RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

May 3, 2018

Cynthia White
Neighborhood Residential Inc. (Life Center Inc.)
15419 Middlebelt
Livonia, MI 48154

RE: License #: AS630312997
Investigation #: 2018A0991016
Terova Home

Dear Ms. White:

Attached is the Special Investigation Report for the above referenced facility. Disciplinary action against your license was recommended in Special Investigation Report #: 2018A0991014. This recommendation remains in effect. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Kristen Donnay

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 296-2783

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630312997
Investigation #:	2018A0991016
Complaint Receipt Date:	02/27/2018
Investigation Initiation Date:	02/27/2018
Report Due Date:	04/28/2018
Licensee Name:	Neighborhood Residential Inc. (Life Center Inc.) (Currently operated by: Integrated Living)
Licensee Address:	15419 Middlebelt Livonia, MI 48154
Licensee Telephone #:	(586) 799-9220
Licensee Designee:	Cynthia White (Karen Harris- Integrated Living)
Name of Facility:	Terova Home
Facility Address:	2448 Terova Troy, MI 48098
Facility Telephone #:	(248) 689-7572
Original Issuance Date:	02/29/2012
License Status:	1ST PROVISIONAL
Effective Date:	09/19/2017
Expiration Date:	03/18/2018
Capacity:	3
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Direct care worker, Eric McCormick, left an untrained staff at home alone with Resident C when he took Resident A and Resident B to the store.	Yes
Direct care worker, Eric McCormick, left Resident A and Resident B unsupervised in the van while he was inside of the store.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/27/2018	Special Investigation Intake 2018A0991016
02/27/2018	Special Investigation Initiated - Telephone Call to Office of Recipient Rights (ORR) worker, Katie Garcia
02/27/2018	Referral - Recipient Rights Contacted ORR
02/27/2018	APS Referral Received from Adult Protective Services (APS)- APS denied referral
03/08/2018	Contact - Face to Face Interviewed staff at Oakland Community Health Network
04/11/2018	Exit Conference Via telephone with Integrated Living licensee designee, Karen Harris, and quality assurance manager, Jeff Swanson
04/23/2018	Contact – Telephone call made To Jeff Swanson re: updated recommendation
04/23/2018	Exit conference Via telephone with Cynthia White, licensee designee from Neighborhood Residential Inc. (Life Center Inc.)

ALLEGATION:

Direct care worker, Eric McCormick, left an untrained staff at home alone with Resident C when he took Resident A and Resident B to the store.

INVESTIGATION:

On 02/27/18, I received a complaint alleging that on 02/25/18 direct care worker, Eric McCormick, left an untrained staff at Terova Home with Resident C when he took Resident A and Resident B to a local 7-Eleven store. Adult Protective Services denied this complaint. I initiated my investigation on 02/27/18, by contacting the assigned Office of Recipient Rights (ORR) worker, Katie Garcia. Ms. Garcia arranged for us to interview staff at the Oakland Community Health Network building due to limited private space at Terova Home.

On 03/08/18, I interviewed direct care worker, Eric McCormick. Mr. McCormick indicated that Jalai Parker is a new staff who has been working at Terova Home for a couple of weeks. Ms. Parker is still in the process of completing her training and will not be certified until 03/15/18. Mr. McCormick stated that he cannot take the residents on outings when he is working with Ms. Parker, because she cannot be left at home with anyone since she is not fully trained. Mr. McCormick did admit that there was an occasion when he took Resident B and Resident C to 7-Eleven and left Ms. Parker at home with Resident A. He also recalled an occasion when he took Resident A and Resident B to 7-Eleven but left Resident C at home with Ms. Parker. Mr. McCormick could not recall the date when this occurred. He indicated that 7-Eleven is located approximately .25 miles from the home, so they were only gone for about 5 minutes.

On 03/08/18, I interviewed the home manager, Ashley Buchanan. Ms. Buchanan stated that Resident B told her that Mr. McCormick took him and Resident A to 7-Eleven and left Resident C at home with Ms. Parker. Ms. Parker started working at the home in February and is not fully trained. Ms. Buchanan stated that staff cannot work by themselves, pass medications, or be unsupervised with residents until they are fully trained. If any of the residents wanted to go to the store while Ms. Parker was working, they all should have gone to the store. Ms. Buchanan stated that she told Mr. McCormick they would all have to go to the store prior to this incident occurring.

On 03/08/18, I interviewed direct care worker, Takela Whitlock. Ms. Whitlock stated that on 02/26/18, Resident B told her that Mr. McCormick took him and Resident A to 7-Eleven, while Ms. Parker stayed home with Resident C. Ms. Whitlock stated that Ms. Parker had only been working in the home for a month and is not fully trained. Untrained staff are required to work with trained staff and cannot be left alone with residents until they are fully trained. Everyone should go along if someone needs to be transported and there is an untrained staff person on shift.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents, and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on the information gathered through my interviews, there is sufficient information to conclude that there was not sufficient direct care staff on duty at all times when Mr. McCormick left an untrained staff person, Jalai Parker, at the home with a resident while taking the other residents to the store. Ms. Parker had not yet completed training and was not supposed to be left unsupervised with residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(3) Any individual, including a volunteer, shall not be considered in determining the ratio of direct care staff to residents unless the individual meets the qualifications of a direct care staff member.
ANALYSIS:	Based on the information gathered through my interviews, there is sufficient information to conclude that Jalai Parker had not yet completed the required training and did not meet the qualifications of a direct care staff member when Mr. McCormick left her alone at Terova Home with a resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Direct care worker, Eric McCormick, left Resident A and Resident B unsupervised in the van while he was inside of the store.

INVESTIGATION:

On 03/08/18, I interviewed direct care worker, Eric McCormick. Mr. McCormick stated that on the occasion when he took Resident A and Resident B to 7-Eleven, he did leave Resident A in the van while he and Resident B went into the store. He indicated that Resident A did not want to go into the store, so he told him to wait in the vehicle while

they went in and got some stuff. He stated that he stood inside 7-Eleven and watched the van from the window while Resident B was picking out what he wanted. Mr. McCormick then had Resident B stand at the window and watch the van while he paid for the items. They were in the store for a few minutes and Resident A never got out of the van while they were in the store.

On 03/08/18, I interviewed the home manager, Ashley Buchanan, and direct care worker, Takela Whitlock. Ms. Buchanan and Ms. Whitlock both stated that Resident B told them Mr. McCormick left Resident A in the van while they went into 7-Eleven. Mr. McCormick bought a drink for Resident B and then told him to go wait in the van with Resident A. Ms. Buchanan and Ms. Whitlock stated that Resident A is very behavioral and should not be left alone. An incident had occurred earlier that weekend were Resident A kicked out the window screen in his bedroom and climbed out the window.

On 03/08/18, I reviewed Resident A's individual plan of service (IPOS) dated 02/01/18, which indicates that Resident A needs to be accompanied at all times in the community within eyesight due to behaviors and support needed to navigate transitions and highly sensory intensive environments. Caregivers need to be within easy reach in crowded situations, i.e. malls, public venues with crowded conditions within 8 feet. The IPOS also states that during transport Resident A should be seated farthest from the driver with two staff accompanying him, utilizing a buckle guard for his safety. While in the community, Resident A should always have two staff accompanying him, as past records indicate he will dart away without warning.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the information gathered through my interviews, there is sufficient information to conclude that staff did not provide supervision, protection, and personal care as specified in Resident A's assessment plan when Mr. McCormick left Resident A in the van unattended while he went into 7-Eleven. Resident A was not accompanied and within eyesight when Mr. McCormick was paying for his purchases and asked Resident B to watch the van. Resident A's assessment plan also specifies that he needs to be accompanied by two staff when he is transported and while in the community; however, Mr. McCormick was the only staff person with him during this outing.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my interviews with Ms. Buchanan and Ms. Whitlock, they both indicated that Resident A's behaviors had escalated recently. On 03/02/18, Resident A attacked staff and on 03/03/18, he attacked the behavioral psychologist from the Macomb Oakland Regional Center who was visiting the home. Resident A was sent to Beaumont Hospital on 03/03/18. Ms. Buchanan stated that incident reports were completed and were sent to the main office at Integrated Living. The office staff at Integrated Living then send out the incident reports to the required parties. I reviewed the licensing file for Terova Home and as of 03/08/18, I had not received any incident reports regarding Resident A's behaviors or hospitalization.

It should be noted that Terova Home is currently being operated by Integrated Living, Inc. (43133 Schoenherr Rd., Sterling Heights, MI 48313). An application was submitted on 11/14/17 and the new enrollment is still pending (AS630391421).

On 04/11/18, I conducted an exit conference via telephone with the Integrated Living licensee designee, Karen Harris, and the quality assurance director, Jeff Swanson to review my findings. Ms. Harris and Mr. Swanson indicated that they understood the citations and were taking the necessary actions to ensure compliance with the licensing rules. They stated that Mr. McCormick would receive additional training with regards to recipient rights and he should have known that it was not okay to leave Ms. Parker at the home or to leave Resident A in the van unattended.

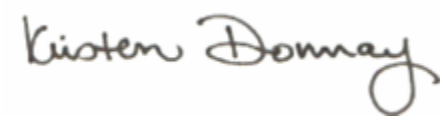
On 04/23/18, I conducted an exit conference with Cynthia White, the licensee designee from Neighborhood Residential Inc., which has merged with Life Center Inc. I informed Ms. White that since the home was on a provisional license and there were additional quality of care violations, a recommendation for revocation would be made. Ms. White did not have any additional information to share. On 04/23/18, I informed Jeff Swanson from Integrated Living of the updated recommendation for revocation and he indicated that he would share the information with the licensee designee, Karen Harris.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (a) The death of a resident. (b) Any accident or illness that requires hospitalization.

	(c) Incidents that involve any of the following: (i) Displays of serious hostility. (ii) Hospitalization. (iii) Attempts at self-inflicted harm or harm to others. (iv) Instances of destruction to property. (d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.
ANALYSIS:	Incident reports were not received by the licensing division within 48 hours of Resident A's hospitalization on 03/02/18 or following his attempts at harm to others.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Revocation of the license which was recommended in Special Investigation Report #2018A0991014 due to quality of care violations while the license is currently on provisional status, remains in effect.



04/23/18

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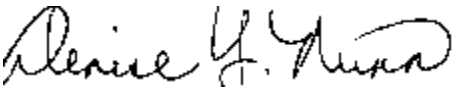
Kristen Donnay Date
Licensing Consultant

Approved By:



04/24/2018

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Denise Y. Nunn Date
Area Manager