GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 6, 2023

Lisa Murrell
Community Living Centers Inc
33235 Grand River
Farmington, MI 48336

RE: License #: AS630012299
Investigation #: 2023A0602037
CLC Magnolia

Dear Ms. Murrell:

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,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS630012299 |
| | |
| **Investigation #:** | 2023A0602037 |
| | |
| **Complaint Receipt Date:** | 09/08/2023 |
| | |
| **Investigation Initiation Date:** | 09/08/2023 |
| | |
| **Report Due Date:** | 11/07/2023 |
| | |
| **Licensee Name:** | Community Living Centers Inc |
| | |
| **Licensee Address:** | 33235 Grand River<br>Farmington, MI 48336 |
| | |
| **Licensee Telephone #:** | (248) 229-0889 |
| | |
| **Administrator:** | Lisa Murrell |
| | |
| **Licensee Designee:** | Lisa Murrell |
| | |
| **Name of Facility:** | CLC Magnolia |
| | |
| **Facility Address:** | 17250 Cornell<br>Southfield, MI 48075 |
| | |
| **Facility Telephone #:** | (248) 569-8454 |
| | |
| **Original Issuance Date:** | 06/13/1978 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 03/13/2022 |
| | |
| **Expiration Date:** | 03/12/2024 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>AGED |

## II. ALLEGATION(S)

| | Violation Established? |
|---|---|
| **On 8/29/23, during the afternoon shift, staff member Dean Parks yelled at all the residents who reside in the home. The residents were uncomfortable with Mr. Parks returning to the home.** | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 09/08/2023 | Special Investigation Intake<br>2023A0602037 |
| 09/08/2023 | Special Investigation Initiated - Telephone<br>Call made to the office of recipient rights. |
| 09/19/2023 | Contact – Telephone call made<br>Interviewed Resident A, Resident B, Resident C, and Resident D. |
| 10/31/2023 | Inspection Completed on-site.<br>Interviewed the home manager, Niejha McAdoo, and staff members Chris Moody and Shamanique Holt. |
| 11/03/2023 | Exit Conference<br>Held with the licensee designee, Lisa Murrell by telephone. |

**ALLEGATION:**

**On 8/29/23, during the afternoon shift, staff member Dean Parks yelled at all the residents who reside in the home. The residents were uncomfortable with Mr. Parks returning to the home.**

**INVESTIGATION:**

On 9/08/2023, a complaint was received and assigned for investigation alleging that on 8/29/2023 during the afternoon shift, staff member Dean Parks yelled at all the residents who reside in the home. The residents were uncomfortable with Mr. Parks returning to the home.

On 9/19/2023, I interviewed Resident A, Resident B, Resident C, and Resident D by telephone. I was unable to interview Resident E or Resident F as they were not available at the time. Resident A said, “Dean yelled at everybody.” Resident A went on

to state that he could not remember what Mr. Parks said but insisted that he was not in a good mood and was yelling.

Resident B stated Mr. Parks was a good staff member, and he really liked him. He believes Mr. Parks was having a bad day and did not mean to yell at the residents. According to Resident B, Mr. Parks no longer works at the home.

Resident C stated Mr. Parks yelled at all the residents, and he is glad he no longer works in the home because he was afraid. Resident C went on to state that he could not remember what Mr. Parks was yelling about but he remembers being very afraid at the time.

Resident D stated he was in his room the day Mr. Parks yelled at everyone. He was unable to recall what he was yelling about but remembers it made him feel uncomfortable. Resident D said Mr. Parks no longer works in the home.

On 10/31/2023, I conducted an unannounced on-site investigation. Staff member Chris Moody answered the door and stated he needed to contact the home manager Niejha McAdoo before providing any information. Once Mr. Moody spoke with Ms. McAdoo, he advised me that there was a positive COVID case in the home and that Ms. McAdoo was on her way back to the home. I then stepped outside of the home and interviewed Mr. Moody on the front porch. Mr. Moody stated he has worked for the company for about six years. He was not working the day the incident occurred and had no firsthand knowledge of the incident. Mr. Moody did state that Mr. Parks no longer works in the home.

Once Ms. McAdoo arrived at the home, I interviewed her on the front porch as well. Ms. McAdoo stated she was informed by Ms. Holt (exact date unknown) that the residents told her Mr. Parks yelled at them and they were afraid for him to return to the home. Ms. McAdoo said when she spoke with the residents although they could not state what Mr. Parks was yelling about, they were afraid. Mr. Parks was removed from the schedule during the investigation. According to Ms. McAdoo she received a call from Mr. Parks (exact date unknown) informing her that he found another job and would no longer be working at the home.

On 10/31/2023, I also interviewed staff member Shamanique Holt at the front door. Ms. Holt stated when she arrived for her morning shift (exact date unknown) to relieve Mr. Parks from his midnight shift, the residents informed her that Mr. Parks yelled at them, and they were afraid. Resident C informed her that he did not feel safe with Mr. Parks. Resident D told her Mr. Parks tried to make him get in the shower but he refused. Ms. Holt contacted Ms. McAdoo and informed her of the incident. This is all the information Ms. Holt had regarding the incident.

On 11/03/2023, I conducted an exit conference with the licensee designee, Lisa Murrell by telephone. I informed Ms. Murrell of the investigative findings and recommendation documented in this report. Ms. Murrell stated she was aware of the incident and took

immediate action. Mr. Parks was suspended pending the outcome of the investigation. While on suspension, Mr. Parks resigned from his position. However, he contacted the agency two weeks after is resignation requesting his job back but was denied.

| **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 the information obtained during the investigation, there is sufficient information to determine that Mr. Parks did in fact yell at the residents causing them to feel afraid.<br><br>According to Resident A, Resident B, Resident C, and Resident D, they were unable to recall what Mrs. Parks said to them, but they were adamant that he yelled at them, and they were afraid.<br><br>Ms. Holt stated she spoke with the residents the morning after the incident occurred. When Mr. Parks left at the end of his shift the residents informed her that he yelled at them, and they were afraid. |
| **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:<br>(f) Subject a resident to any of the following:<br>(i) Mental or emotional cruelty.<br>(ii) Verbal abuse.<br>(iii) Derogatory remarks about the resident or members of his or her family.<br>(iv) Threats. |

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|---|---|
| **ANALYSIS:** | Based on the information obtained during the investigation, there is sufficient information to determine that Mr. Parks did in fact yell at the residents. According to Resident A, Resident B, Resident C, and Resident D, they were unable to recall what Mrs. Parks said to them, but they were adamant that he yelled at them, and they were afraid.<br><br>Ms. Holt spoke with the residents the morning after the incident occurred. When Mr. Parks left at the end of his shift the residents informed her that he yelled at them, and they were afraid. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

11/03/2023

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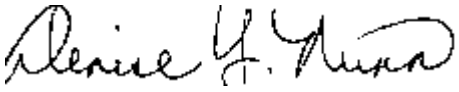
Cindy Berry Date
Licensing Consultant

Approved By:



11/06/2023

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Denise Y. Nunn Date
Area Manager