



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

July 18, 2023

Jenna Tolbert  
Sherwood Care Facilities Inc  
P.O. Box 503  
Lennon, MI 48449

RE: License #: AM250008267  
Investigation #: 2023A0779048  
Sherwood Care Duffield Road Home

Dear Ms. Tolbert:

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,

A handwritten signature in cursive script that reads "Christopher A. Holvey".

Christopher Holvey, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909  
(517) 899-5659

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AM250008267
<b>Investigation #:</b>	2023A0779048
<b>Complaint Receipt Date:</b>	06/05/2023
<b>Investigation Initiation Date:</b>	06/07/2023
<b>Report Due Date:</b>	08/04/2023
<b>Licensee Name:</b>	Sherwood Care Facilities Inc
<b>Licensee Address:</b>	5503 Duffield Rd, Flushing, MI 48433
<b>Licensee Telephone #:</b>	(810) 659-5421
<b>Administrator:</b>	Jenna Tolbert
<b>Licensee Designee:</b>	Jenna Tolbert
<b>Name of Facility:</b>	Sherwood Care Duffield Road Home
<b>Facility Address:</b>	5503 Duffield Rd, Flushing, MI 48433
<b>Facility Telephone #:</b>	(810) 659-7345
<b>Original Issuance Date:</b>	01/30/1992
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	05/08/2022
<b>Expiration Date:</b>	05/07/2024
<b>Capacity:</b>	12
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

## II. ALLEGATION(S)

	Violation Established?
On 6/4/23, a third shift staff brought her children to work with her and residents did not get any sleep because the children keep them awake all night.	No
Additional Findings	Yes

## III. METHODOLOGY

06/05/2023	Special Investigation Intake 2023A0779048
06/07/2023	APS Referral Complaint was referred to APS centralized intake.
06/07/2023	Special Investigation Initiated - Telephone Spoke to licensee designee, Jenna Tolbert.
06/07/2023	Inspection Completed On-site
06/14/2023	Contact - Telephone call made Interview conducted with staff person, Brandy Johnson.
07/13/2023	Exit Conference Held with licensee designee, Jenna Tolbert.

### ALLEGATION:

On 6/4/23, a third shift staff brought her children to work with her and residents did not get any sleep because the children keep them awake all night.

## **INVESTIGATION:**

On 6/7/23, a phone call was received from licensee designee, Jenna Tolbert, who confirmed that part of these allegations are true. Licensee Tolbert stated that staff person, Brandy Johnson, had a babysitter call in on her at the last minute, so staff Johnson had to bring her children to work with her, but for only 2 hours. Licensee Tolbert stated that staff Johnson was the only staff working that shift with a total of 12 residents, but that the children did not spend the night at the home and did not prevent any residents from sleeping. Licensee Tolbert reported that this was a one-time incident that does not typically happen.

On 6/7/23, an on-site inspection was conducted and home manager, Tamikia Paxton-Miller was interviewed. Manager Paxton-Miller stated that staff Johnson is her daughter that started work that day at 7:00pm and that she came to the home and picked the children up at approximately 9:00pm. Manager Paxton-Miller stated that there were 4 children total at the home, all under the age of eight. Manager Paxton-Miller stated that no residents complained about the children and that there were no known issues while the children were there.

During the on-site inspection, Resident A was interviewed. Resident A changed her story a few times related to when staff Johnson's children were in the home. Resident A first stated that the children were at the home for 2 days and then changed to say only one day. Resident A reported that she thinks the children stayed at the home overnight, but she was not sure because she went to bed early. When asked what time she went to bed, Resident A stated that she could not fall asleep until midnight because the children were out of control and being loud.

On 6/7/23, 6 other residents were interviewed separately, and all reported the same information. They all reported that staff Johnson had 4 children at the home, that the children did not spend the night and were only there for 1-2 hours. The residents stated that the children played outside some of the time, were well behaved and that there were no problems during their stay.

On 6/14/23, a phone interview was conducted with staff person, Brandy Johnson, who confirmed that she brought her 4 children with her to work on 6/4/23. Staff Johnson stated that her babysitter backed out on her at the last minute and that she had no choice to bring them, knowing that her mother would be coming to pick them up. Staff Johnson reported that she arrived to work at 7:00pm and that the children were picked up at approximately 9:00pm and that she was the only staff person working during that time. Staff Johnson stated that the children played outside for most of that time and colored pictures with one of the residents. Staff Johnson stated that she had her children at this home for visits in the past, that the residents like visiting with them, but that this was the first time the children were at the home while she was working alone. Staff Johnson claims that no care of the residents was negatively impacted by the 2 hours that the children were at the home.

<b>APPLICABLE RULE</b>	
<b>R 400.14305</b>	<b>Resident Protection</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	It was confirmed that staff person, Brandy Johnson, brought her 4 children, to work with her on 6/4/23, between the hours of 7:00pm and 9:00pm. Many residents stated that the children did not spend the night and that they were well behaved during their 2 hour stay at this home. There was no evidence found to prove that any resident lost any sleep or that they were not properly protected and kept safe.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On 6/7/23, a phone call was received from licensee designee, Jenna Tolbert, who confirmed that part of these allegations are true. Licensee Tolbert stated that staff person, Brandy Johnson, had a babysitter call in on her at the last minute, so staff Johnson had to bring her children to work with her, but for only 2 hours. Licensee Tolbert stated that staff Johnson was the only staff working that shift with a total of 12 residents, but that the children did not spend the night at the home and did not prevent any residents from sleeping. Licensee Tolbert reported that this was a one-time incident that does not typically happen.

On 6/7/23, 6 other residents were interviewed separately, and all reported the same information. They all reported that staff Johnson had 4 children at the home, that the children did not spend the night and were only there for 1-2 hours. The residents stated that the children played outside some of the time, were well behaved and that there were no problems during their stay.

On 6/14/23, a phone interview was conducted with staff person, Brandy Johnson, who confirmed that she brought her 4 children with her to work on 6/4/23. Staff Johnson stated that her babysitter backed out on her at the last minute and that she had no choice to bring them, knowing that her mother would be coming to pick them up. Staff Johnson reported that she arrived to work at 7:00pm and that the children were picked up at approximately 9:00pm and that she was the only staff person working during that

time. Staff Johnson stated that the children played outside for most of that time and colored pictures with one of the residents. Staff Johnson stated that she had her children at this home for visits in the past, that the residents like visiting with them, but that this was the first time the children were at the home while she was working alone. Staff Johnson claims that no care of the residents was negatively impacted by the 2 hours that the children were at the home.

<b>APPLICABLE RULE</b>	
<b>R 400.14206</b>	<b>Staffing requirements.</b>
	<b>(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.</b>
<b>ANALYSIS:</b>	It was confirmed that staff person, Brandy Johnson, brought her 4 children, who are all under the age of 8, to work with her on 6/4/23, that the children were there for approximately 2 hours and that staff Johnson was the only staff at the home during that time providing care to 12 residents. With 12 residents and 4 children being present, the staff ratio requirement dictated by this rule was not met.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 7/13/23, an exit conference was held with licensee designee, Jenna Tolbert. She was informed of the outcome of this investigation and that a written corrective action plan is required.

#### **IV. RECOMMENDATION**

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

*Christopher A. Holvey*

7/18/2023

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Christopher Holvey  
Licensing Consultant

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Date

Approved By:

*Mary Holton*

7/18/2023

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Mary E. Holton  
Area Manager

Date