GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 5, 2022

Mary Black
1357 N. River Road
St Clair, MI 48079

RE: License #: AS740394225
Investigation #: 2022A0604029
Scotland Manor

Dear Mrs. Black:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. A recommendation of revocation was previously made in confirming letter dated 07/22/2021, which remains 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 #:	AS740394225
Investigation #:	2022A0604029
Complaint Receipt Date:	07/22/2022
Investigation Initiation Date:	07/25/2022
Report Due Date:	09/20/2022
Licensee Name:	Mary Black
Licensee Address:	1357 N. River Road St Clair, MI 48079
Licensee Telephone #:	(810) 650-5902
Administrator:	Mary Black
Licensee Designee:	Mary Black
Name of Facility:	Scotland Manor
Facility Address:	Unit B - 1357 N. River Road St. Clair, MI 48079
Facility Telephone #:	(810) 650-5902
Original Issuance Date:	11/08/2019
License Status:	1ST PROVISIONAL
Effective Date:	02/16/2021
Expiration Date:	08/15/2021
Capacity:	6
Program Type:	MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Untrained staff are providing care and administrating medications for residents.	Yes
Residents being left unattended through the night, sometimes during the day and not receiving their medications if staff are unable to work.	No
A man named Bret with convictions and addiction issues is the only person left with the residents most nights.	No
Residents are only being showered once per week.	No
Additional Findings	Yes

III. METHODOLOGY

07/20/2022	Contact- Face to Face Zoom Hearing with Administrative Law Judge, Aaron McClintic re: Notice of Intent to revoke license
07/21/2022	Contact- Face to Face Zoom Hearing with Administrative Law Judge, Aaron McClintic re: Notice of Intent to revoke license
07/22/2022	Special Investigation Intake 2022A0604029
07/25/2022	Special Investigation Initiated - Telephone TC to Adult Protective Services (APS) Supervisor, Jennifer Perrin
07/25/2022	APS Referral Made referral to adult protective services (APS).
07/25/2022	Contact - Document Sent Email to Jennifer Perrin.
07/25/2022	Contact - Telephone call made TC to Jennifer Perrin. Received return call.
07/26/2022	Contact - Document Sent Email to Jennifer Perrin and Marnie DeBell. Received return email from Marnie DeBell.

07/26/2022	Inspection Completed On-site Completed unannounced onsite investigation with Adult Foster Care (AFC) Licensing Consultant Eric Johnson, APS Supervisor Jennifer Perrin and APS Worker Marnie DeBell. Interviewed David and Mary Black. Resident C and Resident D present.
07/27/2022	Contact - Document Sent Email to Mary Black and Attorney, Eric Naslund requesting documents for special investigation
07/28/2022	Contact - Telephone call received TC from Attorney, Eric Naslund. Returned call and referred him to Manager.
09/15/2022	Contact- Document Received Received Proposal for Decision supporting Notice of Intent to revoke license.
10/03/2022	Exit Conference Completed exit conference with Licensee, Mary Black by phone.

ALLEGATION:

- **Untrained staff are providing care and administrating medications for residents.**
- **Residents being left unattended through the night, sometimes during the day and not receiving their medications if staff are unable to work**.
- **A man named Bret with convictions and addiction issues is the only person left with the residents most nights.**

INVESTIGATION:

I received a complaint regarding Scotland Manor on 07/22/2022. It was alleged that untrained staff are providing care and administrating medications for residents. Residents are being left unattended through the night, sometimes during the day and not receiving their medications if staff are unable to work. Residents are only being showered once per week. There are reports of a gentleman by the name of Bret who has convictions and addiction issues, that "lives in an opening in the wall at the end of the hallway", being the only person left with the residents most nights.

I completed an unannounced onsite investigation at River's Edge Assisted Living and Scotland Manor on 07/26/2022 along with AFC Licensing Consultant Eric Johnson, APS Supervisor, Jennifer Perrin and APS Worker, Marnie DeBell. Mary and David Black were present during investigation. A similar licensing complaint was also received for River's Edge Assisted Living on 07/25/2022.

On 07/26/2022, I interviewed Licensee, Mary Black. She stated that all records should be requested from her Attorney, Eric Nasland. She stated that Bret Thurman has been trained through Direct Care Training and has been trained in CPR/First Aid. She stated that she did not have a copy of his clearance and that it could be requested from her attorney. She then stated that he is her "maintenance guy". Ms. Black stated that no one is sleeping in the room at end of hallway. There is only access to the room from the outside of the home. Ms. Black stated that Mr. Thurman does sleep at her home sometimes and can sleep in any bedroom he wants as there are several bedrooms in her home. Ms. Black stated that there are always staff present at both of her homes. Residents are never left alone. She stated that staff always pass medications.

On 07/26/2022, Resident C and Resident D were present at the home. Resident C told APS that he liked it at the home and liked watching the boats. Resident D stated that she gets help and medications from staff. She said that there is staff at the home and a "big guy" works here. David Black did not believe licensing or APS should be interviewing residents during onsite investigation.

On 07/26/2022, AFC Licensing Consultant, Eric Johnson reviewed Resident D's medications and medication log. The medication administration record indicated for Resident D to take Alprazolam, 2 tabs, 2x a day. The label indicated to take one tablet by mouth twice daily. Ms. Black changed the dosage on the medication administration record during the onsite inspection. Also, Resident D's 8:00 AM medications were not initiated by staff on 07/26/2022. The investigation was completed in the afternoon. The medications not initiated by staff included Triamcinolone 0.1 mg cream, Alprazolam .25 mg, Folic Acid 1 mg, Fluticasone spray 50 Mcg, Levothyroxine 100 mcg and Citalopram 20 mg. In addition, Resident D's Divalproex was not present in the home. Ms. Black stated that the medication ran out today, then she said that it did not run out but it was discontinued (DC). She said the DC order would have to be requested from her attorney.

On 07/27/2022, I sent email to Mary Black and her attorney, Eric Naslund requesting order discontinuing medication. As of 10/03/2022, the information has not been received.

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:	Licensee, Mary Black, stated that Bret Thurman's clearance could be requested from her attorney. On 07/27/2022, I sent email to Ms. Black and her attorney, Eric Naslund, requesting clearance. No clearance was provided as of 10/03/2022. No additional employee information has been provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Licensee, Mary Black, stated that Bret Thurman's training records could be requested from her attorney. Ms. Black stated that Mr. Thurman was trained through Direct Care Training. On 07/27/2022, I sent an email to Mary Black and her attorney, Eric Naslund, requesting training records. No training records have been provided as of 10/03/2022. No additional employee information has been provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	There is not enough information at this time to determine that residents are left alone. Licensee, Mary Black, stated that there are always staff at the home. A current staff list was not provided to interview additional staff who work at home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident D's medication administration record indicated to take Alprazolam, 2 tabs, 2x a day. The label indicated to take one tablet by mouth twice daily. Ms. Black was observed to change the dosage on the medication administration record during the onsite inspection.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has the knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**

ANALYSIS:	It is unknown if current staff are trained in the proper handling and administration of medication. Ms. Black did not provide staff list and phone numbers in order to interview staff or any training records. Resident D's 8:00 AM medications were not initiated by staff on 07/26/2022. The investigation was completed in the afternoon. The medications not initiated by staff included Triamcinolone 0.1 mg cream, Alprazolam .25 mg, Folic Acid 1 mg, Fluticasone spray 50 Mcg, Levothyroxine 100 mcg and Citalopram 20 mg. Resident D's Divalproex was not present in the home. Ms. Black stated that the medication ran out today, then she said that it did not run out but it was discontinued. She said the DC order would have to be requested from her attorney
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference confirming letter dated 07/22/2021**

ALLEGATION:

Residents are only being showered once per week.

INVESTIGATION:

It was alleged that residents are only being showered once per week. The license rule only indicates that residents should be bathed at least weekly or more often as necessary.

On 07/26/2022, I interviewed Mary Black at Scotland Manor. Ms. Black stated that residents at Scotland Manor are bathed three times a week. She stated that residents that wet themselves are bathed more often. During the onsite investigation, I observed Resident C and Resident D. The residents appeared to be adequately groomed.

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.

ANALYSIS:	There is not enough information to determine that residents are not bathed weekly at Scotland Manor. Ms. Black stated that residents are bathed three times per week or more often if necessary. On 07/26/2022, I observed Resident C and Resident D to be adequately groomed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/26/2022, I completed an unannounced onsite investigation at Scotland Manor. During the investigation, Licensee Mary Black directed licensing to request all needed records from her Attorney, Eric Naslund. On 07/27/2022, I sent an email to Attorney, Eric Naslund and Mary Black requesting the following records:

- Current staff list and phone numbers
- Fingerprinting clearance and training records for Staff, Bret Thurman, at Scotland Manor
- Fingerprinting clearance and training records for Staff, Anna Swinson, at River's Edge Assisted Living
- Incident reports for (Resident A and Resident B) deaths- Scotland Manor
- Incident report for (Resident C) hospitalization- River's Edge Assisted Living
- Order discontinuing (Resident D) Divalproex- Scotland Manor

As of 10/03/2022, Ms. Black and Mr. Naslund have not provided any of the requested records to licensing.

APPLICABLE RULE	
R 400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(3) The failure of an applicant or licensee to cooperate with the department in connection with an inspection or investigation shall be grounds for denying, suspending, revoking, or refusing to renew a license.

ANALYSIS:	Licensee, Mary Black, has not cooperated with providing records needed for special investigation to licensing. During the onsite investigation, Mary Black told licensing to request all records from her attorney. On 07/27/2022, I sent email to Mary Black and her attorney, Eric Naslund, requesting records. As of 10/03/2022, no records have been provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 07/26/2022, I completed an unannounced onsite investigation at Scotland Manor. During the investigation, Licensee Mary Black stated that Resident A and Resident B had passed away. Incident reports have not been provided to licensing. Ms. Black indicated that incident reports could be requested from her attorney. On 07/27/2022, I sent email to Attorney Eric Naslund and Mary Black requesting incident reports for Resident A and Resident B's deaths. As of 10/03/2022, the incident reports were not provided to licensing.

I completed an exit conference with Licensee, Mary Black on 10/03/2022. I informed her of the findings and recommendations. I also informed her that a copy of the special investigation report would be mailed once approved.

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: **(a) The death of a resident.**
ANALYSIS:	On 07/26/2022, Mary Black stated that Resident A and Resident B had passed way. Incident reports have not been provided for resident deaths.
CONCLUSION:	**VIOLATION ESTABLISHED**

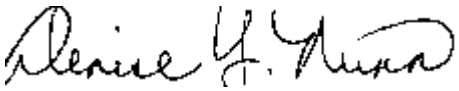
IV. RECOMMENDATION

A previous recommendation of revocation of the license was made in confirming letter dated 07/22/2021, which remains in effect.

10/03/2022

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



10/05/2022

Denise Y. Nunn — Date
Area Manager