GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 30, 2025

Vashu Patel
Hudson's Country Manor, Inc.
9842 Oakland Dr.
Portage, MI 49024

RE: License #: AL390292582
Investigation #: 2025A0578013
Hudson's Country Manor, Inc.

Dear Vashu Patel:

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 (517) 284-9727.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390292582
Investigation #:	2025A0578013
Complaint Receipt Date:	12/09/2024
Investigation Initiation Date:	12/10/2024
Report Due Date:	02/07/2025
Licensee Name:	Hudson's Country Manor, Inc.
Licensee Address:	9842 Oakland Dr. Portage, MI 49024
Licensee Telephone #:	(269) 323-9752
Administrator:	Almetta Whitley
Licensee Designee:	Vashu Patel
Name of Facility:	Hudson's Country Manor, Inc.
Facility Address:	9842 Oakland Dr. Portage, MI 49024
Facility Telephone #:	(269) 323-9752
Original Issuance Date:	08/29/2008
License Status:	REGULAR
Effective Date:	07/26/2023
Expiration Date:	07/25/2025
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff Dani Gritten is rude and yells at residents.	Yes
This facility is understaffed.	Yes

III. METHODOLOGY

12/09/2024	Special Investigation Intake 2025A0578013
12/10/2024	Special Investigation Initiated - On Site
12/10/2024	APS Referral
12/10/2024	Contact-Telephone -Interview with Complainant.
12/10/2024	Special Investigation Completed On-site. -Interview with Resident A, Resident B, and Resident C. Interview with direct care staff Dani Gritten, direct care 1, and direct care 2.
12/10/2024	Contact-Document Reviewed -*Resident Meeting Agenda* dated 11/2024 and 09/2024.
12/10/2024	Contact-Document Reviewed -*Staff Schedules*, December 2024 and November 2024.
01/27/2025	Exit Conference -Completed with licensee designee Vashu Patel.

ALLEGATION:

Direct care staff Dani Gritten is rude and yells at residents.

INVESTIGATION:

On 12/09/2024, I received this complaint through LARA-BCHS-Complaints@michigan.gov. Complainant reported direct care staff Dani Gritten is the home manager for this facility. Complainant alleged Dani Gritten is disrespectful and rude towards residents “all of the time”. Complainant alleged that Dani Gritten yells at residents. No additional details were provided regarding the allegations.

On 12/10/2024, I reviewed the details of the allegations with Complainant. Complainant confirmed the allegations but clarified that direct care staff Dani Gritten was not verbally abusive or used derogatory terms or vulgar language. Complainant clarified that Dani Gritten did not speak to resident in the “proper way.” Complainant reported that on one occasion, Dani Gritten commented that what a resident was talking about was “stupid” within ear shot of residents and staff. Complainant added that on another occasion, Dani Gritten yelled at a resident, “how dare you disturb them” when direct care staff were preparing a meal. Complainant reported this resident was not disturbing or a threat to the direct care staff present. Complainant could not recall the dates of these events. Complainant reported all the direct care staff have observed this type of behavior and it is just something they “deal with.”

On 12/10/2024, I completed an unannounced investigation on-site and interviewed direct care staff 1. Direct care staff 1 did not want to be identified in this investigation due to concerns for retaliation. Direct care staff 1 confirmed that direct care staff Dani Gritten is rude or disrespectful to residents, stating that on one occasion when asked a question by a resident, Dani Gritten responded to a resident, “You know I don’t talk to you.” Direct care staff 1 reported on another occasion, Dani Gritten read out loud the frequency with which residents were incontinent of bowel or bladder at a resident meeting that was held in a common area of the facility. Direct care staff 1 reported residents were present at the time of the meeting and suspected that Dani Gritten was attempting to shame residents in decreasing their frequency of incontinence. Direct care staff 1 reported it was difficult to single out one event related to the allegations, stating that Dani Gritten will talk down to residents or “berate” residents, and when this behavior has been questioned, Dani Gritten has responded with, “I’m petty.” Direct care staff 1 reported that Resident A is often a target of Dani Gritten’s berating behavior, and that Dani Gritten will often “yell over” Resident A’s attempts at questions or will stand over Resident A in close proximity and in an intimidating fashion. Direct care staff 1 reported this type of behavior was previously reported to the administrator and licensee designee for this facility, who came to the facility and talked to residents and staff about this behavior. Direct care staff 1 reported this resulted in retaliation by Dani Gritten against the reporting direct care staff.

On 12/10/2024, I interviewed direct care staff 2 regarding the allegations. Direct care staff 2 did not want to be identified in this investigation due to concerns for retaliation. Direct care staff 2 acknowledged that direct care staff Dani Gritten has yelled at Resident A, and identified the language used by Dani Gritten as either, “don’t come to the office door”, or “go to staff.” Direct care staff 1 reported being unable to identify a specific date or time of when Dani Gritten has yelled at Resident A, stating this is a common occurrence when Dani Gritten is working at this facility, but that Dani Gritten splits her time managing another facility for this licensee.

While at the facility, I interviewed Resident A regarding the allegations. Resident A acknowledged that direct care staff Dani Gritten will sometimes yell at her but denied that Dani Gritten uses any kind of vulgar or derogatory language. Resident A

reported the last time Dani Gritten yelled at her was on 12/09/2024 and previous to this occurrence was 12/06/2024. Resident A reported Dani Gritten yells in response to Resident A asking questions. Resident A reported the response yelled by Dani Gritten is commonly “not right now.” Resident A reported other residents often receive this same response yelled to them as well. Resident A reported this response from Dani Gritten will often make Resident A feel “very agitated.”

While at the facility, I interviewed Resident B and Resident C regarding the allegations. Resident B and Resident C denied ever being yelled at or disrespected by and direct care staff for any reason. Resident B and Resident C denied ever observing any other resident being yelled at or disrespected by any direct care staff. Resident B and Resident C denied having any additional concerns.

On 12/10/2024, I interviewed direct care staff Dani Gritten regarding the allegations. Dani Gritten reported she serves as the regional manager for this facility. Dani Gritten denied the allegations and clarified that she uses a stern, “mom” tone when setting limits with residents and added that she must do this often due to her role in this facility. Dani Gritten denied the language she uses is verbally aggressive or derogatory. Dani Gritten added that some residents are “attention seeking” and she will often have to refer residents to direct care staff when they approach her with questions. Dani Gritten identified Resident A as a resident that requires frequent prompting to address her concerns with direct care staff. Dani Gritten denied ever responding out loud that a resident request or question was “stupid.”

Dani Gritten acknowledged conducting routine resident meetings in this facility in the common areas. Dani Gritten denied ever reviewing incontinence data during a resident meeting with the intention of shaming residents.

Dani Gritten reported she is one of the most consistent staff, and uses “strong, stern” boundaries with all the residents. Dani Gritten reported she instructs residents to make appointments with her to address resident concerns. Dani Gritten reported when a resident makes an appointment, she seeks out that resident at the scheduled time and meets with the resident in private to address the residents’ concerns.

Dani Gritten added that she was previously interviewed by this department regarding her “raised tone” with residents but denied these allegations involved verbal aggression either. Dani Gritten added that she can be blunt but denied her tone is disrespectful. Dani Gritten described her tone as “sassy.”

On 12/10/2024, I reviewed the *Resident Meeting Agenda* dated 11/2024. The *Resident Meeting Agenda* conducted by Dani Gritten included the following comments:

> “Just because we aren’t here that doesn’t mean we don’t find out about every single thing you guys try to sneak and do. We pay very well for staff to run back

and tell us what you guys are doing just like you guys run and tell us everything they do that they aren't supposed to do. Waiting until office hours doesn't work."

"Third shift- If it continues to be an issue of you guys not being willing to stay out of the common areas during third shift, we will start working towards getting approval to just lock the house down for certain hours of the night. You have been warned in every staff meeting and refuse to abide. No more grace."

"Office- You guys have been doing well with staying away from the office door as much as possible and I just want to say that we do appreciate it. Please continue to do so. I will do my best to come out throughout the day and give you guys some of my attention and give you a chance to bug me."

On 12/10/2024, I reviewed the *Resident Meeting Agenda* dated 09/2024. The *Resident Meeting Agenda* conducted by Dani Gritten included the following comments:

"Coffee and Tobacco- If we cannot stop with the coffee and tobacco on the floor, we will find a way to eliminate your ability to keep these things."

According to SIR # 2023A0466046, dated 7/07/2023, the facility was in violation of rule 400.15304 when it was established that on 08/28/2023, Dani Gritten spoke to or about a resident in front of that resident in a way that could have been perceived as belittling and/or embarrassing.

The facility's approved Corrective Action Plan (CAP), dated 11/28/2023, stated that Dani Gritten had received and is currently receiving ongoing coaching from upper management to treat every resident with respect and dignity. The CAP documented that Dani Gritten had received a written warning regarding SIR # 2023A0466046 and would be monitored closely and through periodic interviews with staff and residents. In addition to verbal coaching, the CAP documented that Dani Gritten would complete additional training related to Implicit bias, behavioral intervention\crisis management, cultural gentleness, working with people, role of direct care workers, orientation to direct care, and introduction to special needs of residents by 12/15/2023.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:

	(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy. **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based upon my investigation, which consisted of interviews with Resident A, direct care staff 1, direct care staff 2, and direct care staff Dani Gritten, as well as a review of pertinent documentation relevant to this investigation, Dani Gritten did not treat residents with consideration and respect, with due recognition for personal dignity. In interviews, direct care staff 1, direct care staff 2 and Resident A's statements were consistent with how Dani Gritten would yell in response to resident questions or requests, in a manner that could be perceived as rude or disrespectful. *Resident Meeting Agendas* completed by Dani Gritten for 09/2024 and 11/2024 documented language that could be perceived as belittling and or threatening.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[Reference SIR #2023A0466046 dated 07/07/2023 and CAP dated 11/28/2023].**

ALLEGATION:

This facility is understaffed.

INVESTIGATION:

On 12/09/2024, Complainant alleged that when the facility is "shorthanded," direct care staff are forced to run the facility by themselves. Complainant added this facility has too many residents for one direct care staff to be working by themselves.

On 12/10/2024, I reviewed the allegations with Complainant. Complainant reported there was only one direct care staff working at this facility on 12/08/2024 and could not recall if there were 18 residents present in this facility or if there were 20 residents present in this facility at the time. Complainant confirmed the number of residents at this facility on 12/08/2024 exceeded 15 residents. Complainant reported there was at least one other occurrence where there were more than 15 residents at this facility with only one direct care staff but could not recall the date.

On 12/10/2024, I interviewed direct care staff Dani Gritten regarding the allegations. Dani Gritten reported the allegations were very possible, as they have had one staff

that did not call and did not show up for work on 11/23/2024, 11/24/2024, and 11/25/2024. Dani Gritten confirmed this facility had 16 residents during this time.

On 12/10/2024, I reviewed the *Staff Schedules* at this facility for December 2024 and November 2024. The *Staff Schedules* at this facility documented that two direct care staff were scheduled for second shift with one direct care staff identified as Ebony Hawkins working until 6:30PM on 11/30/2024, 12/01/2024, 12/08/2024, and 12/09/2024. The *Staff Schedules* at this facility documented that two direct care staff were scheduled for second shift with one direct care staff identified as Shanice Duckett working until 6:30PM on 12/07/2024. I noted there were no notes or substitutions regarding any direct care staff that may have been added to these *Staff Schedules* to accommodate the ratio of direct care staff to residents. I reviewed these dates with Dani Gritten. Dani Gritten acknowledged that on these dates, one of the second shift direct care staff left this facility at 6:30PM, leaving one direct care staff to work the remainder of the shift with over 15 residents until third shift direct care staff arrive at 10PM.

On 01/27/2025, I completed an exit conference with licensee designee Vashu Patel. Vashu Patel did not disagree with the findings of this investigation and clarified once she was informed of the scheduled shifts with only one direct care after 6:30PM, she completed immediate training with direct care staff Dani Gritten.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	Based upon my investigation, which consisted of interviews with direct care staff Dani Gritten, as well as a review of pertinent documentation relevant to this investigation, this facility had less than one direct care staff to 15 residents during waking hours on 11/30/2024,12/01/2024, 12/07/2024,12/08/2024, and 12/09/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

01/29/2025

Eli DeLeon Date
Licensing Consultant

Approved By:

01/30/2025

Dawn N. Timm Date
Area Manager