GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 10, 2023

LaTonia Metcalf and Latoyia White
5400 Bermuda Lane
Flint, MI 48505

RE: License #: AS250402472
Investigation #: 2023A0779020
Bermudawood

Dear LaTonia Metcalf and Latoyia White:

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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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 (517) 643-7960.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAIN QUOTE PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS250402472
Investigation #:	2023A0779020
Complaint Receipt Date:	01/27/2023
Investigation Initiation Date:	01/27/2023
Report Due Date:	03/28/2023
Licensee Name:	LaTonia Metcalf and Latoyia White
Licensee Address:	5400 Bermuda Lane Flint, MI 48505
Licensee Telephone #:	(810) 787-3262
Administrator:	LaTonia Metcalf
Licensee Designee:	N/A
Name of Facility:	Bermudawood
Facility Address:	5400 Bermuda Ln, Flint, MI 48505
Facility Telephone #:	(810) 787-3262
Original Issuance Date:	11/24/2021
License **Status:**	REGULAR
Effective Date:	11/24/2022
Expiration Date:	11/23/2024
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has had dried feces in his brief, and his bed linens have been extremely soiled in urine.	No
Staff Shawn Penegar recently yelled and cursed at a resident.	Yes

III. METHODOLOGY

01/27/2023	Special Investigation Intake 2023A0779020
01/27/2023	APS Referral Complaint was referred to AFC licensing by APS centralized intake.
01/27/2023	Special Investigation Initiated - Telephone Spoke to complainant.
01/27/2023	Contact - Telephone call made Spoke to Hospice aide.
01/27/2023	Contact - Telephone call made Spoke to Hospice nurse.
02/02/2023	Inspection Completed On-site Attempted inspection, no one home
02/07/2023	Contact - Telephone call made Telephone call to LaTonia Metcalf
02/07/2023	Contact - Telephone call made Voicemail message left for staff person, Shawn Penegar.
02/08/2023	Contact - Telephone call made Spoke to APS worker, Cynthia Badour.
02/21/2023	Inspection Completed On-site
02/27/2023	Contact - Telephone call made Spoke to APS worker, Cynthia Badour.
02/21/2023	Exit Conference Held with licensee, LaToyia White.

ALLEGATION:

Resident A has had dried feces in his brief, and his bed linens have been extremely soiled in urine.

INVESTIGATION:

On 1/27/23, a phone conversation took place with Complainant. She stated that Resident A has been receiving Hospice care since July 2022 and that it is Hospice personnel that have noticed Resident A in soiled briefs. Complainant reported that Resident A is his own guardian but has recently not passed cognitive tests.

On 1/27/23, a phone conversation took place with Hospice aide, Amanda Hurley, who stated that she is at this home providing services to Resident A twice weekly. She stated that when she is there, Resident A frequently has dried feces in his brief. She reported that she was at this home today and Resident A's brief, pants and shirt were soaked with urine. Ms. Hurley stated that she has been finding Resident A in this type of condition for a few months now, but she could not provide specific dates or a number of times this has happened.

On 1/27/23, a phone conversation took place with Hospice nurse, Celia Potter, who stated that she has not observed Resident A in dirty briefs during her visits to the home. She stated that Resident A frequently looks unkept and his room does sometimes smell of urine, but that he is generally clean. Ms. Potter reported that Resident A has a bedside commode that he uses and can physically use the toilet on his own, but does require help with cleaning himself up after a bowel movement. Ms. Potter stated that Resident A did have one minor fall and he was not hurt, but that they provided him with an alarm on his mattress to notify staff when he gets up out of bed. She stated that they have been trying to educate the staff of this home regarding personal care issues for Resident A and that she has asked them to check and/or change Resident A at least every two hours. Ms. Potter reported that Resident A's Alzheimer's and mobility issues have declined over the last few months and that are looking into getting him a legal guardian and finding him a new home to better meet his increased needs.

On 2/2/23, an unannounced on-site inspection was conducted. Resident A was viewed to be clean and well groomed. His room was viewed to be adequately clean and free of any significant odors. Resident A was able to confirm that he is able to use his bedside commode on his own, but that staff assist him with walking and help change his brief. He believes that staff are taking good care of him here.

On 2/2/23, an interview was conducted with Resident B, who stated that he is Resident A's roommate. Resident B stated that Resident A can use the bedside commode and short distances by himself. He reported that staff come in and help Resident A when he gets out of bed and the alarm goes off. Resident B stated that he thinks that Resident B has been declining the last few months.

On 2/2/23, an interview was conducted with staff person, Elmore Hughes, who denies that Resident A is ever left in a soiled and/or wet brief. Mr. Hughes stated that Resident A is able to get himself out of bed and use his bedside commode on his own and rarely has accidents in his brief, but that they still check on him at least every two hours or more. He reported that they immediately know when Resident A gets out of bed because his alarm goes off. He stated that when they hear the alarm, they always immediately check on Resident A, turn the alarm off and assist Resident A with cleaning himself up if needed after a bowel movement. Mr. Hughes reported that Resident A has only had the bed alarm for a few weeks, so it is possible that before he got it, Resident A may have used the commode without staff knowing and not done a good job of cleaning himself up.

Resident A's *Assessment Plan for AFC Residents* was reviewed. The plan confirms that Resident A only required minimal assistance from staff in order to complete all his activities of daily living, including toileting. It states that Resident A is able to walk short distances but prefers to use a wheelchair.

On 2/3/23, a phone interview was conducted with licensee, LaTonia Metcalf. She denies that Resident A is frequently in soiled briefs and stated that Resident A only needs minimal assistance with cleaning himself up after having a bowel movement. She stated that she is only aware of one time when Hospice had voiced a concern about Resident A being in a wet brief with feces in it. Ms. Metcalf reported that staff are checking and/or changing Resident A at least every two hours, so if he does have an accident in his brief, he does not sit in it for long periods of time.

On 2/8/23, a phone conversation took place with APS worker, Cynthia Badour. She stated that on 1/19/23, an APS worker, Monica Voltz, made an unannounced visit to this home and viewed both Resident A and the living environment to be clean.

On 2/21/23, a second unannounced on-site inspection was conducted. Resident A was viewed to be clean and well groomed. His bedroom was also clean and free from any significant odors.

On 2/21/23, licensee, Latoya White, was interviewed. She stated that she is not aware of Resident A ever spending an extended length of time in a soiled or wet brief. She reported that she works as a staff at this home quite often and that she checks on Resident A quite frequently throughout the day. Ms. White confirmed that Resident A can use commode on his own, but sometimes needs help cleaning himself up after a bowel movement. She also confirmed that Resident A has declined over the last few months and is starting to require additional help from staff.

On 2/27/23, APS worker, Ms. Badour, stated that she had recently made an unannounced visit to this home and viewed Resident A to be very clean. She stated that Resident A's room was also clean and did not smell of urine. Ms. Badour reported that there is a court hearing scheduled to get Resident A assigned a court appointed legal guardian. Ms. Badour stated that she has spoke to Resident A's Hospice staff and

that they have no current concerns regarding Resident A's care, but due to his increasing care needs, they are looking for a new home for Resident A.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	All three staff at this home deny that Resident A is ever left in soiled and/or wet briefs for long periods of time. They stated that he is checked on and/or changed at least every two hours or more frequently if his bed alarm goes off. Although he has appeared to have declined some the last few months, Resident A is still able to use his bedside commode on his own and requires minimal assistance from staff cleaning himself up after a bowel movement. During two unannounced on-site inspections, Resident A was viewed to be clean and well groomed. APS workers have also conducted two unannounced visits to this home and found Resident A to be adequately clean and well groomed. There was insufficient evidence found to prove that Resident A is staying in soiled and/or wet briefs for extended lengths of time or that he is not being provided adequate personal care as specified in his written assessment plan.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff Shawn Penegar recently yelled and cursed at a resident.

INVESTIGATION:

On 1/27/23, Hospice aide, Amanda Hurley, stated that she was at this home on 1/17/23 and she witnessed staff person, Shawn Penegar, yelling and cussing at Resident B. Ms. Hurley stated that Ms. Penegar said the following statements to Resident B; "Shut the fuck up", "Fuck you", and "Stop talking to me". She reported that Resident B was also cussing back at Ms. Penegar.

On 2/2/23, Resident B confirmed that he and Ms. Penegar got into a verbal confrontation. He reported that Ms. Penegar said to him, "Shut the fuck up", as well as

other statements he cannot remember. Resident B stated that Ms. Penegar was fired and has not returned back to work after the day of that incident.

On 2/3/23, licensee, Latonia Metcalf, stated that she spoke with Ms. Penegar and Resident B after learning of the incident and confirmed that Ms. Penegar did inappropriately cuss at Resident B. Ms. Metcalf stated that she terminated Ms. Penegar's employment at this home the same day.

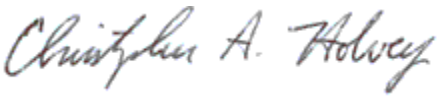
On 2/7/23, a voicemail message was left on Ms. Penegar's phone. She was asked to return the call if she wanted to dispute the allegations. As of the writing the of this report, Ms. Penegar has returned the voicemail message.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.**
ANALYSIS:	It was confirmed that on 1/17/23, a verbal altercation took place between Resident B and staff person, Shawn Penegar. Resident B stated that Ms. Penegar yelled and cussed at him. Hospice aide, Amanda Hurley, was at the home on 1/17/23 and confirmed that she witnessed Ms. Penegar cuss at Resident B. There was sufficient evidence found to support the allegation of Resident B being verbally abused by staff person, Shawn Penegar.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/21/23, an exit conference was held with licensee, Latoyia White. She was informed of the above licensing rule violation and that a written corrective action plan is required.

IV. RECOMMENDATION

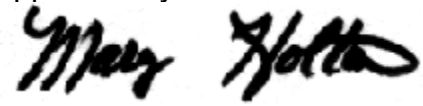
Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's home remain unchanged.



3/10/2023

Christopher Holvey Date
Licensing Consultant

Approved By:



3/10/2023

Mary E. Holton Date
Area Manager