GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 26, 2025

Seth Gyamfi
Marys Residential Care for Seniors Inc
Suite 215
31500 W. 13 Mile Rd.
Farmington Hills, MI 48334

RE: License #: AL500007236
Investigation #: 2025A0990006
Marys Senior Center
AMENDED REPORT
Original Report date: 03/03/2025

Dear Mr. Gyamfi:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

enclosure

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

I. DENTIFYING INFORMATION

License #:	AL500007236
Investigation #:	2025A0990006
Complaint Receipt Date:	12/20/2024
Investigation Initiation Date:	12/20/2024
Report Due Date:	02/18/2025
Licensee Name:	Marys Residential Care for Seniors Inc
Licensee Address:	35225 Silvano Clinton Twp, MI 48035
Licensee Telephone #:	(248) 844-1407
Administrator:	Seth Gyamfi
Licensee Designee:	Seth Gyamfi
Name of Facility:	Marys Senior Center
Facility Address:	35225 Silvano Clinton Twp, MI 48035
Facility Telephone #:	(586) 790-0640
Original Issuance Date:	03/09/1979
License Status:	REGULAR
Effective Date:	09/09/2023
Expiration Date:	09/08/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A cannot get the staff's attention.	No
Resident A is not being showered.	No
Resident A was taken to the hospital on 12/19/2024 for pain and his glucose levels were dangerously high.	No
Resident A is receiving medications in error.	Yes
Resident A is not receiving physical therapy.	No
Additional Findings	Yes

III. METHODOLOGY

12/20/2024	Special Investigation Intake 2025A0990006
12/20/2024	Special Investigation Initiated - Letter I emailed Vikki Bleil, Adult Protective Services Manager. Ms. Belil said there is no active investigation and the last active investigation in Wayne County was in 2023.
12/23/2024	Contact - Face to Face I conducted an unannounced onsite investigation; I interviewed direct care staff Chloe Kelly.
01/24/2025	Contact - Face to Face I conducted an unannounced onsite investigation. I interviewed direct care staff Shalisa Harris and Resident B.
01/27/2025	Contact - Document Received I reviewed Resident A's resident record. I requested the records on 12/23/2024.
01/27/2025	Contact - Telephone call made I called Relative A. I left a detailed voice message.
01/27/2025	Contact - Telephone call made I called Resident A. The phone number was disconnected.

01/27/2025	Contact - Telephone call made I conducted a phone interview with Relative A1.
01/27/2025	Contact - Document Sent I requested additional documents from Seth Gyamfi, licensee designee and home manager Shalanda Bolden. The documents were received via fax on 02/02/2025.
01/27/2025	Contact - Document Sent I emailed Adult Protective Services (APS).
01/27/2025	Contact - Document Received I received an email back from APS. I was informed that Wayne County did have a case open on Resident A who is now placed at Mary’s Senior Center, and they closed their case.
02/04/2025	Contact - Telephone call made I called Resident A. The voicemail box was full. I sent a text message requesting a call back. Resident A respond back on 02/05/2025 "Will do".
02/13/2025	Contact - Document Received I reviewed documents.
02/13/2025	Contact - Telephone call made I conducted a brief phone interview with Ms. Bolden. Ms. Bolden agreed to fax additional documents that were missing.
02/13/2025	Contact - Telephone call made I conducted a phone interview with Sheetal Sabhlok, Resident A's physical therapist.
02/13/2025	Contact - Telephone call made I called direct care staff Shalisa Harris. I left a detailed message.
02/18/2025	Contact - Telephone call made I called Resident A and the voicemail box was full. No return call has been received to date.
02/18/2025	Contact - Document Received I received documents that had been requested twice.
02/18/2025	Contact - Telephone call made I conducted a phone interview with direct care staff Eric Leavy.

02/20/2025	Contact - Document Received I received the correct physician orders for Resident A.
02/21/2025	Contact - Telephone call made I conducted a phone interview with direct care staff Shalisa “Lisa” Harris.
02/24/2025	Exit conference I conducted an exit conference with Seth Gyamfi.

ALLEGATION:

- **Resident A cannot get the staff’s attention.**
- **Resident A is not being showered.**

INVESTIGATION:

On 12/20/204, I received the complaint via email. In addition to the above allegations, it was reported that Resident A's call light in his bedroom did not work, and that staff was turning the call light system off.

On 12/23/2025, I conducted an unannounced onsite investigation; I interviewed direct care staff Chloe Kelly. Ms. Kelly said that Resident A is still hospitalized. According to Ms. Kelly, when Resident A moved into the facility, “he was not in good condition”. Resident A left leg is amputated. Ms. Kelly said that Resident A is uncooperative at times. He refused to get out of bed. Ms. Kelly said that they have a shower schedule for each resident, and he refused to get out of bed; therefore, he was given bed baths on Thursdays as scheduled and as needed. Ms. Kelly said that each resident's room had a call light, and he was the only resident who used it because he stayed in bed. Ms. Kelly said that there are seven residents living in the home. I observed Resident A's bedroom and tested the call light, which worked. Ms. Kelly said one or two residents could probably be interviewed. Still, the others have limited cognitive abilities due to disabilities. Ms. Kelly said the printer was not working then but agreed to fax Resident A's resident record. Ms. Kelly noted that Shalanda Bolden is the manager. I observed six residents eating lunch in the dining room. I observed another staff member working (Eric Leavy); however, he was not interviewed because he was assisting with feeding residents.

On 01/24/2025, I conducted an unannounced onsite investigation. I interviewed Shalisa Harris, the direct care staff member. Ms. Harris has worked at the facility for two years. Ms. Harris said that Resident A never used the call light and would yell for the staff from his bedroom near the facility's common area. Ms. Harris said Resident A had visitors, especially two sons and one son with a girlfriend, raising many questions. Ms. Harris said Resident A liked having his urinal on his bedside table, and the "girlfriend" did not

like it there. Ms. Harris said Resident A was discharged from the facility and did not return after being hospitalized on 12/19/2024.

On 02/18/2025, I called Resident A and the voicemail box was full. There has not been a return call to date.

On 01/24/2024, I interviewed Resident B. Resident B was roommates with Resident A. Resident B said that his call light and Resident A's call light worked adequately. Resident B said that he and Resident A got along well and hoped that Resident A was doing well since he was not returning to the facility. Resident B said that Resident A did not like one or two of the female staff. Resident B did not say why or who, although I asked. Resident B said he likes living in the home and is receiving good care. Resident B denied ever having issue with getting staff attention. Resident B received showers at least twice a week with the assistance of staff.

On 01/27/2025, I reviewed Resident A's resident record. I requested the records on 12/23/2024. I reviewed Resident A's *Assessment Plan*, *Health Care Appraisal*, *Resident Weight Record*, *Resident Care Agreement*, and Medication orders. Resident A does not have a guardian. Resident A was admitted to the facility on 12/23/2023. Resident A is bedbound, with two persons assisting, and uses a Hoyer Lift. Resident A needs assistance with ADLs and toileting (uses a urinal). Resident A is diagnosed with hypertension, high cholesterol, chronic pain, gout, and diabetes. Resident A is prescribed a wheelchair and bedside tray. Resident A's basic fees included ADLs, bathing, feeding, dressing, personal hygiene, meals, medication management, housekeeping, and laundry.

On 01/27/2025, I conducted a phone interview with Relative A1. Relative A1 said Resident A resides at a different facility but did not disclose where. Relative A1 said there were visits with Resident A at least 3-4 times per week. On one visit, it was observed that Resident A's urinal was full and sitting on his bed tray. Resident A was asked to call staff via call light, which he attempted to do. Relative A1 said no one came, so she went to the common area and asked direct care staff member Lisa (Shalisa) Harris to assist. After Ms. Harris emptied the urinal and left the room, she asked Resident A to hit the light again as she stood in the hallways to see if the light flashed, and it did not. Relative A1 then said that Resident A had said, at that time, that they "turn off his call light sometimes." Relative A1 said this is concerning because Resident A is bedridden. Relative A1 also said that on one visit, Ms. Harris brought Resident A's food into the bedroom and placed it on his bed tray as his urinal, which had urine on it. Relative A1 asked Ms. Harris if she could empty it, and to not place urine near food. Relative A1 said that Ms. Harris emptied the urinal with an attitude and sat it back on the bed tray where Resident A's food was seated.

Relative A1 said that Resident A was never showered. Relative A1 said that each time she asked staff, they would tell her that he refused to leave the bed. Relative A1 said that direct care staff Chloe Kelly told her that he has only gotten out of bed four times

since living at the facility for one year. Relative A1 said that Ms. Kelly told her she gives him bed baths.

On 01/27/2025, I received an email back from APS. I was informed that Wayne County had a case open on Resident A, while placed at Mary's Senior Center, and closed their case.

On 02/13/2025, I reviewed documents, including Resident A's shower log. In December 2024, Resident A was given bed baths as follows: 12/2, 12/9, 12/14, and 12/17. Resident A refused bed baths as follows: 12/4, 12/7, 12/11, and 12/16.

On 02/18/2025, I interviewed Eric Leavy, direct care staff. Mr. Leavy said that Resident A's call light worked. Mr. Leavy said that each resident has a call light button next to their beds, and they all work; Mr. Leavy said that he does bedroom checks on residents every ten minutes. Mr. Leavy said most of the residents were up and sitting outside of their rooms, but those who did not leave their rooms, which was Resident A, did room check every ten minutes.

Mr. Leavy said that Resident A received bed baths because he refused to get out of bed. He received a bed bath at least two times a week. Mr. Leavy said that Resident A likes to have his urinal near him. When it's full, he would empty it and remove it from the bed tray at mealtimes.

On 02/21/2025, I conducted a follow-up interview with Shalisa Harris. Ms. Harris said that Resident A liked his urinal to be placed on the left side of his bedside table. She said that she would put his food on the right side of the urinal. Ms. Harris said that Resident A would get upset when his urinal was moved.

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:	Based on the investigation, there is insufficient evidence to support that Resident A cannot get the attention of staff via call light. Resident A was not interviewed, although two attempts were made. Resident A did not return to the facility after being hospitalized on 12/19/2024. During an unannounced onsite, I observed that the call light worked in his bedroom on 12/23/2024. I interviewed Resident B, who said the call light worked in their room.

	There is conflicting information about Resident A's urinal being placed near his food. Ms. Haris claimed that Resident a preferred the urinal near him and would get upset if it was moved.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Based on the investigation, insufficient evidence supports that the staff did not give baths to Resident A. Resident A was assigned a bath or shower for Thursdays. Resident A refused to leave bed in December 2024, and staff gave him bed baths. Resident A refused four-bed baths in December 2024. Interviews with direct care staff Chloe Kelly, Shalisa Harris, and Eric Leavy said Resident A was given bed baths unless he refused.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **Resident A was taken to the hospital on 12/19/2024 for pain, and his glucose levels were dangerously high.**
- **Resident A is receiving medications in error.**
- **Resident A is not receiving physical therapy.**

INVESTIGATION:

On 12/23/2025, I conducted an unannounced onsite investigation and interviewed direct care staff member Chloe Kelly. Ms. Kelly said that Resident A's medications were prescribed by his private physician. She said that, to her knowledge, he received his medications as prescribed. Ms. Kelly said that Resident A does not participate in physical therapy.

On 01/24/2025, I conducted an unannounced onsite investigation and interviewed direct care staff, Shalisa Harris. Ms. Harris said that Resident A's son's girlfriend was in the medical field and constantly questioned why Resident A was not receiving oxycodone

when in pain. Ms. Harris said that the girlfriend expected that this medication should be given around the clock, and it's a PRN.

On 01/24/2024, I interviewed Resident B. Resident B said that he receives all his prescribed medications and that he observed staff giving Resident A medications.

On 01/27/2025, I reviewed Resident A's Resident record. I observed that Resident A is prescribed 14 medications, including glucose testing. Resident A is prescribed the following PRNS: Cal Protect ointment, Melatonin, Lotion, Naloxone, Oxycodone, Polyethylene Glycol, and a Laxative. Per his *health care appraisal*, Resident A is prescribed a diabetic diet.

On 01/27/2025, I conducted a phone interview with Relative A1. Relative A1 said that on 12/19/2024, Resident A called to tell her that the EMS was there to take him to the hospital around 10 AM. Resident A said he had been in pain all morning, having pain in his neck, back, and sore throat. Relative A1 said Resident A told her that direct care staff Eric Leavy told him earlier that morning that he was sending him to the emergency room. Resident A did tell her that he told Mr. Leavy that he did not want to go to the hospital. Resident A was transported to McLaren Hospital. When he arrived at the hospital, his glucose was 380, which is exceptionally high. Relative A1 said Resident A told her his glucose was checked at the facility in the morning, but it did not read that high. Relative A1 said that Resident A was admitted for Diabetic ketoacidosis, which is life-threatening.

Relative A1 said that during a visit with Resident A, he expressed that he was in a lot of pain. This occurred on 12/11/2024 in the evening. Relative A1 noted that she asked Ms. Shalisa Harris to give Resident A his PRN oxycodone. Instead, Ms. Harris returned to the room and checked his glucose level. Relative A1 said that she didn't explain anything to Resident A and was very unprofessional. Relative A1 asked Ms. Harris about the oxycodone, but she walked out of the room without responding. Ms. Harris returned to the room and handed Resident A medication in a white cup but didn't explain what she gave him. After Resident A took the medication, Relative A1 asked Ms. Harris what was given to Resident A, and she responded, "Tylenol." Ms. Harris then told Relative A1 that the oxycodone prescription was out and told Relative A1 to talk to the nurse in the morning. Resident A remained in pain.

Relative A1 said that Resident A was not receiving physical therapy. Resident A needed to gain strength on the left side of his body because his left leg was amputated at the knee. Relative A1 said that when she asked staff about physical therapy, she was told by one of them that the physical therapist quit or there were system issues. Relative A1 did not know the physical therapist's name or company.

On 02/13/2025, I reviewed an incident report. Resident A was hospitalized from 12/19/2024 and did not return to the facility. The Incident Report dated 12/19/2024 by

Eric Leavy, read as follows: Resident A complained of neck pain. Resident A was transported to McLaren Hospital via EMS. The licensee designee, Seth Gyamfi, signed the incident report. I reviewed Chloe Kelly, Shalisa Harris and Eric Leavy employee records and each are fully trained.

On 02/13/2025, I conducted a brief phone interview with Ms. Bolden. Ms. Bolden said that Resident A came to the facility with his private doctor and later moved to their private doctor. He was prescribed oxycodone as a PRN, but Ms. Bolden was unsure if the prescription ended or ran out. I reviewed the medication orders on 11/04/2024 (the most recent), and Resident A was prescribed oxycodone 5mg to take one tablet by mouth as needed for pain.

On 02/13/2025, I interviewed Sheetal Sabhlok, Resident A's physical therapist. Ms. Sabhlok did not have records present but recalled that Resident A was prescribed physical therapy once a week. Resident A was bedbound, and she worked with him doing range-of-motion (ROM) exercises with both arms and his left leg. Ms. Sabhlok said that she had about five to six visits with Resident A before he was hospitalized in December 2024.

On 02/18/2025, I received documents that had been requested twice. I reviewed the medication administration record (MAR). I observed that Resident A's glucose checks were done at 8 AM, 12 PM, and 5 PM from 12/01/2024 to 12/19/2024 (on 12/19/2024; only one was checked at 8 AM). The glucose levels were not documented on the MAR or in the notes. I reviewed menus, and no diabetic diet was observed. I reviewed the medication administration record (MAR) and observed that Resident A was not administered oxycodone in December 2024. A written note on the MAR above the medication read, "Need new script."

On 02/18/2025, I interviewed Eric Leavy, direct care staff. Mr. Leavy said that the morning Resident A went to the hospital on 12/19/2024, he complained that his neck was hurting. Mr. Leavy said Resident A could not move his neck that morning. Mr. Leavy said that he called the manager, Ms. Bolden, to inform her of Resident A's condition, and it was decided that he needed to go to the emergency room. Mr. Leavy prepared for Resident A's transportation. He provided the EMS with his transfer paperwork (Resident A's basic information: medications, allergies, and relative contacts). Mr. Leavy said that Resident A's glucose is checked before each meal. His last meal was breakfast, and Mr. Leavy said his glucose levels were around 165. Mr. Leavy also said he performed his vitals that morning as he does with each Resident in the mornings. Mr. Leavy said that Resident A's vitals were normal.

Mr. Leavy said that he was not sure if Resident A received physical therapy because he primarily worked the midnight shift and only worked the day shift on Thursdays. However, Mr. Leavy said that Resident A was given his medications as prescribed.

On 02/21/2025, I conducted a follow-up interview with Shalisa Harris. Ms. Harris said that Resident A's glucose was checked before each meal. Ms. Harris said that Resident A oxycodone ran out, and he was not given it.

APPLICABLE RULE	
R 400.15310	**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:	Based on the investigation, insufficient evidence supports that the staff did not seek medical care when Resident A complained of pain on 12/19/2024. Mr. Leavy said that he performed vital and glucose checks on Resident A on the morning of 12/19/2024, and all were normal. Mr. Leavy said that he contacted the home manager, Ms. Bolden, and informed her of Resident A's condition. Resident A was transferred to the McLaren Hospital via EMS. According to Relative A1, Resident A's glucose levels were highly elevated, and he was admitted to the hospital.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.** **(b) Special diets.**
ANALYSIS:	There is evidence to support that Resident A was prescribed oxycodone in July 2024 and November 2024 as a PRN. I

	observed on the MAR that oxycodone was not administered, and there was a handwritten note that read, “Need script.” Furthermore, Relative A1 said that she asked direct care staff member Ms. Harris to give Resident A oxycodone for pain on 12/11/2024. When she returned to the room, she gave him medication. When Relative A1 asked her what was offered, she replied, “Tylenol.” I observed on the MAR and Physician orders that Resident A was not prescribed Tylenol. Resident A’s oxycodone was not filled for December 2024. Additionally, Resident A was prescribed a diabetic diet, but no diabetic diet menus were provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Based on the investigation, insufficient evidence supports the claim that Resident A was not receiving physical therapy. According to Sheetal Sabhlok, physical therapist, she visited Resident A weekly for ROM exercises. Ms. Sabhlok had seen Resident A at least five to six times until she was hospitalized in December 2024.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS

INVESTIGATION:

On 01/27/2025, I conducted a phone interview with Relative A1. Relative A1 said that she arrived at the facility around 6 PM. Relative A1 rang the doorbell several times, but

there was no answer. Relative A1 called the facility's phone number, but there was no answer. Relative A1 said that Resident B observed them at the door and attempted to let them in but could not because he did not have enough strength. Relative A1 said that she waited outside for 45 minutes before Ms. Harris came to the door. Relative A1 arrived at the home and did not enter the building until almost 7PM. Relative A1 said that Ms. Harris told her she was using the bathroom and that they have a locked door policy. Relative A1 said that when they got inside, Ms. Harris was working alone and had her son present. Relative A1 video recorded the son playing at the facility. Relative A1 sent the video, and I observed a boy who gave his full name and said he was six years old. In the video, the boy said that his mother was Lisa.

On 02/21/2025, I conducted a follow-up interview with Shalisa Harris. Ms. Harris recalled the incident in which Resident A had visitors. She was working alone on shift and using the bathroom when the door rang. The phone lines were down that day, and a technician came out to fix them the following day.

On 02/24/2025, I conducted an exit conference with Seth Gyamfi and I informed him of the allegations. Mr. Gyamfi said that he was unaware of the medication not being filled. Mr. Gyamfi said that he would investigate this because he believes that there was an insurance issue. Mr. Gyamfi strongly disagreed with the visitation as he believes the reporting person exaggerated the wait time and there is no strong evidence. Mr. Gyamfi said that the facility phone is internet based and there was an issue with the phone line. Mr. Gyamfi was informed of the telephone policy as well.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on the investigation, there is evidence to support that Relative A1 had to wait 45 minutes before entering the building for a visit with Resident A. Ms. Harris admitted to working alone on shift, using the bathroom and being unable to open the door. Ms. Harris’s six-year-old son was also on the shift with her. I observed a video from RelativeA1 showing a boy who gave his full name, said he was six years old and his mother was Lisa.
CONCLUSION:	**VIOLATION ESTABLISHED**

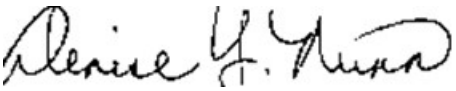
IV. RECOMMENDATION

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

02/24/2025

LaShonda Reed Date
Licensing Consultant

Approved By:



03/03/2025

Denise Y. Nunn Date
Area Manager

Amended Report
SIR#

PURPOSE

The purpose of the amended report is to change the rule violation to no violation established based on additional information received for rule R 400.15204 (2)(a).

METHODOLOGY

03/07/2025	Contact – Document received I received an email from Seth Gyamfi, licensee designee disputing one rule violation. I replied via email.
03/10/2025	Contact – Document sent I emailed Mr. Gyamfi informing of amended report decision. Mr. Gyamfi replied via email.
03/18/2025	Contact – Document received I received an email from Mr. Gyamfi, licensee designee.

DESCRIPTION OF FINDINGS AND CONCLUSION

On 03/07/2025, I received an email from Seth Gyamfi, licensee designee. Mr. Gyamfi sent an email stating that he further investigated rule 400.15204 (2)(a). Mr. Gyamfi said that the former resident family is exaggerating how long they waited outside before the caregiver on the shift let them in. Mr. Gyamfi noted no evidence that the family was outside for 45 minutes. Mr. Gyamfi said the rule "Direct care staff shall possess all of the following qualifications: (a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident" is met. Mr. Gyamfi said that the direct care staff member, Ms. Harris, is one of the most experienced staff members with all the above qualifications. Mr. Gyamfi admitted that Ms. Harris was working alone on shift and using the bathroom and, as such, could not open the door right away. Mr. Gyamfi said that the care and well-being of their residents are the primary responsibilities of direct care staff. As such, staff will not drop that to let a visitor in, especially when it's not an emergency. Mr. Gyamfi further said that the family member was not denied access to the building to interact socially with Resident A. Mr. Gyamfi also said that the rule does not stipulate how long a visitor should not be waiting for a visit. Mr. Gyamfi agreed that the wait may have been an inconvenience, but having to wait a little longer than usual at any place of business is not uncommon.

Mr. Gyamfi said that upon admission, he provided Resident A's main family member, who always calls about Resident A's well-being, his personal cell number, and that of the manager as alternative numbers to get hold to them if they can't reach Resident A. Mr. Gyamfi said that phone and internet outages are beyond their control. Mr. Gyamfi said he strongly disputes this violation and requested it be revised. I responded to Mr. Gyamfi, informing him that I would discuss this concern with the Area Manager and follow up.

On 03/10/2025, I informed Mr. Gyamfi that his concerns were addressed, and we agreed to amend the report. Mr. Gyamfi asked how many minutes a visitor should wait before letting them in so he could ensure to enforce this in the future. Mr. Gyamfi further clarified that internet outages and phone lines going down are beyond their control. Mr. Gyamfi said that he immediately addressed the phone issue. Mr. Gyamfi noted that Ms. Harris had only seven residents to attend to and that the staff-to-resident ratio was not high at the time of this incident.

On 03/18/2025, I received an email from Mr. Gyamfi thanking me for considering amending the report. I previously asked Mr. Gyamfi about their personnel policy regarding staff working on shift with their children. Mr. Gyamfi responded, stating that, in general, children are allowed in the building as most residents enjoy seeing kids. However, he does not expect staff to come to work with their child unless there are exceptional circumstances with management approval.

Based on Mr. Gyamfi's emails regarding R 400.15204 (2)(a), I have determined that Mr. Gyamfi attests to direct care staff Ms. Harris's suitability to meet the needs of residents

in care. Ms. Harris was using the restroom when Resident A's visitors arrived for a visit. The timeframe in which the family waited outside could not be determined, as alleged, to be 45 minutes. Mr. Gyamfi agreed that there was a phone and internet outage beyond the staff's or facility's control. Furthermore, Mr. Gyamfi does not oppose staff bringing their children to work with management's approval.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on the investigation, there is insufficient evidence to support that Relative A1 had to wait 45 minutes before entering the building for a visit with Resident A. Ms. Harris admitted to working alone on shift, using the bathroom and being unable to open the door.
CONCLUSION:	VIOLATION NOT ESTABLISHED

RECOMMENDATION

An acceptable CAP has been submitted on 06/03/2025, it is recommended that the status of the license remains unchanged.

L. Reed 04/08/2025

LaShonda Reed Date
Licensing Consultant

Approved By:

Denise Y. Nunn 06/26/2025

Denise Y. Nunn Date
Area Manager