GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 15, 2024

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

RE: License #: AS630332450
Investigation #: 2024A0605033
Plum Hollow House

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 Dawisha, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd
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 #:	AS630332450
Investigation #:	2024A0605033
Complaint Receipt Date:	06/20/2024
Investigation Initiation Date:	06/24/2024
Report Due Date:	08/19/2024
Licensee Name:	Altum Care Homes, LLC
Licensee Address:	23408 Plum Hollow Southfield, MI 48033
Licensee Telephone #:	(313) 377-3776
Administrator/Licensee Designee:	Ronda Freeman McDonald
Name of Facility:	Plum Hollow House
Facility Address:	23408 Plum Hollow Southfield, MI 48033
Facility Telephone #:	(313) 377-3776
Original Issuance Date:	04/30/2013
License Status:	REGULAR
Effective Date:	01/31/2024
Expiration Date:	01/30/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED/TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 06/04/2024, the home manager (HM) was transporting several residents in the van and she stopped at a restaurant to pick up her lunch leaving the residents in the van unattended. Resident A left the van and went to a smoke shop where she bought marijuana gummies. Resident A consumed all 10 or more gummies and was out of it for three-four days. The HM became aware and did not seek treatment and did not report or document.	Yes

III. METHODOLOGY

06/20/2024	Special Investigation Intake 2024A0605033
06/24/2024	Special Investigation Initiated - Letter Email to Oakland County Office of Recipient Rights (ORR) Alanna Honkanen
06/24/2024	APS Referral Adult Protective Services (APS) referral made
06/24/2024	Contact - Telephone call made Discussed allegations with APS worker Carmen Smith
06/24/2024	Contact - Telephone call made Discussed allegations with Oakland County Office of Recipient Rights (ORR) Natalie Hall
06/25/2024	Inspection Completed On-site Conducted unannounced on-site investigation
07/22/2024	Contact - Telephone call made Discussed allegations with licensee designee Rhonda Freeman
07/23/2024	Contact - Document Received Email from licensee designee Rhonda Freeman
07/29/2024	Contact - Telephone call made Interviewed previous home manager Sheltina McCrainey, current home manager (HM) Felicia Pugh, direct care staff (DCS) Delijah Hall Left message for DCS Carmalita Blunt

07/29/2024	Contact - Document Sent Email to and from APS worker Carmen Smith
08/01/2024	Contact - Telephone call made Interviewed DCS Carmelita Blunt
08/01/2024	Exit Conference Telephone call with licensee designee Rhonda Freeman conducting the exit conference with my findings

ALLEGATION:

On 06/04/2024 the home manager (HM), was transporting several residents in the van and she stopped at a restaurant to pick up her lunch leaving the residents in the van unattended. Resident A left the van and went to a smoke shop where she bought marijuana gummies. Resident A consumed all 10 or more gummies and was out of it for three-four days. The HM became aware and did not seek treatment and did not report or document.

INVESTIGATION:

On 06/21/2024, intake #201340 was referred by Oakland County Office of Recipient Rights (ORR).

On 06/24/2024, I initiated the special investigation by making a referral to Adult Protective Services (APS). Referral was assigned to APS worker Carmen Smith. I discussed the allegations with Ms. Smith. Ms. Smith interviewed Resident A who confirmed that the allegations were true. Resident A used her own money to purchase the marijuana gummies from a smoke shop while the HM Sheltina McCrainey left her and the other residents in the van unsupervised while the HM was inside Bucharest restaurant getting her lunch. Resident A told Ms. Smith that she was “in pain,” so she took “all the gummies.” After taking the gummies, Resident A told Ms. Smith, “I felt out of control. I couldn't walk and had to use my cane.”

On 06/24/2024, I contacted via telephone ORR worker Natalie Hall. Ms. Hall was assigned this investigation. The HM is no longer an employee with this corporation as her employment was terminated by licensee designee Rhonda Freeman McDonald who made the referral to ORR. Staff are supposed to supervise the residents when out in the community including Resident A. Resident A’s individual plan of service (IPOS) allows Resident A to be independent for 30 minutes out in the community; however, Resident A must sign in and out and must indicate when she will return. On 06/04/2024, the HM transported the residents in a van with her to pick up the HM’s lunch from Bucharest. The HM left the residents unsupervised in the van, then Resident A left the van went to the smoke shop located in the same plaza and purchased marijuana gummies, then returned home and consumed all the gummies. The HM was aware that Resident A

purchased the marijuana gummies and aware that Resident A consumed all the gummies at once. The HM never reported this to anyone and never completed an incident report. The HM never sought medical treatment for Resident A after learning Resident A consumed the gummies. On 06/05/2024, DCS Delijah Hall worked that midnight shift and Resident A slept through the night. On 06/06/2024, current HM Felicia Pugh arrived on shift, Resident A was still in bed. Resident A woke up groggy and smelled of urine. Resident A had wet the bed, which is uncommon. Resident A told Ms. Pugh, “I dreamt I was on the toilet, but I wasn’t,” which is why she wet the bed. Ms. Pugh told Ms. Hall, “this was unusual for Resident A.” Ms. Pugh reported to Ms. Freeman McDonald what occurred and wrote an incident report. Ms. Hall will be substantiating her case.

On 06/25/2024, I conducted an unannounced on-site investigation. I interviewed direct care staff (DCS) Crystal Hicks and Residents A, B, C, and D. Resident E was at workshop during this visit.

Resident A was sleeping in her bedroom. DCS Ms. Hicks woke Resident A up, but Resident A stated, “I don’t want to talk;” therefore she was not interviewed.

Resident B was interviewed regarding the allegations. Resident B is her own guardian. On 06/04/2024, the HM Sheltina ordered lunch for herself and her boyfriend from Bucharest. Residents A, B, C, and D went with the HM to Bucharest. Resident E was at program. They arrived at the Bucharest Plaza. The HM left them inside the van alone and went into Bucharest. Resident A left the van to purchase cigarettes from the smoke shop located in the same plaza. Resident A returned with cigarettes, a bag of marijuana gummies and a slushy. Resident A drank the slushy in the van, then 10-15 minutes later, the HM returned to the van with her food, then they returned home. Resident B stated, “I had to help Resident A out of the van because she couldn’t get out.” Resident B told the HM, “Resident A had trouble getting out of the van.” Resident B does not recall what the HM said. Resident B told Resident A, “go lay down,” which Resident A did. The HM never called 911 for an ambulance and then when the midnight staff arrived, (she cannot recall the name) the HM never reported to that staff about Resident A nor did the HM “write it down.” On 06/05/2024, Resident B stated, “Resident A was still out of it. You could see on Resident A’s face that she wasn’t right. She was tired and laughing at everything that wasn’t funny.” On 06/06/2024, Resident B saw that Resident A “was still tired, but not as bad as the days before.” Resident B did not report this to anyone because “I was trying to mind my own business because I’m trying to get into a semi-independent living home.

Resident C was interviewed regarding the allegations. Resident C’s daughter is her guardian. Resident C was in the van on 06/04/2024 when the HM “Sheltina left us alone while she went and got food.” Resident C stated, “the van’s air conditioning was off, and it was hot.” The HM told them they couldn’t leave the van, but “someone did. It was Resident A. Someone gave her a $5 bill. She was acting like a fool.” Resident C was unable to provide anything further regarding the allegations other that the HM was fired, and Resident C was “happy about that.”

Resident D was not interviewed due to her disabilities. She was unable to respond to questions and kept repeating, “What?”

DCS Crystal Hicks was interviewed regarding these allegations. Ms. Hicks has been working for this corporation on and off for about seven years. She works all shifts at all the homes. Ms. Hicks was not present on 06/04/2024 but heard that the previous HM Sheltina McCrainey “left the ladies in the van,” and that “Resident A got out of the van and purchased marijuana gummies.” She also heard that Ms. McCrainey never completed an incident report, nor did she tell any other staff including Ms. McDonald what happened. Ms. Hicks communicates all concerns with each lady via text message. There is a text message thread with all staff including licensee designee Ms. McDonald that keeps everyone abreast of what has happened during their shift. Even if a staff is off, that staff receives the updates via text message. Ms. Hicks never received any communication from Ms. McCrainey regarding this incident. Ms. Hicks does not know if Ms. McCrainey sought medical treatment for Resident A. Per policy, residents are never to be left unsupervised when being transported in the van. Ms. Hicks does not know anything about Resident A missing meals because she had eaten the marijuana gummies.

On 07/22/2024, I interviewed licensee designee Rhonda Freeman McDonald via telephone regarding the allegations. Ms. McDonald was the person who filed the complaint with ORR after learning that the previous HM Sheltina McCrainey did not document the incident. Ms. McCraney’s employment was terminated for failure to report, failure to seek immediate medical treatment for Resident A and for leaving Residents A, B, C, and D alone unsupervised in the van on 06/04/2024. According to the current HM Felicia Pugh, “Resident A was in medical distress.” Ms. McDonald received a frantic call on 06/06/2024 from Ms. Pugh advising Ms. McDonald that Ms. Pugh arrived at her shift and tried waking Resident A up, but Resident A was groggy which was not normal for Resident A. Resident A told Ms. Pugh that she ate marijuana gummies on 06/04/2024 and that “Resident A told Sheltina she ate all the gummies.” Ms. Pugh advised Ms. McDonald there was no incident report written and that Resident A never sought medical treatment. Ms. McDonald stated that Resident A has a strong personality and a history of substance abuse, so Ms. McCrainey put Resident A in a vulnerable setting when she left her and the other residents in the van alone with a tobacco shop in the same plaza as the restaurant. If Ms. McCrainey wanted lunch from Bucharest, she should have placed the order prior and had someone bring her lunch out to the van or took all the residents with her inside, but instead she chose to leave all the residents alone unsupervised. Ms. McDonald believes that Ms. McCrainey was aware that Resident A had purchased marijuana gummies and was aware that Resident A ate the gummies, but never reported it to anyone nor did Ms. McCrainey call 911 or take Resident A to the hospital. Instead, Ms. McCrainey tried to hide what happened which placed Resident A at a greater risk of harm. After this incident, Ms. McDonald held a meeting with all staff regarding policies and procedures and how to appropriately handle this situation moving forward.

On 07/29/2024, I interviewed via telephone previous HM Sheltina McCrainey regarding the allegations. Ms. McCrainey had worked for this corporation for one-year before being terminated. On 06/04/2024, Ms. McCrainey put Residents A, B, C, and D in the van and drove to Bucharest restaurant to pick up her food order. She left the ladies in the van and went inside Bucharest. She was inside for about 10 minutes and then returned to the van and saw that Resident A had a bag in her hand. Resident A told Ms. McCrainey, “I got cigarettes.” Ms. McCrainey did not see a bag of marijuana gummies, nor did she see Resident A with a slushy. They returned home and all the residents went out to smoke cigarettes including Resident A. Ms. McCrainey made dinner around 5:30PM but Resident A did not want to eat and went to bed instead. This is normal for Resident A to go to bed early according to Ms. McCrainey. Nothing happened that night. The morning of 06/05/2024, Ms. McCrainey went to pass medications around 9AM. She went to Resident A’s bedroom and saw that Resident A was still sleeping. She saw a bag on the floor, picked it up and read it. The bag had the word, “Cannabis,” on it. Ms. McCrainey woke Resident A up and asked her about the bag. Resident A told Ms. McCrainey, “I got it from the smoke shop.” Ms. McCrainey stated, “when we got to the plaza, I did not notice the smoke shop.” Ms. McCrainey then put the bag of marijuana gummies in her pocket, administered Resident A’s medications and then Resident A got up went to the bathroom and then returned to bed. Again, Ms. McCrainey stated, “this was normal for Resident A to return to bed to sleep.” Ms. McCrainey denied any concerns with Resident A appearing to be under the influence of marijuana. She denied any issues with Resident A walking to and from the bathroom. Ms. McCrainey stated she felt the bag and there appeared to still be gummies inside, but she never looked inside the bag to confirm. Her intentions were to write an incident report after she dropped the residents to workshop. All the residents including Resident A who was the last to get into the van according to Ms. McCrainey got into the van and Ms. McCrainey dropped Resident E to workshop. She stated that “she misplaced the bag of gummies,” as “they may have fallen out of my pocket,” so “she got scared,” and “never reported it.” Around 3PM, she picked up the residents from workshop, returned home without incident. Resident A was “acting normal,” all day. Resident A smoked her cigarettes like normal and no one including Resident A told Ms. McCrainey that “Resident A ate all the gummies.” Ms. McCrainey left the residents unsupervised because, according to her, “she always leaves them alone when they’re out in the community like shopping or running errands.” She described the residents as “high functioning,” so she believed even though their policy stated that the residents cannot be left unsupervised. Resident A is allowed to be in the community without supervision for 30-minutes, but Resident A must sign in and out, which she did not on 06/04/2024. Ms. McCrainey stated she does not know why she was terminated because she never knew that Resident A ate all the gummies since she had “felt something inside the bag.”

On 07/29/2024, I interviewed current HM Felicia Pugh regarding the allegations. Ms. Pugh has been working for this corporation for three years. She works day shift from 7AM-3PM. On 06/06/2024, she arrived at 7AM, conducted her walk through while DCS Delijah Hall who was working the previous midnight shift from 11PM-7AM. Ms. Hall reported to Ms. Pugh that “Resident A was out of it, sleepy, and appears under the

influence.” Ms. Pugh went into Resident A’s bedroom, woke her up and Resident A “appeared groggy.” Resident A admitted to Ms. Pugh she ate marijuana gummies on 06/04/2024. Ms. Pugh stated that she was present at the home on 06/04/2024 as she went grocery shopping, returned to the home and observed the previous HM Sheltina McCrainey return home with the residents holding a bag from Bucharest restaurant. Ms. Pugh unloaded the groceries, put them away and then left. Ms. Pugh observed Resident A that day and she seemed “normal.” Ms. Pugh did not see the bag of marijuana gummies, nor did she see a slushy. Ms. Pugh believes that Resident A ate the marijuana gummies after Ms. Pugh left. Ms. Pugh stated after she learned that Resident A ate the gummies, she went to the smoke shop to learn how Resident A was sold marijuana gummies and given a free slushy. The smoke shop advised Ms. Pugh that because Resident A was a first-time customer, she was offered a free Kool-Aid slushy. Ms. Pugh stated that Resident A also admitted to eating the marijuana gummies to DCS Delijah Hall. Ms. Hall reported that Resident A was asleep whenever she conducted her wellbeing checks during her shift. Ms. Pugh called licensee designee Rhonda Freeman McDonald advising her what happened and then called Poison Control. Poison Control directed Ms. Pugh to have Resident A drink milk and to watch her, which Ms. Pugh did. Ms. Pugh tried to get Resident A to go to the hospital for medical treatment, but she refused. Ms. Pugh never received any communication in the staff text message thread from previous HM Sheltina McCrainey about Resident A eating marijuana gummies. Ms. Pugh did not see an incident report written by Ms. McCrainey either. Per policy, an incident report should have been written, then Ms. McCrainey should have contacted licensee designee Rhonda Freeman McDonald and then taken Resident A to the hospital. If Resident A refused medical treatment, then 911 should have been contacted. Ms. Pugh stated that the residents cannot be left alone in the van per their policy even if Resident A has a 30-minute community access. Ms. Pugh stated that all staff including Ms. McCrainey was trained when she began employment this corporation’s policy regarding never leaving residents alone and unsupervised. Ms. Pugh stated that Ms. McCrainey’s employment has been terminated.

On 07/29/2024, I interviewed DCS Delijah Hall regarding the allegations via telephone. Ms. Hall has been with this corporation for eight-months. On 06/05/2024, she arrived at work at 11PM and all the residents were sleeping, including Resident A. Ms. Hall continued to conduct wellbeing checks throughout the night and there were no issues. Resident A got up once to use the bathroom and then returned to bed. The morning of 06/06/2024, when Ms. Hall conducted her last wellbeing check, she went into Resident A's bedroom and that is when Resident A told her she ate a bag of marijuana gummies. Resident A told Ms. Hall that when previous HM Sheltina McCrainey took them (residents) with her to get food, Resident A bough gummies from a dispensary and then ate them when they returned home. Ms. Hall reported what was told to her to current HM Felicia Pugh after arriving on shift at 7AM. Ms. McCrainey never told Ms. Hall about Resident A eating the marijuana gummies when she began her shift after relieving Ms. McCrainey. Ms. McCrainey never completed an incident report, nor did she send any communication via text message to all staff regarding this incident.

On 07/29/2024, I received an email from APS worker Carmen Smith stating that she is substantiating her case.

On 08/01/2024, I interviewed DCS Carmalita Blunt via telephone regarding the allegations. Ms. Blunt cannot recall the day she worked her shift from 7PM-11PM but stated that the previous HM Sheltina McCrainey never told her Resident A consumed marijuana gummies. When Ms. Blunt arrived at her shift, some of the residents were in bed and Resident A was sleeping, which Ms. Blunt stated was normal for Resident A. Ms. Blunt went into Resident A's bedroom and said, "hi," and Resident A replied, "Hi," and then went back to sleep. Around 8PM, Ms. Blunt administered medication which Resident A got up and took the medications without any concern. She then returned to bed. About an hour later, Ms. Blunt saw Resident A going to the bathroom. Resident A has a bad right leg, so she walks "a bit wobbly," so she did not notice anything different. Ms. Blunt ended her shift without incident. A week later she learned that Resident A had consumed marijuana gummies and that the residents were left alone in the van. Ms. Blunt had no additional information regarding the allegations.

On 08/01/2024, I conducted the exit conference with licensee designee Rhonda Freeman McDonald with my findings. Ms. McDonald expressed her disappointment with how previous HM Sheltina McCrainey handled the incident regarding Resident A. All staff including Ms. McCrainey were trained on this company's policy and procedures regarding reporting, leaving residents unsupervised, and seeking medical treatment. Ms. McCrainey understood the residents cannot be left alone unsupervised and blatantly did not follow protocol, hence her termination from this company. All staff understand that although Resident A had 30-minute community access, residents are never to be left alone and/or unsupervised especially in the van. Ms. McDonald understands the importance of following policies and procedures regarding reporting and documentation which is why she reported this incident to ORR as her goal is to ensure the safety of Resident A and all the other residents at Plum Hollow. Ms. McDonald conducted an in-service training regarding Resident A's assessment plan and this incident with all staff and will be submitting that in-service training as part of the corrective action plan.

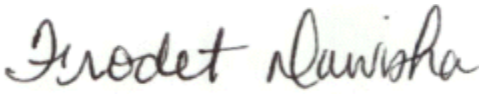
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Sheltina McCrainey did not attend to the personal needs, including protection and safety of Resident A, Resident B, Resident C, and Resident D at all times when she left them in the van unsupervised for over 10 minutes. On 06/04/2024, Ms.

	McCrainey transported Resident A, Resident B, Resident C, and Resident D with her to pick up food from Bucharest restaurant. Ms. McCrainey left the residents unattended in the van for over 10-minutes when she went into Bucharest to pick up her lunch. While she was in the restaurant, Resident A got out of the van, went to a smoke shop in the same plaza and purchased marijuana gummies. After returning home, Resident A consumed all the marijuana gummies, was in medical distress, but Ms. McCrainey did not seek medical attention; therefore, Ms. McCrainey failed to attend to Resident A's personal needs, protection and safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Sheltina McCrainey did not seek immediate medical treatment after she learned that Resident A consumed over 10 marijuana gummies on 06/04/2024. Resident A told Ms. McCrainey she consumed marijuana gummies, but Ms. McCrainey never reported the incident to anyone and never called Poison Control or 911. Ms. McCrainey confirmed that Resident A told her she consumed marijuana gummies, but that she did not seek medical attention. Resident A appeared to be under the influence, was sleeping all day from 06/04/2024-06/06/2024, had to be assisted by Resident B out of the van and was slurring her words. Current HM Felicia Pugh called Poison Control on 06/06/2024 after being informed by DCS Delijah Hall that Resident A consumed over 10 marijuana gummies. Poison Control instructed Ms. Pugh to have Resident A drink milk and monitor her which she did. Ms. Pugh offered to take Resident A to the hospital for medical treatment, but Resident A declined.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

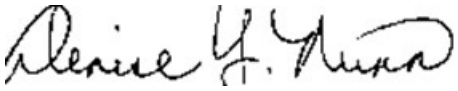
Contingent upon receiving an acceptable correction action plan, I recommend no change to the status of the license.



08/08/2024

Frodet Dawisha — Date
Licensing Consultant

Approved By:



08/15/2024

Denise Y. Nunn — Date
Area Manager