

GRETCHEN WHITMER GOVERNOR STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

MARLON I. BROWN, DPA ACTING DIRECTOR

August 28, 2023

Ronda Freeman-McDonald Altum Care Homes, LLC 23408 Plum Hollow Southfield, MI 48033

> RE: License #: AS630410805 Investigation #: 2023A0605038 Sandy Lane

Dear Rhonda Freeman-McDonald:

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 (248) 975-5053.

Sincerely,

Frodet Navisha

Frodet Dawisha, Licensing Consultant Bureau of Community and Health Systems Cadillac Place, Ste 9-100 Detroit, MI 48202 (248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630410805
License #:	A3030410005
Investigation #:	2023A0605038
Investigation #:	2023A0005030
Complaint Dessint Date:	07/44/2022
Complaint Receipt Date:	07/11/2023
Investigation Initiation Date:	07/11/2023
Report Due Date:	09/09/2023
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Licensee Name:	Altum Care Homes, LLC
Licensee Address:	23408 Plum Hollow
	Southfield, MI 48033
Licensee Telephone #:	(313) 377-3776
Administrator/Licensee	Ronda Freeman-McDonald
Designee:	
Name of Facility:	Sandy Lane
Facility Address:	29475 Briarbank
	Southfield, MI 48034
Facility Telephone #:	(313) 377-3776
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Original Issuance Date:	09/29/2022
License Status:	REGULAR
Effective Date:	03/29/2023
Expiration Date:	03/28/2025
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED/MENTALLY ILL
	DEVELOPMENTALLY DISABLED
	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff sleep during their shifts when they are supposed to be awake.	No
Staff are physically abusive and neglectful to the residents, specifically towards Resident A. Staff call the residents' names and swear at them.	No
Staff have brought Xanax, Benadryl, and Melatonin from home to give to Resident A to make her go to sleep.	No
Staff are stealing Resident A's shopping money.	No
Additional Findings	Yes

III. METHODOLOGY

07/11/2023	Special Investigation Intake 2023A0605038
07/11/2023	Special Investigation Initiated - Telephone Discussed allegations with reporting person (RP)
07/12/2023	Referral - Recipient Rights Complaint emailed to Oakland County Office of Recipient Rights (ORR) worker Darlita Paulding
07/12/2023	APS Referral Referral made to Adult Protective Services (APS)
07/12/2023	Inspection Completed On-site Conducted unannounced on-site investigation
07/13/2023	Contact - Telephone call received Call from licensee designee Rhonda Freeman
07/20/2023	Contact - Document Received Email from licensee designee Rhonda Freeman
08/01/2023	Contact - Telephone call made Interviewed Resident A via telephone in collaboration with ORR Heather Shepherd

08/01/2023	Contact - Telephone call made Left message for Resident A's guardian Jennifer Carney
08/01/2023	Contact - Document Sent Email to Rhonda Freeman
08/02/2023	Contact - Telephone call received Interviewed Resident A's guardian regarding the allegations
08/21/2023	Contact – Telephone call received From ORR Heather Shepherd
08/21/2023	Contact - Telephone call made Interviewed DCS Briahna Mason, Unique Austin, Marla Pulliam, Osheka Ramsey, and Paule Tsoungui-Mbessa regarding the allegations
08/23/2023	Contact - Telephone call made Attempted to call licensee designee Rhonda Freeman to conduct exit conference but mailbox is full. I was unable to leave message.
08/23/2023	Exit Conference Emailed licensee designee Rhonda Freeman with my findings

Staff sleep during their shifts when they are supposed to be awake.

INVESTIGATION:

On 07/11/2023, intake #196355 was assigned for investigation. I initiated the special investigation by contacting the reporting person (RP) and discussing these allegations. The RP stated there were about two direct care staff (DCS) that sleep during their shifts. These individuals were Shanna and Leah who are sisters. These sisters would bring their pillows, blankets, and sheets with them at their shift and sleep. This happened during the midnight shift. In addition, the RP reported that Shanna leaves her shift for hours and then returns. The RP believes that Shanna is at the store but is unsure where she goes.

On 07/12/2023, I conducted an unannounced on-site investigation. Present were Residents B, C, D and DCS Summer Harrison. Resident A was discharged from Sandy Lane to Altium Care Homes, LLC other adult foster care (AFC) home The Strides House. I interviewed Resident B in her bedroom. Resident B reported that there is only one DCS on shift. She is usually in her bedroom but stated sometimes she observed DCS sleeping and sometimes they were awake. Resident B stated the DCS that she observed sleeping are no longer working at Sandy Lane. She does not know their names.

I interviewed Resident C in her bedroom. Resident C is not sure if DCS sleep during their shifts. She has not seen them sleeping but stated she too is mostly in her bedroom. Her mother is her guardian, and she has no concerns at this home.

I attempted to interview Resident D, but she was sleeping and would not wake up during my visit.

I interviewed DCS Summer Harrison regarding the allegations. Ms. Harrison has worked for this corporation for five years. This is her second job, so she does not work at Sandy Lane often. She works different shifts but today she is working from 7AM-7PM. Ms. Harrison works alone as there is only one DCS scheduled per shift. She denied sleeping during her shift and stated she does not know of any other DCS that is sleeping during their shifts because she works alone.

On 07/13/2023, I received a call from licensee designee Rhonda Freeman regarding the allegations. Ms. Freeman received a call from a former DCS informing her that Leah Walker was sleeping during her shift. Ms. Freeman stated that Ms. Walker denied sleeping during her shift. Ms. Freeman sent communication to the entire staff about their responsibilities that included not sleeping during their shifts and "this is not our home and when we come to work, we can't get comfortable and have to maintain a level of professionalism." Ms. Freeman has zero tolerance for staff sleeping during their shifts. Ms. Freeman terminated Ms. Walker not for sleeping but for financially exploiting residents at her other AFC home Plum Hallow. Ms. Freeman stated she terminated several employees from her company because of concerns that were being expressed to her by other DCS.

On 08/01/2023, I in collaboration with Oakland County Office of Recipient Rights (ORR) worker Heather Shepherd conducted an interview with Resident A via telephone. Ms. Shepherd was present at The Strides Home while I was available via telephone. Resident A did not feel comfortable speaking with Ms. Shepherd or me. Her responses were "I don't remember," and then she said, "I don't want to talk to you." The interview ended.

On 08/01/2023, I interviewed Resident C's mother/guardian via telephone. Resident C's mother visited with Resident C a month ago. She had no concerns about staff sleeping on their shifts and has not received any complaints from Resident C regarding her care at the home.

On 08/21/2023, I interviewed DCS Briahna Mason regarding the allegations. Ms. Mason has been with this corporation for about three months. She works the midnight shift but sometimes the day shift too. Ms. Mason denied sleeping on the job and stated she has never witnessed other DCS sleep when she has arrived at her shift. Ms. Mason has

never received a complaint from the residents saying that DCS have been sleeping during their shifts.

On 08/21/2023, I interviewed DCS Unique Austin via telephone regarding the allegations. Ms. Austin has worked for this corporation for two years. She works various shifts. She too denied sleeping on the job and stated, "Ms. Freeman does not tolerate anyone sleeping on the job and that is cause for immediate termination." Ms. Austin denied observing other DCS sleep during their shift when she has arrived at her shift. She also denied that any resident at Sandy Lane has reported to her that staff have been found asleep during their shifts.

On 08/21/2023, I interviewed DCS Marla Pulliam via telephone regarding the allegations. Ms. Pulliam began working for this corporation in March 2023. She denied sleeping on the job and denied other DCS sleeping on the job. Ms. Pulliam was never told by a resident that a resident observed a DCS asleep on their shift.

On 08/21/2023, I interviewed DCS Osheka Ramsey via telephone regarding the allegations. Ms. Ramsey has worked for this corporation over two years. She works the day shift. She denied sleeping during her shifts and denied observing other DCS asleep during their shifts. Ms. Ramsey was never told by any resident that they observed a DCS sleeping on the job.

On 08/21/2023, I interviewed DCS Paule Tsoungui-Mbessa via telephone regarding the allegations. Ms. Tsoungui-Mbessa began working for this corporation two months ago. She is new but denied sleeping on the job and denied witnessing other DCS sleep during their shifts. She denied being informed by a resident that they observed a DCS asleep on the job.

APPLICABLE RU	ILE
R 400.14206	Staffing requirements.
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on my investigation and information gathered, DCS are not sleeping on their shifts and are providing the supervision, personal care, and protection of Residents B, C, and D. I interviewed Resident B who reported that the DCS that was sleeping during their shift is no longer working at Sandy Lane. All the DCS I interviewed denied sleeping on the job and licensee designee Rhonda Freeman sent communication regarding her zero tolerance for any DCS to sleep during their shift.

CONCLUSION:	VIOLATION NOT ESTABLISHED

Staff are physically abusive and neglectful to the residents, specifically towards Resident A. Staff call the residents' names and swear at them.

INVESTIGATION:

On 07/11/2023, I interviewed the RP regarding the allegations. Resident A has bipolar disorder schizophrenia. She is developmentally disabled and can be aggressive and violent and can be sweet. The two DCS that are verbally abusive towards Resident A are Shanna and Leah. Shanna and Leah antagonize Resident A to get a reaction from her and when Resident A reacts aggressively, Shanna and Leah call 911 and Resident A gets hospitalized. Shanna and Leah continuously tell Resident A, "you can't do this, or you can't do that," and then they tell Resident A, "you will get this if you do what we tell you to do." The RP has never observed the staff be physical towards Resident A or any other resident, but the RP has observed Shanna and Leah call Resident A names and swear at her.

On 07/12/2023, I interviewed Resident B at Sandy Lane regarding these allegations. Resident A was living here but has since moved to Ms. Freeman's other home. Resident B recalls staff threatening to call the police on Resident A when Resident A did not calm down, but Resident B cannot recall the names of the staff. She stated they are no longer working at Sandy Lane. Staff have never been physical towards her and have not called her names or swore at her or any other resident here.

On 07/12/2023, I interviewed Resident C at Sandy Lane regarding these allegations. Resident C does not know who Resident A is. Resident C denied any DCS physically abusing her or yelling at her or calling her names. She denied observing any other resident being subjected to physical abuse, yelling, and being called names or being sworn at. She had no concerns about staff.

On 07/12/2023, I interviewed DCS Summer Harrison at Sandy Lane regarding these allegations. About four-five months ago, Ms. Freeman learned that there were a couple of staff members antagonizing Resident A when she lived here, and Ms. Freeman terminated them. Ms. Harrison stated after the staff were fired, there were no other incidents. She denied being physically abusive towards Resident A or any other resident. She denied yelling at residents or calling them names or swearing at them. She has never observed any other staff subjecting residents to any abuse or neglect. Ms. Harrison stated when Resident B or Resident C have any manic episodes, she calls Ms. Freeman if she cannot redirect them and follows Ms. Freeman's instructions which is usually call 911 if the girls are violent.

On 07/13/2023, I interviewed licensee designee Rhonda Freeman regarding the allegations. Resident A was discharge from Sandy Lane June 2023 because Resident A was physically abusive towards staff and destructive. Resident A was destroying the home, throwing things, damaging doors, and walls. Ms. Freeman lost many staff because of Resident A. Resident A was moved to The Strides Home because it's a more contained home and currently Resident A is thriving there. Resident A continues to be a little aggressive, but now has less paranoia. Resident A had been institutionalized for so long because of her behaviors, no group home would accept her. It was brought to Ms. Freeman's attention from staff that a couple of DCS were antagonizing Resident A to get a reaction and when Resident A reacts, they call 911 and she is hospitalized. Resident A never reported any abuse by staff. It is usually staff reporting physical aggression by Resident A towards them. Ms. Freeman terminated Ladonna and Devona who were speaking aggressively to Resident A. Ms. Freeman has zero tolerance of any staff exhibiting any sort of abuse towards any resident.

On 08/02/2023, I interviewed Rowena, with Jennifer Carney's office who is Resident A's guardian. Resident A was in a long-term institution and Ms. Freeman opened Sandy Lane for Resident A. Resident A is aggressive and has violent behaviors. She acts like a young child and does not like to share with others. She throws things, breaks things, pulls doors off are some of her violent behaviors. She moved to Sandy Lane on 11/01/2022 and was discharged to The Strides Home on 06/01/2023. Resident A was physically aggressive towards staff at Sandy Lane and was very destructive towards property. Ms. Freeman terminated close to 2000 people because of Resident A. Resident A would spit in their faces and get right in their face and become physical with staff. Rowena stated, "staff have lost themselves. They call Rhonda saying Resident A went ballistic." Ms. Freeman would investigate the allegations and will either move staff to another home or terminate them. Ms. Freeman does not tolerate any staff subjecting any resident to any form of abuse. Resident A has been the most challenging and difficult case for both Rowena and Ms. Freeman, but Ms. Freeman has an advocate for Resident A to ensure her safety, personal needs, and protection are being met at her homes. Rowena stated she is confident that Resident A is safe in Ms. Freeman's homes and that if there are any concerns, Ms. Freeman will investigate and address the concerns immediately.

On 08/21/2023, I interviewed DCS Briahna Mason regarding the allegations. Ms. Mason denied the allegations. She has never sworn at a resident, become physical, or called any resident names including Resident A. Ms. Mason denied any resident including Resident A reporting concerns about other DCS being physically abusive towards them, swearing at them or calling them names. Ms. Mason would report this to Ms. Freeman immediately.

On 08/21/2023, I interviewed DCS Unique Austin regarding the allegations. Ms. Austin denied the allegations stating, "That's ground for termination." She denied observing other DCS become physical towards residents and denied any yelling, swearing, or calling residents names. None of the residents including Resident A reported any

concerns to her regarding other DCS behaviors towards them. Ms. Austin would report these behaviors immediately to Ms. Freeman.

On 08/21/2021, I interviewed DCS Marla Pulliam regarding the allegations. Ms. Pulliam stated, "these allegations are absolutely not true." She denied any physical abuse towards Resident A or any other resident. She too stated that there is zero tolerance by Ms. Freeman for any behavior by staff towards any resident. She has never heard any DCS subject a resident to any abuse, and she would report it immediately. Ms. Mason denied any resident including Resident A reporting to her that a DCS was abusing them in any way.

On 08/21/2023, I interviewed DCS Osheka Ramsey regarding the allegations. Ms. Ramsey denied the allegations. She stated, "I would never physically hurt anyone or call them names or swear at them. These are untrue." Ms. Ramsey would report these concerns to Ms. Freeman if she had observed any DCS abuse a resident or if a resident reported any abuse by any staff member.

On 08/21/2023, I interviewed DCS Paule Tsoungui-Mbessa regarding the allegations. Ms. Tsoungui-Mbessa also denied the allegations. She stated that Resident A attacked her, but that Ms. Tsoungui-Mbessa redirected Resident A verbally but never put her hands on Resident A. She understands Resident A's condition and behavior so she would never subject Resident A to any abuse. She denied yelling, swearing, or calling any resident names including Resident A. Ms. Tsoungui-Mbessa has never observed another DCS subject any resident to any abuse. She would report those behaviors immediately to Ms. Freeman.

APPLICABLE RU	JLE
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: (b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Based on my investigation and information gathered, DCS at Sandy Lane have not used any physical force towards Resident A when she was residing at Sandy Lane or any other resident. DCS denied any physical abuse towards Resident A and denied observing any other DCS physically abusing Resident A. Resident A has been aggressive and violent towards staff as stated by DCS Paule Tsoungui-Mbessa and by Resident A's guardian, Rowena with Jennifer Carney's office.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RU	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: (f) Subject a resident to any of the following: (i) Mental or emotional cruelty. (ii) Verbal abuse. 	
ANALYSIS:	Based on my investigation and information gathered, DCS have not subjected Resident A or any other resident to any mental or emotional cruelty or any verbal abuse. All DCS denied yelling, swearing, or calling residents' names. The staff members that were antagonizing Resident A or speaking aggressively to Resident A when she lived at Sandy Lane were terminated after licensee designee Rhonda Freeman was made aware of these concerns. Residents B and C denied any DCS subjecting them to any abuse.	
CONCLUSION:	VIOLATION NOT ESTABLISHED	

Staff have brought Xanax, Benadryl, and Melatonin from home to give to Resident A to make her go to sleep.

INVESTIGATION:

On 07/11/2023, I interviewed the RP regarding the allegations. RP stated they observed DCS Shanna and Leah bring Benadryl and Melatonin from their own home to Sandy Lane and administer these medications to Resident A. Shanna and Leah would give these medications to Resident A because "they did not want to deal with her behaviors." RP stated that Resident A would have behaviors because of Shanna and Leah antagonizing her and when someone doesn't bother Resident A, Resident A has no behaviors.

On 07/12/2023, interviewed Resident B regarding the allegations. Resident B does not know if Resident A was given Benadryl or Melatonin. Resident B is aware of what her medications are and only takes medication that she is prescribed. She has not been asked by DCS to take medication that she had not been prescribed.

On 07/12/2023, I interviewed Resident C regarding the allegations. Resident C does not know what medication she takes but denied being given Benadryl or Melatonin by any

DCS. She believes DCS are administering her medications that are only prescribed to her. She does not know anything about Resident A and her medications.

On 07/12/2023, I interviewed DCS Summer Harrison regarding the allegations. Ms. Harrison has not completed medication training, so she does not administer medications. A supervisor comes to Sandy Lane when medications need to be given and pass those medications to the residents. Ms. Harrison opened the locked medication cabinet, and I did not observe Benadryl or Melatonin. I reviewed Resident B's, Resident C's, and Resident D's medication blister packs and all blister packs were prescribed to each resident. I was unable to review the medication logs as Ms. Harrison was unable to access them.

On 07/13/2023, I interviewed licensee designee Rhonda Freeman regarding the allegations. Ms. Freeman was never informed that any DCS including Shanna and Leah were administering Benadryl or Melatonin to Resident A. All staff that have completed medication training only administer medications that are prescribed to residents. Ms. Freeman will be looking into these concerns. I advised Ms. Freeman that I was unable to review the medication logs for Resident A, Resident B, Resident C, and Resident D because Ms. Harrison was unable to access them. Ms. Freeman stated all DCS can access all records but that the system was not accepting Ms. Harrison's password, so she was unable to pull the logs. Ms. Freeman will send me the medication logs for Resident A.

Note: An email was sent to Ms. Freeman on 08/21/2023 regarding medication logs but I never received them.

On 08/01/2023, I interviewed Resident C's mother/guardian regarding the allegations. She reported that Resident C has not advised her of any concerns regarding her medications.

On 08/02/2023, I interviewed Rowena, Resident A's guardian with Jennifer Carney regarding the allegations. Rowena has no concerns of any DCS at Ms. Freeman's homes administering medication not prescribed to Resident A. Resident A has a nurse that visits weekly, and the nurse would have reported any concerns to Rowena if Resident A was being drugged. Rowena stated there are a lot of people involved in taking care of Resident A including Ms. Freeman and her staff because of Resident A's history.

On 08/21/2023, I interviewed DCS Briahna Mason regarding the allegations. Ms. Mason does not pass medication because she has not completed her medication administration training. A supervisor comes to the home if medication is needed to be passed to the residents. Ms. Mason has access to the medication cabinet but has never administered any medications to any resident. She has not observed other DCS administering medications such as Benadryl or Melatonin to Resident A or any other resident.

On 08/21/2023, I interviewed DCS Unique Austin, DCS Marla Pulliam, DCS Marla Pulliam, DCS Osheka Ramsey, and DCS Paule Tsoungui-Mbessa regarding the allegations. All of them completed their medication administration training and denied passing any medications to any resident including Resident A without a script from their prescribing doctors. All DCS denied witnessing any other DCS pass medications that were not prescribed to the residents.

APPLICABLE RU	LE
R 400.14312	Resident medications.
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on my investigation and information gathered, Resident A was only administered medications that were prescribed to her by her physician. All DCS denied administering any medications including Benadryl, Melatonin, and Xanax without a prescription for Resident A. I observed the locked medication cabinet at Sandy Lane and did not observe any of these medications.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14316	Resident records.
	 (1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: (d) Health care information, including all of the following: (ii) Medication logs.

ANALYSIS:	During my on-site investigation on 07/12/2023, I requested to review Resident A's, Resident B's, Resident C's, and Resident D's medication logs but DCS Summer Harrison was unable to access them. Therefore, the medication logs were not available in the home for my review nor were they provided by licensee designee Rhonda Freeman when I requested them on 07/13/2023 and on 08/21/2023.
CONCLUSION:	VIOLATION ESTABLISHED

Staff are stealing Resident A's shopping money.

INVESTIGATION:

On 07/11/2023, I interviewed the RP regarding the allegations. The RP stated that whenever DCS Shanna and Leah took Resident A shopping to Meijer, they would grab stuff for themselves and have Resident A pay for it. RP stated both were terminated.

On 07/12/2023, I interviewed Resident B and Resident C regarding the allegations. Both Resident B and Resident C stated that when staff take them shopping, DCS have never put their own personal stuff with theirs and made them pay for it. Resident B and Resident C have not heard of any DCS doing that to any resident.

On 07/12/2023, I interviewed DCS Summer Harrison regarding the allegations. Ms. Harrison reported that Resident A has minimal allowance and usually does not have much money to spend. She has never made Resident A or any other resident purchase any of her personal stuff when she takes her shopping. Ms. Harrison heard that there were two DCS that were terminated about five months ago for using residents' funds but since the two DCS were terminated, there has not been any concerns regarding residents' funds.

On 07/13/2023, I interviewed licensee designee Rhonda Freeman regarding the allegations. Ms. Freeman advised that there were two DCS she terminated about five months ago that were misusing residents' funds at her other group home, Plum Hollow and it was not regarding Resident A. Resident A receives minimal allowance and when DCS take her shopping they bring receipts that Ms. Freeman reviews to ensure that Resident A's funds are spent properly. She has not had any concerns about Resident A's funds.

On 08/01/2023, I attempted to interview Resident A via telephone with ORR Heather Shepherd regarding the allegations but were unsuccessful. Resident A did not want to talk.

On 08/02/2023, I interviewed Resident A's guardian, Rowena with Jennifer Carney's office regarding the allegations. Rowena stated she has absolutely no concerns about Resident A's funds being misused by Ms. Freeman's staff. The staff take Resident A shopping and bring back the receipts to Ms. Freeman; however, Resident A has minimal funds so Rowena calls Ms. Freeman asking if she needs anything for Resident A. Rowena has an open communication with Ms. Freeman and her staff and Rowena does not see any staff take advantage of Resident A.

On 08/21/2023, I interviewed DCS Briahna Mason, DCS Unique Austin, DCS Marla Pulliam, DCS Marla Pulliam, DCS Osheka Ramsey, and DCS Paule Tsoungui-Mbessa regarding the allegations. They all denied the allegations stating that they would never put their personal items with Resident A's so she can pay for it. Resident A has minimal funds, and they would never take advantage of Resident A or any other resident if they would take them shopping. DCS Unique Austin stated she brings all the receipts back with her that Resident A spent, and Ms. Freeman verifies the purchases with the receipts. She stated, "everything is always accounted for."

On 08/23/2023, I conducted the exit conference via email with licensee designee Rhonda Freeman with my findings as I was unable to leave her a voice mail message, because her mailbox was full.

APPLICABLE RULE	
R 400.14315	Handling of resident funds and valuables.
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	Based on my investigation and information gathered, DCS are not taking money from Resident A. All the DCS I interviewed denied misusing Resident A's funds. When DCS take Resident A shopping, they never put their own personal items along with Resident A so she can pay for it. All the receipts go to Ms. Freeman who matches the receipts with the purchases and makes sure everything is accounted for. There were two DCS Shanna and Leah that were terminated by Ms. Freeman when she learned they were misusing residents' funds at Ms. Freeman's other AFC home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During my unannounced on-site investigation on 07/12/2023, I rang the doorbell and waited a bit for someone to answer the door. I knocked on the door and then Ms. Harrison answered the door. She invited me inside and I observed a blanket on a chair in the living room looking out the window to the backyard with a space heater that was turned on. I interviewed Resident B who stated that "it's normal for Summer to sit in the chair all day during her shift wrapped in the blanket." I walked out and observed Ms. Harrison sitting on the chair, wrapped in a blanket on her cell phone in front of the space heater. I advised Ms. Harrison that portable heaters are not permitted in AFC homes. She stated she was cold. I asked Ms. Harrison what she did during her shift. Ms. Harrison stated, "I cook, pass medication, take them to their appointments and the store."

As I was interviewing Ms. Harrison in the kitchen after observing the medication cabinet, Resident B and Resident C came into the kitchen. Both residents told Ms. Harrison, "I'm hungry, what's for lunch?" Ms. Harrison stated, "I don't know. I asked Ms. Harrison, "I thought you stated that you cook for the residents." She stated, "no, the chef does all the cooking. The chef hasn't brought the food yet." I observed the refrigerator and there were containers of food sitting in the refrigerator that seemed to have been lunch for the residents, but Ms. Harrison was unaware that there was food for the residents. Resident B and Resident C grabbed apples and began eating them in their bedroom. I expressed my concerns to Ms. Harrison that as a DCS she must be attending to the residents' needs and not sitting on the chair wrapped in a blanket.

On 07/13/2023, I interviewed licensee designee Rhonda Freeman regarding my observations at the time of my on-site visit. Ms. Freeman stated that she had no idea that Ms. Harrison was not doing her job and she has informed all staff that her AFC homes are not their homes and that they are all guests at these homes. Ms. Freeman will be addressing these concerns with Ms. Harrison and all her staff. Ms. Freeman advised she has a chef that she hired about a year and a half ago that makes lunch and dinners for all her homes and distributes them. The chef makes family style meals that are healthy and nutritious and meets everyone's dietary needs. She stated all DCS have access to the menus and know exactly what is being served at least one week in advance. Ms. Freeman stated that there was food in the refrigerator for Residents B, C, and D and she is not sure why Ms. Harrison was not aware of this and will be addressing this with her. I also advised Ms. Freeman that portable space heaters are not permitted in any AFC homes. She acknowledged.

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 observation during my on-stie investigation on 07/13/2023, DCS Summer Harrison was not meeting the personal needs of Resident B, Resident C, nor Resident D. I observed Ms. Harrison sitting on a chair, facing the window to the backyard, wrapped in a blanket on her cellphone. Resident B and Resident C told Ms. Harrison they were and asked, "What's for lunch?" Ms. Harrison replied, "I don't know. The chef hasn't brought the food yet." I observed the refrigerator and there was food in Tupperware that was made for the residents. Instead of Ms. Harrison looking in the refrigerator and ensuring the residents had something to eat, she responded, "I don't know."
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14510	Heating equipment generally.
	(5) Portable heating units shall not be permitted.
ANALYSIS:	During the unannounced on-site investigation on 07/12/2023, I observed DCS Summer Harrison sitting in front of the space heater wrapped in a blanket because she was cold.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Frodet Danisha

08/28/2023

Frodet Dawisha Licensing Consultant Date

Approved By:

Denie Y. Murn

08/28/2023

Denise Y. Nunn Area Manager Date