GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 19, 2023

Susan Phipps
Silver Lake Serenity Inc
1687 Pine Tree Lane
Grawn, MI 49637

RE: License #: AM280414474
Investigation #: 2023A0870027
Silver Lake Serenity

Dear Ms. Phipps:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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 (616) 356-0100.

Sincerely,

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM280414474
Investigation #:	2023A0870027
Complaint Receipt Date:	04/04/2023
Investigation Initiation Date:	04/04/2023
Report Due Date:	06/03/2023
Licensee Name:	Silver Lake Serenity Inc
Licensee Address:	1687 Pine Tree Lane Grawn, MI 49637
Licensee Telephone #:	(231) 632-3425
Administrator:	Susan Phipps
Licensee Designee:	Susan Phipps
Name of Facility:	Silver Lake Serenity
Facility Address:	5840 Culver Rd. Traverse City, MI 49685
Facility Telephone #:	(231) 632-3425
Original Issuance Date:	01/13/2023
License Status:	TEMPORARY
Effective Date:	01/13/2023
Expiration Date:	07/12/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, ALZHEIMERS DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Susan Phipps yelled at and shoved Resident A to the ground, causing scratching and bruising.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/04/2023	Special Investigation Intake 2023A0870027
04/04/2023	APS Referral This referral was made to the AFC Licensing Division by Grand Traverse County MDHHS, Adult Protective Services.
04/04/2023	Special Investigation Initiated - Telephone Telephone case discussion with Adam Bragg, APS worker for Grand Traverse MDHHS.
04/05/2023	Inspection Completed On-site Interview with Licensee Designee Susan Phipps. Interview with Resident A.
04/07/2023	Contact - Telephone call made Telephone interviews with staff member Olivia Korson. Telephone interview with staff member Miranda Dyer.
04/10/2023	Inspection Completed On-site Follow up interview with Susan Phipps. Interview with Resident B.
04/11/2023	Contact - Telephone call received Telephone call with Jerry Carpenter.
04/11/2023	Contact - Telephone call received Telephone call with Susan Phipps.
04/13/2023	Contact - Telephone call made Telephone interview with staff members Pat Brown. Telephone interview with staff member Hannah Smith. Telephone interview with staff member Josh Dyer. Telephone interview with staff member Chelsea Kean.

04/17/2023	Inspection Completed-BCAL Sub. Non-Compliance
04/19/2023	Exit Conference Completed with Licensee Designee Susan Phipps

ALLEGATION: Susan Phipps yelled at and shoved Resident A to the ground, causing scratching and bruising.

INVESTIGATION: On April 4, 2023, I spoke with Adam Bragg, Adult Protective Services worker with the Grand Traverse County, Michigan Department of Health and Human Services. Mr. Bragg and I discussed the above stated allegation and coordinated an unannounced on-site investigation for the following day. He further noted that he had contacted the Grand Traverse County Sheriff's Office and provided them with the above allegation for their consideration.

On April 5, 2023, I conducted an unannounced on-site special investigation at the Silver Lake Serenity Adult Foster Care home. I was accompanied by Mr. Bragg. I met with Licensee Designee Susan Phipps and informed her of the above stated allegation. Ms. Phipps denied what was stated in the allegation. She described that on April 1, 2023, she worked at the facility from 6:00 a.m. to 1:00 p.m. and then again from approximately 2:30 p.m. until 9:00 p.m. Ms. Phipps noted that another staff member, Olivia Korson, was present that day, working a 7:00 a.m. to 9:00 p.m. shift. Ms. Phipps stated that at approximately 7:45 p.m. on April 1, 2023, Resident A was looking out the front windows, spreading the blinds with her hands. She stated that because the blinds are made of metal, she told Resident A “no no” and using her own hands, removed Resident A’s hands from the blinds, so that she would not cut her hand on the metal blinds. Ms. Phipps noted that as Resident A moved away from the window, she started to trip over a bean bag chair. She described that she attempted to catch Resident A but ended up lowering Resident A to the ground. Ms. Phipps stated she called for staff member Olivia Korson, who was with another resident down the hallway, so together they could lift Resident A back to her feet. She stated that once Resident A was assisted to her feet, she took Resident A to her bedroom and sat her in her chair. Ms. Phipps stated she examined Resident A for injuries, finding none. Ms. Phipps stated that the next morning, Resident A told staff member Josh Dyer that, “some guy hit her in the arm and slammed her on the cement.” She further noted that Resident A told home manager Miranda Dyer that “some crazy old lady with gray hair pushed her to the floor.” Ms. Phipps noted that Resident A has dementia and is diagnosed as having Alzheimer’s Disease. She stated that Resident A often says she will call her husband, and Ms. Phipps stated she will tell Resident A, “Remember that your husband and brother are dead.”

Ms. Phipps provided me with a copy of Resident A’s *Resident Health Care Appraisal, (BCAL-3947)*, for my review. This form was dated September 9, 2022, and noted that Resident A is diagnosed with Alzheimer’s Disease.

Ms. Phipps stated that the facility has nine residents in care as of April 5, 2023.

I observed Ms. Phipps to have blonde colored hair.

On April 5, 2023, I conducted a private interview with Resident A in her bedroom at the facility. Mr. Bragg was present and participated in the interview. Resident A stated she has lived in the facility for "about a year." She noted the staff are nice and living here is "smooth and easy." She stated that no one has ever done anything to hurt her and that no one has ever knocked her down. Resident A stated that she is not afraid of anyone at this home. When asked if I could see her arms, Resident A stated yes, and pulled up the sleeves of her sweater, exposing her arms from her fingers to her biceps. I observed a small, curved cut just above the wrist of her outside right arm, it was scabbed over. Resident A was unable to explain the cut or any of the circumstances of how she obtained the cut. It was obvious during this interview that Resident A has memory deficiencies.

On April 7, 2023, I conducted a telephone interview with staff member Olivia Korson. I informed Ms. Korson of my purpose in calling her, and explained the allegations as noted above. Ms. Korson stated, "I watched it happen." She noted that although she did not see Resident A go to the floor, she heard Ms. Phipps "screaming", "(Resident A) don't touch that, this is my house, not yours." Ms. Korson also stated she heard Resident A say, "don't you touch me, why are you grabbing me." She stated she was down the hallway at the time with another resident and quickly ran to see what was happening. Ms. Korson stated that when she entered the living room, she saw Resident A on the floor and Ms. Phipps "pulling on her arm." She further noted that Resident A said to Ms. Phipps, "why are you doing this, I don't understand what I did." Ms. Korson noted that Ms. Phipps told her, "help me drag her (Resident A) to her room." She noted that they stood Resident A up to her feet and did not drag her to her room. Ms. Korson stated she observed Ms. Phipps, "all up in her (Resident A) face, screaming in her face" that "your husband is dead, and your brother is dead." She further noted that later that evening, Ms. Phipps told her that she was going to take Resident A's phone, "so she can't call anyone." Ms. Korson noted that this event happened on April 1, 2023, at approximately 8:30 p.m., that she was the only staff working, along with Ms. Phipps, no other residents were present in the area of the living room at the time, and no other nonresidents were present. She stated that Resident B, "may have heard what was going on" as Resident B commented to her later that evening, "I heard what you've been dealing with."

Ms. Korson noted that the following day, April 2, 2023, at approximately 8:00 a.m. she received a call from home manager Miranda Dyer. She noted Ms. Dyer asked her, "why does (Resident A) have a bruise on her butt." Ms. Korson stated she explained to Ms. Dyer what she observed from the previous evening. She further noted that she worked the 11:00 a.m. to 9:00 p.m. shift on April 2, 2023, and saw "scratches" on Resident A's arm. Ms. Korson stated that Resident A asked her during this shift, "why did the blonde lady beat me up."
Ms. Korson stated she resigned her position at the facility shortly after this incident.

On April 7, 2023, I conducted a telephone interview with home manager Miranda Dyer. I informed Ms. Dyer of the purpose of my call and explained to her the above stated allegation. Ms. Dyer stated she was aware of the incident but was not working on the day it happened. She stated that on April 2, 2023, she was approached by staff member Josh Dyer who informed her that he was told by Resident A during breakfast that she was, “jumped by a blonde lady in the living room.” Resident A also informed Mr. Dyer that “her tailbone hurt.” Ms. Dyer stated she took Resident A to her bedroom to see if Resident A had any injuries. She noted no bruise, but Resident A pointed to her tailbone and said “right there” indicating tenderness to her tailbone area. Ms. Dyer stated she also saw two or three small bruises on Resident A’s lower arm and a “fresh” mark which she described as “just starting to scab over.” Ms. Dyer stated she asked Resident A what happed and Resident A responded that a “crazy lady pushed me down” and commented that she didn’t understand why this happened. She stated she then called Ms. Phipps to inform her of Resident A’s comments and injuries. Ms. Dyer noted that Ms. Phipps “immediately” asked how Resident A was and commented that Resident A “was horrible last night.” Ms. Dyer further stated that Ms. Phipps told her that Resident A was “touching my blinds” and that “I kind of freaked out.” Ms. Dyer stated that Ms. Phipps did not elaborate on what she meant by “freaked out.”

Ms. Dyer stated that after she spoke with Ms. Phipps, she called Ms. Korson. Ms. Dyer noted Ms. Korson told her that at approximately 8:30 p.m. the evening prior, she heard Ms. Phipps “screaming”, “don’t touch my blinds.” Ms. Dyer further stated that Ms. Korson told her that she observed Ms. Phipps “towering” over Resident A, who was on the floor, and yelling at Resident A about touching the blinds. She also noted that Ms. Korson told her that Ms. Phipps took Resident A’s telephone from her room.

Ms. Dyer stated that after she spoke with Ms. Korson, she discovered Resident A’s telephone in a basket in the facility laundry room. She further commented that she had previously, on occasion, observed “this type of behavior from Susan (Phipps) before.”

Ms. Dyer stated she took several photos of Resident A’s lower right arm which shows the above-described scratches/marks. She also has a photo of Resident A’s telephone which she states she found in a basket in the laundry room and a voice recording which Ms. Dyer states is her conversation with Resident A taken on the morning of April 2, 2023. She provided these photos/recordings to me for my investigation.

In these photos I observed what appears to be a scratch on Resident A’s wrist area of her outside right arm. The scratch appears to be in the beginning stages of scabbing over. I also observed, in the same area, what appears to be a single linear

bruise. Another photo shows a white cellular telephone in a basket sitting on what appears to be either a washing machine or a dryer.

In the recording, I hear Ms. Dyer ask Resident A, “what happened.” Resident A is heard to respond that she was, “talking to a lady, and she was kind of wound up, and she was the one that took the push, pushed me or something, I don’t know, I got up, I was kind of stung, and that is all I can tell you about that, I couldn’t tell you who she was, what she looked like or anything.”

Ms. Dyer stated she resigned her position at the facility shortly after because of this incident.

On April 10, 2023, I conducted a follow-up on-site investigation at the facility. I conducted a private interview with Resident B in her bedroom. I asked Resident B if she knows who Resident A is and she affirmed that she does. She noted that she shares a bathroom with Resident A. I asked her if she had recently heard anything unusual or concerning involving Resident A. Resident B stated she heard a “commotion” between Ms. Phipps and Resident A but does not know what it was about. I asked Resident B if she could describe what she meant by “commotion.” Resident B stated she heard Ms. Phipps, “yelling at (Resident A)” but again noted that she did not hear any specifics of what the yelling was about. Resident B commented that, “when Susan (Phipps) gets angry, then all hell breaks loose.” Shortly thereafter Ms. Phipps entered Resident B’s bedroom and insisted I could not speak with Resident B any further. I departed Resident B’s bedroom without concluding my interview with her.

Shortly after departing Resident B’s bedroom, Ms. Phipps, in a loud and threatening tone, instructed me to leave the building immediately. She commented that she “had enough” and was going to close her home and “turn in” her license. She insisted I provide the name and telephone number of my supervisor, which I provided prior to departing in the facility. As a result, I was unable to conduct any further resident interviews or review any additional staff or resident files.

On April 13, 2023, I conducted a telephone interview with staff member Pat Brown. I informed Ms. Brown of the purpose of my call and explained to her the above allegations. Ms. Brown stated she had heard of this incident from other facility staff but was not working on the day this allegedly happened. She further noted that she resigned her position shortly thereafter and had not worked any shifts since this alleged incident between Resident A and Ms. Phipps. Ms. Brown noted that what she heard from other staff was “basically what you describe in the allegation.”

On April 13, 2023, I conducted a telephone interview with staff member Hannah Smith. I informed Ms. Smith of the purpose of my call and explained to her the above allegation. Ms. Smith stated she was not at work at the time of the alleged incident but had heard about it from another staff member who had called her the next day. Ms. Smith stated she has observed Ms. Phipps, “yelling at residents”

noting this occurred multiple times with multiple residents. She stated that Ms. Phipps would “get red faced” while yelling. Ms. Smith stated she observed Ms. Phipps “get in Resident A’s face and yell.” She noted Resident A would hide when Ms. Phipps was around the facility. Ms. Smith noted that she resigned her position “after I heard about this.”

On April 13, 2023, I conducted a telephone interview with staff member Josh Dyer. I informed Mr. Dyer of the purpose of my call and explained to him the above allegation. Mr. Dyer informed me that he had worked at the facility for the past three or four months and had recently resigned because of the issues stated in the allegation. He noted he was not working on April 1, 2023, the day of the alleged incident, but did work the following morning. Mr. Dyer stated that Resident A approached him on the morning of April 2, 2023, and told him that she, “got jumped by a lady with blonde hair.” He stated that upon further inquiry, Resident A described Susan Phipps “to a tee” as the individual who “jumped her.” Mr. Dyer noted that he saw “fingernail marks” on Resident A’s arms and he immediately went to inform home manager Miranda Dyer, who further examined Resident A for any injuries. He further noted that, “Susan (Phipps) is not a nice lady to the residents.” Mr. Dyer explained that he has observed Ms. Phipps, “get in resident’s faces, screaming and swearing at them.” He stated he has observed this type of behavior “several times” from Ms. Phipps with “several different residents.”

On April 13, 2023, I conducted a telephone interview with staff member Chelsea Kean. I informed Ms. Kean of the purpose of my call and explained to her the above allegation. Ms. Kean stated that she had worked at the facility for approximately three months and last worked there on March 25, 2023. She noted she no longer is employed at Silver Lake Serenity AFC home and does not know anything about the specific issue in the allegation. Ms. Kean stated that she has observed Ms. Phipps yell at residents “many times, more than 10 times” and “at many residents.” She described Ms. Phipps as using a “raised voice, threatening and using swear words” when “yelling at the residents.” Ms. Kean also noted that she “saw her (Ms. Phipps) shove a stuffed animal in a resident’s face once”, “saw her shove another resident onto the couch” and “also have seen her aggressively grab residents.” Ms. Kean described Ms. Phipps as “not the nicest person” and that she “treats people not ok, she is mean.”

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:	Multiple staff members state they have observed Licensee Designee Susan Phipps yell at Resident A and other facility residents, using an aggressive and threatening tone. Staff member Olivia Korson stated she observed Ms. Phipps standing over Resident A pulling on her arm. Ms. Phipps asked Ms. Korson to help her "drag" Resident A to her room. Resident A was observed by staff members Miranda Dyer and Josh Dyer to have marks and bruising on her lower right arm. Photos provided by Ms. Dyer of Resident A's arm shows a mark and linier bruising. Resident B stated she heard Ms. Phipps yelling at Resident A. Licensee Designee Susan Phipps did not treat Resident A and other residents with dignity, nor did she ensure that the residents' personal needs, including protection and safety, were attended to in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means. **(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:** **(b) Use any form of physical force other than physical restraint as defined in these rules.** **(f) Subject a resident to any of the following:** **(ii) Verbal abuse.**

ANALYSIS:	Licensee Designee Susan Phipps did mistreat Resident A by yelling at her and did use physical force with Resident A by pulling at her arm. Ms. Phipps did subject Resident A to verbal abuse.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: On April 10, 2023, while in the process of conducting a special investigation into the above stated allegations, and while conducting a private interview with Resident B, Ms. Phipps entered Resident B's bedroom and insisted I could not speak with Resident B any further. I departed Resident B's bedroom without concluding my interview with her.

Shortly after departing Resident B's bedroom, Ms. Phipps, in a loud and threatening tone, instructed me to leave the building immediately. She commented that she "had enough" and was going to close her home and "turn in" her license. She insisted I provide the name and telephone number of my supervisor, which I provided prior to departing in the facility.

As a result of Ms. Phipps failure to cooperate with me, and her insistence that I leave her facility, I was unable to conduct any further resident interviews, or review any further resident or staff files for this investigation.

On April 11, 2023, I spoke by telephone with Jerry Carpenter, husband of Licensee Designee Susan Phipps, and Partner in Serenity Silver Lake Incorporated. Mr. Carpenter stated that they are, "selling the home, it's in process" and they will be sending out letters to the resident's families "today or tomorrow" informing them of the pending closure of the home. He stated they will close "the end of April."

On April 11, 2023, I spoke with Ms. Phipps. She stated that, "all the residents will be gone July 1, 2023." Ms. Phipps stated she will send out notices to the resident's families on June 1, 2023. I instructed her to send a letter to AFC Licensing Consultant Rhonda Richards informing Ms. Richards of her intent to close the home, as Ms. Richards is the Consultant assigned to the facility.

APPLICABLE RULE	
R 400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(3) The failure of an applicant or licensee to cooperate with the department in connection with an inspection or investigation shall be grounds for denying, suspending, revoking, or refusing to renew a license.

ANALYSIS:	Licensee Designee Susan Phipps failed to cooperate with the department in connection with a special investigation into allegations of resident mistreatment.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: During the course of this special investigation, Licensee Designee Susan Phipps was unable to provide verification that the following current, and former direct care staff members had been tested for communicable tuberculosis (Tb): Chelsea Kean, Olivia Korson, Hannah Smith, Connie Allen and Pat Brown.

Ms. Brown stated she had not been tested for Tb.

Ms. Smith stated she had not been tested for Tb.

Ms. Kean stated she had not been tested for Tb.

It is noted that Ms. Phipps refused to further participate in this special investigation prior to the time where I had the opportunity to question her about this finding.

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.
ANALYSIS:	The Licensee failed to obtain written evidence that several direct care staff members had been tested for communicable tuberculosis prior to those staff members assumption of duties in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: During the course of this special investigation, Licensee Designee Susan Phipps was unable to provide verification that the following direct care staff members had submitted fingerprints to the Michigan State Police to have a criminal background check conducted: Chelsea Kean, Hannah Smith, Pat Brown, and Connie Allen.

Ms. Brown stated she had not submitted her fingerprints to the MSP.

Ms. Smith stated she had not submitted her fingerprints to the MSP.

It is noted that Ms. Phipps refused to further participate in this special investigation prior to the time where I had the opportunity to question her about this finding.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(5) Upon receipt of the written consent to conduct a criminal history check and identification required under subsection (3), if the individual has applied for employment either as an employee or as an independent contractor with an adult foster care facility or staffing agency, the adult foster care facility or staffing agency that has made a good faith offer of employment or independent contract shall comply with subsection (4) and shall make a request to the department of state police to forward the individual's fingerprints to the federal bureau of investigation. The department of state police shall request the federal bureau of investigation to make a determination of the existence of any national criminal history pertaining to the individual. An individual described in this subsection shall provide the department of state police with a set of fingerprints. The department of state police shall complete the criminal history check under subsection (4) and, except as otherwise provided in this subsection, provide the results of its determination under subsection (4) and the results of the federal bureau of investigation determination to the department within 30 days after the request is made. If the requesting adult foster care facility or staffing agency is not a state department or

	agency and if criminal history record information is disclosed on the written report of the criminal history check or the federal bureau of investigation determination that resulted in a conviction, the department shall notify the adult foster care facility or staffing agency and the individual in writing of the type of crime disclosed on the written report of the criminal history check or the federal bureau of investigation determination without disclosing the details of the crime. The notification shall inform the adult foster care facility or staffing agency and the applicant regarding the appeal process in section 34c and shall include a statement that the individual has a right to appeal the information relied upon by the adult foster care facility or staffing agency in making its decision regarding his or her employment eligibility based on the criminal history check. Any charges imposed by the department of state police or the federal bureau of investigation for conducting a criminal history check or making a determination under this subsection shall be paid in the manner required under subsection (4).
ANALYSIS:	The Licensee failed to provide written evidence that several direct care staff members had submitted fingerprints to the MSP to have criminal clearances conducted.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: During the course of this special investigation, Licensee Designee Susan Phipps was unable to provide a copy of a *Resident Health Care Appraisal (BCAL-3947)* for Resident C and Resident D.

It is noted that Ms. Phipps refused to further participate in this special investigation prior to the time where I had the opportunity to question her about this finding.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written

	health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	The Licensee failed to obtain a written health care appraisal at the time of admission for two facility residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: During the course of this special investigation, I was informed by Ms. Korson that Ms. Phipps had told her, on April 1, 2023, that she was, "taking (Resident A's) phone so she can't call anyone."

Ms. Dyer stated she found Resident A's cell phone on April 2, 2023, in a basket in the facility laundry room. Ms. Dyer provided me with a photo of a phone, which she described as belonging to Resident A, sitting in a basket in what appears to be a laundry room.

It is noted that Ms. Phipps refused to further participate in this special investigation prior to the time where I had the opportunity to question her about this finding.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.**

	(g) The right to associate and have private communications and consultations with his or her physician, attorney, or any other person of his or her choice. **(j) The right of reasonable access to and use of his or her personal clothing and belongings.** **A Licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Licensee Susan Phipps took Resident A's telephone from her possession without her permission, thus denying her right to accessing her telephone for private communications and denying her right to her personal belongings.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: During the course of this special investigation Ms. Phipps stated that she records video from her camera system located in the facility. She specifically noted that the cameras stopped recording "the end of March" for technical reasons and began recording again, "as of April 8, 2023."

Ms. Dyer stated, "I think the cameras do record" and "Susan has gone back and forth on whether the cameras record."

Ms. Kean stated that "the cameras record, Susan can see stuff on her phone."

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **A Licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	The Licensee, by using video recording devices, is not respecting, and safeguarding the facility residents right to privacy.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Ms. Kean stated she had not received any training in medication administration during her employment at the facility. She further stated she had dispensed resident prescription medication to the facility residents.

Ms. Smith stated she had not received any training of medication administration during her employment at the facility. She stated she had dispensed resident prescription medication to the facility residents.

It is noted that Ms. Phipps refused to further participate in this special investigation prior to the time where I had the opportunity to question her about this finding.

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: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	The Licensee failed to provide training in the proper handling and administration of medication prior to staff members Kean and Smith supervising the taking of medication by facility residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

On April 19, 2023, I provided Licensee Designee Susan Phipps with an exit conference. I informed her of the above cited licensing rule violations and my recommendation that the AFC license issued to Silver Lake Serenity Inc. be revoked. Ms. Phipps indicated she disagreed with the findings and the recommendation. I informed her that she would be notified by the State in the coming days with options for possible resolution of this matter.

IV. RECOMMENDATION

I recommend the license be revoked.

April 19, 2023

Bruce A. Messer — Date
Licensing Consultant

Approved By:

April 19, 2023

Jerry Hendrick — Date
Area Manager