GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 10, 2023

Ellen Angeles
Golden Haven Adult Foster Home LLC
52249 Hawthorne Drive
Chesterfield, MI 48047

RE: License #: AS500337345
Investigation #: 2023A0604003
Golden Haven Foster Home Warren

Dear Ms. Angeles:

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,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 West Grand Blvd Ste 9-100
Detroit, MI 48202
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500337345
Investigation #:	2023A0604003
Complaint Receipt Date:	11/03/2022
Investigation Initiation Date:	11/04/2022
Report Due Date:	12/03/2022
Licensee Name:	Golden Haven Adult Foster Home LLC
Licensee Address:	52249 Hawthorne Drive Chesterfield, MI 48047
Licensee Telephone #:	(586) 354-0787
Administrator:	Ellen Angeles
Licensee Designee:	Ellen Angeles
Name of Facility:	Golden Haven Foster Home Warren
Facility Address:	28740 Roan Drive Warren, MI 48093
Facility Telephone #:	(586) 806-0528
Original Issuance Date:	01/08/2014
License Status:	REGULAR
Effective Date:	07/08/2022
Expiration Date:	07/07/2024
Capacity:	6
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A stated that Person B wanted her to touch his penis and he wanted to penetrate her.	No
Additional Findings	Yes

III. METHODOLOGY

11/03/2022	Special Investigation Intake 2023A0604003
11/03/2022	APS Referral Intake indicates Adult Protective Services (APS) denied referral.
11/04/2022	Special Investigation Initiated - Telephone TC to Complainant. Left message.
11/04/2022	Inspection Completed On-site Completed unannounced onsite investigation. I interviewed Staff, Joanne Medianero, Sola Sunga, Resident A and Resident B. I observed Resident C, Resident D and Resident E.
11/07/2022	Contact - Telephone call received TC from Complainant. Unsure if complaint is possible delusion.
11/10/2022	Contact - Document Sent Email to licensee designee, Ellen Angeles. Requested contact information for Person B.
11/14/2022	Contact - Telephone call made TC to Licensee Designee, Ellen Angeles
11/14/2022	Contact - Document Sent Email to Ellen Angeles. Requested records.
11/17/2022	Contact - Document Received Email from Ellen Angeles re: faxing requested documents.
11/18/2022	Contact - Document Sent Email to Ellen Angeles

11/20/2022	Contact - Document Received Received resident register, staff list, resident care agreements and assessment plans from Ellen Angeles by fax.
01/09/2023	Contact- Telephone call made TC to Ellen Angeles
01/09/2023	Contact- Telephone call made Left message for Person B
01/09/2023	Exit Conference Completed exit conference during phone call to Licensee Designee, Ellen Angeles.

ALLEGATION:

Resident A stated that Person B wanted her to touch his penis and he wanted to penetrate her.

INVESTIGATION:

I received a complaint regarding Golden Haven Foster Home Warren on 11/03/2022. It was alleged that Resident A is a resident at the home. Her diagnosis is schizophrenia, and she has a guardian. Resident A stated that Person B wanted her to touch his penis, and he wanted to penetrate her. She did not do it, but she does not feel she can trust him. It is unknown when this occurred (six months to a year ago). The incident has not been reported. It is believed that Person B is relative of the licensee. Resident A loves living in the home. Golden Haven Adult Care takes good care of Resident A. Resident A is afraid that if Person B is reported, she will no longer be allowed to live at Golden Haven Adult Care and she does not want to lose friendship. Person B has stage IV pancreatic cancer and is taking chemotherapy. Person B no longer assists at residence.

On 11/04/2022, I completed an unannounced onsite investigation. I interviewed Staff, Joanne Medianero and Sola Sunga, Resident A and Resident B. I observed Resident C, Resident D and Resident E. Person B was not present during the onsite investigation.

On 11/04/2022, I interviewed Staff, Joanne Medianero at the home. Ms. Medianero stated that she typically works six days a week. She stated that there are five residents in the home and most have dementia. She stated that she is not aware of anyone making inappropriate comments to residents. She did not report any concerns.

On 11/04/2022, I interviewed Staff, Sol Sunga. Ms. Sunga stated that she is an on-call worker. They typically have one to two staff scheduled per shift. She stated she has not observed anyone making inappropriate comments to residents. She indicated staff may speak in a high voice.

On 11/04/2022, I interviewed Resident A. She stated that she loves living at the home. Resident A stated that Person B made sexual advances towards her about three times. He asked her to touch his penis and wanted to penetrate her. She told him that her boyfriend would not like it. Resident A indicated that Person B is a relative of owner. He used to work at the home. He still visited the home, then he left for Philippines, and came back. She has not seen inappropriate comments being made to anyone else in the home.

On 11/04/2022, I interviewed Resident B. She stated that she has lived in home for a year. Resident B stated that she loves living here. Resident B stated that her only concern is that her niece gets involved in her care and does not need to because they know what they are doing at the home. She has not observed anyone making inappropriate comments. She had no concerns about Person B. She indicated that he was a relative of owner and Person B and his wife have been very good to her. She stated that no one has been bad to her at home.

On 11/04/2022, I attempted to interview Resident C. She was Resident A's roommate. Resident C had limited verbal ability and did not respond to questions. I observed Resident D during the visit. I was informed Resident D has dementia. She was sleeping during the visit. I also observed Resident E who I was informed was non-verbal.

On 11/07/2022, I interviewed Complainant by phone. Complainant stated that Resident A has not reported any allegations like this before. However, there is no way to know if report is a delusion or reality. Complainant stated that Resident A says she is uncomfortable around Person B. Complainant stated that she wrote an order that only female staff should assist Resident A with personal care such as dressing.

On 11/10/2022, I sent email to Licensee Designee, Ellen Angeles. I requested clarification regarding Person B's role at the home and his contact information. I did not receive a response.

On 11/14/2022, I interviewed Licensee Designee, Ellen Angeles by phone. She stated that Person B was previously a caregiver at the home. He has not worked at the home since 2019. Ms. Angeles stated that he is now a resident at the home. Ms. Angeles stated that she is not aware of Person B making any inappropriate sexual comments at the home.

On 11/20/2022, Licensee Designee provided copies of resident register, staff list, resident care agreements and assessment plans by fax. A copy of the staff list was provided. Person B was not listed as a staff at the home. The resident register indicates that Person B has been a resident at the home since 10/01/2022. A copy of Person B's resident care agreement and assessment plan dated 10/01/2022 were provided. Person B's assessment plan had no comments regarding a history of making inappropriate sexual comments or advances. I reviewed Resident A's resident care agreement dated 06/06/2022. The resident care agreement is only signed by Resident A and Ms.

Angeles. The resident care agreement indicates that she agrees to receive assistance in bathing, dressing, or personal hygiene by a staff member of the opposite sex, if a member of the same sex is not available. I reviewed Resident A's assessment plan dated 06/06/2022. Resident A's assessment plan is only signed by Resident A and Ms. Angeles. The assessment plan does not indicate that Resident A has a history of making allegations regarding sexual advances.

On 01/09/2023, I interviewed license designee, Ellen Angeles by phone. She confirmed that Person B is a relative. She stated that he moved into the home when he was diagnosed with pancreatic cancer. Ms. Angles believes that staff did not report him as a resident because he is more independent than the other residents. She stated that he was not present during day of onsite investigation because he receives cancer treatments three days a week. The treatments take a full day. Ms. Angeles stated that she spoke with Person B and he denied making any sexual comments to residents in home. Person B stated that he may have told a resident they looked pretty that day. Ms. Angeles confirmed that provider has requested that only female staff assist Resident A with dressing and she has had female staff for Resident A. Ms. Angeles provided a contact number for Person B. On 01/09/2023, I left a message for Person B requesting a return call. I have not received a response.

On 01/09/2023, I completed an exit conference with Ms. Angeles by phone. I informed her of the violations found and that a corrective action plan would be requested. I also informed her that a copy of the special investigation report would be mailed once approved.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	There is not enough information to determine that Person B made sexual comments to Resident A. Resident A indicated that the statements were made, however, there are no other witnesses. Person B denied making the comments to Licensee Designee, Ellen Angeles. According to Ms. Angeles, Person B used to work at the home, however, became a resident when he was diagnosed with pancreatic cancer.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 11/20/2022, Licensee Designee, Ellen Angeles, provided copies of the resident register, staff list, resident care agreements and assessment plans by fax. I reviewed Resident A's resident care agreement dated 06/06/2022. The resident care agreement is only signed by Resident A and Ms. Angeles. The resident care agreement indicates that she agrees to receive assistance in bathing, dressing, or personal hygiene by a staff member of the opposite sex, if a member of the same sex is not available. I reviewed Resident A's assessment plan dated 06/06/2022. Resident A's assessment plan is only signed by Resident A and Ms. Angeles. On 01/09/2023, Ms. Angeles confirmed that Resident A does have a guardian.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A's assessment plan dated 06/06/2022 was not signed by her guardian. The assessment plan was only signed by Resident A and Licensee Designee, Ellen Angeles.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.

ANALYSIS:	Resident A's resident care agreement dated 06/06/2022 is only signed by Resident A and Licensee Designee, Ellen Angeles. The resident care agreement is not signed by Resident A's guardian. Resident A's resident care agreement needs to be updated to indicate that only staff of the same sex can assist her with bathing, dressing and personal hygiene.
CONCLUSION:	**VIOLATION ESTABLISHED**

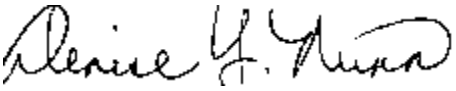
IV. RECOMMENDATION

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

01/09/2023

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



01/10/2023

Denise Y. Nunn — Date
Area Manager