GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 18, 2023

Jacqueline Swanson
Swansons Foster Home Inc
P.O. Bo 3867
Highland Park, MI 48203

RE: License #: AM820009970
Investigation #: 2023A0992034
Swanson's AFC Home, Inc.

Dear Ms. Swanson:

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 (313) 456-0380.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

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 #:	AM820009970
Investigation #:	2023A0992034
Complaint Receipt Date:	08/16/2023
Investigation Initiation Date:	08/18/2023
Report Due Date:	10/15/2023
Licensee Name:	Swansons Foster Home Inc
Licensee Address:	P.O. Bo 3867 Highland Park, MI 48203
Licensee Telephone #:	(313) 865-3205
Administrator:	Jacqueline Swanson
Licensee Designee:	Jacqueline Swanson
Name of Facility:	Swanson's AFC Home, Inc.
Facility Address:	211 Cortland Highland Park, MI 48203
Facility Telephone #:	(313) 865-3205
Original Issuance Date:	10/10/1984
License Status:	REGULAR
Effective Date:	10/16/2021
Expiration Date:	10/15/2023
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Jacqueline Swanson, licensee designee, is not administering Resident A's medications as prescribed. Jacqueline Swanson often administers the morning medication in the evening and the evening medications in the morning. Resident A is not receiving her medication to aid her digestion and she is losing weight.	Yes
Jacqueline Swanson, licensee designee, is not meeting Resident A's dietary needs. The residents are not being fed properly.	No
Resident A washes her clothes in sink due to staff not doing laundry.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/16/2023	Special Investigation Intake 2023A0992034
08/18/2023	Special Investigation Initiated - Telephone Complainant not available. Message left.
08/18/2023	Inspection Completed On-site Jacqueline Swanson, licensee designee, and Residents A-D.
08/23/2023	Contact - Telephone call made Lynnette Shoats, Resident A's guardian with Heitmanis Law Group
08/28/2023	Contact - Telephone call made Ms. Swanson was not available. Message left.
08/29/2023	Contact - Telephone call made Ms. Swanson was not available. Message left.
08/30/2023	Contact - Telephone call made Ms. Swanson
08/31/2023	Inspection Completed On-site Ms. Swanson
08/31/2023	Contact - Telephone call made

	Dr. Mohammad Sunbulli
09/07/2023	APS Referral
09/07/2023	Referral - Recipient Rights
09/08/2023	Contact - Telephone call received Vickie Adams, Office of Recipient Rights.
09/14/2023	Exit Conference Ms. Swanson

ALLEGATION: Jacqueline Swanson, licensee designee is not administering Resident A's medications as prescribed. Jacqueline Swanson often administers the morning medication in the evening and the evening medications in the morning. Resident A is not receiving her medication to aid her digestion and she is losing weight.

INVESTIGATION: On 08/18/2023, I completed an unannounced onsite inspection and interviewed Jacqueline Swanson, licensee designee, and Residents A-D regarding the allegation. Ms. Swanson denied the allegations and said she has been experiencing problems with Resident A since she was admitted into the home. Prior to addressing the allegations, Ms. Swanson made me aware that she issued Resident A a 30-day discharge notice on 08/15/2023. Ms. Swanson said Resident A has called the police fifteen times or more when things do not go her way. She said Resident A continuously disrupts the home with her behaviors including being verbally abusive towards her, alcohol abuse and smoking in the home. As far as the medications, Ms. Swanson said there have been several instances when Resident A would return to the home intoxicated, therefore, she did not administer her medication. Ms. Swanson said there have been times when Resident A is so inebriated that she passes out and does not wake up for her medications after several attempts to get her up. Ms. Swanson said recently Resident A woke up at 3:00 a.m. and demanded her medications; she said she did not give it to her because the medications can be administered up to an hour before or an hour after, not hours after. I requested to review Resident A's medication administration records (MARs) for this month. I observed several discrepancies. Resident A's MARs contained initials "JS" on some days and "X" on other days. Ms. Swanson confirmed "JS" are her initials and the "X" mean the medication was not given for whatever reason. There was no explanation documented on the back of the MARs. Ms. Swanson explained that Resident A's medication are not administered as prescribed due to her alcohol abuse. I noticed Resident A's MARs were not initialed on 08/17 – 08/18/2023 and did not contain an X. Ms. Swanson said all the residents received their medications. I reviewed Residents B-F's MARs for this month and their MARs were not initialed for 08/18/2023. Residents G-H's MARs were not initialed 08/15 –

08/18/2023, there was no explanation provided. Ms. Swanson said she must have forgot to initial, but all the all the residents received their medication.

I interviewed Resident A regarding the allegation. Resident A said she has been experiencing so many problems with her medications. She said she is not receiving her medication as prescribed. She said Ms. Swanson is giving her evening medications in the morning and morning medications in the evening. She said the home is so big that she cannot always hear her when she calls for medications and when she asks about her medication, Ms. Swanson refused to give it to her.

I interviewed Residents B-D regarding the allegation. Resident B-D, all stated they received their medications this morning. Residents B-D further stated that they receive their medications as prescribed daily. Residents B-D denied having any concerns.

While onsite, I observed Resident A walking through the home. As Ms. Swanson walked pass Resident A she told her “move out my way” in a very demeaning tone. I made Ms. Swanson aware that her actions were very rude. She said Resident A makes complaints against her and she is causing problems. She said Resident A calls her “black bitches” all the time. Resident A denied calling Ms. Swanson a “black bitch” and said she calls her a “money hungry troll.” I explained to Ms. Swanson that as a professional, she should not interact with the residents negatively.

On 08/23/2023, I contacted Lynnette Shoats, Resident A's guardian with Heitmanis Law Group regarding the allegation. Ms. Shoals said she is aware that Resident A has made several complaints against the home. She said she has a history of making complaints wherever she goes. She said Resident A has been in over 30 placements within 4 years. Ms. Shoats denied having any knowledge of Resident A not receiving her medications as prescribed. Ms. Shoats denied having any knowledge of Ms. Swanson terminating Resident A’s primary physician. She said it is her understanding that her former primary physician refused to treat her because of her behaviors towards him. Ms. Shoats said Ms. Swanson was in the process of finding Resident A another doctor, but she does not have identification, so they have been working on getting that first. Ms. Shoats said she recently received Resident A’s birth certificate and she needs to notify Ms. Swanson. Ms. Shoats denied having any knowledge of Resident A having special dietary needs. Ms. Shoats said Resident A does have some medical issues that are triggered by her alcoholism. She said Resident A has a friend that picks her up and she returns to the home inebriated. I made Ms. Shoats aware that Resident A seems to be very uncomfortable at the current placement and she does not have a good relationship with Ms. Swanson. Ms. Shoats said she understands. However, she said Resident A can be very problematic and she does not have many placement options at this point, other than a homeless shelter.

On 08/31/2023, I contacted Dr. Mohammad Sunbuli regarding Resident A. Dr. Sunbuli stated that Resident A has medical issues and behaviors. He said Resident

A seeks pain medication and always request additional medication, mainly controlled substances. He said in between his visits, she would go to the emergency room for pain medication. Dr. Sunbuli said he would prescribe her a lower dose non-narcotic pain medication for pain. However, she would request Tylenol 4 and Diazepam. Dr. Sunbuli said the visits were very confrontational, so he stopped the home visits. He said the group home staff said they were going to find another physician for Resident A. I asked Dr. Sunbuli if Resident A has special dietary needs and he said not to his knowledge. He said Resident A does have irritable bowel syndrome (IBS) so her diet should consist of a regular amount of fiber. I asked if Resident A is prescribed Lotomil to aid her digestions or IBS, he said no. He said Lotomil is a controlled substance.

On 09/08/2023, I received a call from Vickie Adams, Office of Recipient Rights. Ms. Adams made me aware that the reported home is outside of the Detroit Wayne Integrated Health Network (DWIHN) jurisdiction and the allegations will not be investigated. She said DWIHN is not providing any services to the home or Resident A.

On 09/14/2023, I completed an exit conference with Ms. Swanson regarding the investigative findings. I made Ms. Swanson aware upon review of the residents MARs, the MARs were not initialed as required. In addition, I explained that although Residents B-D stated they received their medication regularly, Resident A stated she is not receiving her medications as prescribed. The MARs don't reflect the medications are being administered pursuant to label instructions. I made Ms. Swanson aware that due to the substantiated violations identified in the report, a written corrective action plan is required. Ms. Swanson denied having any questions, she agreed to review the report and submit the corrective action plan as required.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	During this investigation, I interviewed Jacqueline Swanson, licensee designee; Dr. Mohammad Sunbuli, Resident A's former physician; Lynnette Shoats, Resident A's guardian with Heitmanis Law Group and Residents A-D regarding the allegations, which Ms. Swanson and Residents B-D denied. Resident A stated she is not receiving her medications as prescribed. Upon review of the MARs for Residents A-H, there were discrepancies. The MARs were not initialed and did not confirm the residents are receiving their medications pursuant to label instructions. Based on the findings there is evidence that the medications were not given, taken, or applied pursuant to label instructions. The allegation is substantiated.
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: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**

ANALYSIS:	During this investigation, I reviewed Residents A-H's MARs, there were discrepancies. The MARs were not initialed, and an explanation was not provided. Ms. Swanson admitted that she forgot to initial the MARs. Based on the findings there is evidence that the person who administered the medication, failed to initial the MARS at the time the medication was given. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Jacqueline Swanson, licensee designee is not meeting Resident A's dietary needs. The residents are not being fed properly.

INVESTIGATION: On 08/18/2023, I completed an unannounced onsite inspection and interviewed Jacqueline Swanson, licensee designee, and Residents A-D regarding the allegation. Ms. Swanson denied the allegations. Ms. Swanson said she prepares well balanced meals for all the residents. She said Resident A refuses to eat. I asked Ms. Swanson if Resident A has a special diet and she said no. I observed Resident A's health care appraisal and her assessment plan that was completed at the time of admission. The health care appraisal did not specify any special dietary or caloric needs. According to the assessment plan it was documented that Resident A has no appetite and refuses breakfast, lunch and dinner which was signed by Ms. Swanson and Resident A's guardian, Heitmanis Law Group.

I interviewed Resident A regarding the allegation. Resident A said she is prescribed Lomotil to help digest her food otherwise she cannot eat processed meats. Resident A said she is out of the medication, so she has not been eating. She said Ms. Swanson is fully aware of her issue and she refuses to accommodate her dietary needs. She said Ms. Swanson terminated her services with her physician that was prescribing her medicine and forced her to use the house physician. She said either way she does not have her medication and cannot eat the meals Ms. Swanson prepares. Resident A said she's been drinking Ensure for nutrients.

I interviewed Residents B-D regarding the allegation. Residents B-D, all stated they receive three meals a day and snacks in between meals. Residents B-C reported having cereal for breakfast this morning and Resident D could not recall. Residents B-D stated they had baked fish and a salad. Residents B-D said they receive enough food during each meal. Residents B-D denied having any concerns.

On 08/30/2023, I contacted Ms. Swanson and requested a copy of Resident A's current health care appraisal and weight record to compare Resident A's weight

from the time of admission to present. Ms. Swanson agreed to provide copies of the requested documents.

On 08/31/2023, I completed an on-site and obtained copies of the requested documents. Resident A's health care appraisal dated 04/21/2023 was blurred and I am unable to determine her weight. Resident A's weight is documented as 135lb on her health care appraisal dated 05/03/2023. Resident A's weight record was as follows:

Month/Date/Year	Weight	Comments
04/24/2023	140	Refuse to eat
05/02/2023	135	Refuse to eat
06/14/202	128	Refuse to eat
07/14/2023	128	Refuse to eat
08/29/2023	116	Refuse to eat

While onsite, I also asked to review the menus, Ms. Swanson provided me a menu that was titled "St. Joseph Medical Center Diet (you can lose up to 40lb in one month) if you stick to this diet, it is a safe diet." I asked Ms. Swanson if this is the menu she use for the residents. She took a second look and said no. Ms. Swanson was unable to locate the menu. She said the residents tend to move things. I observed the food supply in the home. In the refrigerator freezer was burnt roast, pudding, sour cream, eggs, potato salad, cheese, deli meat and various leftovers. The vegetable tray was broken and not in good repair. The cucumbers observed in the vegetable tray were molded; I brought this to Ms. Swanson's attention. She said the refrigerator was recently cleaned out and the cucumbers were supposed to be discarded. I observed freezer burnt chicken fried rice, breakfast sausages and hamburger patties. I asked Ms. Swanson how often she rotates her food and she said weekly. I observed a large number of dead gnats at the bottom of the freezer. The side-by-side refrigerator/freezer in the kitchen was dirty. In the deep freezer upstairs, I observed plenty meat including several bags of chicken parts, fish sticks, roast, ground beef patties. In the deep freezer in the basement, I observed plenty frozen vegetables and more meat. The pantry contained non-perishable items including crackers, noodles, rice, cereal, pasta noodles, canned beans, and vegetables.

On 08/31/2023, I contacted Dr. Mohammad Sunbuli regarding Resident A. I asked Dr. Sunbuli if Resident A has special dietary needs and he said not to his knowledge. He said Resident A does have irritable bowel syndrome (IBS) so her diet should consist of a regular amount of fiber. I asked if Resident A is prescribed Lotomil to aid her digestions or IBS, he said no.

On 09/14/2023, I completed an exit conference with Ms. Swanson regarding the investigative findings. I made Ms. Swanson aware that upon review of Resident A's health care appraisals, there is no evidence that she has special dietary needs. However, she has experienced weight loss since she as admitted into the home. At

the time of admission, she weighed 140lbs and as of 08/29/2023, she weighed 116, which is 24lbs within four months. Ms. Swanson said Resident A refuses to eat. I suggested Ms. Swanson inquire about Resident A's food preference and incorporate it in the menu options. I also referenced the food supply observed in the home was plentiful. I made Ms. Swanson aware that the allegation is, unsubstantiated.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	During this investigation, I interviewed Jacqueline Swanson, licensee designee; Dr. Mohammad Sunbuli, Resident A's former physician; Lynnette Shoats, Resident A's guardian with Heitmanis Law Group and Residents A regarding the allegations, which Ms. Swanson, Ms. Shoats and Dr. Sunbuli denied. Ms. Swanson said Resident A refuses to eat. I reviewed Resident A's health care appraisals and there is no indication that she has special dietary needs. Based on the findings, there is insufficient evidence to support the allegation. The allegation is unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

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:	During this investigation, I interviewed Jacqueline Swanson, licensee designee; Residents A-D regarding the allegations, which Ms. Swanson and Residents B-D denied. Resident B-D stated they receive three meals daily and snacks in between. I observed the food supply, which was plentiful. Resident A has experienced weight loss since she as admitted into the home; 24lbs within four months. However, I am unable to determine that the cause of Resident A's weight loss is due to lack of the availability of nutritious meals. Based on the findings there is insufficient evidence to support the allegations. The allegation is unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A washes her clothes in sink due to staff not doing laundry

INVESTIGATION: On 08/18/2023, I completed an unannounced onsite inspection and interviewed Jacqueline Swanson, licensee designee, and Residents A-D regarding the allegation. Ms. Swanson said doing Resident A's laundry is not an identified need for her. I asked her where the washer and dryer are located, and she said the basement. I explained that if the home does not have an approved second means of egress in the basement, the basement cannot be used for resident use. I further explained that she must afford all residents and opportunity to routinely launder their clothing. Ms. Swanson said she agreed to go in the basement and assist, Resident A. I reiterated; residents are not allowed in the basement because the home is not equipped with an approved second means of egress. Ms. Swanson said she is not doing laundry for someone that calls her "bitches."

I interviewed Resident A regarding the allegation. Resident A said her clothes have not been washed since 07/30/2023. She said she handwash her clothes in the bathroom sink. She said When she asked Ms. Swanson about it, she told her she does not pay enough for laundry services.

I interviewed Residents B-D regarding the allegation. Residents B-D stated the staff does their laundry regularly or as often as needed. Residents B-D denied having any concerns.

On 09/14/2023, I completed an exit conference with Ms. Swanson regarding the investigative findings. I made Ms. Swanson aware that based on the information received there is evidence to support the allegations that Resident A was not afforded the opportunity to launder her clothes. Ms. Swanson said she will take Resident A in the basement and show her how to wash her clothes. I reiterated;

residents are not allowed in the basement because the home is not equipped with an approved second means of egress and that she need to make provisions for Resident A to launder her clothes. I made Ms. Swanson aware that due to the substantiated violations identified in the report, a written corrective action plan is required. Ms. Swanson denied having any questions, she agreed to review the report and submit the corrective action plan as required.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(5) A licensee shall afford a resident with opportunities, and instructions when necessary, to routinely launder clothing. Clean clothing shall be available at all times.
ANALYSIS:	During this investigation, I interviewed Jacqueline Swanson, licensee designee; Residents A-D regarding the allegations, which Residents B-D denied. Resident A stated she has washed her clothes out by hand in the bathroom because Ms. Swanson refuse to wash her clothes. Ms. Swanson admitted she refused to wash Resident A's clothes because Resident A would call her "bitches." Based on the findings there is sufficient evidence to support the allegations. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 08/18/2023, while onsite, I observed Resident A walking through the home. As Ms. Swanson walked passed Resident A she told her "move out my way" in a very demeaning tone. I made Ms. Swanson aware that her actions were very rude. She said Resident A is making complaints against her and causing problems. She said Resident A calls her "black bitches" all the time. Resident A denied calling Ms. Swanson a "black bitch" and said she called her a "money hungry troll." Ms. Swanson and Resident A were going back and forth with each other. I explained to Ms. Swanson that as a professional, she should not interact with the residents negatively.

On 09/14/2023, I completed an exit conference with Ms. Swanson regarding the additional findings. I discussed the negative interaction, I observed between her and Resident A. I made M. Swanson aware that as the professional, she cannot

negatively interact with the residents. Ms. Swanson said Resident A often calls her a "bitch." I explained that although that is disrespectful, as the licensee designee and professional she cannot retaliate against Resident A by being demeaning and disrespectful.

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:	At the time of inspection, Resident A was not being treated with dignity by Ms. Swanson.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 08/31/2023, I observed molded cucumbers in the refrigerator and the vegetable tray was broken. I observed a large number of dead gnats at the bottom the freezer. The side-by-side refrigerator/freezer in the kitchen was dirty.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	At the time of inspection, the housekeeping standards did not present clean, and orderly appearance.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 08/31/2023, the home was not equipped with a menu. Ms. Swanson was unable to locate the menu.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	At the time of inspection, the home was not equipped with a menu written at least 1 week in advance and posted.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend that the status of the license remains the same.

09/15/2023

_____

Denasha Walker Date
Licensing Consultant

Approved By:

09/18/2023

_____

Ardra Hunter Date
Area Manager