GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 16, 2022

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

RE: License #: AS740394225
Investigation #: 2023A0604004
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 previous recommendation of revocation was 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 #:	2023A0604004
Complaint Receipt Date:	11/15/2022
Investigation Initiation Date:	11/15/2022
Report Due Date:	12/15/2022
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?
David Black is not supposed to be around residents. There are individuals with felonies living in the home.	Yes
Dogs are bullying residents.	No
Residents are neglected and not given showers, oral care, bowel therapy or blood pressure taken.	No
Medications are not given as prescribed. Resident E was hospitalized due to seizure medication not being given.	No
Medications are not locked up and are in reach of residents.	Yes
Staff had to beg for food to feed residents.	No
Resident E has no clothes.	No
House is dirty and need deep cleaning.	No
Toilet is leaking and creating a fall risk.	No
Additional Findings	Yes

III. METHODOLOGY

11/15/2022	Special Investigation Intake 2023A0604004
11/15/2022	Special Investigation Initiated - Telephone TC to Complainant. Text message from Complainant. Returned messages.
11/15/2022	APS Referral Referral made to Adult Protective Services (APS).
11/15/2022	Contact - Document Sent Email to APS Supervisor, Jennifer Perrin and APS Worker, Steven Dutcher
11/16/2022	Contact - Telephone call received Received message from APS Worker, Steven Dutcher. Returned call.
11/16/2022	Inspection Completed On-site Completed unannounced onsite investigation with Area Manager, Denise Nunn and Adult Foster Care (AFC) Licensing Consultant, Eric Johnson. Interviewed Mary Black and observed Resident C, Resident E, Resident F and Resident G.

11/16/2022	Contact - Telephone call received Received TC and text messages from Complainant. Returned phone call and messages.
11/18/2022	Contact - Document Sent Email to Mary Black. Requested documents for special investigation.
11/22/2022	Contact - Document Sent Email to and from APS Worker, Steven Dutcher
11/23/2022	Exit Conference I attempted to conduct the exit conference with Mary Black by phone. Unable to leave message. Sent email to Mary Black with findings.

ALLEGATION:

David Black is not supposed to be around residents. There are individuals with felonies living in the home.

INVESTIGATION:

A complaint was received regarding Scotland Manor on 11/14/2022. It was alleged that there are a total of four residents that live at Scotland Manor. The residents have physical, cognitive and mental health issues. It is unclear if the residents have a legal guardian or a power of attorney. The group home is understaffed and does not have staff properly trained to care for the residents. The residents are given the wrong medication and are not bathed regularly. The residents are unable to advocate for themselves due to their disabilities. David is the homeowner and is aware of the issues. Law enforcement has been contacted, but they have not intervened. There are concerns for the resident's safety and well-being in the home.

On 11/14/2022, I received a phone call from Complainant. The Complainant stated that residents are being abused and neglected. Complainant stated that they are scared for the residents. The Complainant stated that owner, David Black, is a felon and should not be around the residents. He is being threatening to staff. Staff has worked 144 hours in one week and not been paid. Medications are not being passed correctly.

On 11/15/2022, I contacted the Complainant by phone. The Complainant confirmed that the allegations are regarding both River’s Edge Assisted Living and Scotland Manor. The Complainant indicated that David Black was threatening and not paying staff. I received texts from Complainant regarding allegations at Scotland Manor. The Complainant alleged that Resident E was hospitalized due to seizure medications not being given. Complainant stated that Resident C was not given medications correctly. There are extra pills and medication errors. The medications are not locked up and are

within reach of the residents. There are extra medications in unlocked kitchen cabinets from prior residents. The Complainant stated that the house needs deep cleaning. The doctor has ordered for resident blood pressures to be taken, however, Mary Black told staff not to take them. Staff must use their own gait belts. Residents are being neglected and do not receive showers, oral care, or bowel therapy. Resident E does not have any clothes. David Black's dogs are bullying the residents. There are felons that live in the home. Complainant stated that staff had to beg for food to cook for residents. Resident F and Resident G's bathroom has a toilet leak causing a fall risk. The Complainant alleged that Mary Black takes pills affecting her ability to care for residents.

On 11/16/2022, I completed an unannounced onsite investigation at Scotland Manor. APS Worker, Steven Dutcher was also present with an observing APS Worker. Upon arrival, we were met by David Black at the front of the home. Mr. Black began filming on his phone and requested each worker to state their name. Mr. Black initially stated that he would only allow one worker into the home at a time. However, he later agreed to let myself and Area Manager, enter the AFC portion of the home and allowed Mr. Johnson and APS workers upstairs. The state police were also present as Mr. and Mrs. Black have alleged that Mrs. Black was assaulted by a staff. I asked Mr. Black if he was currently living at the home and he indicated that he would not answer the question. However, later he stated that I approved him to live in home. Mrs. Black has previously reported that Mr. Black was residing in St. Clair Shores, MI and provided a copy of his driver's license on 11/19/2020 with an updated address sticker on back. A workforce background check exclusion notice was received for David Black on 11/10/2020. Mr. Black is not eligible to work in a job that involves direct access or provide direct services to a patient or resident in an adult foster care before 12/15/2025.

Mr. Black has been present at Scotland Manor during the last two unannounced onsite investigations. On 07/26/2022, David Black was present at River's Edge Assisted Living and later at Scotland Manor during onsite investigations. On 07/26/2022, I interviewed David Black. He stated that he was not involved with home and was working in the yard. He stated that he was getting ready for boat races.

On 11/16/2022, I interviewed Mary Black at Scotland Manor. Ms. Black was visibly upset and indicated that she felt like she was going to pass out. Ms. Black stated that she believed allegations were being made by a staff who allegedly assaulted her. The state police were present at Scotland Manor when we arrived, and Ms. Black stated that she was making a police report against the staff. Ms. Black indicated that there were no individuals living in the home that had felonies. Ms. Black stated that there are currently two residents at Scotland Manor, Resident C and Resident E. She stated that Resident F and Resident G are not residents and only at the home for respite care. Ms. Black stated that she did not want to provide last names or guardian information for Resident F and Resident G as they were only there for respite care.

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:	David Black has been present at Scotland Manor during the last two onsite investigations on 07/26/2022 and 11/16/2022. On 11/16/2022, David Black was the person responsible onsite for allowing access to the AFC portion of the home and residents. A workforce background check exclusion notice was received for David Black on 11/10/2020. Mr. Black is not eligible to work in a job that involves direct access or provides direct services to a patient or resident in an adult foster care before 12/15/2025. There is not enough information to determine that there are any other individuals with felonies living in the home.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2022A0604029 dated 10/05/2022**

ALLEGATION:

- **Dogs are bullying residents.**
- **Residents are neglected and not given showers, oral care, bowel therapy or blood pressure taken.**

INVESTIGATION:

On 11/16/2022, I completed an unannounced onsite investigation. I did not observe any dogs in the AFC portion of the home. I interviewed Licensee, Mary Black. She stated that she has many dogs, however, denied that dogs have ever bitten any residents or destroyed any property. Ms. Black denied that residents are neglected and not given showers, oral care or bowel therapy. She stated that no residents have doctors' orders for blood pressure to be taken by home. She indicated that residents' teeth are brushed when they get ready in the morning. Ms. Black provided a Monthly Shower Assistance Log. The log tracks if residents are given a shower, bath or sponge bath and whether they had their hair washed. The schedule indicated that residents are receiving one to two showers a week. I observed residents to be adequately clean during the onsite investigation.

On 11/18/2022, I sent an email to Mary Black requesting staff names, phone numbers and resident assessment plans. I did not receive a response or the requested information. I was unable to interview additional staff or review records to obtain additional information on resident care.

APPLICABLE RULE	
R 400.14305	**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:	There is not enough information to determine that residents are not being protected and dogs are bullying residents. On 11/16/2022, I completed an unannounced onsite investigation. I did not observe any dogs in the AFC portion of the home. I interviewed Licensee, Mary Black. She stated that she has many dogs, however, denied that dogs have ever bitten any residents or destroyed any property. There is not enough information at this time to determine that residents are neglected and not given showers, oral care, bowel therapy or blood pressure taken. Information requested on 11/18/2022 was not provided to licensing.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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 at this time to determine that residents are neglected and not given showers or oral care. The Monthly Shower Assistance Log indicated that residents are receiving one to two showers a week. Residents were observed to be adequately clean during the onsite investigation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **Medications are not given as prescribed. Resident E was hospitalized due to seizure medication not being given.**
- **Medications are not locked up and are in reach of residents.**

INVESTIGATION:

On 11/16/2022, I completed an unannounced onsite investigation. I observed the medication cabinet in the kitchen with a key still in the lock. I observed medications that were stored in an unlocked cabinet to the left of the cabinet with the key. Mary Black stated that they were medications that were no longer being used. I also observed medications being stored in the lower cabinet on the opposite side of kitchen. The cabinet did not have a lock. I observed weekly pill containers in this cabinet, however, Ms. Black quickly shut the cabinet so I could not verity that they were not in use as she stated.

I interviewed Mary Black. She stated that Resident E was not hospitalized due to seizure medication not being given. She stated that Resident E did not have a seizure and does not take a seizure medication. She stated that Resident E had a TIA (transient ischemic attack which is a mini stroke) and went to hospital to get checked out and came back home. She was not admitted to hospital.

During the onsite investigation, I requested to see resident medication logs. Ms. Black stated that logs were upstairs. Ms. Black went upstairs and came back with a blank medication log that she stated was for a resident at River's Edge Assisted Living. Ms. Black went upstairs a second time and returned with an empty binder stated that she had medication logs, however, could not locate them.

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 11/16/2022, I observed medications being stored in two kitchen cabinets that did not have locks. The cabinet with a lock still had the key in the lock.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	There is not enough information at this time to determine that medications are given, taken or applied pursuant to label instructions. Medications could not be reviewed during the onsite investigation as the medication logs were not available.
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.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	On 11/16/2022, I requested to review resident medication logs at Scotland Manor. Licensee, Mary Black, was unable to locate medication logs for any of the residents during the investigation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Confirming Letter dated 07/22/2021 and SIR #2022A0604029 dated 10/05/2022**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	On 11/16/2022, Licensee, Mary Black indicated that medications in an unlocked cabinet were no longer used by residents. Medications no longer required should be properly disposed of.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff had to beg for food to feed residents.

INVESTIGATION:

On 11/16/2022, I completed an unannounced onsite investigation at Scotland Manor. Licensee, Mary Black, stated that there is food available for staff to cook for residents. I observed an adequate amount of food in the refrigerator and fresh fruit.

On 11/18/2022, I sent email to Mary Black requesting staff names and phone numbers. I did not receive a response or requested information. I was unable to interview additional staff regarding food availability in the home.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	There is not enough information at this time to determine that food is not available in the home. On 11/16/2022, I completed an unannounced onsite investigation and observed an adequate amount of food in the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident E has no clothes.

INVESTIGATION:

On 11/16/2022, I completed an unannounced onsite investigation. Licensee, Mary Black, stated that Resident E has clothes available at the home. I observed Resident E's bedroom. Resident E had a dresser with clothing available. There was also a new winter coat in the bedroom that Ms. Black stated was recently purchased for Resident E.

On 11/18/2022, I sent email to Mary Black requesting staff names and phone numbers. I did not receive a response or requested information. I was unable to interview additional staff regarding availability of clothing in the home.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(4) A licensee shall afford a resident opportunities, and instruction when necessary, to dress as fashion, fit, cleanliness, and season warrant.
ANALYSIS:	There is not enough information to determine Resident E has no clothes. On 11/16/2022, I completed an unannounced onsite investigation and observed that Resident E had a dresser full of clothing and winter jacket.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

House is dirty and need deep cleaning.

INVESTIGATION:

On 11/16/2022, I completed an unannounced onsite investigation. I observed that the home was adequately clean. I did not observe any soiled surfaces or excessive clutter.

On 11/18/2022, I sent email to Mary Black requesting staff names and phone numbers. I did not receive a response or requested information. I was unable to interview additional staff regarding cleanliness of home.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	There is not enough information to determine that the house is dirty and needed deep cleaning. On 11/16/2022, I completed an unannounced onsite investigation and the home was adequately clean.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Toilet is leaking and creating a fall risk.

INVESTIGATION:

On 11/16/2022, I completed an unannounced onsite investigation. I observed the three bathrooms located in the home. I did not observe any water on the bathroom floors. None of the toilets leaked when flushed. Ms. Black stated that toilet leak had been repaired.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(6) All plumbing fixtures and water and waste pipes shall be properly installed and maintained in good working condition. Each water heater shall be equipped with a thermostatic temperature control and a pressure relief valve, both of which shall be in good working condition.

ANALYSIS:	On 11/16/2022, I completed an unannounced onsite investigation. I observed all three bathrooms. None of the toilets were leaking or creating a fall risk.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(7) All water closet compartments, bathrooms, and kitchen floor surfaces shall be constructed and maintained so as to be reasonably impervious to water and to permit the floor to be easily kept in a clean condition.
ANALYSIS:	On 11/16/2022, I completed an unannounced onsite investigation. I did not observe any water on the bathroom floors creating a fall risk.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 11/18/2022, I sent email to Mary Black requesting documents for River's Edge Assisted Living and Scotland Manor special investigations. I requested Ms. Black to fax or email the documents by 11/22/2022. I requested the following documents for Scotland Manor:

- Resident Register
- Guardian's names and phone numbers
- Staff list and phone numbers
- Resident assessment plans
- November 2022 medication administration records
- Verification of medication training for staff passing medications

As of 11/23/2022, Mary Black has not provided any of the requested documents to licensing.

I attempted to complete an exit conference with Licensee, Mary Black, by phone on 11/23/2022. I was unable to leave a message. I sent Ms. Black an email with my findings and also notified her that a copy of special investigation report would be mailed once approved.

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/documents needed for this special investigation to licensing. On 11/18/2022, I sent an email to Mary Black requesting records by 11/22/2022. As of 11/23/2022, no records or response has been received.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2022A0604030 dated 10/05/2022**

IV. RECOMMENDATION

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

Kristine Cilluffo 11/23/2022

Kristine Cilluffo Date
Licensing Consultant

Approved By:

Denise Y. Nunn 11/23/2022

Denise Y. Nunn Date
Area Manager