GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 25, 2023

Paula Martin
Stay At Home Senior Care1 LLC
21725 Ulrich
Clinton Twp, MI 48036

RE: License #: AS500395750
Investigation #: 2022A0990028
Our Place Senior Assisted Living Ulrich

Dear Ms. Martin:

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.

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,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500395750
Investigation #:	2022A0990028
Complaint Receipt Date:	07/13/2022
Investigation Initiation Date:	07/13/2022
Report Due Date:	09/11/2022
Licensee Name:	Stay At Home Senior Care1 LLC
Licensee Address:	21725 Ulrich Clinton Twp, MI 48036
Licensee Telephone #:	(586) 625-2231
Administrator:	Paula Martin
Licensee Designee:	Paula Martin
Name of Facility:	Our Place Senior Assisted Living Ulrich
Facility Address:	21725 Ulrich Clinton Twp, MI 48036
Facility Telephone #:	(586) 333-5594
Original Issuance Date:	10/31/2019
License Status:	REGULAR
Effective Date:	04/30/2022
Expiration Date:	04/29/2024
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Layne Martin is the licensee designee's spouse and direct care staff. When Mr. Martin works to fill in on a shift, he does not change the residents' diapers. The residents have body odors from not being changed.	Yes
There is a lack of staff.	No
The residents at the facility are being over medicated.	No
The resident's medications are not managed or properly stored.	No
There are residents with suspicious bruises.	No
There are residents with urinary tract infections that are getting worse.	No
The residents are not fed properly.	No
The staff are not following menus for meals and the menus are outdated.	Yes
There are no special diet menus.	No
There was old food from 2019 in the freezer.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/13/2022	Special Investigation Intake 2022A0990028
07/13/2022	Special Investigation Initiated - Telephone I conducted a phone interview with the Reporting Person (RP).
07/13/2022	APS Referral Adult Protective Services (APS) complaint denied at intake.

07/15/2022	Inspection Completed On-site I conducted an onsite, unannounced special investigation. I interviewed Paula Martin, licensee, Layne Martin, direct care staff Dalisha Garivett-Hunt, Resident A and Resident B.
09/14/2022	Contact - Document Received I reviewed documents relevant to allegations.
09/14/2022	Contact - Telephone call made I called direct care staff Jacquis Coulter. The phone number was disconnected.
09/14/2022	Contact - Telephone call made I conducted a phone interview with former direct care staff Kira Weigand.
09/20/2022	Contact - Telephone call made I left detailed messages for Relative C, Relative D and Relative F. I called Relative G, no answer or voicemail box set-up.
09/20/2022	Contact - Telephone call made I conducted a phone interview with former direct care staff Jessica Watson.
09/20/2022	Contact - Telephone call made I conducted a phone interview with former direct care staff Candace Bridges.
09/20/2022	Contact - Telephone call made I conducted a phone interview with former direct care staff Kyra Whitesell.
09/20/2022	Contact- Telephone call made I conducted a phone interview with Kira Weigand.
09/23/2022	Contact - Telephone call received I conducted a phone interview with Relative F.
09/26/2022	Contact - Telephone call received I conducted a phone interview with Relative D.
09/26/2022	Contact – Telephone call received I conducted a phone interview with Relative D1. Relative D1 sent medical documents via email.

10/04/20222	Contact – Document received I received additional requested documents via email from Mrs. Martin. I reviewed the documents in the resident record.
10/20/2022	Exit conference I conducted an exit conference with Mr. and Mrs. Martin.

ALLEGATION:

- **Layne Martin is the licensee designee's spouse and direct care staff. When Mr. Martin fills in to work a shift, he does not change the residents' diapers. The residents have body odors from not being changed.**
- **There is a lack of staff.**

INVESTIGATION:

On 07/13/2022, I received the complaint via email. In addition to the above allegations, it was reported that Paula Martin is the owner of Our Place Senior Assistant Living. The Reporting Person (RP) said that when Layne Martin (Mrs. Martin's husband) is working, he is no help at all. It is reported that Mr. Martin makes the staff clean up after him. Staff are forced to work double shifts and are treated like "slaves" and the staff are "tired." Mr. Martin when working the third shift, leaves the residents in the same briefs overnight until the day shift begins.

On 07/13/2022, I conducted a phone interview with the Reporting Person (RP). The RP said that the 3PM to 11PM shift is responsible for bathing residents. The RP said that many times when working the day shift, it was observed that the residents would have a body odor and are unbathed. The residents would be in wet diapers frequently and specifically when Mr. Martin worked the midnight/third shift. The RP said that there is a staffing shortage because the owners are controlling and terminates staff that disagrees with them about anything. The RP said they were terminated via text message.

On 07/15/2022, I conducted an onsite, unannounced special investigation. I interviewed Paula Martin, licensee, Layne Martin licensee's spouse/direct care staff, direct care staff Dalisha Garivett-Hunt, Resident C and Resident D.

Ms. Garivett-Hunt said that she is fully trained. Ms. Garivett-Hunt said that the residents are bathed or showered during the afternoon or midnight shift. There are no residents that are left in wet diapers for prolonged period during her day shift. Ms. Garivett-Hunt does diaper checks every two hours. I did not interview Resident A and Resident B and Resident F due to their limited cognitive abilities related to dementia.

I interviewed Resident C. Resident C said that she is changed and showered frequently. Resident C said that she was showered this morning. I did not detect a body odor and

Resident C appeared neat and clean. Resident C did not answer questions asked about the staffing in the home.

I interviewed Resident D. Resident D was confused and difficult to follow. Resident D said that he received some assistance with bathing and hygiene. I did not detect a body odor and Resident D appeared neat and clean. Resident D became confused and was not able to understand the questions about the staffing in the home.

I interviewed Mr. Martin. Mr. Martin said that the residents are changed while he is working on shifts. Mr. Martin said that he typically works when there is a staff call-in with short notice and there are no other staff available to fill-in. Mr. Matin denies leaving residents in wet diapers.

I interviewed Mrs. Martin. Mrs. Martin said that residents are showered by a shower day chart. Mrs. Martin provided a copy of the shower chart which documented that on Monday, Wednesday and Friday Resident A is showered and Resident B is given a bed bath; Tuesday, Thursday and Saturday Resident D is showered (he must be supervised and does not like to be helped). There are no showers on Sunday. Mrs. Martin said that the residents are changed and showered frequently. Mrs. Martin said that she and Mr. Martin fill in shifts and they both do diaper checks and changes. The only time that showers are not followed by the schedule are due to hospice orders. Mrs. Martin said that Resident D does not like assistance showering however, staff does check in on him while he is showering.

Mrs. Martin said that there has been a high staff turnover and it was due to the staff disliking the prior manager who no longer works at the home. The prior manager wanted to work several hours, and Mrs. Martin discovered that the prior manager would terminate staff therefore, she could receive more hours for compensation. Mrs. Martin said that she terminated the former manager and as a result she has been harassed via text messages and threats to call licensing and other agencies to retaliate. Mrs. Martin admits that there has been a high turnover due to staff refusing to be trained within 30 days of employment and/or not wanting to work.

On 09/14/2022, I reviewed documents relevant to allegations. I reviewed staff schedules for July and August 2022. I observed that there is one staff per shift as follows: 7AM- 3PM: 3PM-11PM and 11PM-7AM. I reviewed Mr. Martin's employee record, and he is fully trained.

On 09/20/2022, I conducted a phone interview with former direct care staff Jessica Watson. When Ms. Watson was employed at the home in July 2022 for two weeks, she observed that they were short staffed often. Ms. Watson said when Mr. Martin filled-in on shifts he would not change residents leaving them wet or dirty all night. Ms. Watson denied that the residents had an odor from lack of bathing but from urine when left in wet diapers. Ms. Watson said this only occurred when Mr. Martin worked. Ms. Watson said that the shift she worked, residents were not given baths or showers on the day shift. Ms. Watson said that there was one staff per shift. Ms. Watson described that

they were short staffed most times because no one stays employed long. Most staff quit or are fired. Ms. Watson said that her job description did not indicate that she would be required to give baths, and this was a problem for her. Ms. Watson said that Mrs. Martin does not properly communicate to her staff respectfully.

On 09/20/2022, I conducted a phone interview with former direct care staff Candace Bridges. Ms. Bridges is a former employee that worked at the home for one month on the midnight/third shift. Ms. Bridges denied that residents are left in wet diapers. Ms. Bridges said that the residents were bathed frequently. Ms. Bridges denied detecting body odors from residents. Ms. Bridges said that staffing “was ok” and that some staff were good, and others were not good workers. Ms. Bridges denied having knowledge regarding Mr. Martin leaving residents in wet diapers.

On 09/20/2022, I conducted a phone interview with former direct care staff Kyra Whitesell. Ms. Whitesell said that she worked at the home for five months and left because she found a different job. Ms. Whitesell denied that the residents were left sitting in wet diapers. Ms. Whitesell said that the residents are bathed frequently and did not have body odors. Ms. Whitesell had not observed Mr. Martin leaving residents in dirty or wet diapers but heard from other staff. Ms. Whitesell said that the home was understaffed and that she worked the afternoons or midnight shift.

On 09/20/2022, I conducted a phone interview with former direct care staff Kira Weigand. Ms. Weigand said that she worked at the home and a different home owned by Mrs. Martin for 3-4 months. Ms. Weigand said she did not observe any issues with resident’s not being cleaned or showered frequently. The only time a shower may have been skipped was if the resident was ill or being combative. Ms. Weigand denied that residents had body odors. Ms. Weigand said due to lack of staffing the owners would have other staff from other homes work for a couple of hours to cover shifts. Ms. Weigand said that the former manager Ms. Binion worked 70-80 hours per week to cover shifts due to the high staff turnover. Mr. Martin worked the midnight shifts at times and he rarely changed diapers.

On 09/23/2022, I conducted a phone interview with Relative F. Relative F said that he believes that the residents were bathed frequently by the staff. Relative F said that he did not observe residents sitting in soiled diapers. The only time he detected that Resident F had an odor was when he had a urinary tract infection due to the strong urine smell. Relative F said that there is adequate staffing but there is a high turnover. Relative F said that there is always staff present in the home. Relative F said that he has witnessed Mr. Martin working in the home but not with residents. Relative F said that he has observed Mr. Martin doing maintenance work in the home.

On 09/26/2022, I conducted a phone interview with Relative D. Relative D said that the residents are not bathed properly, and Resident D is no longer living in the home as of 09/19/2022. Relative D said they were showing Resident D infrequently and he would be wearing the same clothes frequently. Relative D said that they failed to do oral hygiene for Resident D. Relative D talked to staff multiple times asking them to do

Resident D's oral hygiene and was told that they will remind him to do it himself. This was concerning because Resident D has dementia and reminders would not always be helpful. Resident D has been observed in wet clothing at least two times. Relative D said that Resident D had an odor while living in the home due to infrequent showers. Relative D said that there were staffing issues and a high turnover. Relative D has observed Mr. Martin working in the home two times because he was filling in on shift. Relative D said that Mr. Martin was not working but was observed sitting on the couch napping.

On 09/26/2022, I conducted a phone interview with Relative D1. Relative D1 sent medical documents via email. Relative D1 said that there was no issue with Resident D showering but there was an issue with lack of his oral hygiene. Resident D looked unkempt frequently but did not have an odor and was not dirty. Relative D1 said that when they needed to take Resident D out on outings, they would need to tell the staff to make sure he looked appropriate. Resident D would frequently have old food stuck in his teeth and bad breath. Relative D1 said that there were always unfamiliar staff and at times she was told by the other staff that everyone was fired. Relative D1 said that Mr. Martin would work in the home and when he worked, he usually sat on the couch near a picture window and napped.

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:	Mr. Martin denied leaving residents in wet diapers when he worked as a fill-in staff. Resident C and Resident D denied being left in wet diapers or unclean. I did not detect an odor on Resident A, Resident B, Resident C, Resident D or Resident F during my unannounced onsite on 07/15/2022. Mrs. Martin said that she and Mr. Martin fill-in on shifts and they both do diaper checks and changes. Mrs. Martin said that the only time that showers are not followed by schedule are due to hospice orders. There is information to support that there have been issues with some residents being left wet or unchanged specifically while Mr. Martin covered shifts. According to the Reporting Person (RP), it was observed that many times while working the day shift, residents would have body odor and are unbathed from the previous night. The RP said that the residents would be in

	wet diapers frequently and specifically when Mr. Martin worked a shift. According to former direct care staff Ms. Jessica Watson, who was employed at the home from July 2022 for two weeks, when Mr. Martin filled-in on shifts, he would not change residents leaving them wet or dirty all night. Former direct care staff Ms. Kira Weigand said that Mr. Martin worked the midnight shifts at times and he rarely changed diapers. Former direct care staff Ms. Kyra Whitesell had not observed Mr. Martin leaving residents in dirty or wet diapers but heard from other staff that he did. In addition, according to Relative D and Relative D1, Mr. Martin worked shifts and he was observed sitting on the couch napping. Furthermore, Relative D and Relative D1 said that Resident D's oral hygiene was neglected by evidence of old food stuck in his teeth and bad breath. Relative D and Relative D1 described that Resident D was often unkempt or wearing the same clothing more than one day.
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:	According to Mrs. Martin, there has been a staffing shortage due to a prior manager frequently terminating staff to receive more hours for herself. Mr. Martin typically works when there is a staff call-in with short notice and there are no other staff available to fill-in. Mr. Martin is fully trained. Mrs. Martin also said that many staff were terminated because they refused to complete the required training. Former direct care staff Ms. Watson said that they were short-staffed due to staff quitting or being fired due to poor management. Former direct care staff Ms. Whitesell said that the home was understaffed, and she worked afternoons or midnight shift. Former direct care staff Ms. Weigand said that at times due to lack of staffing, the owners would have other staff

	from other homes work in the home to cover shifts. Ms. Weigand said that the former manager Ms. Binion use to work 70-80 hours per week to cover shifts due to high turnover. Relative D said that there is adequate staffing but there is a high turnover. Relative D1 said that there were aways unfamiliar faces due to staff being fired. I reviewed staff schedules and there was one staff scheduled per shift as required and needed. The concern is high staff turnover, issues with management style and lack of staff retention. Therefore, there is not enough information to support that there was inadequate staffing. Due to the high turnover, the manager worked 70-80 hours, but shifts were covered.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **The residents at the facility are being over medicated.**
- **The resident's medications are not managed or properly stored.**

INVESTIGATION:

On 07/13/2022, it was reported that two residents passed away on hospice care. The RP said that the residents and medical staff believe that the two residents died of natural causes however, it is believed that the two residents were over medicated and forced to take sleeping pills.

On 07/13/2022, I conducted a phone interview with the Reporting Person (RP). The RP said she suspects that Resident A and Resident B were overly medicated, The RP was not sure what medications were overused because both residents were hospice patients. The RP said that both residents' behaviors changed drastically and appeared "drugged" most of the time. The RP said that medications were passed to the residents on day and evening shifts. The RP suspects that the owners were giving Resident G and Resident H sleeping pills. The RP said that she addressed her suspicion with the owners, but it was "brushed off."

On 07/15/2022, I conducted an onsite, unannounced special investigation. I interviewed Paula Martin, licensee, Layne Martin, direct care staff Dalisha Garivett-Hunt, Resident C and Resident D.

Ms. Garivett-Hunt said that she passed meds on her shift and denied that there are current residents that are prescribed sleeping pills. Ms. Garivett-Hunt said that there were two residents that were on hospice care and were showered by hospice and are deceased. Ms. Garivett-Hunt did not specify the names of the residents that were in

hospice. Ms. Garivett-Hunt said that recently two residents passed away on hospice care. One of the residents had cancer.

During the onsite, I observed medications locked and stored properly. I reviewed the medication administration record (MAR) and there were no issues observed.

I interviewed Resident C. Resident C said that she believes that her medications are given to her correctly. Resident C said that she receives “good care” in the home.

I interviewed Resident D. Resident D said that he believes that he is given his medications properly.

I interviewed Mrs. Martin. Mrs. Martin said that she heard that Ms. Binion texted one of the previous hospice nurses (names unknown) allegedly that Resident H who has passed away, telling her that Resident H had been given too much medication. Mrs. Martin said that she would send verification of this information later however, it was not received. Mrs. Martin said that medications are given to residents as prescribed. The manager’s role was to separate and sort medications. Mrs. Martin said that Resident H had a medication change and it was making her sleepy. Resident H’s family contacted the doctor and had that medication stopped. Mrs. Martin said that her previous manager who she terminated (Shawn Binion) called Resident G’s family and told them that the staff are drugging Resident G. Ms. Binion specifically accused Ms. Garivett-Hunt of doing this. Mrs. Martin said that currently Resident A and Resident F are on hospice care.

On 0914/2022, I reviewed Resident A’s medication administration record (MAR). I observed that she was prescribed Ativan and Morphine as a PRN. In August of 2022, she was given both medications three times. I reviewed Resident A MAR and observed that she is prescribed Lorazepam and Ativan and was given both medication four times each as PRN for the month of August. I reviewed Resident G’s MAR, and all medications were administered June and July 2022. I observed Resident A and Resident G’s hospice orders.

On 09/20/2022, I conducted a phone interview with former direct care staff Jessica Watson. Ms. Watson said that she has no evidence that residents were overly medicated however, it was concerning that Resident B slept most of the time. Ms. Watson said that medications are stored in a locked cabinet in the kitchen. Ms. Watson said that medications were managed by the manager but only the day and afternoon shift passed medications.

On 09/20/2022, I conducted a phone interview with former direct care staff Candace Bridges. Ms. Bridges denied having knowledge about residents being over medicated. Ms. Bridges said that the medications were stored in a locked cabinet in the kitchen. Ms. Bridges said that each time she administered meds she initialed the MAR.

On 09/20/2022, I conducted a phone interview with former direct care staff Kyra Whitesell. Ms. Whitesell said that she has no knowledge of residents being over medicated. Ms. Whitesell said that the medications were in packages and locked in a cabinet in the kitchen. Ms. Whitesell said that the manager managed the medications.

On 09/20/2022, I conducted a phone interview with firmer direct care staff Kira Weigand. Ms. Weigand said that she had concerns that a prior resident, Resident H, was over medicated because they were giving her morphine. Ms. Weigand did not understand why they were giving her morphine because she did not appear to be in pain. The morphine was prescribed. Ms. Weigand said that Resident E was on hospice. Ms. Weigand said the resident medications are stored in a cabinet in the kitchen. Ms. Weigand said medications were locked and the resident MARs are on clipboard. Ms. Weigand said that the manager and staff passed medications.

On 09/23/2022, I conducted a phone interview with Relative F. Relative F said he has no knowledge of residents being over medicated. Relative F said that the medications are stored in the kitchen area, and he observes staff signing a book after medications are passed. Relative F said the medications are secure.

On 09/26/2022, I conducted a phone interview with Relative D. Relative D said that the resident medications are stored in blister packs and kept in the closet. Relative D did not have any issues or concerns regarding medications.

On 09/26/2022, I conducted a phone interview with Relative D1. Relative D1 said that she does not know if residents were over medicated but most “looked out of it”. Relative D1 said the medications were pre-packaged and is unsure if they were not given properly.

On 10/04/2022, I received and reviewed additional requested documents via email from Mrs. Martin. Mrs. Martin clarified that Resident H was not on hospice because the family refused. She passed away on May 28, 2022 of cancer. Mrs. Martin said that Resident C was on hospice and passed away on 07/18/2022. I reviewed Resident A, Resident B, Resident C, Resident D and Resident F MAR and there were no concerns observed.

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: (e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.

ANALYSIS:	There is insufficient information that the residents on hospice were over medicated and/or given sleeping pills. It was determined that there were current hospice and previous hospice residents in the home. I reviewed Resident A and Resident G's MAR and they were administered medications as prescribed per hospice orders. Former Resident H was not on hospice but passed away from terminal cancer. Resident F entered hospice recently (during the investigation). Resident C was on hospice and passed away shortly after the investigation was initiated. I interviewed staff Ms. Garivett-Hunt and former direct care staff Ms. Bridges, Ms. Whitesell and Ms. Weigand and all deny that medications were adjusted or modified. Although, there were reports that Resident A and Resident G appeared "sleepy" however, it was due to being prescribed comfort medications for hospice patients. Both Resident G and Resident H that were alleged to be overmedicated have passed away. Both were prescribed Ativan and Morphine as PRN and Resident A was prescribed Lorazepam. These medications can cause residents sleep more or appear drowsy.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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 S333.1101 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 07/15/2022, I observed medications locked and stored properly. I reviewed the medication administration record (MAR) and there were no issues observed. There is insufficient information to support that the medications were managed and stored improperly. I interviewed staff Ms. Garivett-Hunt and former direct care staff Ms. Bridges, Ms. Whitesell and Ms. Weigand and all deny that the medications were improperly stored or managed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **There are residents with suspicious bruises.**
- **There are residents with urinary tract infections that are getting worse.**

INVESTIGATION:

On 07/13/2022, I conducted a phone interview with the Reporting Person (RP). The RP said that Resident G (deceased as of 07/10/2022) was hospitalized for three weeks due to having a urinary tract infection (UTI). The RP said that she observed unusual bruises on Resident A but could not provide specific dates, but the bruises were on her back and described as being bluish and purple. The RP said that she discussed the bruises with Mrs. Martin who told her that nothing was happened or was reported by staff to her.

On 07/15/2022, I interviewed Mrs. Martin. Mrs. Martin said that Ms. Binion nor any staff reported residents with bruises. I observed Resident A's back and arms and did not see any marks or unusual bruises. I interviewed Resident C and Resident D who both denied having bruises. Resident C passed away on 07/18/2022.

On 09/20/2022, I interviewed former staff Jessica Watson. Ms. Watson denied observing suspicious bruises on residents. Ms. Watson denied having knowledge about residents with frequent UTI's.

On 09/20/2022, I conducted a phone interview with former direct care staff Candace Bridges. Ms. Bridges said that she was aware of one resident whose name she did not recall, was hospitalized for a UTI. Ms. Bridges said that she did not observe suspicious bruises on residents.

On 09/20/2022, I conducted a phone interview with former direct care staff Kyra Whitesell. Ms. Whitesell said that she did not observe suspicious bruises on residents. Ms. Whitesell said that she did not have any knowledge regarding residents with UTI's.

On 09/20/2022, I conducted a phone interview with former direct care staff Kira Weigand. Ms. Weigand said that she was not aware of residents with bruises. Ms. Weigand said that the only resident she recalled having a few UTI's was Resident H.

On 09/23/2022, I conducted a phone interview with Relative F. Relative F said that Resident F has frequent UTI's and has had them prior to moving into the home. Relative F said that Resident F gets a UTI at least one time a year. Resident F said that the UTI's are not due to uncleanliness. Relative F denied observing bruises except one-time Resident F had a small tailbone wound due to being wheelchair bound. Relative F said that the wound was rectified by staff and there were no issues thereafter.

On 09/26/2022, I conducted a phone interview with Relative D. Relative D said that Resident D was hospitalized two weeks ago due to a UTI, which was his first one. Relative D said that Resident D had fever and chills and ended up admitted into the hospital as a result. Relative D said that Resident D had a bad fall on 07/03/2022. Staff notified him about two days after the fall and minimized the injury. When Relative D was notified, he went to the home and observed that Resident D's face was bruised in the corner on several spots. Relative D said that you could see dried blood and scabbing. Relative D said that he then did take Resident D to the hospital. When he asked Resident D what happened, he said that he ran into the door jam in his bedroom. Relative D said that a doctor should have seen because Resident D is prescribed blood thinners. Relative D said that there was poor communication between the owners which lead them to discharge Resident D from the home.

On 09/26/2022, I conducted a phone interview with Relative D1. Relative D1 said that Resident D is on blood thinners and bruises easily. Relative D1 said when she would observe bruises on Resident D, he would tell her that he has fallen. Relative D1 believes that Resident D's falls were unreported.

On 10/22/2022, I received an email from Mrs. Martin after emailing her regarding latest information obtained about Resident D's falls. There were ten screen shot texts below regarding Resident D falls and UTI.

- 07/03/2022 at 9:41AM, Mrs. Martin sent two photos to Relative D of Resident D's face with a bruise on his face.
- 07/04/2022, Relative D1 replied to Mrs. Martin texts telling her that Resident D did not need to be taken to the hospital and she talked to him on the phone and seemed OK.
- 07/13/2022 at 11:06PM Mrs. Martin sent a text to Relative D about Resident D's bruise on his nose and reported that Resident D said he was dizzy.
- 07/14/2022 at 10:22AM, Mrs. Martin sent a text to Relative D informing them that his dementia was worsening. Relative D responded by telling Mrs. Martin to share this information with Relative D1.
- 08/10/2022, Mrs. Martin texted Resident D's family requesting more pull-ups because they had been using double.

- 09/15/2022, Mrs. Martin texted Resident D's family informing them that Resident D was bit feeling well. Relative D responded later stating that Resident D has a UTI.
- 09/18/2022, Relative D texted Mrs. Martin informing her that Resident D is going to go into rehab from the hospital because he is weak, and septic.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	On 07/15/2022, during the onsite observed Resident A's back and arms and did not see any marks or unusual bruises. Resident C and Resident D denied having marks or bruises and none were observed. Former direct care staff, Jessica Watson, Kyra Whitesell and Kira Weigand denied observing suspicious bruises on residents. Relative F said that Resident F gets a UTI at least one time a year even before living in the home. Relative F denied observing bruises except one-time Resident F had a small tailbone wound due to being wheelchair bound. There is insufficient information to support that Resident D's UTI and falls were not reported to the family. Mrs. Martin provided seven texts messages that were exchanged with Relative D and Relative D1 regarding Resident D's falls, status change, dizziness, and dementia worsening. There is a text that Relative D1 informed Mrs. Martin to not take Resident D to the hospital. Resident D was diagnosed with a UTI and entered rehab and discharged from the home September 2022.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **The residents are not fed properly.**
- **The staff are not following menus for meals and the menus are outdated.**
- **There are no special diet menus.**
- **There was old food from 2019 in the freezer.**

INVESTIGATION:

On 07/3/2022, in addition to the above allegations it was reported that there are concerns that the residents are not being fed properly. There are no special diets for the residents that are not able to chew due to having no teeth. It was observed that the home was discarding food from the freezer that was dated 2019. It was also reported that the residents are being fed weird food combinations.

On 07/13/2022, I conducted a phone interview with the Reporting Person (RP). The RP said that Mrs. Martin gives the appearance that “everything is beautiful” but it is not. The RP said that the staff do not follow the menus for meals and the meals are unbalanced. The RP could not provide examples on what was unbalanced, or which staff were not following menus.

On 07/15/2022, I conducted an onsite, unannounced special investigation. I interviewed Paula Martin, licensee, Layne Martin, direct care staff Dalisha Garivett-Hunt, Resident C and Resident D. Ms. Garivett-Hunt said that the residents are properly fed. Ms. Garivett-Hunt said this morning for breakfast, the residents were provided with boiled eggs, toast, fruit and cold cereal. I observed all food supply which was fully stocked and appeared to be in good condition. Mrs. Martin said that the manager makes the menus, and they are placed in a book. Mrs. Martin said that the menus are not posted and was not aware that they should be. During the onsite, I observed the menus in a large book and not posted.

I interviewed Resident C, and she did not report any concerns with meals. I interviewed Resident D and he said that he sometimes enjoys the food and sometimes he does not. Resident D said that there is a lack of variation with the meals. Resident D said the meals are balanced.

I interviewed Mrs. Martin. Mrs. Martin said that the manager makes the menus, and they are placed in a book. Mrs. Martin said that the menus are not posted and was not aware that they should be. The manager makes changes to the menu as required due to groceries and preparing meals. Mrs. Martin said that if there is something a resident does not like to eat, they will provide a substitute. Breakfast and lunch meals are heavy, and dinner is a lighter meal. At 3PM they have teatime, and the residents are given ice cream floats, tea, or coffee. During this time, they do crafts as well. Mrs. Martin said that the afternoon shift sends her photos daily that teatime is done. Mrs. Martin denied that there are any current special diets in the home.

I requested menus from Mrs. Martin twice and received copies that were not clear.

On 09/20/2022, I interviewed former staff Jessica Watson. Ms. Watson said that she was not aware of special diets. Ms. Watson said that the menus were in a book and not posted or followed.

On 09/20/2022, I conducted a phone interview with former direct care staff Candace Bridges. Ms. Bridges said that she only worked the midnight shift and believes that the residents were properly fed. Ms. Bridges has no information to provide regarding special diets or expired food. Ms. Bridges said the owners were strict about cleaning and order in the home therefore, she does not believe there would be expired food. Ms. Bridges denied the menus were outdated and not followed but emphasized that she worked midnights therefore, she did no meal prep or plan.

On 09/20/2022, I conducted a phone interview with former direct care staff Kyra Whitesell. Ms. Whitesell said that the residents were properly fed and denied that the menus were outdated. Ms. Whitesell was not aware of any special diets.

On 09/20/2022, I conducted a phone interview with former direct care staff Kira Weigand. Ms. Weigand said that the menus are outdated. Ms. Weigand said repeatedly they had to change the menu because the food available did not match what was on the menu. Ms. Weigand said that the special diets were enforced and only recalled that one resident (name could not be recalled) was on a diabetic diet. Ms. Weigand said that some residents received a pureed diet due to the inability to chew. Ms. Weigand did observe some food with freezer burn and expired. There were months of expired food that needed to be thrown out. Ms. Weigand believes that the residents were fed properly.

On 09/23/2022, I conducted a phone interview with Relative F. Relative F said that the residents are properly fed. Relative F said that he has never seen a menu in the home. Relative F said that Resident F receives a regular diet and does not know if special diets are not followed. Resident F said that he has not observed expired food in the home. Relative F said that Resident F is happy in the home and has lived there for three years.

On 09/26/2022, I conducted a phone interview with Relative D. Relative D does not think that Resident D was fed properly because he has lost weight since living in the home. Relative D said that Resident D has lost 5-10 pounds and was already a smaller framed man. Resident D was 142 pounds when he was admitted to the hospital. Resident D lived in the home from June 2022 until September 2022. Relative D said that he had never saw menus and does not know of special diets. Relative D denied observing expired food.

On 09/26/2022, I conducted a phone interview with Relative D1. Relative D1 said that there were no menus in the home and that Resident D was on a regular diet. Relative D1 said there was concern with Resident D losing weight. They had to buy Resident D new pants due to the 10-pound weight loss. Relative D1 said that she did not visit during mealtimes, therefore, does not know how the meals looked or if there was expired food. Relative D1 sent medical documents via email which documented that Resident D was admitted into Henry Ford Macomb Hospital on 09/20/2022 at 130 pounds and 5’6” in height for UTI. Henry Ford Macomb Hospital documented one of his diagnoses as moderate malnutrition.

On 09/27/2022, I reviewed Resident D's weight records that showed Resident D weighed 156 pounds at admission in February 2022 and his last weight was 138 pounds August 2022.

On 10/04/2022, I received additional requested documents via email from Mrs. Martin. I reviewed Resident D and Resident F *Health Care Appraisal* and weight records. Resident F's weight beginning on 01/23/2022 was 144 pounds and last weight recorded was on 09/01/2022 was 142 pounds. Resident F has a regular diet. Resident D is prescribed a regular diet. Resident D's last weight recorded was on 08/22/2022 and 140 pounds.

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 no information to support that there were no regular meals served as evidence by the observations of adequate food supply on 07/15/2022 during my onsite investigation. During interviews with current and former staff Ms. Watson, Ms. Weigand and Ms. Whitesell, the residents were fed adequate meals. Resident C said that the meals were "OK" and Resident D said that the meals lacked variation but balanced. Relative F said that Resident F is fed properly.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	There is insufficient information to support that there are special diets in the home. According to Mrs. Martin, there are no residents with a special diet prescribed. Former direct care staff Ms. Weigand said that the special diets were enforced and only recalled that one resident (name could not be recalled) was on a diabetic diet.

	I reviewed Resident D and Resident F's *Health Care Appraisals*, and both are prescribed a regular diet. Relative F and Relative D denied that special diets were prescribed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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:	On 07/15/2022, Mrs. Martin admitted that the menus are not posted in the home. On 07/15/2022, I observed menus in a book in the office and not posted. The menus are drafted by the manager and placed into a book for staff. The RP said that the meals were not followed by the menu. Former direct care staff, Ms. Watson said that the menus were in a book and not posted nor followed. Former direct care staff Ms. Weigand said that the menus are outdated. Relative F said that he has never seen a menu in the home. Relative D and Relative D1 said that there were no menus in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14402	**Food service.**
	(1) All food shall be from sources that are approved or considered satisfactory by the department and shall be safe for human consumption, clean, wholesome and free from spoilage, adulteration, and misbranding.
ANALYSIS:	There is sufficient information to support that the meals were not wholesome. The RP said that that there were weird food combinations. Resident D said that the meals lacked variation. Former direct care staff Ms. Weigand observed some food with freezer burn and expired. Relative D does not think that Resident D was fed properly because he has lost weight since living in the home.

	There is concern that due to the lack of variation and dislike of the food Resident D did not eat the meals as evidenced by the Henry Ford Macomb Hospital discharge notice that documented one of his diagnoses as moderate malnutrition. I did not observe expired food during my onsite investigation on 07/15/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/13/2022, during onsite investigation Mrs. Martin admitted that she did not have a job description signed by the former manager. It was being alleged that she was doing things in her position such as watering plants and cleaning other homes and it was not part of her job description. When I was onsite, the owners were blaming the former manager for the complaint saying she refused to do things asked of her.

On 09/20/2022, I conducted a phone interview with former direct care staff Jessica Watson. Ms. Watson said her job description did not indicate that she would be required to give baths to residents, and this was a problem for her.

APPLICABLE RULE	
R 400.14207	**Required personnel policies.**
	(3) A licensee shall have a written job description for each position. The job description shall define the tasks, duties, and responsibilities of the position. Each employee and volunteer who is under the direction of the licensee shall receive a copy of his or her job description. Verification of receipt of a job description shall be maintained in the individual's personnel record.
ANALYSIS:	Mrs. Martin admitted she did not have a job description signed by the former manager. There was no job description available while onsite.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 07/13/2022, during the onsite investigation, Mrs. Martin said that Resident G (July 10, 2022), and Resident H (May 28, 2022) passed away. Mrs. Martin said that she did not send incident reports to licensing because she was not aware that this was required.

On 10/20/2022, I conducted an exit conference with Mr. Martin and Mrs. Martin. Mr. and Mrs. Martin feel that the investigation stems from many disgruntled employees that have threatened their safety and business. Mr. and Mrs. Martin said that due to this investigation and the lack of staffing they are requesting the closure of the license. Mr. and Mrs. Martin said that they were leaving for vacation and would submit a corrective action plan. Mr. and Mrs. Martin were informed that the investigation was prolonged due to multiple complaints and additional concerns.

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:	Resident G and Resident H passed away in the home this year. Mrs. Martin admitted that incident reports were not sent to the licensing unit because she was not aware of this requirement.
CONCLUSION:	**VIOLATION ESTABLISHED**

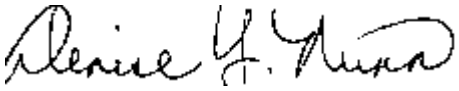
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend voluntary closure of the license as requested by the licensee October 2022. There were no residents in the home as of October 20, 2022, and the home was sold on 10/29/2022.

01/12/2023

LaShonda Reed Date
Licensing Consultant

Approved By:



01/25/2023

Denise Y. Nunn Date
Area Manager