GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 19, 2023

Maria Espinoza
Senior's Haven LLC
50075 Shenandoah Drive
Macomb, MI 48044

RE: License #: AS500382356
Investigation #: 2023A0617030
Senior's Haven, LLC

Dear Ms. Espinoza:

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.

611 W. OTTAWA • P.O. BOX 30664 • LANSING, MICHIGAN 48909
www.michigan.gov/lara • 517-335-1980

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,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd.
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500382356
Investigation #:	2023A0617030
Complaint Receipt Date:	07/17/2023
Investigation Initiation Date:	07/18/2023
Report Due Date:	09/15/2023
Licensee Name:	Senior's Haven LLC
Licensee Address:	50075 Shenandoah Drive Macomb, MI 48044
Licensee Telephone #:	(248) 787-2256
Administrator:	Maria Espinoza
Licensee Designee:	Maria Espinoza
Name of Facility:	Senior's Haven, LLC
Facility Address:	50075 Shenandoah Drive Macomb, MI 48044
Facility Telephone #:	(248) 787-2256
Original Issuance Date:	03/24/2017
License Status:	REGULAR
Effective Date:	09/24/2021
Expiration Date:	09/23/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS; AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is being restrained by the staff at the group home.	Yes

III. METHODOLOGY

07/17/2023	Special Investigation Intake 2023A0617030
07/17/2023	APS Referral Adult Protective Services (APS) Referral received - worker assigned Heather Horan
07/18/2023	Special Investigation Initiated - On Site Conducted an unannounced onsite investigation
07/18/2023	Inspection Completed On-site I completed an unannounced onsite investigation of the facility. During my onsite investigation I interviewed Licensee Designee Ms. Maria Espinoza, staff Geraldine (Gigi) Haught, and hospice aid Tania Saveski. I also observed Resident A sleeping in her bed.
07/24/2023	Contact - Document Received I interviewed Adult Protective worker Heather Horan
08/29/2023	Contact - Telephone call made TC to Ms. Barbara Harrison
09/11/2023	Contact - Telephone call made TC to Barbara Harrison
09/11/2023	Contact - Document Sent Email sent to Licensee Maria Espinoza
09/11/2023	Contact - Document Received Email received from Licensee Maria Espinoza
09/11/2023	Exit Conference I conducted an exit conference with Licensee Maria Espinoza to discuss the findings of this report.

ALLEGATION:

Resident A is being restrained by the staff at the group home.

INVESTIGATION:

On 07/17/23, I received a complaint regarding the Senior Haven's facility. The complaint indicated that Resident A is diagnosed with Alzheimer's disease, rheumatoid arthritis, hypertension, heart disease, and heart failure. Resident A's cognitive decline has caused some behavioral concerns. She requires assistance completing all activities of daily living. Resident A is being restrained by the staff at the group home. There is no order in place by the physician for these restraints to take place. The staff places mittens on Resident A that has caused bruising to her wrist. They tie her to her wheelchair using a blanket and gate belt. Kathryn has been observed with bruises consistent with fingers and pressure points on her arms, wrists, and in the middle of her chest. Resident A has been observed lying her bed with the bottom of the bed lifted high and the top of the bed down. This caused her to not be able to sit up in bed. The staff also place puppy pads in Resident A's bathroom so that the dogs in the home can urinate. I have personally observed the puppy pads and Resident A's bruises.

On 07/18/23, I completed an unannounced onsite investigation of the facility. During my onsite investigation I interviewed Licensee Designee Ms. Maria Espinoza, staff Geraldine (Gigi) Haught, and hospice aid Tania Saveski. I also observed Resident A sleeping in her bed. During the onsite investigation, I observed residents sitting in the living room watching TV. I interviewed the residents and they all reported that they enjoy residing in the facility. Residents did not have any concerns to report. Residents appeared to be clean and did not have a noticeable odor.

According to Ms. Haught, Resident A is very physically combative with staff when they try and service her. Resident A's behaviors include hitting and scratching. Ms. Haught stated that staff would tie mittens to Resident A's hand to prevent her from hitting and scratching staff. Ms. Haught stated that staff would take the mittens off once they were done servicing Resident A. Ms. Haught is aware of the bruises on Resident A and stated that those are self-inflicted bruises that Resident A does because she believes she is grabbing and attacking staff. According to Ms. Haught, staff used the mittens for about a month until the hospice nurse found out and told them to stop. According to Ms. Haught, staff ties a blanket around Resident A's waist and wheelchair to prevent her from falling out of the chair. Ms. Haught stated that she wasn't aware that was not allowed.

According to Ms. Saveski, she is a hospice care aid and she comes to the facility twice a week to provide services. Ms. Saveski stated that she has observed Resident A with mittens on that were placed on her by staff. Ms. Saveski stated that Resident A can become very combative, however Ms. Saveski has never needed the assistance of

mittens. Ms. Saveski provided services to Resident A without the assistance of staff or team member.

During the onsite investigation, I also observed Resident A sleeping in her bed. Ms. Saveski showed me several bruises on Resident A's wrists. I also observed several dog urination pads placed on the floor of the bathroom attached to Resident A's bedroom. During the onsite investigation, I observed several small dogs in the home.

According to licensee designee Ms. Maria Espinoza, Resident A is very physically combative with staff when they try and service her. Resident A's behaviors include hitting and scratching. Ms. Espinoza stated that staff would tie mittens to Resident A's wrist to prevent her from hitting and scratching staff. Ms. Espinoza stated that she believed it would be a good preventative measure. Ms. Espinoza stated that she did not consult Resident A's doctor or any medical professional. According to Ms. Espinoza, the previous hospice nurse became aware of the mittens being used on Resident A and told Ms. Espinoza to discontinue using them because they were not appropriate and just follow the medical orders. Ms. Espinoza explained to the nurse the medications were not working to decrease Resident A's combativeness. According to Ms. Espinoza the nurse told her to continue the with the medication regiment and to discontinue using the mittens. Ms. Espinoza stated that they stopped using the mittens immediately after being told to do so.

Ms. Espinoza stated that she observed bruising on Resident A and she believes the bruises are self-inflicted. According to Ms. Espinoza staff ties a blanket around Resident A's waist and wheelchair to prevent her from falling out of the chair. Ms. Espinoza stated that she wasn't aware that was not allowed. According to Ms. Espinoza, she resides in the home, and she has a small dog as well. Ms. Espinoza also allows staff Ms. Haught to bring her two dogs to the facility when she works. Ms. Haught works five days a week and brings her dogs nearly every day she works. According to Ms. Espinoza, prior to Resident A moving into the home, Resident A's room was vacant, and Ms. Espinoza placed the dog urination pads in the attached bathroom for the dogs to urinate. Ms. Espinoza stated she never relocated the dog urination pads because Resident A is bedbound and does not use the attached bathroom to her room. All three dogs urinate on the pads in Resident A's bathroom, and they go outside to defecate according to Ms. Espinoza.

On 07/24/23, I interviewed Adult Protective Services worker Heather Horan. Ms. Horan stated that she received allegations of physical abuse/restraint use. Ms. Horan sent me pictures of bruising on Resident A's wrist and arm that Ms. Horan observed. Ms. Horan stated that nurse Barbara Harrison also provided an image of Resident A wearing a belt in a wheelchair. I reviewed the picture of Resident A sitting in a wheelchair with a blanket tied around her waist. According to Ms. Horan, the licensee designee Maria Espinoza admits to using "mittens" on Resident A. Ms. Horan observed puppy pads in Resident A's bathroom that is connected to her bedroom. Ms. Horan stated that she plan to submit the investigation for closure, substantiated for neglect.

On 09/11/23, I interviewed Accent Care Hospice nurse Barbara Harrison who provides hospice services to Resident A. According to Ms. Harrison, she has observed on numerous occasions Resident A with non-authorized mittens on her, hospital restraints tying one of Resident A's wrist to her wheelchair, gait belt or blanket tied around Resident A's waist and wheelchair, and bruises on Resident A. Ms. Harrison stated that she observed this over the course of several months, however she has not witnessed any of the previously mentioned improper care in the last several weeks. Ms. Harrison stated that multiple members of her agency has witnessed the improper care and have tried to educate the licensee designee and staff on proper care for Resident A however, they were unsuccessful prior to APS involvement.

On 09/11/23, I conducted an exit conference with Licensee Maria Espinoza Strickland to discuss the findings of this report.

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:	Licensee designee Ms. Maria Espinoza, facility staff, APS Ms. Horan and several Accent Care Hospice staff have witnessed Resident A with unauthorized mittens and other restraints on her. Licensee designee Ms. Maria Espinoza, and facility staff admitted to using the restraints and mittens due to Resident A's combativeness.
CONCLUSION:	**VIOLATION 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: **(a) Use any form of punishment.** **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.**

	(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:	Licensee designee Ms. Maria Espinoza, facility staff, APS worker Ms. Horan and several Accent Care Hospice staff have witnessed Resident A with unauthorized mittens and other restraints on her. Licensee designee Ms. Maria Espinoza, and facility staff admitted to using the restraints due to Resident A's combativeness. According to Ms. Espinoza, staff ties a blanket around Resident A's waist and wheelchair to prevent her from falling out of the chair. According to Ms. Harrison, she has observed on numerous occasions Resident A with non-authorized mittens on her, hospital restraints tying one of Resident A's wrist to her wheelchair, gait belt or blanket tied around Resident A's waist and wheelchair, and bruises on Resident A. During the onsite investigation, I also observed Resident A sleeping in her bed. Ms. Saveski showed me several bruises on Resident A's wrists.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	Ms. Espinoza resides in the home and has a small dog. Ms. Espinoza also allows staff Ms. Haught to bring her two dogs to the facility when she works. Ms. Haught works five days a week and brings her dogs with her nearly every day she works. According to Ms. Espinoza, prior to Resident A moving into the home, Resident A's room was vacant, and Ms. Espinoza placed the dog urination pads in the attached bathroom for the dogs to urinate. Ms. Espinoza never relocated the dog urination pads because Resident A is bedbound and does not use the attached bathroom to her room. All three dogs urinate on the pads in Resident A's bathroom, and they go outside to defecate according to Ms. Espinoza. I also observed several dog urination pads placed on the floor of the bathroom attached to Resident A's bedroom. During the onsite investigation, I observed several small dogs in the home.

CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

09/11/23

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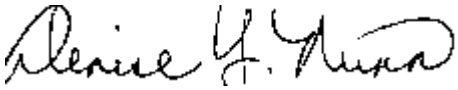
Eric Johnson Date
Licensing Consultant

Approved By:



09/19/2023

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Denise Y. Nunn Date
Area Manager