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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 21, 2022

Susan McKiddy
10892 Abbey Drive
Brighton, MI 48114

RE: License #: AS630407256
Investigation #: 2023A0991004
Victor Manor

Dear Ms. McKiddy:

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 (248) 975-5053.

Sincerely,

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630407256
Investigation #:	2023A0991004
Complaint Receipt Date:	11/04/2022
Investigation Initiation Date:	11/07/2022
Report Due Date:	01/03/2023
Licensee Name:	Susan McKiddy
Licensee Address:	10892 Abbey Drive Brighton, MI 48114
Licensee Telephone #:	(810) 923-6550
Name of Facility:	Victor Manor
Facility Address:	1305 Ford Rd White Lake, MI 48383
Facility Telephone #:	(810) 923-6550
Original Issuance Date:	06/09/2021
License Status:	REGULAR
Effective Date:	12/09/2021
Expiration Date:	12/08/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Residents in the home have bedsores due to staff not moving or positioning the residents appropriately.	No
Food is withheld from the residents. The residents are only allowed to eat at the table and then go back to their chairs.	No
There are two unknown individuals living in the basement of the home who fill in for staff who want days off.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/04/2022	Special Investigation Intake 2023A0991004
11/04/2022	APS Referral Received from Adult Protective Services (APS)
11/07/2022	Special Investigation Initiated - Telephone Call to assigned APS worker, Jonathan Johnson
11/10/2022	Inspection Completed On-site Unannounced onsite inspection- interviewed staff, home manager, and residents.
11/18/2022	Contact - Document Received Staff schedules, training, medical information
11/22/2022	Contact - Telephone call received From APS worker, Jonathan Johnson
12/20/2022	Contact - Telephone call made To nurse practitioner, Tamber Townsend
12/20/2022	Exit Conference Via telephone with licensee, Susan McKiddy

ALLEGATION:

Residents in the home have bedsores due to staff not moving or positioning the residents appropriately.

INVESTIGATION:

On 11/04/22, I received a complaint from Adult Protective Services (APS) alleging that residents at Victor Manor have bedsores from not being moved or positioned appropriately. The complaint also alleged that staff were withholding food from the residents, and that there are two unknown individuals living in the basement of the home who fill in for staff who want the day off.

I initiated my investigation on 11/07/22, by contacting the assigned APS worker, Jonathan Johnson. Mr. Johnson stated that he went to the home on 11/04/22. He spoke with the residents and observed them eating lunch. Most of the residents were wheelchair bound, but they were not bed bound. Mr. Johnson stated that the home felt comfortable. All of the residents were neat, clean, and dressed appropriately. They appeared to be well taken care of and did not voice any complaints about the home. Mr. Johnson stated that the hospice nurse was present during his onsite investigation. The nurse did not express any concerns about wounds. Staff stated that Resident A has a small wound, but the nurse practitioner has addressed the wound and it is healing. Mr. Johnson stated that the staff and residents denied that anyone lives in the basement. The owner told him that there is a bed being stored in the basement. The manager stated that she sometimes takes a nap in the basement. Mr. Johnson stated that he did not have any immediate concerns about the care of the residents in the home.

On 11/10/22, I conducted an unannounced onsite inspection at Victor Manor. I interviewed direct care worker, Angela Caufield. Ms. Caufield stated that she has worked in the home for three years. She does not have any concerns regarding the care of the residents in the home. Resident A is currently on hospice. He has a small skin tear on his bottom. He is receiving nursing services through hospice, and they put a small patch on his bottom. Resident A is not bed bound. He sits in his wheelchair and in a recliner. He is transferred throughout the day from his recliner to the table and to the toilet. He has a cushion for his wheelchair. Resident A wears briefs and is toileted every two hours. Ms. Caufield did not have any concerns about Resident A not being changed or toileted regularly. Staff also reposition Resident A every two hours at night. Resident A is seen by the visiting nurse through hospice and by the home's visiting nurse practitioner. The medical professionals have never expressed any concern that Resident A was being neglected or that his wounds were caused from him being left in his wheelchair or bed. Ms. Caufield stated that they regularly engage the residents in activities. They do armchair exercises, bingo, pool noodle activities, trivia, and music activities. Ms. Caufield stated that they have frequent visitors to the home. Family members can come in whenever they want to visit. None of the residents' family members have complained about the care the residents are receiving at the home.

On 11/10/22, I interviewed a direct care worker, who would like to remain anonymous (DCW 1). DCW 1 has worked in the home for approximately one month. She did not have any concerns about the care the residents are receiving in the home. She stated that Resident B had a very small wound. He had a nurse coming out to treat it and it is almost gone. DCW 1 did not have any concerns about any of the residents being neglected. She stated that they go to the restroom every hour. The residents are pretty vocal and will let them know if their brief is wet or soiled. DCW 1 stated that the residents are always up and being moved around. They are not left in their beds or wheelchairs for an extended period of time. Staff engage the residents in activities throughout the day.

On 11/10/22, I interviewed the home manager, Mary Henderson. Ms. Henderson stated that the residents are not stuck in their beds or wheelchairs all day. Staff try to get the residents up and walk with them if they are able to do so. They move the residents out of their wheelchairs and into recliners. The residents are toileted at least every two hours or more often if necessary. They engage the residents in activities throughout the day. The residents can watch tv, work on puzzles, or go out on the porch. She stated that they have cats outside and the residents enjoy watching the cats. Ms. Henderson did not have any concerns about the residents not being changed or toileted. Ms. Henderson stated that Resident A is on hospice and had a small sore on his bottom. They contacted his nurse right away to address the wound. She did not believe the wounds were caused from the residents being neglected. They have hospice nurses and a visiting nurse practitioner who frequently come out to the home. They have not expressed any concerns about the care of the residents. Ms. Henderson provided documentation stating that Resident A had a small red spot on his left buttocks. They contacted the nurse practitioner, Tamber Townsend, who gave a verbal order to apply Calmoseptine, an over-the-counter moisture barrier ointment, with each brief change. The wound is healing. She also provided documentation that noted Resident B had the start of a bed sore on his buttocks. Resident B's nurse was contacted and came out the next day. She applied a patch on his buttocks, which she changes twice a week. Ms. Henderson stated that Resident B has multiple sclerosis and sometimes slides down in his chair. It is difficult to reposition him.

During my onsite inspection, I observed the residents eating lunch at the dining room table. All of the residents were up and out of bed. They appeared clean and had good hygiene. After lunch, staff were engaging the residents in a trivia game. Resident C stated that staff in the home are good to them. They get out of their chairs and do things throughout the day. Staff take good care of the residents and help them go to the bathroom. She did not have any complaints. Resident D stated that the home is okay. He did not have any complaints. The other residents were unable to engage in an interview due to limited cognitive and verbal abilities.

On 11/22/22, I spoke with the assigned APS worker, Jonathan Johnson, via telephone. Mr. Johnson stated that he spoke with the guardians of the residents in the home. None

of the guardians expressed any concerns about the care provided in the home. Mr. Johnson stated that he would not be substantiating the allegations.

On 12/20/22, I interviewed nurse practitioner, Tamber Townsend, via telephone. Ms. Townsend stated that she conducts visits to Victor Manor at least monthly or when a new resident moves into the home. She stated that she does not have any concerns about the care that the residents in the home are receiving. She stated, “They are top notch.” Staff do activities with the residents and get them up and moving around. The residents are always clean, and their briefs are changed regularly. They feed them good meals. She stated that Resident B has a bed sore; however, he is diagnosed with multiple sclerosis (MS) and cannot move around. Staff do turn him and reposition him. She stated that bed sores are expected due to his condition, and it is not an indicator of neglect. Ms. Townend stated that Resident A also had a small wound on his buttocks. Resident A was on hospice and his skin was breaking down, as he was eating and drinking less. This is also to be expected for someone on hospice. She stated that staff put cream on the sore and repositioned Resident A regularly. The wound did not get any worse, which would have been expected in his condition. Ms. Townsend stated that she does skin and body checks when she comes out to the home. Ms. Townsend stated that staff call or text her whenever an issue arises. The staff all appear to be competent and take good care of the residents. She did not have any concerns to report.

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:	Based on the information gathered through my investigation, there is insufficient information to conclude that the personal needs of the residents are not being met. The staff and home manager indicated that they change, reposition, and get the residents up and moving around throughout the day. The residents engage in activities and do not stay in their beds or wheelchairs all day. Two of the residents in the home had small bedsores; however, the nurse practitioner, Tamber Townsend, did not feel these were caused from neglect. She did not have any concerns about the care provided in the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Food is withheld from the residents. The residents are only allowed to eat at the table and then go back to their chairs.

INVESTIGATION:

The complaint also alleged that food is being withheld from the residents. This is being done because the residents are messy, and the staff do not want food on the floor. The residents are only allowed to eat at the table and then go back to their chairs.

On 11/10/22, I interviewed direct care worker, Angela Caufield. Ms. Caufield stated that she did not have any concerns about food in the home. The residents receive at least three meals and two snacks every day. They can have snacks whenever they want. Ms. Caufield stated that they follow a menu in the home and there is always more than enough food. The residents typically eat at the dining room table, but they can eat in their rooms if they are not feeling well. Staff will bring food to them if they do not want to come to the table. She was not aware of any time when staff withheld food from the residents.

On 11/10/22, I interviewed DCW 1. DCW 1 stated that the residents get three meals a day at 8:00am, 12:00pm, and 5:00pm. They can eat snacks all day long. They prefer for the residents to eat at the table. She was not aware of staff ever withholding food from the residents. She stated that if a resident is not feeling well, they might have them eat separately so they do not get anyone else sick. They follow a menu for meals and there is always food in the house.

On 11/10/22, I interviewed the home manager, Mary Henderson. Ms. Henderson stated that food has never been withheld from the residents. They get three meals a day and snacks in between. Residents can eat in their rooms if they are not feeling well or if they do not want to come to the table. Ms. Henderson stated that she is a stickler for getting the residents up and out of their rooms, so she prefers that the residents come and eat at the table, but nobody is forced to do so. Ms. Henderson stated that she has never heard any resident complaining about not getting food. There is always food in the home.

During the onsite inspection, I observed the residents eating a well-balanced lunch at the dining room table. Resident C and Resident D stated that they get three meals a day. Resident C stated that there is always food in the home, and they can get snacks if they want. There was never a time that staff did not feed them. During the onsite inspection, I reviewed the menus for the home and observed that the home was well-stocked with food. They had three freezers and a full-size refrigerator. There was food and snacks in the laundry room and pantry.

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:	Based on the information gathered through my investigation, there is insufficient information to conclude that the residents are not receiving three regular, nutritious meals daily. The staff and residents who were interviewed all indicated that they get three meals and snacks. Staff prefer for the residents to eat at the table, but they can have meals in their rooms if they are not feeling well. None of the staff or residents stated that food was withheld. I observed that the home was well-stocked with food during my unannounced onsite inspection.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

There are two unknown individuals living in the basement of the home who fill in for staff who want days off.

INVESTIGATION:

The complaint also alleged that there are two unknown Jamaican girls that live in the basement of the home. They fill in for staff who want days off. The females that live in the basement do not have any prior experience working with the elderly population, but they do have experience shadowing staff.

On 11/10/22, I interviewed direct care worker, Angela Caufield. Ms. Caufield stated that there are currently six residents living at Victor Manor. Nobody else lives in the home. She stated that if it is snowing or if the weather is bad, she will stay overnight at the home. There are hospital beds being stored in the basement that belonged to previous residents. She has slept on these beds before. She was not aware of anyone else living in the home. They previously had staff working in the home who were Jamaican, but they were fully trained staff. Ms. Caufield stated that she was not aware of any untrained or inexperienced staff covering shifts in the home. There is always a fully trained staff person on shift. If someone new is hired, they work on shift with a trained staff for a few weeks until they are fully trained.

On 11/10/22, I interviewed DCW 1. DCW 1 stated that there are currently six residents in the home. She was not aware of anyone else living in the home or staying in the basement. She was not aware of any untrained person covering a shift in the home. She stated that all of the staff are fully trained as far as she knows.

On 11/10/22, I interviewed the home manager, Mary Henderson. Ms. Henderson stated that they do not have any staff living in the home. Staff have stayed the night in the home if the weather is bad or if they are doing a double and don’t want to drive home.

They have stayed the night in the basement, but nobody lives in the basement. Ms. Henderson stated that they do not randomly pull people in to cover shifts at the home. Everybody working in the home is either fully trained or works on shift with someone who is fully trained. They do not have people covering shifts who are untrained or inexperienced. Ms. Henderson stated that they did have Jamaican staff working in the home, but they were fully trained and were not living in the basement. They no longer work in the home.

I reviewed copies of the staff schedule and training and did not note any shifts being covered by untrained staff.

During the onsite inspection, I observed the basement of the home. I observed two twin size beds on box springs in one area of the basement. The beds were fully made up with sheets, blankets, and comforters, but the mattresses were flipped up against the wall to look like they were not in use. There were two pairs of shoes next to one of the beds. I observed a set of plastic storage drawers that was covered with a blanket. Upon removing the blanket, I observed that the drawers had clothes and charging cords in them. There was a small table by one of the beds that had a vase with dead flowers, candy, gum, vitamins, Tylenol, lotion, baby oil, deodorant, a puzzle book, headphones, a cosmetic case, and other random items on it. The home manager, Mary Henderson, initially stated that these were items that had been donated to the facility in the past. I informed Ms. Henderson that these things appeared to be someone's personal items and it did look as though someone was staying in the basement. Ms. Henderson spoke with the staff upstairs and determined that staff, DCW 1, had been staying there temporarily. Ms. Henderson had been on vacation and did not know anyone was staying downstairs. She stated that DCW 1 was in an abusive relationship, so she did not want anyone to know that she was staying there.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(2) A living room, dining room, hallway, or other room that is not ordinarily used for sleeping or a room that contains a required means of egress shall not be used for sleeping purposes by anyone.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the basement area was being used for sleeping purposes by staff in the home. Staff sleep in the basement if the weather is bad and DCW 1 had been temporarily sleeping in the basement without the home manager's knowledge. I observed that there were beds in the basement that were fully made up as well as personal belongings, hygiene products, and clothing.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite inspection on 11/10/22, I observed two portable heaters on the floor in the area of the basement that was being used as a bedroom. The home manager stated that they were not being used. I informed her that they needed to be removed from the home.

On 12/20/2022, I conducted an exit conference via telephone with the licensee, Susan McKiddy, and reviewed my findings. Ms. McKiddy stated that she would submit a corrective action plan to address the violations that were identified during the investigation. Ms. McKiddy stated that she would remove the beds from the basement, and it would not be used as a sleeping area by anyone, as there is not an egress door or window in the basement area. She stated that the portable heaters were removed from the home.

APPLICABLE RULE	
R 400.14510	**Heating equipment generally.**
	(5) Portable heating units shall not be permitted.
ANALYSIS:	During my unannounced onsite inspection on 11/10/22, I observed portable space heaters in the basement of the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

12/20/2022

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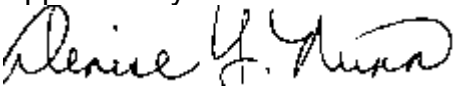
Kristen Donnay Date
Licensing Consultant

Approved By:



12/21/2022

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Denise Y. Nunn Date
Area Manager