GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 30, 2023

Kelsey Kennedy
KnL Services LLC
8716 South River Rd
Cheboygan, MI 49721

RE: License #: AS240414325
Investigation #: 2024A0009001
Kennedys River Bend

Dear Kelsey Kennedy:

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 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 (231) 922-5309.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
701 S. Elmwood, Suite 11
Traverse City, MI 49684
(231) 350-0939

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 #:	AS240414325
Investigation #:	2024A0009001
Complaint Receipt Date:	10/06/2023
Investigation Initiation Date:	10/06/2023
Report Due Date:	11/05/2023
Licensee Name:	KnL Services LLC
Licensee Address:	8716 South River Rd Cheboygan, MI 49721
Licensee Telephone #:	(701) 641-6472
Administrator:	Lynn Kennedy
Licensee Designee:	Kelsey Kennedy
Name of Facility:	Kennedys River Bend
Facility Address:	8889 Reed Rd. Carp Lake, MI 49718
Facility Telephone #:	(701) 641-6472
Original Issuance Date:	12/20/2022
License Status:	REGULAR
Effective Date:	06/20/2023
Expiration Date:	06/19/2025
Capacity:	6
Program Types:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL & AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is mistreated by Resident B and staff do not intervene.	No
Direct care worker Dottie Bailey-Loy did not provide Resident A with his allergy medication or an as-needed medication when he asked for it.	No
Direct care worker Dottie Bailey-Loy yells at residents and "gets into their faces".	Yes
Additional Finding	Yes

III. METHODOLOGY

10/06/2023	Special Investigation Intake 2024A0009001
10/06/2023	APS Referral
10/06/2023	Special Investigation Initiated – Telephone call received from adult protective services worker Lane Stopher
10/09/2023	Contact - Face to face interview with Resident A and Resident A's Family Member
10/09/2023	Contact – Face to face interview with former direct care worker Amy Malice
10/09/2023	Contact – Face to face interview with direct care worker Chris Fox
10/09/2023	Contact – Face to face interview with direct care worker Janus Hughes
10/09/2023	Contact – Face to face interview with Resident C and D's Representative
10/10/2023	Contact – Telephone call received from adult protective services worker Lane Stopher
10/11/2023	Contact – Telephone call received from Community Mental Health (CMH) recipient rights officer Brandy Marvin
10/13/2023	Inspection Completed On-site Interviews with Resident B, Resident C, Resident D, direct care worker Dottie Bailey-Loy and direct care worker Terri Layman

10/17/2023	Contact – Telephone call made to administrator Lynn Kennedy
10/17/2023	Contact – Telephone call made to direct care worker Terri Shoenith
10/17/2023	Contact – Telephone call made to direct care worker Patrick Shoenith
10/25/2023	Contact – Telephone call made to adult protective services worker Lane Stopher
10/30/2023	Exit conference with licensee designee Kelsey Kennedy

ALLEGATION: Resident A is mistreated by Resident B and staff do not intervene.

INVESTIGATION: I received a telephone call from adult protective services worker Lane Stopher on October 6, 2023. He reported that he was investigating abuse of Resident A by Resident B who both reside at Kennedys River Bend adult foster care home. The nature of the allegation was that Resident A was being mistreated by Resident B sexually. He said that he was in the process of setting up an interview with Resident A. Mr. Stopher said that he planned on making a referral to law enforcement and notifying Community Mental Health (CMH) recipient rights of the complaint. Resident A's Family Member has taken Resident A for an extended visit from the foster home and is in communication with him.

Mr. Stopher called later to report that he had been able to set up a meeting with Resident A and Resident A's Family Member at a neutral location to interview him.

I met Mr. Stopher, Detective Fuller Cowell with the Emmet County Sheriff's Department and Brandy Marvin with CMH recipient rights on October 9, 2023 at a neutral location. Resident A was present with Resident A's Family Member. Resident A's Representative was communicating with those gathered from a laptop computer. Resident A's Family Member indicated that it might be difficult for us to understand Resident A without her there to help interpret for him. Resident A has a physical disability which makes it hard to understand much of what he says. A lot of what he told us was interpreted through his sister, who also had difficulty understanding him at times. Resident A was asked about his concerns regarding his roommate, Resident B. Resident A said that he was watching a movie and Resident B swore at him. He said that Resident B "hit his TV". Resident A said something that was difficult to understand. His sister interpreted that Resident B takes his privates out and rubs it on Resident A's belongings. Resident A has a large DVD collection and a DVD player and these were what Resident B had allegedly rubbed his genitals on. Resident A also stated, as interpreted by his sister, that Resident B puts his hands all over him when Resident A is laying on his bed. He said, "He's a

gay guy." When asked where Resident B put his hands, he indicated the top half of his body including his belly. Someone asked whether Resident B had touched him in the crotch area and Resident A agreed but did not offer any further clarification. Resident A said that he was wearing pajamas at the time this happened. He denied that Resident B touched him under the pajamas. Resident A said that one evening, Resident B got on top of him in bed. He said that he didn't lay still and got up and left the room. He said that he went to the office where (direct care worker) Amy was and told her about it. She told him to go to bed. He was asked if Resident B had touched him anywhere on his body that night. Resident A replied that Resident B touched his hair and beard. He said that another time Resident B put his "balls" in his face and sometimes Resident B masturbates. He denied that Resident B touched him with his "balls" or that he involved him in masturbation. One time, Resident B touched Resident A's butt when Resident A was getting dressed. He told him he has a "cute butt". He said that another time, Resident B was watching a "porn movie" and asked him if he wanted to watch. Resident A said that Resident B had pulled down his own underwear once and showed Resident A his butt. He told Resident B to get away from him and he did. He has also put his dirty underwear near his face. When asked what else had happened, Resident A stated, "That's it." He did not seem to have anything else to report. He did say that he had a dream about Resident B "raping" him. He was asked if he told staff about these things. He said that he did tell administrator Lynn Kennedy about it and that she believed him.

We then spoke with former direct care worker Amy Malice who had shown up at the neutral location. She had heard we were going to be there and wanted to tell us what she knew. Ms. Malice wanted to talk to us about what had been happening at the Kennedys River Bend home. She said that she had quit because of what had been going on there. We asked her what she knew about any inappropriate behavior occurring between Resident A and Resident B. She said that she heard Resident B say something about Resident A's privates and that Resident A told him to "shut the fuck up". The two of them often argue back and forth. Resident A yells at Resident B just as much as Resident B yells at Resident A. We asked her about any sexual activity between them. She said that one time when she was working Resident A came out of the bedroom to tell her that Resident B had put his "junk" on Resident A's "computer". We asked her how she responded to that. She said that she asked Resident B about the complaint and he denied it. The two of them were bickering about it so she separated them. She had Resident A stay near her until things settled down. She put it in the communication log so that other staff knew about it. She later told administrator Lynn Kennedy about it. It happened about a month and a half ago. Resident A did not mention that Resident B did anything directly to him. Ms. Malice went on to say that she had asked a fellow direct care worker, Dottie Bailey-Loy, whether Resident A could sleep on the couch that night. Ms. Bailey-Loy told her no, that Resident A needed to have access to his bedroom. We asked her what else had happened between Resident A and Resident B. She said that another time, Resident A told them that Resident B pulled his pants down in front of Resident A and "farted" in his face. Yet another time, Resident A reported that he had woke up and found Resident B near his bed and that he "exposed

himself". She said that she could not remember his exact words. Ms. Malice was asked what staff or administration were doing about these reports. She said that they talk to both Resident A and Resident B to try to get to the bottom of what happened and then separate them until they settle down. Ms. Malice said that Resident A and Resident B are allowed to be back together because they share a bedroom. They often bicker but then get along okay and have no problems. Ms. Malice said that she felt they were safe to be alone together given what she knew. She was told that Resident A had shared that Resident B had done more in his presence than what he had told her. She was asked what she thought about that. She did believe a lot of what he told her but said that she thought Resident A was capable of exaggerating what has happened when he gets attention for it.

We then spoke with current direct care worker Chris Fox who had also shown up at the neutral location. We asked her about her knowledge of any inappropriate activity between Resident A and Resident B. Ms. Fox said that sometimes Resident A comes out of their bedroom complaining of things that Resident B has done. One time, he came out and told them that Resident B had pulled his pants down and "farted" in his face. During these complaints by Resident A, Resident B often comes out to deny it and then Resident A will go back in the room. They keep the two of them separated until things settle down. They will often have them leave the bedroom door open if they are in the room together and they will often check on them. One time, Resident A complained that Resident B placed his genitals on Resident A's tablet. Resident B had then complained about Resident A trying to get into his (Resident B's) computer to look at "lady body parts".

We then spoke with current direct care worker Janus Hughes who had shown up at the neutral location. We asked her about any inappropriate activity between Resident A and Resident B. She said that Resident B had tried to show Resident A and a female resident some pornographic images on his computer. The female resident was not interested in seeing the images but Resident A did want to see them. Ms. Hughes said that she told Resident B to put it away. Another time Resident B wanted to show the residents his pubic area that he had shaved. One of the female residents told him that she did not want to see that. Ms. Hughes said that she was able to redirect Resident B at that time and he stopped trying to show that to anyone. She said that there are some inappropriate things that happen like that but nothing she would consider to be of a criminal nature. She said that the staff try to know what is going on at all times and step in to intervene when needed.

I spoke with adult protective services worker Lane Stopher by telephone on October 10, 2023. He stated that he had spoken with Detective Fuller Cowell and was informed that they would not be pursuing any criminal charges. Mr. Stopher and I set up a time to meet at the Kennedy's River Bend home on October 13th to conduct further interviews.

Adult protective services worker Lane Stopher and I conducted an unannounced site visit at the Kennedy's River Bend adult foster home on October 13, 2023. Direct

care workers Dottie Bailey-Loy and Terri Layman were present at the time of the visit. They allowed us into the home and let us use the staff office to speak with Resident B. He spoke about recently having a “mental breakdown” and after some discussion about that we asked him about the sexual inappropriateness that was reported involving him. He said that those things were not true and that he would never show his “junk” to another man. Resident B went on to say that he knew that Resident A said that he was pulling his pants down and “wiping myself” on his stuff. Resident B said that never happened. He said that Resident A says some inappropriate things to him as well. He said that he was changing his underwear in the bedroom and that Resident A told him that his new underwear makes his “balls look big”. He said that Resident A watches “nudie” movies and asks him if he also wants to watch. Resident B said that he is not into that kind of stuff anymore. He admitted that he used to joke around with Resident A about this kind of stuff but it was nothing serious. He denied that he ever touched him or anything. The only time he would have pulled down his pants is when he was changing his clothing. Resident A tried to get in bed with him one time and asked if he wanted to lay in bed as buddies. He then asked if he wanted to get on top of him. Resident B denied that they did anything. He said that he was not into other guys. We asked Resident B about him exposing himself after he had shaven his pubic area. He said that he never exposed anything but his lower stomach when he was showing the others that he had razor burns from it. He denied that he pulled his pants down any further than that. Resident B said that staff jumped right in and told him to be careful about what he was doing and he listened to them. Resident B said that he masturbates in the bathroom and keeps that stuff private. He did admit that he has told Resident A about the things he wants to do to his girlfriend but that is all.

We also spoke with direct care worker Dottie Bailey-Loy during our site visit on October 13, 2023. Ms. Bailey-Loy said they had been having “issues” with Resident B for some time now. She said that Resident A and Resident B often “antagonize” each other. Resident A just wants to be left alone and Resident B “picks at him”. The staff repeatedly remind him about his boundaries and personal space. She said that Resident A and Resident B bother each other equally and that they both “give and take”. She did know that Resident B had put his private parts on Resident A's DVD player and that Resident B had crawled into bed with Resident A. Resident A told him that he was not into that and it ended there. She said that those incidents have been reported to CMH. She said that she has faxed incident reports to CMH and kept the confirmation that it was successfully faxed. Ms. Bailey-Loy showed us an incident report they had faxed to CMH in May of 2023 that Resident B was “putting his hands” all over Resident A. She said that both Resident A and Resident B complain about the other and that staff always ask what is going on and get to the bottom of it. They talk to them about why certain things they do are not appropriate. She said that they separate the two of them and redirect them. They try to always be aware of what is going on with all the residents in the home. They keep an eye on them. She said that Resident B has had some frustrating behavior recently but she did not believe that he is a danger to any of the others.

Both Resident C and Resident D denied that anything inappropriate had been done to them in the home. Resident D did say that he hears Resident A and Resident B argue with each other quite a bit. He has only heard Resident B complain about Resident A playing his movies in their bedroom in the middle of the night when Resident B is trying to sleep.

I then spoke with direct care worker Terri Layman on October 13, 2023. She said that she had heard about things happening with Resident A and Resident B but did not have any direct knowledge of it happening. She said that she has seen Resident A try to avoid Resident B. They sometimes bicker with one other and staff intervene and try to resolve whatever issue they are having with each other.

I spoke with administrator Lynn Kennedy by telephone on October 17, 2023. She said that she had spoken with Resident A about some of his complaints regarding Resident B. He told her that he had seen Resident B's privates and that Resident B had put his privates on Resident A's DVD player. Resident A also reported that Resident B tried to lay down next to him in his bed but Resident A told him, "No, I'm not a faggot". She said that Resident A denied that Resident B actually got on top of him. Ms. Kennedy said that she passed that information on to Resident A's Representative. She said that she felt that Resident A was very good about telling staff when Resident B does something he doesn't like. Ms. Kennedy said that she has sent incident reports about what Resident A has said to CMH and talked to the case manager and behavioral specialist who work with Resident A and Resident B about these issues. She stated that CMH often tells her that they never got a certain incident report and that is why they now always keep a copy of the facsimile confirmation statement with the actual incident report to prove it was faxed. Ms. Kennedy said that she provides information on the incident report exactly as it is told to her by the resident or staff. Ms. Kennedy said that she had provided CMH and the guardian a 30-day discharge notice for Resident B because of his disruptive behavior in the home.

I spoke with adult protective services worker Lane Stopher by telephone on October 27, 2023. He told me that Resident A's Family Member who had Resident A on an extended visit decided to allow him to move back to Kennedy's River Bend. She felt that it was safe enough for him to move back with a safety plan in place. This safety plan involved Resident A telling staff or her whenever he felt Resident B did anything he did not like. Mr. Stopher said that he was still in the process of investigating these matters.

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:	Resident A and Resident B share a bedroom at the Kennedys River Bend home. Resident A has reported several incidents of inappropriate activity on the part of Resident B. These include Resident B exposing himself, Resident B putting his genitals on Resident A's personal belongings and Resident B trying to or getting into bed with Resident A. Resident A also reported that Resident B had "touched him all over" but was vague about whether he had touched Resident A's genitals. Resident A does not seem to be fearful of Resident B and has always felt comfortable telling staff immediately when events occurred. Staff always responded to the complaints by talking with both residents to try and determine what happened, separating the residents until things settled down and reporting what was reported to have happened. There was no evidence of force or coercion on the part of Resident B towards Resident A and it seems as if the incidents are more juvenile in nature rather than predatory. It was confirmed through this investigation that Resident A and Resident B were treated with dignity and their personal needs, including protection and safety, were attended to at all times.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Direct care worker Dottie Bailey-Loy did not provide Resident A with his allergy medication or an as-needed medication when he asked for it.

INVESTIGATION: When I spoke with adult protective services worker Lane Stopher by phone on October 6, 2023, he also stated that there had been a report of direct care worker Dottie Bailey-Loy not providing as-needed medication to Resident A.

During our interview with Resident A on October 9, 2023, Resident A told us he is given medication by staff. He said that they put the medication "in his hands" and they do this "morning, noon and night". Resident A said that he had foot surgery and they gave him medication that he was supposed to take after that. He said that the staff were also changing the bandage on his foot after he took showers. Resident A spoke about going on a bowling activity where he had a beer unbeknownst to the staff who went along. The next morning, Resident A said that he had a headache. When he told Ms. Bailey-Loy that he needed a Tylenol (an as-needed medication) for his headache, she told him to go lie down. He then told her that his toe, from the surgery, was hurting and she then did give him a Tylenol on an as-needed basis.

Resident A's Family Member said that she did not believe that Resident A was being given his allergy medication as prescribed. Her evidence of this was that she was

given a packet of Zyrtec on October 6, 2023, of which 6 pills were missing. It was filled on August 15, 2023. She believed that more of the pills should have been used if it had been given as prescribed.

During out interview with former direct care worker Amy Malice on October 9, 2023, we asked her about Resident A receiving his medication as prescribed and any as-needed medication being given to him that he required. She said that Resident A had asked her for a Tylenol on one occasion which is prescribed to him as an as-needed medication. She did administer that to him at the time and logged it in his medication administration record (MAR). She said that she was also aware of his allergy medication. She knew that it had started as an as-needed medication and then transitioned to a scheduled medication. That occurred just recently. Ms. Malice denied that she knew of any instance of Resident A not receiving either a scheduled medication or an as-needed medication if he required it.

During our interview with current direct care worker Chris Fox on October 9, 2023, we asked about any medication administration issues at the facility she was aware of. She said that the only thing she has ever wondered about was that sometimes the administrator Lynn Kennedy leaves sticky notes telling them to give a resident a medication at a certain time. Ms. Fox denied that she knew if this was outside of the time that it was supposed to be administered. She said that she could not say whether this was at odds with when it was supposed to be administered. Ms. Fox said that other than that, medications are always given as prescribed or as-needed.

We then spoke with Resident C and Resident D's Representative. She said that she did believe that Resident C and Resident D receive their medication as prescribed.

We spoke with Resident B during our site visit on October 13, 2023. He said that he thought that he was receiving medication as prescribed.

We spoke with direct care worker Ms. Bailey-Loy during our site visit on October 13, 2023. We asked her about the report of Resident A having a beer one night and what had happened after that. She said that Resident A did get a hold of a beer that night. She said that he was bragging about it. The next day he was continuing to brag about it and said that he had a headache. Resident A had also complained of his toe hurting that same morning. She said that she gave him a Tylenol at that time which he is prescribed on an as-needed basis. Ms. Bailey-Loy showed us the medication log which showed that she had given him Tylenol on October 4, 2023 at 8:00 a.m. We asked her about the report of Resident A not getting his allergy medication. She said that it had been an as-needed medication but since he was asking for it each day, they asked his physician if it could be a scheduled medication. It had been given each day since then. She showed us the MAR which showed that he had been given Zyrtec as an as-needed medication 7 days in July of 2023 and 5 days as an as-needed medication in early August of 2023. On August 15, 2023, it had been prescribed as a scheduled medication and had been given

each day since that until Resident A left with his sister on October 6, 2023. That medication was provided to the sister when he left with her.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	It was reported that Resident A was not given an as-needed Tylenol after he drank a beer and had a headache the next morning. The direct care worker involved, Ms. Bailey-Loy, reported that Resident A was bragging about having the beer and the headache the next morning. She said that he also complained about his toe hurting from a recent surgery at the same time. She did give him a Tylenol at that time and showed us the MAR that documented that. Resident A's Family Member was concerned that Resident A had not received his Zyrtec on a daily basis. The staff who were interviewed regarding this issue all reported that Resident A and the other residents received their medication as prescribed. The MAR showed that the Zyrtec had been given to Resident A as an as-needed medication until August of 2023 and then prescribed as a scheduled medication.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Direct care worker Dottie yells at residents and "gets into their faces".

INVESTIGATION: When I spoke with adult protective services worker Lane Stopher by phone on October 6, 2023, he stated that there had been a report that direct care worker Dottie Bailey-Loy yells at residents and "gets in their faces".

During our interview with Resident A on October 9, 2023, Resident A told us about direct care worker Dottie Bailey-Loy yelling at him. Some of this information was interpreted by his sister at that time. Resident A said that Ms. Bailey-Loy often yells at him. He said that she always puts her finger in his face. He said that another staff person Terry also yells at him. When asked why they were yelling, he stated that they thought he was getting too close to one of the female residents. This was apparently out in the yard and they told him to go in the house. He said that everyone there uses the "F word". When asked who, he replied "everyone" the staff and residents. Sometimes staff use the "F word" when yelling at residents.

During out interview with former direct care worker Amy Malice on October 9, 2023, she told us about direct care worker Dottie Bailey-Loy speaking inappropriately to residents. She said that Ms. Bailey-Loy often yells at Resident B. She uses a raised voice, not screaming at the top of her lungs but she does yell sometimes. This often occurs during arguments with Resident B when one of them is trying to speak over the other. She has not known her to threaten the residents, put them down or call them swear words.

During out interview with current direct care worker Chris Fox on October 9, 2023, she told us about direct care worker Dottie Bailey-Loy always arguing with residents and raising her voice with them. She often uses profanity during these times. Ms. Fox said that once when Ms. Bailey-Loy was especially frustrated with Resident B she told, “Your ass is going to be out of here!”

During our interview with current direct care worker Janus Hughes on October 9, 2023, she told us about direct care worker Dottie Bailey-Loy being inappropriate with Resident C. She said that one time recently Ms. Bailey-Loy was helping Resident C down the hallway to his bedroom. As they passed the bathroom, she asked him if he needed to use the bathroom. He either said no or didn’t answer right away. When they got to his room, Resident C then said that he did need to go. Ms. Bailey-Loy whipped him around angrily saying that she just asked him if he needed to go. Ms. Hughes said that she observed Resident C fall over a little bit when this happened. She did not think he was hurt but he could have been. Ms. Hughes did not know of Ms. Bailey-Loy ever hurting the residents. She has observed Ms. Bailey-Loy listening in on conversations between Resident C, Resident D and Resident C and D’s Representative, though. Ms. Bailey-Loy has done this by using a second landline phone while they talked or listened at the door if they were talking by speaker phone. We asked Ms. Hughes why she thought Ms. Bailey-Loy would do this. She replied that she thought it was because she was worried about what Resident C and Resident D might tell their mother. We asked Ms. Hughes if she ever reported any of this to anyone. She said that she reports everything to administrator Lynn Kennedy.

Direct care worker Janus Hughes went on to say that Ms. Bailey-Loy often says inappropriate things to residents. She yelled at a previous resident to “Sit your ass down!” or “Get your ass up!”. She said that this caused the resident to get Ms. Bailey-Loy into a headlock and Ms. Hughes had to intervene. She said that she didn’t know what would have happened if she had not been there at the time. She got between the two of them and told Ms. Bailey-Loy to go sit in the staff room until she settled down. Ms. Hughes also reported that one time she was talking to Ms. Bailey-Loy about why Resident A was having behavior difficulties and that it might have something to do with his father’s death. Ms. Bailey-Loy said, “Oh, his dad was a fucking drunk.” Ms. Hughes said that she believed that Resident A overheard her say this because it was said loud enough for him to hear. Resident A later stated that he knew that Ms. Bailey-Loy thought his dad was a drunk.

We then spoke with Resident C and Resident D's Representative. She said that she knew that there is a lot of yelling and screaming at the house. She reported that Resident C and Resident D have both told her that Ms. Bailey-Loy yells at Resident A and Resident B to "Shut your fucking mouth!".

On October 13, 2023, Mr. Stopher and I asked Resident B about staff speaking inappropriately to residents. He said that they do swear sometimes and are often sarcastic. He said that someone thought that Ms. Bailey-Loy had sworn at him but that it wasn't true. The two of them were just arguing. When the two of them are mad at each other, he and Ms. Bailey-Loy, they yell and swear at each other. He said that one time Ms. Bailey-Loy was "up in (Resident A's) face" and he thought she was "going to do something" to him. She ended up saying, "Sit your ass down. Listen to me!". Resident B said that he thought they should have a counselor in the house to help them all get along.

On October 13, 2023, Mr. Stopher and I asked Ms. Bailey-Loy about the report of her talking inappropriately to residents. She admitted that Resident B has been very frustrating lately. She said that she did raise her voice one time when they were driving because he was distracting her. She only raised her voice because she was afraid they were going to get in an accident. We asked her about the swearing. She replied that if she were to swear while talking with a resident that it was only joking. We asked her about the allegation of her telling a former resident to "Sit your ass down". She admitted that she might have said that once to the former resident when she was frustrated with her. We asked her about the report of her telling a resident, "You're ass is going to be out of here!". She said that she might have told them that their behavior might affect whether they stay or not. She admitted that she might get too close to them and say, "You have to stop". She denied putting her finger in their faces. She admitted that she has a "potty mouth". She said, "It's a habit, I guess. Sometimes, I don't think before I speak." One time, Resident A and Resident B were both bickering on either side of her and she told them, "You need to both shut up and sit down." Ms. Bailey-Loy stated that she has recently gotten better at "choosing her words". We asked her about her saying that Resident A's father had been a "fucking drunk" within his hearing. She denied that she said that. She admitted that she does know their family outside of work. We asked Ms. Bailey-Loy about the report of her jerking Resident C around after he had told her he needed to use the bathroom. She seemed to know about which incident we were referring to. She said that she had only pointed out that she had just asked him if he needed to go and denied jerking him around at that time. She said that he was in his standing chair and that it is unsteady. She said that it is hard to move and that it "makes it jerky". She said that if he did jerk to the side a little bit, it was not intentional.

Resident C knew me from previous visits to the home. He was waiting to talk to me after our interview with Ms. Bailey-Loy. Resident C told me that he is tired of all the yelling and screaming in the home. He said that he won't be able to handle being in the home if Resident B keeps yelling and screaming all the time. Resident C said that some of the staff yell back at him but not all the staff. He said that some of the

staff do yell at him and point a finger at him. Resident C said that it was not all the staff and it was not all the time. He denied that they used “mean” words. They have yelled at and sworn at Resident B. It took some time to get this information from Resident C because of his disability. He continued to be upset during the interview and said that was all he wanted to tell me.

I then spoke with Resident D. He also spoke about the yelling in the house and that a lot of it was coming from Resident B. He said that some of the staff yell as well. I asked him if the staff ever swore at the residents. He asked me what I heard. I told him that I heard that a staff person had told a resident to “Sit your ass down”. He said that Ms. Bailey-Loy had said that to (the previous resident). He has also heard her tell Resident B to “quit your bullshit”. Resident D said that he felt bad because he wishes he could also tell Resident B that. He said that he does blame the staff for saying some of the things they say to Resident B but he admitted that he is also fed up with Resident B. He denied that he ever heard Ms. Bailey-Loy say that Resident A’s father was a “fucking drunk”.

I then spoke with direct care worker Terri Layman on October 13, 2023. She denied that she has heard Ms. Bailey-Loy use inappropriate behavior intervention with the residents. She has heard her raise her voice and tell them, “you guys sit down there now” or tell them they need to go find something to do. She has not heard her use the word “ass” with them. Ms. Layman also denied that she had heard anything about Ms. Bailey-Loy calling Resident A’s father a drunk.

I spoke with administrator Lynn Kennedy by telephone on October 17, 2023. She denied that she has known staff to use language like that with the residents before. She said that one staff used a loud voice with residents and she addressed that with her and talked to her about always being in control with how she spoke to residents.

I spoke with direct care worker Terri Shoenith by telephone on October 17, 2023. She denied that she has heard staff use inappropriate language with residents or that she, herself, has ever used inappropriate language with residents.

I spoke with direct care worker Patrick Shoenith by telephone on October 17, 2023. I asked him about the report of staff using inappropriate language with residents. He said that “maybe some inappropriate things have been said in the heat of the moment”. He agreed that it was inappropriate for staff to yell profanities at residents but denied that it ever happened during his shift.

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. (iii) Derogatory remarks about the resident or members of his or her family. (iv) Threats.
ANALYSIS:	Direct care worker Dottie Bailey-Loy was reported by several sources, including other staff and residents to have used inappropriate language with residents. These comments include, “Shut your fucking mouth”, “Sit your ass down”, “Get your ass up” and “Quit your bullshit”. She also reportedly said that a resident’s deceased father was a “fucking drunk” within that resident’s hearing. She once responded angrily when a resident did not tell her quickly enough that he needed to use the bathroom. These statements and actions used by a caregiver towards a vulnerable adult subjected them to mental or emotional cruelty, verbal abuse and/or were derogatory remarks about the resident or members of their family.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

During out interview with current direct care worker Chris Fox on October 9, 2023, she told us that direct care worker Dottie Bailey-Loy sets up medication for other staff ahead of the time when it is administered. She has seen on several occasions that Ms. Bailey-Loy has placed medication in cups for each resident so that the morning staff can administer it more easily. The cups that contain the loose medication is locked in the medication cart in each of the residents’ drawers.

During out interview with current direct care worker Janus Hughes on October 9, 2023, she also told us that direct care worker Dottie Bailey-Loy sets up medication for other staff ahead of the time when it is administered. She said that Ms. Bailey-Loy will “pop the pills” ahead of time. She knows that Ms. Bailey-Loy will start preparing the medication ahead of time at around 6:30 or 7:00 p.m. for the 8:00 p.m. administration. The pills will sit in the residents’ pill cups until they are administered. Sometimes, Ms. Bailey-Loy will tell another staff to administer the medication even though they were not the ones who prepared the medication. Ms. Hughes says that she refuses to do this because she has worked in licensed facilities and knows this is not the way it is supposed to be done. The pills in the cups are placed in the medication cart until they are given later. Ms. Hughes said that the medication cart is often unlocked. When it is locked, the keys are hanging right above the cart. Ms.

Hughes said that she wanted us to know that the cart being unlocked occurs when staff are in other parts of the home and are not present in the staff office where the cart is located.

During our visit at the Kennedy's River Bend home on October 13, 2023, Mr. Stopher and I were using the staff office to conduct interviews. Ms. Bailey-Loy entered the office during one point saying that she had to get a medication from the medication cart. I asked her to step away from the cart for a moment so I could check something. I noted that the medication cart was unlocked at that time. We later asked Ms. Bailey-Loy about the report of her setting up medication before the time that it was administered. She seemed vague on this subject but admitted, "We will get them set-up if we are busy." She said that they sometimes start getting the medications ready at 7:00 or 7:30 p.m. for when they administer them at 8:00 p.m. She said that the two female residents leave very early in the morning on some days and that she will get their medication ready the night before she goes to bed to save time in the morning.

I then spoke with direct care worker Terri Layman on October 13, 2023. She denied that she had known the medication cart to be left unlocked when unattended. She said that it was locked when she checked it at noon that day. I asked her about medication being set up before-hand by staff for later administration. She said that she had observed that before but insisted she had not done it herself. She said that she has seen residents' medication that has been taken from their pharmacy-supplied containers and left together in cups designated for each resident. She confirmed that she has known this to be done the night before for the two female residents' morning administration because those two residents leave early in the morning at 7:20 a.m.

I spoke with administrator Lynn Kennedy by telephone on October 17, 2023. She denied that she had ever personally found the medication cart unlocked when she has stopped in at the facility but that Ms. Bailey-Loy admitted it had been left unlocked during the time of my visit. She said that Ms. Bailey-Loy also admitted to sometimes setting up medication before-hand but only admitted that she would do it 15 minutes before-hand. She said that she has addressed this specifically with staff in the past and they know this is not acceptable.

APPLICABLE RULE	
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:	It was reported that the medication cart located in the staff office is sometimes left unlocked when staff are in other parts of the home. I did observe it to be unlocked during my site visit on October 13, 2023. It was also reported that medication was taken out of the pharmacy-supplied containers up to an hour before or even the night before being administered. The medication was reported to be taken out of the pharmacy-supplied containers at those times and placed in a cup for each resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with licensee designee Kelsey Kennedy by telephone on 10/30/2023. I told him of the findings of my investigation and gave him the opportunity to ask questions.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

Adam Robarge 10/30/2023

Adam Robarge Date
Licensing Consultant

Approved By:

Jerry Hendrick 10/30/2023

Jerry Hendrick Date
Area Manager