GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 24, 2023

Judith Opiyo-Ouma
Hutcheson Manor Residential Care Inc
21620 Middlebelt Rd
Farmington Hills, MI 48336

RE: License #: AM630076165
Investigation #: 2023A0605033
Hutcheson Manor

Dear Judith Opiyo-Ouma:

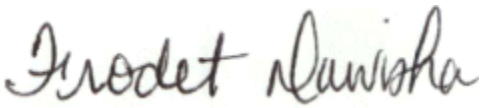
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
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(248) 303-6348
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM630076165
Investigation #:	2023A0605033
Complaint Receipt Date:	06/12/2023
Investigation Initiation Date:	06/14/2023
Report Due Date:	08/11/2023
Licensee Name:	Hutcheson Manor Residential Care Inc
Licensee Address:	21620 Middlebelt Rd Farmington Hills, MI 48336
Licensee Telephone #:	(248) 476-3798
Administrator/Licensee Designee:	Judith Opiyo-Ouma
Name of Facility:	Hutcheson Manor
Facility Address:	21620 Middlebelt Road Farmington Hills, MI 48336
Facility Telephone #:	(248) 476-3798
Original Issuance Date:	01/09/1998
License Status:	REGULAR
Effective Date:	07/06/2022
Expiration Date:	07/05/2024
Capacity:	9
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A is lashing out possibly due to being in room all the time with door closed. Resident A was crawling around naked on floor. On 6/7/23, Resident A left the home due to the door not being locked and was almost hit by a car. Resident A was transported to Botsford Hospital the same day and demonstrated none of the behaviors mentioned by Judy, the provider.	No
Provider wanted to get Resident A on blood pressure medications even though not needed.	No
Additional Findings	Yes

III. METHODOLOGY

06/12/2023	Special Investigation Intake 2023A0605033
06/14/2023	Special Investigation Initiated - Telephone Interviewed reporting source (RP) regarding allegations
06/14/2023	APS Referral Adult Protective Services (APS) made referral and will not be investigating these allegations
06/15/2023	Inspection Completed On-site Conducted unannounced on-site investigation
06/16/2023	Contact - Document Received Email from licensee designee Judith Ouma
08/01/2023	Contact - Telephone call made Interviewed Resident A's son, DCS Christella, Resident C's daughter, and Resident F's daughter. Left messages for nurse practitioner (NP) Stephanie Slate, Resident B's son, Resident D's daughter and Resident E's daughter.
08/01/2023	Contact - Telephone call received Call from Resident D's daughter

08/01/2023	Contact - Telephone call made Verified that Resident A is residing at an AFC home. The licensee at that home stated Resident A is doing well
08/02/2023	Contact - Telephone call received Resident E's daughter left message
08/03/2023	Contact - Telephone call made Discussed concerns with Resident E's daughter
08/03/2023	Exit Conference Conducted exit conference with licensee designee Judith Opiyo-Ouma regarding my findings

ALLEGATION:

Resident A is lashing out possibly due to being in room all the time with door closed. Resident A was crawling around naked on floor. On 6/7/23, Resident A left the home due to the door not being locked and was almost hit by a car. Resident A was transported to Botsford Hospital the same day and demonstrated none of the behaviors mentioned by Judy, the provider.

INVESTIGATION:

On 06/14/2023, intake #195817 was referred by Adult Protective Services (APS). I initiated the special investigation by contacting the reporting person (RP) via telephone. Resident A had been residing at this facility for only two months. Resident A was being neglected by the previous facility and RP informed licensee designee Judith (Judy) Opiyo-Ouma of these concerns. Ms. Opiyo-Ouma reassured RP that Resident A will be cared for at this facility. About three weeks later, RP because receiving calls from Ms. Opiyo-Ouma regarding Resident A's behaviors and that Resident A needs to be on medications to stabilize these behaviors. Ms. Opiyo-Ouma then contacted Resident A's son requesting an additional $1000 for the care of Resident A due to her behaviors. Ms. Opiyo-Ouma advised the son that "additional staff will be hired," to help in supervising Resident A. The RP stated that additional staff was never hired. Ms. Opiyo-Ouma described Resident A's behaviors as being "out of control," and that Resident A was "very active." The RP agreed for Resident A to go on Ativan and advised Ms. Opiyo-Ouma to call the doctor. The RP stated Ms. Opiyo-Ouma never called the doctor for the medication and then RP was advised by Ms. Opiyo-Ouma that Resident A should be on hospice and that if Resident A does not go on hospice, then Resident A needed to move from this facility. The RP advised that Resident A can become "combative," and has "fought RP not to get into the car." However, RP does not believe that Resident A should be on hospice. Resident A was hospitalized because of her behaviors and then discharged to another facility as Ms. Opiyo-Ouma provided RP with a 30-discharge notice.

On 06/15/2023, I conducted an unannounced on-site investigation. There were two direct care staff (DCS) members and licensee designee Judy Opiyo-Ouma working the morning shift and a total of seven residents. I observed all the residents sitting either at the dining room table or in the living room watching TV. DCS Salimata Traoe was doing Resident C's hair at the dining table.

Resident A had been discharged; therefore, she was not present or interviewed during this visit.

I interviewed Resident B regarding the allegations. Resident B stated, "it's a fine place. There's lots of colors in my room. I like sports and the staff put sports on the TV sometimes for me." Staff care for him very well but he does get confused about their names. The staff do an excellent job, and he has no complaints. When asked about Resident A, Resident B stated, "in my opinion, she was a difficult person to live with because of her frequent disruption. She wasn't where she needed to be and was where she wasn't supposed to be. She was frequently in my way, and she didn't want to fit in with the rest of us. She touches everything and staff had to always be by her side telling her don't do that and then Resident A would get sassy with them." He never witnessed staff yell at Resident A or do anything to hurt Resident A. He never witnessed Resident A leave the home without staff and never witnessed staff force Resident A to remain in her bedroom.

I attempted to interview Resident C, but she was unable to carry out a conversation. I gathered that she liked living here and like all the staff.

I attempted to interview Resident D, but she was not responding to my questions.

I interviewed Resident E regarding the allegations. Resident E stated," it's very good here. It's home to me." Staff are wonderful to her, and she has no complaints about staff. When asked about Resident A, she stated, "I remember Resident A as being very disturbing to everyone. When everyone is sitting in the TV room watching TV, she touches everyone's things and then throws herself on the floor and would just lay there." Resident E has witnessed Resident A try to hit staff and that all the staff were trying their best to making living here good for Resident A, but Resident A was not fitting in. Resident E never witnessed Resident A get out of the house without staff. She never witnessed staff force Resident A to remain in her bedroom.

I interviewed Resident F regarding the allegations. Resident F stated, "I have no complaints here. The staff is pretty good and wonderful." Resident F remembers some of the residents finding Resident A "threatening." Resident A would tell residents, "I'm going to get you and then points her finger at them and then uses terrible language." Resident F stated that staff were very patient with her. They would try to redirect her but sometimes that did not work. He has never seen staff force Resident A into her room and tried helping Resident A, but Resident A did not want staff's help. He too never witnessed Resident A try to leave the home without staff.

I interviewed DCS Silain Terry regarding the allegations. Ms. Terry has been working for this facility since April 2022. She works the day shift. There are always two staff during the day shift plus the licensee designee Judy Opiyo-Ouma. Ms. Terry described Resident A as “very busy, cussed a lot and was difficult to deal with.” During lunch, Resident A would pull everything off the table while the other residents were eating. Staff would redirect her and then she begins touching the residents. Ms. Terry stated, “She grabbed by breasts and my butt one time. She has no boundaries.” Ms. Terry kept a tight eye on Resident A as she did not want Resident A touching any of the other residents. Ms. Terry would not complete her other duties because she was mostly keeping her eye on Resident A. Resident A then began following Ms. Terry around the house when Ms. Terry did not mind as this was keeping Resident A occupied and not harassing the other residents. There is a schedule Ms. Terry follows in the morning with all the residents. She and the other staff she is working with get the residents up around 8AM, get them dressed and have them sit in the TV room. She gets Resident A up, dressed and in the TV room, but then about 10 minutes later, Resident A is back in her bedroom. When Ms. Terry goes into Resident A’s bedroom, Resident A says, “Get the fuck out.” Ms. Terry denied sending Resident A to her bedroom and denied forcing Resident A to remain in her bedroom. Ms. Opiyo-Ouma advised the staff not to disturb Resident A in her bedroom and when Resident A feels like coming out, she will come out. All the residents come and go in this home as they please and there are no staff that force them to do anything they do not want to do. Ms. Silain does not know much about Resident A requiring hospice but stated that Ms. Opiyo-Ouma was trying to get Resident A on the right mental health medication. Ms. Terry stated, “The family was in denial of Resident A’s mental health needs.” Ms. Terry advised she saw Resident A’s family member come to the home visit and put CBD oil in Resident A’s mouth. Ms. Terry immediately contacted Ms. Opiyo-Ouma who advised Ms. Terry not to allow the family member to put anything in Resident A’s mouth and not to take the CBD oil from the family member. The next day, the same family member returned to visit Resident A and again wanted to put CBD oil in Resident A’s mouth, but this time Ms. Opiyo-Ouma was present and said, “No,” to the family member and then this complaint was received. Resident A has tried to open doors, but due to the alarms being on the doors, staff are alerted to the sound and immediately redirect Resident A away from the doors. Resident A has never left the home unsupervised without staff. Resident A’s assessment plan does not state that Resident A was a one-on-one; however, staff were keeping an extra eye on Resident A due to her behaviors.

I interviewed DCS Salimata Traoe regarding the allegations. Ms. Traoe works the morning shift. There are always two DCS during the day shift plus the licensee Judith Opiyo-Ouma. Resident A had significant behavioral issues that included cussing, going into residents’ rooms and trying to run outside the home. Resident A opens the door, the alarm sound goes off and staff get to Resident A before she leaves the home. Resident A has never ran out of the home without staff supervision, even when she tries to. Staff had to constantly watch Resident A and even then, her behaviors were difficult to deal with. She acts out during the morning when staff are trying to get all the residents up out of bed, dressed and out into the TV room. Ms. Traoe stated, “One of

the staff is always running behind Resident A because of how she acts." Ms. Traoe has never made Resident A stay in her bedroom. Resident A chooses to go into her bedroom and comes out whenever she wants to. Ms. Traoe had no other information to provide.

I interviewed licensee designee Judith Opiyo-Ouma regarding the allegations. Ms. Opiyo-Ouma was advised by Resident A's family to send Resident A to the hospital because of her behaviors. While Resident A was at the hospital, the family son who is Resident A's durable power of attorney (DPOA) and family member who is secondary DPOA placed Resident A at another group home. Resident A moved in on 04/15/2023 by her son and another family member. Resident A was only at this facility for about five weeks. On 04/15/2023, the assessment plan was completed with the son and the family member who never reported any of Resident A's behaviors. The cost of care was agreed upon and the family left. That night, Resident A began exhibiting behaviors, cursing and staff were unable to redirect her. Ms. Opiyo-Ouma reached out to the family member who stated, these are "normal behaviors." The behaviors continued with Resident A who was now disturbing the other residents; touching the residents, trying to take their things, throwing herself on the floor and trying to get out of the house. Resident A made several attempts to leave the home but because there are door alarms, staff were able to get to her before she left the house. Resident A has never left the home unsupervised. On 04/25/2023, Ms. Opiyo-Ouma updated the assessment plan to include Resident A's behaviors. In addition to charging Resident A's family an additional $1000 for an additional staff on occasion. Ms. Opiyo-Ouma was unable to hire additional staff; however, she was working shifts with staff to add additional supervision for Resident A. Ms. Opiyo-Ouma stated that the family member DPOA initially was extremely happy with the care Resident A was receiving. The family member DPOA posted on Facebook on 05/04/2023 how wonderful the owner and staff are, and that this facility was caring, respectful and loving. Ms. Opiyo-Ouma documented Resident A's behaviors and provided me with the documentation. According to the notes, Resident A's behaviors began the night of 04/15/2023 and increased throughout her admission until she was hospitalized on 06/06/2023. Ms. Opiyo-Ouma was in constant contact with the family member DPOA regarding Resident A's behaviors. Resident A was administered with Clozapine and Ativan after several redirections were unsuccessful. Resident A was calm for about 30 minutes after the medication but then her behaviors began again. On 06/06/2023, Ms. Opiyo-Ouma advised Resident A's family member DPOA that Resident A attempted to leave the home twice and one of those times, it was the door towards the main road. Resident A's behaviors increased, calling staff "bitches," and becoming physically and verbally aggressive. The family member DPOA told Ms. Opiyo-Ouma to call 911 and have Resident A hospitalized. The police were contacted, and Resident A was transported to the hospital. Ms. Opiyo-Ouma issued a 30-day discharge notice as she was no longer able to keep Resident A safe at this facility.

Ms. Opiyo-Ouma never recommended or suggested hospice to the family member DPOA. In fact, it was the family member DPOA requesting the hospice contact number from Ms. Opiyo-Ouma for Resident A. I read text messages from the family member

DPOA to Ms. Opiyo-Ouma asking, “hey Judy I already forgot, what was the name of the hospice you’re using again?

Note: I reviewed the assessment plan completed on 04/25/2023. It did not state that Resident A was a one-on-one, but it did state all Resident A’s behaviors and Resident A’s DPOA signed the assessment plan and the resident care agreement which was also signed by the DPOA agreeing to the increase of the cost of care for Resident A.

On 08/01/2023, I discussed the allegations with Resident A’s son/DPOA via telephone. The son stated that Resident A was being “locked in the room,” and that if Resident A remained at this facility, Resident A “needed to be on hospice.” The son/DPOA was upset that there was an increase of $1000 in the cost of care for Resident A when Ms. Opiyo-Ouma never hired additional staffing. The son/DPOA stated Resident A is doing extremely well at her new placement and there has not been any behavioral issues.

On 08/01/2023, I contacted the new group home Resident A was residing at and spoke to the owner/licensee designee of the group home. He advised that Resident A was doing extremely well since her admission on 06/09/2023. She has not exhibited any behavioral issues and he had no concerns.

On 08/01/2023, I interviewed DCS Christella who refused to provide her last name via telephone. Christella no longer works for this facility and was only working at this facility on the weekends. When she worked, there was always two staff working the weekends. Christella advised that Resident A was not a one-on-one, but dealing with Resident A was like dealing with “10 residents.” Resident A’s behaviors were “out of control,” and staff tried numerous times to redirect her, but was unsuccessful. Resident A would take other residents’ stuff and would put her hands in “their faces.” The other residents would not like this, but Resident A would continue. Resident A never tried leaving the facility during her shift. Resident A was never locked or left in her bedroom. The bedroom door would always be left open unless Resident A closed the door herself.

On 08/01/2023, I interviewed via telephone Resident C’s daughter. Resident C’s daughter visits regularly to see her father. Every time she’s there, there are at least two if not three staff members on shift. She has made both announced and unannounced visits to the facility. Resident C’s daughter stated the staff is wonderful and she has no concerns. She reported an incident one time when she was visiting with her father in his bedroom. A female resident (Resident A) entered the room and before Resident A could grab something from the room, a staff member immediately came in after her and redirected her out of the bedroom. Resident C’s daughter stated the female resident is no longer at this facility. She reported no concerns.

On 08/01/2023, I interviewed Resident D’s niece via telephone. Resident D’s niece stated she just placed both her mother and father at this facility because of the wonderful staff and care her aunt receives. Resident D’s niece has been working with Ms. Opiyo-Ouma since 2020 and is very happy with the care Resident D receives and now her parents receive. Resident D’s niece has never seen staff isolate Resident D or

any other resident in their bedroom. Whenever she visits, Resident D and the other residents seem happy. Ms. Opiyo-Ouma celebrates all the residents' birthdays and family members are involved too. The staff and Ms. Opiyo-Ouma pay attention to the needs of the residents, and she has no complaints about this facility.

On 08/01/2023, I interviewed Resident F's daughter via telephone. Resident F stated that Resident F has since passed away. While he resided at this facility, he received "great care," and was "very happy." Resident F's daughter never had to worry about Resident F's care or that his needs were not being met. She was happy with the staff and Resident F never complained.

On 08/03/2023, I received a return call from NP Stephanie Slate regarding the allegations. The NP has only met Resident A twice, once via Telehealth and once in person at this facility. The NP has no concerns with the care Resident A was receiving when she lived at this facility. Resident A was always clean, and staff were attentive to her and all the other residents. The NP also visits other residents at this facility and has never had any concerns about the residents' care.

On 08/03/2023, I received a return call from Resident E's daughter. Resident E's daughter stated that the previous home Resident E was residing at was horrible. This facility was recommended by someone, and she is happy with the care her father is receiving. Resident E ambulates and is doing well. He has never complained about staff or the care he receives. She visits Resident E every Friday, and he has never been isolated in his bedroom. He's never laying in bed and is always up and doing activities with the staff. She has no concerns.

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:	Based on my investigation, Resident A was treated with dignity and her personal needs, including protection and safety were attended to at all times when she resided at this facility. Resident A attempted to elope twice from this facility, but because of the alarm on the doors staff redirected Resident A and she never left the facility unsupervised.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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: **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.**
ANALYSIS:	Based on my investigation and information gathered, Resident A was never confined to her bedroom while she resided at this facility. Resident A can ambulate and was informed by DCS Silain Terry and Salimata that Resident A wanted to be in her bedroom and that the door was always open, allowing Resident A to come and go into her bedroom without any restrictions. I interviewed family members of various residents who all stated that they have never observed a resident including their loved ones confined to their bedrooms.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Provider wanted to get Resident A on blood pressure medications even though not needed.

INVESTIGATION:

On 06/14/2023, I interviewed the RP regarding the allegations. The RP recommended to Ms. Opiyo-Ouma to call the doctor for Ativan because of Resident A's behaviors. The RP stated that Ms. Opiyo-Ouma never contacted the doctor. Instead, Ms. Opiyo-Ouma recommended hospice and then told the RP that Resident A needed to be on blood pressure medications. The RP is not sure if Resident A was given blood pressure medications.

On 06/15/2023, I interviewed DCS Silain Terry regarding the allegations. Ms. Terry advised that she has not administered any medication that was not prescribed to Resident A. She stated that Resident A is not on any blood pressure medication.

On 06/15/2023, I interviewed DCS Salimata Traoe regarding the allegations. Ms. Traoe stated she does not administer medication, so she does not have any knowledge regarding Resident A's medications.

On 06/15/2023, I interviewed Ms. Opiyo-Ouma regarding the allegations. Ms. Opiyo-Ouma stated that Resident A is not prescribed a blood pressure medication; therefore, it

was never administered to Resident A. Ms. Opiyo-Ouma never recommended blood pressure medication and would never administer any medications that is not prescribed by a physician to Resident A or any other resident.

On 06/15/2023, I reviewed Resident A's April 2023-May 2023 medication logs and did not see any blood pressure medications on any of the logs. All the medications were prescribed by a physician to Resident A.

On 08/03/2023, I interviewed the NP regarding the allegations. The NP stated that Resident A was never prescribed with blood pressure medications. Ms. Opiyo-Ouma is in constant contact with the NP regarding all medications for each resident that the NP is responsible for. The NP stated that she has never had concerns about Ms. Opiyo-Ouma administering medication to residents that was not prescribed to them.

On 08/03/2023, I conducted the exit conference via telephone with licensee designee Judith Opiyo-Ouma regarding my findings. Ms. Opiyo-Ouma acknowledged and stated she will submit a corrective action plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my investigation and information gathered, Resident A was administered medications that were only prescribed to her by a licensed physician. I reviewed Resident A's May 2023-June 2023 medication logs and did not see any blood pressure medications or any medications on the logs that were not prescribed to Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/15/2023, I reviewed Resident A's April 2023-May 2023 medication logs and found the following medication errors:

- **Calmoseptine OIN (Risamine)**: apply to buttocks twice daily for redness was applied at 5PM on 05/31/2023, but staff did not initial the medication log.
- **Memantine TAB HCL 10MG**: take one tablet twice daily for dementia was given at 5PM on 05/31/2023, but staff did not initial the medication log.
- **SMC-TMP DS TAB 800-160**: take one tablet by mouth every 12 hours for seven days for finger infection was given at 8PM on 04/19/2023 and 04/20/2023 but staff did not initial the medication log.

- **Ativan 0.5MG**: take one tablet by mouth as needed was given at 9AM on 05/01/2023, but the reason for this as needed medication was not recorded.

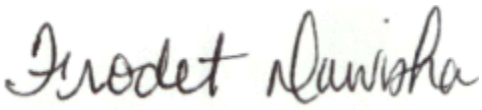
APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	During the on-site investigation, I reviewed Resident A's medication logs and found the following errors: • **Calmoseptine OIN (Risamine)**: apply to buttocks twice daily for redness was applied at 5PM on 05/31/2023, but staff did not initial the medication log. • **Memantine TAB HCL 10MG**: take one tablet twice daily for dementia was given at 5PM on 05/31/2023, but staff did not initial the medication log. • **SMC-TMP DS TAB 800-160**: take one tablet by mouth every 12 hours for seven days for finger infection was given at 8PM on 04/19/2023 and 04/20/2023 but staff did not initial the medication log.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.**

ANALYSIS:	During the on-site investigation, I reviewed Resident A's medication logs and found the following errors: • **Ativan 0.5MG**: take one tablet by mouth as needed was given at 9AM on 05/01/2023, but the reason for this as needed medication was not recorded.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

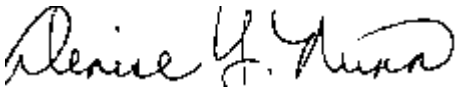
Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



08/09/2023

Frodet Dawisha — Date
Licensing Consultant

Approved By:



08/24/2023

Denise Y. Nunn — Date
Area Manager