GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 25, 2023

Sally Londry
S & D Senior Living Home
1359 S. Colling Rd.
Caro, MI 48723

RE: License #: AM790388202
Investigation #: 2023A0572032
S&D Senior Living Home

Dear Ms. Londry:

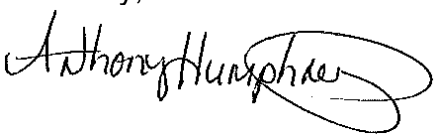
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,



Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM790388202
Investigation #:	2023A0572032
Complaint Receipt Date:	04/03/2023
Investigation Initiation Date:	04/07/2023
Report Due Date:	06/02/2023
Licensee Name:	S & D Senior Living Home
Licensee Address:	1359 S. Colling Rd. Caro, MI 48723
Licensee Telephone #:	(989) 286-3711
Administrator:	Brooke Londry
Licensee Designee:	Sally Londry
Name of Facility:	S&D Senior Living Home
Facility Address:	1359 S. Colling Rd. Caro, MI 48723
Facility Telephone #:	(989) 286-3711
Original Issuance Date:	10/18/2018
License **Status:**	REGULAR
Effective Date:	04/18/2023
Expiration Date:	04/17/2025
Capacity:	10
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
• Resident A had her TV remote taken for 3 days and said good behavior would get it returned. • Resident A had to have her bags inspected after returning to the home. Resident A takes a lot of food and gets seconds and throws a lot away and so they implemented a rule where she has to wait for everyone to get done eating or at least 15-20 min after eating to leave the table. • Resident A has reported suicidal thoughts and the bedroom door was required to be open.	Yes

III. METHODOLOGY

04/03/2023	Special Investigation Intake 2023A0572032
04/07/2023	Special Investigation Initiated - Letter Complainant.
04/26/2023	Inspection Completed On-site Licensee, Sally Londry and Resident A.
04/26/2023	Contact - Telephone call received Family Member #1.
05/22/2023	Exit Conference Licensee, Sally Londry
05/23/2023	Exit Conference Licensee, Sally Londry

ALLEGATION:

- Resident A had her TV remote taken for 3 days and said good behavior would get it returned.
- Resident A had to have her bags inspected after returning to the home. Resident A takes a lot of food and gets seconds and throws a lot away and so they implemented a rule where she has to wait for everyone to get done eating or at least 15-20 min after eating to leave the table.
- Resident A has reported suicidal thoughts and the bedroom door was required to be open.

INVESTIGATION:

On 04/03/2023, the local licensing office received a complaint for investigation. There were no other entities involved with this investigation.

On 04/26/2023, an unannounced onsite was made at S&D Senior Living Home, located in Tuscola County. Interviewed were Licensee, Sally Londry and Resident A.

On 04/26/2023, I interviewed Licensee Sally Londry regarding the allegation. Ms. Londry informed that they are following the plan implemented by Resident A's Family Member #1, who is the guardian. Every time they try to follow Resident A's Guardian's plan, Recipient Rights tells them that they are violating Resident A's rights and then they receive another complaint. Ms. Sally Londry informed that she does not know what to do and indicated it seems like no matter who she listens to, they will be investigated. Ms. Sally Londry indicated that Resident A had some behaviors, so the guardian suggested that Ms. Sally Londry take her remote so she can earn the privilege to watch tv in her room. Resident A actually could still watch tv without the remote and she wasn't kept from watching tv in the living room. In regard to looking through Resident A's bags when she returns home, the guardian put this in the plan as Resident A has a history of swallowing objects and inserting objects inside of her private parts. With regards to eating, Ms. Sally Londry is not fully aware of what the allegation is suggesting about the food. They do tell the residents to take their time, instead of eating so fast. There is no requirement for anyone to stay at the table for 15 or 20 minutes after they have finished eating, but they would like for them to slow down, take their time and use that time to socialize with their housemates. Resident A has suicidal thoughts which she was not aware of previously. The guardian wanted them to keep her bedroom door open while she's in her room on the day she was having suicidal thoughts.

On 04/26/2023, I interviewed Resident A regarding the allegation. Resident A informed that there is a tv in every room, but it's not actually part of her room and board. Staff, Brooke Londry took her remote to her tv and believe it was implemented in her plan per her guardian. Resident A informed that she had brought 3 bags home with her and Ms. Londry had to go through her bags. It caught her off guard initially because they weren't doing this before but found out this was implemented by her guardian. In regard to not being able to leave the table until 15-20 minutes after they finish eating, this was only done once because they were all

eating too fast. They would hurry up and eat their food and then go in the living room to watch tv. Staff wanted them to slow down, talk amongst each other and then be excused from the table. In regard to staff sitting outside her room, because she was having suicidal thoughts, Resident A indicated that staff were told to do line of sight until her guardian arrived.

On 04/26/2023, I reviewed Resident A's Assessment Plan to confirm that everything that was alleged was indicated in the plan. The Assessment Plan did not specify a plan to encourage positive behaviors. The plan that that staff followed were verbalized from the guardian during moments of her misbehaviors.

On 04/26/2023, Resident A's Family Member #1 regarding the allegation. She informed that she implemented the plan to take away her remote to the tv in her room because she needed an incentive for good behavior. She could still turn on the tv without the remote, so the tv wasn't actually taken away from her, just the convenience of having the remote. Family Member #1 informed that this plan had worked for a while, but there is 25 years of behavioral issues and due to these issues, she is running out of placements to place her in. Due to her history of swallowing things and inserting objects inside of her, she put in the plan for staff to check her bags when she returns home. She also has a caffeine addiction and will sneak in a whole 2-liter and guzzle it down before anyone finds out about it and then lie about it if she gets caught. It's also possible that Resident A is a shoplifter because she always comes home with so many items but has no income. Due to Resident A's history of growing up with no food in the home, she tends to go to the kitchen table and gobble up her food within a couple minutes and asks for more, but it will be too much, and she will end up throwing the food out. In her mind, she has to eat as much as she can really fast because she grew up where she didn't know when her next meal would be. Family Member #1 wants Resident A to take her time to eat and socialize with her housemates, instead of eating her food within a couple of minutes and then leaving. Family Member #1 also indicated that one morning Resident A decided not to go to church because she was having suicidal thoughts. Because of her history, she knew that Ms. Sally Londry would take it seriously, so she told her to put her on line-of-sight and she will be right over. Ms. Londry has to have a 2nd person as a witness during line-of-sight because Resident A will make things up.

On 05/23/2025, Ms. Sally Londry informed that they were doing what the guardian was asking them to do, but the case manager and her supervisor were upset because they were not aware of the plan until they all had a meeting to discuss Resident A's Plan. When they did meet, the guardian and the case manager could not come to an agreement regarding the plan because the case manager believed that it violated Resident A's rights and the guardian believed that it encouraged continued bad behaviors.

On 05/25/2023, Ms. Sally Londry informed that because Resident A would leave the home with nothing and no money but would come home with 3 or 4 bags of items,

the Guardian wanted them to check Resident A's bags. Ms. Londry denied that Resident A was ever made to stay at the table after eating her meals. When she was done eating, she could be excused from the table.

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	Based on my interviews of the Licensee, Resident A and the guardian, there is enough evidence to establish a rule violation. Resident A has a plan that was created by the Guardian, however; the Case Manager had not been aware of the plan until afterwards. This plan has not been approved or established by a licensed professional as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/22/2023, an Exit Conference was held with Licensee, Sally Londry regarding the allegation and the results of the special investigation. On 05/23/2023 another Exit Conference was held with additional information regarding the results of the special investigation.

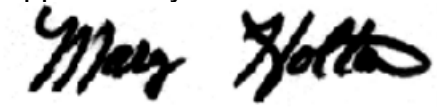
IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of correction, I recommend that no changes be made to the licensing status of this medium size adult foster care group home, (Capacity 1–12).

05/25/2023

Anthony Humphrey Date
Licensing Consultant

Approved By:



05/25/2023

Mary E. Holton Date
Area Manager