sleeping arrangements. Ms. Julian indicated during investigation that there are always staff at the home.

On 05/31/2022, I received an email from Genesis Secretary, Alexandria Smith. She stated that the schedule has been revised effective immediately. Shifts have been converted to 8:00 am to 8:00 pm and second shift at 8:00 pm to 8:00 am. She stated the living arrangements was also addressed, Jhon is on the second shift so during the day he and his daughter stay in the basement. Ms. Smith stated that is a temporary situation as they look for a more permanent living situation. I advised Ms. Smith that they should check city/township requirements regarding the use of basement bedrooms as an egress window is typically required and there may be additional safety requirements. The basement is also unfinished.

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:	The home was not providing 24-hour supervision, personal care, and protection for residents in the home. Staff, Jhon Giuagiw and Haidee Cruz, indicated that they work from 7:00 am-7:00 pm. After 7:00 pm they stay in the living room. Resident A stated that she tries to ask for anything she needs before 7:00 pm because staff shifts ends at 7:00 pm.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 05/26/2022, Ms. Cruz and Mr. Giuagiw indicated that they sleep in the living room when they are not working. They do not have a bedroom. Their minor daughter is also living with them in the home.

On 06/15/2022, I completed an unannounced onsite investigation and interviewed Licensee, Ms. Julian. She also stated that staff and their daughter were sleeping in the unfinished basement. I again advised her to check basement bedroom requirements.

On 07/13/2022, I completed an exit conference by phone with designated person/ administrator, Eddie Ibarra. I informed Mr. Ibarra of the violations found and that a corrective action plan would be requested. I also informed him that a provisional license would be recommended. Mr. Ibarra stated that he has already been to the home and ensured that weekly pill containers are not being used. He stated that there has always been staff at the home 24 hours a day. Mr. Ibarra indicated that he has spoken to Staff, Haidee Cruz and John Giuagiw, and informed them that they will need to get their own apartment.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(2) A living room, dining room, hallway, or other room that is not ordinarily used for sleeping or a room that contains a required means of egress shall not be used for sleeping purposes by anyone.

ANALYSIS:	On 05/26/2022, I completed an unannounced onsite investigation. Staff, Jhon Giuagiw and Haidee Cruz, indicated that they are live in caregivers. They live in the home with their minor child and sleep in the living room.
CONCLUSION:	**VIOLATION ESTABLISHED**

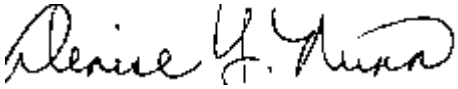
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend issuance of a provisional license.

08/11/2022

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



08/11/2022/

Denise Y. Nunn — Date
Area Manager