GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 31, 2023

Tamisha Turner
A Caring Home of Michigan, LLC
P.O. Box 81
Walled Lake, MI 48390

RE: License #: AS630406325
Investigation #: 2023A0465018
Chateau of Novi-Durson Home

Dear Ms. Turner:

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,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-308-6012
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630406325
Investigation #:	2023A0465018
Complaint Receipt Date:	03/24/2023
Investigation Initiation Date:	03/29/2023
Report Due Date:	05/23/2023
Licensee Name:	A Caring Home of Michigan, LLC
Licensee Address:	45750 Eleven Mile Novi, MI 48374
Licensee Telephone #:	(248) 380-4663
Administrator:	Tamisha Turner
Licensee Designee:	Tamisha Turner
Name of Facility:	Chateau of Novi-Durson Home
Facility Address:	44039 Durson Novi, MI 48374
Facility Telephone #:	(248) 380-4663
Original Issuance Date:	06/22/2021
License Status:	REGULAR
Effective Date:	12/22/2021
Expiration Date:	12/21/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 11/1/2022, direct care staff, Janae Miles, threatened to beat up Resident A. On this same day, Ms. Miles cussed at Resident A.	Yes
On an unknown date, direct care staff, Janae Miles, physically hit Resident B.	No
The facility did not provide adequate nutrition to Resident E during the time that she resided at the facility.	No
Licensee designee/administrator, Tamisha Kaplan, took Resident A's briefs without her knowledge, and gave them to other residents.	No
The facility has refused to return Resident E's personal property and belongings to Guardian E1.	No

III. METHODOLOGY

03/24/2023	Special Investigation Intake 2023A0465018
03/29/2023	Special Investigation Initiated - Letter Spoke to Complainant via email exchange
03/29/2023	Contact – Document sent I spoke to Office of Recipient Rights Officer, Dawn Krull, via email exchange
04/05/2023	Contact – Telephone call received I spoke to APS Worker, Donna Dennis
04/05/2023	Inspection Completed On-site I conducted a walkthrough of the facility, reviewed resident files, interviewed Resident A and Resident B, and interviewed direct care staff, Shatara Harris, Tamiko Cheeseboro, Glendora Jackson, and licensee Tamisha Kaplan via telephone
04/17/2023	Contact - Telephone call made I spoke to Guardian A1 via telephone

04/24/2023	Contact - Telephone call made I attempted to contact direct care staff, Janae Miles. Phone number not in service
05/05/2023	Contact - Document Received Email exchange with APS Worker, Donna Dennis. Voice recording was sent as an attachment
05/05/2023	Contact - Document Sent Email exchange with Recipient Rights Officer, Dawn Krull
05/08/2023	Contact - Document Received Email exchange with APS Worker, Donna Dennis
05/09/2023	Contact - Telephone call made I spoke to Guardian C1 via telephone
05/12/2023	Contact – Telephone call made I spoke to direct care staff, Brittany Taylor, via telephone
05/12/2023	Contact - Telephone call made I spoke to direct care staff/home manager, Marcy Gonzalez, via telephone
05/12/2023	Contact - Telephone call made I spoke to Guardian E1
05/15/2023	Contact - Telephone call made I spoke to direct care staff, Janae Miles via telephone
05/15/2023	Contact - Document Sent Email exchange with ORR Officer, Ms. Krull and APS Worker, Donna Dennis
05/15/2023	Exit Conference I conducted an Exit Conference with Licensee Designee/Administrator, Tamisha Kaplan via telephone

ALLEGATION:

On 11/1/2022, direct care staff, Janae Miles, threatened to beat up Resident A. On this same day, Ms. Miles cussed at Resident A.

INVESTIGATION:

On 3/24/2023, a complaint was received, alleging that on 11/1/2022, direct care staff, Janae Miles, threatened to beat up Resident A. The complaint indicated that on this same day, Ms. Miles cussed at Resident A and called her a “bitch” and that direct care staff, Brittany Taylor, witnessed this incident.

On 3/29/2023, I spoke to Complainant via email exchange. Complainant confirmed that the information contained in the complaint is accurate.

On 4/5/2022, 5/5/2023 and 5/8/2023, I spoke to Adult Protective Services Worker, Donna Dennis, via telephone and email exchange. Ms. Dennis stated that she is still in the process of completing her investigation and will be substantiating against Ms. Miles for the incident that occurred on 11/1/2022.

On 3/29/2023, 5/5/2023, and 5/15/2023, I spoke to Office of Recipient Rights Officer, Dawn Krull, via email exchange. Ms. Krull stated that she is still in the process of completing her investigation but intends to substantiate a rights violation related to Ms. Miles conduct toward Resident A on 11/1/2022.

On 4/5/2023, I conducted an unannounced onsite investigation at the facility. At the time of the onsite investigation, there were four residents residing in the facility, and two of the residents are non-verbal and were unable to be interviewed. I conducted a walkthrough of the facility, reviewed resident files, interviewed Resident A and Resident B, and interviewed direct care staff, Shatara Harris, Tamiko Cheeseboro, and Glendora Jackson. I also spoke to licensee designee/administrator, Tamisha Kaplan, via telephone while onsite at the facility.

Resident A’s *Face Sheet* stated that she has been residing at the facility since 9/12/2022 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A’s medical diagnosis as Depression, Anxiety and COPD. The *Assessment Plan for AFC Residents* stated that Resident A requires supervision in the community, requires assistance with all self-care tasks and uses a walker and wheelchair for mobility assistance.

I interviewed Resident A, who stated that she likes living at the facility. Resident A stated, “I like living here but there is one staff that is mean to me. Janae yells at me and a while ago, she called me a lot of cuss words and told me she was going to beat me up. She has called me a “bitch” and a lot of other mean names.” Resident A denied any other concerns related to staff.

I interviewed Resident B, who stated that he likes living at the facility. Resident B stated, “The people that work here are good to me. But one staff, Janae, is not very nice. She has yelled at me She is not nice to me.” Resident B denied any other concerns related to staff.

I interviewed direct care staff, Shatara Harris, who stated that she has worked at the facility for one year. Ms. Harris stated, “I have never yelled at or mistreated any resident. I have never observed any other staff treat a resident rudely either. I have never had any concerns with staff treatment of residents. Ms. Harris denied knowledge of this allegation being true.

I interviewed direct care staff, Tamiko Cheeseboro, who stated that she has worked at the facility for two weeks. Ms. Cheeseboro stated, “I have never yelled at or mistreated any resident. I have not seen any staff be mean to any residents since I have started working here.”

I interviewed direct care staff, Glendora Jackson, who stated that she has worked at the facility for one year. Ms. Jackson stated, “I have no knowledge of any staff yelling at or hitting a resident. I have never observed anything like that when I am at work.”

On 4/17/2023, I spoke to Guardian A1 via telephone. Guardian A1 stated that she is not aware of any concerns related to the care being provided by staff to Resident A and does not have any knowledge of whether this allegation is true.

On 5/5/2023, I received a copy of a voice recording from Ms. Dennis. The recording was of the 11/1/2022 incident involving Ms. Miles and Resident A. The recording is time stamped for the date of 11/1/2022 and contains the voices of Ms. Miles and Resident A. In the recording, Ms. Miles is speaking to Resident A, and is speaking in a loud and assertive manner. Throughout the recording, Resident A occasionally replies back but does not yell at Ms. Miles, nor make any threats or use cusswords. Ms. Miles made the following statements to Resident A:

- “You ass naked!”
- “I don’t care! You’re disrespectful!”
- “You think I won’t slap a bitch.”
- “You been on my nerves all week. Since you been here. Since you been here all month!”
- “You, cuz you nasty. It’s got people like you in it.”
- “Good! Good! Good! That’s why sitting her naked! With nothing on! In my care!”
- “You’re very disrespectful! Go back to 11 Mile!”
- “Shut up! Shut up {Resident A}!”
- “Why you so nasty?”
- “You go to hell! You go to hell {Resident A}! You’re nasty!”

On 5/12/2023, I spoke to direct care staff, Brittany Taylor, who stated that she was working on 11/1/2022, and is the person that recorded the incident between Ms. Miles and Resident A. Ms. Taylor stated, “I came into work at 7am on 11/1/2022. Ms. Miles had worked overnight, and her shift was going to end at 8am. Resident A had just returned home from the hospital and was adjusting to being back at the facility. When I came into the home, Resident A was sitting in the living room. Ms. Miles immediately told me that Resident A had a bowel movement and was playing with the feces and had

smeared it on the wall. Ms. Miles was very upset and from the moment I walked in the door, Ms. Miles was going back and forth with Resident A and arguing with Resident A. I felt the way Ms. Miles was acting was very excessive and inappropriate, so that it why I decided to record. I recorded because I was in shock at what Ms. Miles was saying to Resident A and I felt that Ms. Kaplan needed to know. Eventually, the situation died down and Ms. Miles left work. I recorded the interaction, but I never intervened or said anything to Ms. Miles while the incident was taking place. I did send the recording to Ms. Kaplan via text message the same day. Ms. Kaplan texted me back and asked me if the recording was of Ms. Miles and Resident A, and I told her yes. I told Ms. Kaplan that the recording was of Ms. Miles and Resident A arguing back and forth. Ms. Kaplan stated that she was going to take care of it. Ms. Miles was off work for a few days and then she returned to work. I am not aware of anything else happening after this incident."

On 5/15/2023, I spoke to direct care staff, Janae Miles, via telephone. Ms. Miles stated that she has worked at the facility for 13 years. Ms. Miles stated, "There was an incident in November 2022 between Resident A and I, but I didn't know it had been recorded. On that day, Resident A was calling me names, she hit me, and she peed on herself. Resident A was being very difficult. I did leave her in her urine so that the next staff could see what she had done. I could have been a little different in my approach. My voice is very deep and can be taken as me being aggressive but that is not the case. Whatever is in the recording is of me talking to Ms. Taylor. I was not talking to Resident A. I was telling Ms. Taylor all of the things that Resident A did to me. I don't remember saying anything mean to Resident A and I don't remember yelling at her or calling her nasty or threatening to slap her." Ms. Miles denied knowledge of the information in the recording having occurred.

On 4/5/2023 and 5/15/2023, I spoke to licensee designee/administrator, Tamisha Kaplan, via telephone. Ms. Kaplan stated, "I had no idea this incident occurred. I was never told of this incident nor was I provided with a copy of the recording. I did suspend Ms. Miles for five days in November 2022, but that was due to an unrelated reason. If I had known of this incident before now, I would have ended her employment. Now that I know that this incident occurred, I cannot have someone working from me that has treated residents this way. I will be ending Ms. Miles employment with my company effective today."

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.**

	(iii) Derogatory remarks about the resident or members of his or her family. **(iv) Threats.**
ANALYSIS:	On 11/1/2022, a recording was taken of Ms. Miles yelling at, and speaking in a disrespectful tone, to Resident A. In the recording, Ms. Miles threatens to slap Resident A, calls Resident A a "bitch," and repeatedly calls her nasty and tells her to move out of the facility. According to Resident A, Ms. Miles has yelled at her, and made negative comments and verbal threats to her on many occasions. Resident A confirmed the information contained in the recording is accurate. According to Resident B, Ms. Miles has yelled at him, and spoken to him in a rude and disrespectful manner, on several occasions. According to Ms. Taylor, on 11/1/2022, she witnessed Ms. Miles yell, verbally abuse, and threaten Resident A. According to Ms. Miles, she acknowledges that on 11/1/2022, she was frustrated with Resident A. Ms. Miles stated that she did make multiple comments regarding her frustration with Resident A but does not recall making these comments directly to Resident A. Ms. Miles denied knowledge of the information in the recording having occurred. Based on the information above, there is sufficient information to confirm that, on 11/1/2022, Ms. Miles subjected Resident A to mental cruelty, verbal abuse, derogatory remarks and threats.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On an unknown date, direct care staff, Janae Miles, physically hit Resident B.

INVESTIGATION:

On 3/24/2023, a complaint was received, alleging that on an unknown date, direct care staff, Janae Miles, physically hit Resident B.

The *Face Sheet* stated that Resident B has been residing at the facility since 6/22/2021 and does not have a legal guardian. The *Health Care Appraisal* listed Resident A's medical diagnosis as Schizophrenia, Depression and Anxiety. The *Assessment Plan for AFC Residents* stated that Resident A does not require supervision in the community,

can independently complete all self-care tasks with minimal prompting, and does require use of assistive devices for mobility assistance.

While onsite at the facility on 4/5/2023, I interviewed Resident B, Ms. Harris, Ms. Cheeseboro and Ms. Jackson.

I interviewed Resident B, who stated that he likes living at the facility. Resident B stated, “The people that work here are good to me. But one staff, Janae, hit me about a month ago. She was mad and me and she smacked my hand. I don’t remember when it happened, and no one saw it happen to me.”

I interviewed direct care staff, Shatara Harris, who stated that she has worked at the facility for one year. Ms. Harris stated, “I have never mistreated or physically harmed a resident. I have never observed any other staff do this either. I have never had any concerns with staff treatment of residents. Ms. Harris denied knowledge of this allegation being true.

I interviewed direct care staff, Tamiko Cheeseboro, who stated that she has worked at the facility for two weeks. Ms. Cheeseboro stated, “I have never mistreated or physically harmed any resident. I have not seen any staff do anything like this to any residents during the time that I have been working here.”

I interviewed direct care staff, Glendora Jackson, who stated that she has worked at the facility for one year. Ms. Jackson stated, “I have no knowledge of any staff hitting a resident. I have never observed anything like that when I am at work.”

On 4/17/2023, I spoke to Guardian A1 via telephone. Guardian A1 stated that she is not aware of any concerns related to the care being provided by staff to Resident A.

On 4/17/2023, I spoke to Guardian C1 via telephone. Guardian C1 stated that he is not aware of any concerns related to the care being provided by staff to Resident C.

On 5/12/2023, I interviewed Ms. Taylor, via telephone. Ms. Taylor stated, “I have never mistreated or physically harmed a resident. I have never witnessed any other staff do anything physically harmful to a resident either. I have never observed any staff hit Resident B or any other resident.”

On 5/15/2023, I spoke to Ms. Miles, via telephone. Ms. Miles stated, “This is not true. I have never hit Resident B nor any other resident.” Ms. Miles denied this allegation is true.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) 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.
ANALYSIS:	According to Resident B, on an unknown date and time, Ms. Miles became upset with him and slapped his hand. According to Ms. Miles, she has never caused physical harm to any resident and denied this allegation is true. According to Ms. Harris, Ms. Cheeseboro, and Ms. Jackson, they have never caused physical harm to a resident and have no knowledge of Ms. Miles causing physical harm to Resident B. Based on the information above, there is not sufficient information to confirm that, on an unknown date and time, Ms. Miles slapped Resident B's hand.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The facility did not provide adequate nutrition to Resident E during the time that she resided at the facility.

INVESTIGATION:

On 4/18/2023, a complaint was received, alleging that the facility did not provide adequate nutrition to Resident E during the time that she resided at the facility. The complaint stated that on 11/5/2022, Resident E was transported to the hospital, and it was determined that she was severely malnourished. The complaint indicated that there is concern that Resident E was not provided adequate nutrition while residing at the facility. Resident E never returned to the facility after admission to the hospital and was discharged to an alternate licensed facility.

During my walk-through of the facility on 4/5/2023, I observed all four residents residing in the home and conducted a walkthrough of resident bedrooms and the kitchen area. I observed all residents to be adequately dressed and with appropriate hygiene. I observed the home to properly stocked with food items. I reviewed the meal menus for the months of March 2023 and April 2023. I observed the menu to have sufficient meal and snack items listed and available in the home.

The *Face Sheet* states that Resident E resided at the facility from 6/22/2021 – 11/5/2022 and has a legal guardian, Guardian E1. The *Health Care Appraisal* listed

Resident E's medical diagnosis as Developmental Delay and Intellectual Disability, with a prescribed pureed diet. The *Assessment Plan for AFC Residents* stated that Resident E required supervision in the community, was non-verbal, required assistance with all self-care tasks and was bed-bound. I was unable to locate any hospital discharge paperwork in Resident E's file. I reviewed the *Weight Record*, which documented the following monthly weights for Resident E during the time that she resided at the facility:

June 2022: 97.2 lbs
July 2022: 97.1 lbs
August 2022: 97.1 lbs
September 2022: 97.2 lbs
October 2022: 97.1 lbs

I did not observe any significant weight loss changes for Resident E during the time that she resided at the facility.

On 5/12/2023, I spoke to Guardian E1 via telephone. Guardian E1 stated, "When Resident E went into the hospital for sepsis, she was also malnourished and had a pressure wound on her foot. I cannot prove that the staff did something intentionally to neglect Resident E, but I am concerned she was not given proper nutrition while she was residing at the facility." Guardian E1 did not have any paperwork to confirm that Resident E was malnourished and stated that Resident E passed away in 2022.

On 4/5/2023, I interviewed Ms. Harris while onsite at the facility. Ms. Harris stated, "I am familiar with Resident E and provided care to her while she was living here. We provided her with a pureed diet and always ensured that we served her meals as prescribed. If there were times that she did not want to eat a lot, we could not force her, but we never had any issues with meals that I can recall." Ms. Harris denied knowledge of this allegation being true.

While onsite at the facility, on 4/5/2023, I interviewed Ms. Jackson, who stated, "We always serve three meals a day to all residents. We served meals to Resident E as required. It has been a while and I cannot recall specific details, but we never had any issues with her not wanting to eat the food we served her." Ms. Jackson denied this allegation is true.

On 5/12/2023, I interviewed Ms. Taylor, via telephone. Ms. Taylor stated, "I remember Resident E. I do not recall any issues with her. We provided her three meals a day, the same as all other residents. And I do not remember any issues with her refusing to eat or being malnourished." Ms. Taylor denied this allegation is true.

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:	According to Resident E' *Weight Record*, her weight remained consistently at 97 lbs. There was no documentation to confirm significant weight loss or nutrition changes for Resident E during the time that she resided at the facility. According to Ms. Harris, Ms. Jackson, and Ms. Taylor, Resident E was served three nutritious meals per day and there were no issues related to malnutrition or significant weight loss. I observed the meal menus to be sufficient, with three nutritious meals and snacks provided daily to residents. Based on the information above, there is not sufficient information to confirm that the facility did not adequately provide three nutritious meals per day to Resident E during the time she resided at the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Licensee designee/administrator, Tamisha Kaplan, took Resident A's briefs without her knowledge, and gave them to other residents.

INVESTIGATION:

On 3/24/2023, a complaint was received, alleging that licensee designee/administrator, Tamisha Kaplan, took Resident A's briefs without her knowledge and gave them to other residents. The complaint stated that Ms. Kaplan used Resident A's insurance to purchase brief supplies for other residents. The complaint stated that Resident A recently discovered that her briefs, paid for and provided by her insurance company, have been being mailed to an alternate address owned by the facility's corporation.

On 4/5/2023, while onsite at the facility, I conducted a walk-through of Resident A's bedroom and supply area in her closet. I observed there to be a large pack of large-size briefs in Resident A's bedroom. The *Face Sheet* indicates that Resident A has been living at the facility since 9/12/2022. I reviewed the *Prescription Order for Adult Diapers* for Resident A, which stated that Resident A has an ongoing prescription order for adult diapers. The *J&B Medical Assignment of Benefits* document stated that the briefs are being mailed to the following address: 36520 Grand River Ave, Suite 102, Farmington Hills, MI. The *ACHOM Fax Transmittal Letter*, stated that during the month of February 2023, J&B Medical shipped the incorrect size briefs and Ms. Kaplan notified the medical supply company of this error. The document stated that a new shipment of briefs was received by the facility on 4/23/2023 and no further concerns noted.

During the onsite investigation on 4/5/2023, I interviewed Resident A, Ms. Kaplan, Ms. Harris, and Ms. Jackson.

I interviewed Resident A, who stated, “My insurance company pays for my briefs, and they should be mailed to this home. But when I called the insurance company, they stated that the briefs are being mailed to a different address under Ms. Kaplan’s name. I think she is giving my briefs to other people. If the briefs aren’t being mailed to me directly here to this home, there has to be a reason. I was given a size XL brief and I can’t fit those. I wear a large, not an XL. I have been waiting for a new supply of briefs to come, and it has been a while. Ms. Kaplan has had staff buy me briefs from the store, but I want the briefs that I am supposed to get through my insurance. Staff always make sure I have briefs to use, but I still want the ones from my insurance company. I don’t know what is going on.”

I interviewed Ms. Harris, who stated, “All residents that require hygiene supplies, receive them. We always make sure that Resident A has briefs available. We place a bag of briefs in her room for her personal use and we also have a large supply of briefs in the garage and hallway closet that we use as needed for residents. I am not aware of anyone taking or using Resident A’s briefs. I do not deal with insurance companies, so I do not know anything about that. I do know that we purchase briefs for Resident A, and the other residents when needed.”

I interviewed Ms. Jackson, who stated, “Resident A does have briefs. I am not aware of a time when she did not have briefs to use. We always have a stockpile of briefs in the garage, and in the storage room inside the house. Resident A also has her own briefs in her bedroom that are for her use. But if she ever runs out, we have more put aside for her to use. I have never heard of any one stealing Resident A’s briefs.” Ms. Jackson denied knowledge of this complaint being true.

On 4/5/2023, I spoke to Ms. Kaplan via telephone. Ms. Kaplan stated, “This allegation is not true. I have never stolen or taken any resident’s briefs. I have never stolen Resident A’s briefs and given them to other residents. It is true that Resident A’s briefs are not being mailed directly to the facility. I have so many supply companies sending items for residents on an ongoing basis, so I have all the items shipped to the corporate office, and then I disperse items to the facility as needed. I can ask the medical supply company to specifically mail Resident A’s briefs directly to the facility moving forward. We did have an issue with the medical supply company that supplies Resident A’s briefs. They accidently shipped us the incorrect size. They sent us a size XL and Resident A wears a large, not XL size. So, I had to contact the company and request they mail out a new supply of briefs with her correct size. So, during that time, when Resident A inquired about her briefs, I told her that the wrong size had come, and she was upset but I tried to explain to her that it was a medical supply company error. While we waited for the new briefs to come, I purchased the correct size briefs for Resident A and made sure she had briefs available as needed. There was never a time when Resident A did not have access to briefs when needed. I purchased a large supply of

briefs and leave them in the home in case a resident needs them." Ms. Kaplan denied this complaint is true.

On 5/12/2023, I interviewed direct care staff, Marcy Gonzalez, via telephone. Ms. Gonzalez stated, "We always have briefs in stock and available for resident use. I not aware of a time when Resident A did not have access to briefs when needed and I not aware of anyone taking or stealing Resident A's briefs to give to other residents. I am the person in charge of all the medical inventory supply needs for the facility. I check in all items when received and I keep track of when supplies are getting low. All of our resident's brief supplies are shipped to our main office, and then from there, I review the inventory and then disperse to the facility on an ongoing basis as supplies get low. There was one issue a few months ago when the medical supply company sent the incorrect size, and we bought briefs for Resident A until the new shipment came. But the address that Resident A's briefs have been being mailed to is our corporate office, not another facility. We have never taken or stolen Resident A's briefs and given them to another resident."

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	According to the *J&B Medical Assignment of Benefits*, Resident A's briefs are being mailed to the following address: 36520 Grand River Ave, Suite 102, Farmington Hills, MI, which is the corporate address for the facility. According to the *A Caring Heart Of Michigan Fax Transmittal Letter*, stated that during the month of February 2023, J&B Medical shipped the incorrect size briefs and Ms. Kaplan notified the medical supply company of this error. The document indicated that a new shipment of the correct size briefs was received by the facility on 4/23/2023. According to Resident A, she believed Ms. Kaplan was taking/stealing her briefs when she discovered the briefs were being mailed to an address different from the facility's address. Resident A acknowledged that she has always been provided briefs by the facility as needed and denied any other concerns related to this complaint.

	According to Ms. Harris and Ms. Jackson, Resident A always has access to her personal belongings and valuables. Ms. Harris and Ms. Jackson denied knowledge of a time when Resident A did not have access to her valuables or belongings and denied knowledge of Resident A's briefs being taken or stolen by staff. According to Ms. Gonzalez and Ms. Kaplan, Resident A's briefs have been being mailed to the corporate office for storage, and then dispersed to the facility as needed for Resident A's use. Ms. Gonzalez and Ms. Kaplan denied knowledge of taking or stealing Resident A's briefs to give to other residents. Based on the information above, there is not sufficient information to confirm that Ms. Kaplan, or any other direct care staff, took or stole, Resident A's briefs.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The facility has refused to return Resident E's personal property and belongings to Guardian E1.

INVESTIGATION:

On 4/18/2023, a complaint was received, alleging that the facility has refused to return Resident E's personal property and belongings to Guardian E1.

On 4/5/2023, I conducted a walk-through of the facility and did not observe Resident E's personal property and belongings in the home.

On 5/12/2023, I spoke to Guardian E1 via telephone. Guardian E1 stated, "Resident E passed away 2022. I was made aware by the facility that Resident A had personal property and belongings at the home that needed to be picked up. Since Resident E's discharge from the home, I have made several attempts to contact the facility via email in an effort to obtain all of her belongings and personal items. I did not speak to Ms. Kaplan, but I spoke to several people at the corporate office, but I cannot recall their names. I have not received a response as of yet and I am frustrated with this situation. I provided the facility with a P.O. Box to mail all the items and have yet to receive them. I have even gone through the court to request their involvement to order the facility to return the items. I just want my sister's belongings back."

On 4/5/2023 and 5/15/2023, I spoke to Ms. Kaplan via telephone. Ms. Kaplan stated, "This allegation is not true. We properly notified Guardian E1 of the need to pick up Resident E's personal belongings and property via written notice. My corporate office

staff communicated with Guardian E1. We have made numerous efforts to contact Guardian E1 to return Resident E's personal property and belongings. When we reached out to Guardian E1, she provided us with a P.O. Box. We cannot mail these items to a P.O. Box. I have all of Resident E's belongings at the corporate office, being kept in a storage area. I will contact Guardian E1 immediately to again attempt to return Resident E's belongings. I can also have staff drops the items off at an address, if Guardian E1 is willing to provide one." Ms. Kaplan denied this complaint is true.

On 5/15/2023, I sent an email, which include both Guardian E1 and Ms. Kaplan, to assist in facilitating return of Resident E's personal property and belongings to Guardian E1, and to ensure that a physical address was provided for shipment of the items.

On 5/15/2023, I conducted an exit conference with Mrs. Kaplan via telephone. Ms. Kaplan is in agreement with the findings of this report.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(16) Personal property and belongings that are left at the home after discharge shall be inventoried and stored by the licensee. The resident and designated representative shall be notified by the licensee, by registered mail, of the existence of property and belongings. Personal property and belongings that remain unclaimed, or for which arrangements have not been made, may be disposed of by the licensee after 30 days from the date that the written notification is sent to the resident and the designated representative.
ANALYSIS:	According to Guardian E1, she was notified by the facility that Resident E had personal property and belongings that were available for pickup. Guardian E1 stated that she did not know that the items could not be delivered to a P.O. Box and acknowledged that she would provide a physical mailing address to Ms. Kaplan. According to Ms. Kaplan, she has made multiple attempts to contact Guardian E1 to obtain a physical address to mail the items to. Ms. Kaplan stated that she has been storing Resident E's belongings at the corporate office awaiting receipt of a physical address for shipment. According to Guardian E1 and Ms. Kaplan, they both acknowledged that the P.O. Box was the primary reason for delay in return of Resident E's belongings.

	On 5/15/2023, Guardian E1, Ms. Kaplan and I, communicated via email exchange. Guardian E1 and Ms. Kaplan coordinated a plan for return of Resident E's personal property and belongings to Guardian E1 via a physical address. Based on the information above, there is not sufficient information to confirm that Ms. Kaplan, or any other direct care staff, refused to return Resident E's personal property and belongings to Guardian E1.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the special investigation be closed with no change to the status of the license.

Stephanie Gonzalez

5/22/2023

Stephanie Gonzalez — Date
Licensing Consultant

Approved By:

Denise Y. Nunn

05/25/2023

Denise Y. Nunn — Date
Area Manager