GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 15, 2024

Lijo Antony
Barns Senior Living,LLC
71 North Ave
Mt.Clemens, MI 48043

RE: License #: AS630415337
Investigation #: 2024A0993006
The Barns Senior Living 2

Dear Mr. Antony:

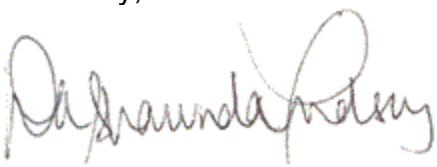
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste. 9-100
Detroit, MI 48202
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630415337
Investigation #:	2024A0993006
Complaint Receipt Date:	01/02/2024
Investigation Initiation Date:	01/02/2024
Report Due Date:	03/02/2024
Licensee Name:	Barns Senior Living, LLC
Licensee Address:	1823 Crooks Rd Rochester Hills, MI 48309
Licensee Telephone #:	(248) 710-3960
Administrator:	Lijo Antony
Licensee Designee:	Lijo Antony
Name of Facility:	The Barns Senior Living 2
Facility Address:	1823 Crooks Rd Rochester Hills, MI 48309
Facility Telephone #:	(248) 710-3960
Original Issuance Date:	06/01/2023
License Status:	REGULAR
Effective Date:	12/01/2023
Expiration Date:	11/30/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There are 10 residents in the facility.	No
• Staff sleeps during shifts and do not check on the residents. • Staff, who are not fully trained are administering medications and left alone with residents. • A lot of the staff are not able to pass the background check and can barely speak English. • Staff are overworked.	No
Additional Findings	Yes

III. METHODOLOGY

01/02/2024	Special Investigation Intake 2024A0993006
01/02/2024	Special Investigation Initiated - Telephone Telephone call made to the complainant. Left a message.
01/05/2024	Contact - Telephone call received Telephone call received from the complainant
01/05/2024	Inspection Completed On-site Conducted an unannounced onsite investigation
01/10/2024	Contact - Document Sent Emailed licensee designee Lijo Anthony to request documents
01/11/2024	APS Referral I forwarded the allegations to adult protective services (APS).
01/17/2024	Contact - Document Sent Sent follow up email to licensee designee Lijo Anthony to request documents
01/17/2024	Contact - Document Received Received documents

01/18/2024	Contact - Telephone call made Telephone call made to staff Sherlian Austin. Left a message.
01/18/2024	Contact - Telephone call made Telephone call made to staff Jennifer Hiller. Left a message.
01/18/2024	Contact - Telephone call made Telephone call made to staff Houa Santos. Left a message.
01/18/2024	Contact - Telephone call made Telephone call made to staff Christah Sweeney. Left a message.
01/19/2024	Contact - Telephone call made Telephone call made to staff Sherlian Austin. Left a message.
01/19/2024	Contact - Telephone call made Telephone call made to staff Jennifer Hiller
01/19/2024	Contact - Telephone call made Telephone call made to staff Houa Santos
01/19/2024	Contact - Telephone call made Telephone call made to staff Christah Sweeney. Left a message.
01/19/2024	Contact - Telephone call received Telephone call received from Christah Sweeney
01/19/2024	Contact - Document Sent Emailed licensee designee Lijo Anthony to request January's staff schedule
01/24/2024	Contact - Document Received Received January's staff schedule
01/31/2024	Contact - Document Sent Telephone call made to staff Sherlian Austin. Left a message.
02/15/2024	Contact - Telephone call made Telephone call made to staff Sherlian Austin. Left a message.
02/15/2024	Contact - Document Sent Emailed licensee designee Lijo Anthony to request a copy of the resident register
02/15/2024	Contact - Document Received Received a copy of the resident register

02/15/2024	Exit Conference Held with licensee designee Lijo Anthony

ALLEGATION:

There are 10 residents in the facility.

INVESTIGATION:

On 01/02/2024, I received the allegations from the Bureau of Child and Adult Licensing (BCAL) Online Complaints.

On 01/05/2024, I conducted a telephone call with the complainant. The complainant stated there are six residents in the facility.

On 01/05/2024, I conducted an unannounced onsite investigation. I interviewed staff Stephanie Santos. Ms. Santos denied there are 10 residents in the facility. She stated there are only five residents living in the facility. One of the residents recently died.

During the onsite investigation, I interviewed Resident A and Resident B. They confirmed there are only five residents living in the facility. They stated one of the residents recently died.

I observed Resident C, Resident D, and Resident E. They were sleeping during the onsite investigation. Ms. Santos reported that Residents C, D, and Resident E have Dementia.

While at the facility, I conducted a telephone interview with licensee designee Lijo Anthony. He denied the allegations. He stated there are not 10 residents in the facility.

On 01/18/2024, I conducted a telephone interview with staff Jennifer Hiller. Ms. Hiller denied there are 10 residents in the facility. She stated there are six residents living in the facility.

On 01/19/2024, I conducted a telephone interview with Houa Santos. Ms. Santos confirmed I interviewed her on 01/05/2024 during the unannounced onsite investigation. She stated her legal name is Houa Santos, but she goes by Stephanie. Ms. Santos will be referred to as Stephanie Santos for the rest of the report.

On 01/19/2024, I conducted a telephone interview with staff Christah Sweeney. Ms. Sweeney denied there are 10 residents in the facility. She stated the facility has a maximum capacity of six residents.

On 02/15/2024, I reviewed the resident register. There are six residents in the facility. Resident F, the sixth resident, was admitted into the facility on 02/06/2024.

APPLICABLE RULE	
R 400.14105	**Licensed capacity.**
	(1) The number of residents cared for in a home and the number of resident beds shall not be more than the capacity that is authorized by the license.
ANALYSIS:	Ms. Santos, Ms. Hiller, and Ms. Sweeney denied there 10 residents in the facility. Ms. Santos, Resident A and Resident B stated there are only five residents in the facility. During an unannounced onsite investigation on 01/05/2024, I observed five residents in the facility. On 02/15/2024, I reviewed the resident register. Per the register, there are six residents in the facility. Resident F, the sixth resident, was admitted in the facility on 02/06/2024.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- Staff sleeps during shifts and do not check on the residents.
- Staff, who are not fully trained are administering medications and left alone with residents.
- A lot of the staff are not able to pass the background checks and can barely speak English.
- Staff are overworked.

INVESTIGATION:

On 01/05/2024, I conducted a telephone interview with the complainant. The complainant stated staff sleep during shifts and do not check on residents. Staff works 24-hours shifts, sometimes for three to four consecutive days. There is a live-in staff. Staff are not fully trained but are administering medications and left alone with residents. Staff are overworked. In the past, there were staff who could not speak English or pass a background check.

On 01/05/2024, I conducted a telephone interview with staff Stephanie Santos. Ms. Santos denied the allegations. She stated she is fully trained. She checks on the residents every two to four hours. She works 24-hour shifts six days per week. She is off on Sundays. She denied that staff are overworked. All staff have been properly trained and completed a background check. All staff speaks English. No staff sleeps during shift.

During the onsite investigation, I interviewed Resident A and Resident B. They stated staff sleeps at night, but staff helps the residents when needed. The residents are not neglected. There are no concerns in the facility.

While at the facility, I conducted a telephone interview with licensee designee Lijo Anthony. He denied all the allegations. He stated the allegations were likely reported by a disgruntle former staff.

On 01/17/2024, I received verification that a background check was completed for Ms. Santos, Ms. Hiller, Ms. Sweeney, and Ms. Austin. They are eligible to work in the facility. I received verification they completed all required trainings (medication administration, reporting requirements, personal care, supervision and protection, resident rights, safety and fire prevention as well as prevention and containment communicable diseases. I also received current CPR and First Aid certification for them. I received a copy of the staff schedule from 12/03/2023 to 01/06/2024. Each staff was only scheduled a 12-hour staff per day.

On 01/19/2024, I conducted a telephone interview with staff Jennifer Hiller. Ms. Hiller denied the allegations. All staff are fully trained. Staff check on the residents every two hours. Staff are scheduled to work 12-hour staff. No staff are scheduled to work 24-hour shifts. She denied knowledge of Ms. Santos ever working a 24-hour shift. Staff are not overworked. All staff have completed a background check. All staff speaks English.

On 01/19/2024, I conducted a follow-up interview with Ms. Santos. She confirmed she works a 24-hour shift on Monday, Wednesday, and Friday. She works a 12-hour shift every other day.

On 01/19/2024, I conducted a telephone interview with staff Christah Sweeney. Ms. Sweeney denied sleeping on shift. She checks on the residents. She stated she has been fully trained and passed her background check. She works a 12-hour shift. She denied being overworked. In the past, there was a staff who barely spoke English. Ms. Sweeney did not know if the staff still worked in the facility. Ms. Sweeney did not know if the allegations were true for other staff.

On 01/24/2024, I received a copy of the staff schedule from 01/01/2024 to 02/03/2024. Each staff was only scheduled a 12-hour staff per day.

On 02/15/2024, I reviewed Bureau Information Tracking System (BITS) and observed that Ms. Santos is a live-in staff.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**

	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	On 01/17/2024, I received verification that a background check was completed for Ms. Santos, Ms. Hiller, Ms. Sweeney, and Ms. Austin. They are eligible to work in the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	On 01/17/2024, I received verification that Ms. Santos, Ms. Hiller, Ms. Sweeney, and Ms. Austin completed all required trainings (reporting requirements, personal care, supervision and protection, resident rights, safety and fire prevention as well as prevention and containment communicable diseases. I also received current CPR and First Aid certification for them.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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:	Ms. Santos, Ms. Hiller and Ms. Sweeney denied that they sleep during their shifts and fail to check on the residents. The residents are checked on at least every two hours. Resident A and Resident B stated staff sleeps at night, but staff helps the residents when needed. The residents are not neglected. There are no concerns in the facility. Ms. Santos is live-in staff.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (a) Be trained in the proper handling and administration of medication.
ANALYSIS:	On 01/17/2024, I received verification that Ms. Santos, Ms. Hiller, Ms. Sweeney, and Ms. Austin completed medication administration training.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 01/05/2024, I conducted a telephone interview with the complainant. The complainant stated staff works 24-hours shifts, sometimes for three to four consecutive days.

On 01/05/2024, I conducted a telephone interview with staff Stephanie Santos. Ms. Santos stated she works 24-hour shifts six days per week. She is off on Sundays.

On 01/17/2024, I received a copy of the staff schedule from 12/03/2023 to 01/06/2024. Each staff was only scheduled a 12-hour staff per day. The job titles of staff or hours worked were not listed. Scheduling changes were also not documented.

On 01/19/2024, I conducted a follow-up interview with Ms. Santos. She confirmed she works a 24-hour shift on Monday, Wednesday, and Friday. She works a 12-hour shift every other day.

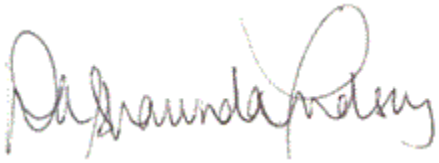
On 01/24/2024, I received a copy of the staff schedule from 01/01/2024 to 02/03/2024. Each staff was only scheduled a 12-hour staff per day.

On 02/15/2024, I conducted an exit conference with licensee designee Lijo Anthony. I informed him of the findings. He stated he will follow up with management to discuss staff working a 24-hour shift. He agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(b) Job titles.** **(c) Hours or shifts worked.** **(e) Any scheduling changes.**
ANALYSIS:	The complainant stated some staff work 24-hour shift. Ms. Santos confirmed she works some 24-hour shifts. Per the schedule, no staff works 24-hour shifts. The job titles of staff or hours worked were not listed on the staff schedule. Scheduling changes were also not documented on the staff schedule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

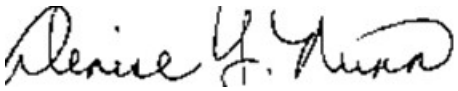
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



02/15/2024

DaShawnda Lindsey Date
Licensing Consultant

Approved By:



02/15/2024

Denise Y. Nunn Date
Area Manager