STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

August 17, 2022

Donitia Strickland
RSR Serenity LLC
47640 Gratiot Avenue
Chesterfield, MI 48051

RE: License #: AL500408375
Investigation #: 2022A0604022
Sandalwood Village III

Dear Ms. Strickland:

Attached is the Special Investigation Report for the above referenced facility. Disciplinary action against your license is recommended. A recommendation of revocation was previously made in special investigations #2022A0604013 and #2022A0990008, which remain in effect. You will be notified in writing of the department's action and your options for resolution of this matter.

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

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 #:	AL500408375
Investigation #:	2022A0604022
Complaint Receipt Date:	05/09/2022
Investigation Initiation Date:	05/09/2022
Report Due Date:	07/08/2022
Licensee Name:	RSR Serenity LLC
Licensee Address:	47640 Gratiot Avenue Chesterfield, MI 48051
Licensee Telephone #:	(586) 949-6220
Administrator:	Donitia Strickland
Licensee Designee:	Donitia Strickland
Name of Facility:	Sandalwood Village III
Facility Address:	47640 Gratiot Avenue Chesterfield, MI 48051
Facility Telephone #:	(586) 949-6220
Original Issuance Date:	11/01/2021
License Status:	TEMPORARY
Effective Date:	11/01/2021
Expiration Date:	04/30/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED; AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There are residents with facial bruising and head injuries with no explanations.	No
Residents are sitting in soiled briefs for long periods of time. There has been noticeable skin breakdown for at least one resident. Resident found with food on her.	Yes
Professionals have heard staff yelling at residents to sit down.	No
Supplies are not available for showering. There has been trash and a washcloth on the shower floor and not picked up.	No

III. METHODOLOGY

05/09/2022	Special Investigation Intake 2022A0604022
05/09/2022	APS Referral Adult Protective Services (APS) referral denied on 05/05/2022 and referred to licensing.
05/09/2022	Inspection Completed On-site Completed an unannounced onsite investigation on 05/06/2022. Intake initially created for incorrect facility.
05/09/2022	Contact - Document Received Received email from Donitia Strickland with medical records on 05/07/2022. Correct intake not created until 05/09/2022.
05/09/2022	Contact - Document Sent Email to and from APS Worker, Shelly Anders. Ms. Anders has a different set of allegations.
05/09/2022	Contact - Document Received Received email from intake with additional complaint information.
05/09/2022	Special Investigation Initiated - On Site Completed an unannounced onsite investigation on 05/06/2022. Intake initially created for incorrect facility.

05/11/2022	Contact - Document Received Email from Shelly Anders. Sent return email.
05/11/2022	Contact - Document Received Email from Donitia Strickland
05/11/2022	Contact - Document Sent Email to and from Donitia Strickland. Received resident records from Ms. Strickland by email that were requested by APS Worker.
05/12/2022	Contact - Document Received Email from Ms. Strickland
05/13/2022	Contact - Document Received Email from APS Worker, Shelly Anders.
05/16/2022	Contact - Document Sent Email to and from APS Worker Shelly Anders.
05/23/2022	Contact - Document Received Received emails from Donitia Strickland with resident records
05/24/2022	Contact - Document Sent Email to Donitia Strickland
06/09/2022	Contact - Telephone call made Returned call from Ms. Strickland. Confirmed with Josh Hargrove that we are moving forward with recommendation for revocation.
06/09/2022	Contact - Document Sent Email to Ms. Strickland
06/17/2022	Contact - Telephone call made Returned call from Ms. Strickland.
06/21/2022	Contact - Document Received Email from Shelly Anders.
06/22/2022	Contact - Document Sent Email to and from Shelly Anders.
07/06/2022	Contact- Telephone call made Telephone call to Staff, Akikia Green

07/06/2022	Contact- Telephone call made TC to Staff, Macayla Shahid. Left message and received return call.
07/06/2022	Contact- Document Sent Email to APS Worker, Shelly Anders
07/06/2022	Contact- Telephone call made TC to Staff, Latasha Shelton
07/06/2022	Contact- Telephone call made TC to Staff, Mikael Valentine. Left message.
07/06/2022	Exit Conference TC from Licensee Designee, Donitia Strickland. Discussed allegations and completed exit conference by phone.
07/07/2022	Contact- Document Sent Email to Donitia Strickland

ALLEGATION:

- **There are residents with facial bruising and head injuries with no explanations.**
- **Residents are sitting in soiled briefs for long periods of time. There has been noticeable skin breakdown for at least one resident. Resident found with food on her.**
- **Professionals have heard staff yelling at residents to sit down.**

INVESTIGATION:

I received a complaint regarding Sandalwood Village II and III on 05/06/2022. The complaint was originally received for Sandalwood Village I on 05/05/2022, however, it was determined that all residents from Sandalwood Village I had moved to the other buildings. The complaint stated that there are concerns about facility with multiple residents. It was alleged that there are residents with facial bruising and head injuries with no explanations. There are no reports or explanations witnessed. There is more than one patient in the facility in this condition. There are black eyes on some of the residents and concerns about the injuries occurring to the head and faces. The residents are sitting in soiled briefs with feces and urine for a long period of time. There has been noticeable skin breakdown for at least one resident.

A second complaint was received on 05/09/2022 for Sandalwood Village II and III. It was alleged that there is a decline in the level of care provided to residents of facility. There has been trash and a washcloth on the shower floor and not picked up.

Professionals have heard staff yelling at residents to sit down. Staff names and residents unknown. The supplies are not available for showering. Continence checks are not completed or done correctly. Resident has been found in old stool and for the first time has a red and raw bottom. She now has an open pressure sore. Resident has been found with food left on her person which appear to have been there for a long period of time.

I completed an unannounced onsite investigation on 05/06/2022. I interviewed Licensee Designee, Donitia Strickland and Home Manager, Shaundria Washington. They stated that APS Worker, Shelly Anders had just left the facility. I interviewed and/or observed all residents at Sandalwood Village II and III during the onsite investigation. Ms. Strickland and Ms. Washington were not aware of any residents with facial bruising or head injuries. Ms. Strickland stated that they continue to have staffing issues. Ms. Strickland has been enforcing rules and getting push back from some of the staff including them calling off or showing up late. She indicated that some staff are resistant to the recent change of ownership/management.

On 05/06/2022, I attempted to interviewed Resident D. She was getting ready to participate in physical therapy. I did not observe any marks or bruises on Resident D. Resident D has dementia and was speaking about being with kids at apartment.

On 05/06/2022, I observed Resident F. Resident F was sleeping. I did not observe any marks or bruises on Resident F.

On 05/06/2022, I interviewed Resident M. He stated that he was out of bandages for sore on bottom. I observed that Resident M had red sores covering the top of his legs below the knee. Some of the sores were open and some had scabs. The sores appeared to be covered in a clear ointment. During onsite investigation, I received an appointment record from Total Care Physician Group which stated that Resident A was seen in 04/2022 (day not indicated) for wounds on legs. Ms. Strickland provided records that Resident A was seen by Dr. Pou on 04/02/2021 and received wound care from McLaren Health Management Group on 03/11/2021, 04/01/2021 and 04/07/2021. On 05/07/2022, Ms. Strickland emailed records from Total Care Physician Group that indicated Resident M was seen on 02/21/2022, 03/29/2022, 04/22/2022 and 05/02/2022. On 05/16/2022, I received an email from APS Worker, Shelly Anders. She stated that on 05/13/2022 she met with Resident M and he indicated that staff did not bring him a bed pan for about three hours then he had to go in his pants. The AM staff cleaned it up. On 05/23/2022, I received an email from Ms. Strickland with appointment record that stated Resident M had a wound care consult on 05/18/2022 with Mendota Health.

On 05/23/2022, I received four employee counseling memos from Donitia Strickland by email. Staff, Sabrina Gaston, Destiny Beecham and Danisha Williams were written up on 05/13/2022 for neglecting Resident M. The memos stated that on 05/13/2022 it was brought to the Administrators attention that the midnight staff members failed to check on and provide care for Resident M. When he pushed his alarm to ask for assistance no

one came to help or assist him until the morning of the next shift. As a result, Resident M was forced to soil himself and sit and wait until someone came into his room to provide care. Staff, Shaquell Moore, was written up on 05/13/2022 as it was brought to the Administrators attention that they failed to provide breakfast to Resident M and help assist him with eating during the morning. As a result, Resident M was forced to wait until someone came into his room to feed him for this next meal. Ms. Strickland also provided two attendance sheets that indicated two employee orientation/communication meetings were held for staff on 05/19/2022. The agenda indicates that resident care was covered during the meetings.

On 05/06/2022, I observed Resident N. Resident N was sleeping and was on hospice. Resident N passed away on 05/07/2022. I observed that Resident N had a dark purple bruise on left ear. Resident N had an oxygen tube that ran behind ear. Relative N was visiting during the onsite investigation. She stated that she visited on Wednesday, 05/04/2022 and Resident N did not have bruise on her ear. She stated that she first saw bruise today and was not sure what happened. Relative N did not report any concerns. Ms. Washington believed the bruise may have been caused by the oxygen tube and Resident N being at the end of life. On 05/07/2022, I received an email from Donitia Strickland regarding Resident A's ear. The incident report is dated 05/06/2022 and stated that Resident N was observed in morning and as she was turned to her left staff noticed a blood clot or what "appears to be" a bruise. Staff contacted hospice and adjusted oxygen tube as the left ear tube was not correctly behind the ear. I received a second incident report on 05/09/2022 stating that Resident N had passed away on hospice on 05/07/2022.

On 05/06/2022, I interviewed Resident O. She stated that she is doing ok and did not report any concerns. She stated that she gets help from staff when needed. I did not observe any marks or bruises on Resident O.

On 05/06/2022, I interviewed Resident P. She stated that she is doing good, and all the girls (staff) are great. She stated that she loves all of them. I observed that Resident P was sitting on sheets that had urine on them. Ms. Washington stated that staff tried to change Resident P's sheets but she did not want them changed. Ms. Washington asked Resident P again if staff could change her sheets. Resident P stated that she did not want sheets changed until tomorrow morning. I did not observe any marks or bruises on Resident P.

On 05/06/2022, I interviewed Resident Q. She stated that she was doing "ok". She stated that she gets help with everything and has lived at Sandalwood for about 30 days. I observed small scratches on Resident Q's forehead. Resident Q stated that nothing happened to her head. Ms. Washington indicated that she believed the scratches were caused by Resident Q having her hair combed. I did not observe any other marks or bruises on Resident Q.

On 05/06/2022, I interviewed Resident R. She stated that she was doing "ok" and was taking a little nap. Resident R stated that she was receiving help from staff when

needed. She did not report any concerns. I did not observe any marks or bruises on Resident R.

On 05/06/2022, I interviewed Resident S. She stated that she is getting the help she needs from staff. She staff that the staff are good to her. I did not observe any marks or bruises on Resident S.

On 06/22/2022, I received an email from APS Worker, Shelly Anders. Ms. Anders stated that Ms. Strickland wrote up staff so she is substantiating complaint.

On 07/06/2022, I attempted to interview Staff, Akikia Green by phone. She stated that she was at working feeding residents and would call back after work. I did not receive a return call.

On 07/06/2022, I left message for Staff, Mikael Valentine. I did not receive a return call.

On 07/06/2022, I interviewed Staff, Latasha Shelton by phone. She stated that she has been a Direct Care Worker at Sandalwood Village since 02/15/2022. She works midnights. Ms. Shelton mainly works at Sandalwood Village III but has worked at Sandalwood Village II. She stated that she has not observed any residents with head injuries or bruises that had no explanation. She did not report any concerns regarding injuries to residents. Ms. Shelton stated that there are times when she comes onto her shift and the prior shift has not changed the residents briefs or bedding. Ms. Shelton stated that she immediately takes care of it when she starts her shift. Ms. Shelton stated that they have a new resident, Resident T, who has bed sores. Staff were told that he has a cream in medication cart that can be used for sores. Ms. Shelton stated that his wife does not want him changed when visiting and this can delay his brief being changed. Ms. Shelton stated that the only staff she observed yelling at residents was "Shay". She stated that Shay was written up for yelling and has since been fired. Ms. Shelton indicated that Shay would come to work with an attitude. She has not observed any other staff yelling at residents. Ms. Shelton stated that she has noticed that there are times when residents do not get showers. The daily log will be marked "no" as to whether they received a shower. She has also seen residents with food on them. Ms. Shelton indicated that she had found Resident N who has since passed "a mess". Ms. Shelton also stated that there has been a couple times she has found residents with dirty linens. She believes that there can be a lack of communication at Sandalwood. Ms. Shelton indicated that a staff meeting was held to address issues.

On 07/06/2022, I interviewed Staff, Macayla Shalid by phone. She has been a Direct Care Worker at Sandalwood Village since March 2022. She works the afternoon shift. Ms. Shalid was not aware of any residents with head injuries or bruises that did not have any explanation. She did not report any concerns regarding injuries to residents. Ms. Shalid stated that Resident J (Sandalwood Village II) has sensitive skin which does cause her arms to bruise easily. Ms. Shalid stated that there have been times where residents have not been changed timely. Ms. Shalid stated that it has improved though, and everything is getting better with new Administrator. She indicated that Resident T is

a new resident who does have bed sores. He has lived at Sandalwood for about a week. He came to the facility with sores, however, they are getting worse. She stated that his wife will let staff change him during visits if staff ask. Ms. Shalid indicated that Ms. Strickland showered then used cream for Resident T's sores. Ms. Shalid has not observed staff yelling at residents. She indicated that there are times staff are firm with residents and tell them to sit down for their own safety. Ms. Shalid stated that each shift is responsible for showering different residents. She stated that some residents will scream, fight and hit them when they try to give them a shower and so they will not get a shower that day. Some residents require three people to shower them. Ms. Shalid indicated that she has two residents during her shift that are very difficult to shower. Ms. Shalid stated that when she first started, she noticed things were unorganized and staff would neglect things such as showers, changing linens and there were residents left soiled. However, she has noticed that things have gotten better and the morning shift does a good job. She has noticed a positive change and that things are more organized with Donitia Strickland becoming Administrator. Ms. Shalid believed that they could improve by everything becoming more organized and getting everyone on the same page. She stated that one concern is staff not wearing masks at the facility.

On 07/07/2022, I returned call from Licensee Designee/Administrator, Donitia Strickland and completed an exit conference. I informed her of the violation found and that recommendation was to continue revocation that is already in process. Ms. Strickland stated that Resident T's bed sores did start before he moved to Sandalwood Village, and they have a cream to treat sores. Ms. Strickland stated that she is working on a change card for staff to document residents checks that should be implemented this week. Ms. Strickland continues to be open to suggestions and working towards improving care at Sandalwood Village. Ms. Strickland indicated that staff "Shay" is Shaquell Moore. She stated that Ms. Moore did have had attitude with residents and staff and was terminated. Ms. Strickland stated that each resident is scheduled to be showered two times per week with AM, PM or midnight shift. Residents are showered more often if needed. She stated that if a resident refuses a shower, they try to get them showered another day. They also may contact family to see if they can help with getting resident to shower.

APPLICABLE RULE	
R 400.15305	**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:	Resident M's personal needs were not met at Sandalwood Village III. Three staff were written up on 05/13/2022 due to neglecting his care. Resident M pushed his alarm to ask for assistance and no one came to help or assist him until the morning of the next shift. As a result, Resident M was forced to

	soil himself and sit and wait until someone came into his room to provide care. In addition, a fourth staff was written up on 05/13/2022 for failing to provide breakfast to Resident M and help assist him with eating during the morning. As a result, Resident M was forced to wait until someone came into his room to feed him for this next meal. Resident M was found to have wounds on his legs and stated he had sore on bottom. Ms. Strickland provided documentation that he was receiving medical treatment. In addition, Staff, Latasha Shelton and Macayla Shahid did confirm there have been instances at Sandalwood Village where resident's personal needs have not been met including being changed timely, having linens changed or given showers when needed.
CONCLUSION:	**VIOLATION ESTABLISHED**

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.** **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.**
ANALYSIS:	On 05/06/2022, I observed all residents on Sandalwood Village II and III. I did not find any residents with facial bruising and head injuries with no explanations. Resident N did have a dark purple bruise on left ear; however, this was believed to be from oxygen tube. Resident N passed away the next day on 05/07/2022. Staff, Shaquell Moore, was reported to have yelled at residents in the past. Ms. Moore was also staff written up on 05/13/2022 for failing to provide breakfast to Resident M. On 07/06/2022,

	Ms. Strickland confirmed that Ms. Moore no longer works at the facility and had already been terminated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Supplies are not available for showering. There has been trash and a washcloth on the shower floor and not picked up.

INVESTIGATION:

On 05/06/2022, I completed an unannounced onsite investigation at Sandalwood Village II and III. The resident bedrooms and common areas appeared to be generally clean and well kept. I did not observe any trash on the floor.

On 05/11/2022, I received an email from Donitia Strickland. The email contained pictures of shampoo, conditioner, soap available at the facility.

On 07/06/2022, I interviewed Staff, Latasha Shelton by phone. Ms. Shelton stated that they have supplies available such as shampoo, conditioner, and soap to give residents showers. She stated that each shift is assigned different residents to shower. Ms. Shelton did feel there was a lack of communication at Sandalwood which includes housekeeping responsibility. Some staff think housekeeping is not their job.

On 07/06/2022, I interviewed Staff, Macayla Shalid by phone. Ms. Shalid stated that residents have their own supplies available for showers. She indicated that staff are responsible for showering certain residents during each shift. Ms. Shalid stated that Resident E did not have her own soap, however, management was helping her get some. Resident E resides at Sandalwood Village II.

APPLICABLE RULE	
R 400.15314	**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.
ANALYSIS:	There is not enough information to determine that supplies are not available to give residents showers. Ms. Strickland provided pictures of supplies available at Sandalwood Village. Also, staff interviewed stated that they had supplies such as shampoo, conditioner and soap available.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	On 05/06/2022, I completed an unannounced onsite investigation at Sandalwood Village II and III. The facility appeared to be generally clean and well kept.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

A previous recommendation of revocation of the license is being made in special investigations #2022A0604013 and #2022A0990008, which remains in effect. Upon receipt of an acceptable corrective action plan, this investigation will be closed.

07/07/2022

Kristine Cilluffo — Date
Licensing Consultant

Approved By:

08/17/2022

Denise Y. Nunn — Date
Area Manager