GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 2, 2021

Fredrick Hayes
18759 Greenwald
Southfield, MI 48075

RE: License #: AF630313888
Investigation #: 2021A0602030
Good Faith Manor

Dear Mr. Hayes:

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,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF630313888
Investigation #:	2021A0602030
Complaint Receipt Date:	07/30/2021
Investigation Initiation Date:	07/30/2021
Report Due Date:	09/28/2021
Licensee Name:	Fredrick Hayes
Licensee Address:	18759 Greenwald Southfield, MI 48075
Licensee Telephone #:	(248) 632-3778
Administrator:	N/A
Licensee Designee:	Fredrick Hayes
Name of Facility:	Good Faith Manor
Facility Address:	18759 Greenwald Southfield, MI 48075
Facility Telephone #:	(248) 632-3778
Original Issuance Date:	10/26/2012
License Status:	REGULAR
Effective Date:	11/11/2019
Expiration Date:	11/10/2021
Capacity:	6
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A has gone days without eating because she believes someone is poisoning her food.	No
Resident A must plead with staff to take her to the bathroom.	No
Staff has not been nice to her for three years.	No
Additional Findings	Yes

III. METHODOLOGY

07/30/2021	Special Investigation Intake 2021A0602030
07/30/2021	Special Investigation Initiated - Telephone Call made to APS – referral not assigned.
07/30/2021	APS Referral Adult protective services (APS) referral denied.
08/06/2021	Inspection Completed On-site No response.
09/02/2021	Inspection Completed On-site Interviewed staff member, Nathaniel Waller, and residents.
09/02/2021	Contact – Telephone call received Received a message from Resident A's physician.
09/03/2021	Contact – Document received Received email from Allysa Hayes.
09/03/2021	Contact – Telephone call made Message left for Resident A's physician.
10/20/2021	Contact – Document sent Email sent to Allysa Hayes; Resident A is back in the hospital.
11/03/2021	Contact – Document sent I sent an email to Allysa Hayes requesting a contact number for the licensee, Fredrick Hayes.

11/05/2021	Exit Conference Message left for the Fredrick Hayes.
11/08/2021	Contact – Telephone call received Spoke with Mr. Hayes – exit conference conducted.

ALLEGATION:

- **Resident A has gone days without eating because she believes someone is poisoning her food.**
- **Resident A must plead with staff to take her to the bathroom.**
- **Staff has not been nice to her for three years.**

INVESTIGATION:

On 7/30/2021, a complaint was received and assigned for investigation alleging that Resident A has gone days without eating because she believes someone is poisoning her food, Resident A must plead with staff to take her to the bathroom and staff has not been nice to her for three years.

On 8/06/2021, I conducted an unannounced on-site investigation but there was no response.

On 9/02/2021, I conducted another unannounced on-site investigation. Staff member Nathaniel Waller answered the door and stated he could not allow me into the home due to COVID. I identified myself and explained that he could not refuse my entry into the home as I was wearing appropriate personal protection equipment (PPE) and I needed to interview the residents to address the allegations documented in the complaint. Mr. Waller allowed me into the home. Mr. Waller stated Resident A was not home as she was hospitalized for psychiatric treatment. According to Mr. Waller, Resident A would not eat some meals because she believed someone was poisoning her food. He had no information about any staff member not being nice to her or not assisting her with going to the bathroom.

On 9/02/2021, I interviewed Resident B, Resident C and Resident D. Residents B, C, and D stated they were unaware of staff being mean to Resident A and did not have any other information to report regarding Resident A.

I was unable to interview Resident A as she was not home at the time the on-site investigation was conducted. On 10/20/2021 and 11/08/2021, I attempted to interview Resident A again by telephone, but she had been hospitalized again.

APPLICABLE RULE	
R 400.1412	**Resident behavior management; prohibitions.**
	(1) A licensee shall not mistreat or permit the mistreatment of a resident by responsible persons or other occupants of the home. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm.
ANALYSIS:	Based on the information obtained during the investigation, I was unable to determine if Resident A was in fact mistreated by staff as she was not home at the time the inspection was conducted. I attempted to interview Resident A again on 10/20/21 and 11/08/21, but she had been hospitalized again. According to Mr. Waller, Resident A would not eat some meals because she believed someone was poisoning her food and he had no information about any staff member not being nice to her or not assisting her with going to the bathroom. Residents B, C, and D were unaware of staff being mean to Resident A and did not have any other information to report regarding Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

Upon entering the home on 9/02/2021, there was an odor mimicking the smell of sewage. Mr. Waller had no explanation for the odor.

I observed 12 residents sitting on the couch in the living room and in chairs in the dining room. The residents were eating what appeared to be tuna or chicken salad, peanut butter and crackers and drinking water. They were using paper plates, cups, and plastic forks. There were two residents sitting on the deck at the back of the home. I requested to see the resident registry and Mr. Waller was unable to provide it. I asked Mr. Waller to identify the residents in the home. He identified Residents A, C, D, E, L and M as the only residents who reside in the home. He stated Resident E was not home at the time, but Resident B, according to Mr. Waller, does not reside in the home. However, she was laying in Resident E's bed taking a nap. Mr. Waller then said he needed to contact his mother, Christine Hayes.

While in the home I spoke with Ms. Hayes by telephone. Ms. Hayes stated there are only six residents who reside in the home. The other residents reside in a room and board facility not far from the home. She said they came to the home to do arts and crafts with the residents at Good Faith Manor. The operator of the room and board

facility paid an agency to do the arts and craft and agreed to pay for the residents of Good Faith Manor to participate if it could be conducted at their home. Ms. Hayes could not provide the name of the agency who was scheduled to come to the home and facilitate the activities. I informed Ms. Hayes that there was no one at the home facilitating any arts and crafts nor was there enough room for 14 residents to participate in arts and crafts in a three-bedroom ranch-styled home. I informed Ms. Hayes that there was a foul odor in the home that smelled like sewage. She stated there is an issue with the sump pump that is scheduled to be repaired.

APPLICABLE RULE	
R 400.1426	**Maintenance of premises.**
	(1) The premises shall be maintained in a clean and safe condition.
ANALYSIS:	Based on my observation during the investigation, there was a foul odor in the home. According to Ms. Hayes, there was an issue with the sump pump that was scheduled to be repaired. According to Mr. Hayes, the issue was not with the sump pump but rather with the sanitation piping but was repaired two weeks ago.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Licensing Study Report dated 11/3/15, CAP approved 11/4/15; Special Investigation Report #2018A0602029, CAP approved 9/7/2018; Licensing Study Report dated 10/25/19. CAP approved 11/05/19**

INVESTIGATION:

While interviewing Mr. Waller, I observed an unlocked medication cart in the dining room of the home. Regarding if it was time to administer medication, Mr. Waller stated staff members are not allowed to administer residents their medication. Mr. Hayes keeps the medications locked in his room and he administers them. Mr. Waller was asked if I could look in the medication cart and he responded, “the resident’s medication is not stored there.” When he opened the cart, I observed numerous medications that were not organized at all. There were loose insulin needles, an open bottle of vitamins and an empty bottle of acetaminophen along with several other medications prescribed for several different people. Mr. Waller said the medications were old and for residents who no longer resided in the home. According to Mr. Waller, Resident A and Resident E currently reside in the home and I observed medications prescribed for them in the cabinet. There were three bottles of Sevelamer Carb 800 mg Tab (4 tabs, 3 times daily with meals) prescribed to Resident A that were not expired.

The following medications were prescribed to Resident E but were expired:

- Olanzapine 7.5 mg Tab – 1 tab by moth at bedtime
- Bupropion 100 mg Tab – 1 tab by mouth every morning
- Levothyroxin 50 mcg Tab – 1 tab by mouth every Friday
- Levothyroxin 100 mcg Tab – 1 tab by mouth once daily
- Simvastatin 20 mg Tab – 1 tab by mouth at bedtime
- Divalproex 250 mg Tab – 1 tab by mouth twice daily
- Aspirin 81 mg Tab – 1 tab by mouth once daily

The following medication was prescribed to Resident F and were expired:

- Insulin Syringes 0.5/31 g
- Linezolid 600 mg – 1 tab every 12 hours for 7 days (2 blister packs were observed)

The following medication was prescribed to Resident G and was expired:

- Cephalexin 500 mg – 1 capsule by mouth every 12 hours for 10 days (2 blister packs were observed)

The following medication was prescribed to Resident H and was expired:

- Nicotine TD DIS 14 mg/24H – apply 1 patch transdermal (remove old patch)

The following medications were prescribed to Resident I and were expired:

- Benztropine 1 mg Tab – 1 tab by mouth twice daily
- Haloperidol 5 mg Tab – 1 tab by mouth twice daily
- Esomepra 20 mg MAG CAP – 1 capsule by mouth once daily before a meal
- Metoprol 100 mg ER Tab – 1 tab by mouth once daily
- Vitamin B-1 100 mg Tab – 1 tab my mouth once daily

The following medications were prescribed to Resident J and were expired:

- Atorvastatin 10 mg Tab – 1 tab by mouth once daily
- Calcium 500 mg Tab – 1 tab by mouth twice daily
- Lisinopril 10 mg Tab – 1 tab by mouth once daily
- Metformin 500 mg Tab – 1 tab by mouth twice daily with morning and evening meals

The following medication was prescribed to Resident K and was expired:

- Latanoprost 0.005% eye drops – 1 drop in both eyes every night at bedtime

I also observed insulin stored in the refrigerator that was not contained in a locked box.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(5) Prescription medication shall be kept in the original pharmacy-supplied and pharmacy-labeled container, stored in a

	locked cabinet or drawer, refrigerated if required, and labeled for the specific resident.
ANALYSIS:	Based on the information obtained during the investigation and my own observation, on 9/02/2021 the medication cabinet was unlocked and there was insulin stored in the refrigerator without being contained in a locked box.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(7) Prescription medication which is no longer required by a resident shall be destroyed after consultation with a physician or a pharmacist.
ANALYSIS:	Based on the information obtained during the investigation and my own observation, there were numerous medications stored in an unlocked medication cabinet. Mr. Waller stated the medication belonged to residents who no longer reside in the home. However, there were medications stored in cabinet that were prescribed to Resident A and Resident E. Mr. Hayes stated he was instructed by a doctor not to discard any old medication or medication for residents who no longer reside in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite I observed the refrigerator to be unclean and contained what appeared to be old, dried food and or some sort of dried liquid throughout the entire refrigerator. There was a bowl of canned peaches that were uncovered, the bottom drawer was missing, and the water filtration tubing was dirty and laying in the bottom of the refrigerator. The freezer was also unclean with a light brown yellowish color substance stained at the bottom and one of the shelves was broken. The two freezers located in the garage were also unclean with a brown frozen substance contained at the bottom of one and a brown substance on the shelves located on the inside of the door of the other. I did not observe any fresh fruit, milk, juice, or bread in the refrigerator.

On 9/02/2021, I interviewed Resident B, Resident C and Resident D while at the home. Resident B stated she does in fact reside at the home and was laying in her own bed. She said she receives her medication, but she had concerns about the food and the number of people living in the home. The residents are not provided coffee and there is

rarely any milk, orange juice or eggs available. Residents are served Kool-Aid or water almost daily with each meal. The meals that are provided are small portions and some of the residents' have stolen food from one another. Meals are served on paper plates and drinks are served in disposable plastic cups. Staff wash the plastic cups and residents must reuse them. Resident B stated that residents from a room and board come to the home during the day and leave at night during the week. On the weekends, some of these same residents spend the night at the home. Resident B said there are numerous people in the home and is unable to keep count of all of them.

Resident C stated there are about eight residents who live in a room and board facility that sleep at the home on the weekends because there is no staffing where they live. She said the home is overcrowded when this happens. Resident C said the residents are not provided coffee and they use paper plates and plastic utensils when eating.

Resident D stated he suffers from rheumatoid arthritis and has some difficulty keeping his balance when walking. He is prescribed 7 medications and staff administers them to him daily. Resident D stated he does not know how many residents live in the home but there are more than 6.

While interviewing the residents, a man driving an SUV pulled in the driveway, entered the home, and began escorting several residents from the home and into the vehicle before driving off.

On 9/03/2021, I received an email from staff member Allysa Hayes with a copy of the resident registry and medication logs for Resident A for the months of August and September 2021. The resident registry contained the names of Resident A, Resident B, Resident C and Resident D. The registry did not contain the names of any of the residents who had moved out of the facility or died (Residents E, F, G, H, I, J and K). According to Resident A's medication logs, Resident A was prescribed the following medication:

- Seroquel 50 mg – 1 tab by mouth at bedtime
  Risperidone 0.05 mg – 2 tabs by mouth daily
- Midodrine Hydrochloride 5 mg – 1 tab by mouth 3 times weekly (Tuesday, Thursday, Saturday)
- Sevelamer 800 mg – 3 tabs by mouth 3 times daily

It is documented at the bottom of the August and September 2021 medication log that Resident A was hospitalized between 8/14 - 8/17 and again 8/31 – 9/2. However, there is nothing documented for each medication that was not given on 8/31/2021.

On 11/05/2021, I left a message for the licensee, Fredrick Hayes requesting a return call so that an exit conference could be conducted.

On 11/08/2021, I received a return telephone call from Mr. Hayes and was able to conduct an exit conference. I informed Mr. Hayes of the allegations received as well as the investigative findings and recommendation documented in this report. Mr. Hayes

stated Resident A has resided in the home for a couple of years and recently began displaying erratic behaviors such as making false complaints about her health so she can be transported to the hospital, believing her food is poisoned and ordering fast food from Happy's Pizza. Resident A is a diabetic and receives dialysis three times weekly. Resident A suffers from diabetes, is a left leg amputee and receives dialysis three times each week. Mr. Hayes had no knowledge of Resident A pleading with staff to assist her to the bathroom or any staff being mean to her. He went on to state that the smell of sewage in the home was not a result of the sump pump. He had three or four different plumbers come to the home to assess the situation and was informed that the sanitation piping was not connected correctly, and this was causing the odor in the home. The piping was repaired about two weeks ago. Mr. Hayes said there were numerous people in the home at the time the on-site was conducted because they were visiting from another facility. The residents have been unable to attend their workshops because of COVID-19 and he thought it would be a good idea for them to socialize with others. They are only in the home for about an hour or two to play bingo or do arts and crafts. Mr. Hayes denied that any of the residents from the room and board facility spend the night at the home. He went on to state that he was instructed by a doctor not to discard any old medication or medication for residents who no longer reside in the home. I explained to Mr. Hayes any medication that is no longer required for a resident should be destroyed, the medication cabinet needs to be locked, and any medication requiring refrigeration should also be contained in a locked box. He agreed to discard the expired medication and any medication that is no longer required by a resident. Mr. Hayes said he recently purchased a new refrigerator because the previous one was old and stained. Mr. Hayes asked if he could provide receipts and or pictures of the new refrigerator and the plumbing work that was done. I informed him to submit that along with the corrective action plan.

APPLICABLE RULE	
R 400.1419	**Resident nutrition.**
	(3) Meals shall meet the nutritional allowances recommended under the "Suggested Daily Eating Guide" section, which is adapted from the "United States Department of Agriculture's Daily Food Guide (1979)," and based upon the "Recommended Dietary Allowances (1980)," and contained in the publication entitled "Basic Nutrition Facts," pages 28 and 29, Michigan department of public health publication no. H-808, 1980. This publication may be obtained without charge from Nutrition Services, Bureau of Personal Health Services, Michigan Department of Public Health, P.O. Box 30035, Lansing, Michigan 48909.

ANALYSIS:	Based on the information obtained during the investigation and my own observation, there was no bread, milk, juice, or fresh fruit in the home. The only fresh vegetable observed in the refrigerator was one bag of lettuce. Resident B stated there is rarely any milk, juice, coffee, or eggs in the home and residents are served water or Kool-Aid with their meals.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1425	**Food service.**
	(4) All equipment and utensils shall be so designed and of such material and workmanship as to be easily cleanable. All eating and drinking utensils shall be thoroughly cleaned after each usage.
ANALYSIS:	Based on my observation during the investigation, I determined that the refrigerator, freezer, and deep freezer were not clean. They were stained with old food and some sort of dried-up liquid. The refrigerator had missing shelves and contained uncovered food.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1406	**Ratio of responsible persons to residents.**
	(2) The number of occupants in a home, other than the licensee and the licensee's spouse, shall not exceed 10 persons.
ANALYSIS:	Based on the information obtained during the investigation and my own observation, there were at least 14 residents in the home not including the licensee or the licensee’s spouse. Resident B, C and D all stated there are more than 6 residents who come to the home during the week and who sleepover on the weekends.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1427	**Living space.**
	(1) A licensee shall provide, per occupant, not less than 35 square feet of indoor living space, exclusive of bathrooms, storage areas, hallways, kitchen, and sleeping areas.
ANALYSIS:	Based on my observation during the investigation, there were 12 residents inside the home and two residents on the deck at the back of the home. Resident B, C and D stated there are more than six residents who reside in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend modification of the license to provisional.

12/02/2021

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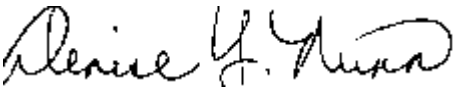
Cindy Berry Date
Licensing Consultant

Approved By:



12/02/2021

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Denise Y. Nunn Date
Area Manager