GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 16, 2024

Cori Sharrard
Lourdes Alz Special Care Ctr Inc
2400 Watkins Lake Road
Waterford, MI 48328

RE: License #: AL630007360
Investigation #: 2025A0465002
Clausen Manor

Dear Ms. Sharrard:

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,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-308-6012
Fax: 517-763-0204

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630007360
Investigation #:	2025A0465002
Complaint Receipt Date:	10/13/2024
Investigation Initiation Date:	10/16/2024
Report Due Date:	12/12/2024
Licensee Name:	Lourdes Alz Special Care Ctr Inc
Licensee Address:	2400 Watkins Lake Rd Waterford, MI 48328
Licensee Telephone #:	(248) 886-5830
Administrator:	Cori Sharrard
Licensee Designee:	Cori Sharrard
Name of Facility:	Clausen Manor
Facility Address:	2400 Watkins Lake Road Waterford, MI 48328
Facility Telephone #:	(248) 886-5800
Original Issuance Date:	01/13/1995
License Status:	REGULAR
Effective Date:	02/01/2024
Expiration Date:	01/31/2026
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 10/2/2024, direct care staff, Ijuene Moodey, mistreated Resident A, which caused Resident A to become emotionally distressed and faint.	Yes
Resident B and Resident C are sexually harassing the female residents and direct care staff are not intervening to protect the female residents.	No

III. METHODOLOGY

10/13/2024	Special Investigation Intake 2025A0465002
10/13/2024	APS Referral Adult Protective Services (APS) referral assigned to Tina Edens for investigation
10/16/2024	Special Investigation Initiated - Letter Email exchange with APS Worker, Tina Edens
10/21/2024	Contact - Document Sent Email exchange with APS Worker, Tina Edens
10/21/2024	Inspection Completed On-site I conducted an onsite investigation. I completed a walk-through of the facility, observed residents, reviewed facility files and interviewed licensee designee/administrator, Cori Sharrard
10/28/2024	Contact - Document Received Facility documents received via email
10/28/2024	Contact - Telephone call made I spoke to Ms. Edens via telephone
11/01/2024	Contact - Telephone call made Telephone interview with direct care staff, Ijuene Moodey and Ms. Edens
11/01/2024	Contact - Document Received Intake #203144 received and added onto this investigation

11/08/2024	Contact - Telephone call made I spoke to Guardian A1 via telephone
11/11/2024	Contact - Telephone call made I spoke to Ms. Edens via telephone
11/18/2024	Contact - Telephone call made I spoke to direct care staff, Tatayana Bones via telephone
11/25/2024	Contact - Telephone call made I spoke to direct care staff, Natalie Barkley via telephone
11/25/2024	Contact - Telephone call made I spoke to direct care staff, Vicki Day, via telephone
12/02/2024	Contact - Telephone call made I spoke to Guardian B1 via telephone
12/02/2024	Contact - Telephone call made I spoke to Guardian C1 via telephone
12/02/2024	Contact - Telephone call made I spoke to Guardian D1 via telephone
12/02/2024	Exit Conference I conducted an exit conference with licensee designee/ administrator, Cori Sharrard via telephone

ALLEGATION:

On 10/2/2024, direct care staff, Ijuene Moodey, mistreated Resident A, which caused Resident A to become emotionally distressed and faint.

INVESTIGATION:

On 10/13/2024, a complaint was received, alleging that on 10/2/2024, direct care staff, Ijuene Moodey, mistreated Resident A, which caused Resident A to become emotionally distressed and faint. The complaint stated that Resident A was walking into the library holding two dolls and Ms. Moodey took the dolls from Resident A, restrained her and put her in a chair. The complaint stated that during this incident, Resident A was upset, scared, screaming and eventually passed out. The complaint stated that Resident A was observed with bruising on her face on 10/4/2024, and it is unknown if this incident is the reason for the bruising.

On 10/16/2024, 10/21/2024, 10/28/2024, 11/1/2024 and 11/11/2024, I spoke to the complainant, adult protective services worker, Tina Edens, via both email and telephone. Ms. Edens stated that she has completed an investigation of this complaint and determined that there is sufficient evidence to confirm that this allegation is true. Ms. Edens stated that she will be substantiating for abuse and neglect against Ms. Moodey.

On 10/21/2024, I conducted an onsite investigation. The facility is a secured building that specializes in caring for the Aged/Alzheimer's/Dementia population. At the time of my onsite investigation, there were 18 residents residing at the facility. Due to residents' medical diagnosis and memory deficits, I was unable to interview them as part of this investigation. I observed all residents to be properly dressed and with adequate hygiene. I did not observe any marks or bruises on any resident, including Resident A. I completed a walk-through of the facility, observed residents, reviewed facility files and interviewed licensee designee/administrator, Cori Sharrard.

The *Face Sheet* stated that Resident A has resided at the facility since 2/15/2023 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Dementia, Confusion and Speech Difficulty. The *Assessment Plan for AFC Residents* stated that Resident A requires supervision in the community, altered mental status/confusion, needs assistance with personal care tasks and uses a wheelchair for mobility assistance.

I spoke to licensee designee/administrator, Cori Sharrard, who stated that she has been in her position since May 2024. Ms. Sharrard stated, "I am very familiar with this incident. On 10/4/2024, I came into work and observed that Resident A had bruising on both sides of her cheeks. It was faint but noticeable. Due to Resident A's Dementia, she was unable to tell us what happened. Resident A attends a daycare program two days per week at a nearby senior center and I was unsure if she sustained the bruising while there. I decided to look through our facility's video footage to see if I observed anything of concern that may have happened here. I observed video footage from 10/2/2204 at 6:14pm. The footage showed Resident A in the library with Ms. Moodey. In the video, Ms. Moodey grabbed dolls from Resident A's hands and Resident A resisted. At some point in the video, it looks like Resident A passed out in a chair and Ms. Moodey leaves her in the chair for a minute and then returns and moves her out of the room. In the video, Ms. Moodey does touch Resident A's face, and I am unsure if this is how the bruises were sustained. I was upset by what I saw in the video, and I do believe that Ms. Moodey acted inappropriately and that it was mistreatment. Ms. Moodey used excessive force that was unnecessary and unprofessional. Ms. Moodey was reprimanded, suspended for two days and received refresher training."

I reviewed the facility's video footage dated 10/2/2024, from 6:14pm – 6:16pm. I observed the following:

> *Resident A walked into the library holding two baby dolls in her hands. Ms. Moodey walked into the library a few seconds later and approached Resident A from the right*

side. Ms. Moodey walked up to Resident A and began to take the dolls out of Resident A's hands. Resident A tries to hold onto the dolls and resist Ms. Moodey's request to take the dolls from her. Ms. Moodey continued to pull the dolls out of Resident A's hands and Resident A began to flap her hands up and down towards Ms. Moodey. Resident A tried to hold onto the dolls and take them back from Ms. Moodey. Ms. Moodey resisted back against Resident A and ultimately was able to take both dolls from Resident A. Resident A appeared upset and to be crying and/or screaming, at which point Ms. Moodey took Resident A's hands and pushed her body towards a chair. Ms. Moodey placed Resident A into the chair, at which time it appears that Resident A fainted. Ms. Moodey was observed touching Resident A's shoulder, face and chin area while Resident A was non-responsive. Ms. Moodey then left Resident A in the chair and moved out of the camera view for approximately 25 seconds. When Ms. Moodey returned to check on Resident A, Resident A appeared to be waking up. Ms. Moodey assisted Resident A up from the chair and took her out of the camera view. This incident lasted approximately 2 minutes.

On 11/1/2024, I spoke to direct care staff, Ijuene Moodey, via telephone along with Ms. Eden. Ms. Moodey stated that she has worked at the facility for one year. Ms. Moodey stated, "I was working the day of this incident. It was in the evening, after dinner time. Resident A took baby dolls that didn't belong to her. They belong to another resident. The other resident had not asked for the dolls yet, but I still wanted to get them from her since they weren't hers. I went into the library to get the dolls from Resident A. Resident A refused to give me the dolls, so I took both dolls from her, and she hit me. After I took the dolls from her, I took her to a chair to sit down and she then pretended to pass out or go to sleep. I touched her face and chest to ask if she was okay and she said yes. I felt the dolls needed to go back to the other resident. I did take the dolls from her in a wrong way. But I felt that if I had asked her for the dolls, she would have hit me. I was suspended for two days and had to do some training courses for this incident." Ms. Moodey acknowledged that she did mishandle this situation.

On 11/8/2024, I spoke to Guardian A1 via telephone. Guardian A1 stated, "I moved Resident A out of the facility on 11/1/2024. I do not have any concerns related to the care that was provided to Resident A during the time that she resided at the facility, with the exception of this incident."

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.

ANALYSIS:	On 10/21/2024, during my onsite investigation, I observed all residents to be properly dressed and with adequate hygiene. I did not observe any marks or bruises on any resident, including Resident A. According to Ms. Sharrard, Ms. Moodey's interaction with Resident A on 10/2/2024 was inappropriate and excessive, resulting in Ms. Moodey being suspended for two days and completing refresher training. According to the video footage, dated 10/2/2024, from 6:14pm – 6:16pm, Ms. Moodey intentionally and forcefully grabbed dolls from Resident A's hands, forcefully moved Resident A to a chair, and left her unattended for approximately 25 seconds while she was non-responsive. According to Ms. Moodey, she confirmed the incident in the video as accurate. Ms. Moodey acknowledged that she mishandled this situation. Based on the information above, there is sufficient information to confirm that on 10/2/2024, Ms. Moodey exposed Resident A to physical and emotional harm by intentionally using physical force to remove the dolls from Resident A's hands.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B and Resident C are sexually harassing the female residents and direct care staff are not intervening to protect the female residents.

INVESTIGATION:

On 11/1/2024, a second complaint was received, that Resident B and Resident C are sexually harassing the female residents and direct care staff are not intervening to protect the female residents.

I reviewed Resident B's record. The *Face Sheet* stated that Resident B moved into the facility on 2/21/2022 and has a legal guardian, Guardian B1. The *Health Care Appraisal* listed Resident B's medical diagnosis as Dementia. The *Assessment Plan for AFC Residents* stated that Resident B requires supervision the community, history of sexually inappropriate behavior, has limited verbal communication, not alter to surroundings, can become easily frustrated, needs assistance with personal care tasks and uses a walker and wheelchair for mobility assistance. The *Psychiatric Note*, dated 10/10/2024, documented that Resident B has been seeing a psychiatrist since

10/10/2024 due to a new onset of sexualized behavior not previously observed. I reviewed psychiatry notes for 10/10/2024, 11/6/2024, and 11/20/2024, all of which documented continued efforts to modify prescribed medication to assist in behavior management and mood stabilization. The *Safety Plan* stated the following:

> *This plan is in place to prevent Resident B from inappropriately approaching other residents and touching them without their permission as well as taking unwanted action against other residents when he is angry or having an outburst. The goal is to separate Resident B from, and stop, any physical interaction between Resident B and other residents before any unwanted interaction may occur.*

1. *Intervene and redirect Resident B as necessary from any and all unwanted interaction between himself and any resident.*
2. *Redirect Resident B as necessary using the following techniques:*

a. *Call out his name, separate him from whatever resident and or incident he is involved in. If necessary, separate other residents from the area.*
b. *Staff is to stay with Resident B and encourage him to calm down, ask him to take deep breaths.*

3. *Resident B is not to be left alone in the common area with members of the opposite sex.*
4. *Do not allow Resident B to enter any other resident's apartments.*
5. *If Resident B refuses to cooperate continue to keep him away from other residents until such time that he has been able to calm himself, continue to do a one on one until this occurs.*
6. *DO complete an incident report*
7. *ALL staff need to be aware of Resident B's mood, his location in the facility and respond accordingly at all times.*

I reviewed Resident C's record. The *Face Sheet* stated that Resident C moved into the facility on 1/25/2024, and has a legal guardian, Guardian C1. The Health Care Appraisal listed Resident C's medical diagnosis as Dementia and Cognitive Impairment. The *Assessment Plan for AFC Residents* stated that Resident C requires supervision in the community, limited verbal communication, not alert to surroundings, some inappropriate sexual behavior, requires assistance with personal care and uses a wheelchair for mobility assistance. The *Incident/Accident Report*, dated 10/3/2024, stated the following:

> *10/3/2024 at 3:50pm; Completed by April Smith: Resident C was found in Resident D's bedroom naked with no clothes on this has been a repeat act. I went and got Resident C some clothes for him to put on and took him out of the room and locked the door. We went to great measure to keep everyone's door closed and to ensure this doesn't happen again.*
>
> *10/21/2024; Completed by Vicki Day: We had seen Resident C wandering, and we didn't see him anymore, so we went to look for him. I remember room 16 had the door opened the closed. I went in there and Resident C was naked sitting on the*

couch. We walked him back to his room and got him dressed. Staff reports Resident D was in the bedroom while Resident C was in their room. Staff observed Resident D sleeping in the bed and never woke up while Resident C was in the room or while Resident C was removed from the room.

On 11/18/2024, I spoke to direct care staff, Tatayana Bones via telephone. Ms. Bones stated, “I have worked at the facility for two years. I am familiar with Resident B and Resident C. Resident B uses a wheelchair for mobility and does like to interact and move around the facility. Resident B is a good person. He does try to interact with the female residents and will try to hold their hands or try to kiss them, but we always redirect Resident B. He is easily re-directed, and this also does not happen often. We have a safety plan to redirect and manage these behaviors. As for Resident C, I have not personally seen him act inappropriately. I have heard he has gotten undressed and been found walking around naked by staff but that is nothing something I have seen. He does sometimes undress but I think it is not harmful intentions. He likes to sleep naked, and I do not think he realizes he has no clothes on due to his confusion. He is easily redirected when needed.” Ms. Bones denied that she has allowed Resident B to interact sexually inappropriately towards female residents. Ms. Bones stated that she redirects inappropriate behaviors of all residents to ensure safety and protection for everyone living at the facility.

On 11/25/2024, I spoke to direct care staff, Natalie Barkley via telephone. Ms. Barclay stated that she has worked at the facility for nine years. Ms. Barkley stated, “None of these allegations are true. This is a memory care facility, and the residents have memory difficulties. Sometimes they will do things because they are confused. They are not doing things to intentionally hurt anyone. We all received training to properly understand and care for Alzheimer’s/Dementia residents. I have never seen any female resident be harmed by a male resident. Staff always intervene and are constantly supervising all residents to ensure they are safe. Resident B is wheelchair bound and is unable to physically ambulate in an aggressive manner. He does on occasion ask to hold a female residents’ hands or ask for a kiss on the cheek, but we redirect him, and this also is not something that happens every day. It is maybe once a month at most. It is not a significant issue and again, Resident B is easily redirected without issue. We utilize a safety plan for Resident B and medication management. As for Resident C, again he is confused at times and not alert. He has been observed coming out of his room naked and we immediately redirect him to his room, and we assist him with putting clothing on. I do not believe he is doing anything harmful. I do not believe he realizes he is naked. Guardian C1 is aware of this issue and has purchased onesies for Resident C, to assist with helping to keep clothing on. I have never observed Resident B or Resident C try to harm any of the other residents. And if I do ever observe something inappropriate happening, I will intervene to ensure the residents are safe.” Ms. Barkley denied knowledge of this complaint being true.

On 11/25/2204, I spoke to direct care staff, Vicki Day, via telephone. Ms. Day stated that she has worked at the facility for six months. Ms. Day stated, “Resident B is in a wheelchair and has limited mobility. However, he has tried to touch female resident’s hands or body parts, but he is easily redirected. Last month, I did find Resident B in a female residents’ bedroom, but I was able to redirect him out of the room right away and he did not hurt her or anyone else. Resident C has had issues with taking his clothes off. He has been found in the hallway stripping off his clothes and we take him to his room and help him put clothes back on. Resident B and Resident C have had some sexually inappropriate behaviors, but it was not often, and it is not happening as much anymore. We do provide supervision and protection to all residents here and we redirect residents when needed.” Ms. Day denied knowledge of this complaint being true.

On 12/2/2024, I spoke to Guardian B1 via telephone. Guardian B1 stated, “I do not have any concerns related to staff protection of residents. Resident B is a good person but sometimes does not know what he is doing. He does like to hold female residents’ hands, but he is also easily redirected. If he is told no, he listens and stops the behavior. He has never been hurtful or harmful towards anyone at the facility. Also, he has been seeing a psychiatrist and the medication changes have helped his behavior a lot. His behavior has significantly improved. The staff have been great at communicating, implementing a safety plan, and providing care to Resident B. I have no concerns.”

On 12/2/2024, I spoke to Guardian C1 via telephone. Guardian C1 stated, “Resident C has never put hands on any other resident, and he has not hurt anyone. Resident C has had issues with getting unclothed, but I think that is due to confusion and memory issues. I think he gets unclothed to use the bathroom and the forgets to redress before leaving his room. I did recently purchase some zip-up onesies for Resident C, and this has helped a lot. Also, Resident C has transitioned to hospice and his mobility has significantly decreased. I do not believe Resident C is a harm to anyone and I feel the staff are doing a good job at supervising and providing protection and safety to the residents in the facility.”

On 12/2/2024, I spoke to Guardian D1 via telephone. Guardian D1 stated, “I do not have any concerns related the protection and safety being provided by staff. I have not had any issues with the care being provided to Resident D.”

On 12/2/2204, I conducted an exit conference with licensee designee/administrator, Cori Sharrard, via telephone. Ms. Sharrard stated, “This complaint is absolutely not true. Resident B and Resident C have displayed some inappropriate sexual behavior, but it has not been intentional, nor has it caused physical harm or mistreatment to any of the other residents. The staff are aware of Resident B and Resident C’s behaviors and have been able to easily redirect them. We have also implemented a safety plan and medication management for Resident B, which has helped significantly. We also have been able to easily redirect Resident C without incident. Ms. Sharrard is in agreement with the findings of this report.

APPLICABLE RULE	
R 400.15305	**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:	According to the *Health Care Appraisals* and *Assessment Plans for AFC Residents* for Resident B and Resident C, they both have medical diagnoses of Dementia and a history of confusion and sexualized behavior and require staff supervision and redirection as needed. According to Resident B's *Psychiatric Notes*, dated 10/10/2024, 11/6/2024, and 11/20/2024 and *Safety Plan*, the facility has implemented ongoing efforts for prescription medication to assist in behavior management and mood stabilization. According to Guardian C1, he recently purchased specific Dementia-friendly clothing with zippers to assist in easy maneuvering of taking clothes on and off to prevent incidents of nudity. According to Ms. Bones, Ms. Barckley, Ms. Day, and Ms. Sharrard, Resident B and Resident C are easily redirected when they display inappropriate sexual behavior. Ms. Bones, Ms. Barckley, Ms. Day, and Ms. Sharrard stated that they provide constant supervision and redirection of inappropriate behaviors of all residents to ensure safety and protection of all residents living at the facility. Ms. Bones, Ms. Barckley, Ms. Day, and Ms. Sharrard denied knowledge of a time when they refused to intervene and/or provide safety and protection to a resident. Based on the information above, there is not sufficient information to confirm that direct care staff are refusing to attend to the personal care, safety and protection needs of residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend this special investigation be closed with no change to the status of the license.

12/4/2024

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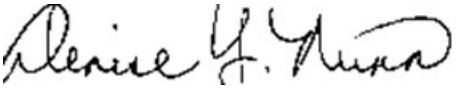
Stephanie Gonzalez Date
Licensing Consultant

Approved By:



12/17/2024

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Denise Y. Nunn Date
Area Manager