GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 22, 2025

Sunil Bhattad
Drake Wood Manor Inc
1040 S. State Road
Davison, MI 48423

RE: License #: AL630280923
Investigation #: 2025A0602007
Caremore Assisted Living

Dear Mr. Bhattad:

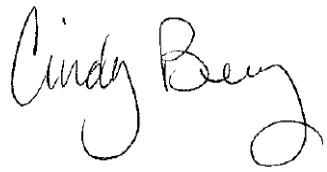
Attached is the Special Investigation Report for the above-mentioned facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Cindy Berry, Licensing Consultant
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630280923
Investigation #:	2025A0602007
Complaint Receipt Date:	01/19/2025
Investigation Initiation Date:	01/21/2025
Report Due Date:	03/20/2025
Licensee Name:	Drake Wood Manor Inc
Licensee Address:	1040 S. State Road Davison, MI 48423
Licensee Telephone #:	(248) 797-8519u
Administrator:	Sunil Bhattad
Licensee Designee:	Sunil Bhattad
Name of Facility:	Caremore Assisted Living
Facility Address:	4353 W. Walton Blvd. Waterford, MI 48329
Facility Telephone #:	(248) 674-2658
Original Issuance Date:	08/21/2006
License Status:	REGULAR
Effective Date:	03/19/2024
Expiration Date:	03/18/2026
Capacity:	18
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED ALZHEIMERS; AGED

II. ALLEGATION(S)

	Violation Established?
Residents sit in soiled undergarments and cannot find staff to assist them and are left in the bathroom with no one to assist them.	No
Resident A has fallen trying to get out of her wheelchair on her own.	No
Residents are served cold food.	No
Additional Findings	Yes

III. METHODOLOGY

01/19/2025	Special Investigation Intake 2025A0602007
01/21/2025	Special Investigation Initiated - Telephone Call made to the facility.
01/24/2025	Inspection Completed on-site I interviewed Resident A, Resident B, Resident C, and the home manager.
02/10/2025	Contact – Telephone call made Spoke with staff member, Felicia Avis.
02/10/2025	Contact – Telephone call made Message left for staff member Angela Horton.
02/14/2025	Contact – Telephone call made Message left for staff member Angela Horton.
03/25/2025	Contact – Telephone call made Call made to staff member Angela Horton, no answer and unable to leave a message.
03/27/2025	Contact - Telephone call made Spoke with the home manager, Amanda D'Amore. Ms. Horton is currently on vacation.

04/11/2025	Contact – Telephone call made Message left for the licensee designee, Sunil Bhattad.
05/07/2025	Exit Conference Held with the licensee designee, Sunil Bhattad by telephone.

ALLEGATION:

- **Residents sit in soiled undergarments and cannot find staff to assist them and are left in the bathroom with no one to assist them.**
- **Resident A has fallen trying to get out of her wheelchair on her own.**
- **Residents are served cold food.**

INVESTIGATION:

On 1/19/2025, a complaint was received and assigned for investigation alleging that residents sit in soiled undergarments and cannot find staff to assist them, residents are left in the bathroom with no one to assist them, Resident A has fallen trying to get out of her wheelchair on her own and residents are served cold food.

On 1/24/2025, I conducted an unannounced on-site investigation at which time I interviewed the home manager, Amanda D'Amore, Resident A, Resident B, and Resident C. Ms. D'Amore stated she has been the home manager for 5 years but has worked for the company for 16 years. She said residents are not left to sit in soiled undergarments. Staff check residents briefs every two hours and at the end of their shifts. If a resident has a soiled diaper at the end of their shift (even if it is less than two hours from the last check) they are required to change the resident before they can leave their shift. She stated residents are not left in the bathroom without assistance. Resident A suffers from dementia and is very confused. She started declining mentally about 6 months ago but believes she can still walk and stand on her own. She wheeled herself into the bathroom without staff assistance, attempted to stand on her own and fell. Ms. D'Amore went on to state that the residents are not served cold food. There was an incident (exact date unknown) when Resident A's daughter was visiting with her in her bedroom during dinner. Staff put Resident A's meal on the dining room table and informed her daughter it was there. When Resident A and her daughter came to the dining room table, it was reported that the food was cold. Ms. D'Amore was not working the day this incident occurred.

On 1/24/2025, I interviewed Resident A in private in her bedroom. Resident A stated she has resided in the home about a year now. She said she can stand but is very unsteady on her feet and uses a wheelchair to ambulate. She requires assistance from staff to transfer to and from her wheelchair. Resident A said there was a time when she was in the bathroom on the toilet and staff told her to push the button when she was ready. However, she did not recall being left in a soiled diaper. She went on to state that

she did not remember falling while attempting to get out of her wheelchair. Resident A had no complaints about the food.

On 1/24/2025, I interviewed Resident B in private in her bedroom. Resident B stated she could not remember how long she has resided at the facility, but she had no complaints to report. She said she cannot stand very well and requires staff assistance to transfer to and from her wheelchair. Resident B said she could not recall being left in a soiled diaper for long periods of time nor could she remember a time when the food was served cold. She said, “The food is fine.”

On 1/24/2025, I interviewed Resident C in private in her bedroom. Resident C stated she has resided in the home for about 2.5 years. She has her gripes but overall likes living in the home. Resident C denied being left in a soiled diaper for extended periods of time or being served cold food. She went on to state that she cannot walk but uses a wheelchair to ambulate.

On 1/24/2025, I reviewed copies of the resident menus, observed food in the pantry as well as in the refrigerator and freezer. According to the menus, meals are rotated monthly with an array of hot and cold meals. I observed fresh vegetables, milk, eggs, juice, and bread in the refrigerator as well as meat and some frozen meals in the freezer. I also observed adequate canned goods and other non-perishable foods in the pantry.

On 2/10/2025, I interviewed staff member Felicia Avis by telephone. Ms. Avis stated the residents are not left in soiled briefs for extended periods of time. Residents are checked after each meal and every two hours. If they are soiled, they will be changed immediately. She went on to state that Resident A’s daughter was visiting (exact date unknown) around 5 pm during dinner. They were in Resident A’s bedroom. Ms. Avis said she informed Resident A’s daughter that dinner was ready while staff member Angela Horton was preparing to serve the meal. Ms. Avis had to leave her shift early (around 5 pm) due to a family emergency so she was unable to say if Ms. Horton plated Resident A’s food before she came out of her room or not. Ms. Avis stated that Resident A’s food was not on the table when she left home at 5 pm. This is all the information Ms. Avis had regarding the allegations.

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 information obtained during the investigation, there is insufficient information to determine that residents' needs were not met. Ms. D'Amore stated Resident A believes she can still walk and stand on her own. She wheeled herself into the bathroom (exact date unknown) without staff assistance, attempted to stand on her own and fell. According to Resident A, Resident B, Resident C, they have never been left in soiled diapers for extended periods of time. Ms. D'Amore and Ms. Avis stated residents are checked every 2 hours and changed if needed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on the information obtained during the investigation, there is insufficient information to determine that residents are served cold food. According to Resident A, Resident B, and Resident C, they had no complaints about the food and denied that cold food had ever been served to them.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

On 2/20/2025, I received and reviewed a copy of the resident registry and staff schedules dated 1/26/2025 through 3/01/2025. The resident registry documents 8 residents currently residing in the facility. Ms. D'Amore stated 1 of the 8 residents was currently hospitalized. She went on to state that Resident A can stand but is very weak and unsteady of her feet and utilizes a wheelchair, Resident B can stand with assistance and utilizes a wheelchair, Resident C and Resident D both utilize wheelchairs, Resident E can stand for transfers and utilizes a wheelchair, Resident F

can walk with staff assistance but utilizes a wheelchair, Resident G utilizes a wheelchair and Resident H is ambulatory. According to the schedules reviewed, there is only one staff member working the midnight shift with 7 residents who utilize a wheelchair and/or depend on staff for assistance to transfer in and out of their wheelchair. Most Sundays the schedule reflects 1 staff member working between the hours of 7 am-3 pm, 7 am-8 pm, and 3 pm-7 am leaving 1 staff working alone from 8 pm-7 am. Most Mondays the schedule reflects 1 staff member working between the hours of 7 am-3 pm, 11 am-8 pm and 3 pm-7 am leaving 1 staff member working alone from 8 pm-7 am. Tuesday through Saturday there is 1 staff member working between the hours of 11 pm-7 am.

On 1/24/2025, I received and reviewed Resident A's health care appraisal and assessment plan. According to the health care appraisal (dated 10/7/2024) Resident A has a diagnosis of hypertension, Parkinson's, dementia, irritable bowel syndrome, hypothyroidism, GERD and osteoporosis. She has the following physical limitations, poor mobility, falling, dementia and forgetfulness. It is also documented that she is a fall risk and does not follow or remember directions. The assessment plan documents that Resident A is weak with transfers and needs contact assistance. She utilizes a wheelchair, walker and hospital bed. I observed that Resident A's assessment plan was not signed or dated.

On 5/07/2025, I conducted an exit conference with the licensee designee, Sunil Bhattad by telephone. I informed Mr. Bhattad of the investigative findings and recommendation documented in this report. Mr. Bhattad stated there is a staff member who resides a few minutes away from the facility who is on call in case of an emergency. I explained to Mr. Bhattad that an on-call employee cannot be utilized in this manner. He went on to state that he has this in place as he has had great difficulty employing additional staff. I informed Mr. Bhattad that having 1 staff member on shift with 7 residents who utilize wheelchairs and/or require assistance from staff to transfer to and from their wheelchair does not meet the needs of the residents. Ms. Bhattad agreed to submit a corrective action plan upon receipt of this report.

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 on the information obtained during the investigation there is sufficient information to determine that the staff to resident ratio does not meet the requirement for this rule.

	As of 2/20/2025 the resident registry indicates 8 residents residing in the facility. Ms. D'Amore stated 7 of the 8 residents utilize wheelchairs. According to the staff schedules reviewed, there is only 1 staff member working on most Sundays and Mondays between the hours of 8 pm-7 am, and 1 staff member working Tuesday through Saturday between the hours of 11 pm-7 am.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the residents designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on the information obtained during the investigation and from my own observation, there is sufficient information to determine that Resident A's assessment plan was not signed or dated. On 2/20/2025, I reviewed Resident A's assessment plan and observed that there was no resident, legal guardian or designated representative's signature or date documented on the form.
CONCLUSION:	**VIOLATION ESTABLISHED**

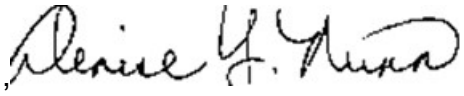
IV. RECOMMENDATION

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

5/13/2025

Cindy Berry — Date
Licensing Consultant

Approved By:



05/22/2025

Denise Y. Nunn — Date
Area Manager