GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 1, 2019

Cathy McCowan
Able Manor LLC
5221 Westview
Clarkston, MI 48346

RE: License #: AS630288437
Investigation #: 2019A0993035
Able Manor

Dear Ms. McCowan:

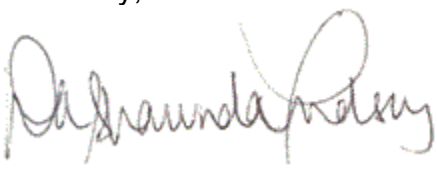
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630288437
Investigation #:	2019A0993035
Complaint Receipt Date:	06/05/2019
Investigation Initiation Date:	06/05/2019
Report Due Date:	08/04/2019
Licensee Name:	Able Manor LLC
Licensee Address:	5221 Westview Clarkston, MI 48346
Licensee Telephone #:	(248) 599-9407
Administrator:	Jamie Davis
Licensee Designee:	Cathy McCowan
Name of Facility:	Able Manor
Facility Address:	5221 Westview Clarkston, MI 48346
Facility Telephone #:	(248) 599-9407
Original Issuance Date:	03/17/2008
License **Status:**	REGULAR
Effective Date:	09/14/2018
Expiration Date:	09/13/2020
Capacity:	6
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is blind and has a history of strokes. When he gets upset, he tries to walk away from the facility. Resident A tried to walk away on 06/04/2019. Staff went after Resident A, and physically grabbed him to bring him back into the facility. Resident A suffered some cuts and bruises to his arm.	Yes

III. METHODOLOGY

06/05/2019	Special Investigation Intake 2019A0993035
06/05/2019	APS Referral Allegations received from adult protective services (APS)
06/05/2019	Special Investigation Initiated - Telephone Telephone call made to APS specialist Tameia Kelly. Left a message.
06/05/2019	Contact - Telephone call received Telephone call received from APS specialist Tameia Kelly. Assigned APS specialist is Candid Jamerson
06/05/2019	Contact - Telephone call made Telephone call made to APS specialist Candid Jamerson. Left a message.
06/06/2019	Contact - Telephone call received Telephone call received from APS specialist Candid Jamerson
06/06/2019	Contact - Telephone call made Telephone call made to Resident A's guardian (and daughter)
06/06/2019	Contact - Face to Face Interviewed Resident A at his current residence
06/20/2019	Contact - Telephone call made Telephone call made to staff Jimmie McCowan and Vickie Sumner
06/25/2019	Contact - Document Received Received a copy of Oakland County Sherriff's Office police report
07/24/2019	Inspection Completed On-site Conducted an announced onsite investigation

07/24/2019	Contact - Telephone call made Telephone call made to staff Jimmie McCowan
07/30/2019	Exit Conference Exit conference with licensee designee Cathy McCowan

ALLEGATION:

Resident A is blind and has a history of strokes. When he gets upset, he tries to walk away from the facility. Resident A tried to walk away on 06/04/2019. Staff went after Resident A, and physically grabbed him to bring him back into the facility. Resident A suffered some cuts and bruises to his arm.

INVESTIGATION:

On 06/05/2019, I received the allegations from adult protective services (APS).

On 06/06/2019, I conducted a telephone interview with APS specialist Candid Jamerson. She stated she is also investigating the allegations.

On 06/06/2019, I conducted a telephone interview with Resident A's guardian (and daughter). She stated she received a telephone call from staff Jimmie McCowan on 06/04/2019 at approximately 4:00pm. He requested she talked to Resident A and calm him down. Mr. McCowan stated Resident A became upset about not receiving a cigarette and tried to run away from the facility. Mr. McCowan stated he had to drag Resident A back into the facility. Resident A's guardian (and daughter) stated when Resident A got on the phone, he asked to speak with her husband who is a police officer. Then Resident A started to hyperventilate and cry. According to Resident A's guardian (and daughter), this is not a common emotional response from Resident A. Resident A proceeded to say that he was abused, and his arm would not stop bleeding. Resident A's guardian (and daughter) asked Resident A to put Mr. McCowan back on the phone. When she inquired about the extent of Resident A's injuries and how he sustained it, Mr. McCowan informed her Resident A may have sustained the injuries during the struggle. Resident A was fighting him while he drugged him back into the facility. Resident A's guardian (and daughter) stated she went to the facility that day and observed three to four lacerations on Resident's arm. Two of the lacerations were actively bleeding. Although there were bandages on the lacerations, two of them were bleeding through them. Resident A's guardian (and daughter) stated Resident A is legally blind. Mr. McCown admitted to physically dragging Resident A back into the facility because he was trying to keep him safe and prevent him from going into the road. After talking with Mr. McCowan, she took Resident A to McLaren Hospital for treatment. Resident A is temporarily staying at an assisted living facility until a permanent residence is located for him.

On 06/06/2019, I interviewed Resident A at his current residence. Resident A stated Mr. McCowan's girlfriend (also referred to as staff Vickie Sumner in this report) was working in the facility when he told her to "f*ck off." Although Mr. McCowan was off duty, Ms. Sumner called him for assistance. Mr. McCowan threw Resident A into his bedroom. Resident A stayed in his bedroom for about five minutes, and then he left out of his room and decided he was leaving the facility to go to his daughter's home. Resident A stated he got as far as the driveway before Mr. McCowan came after him. Mr. McCowan grabbed and squeezed him, threw him against the wooden ramp, and then drugged him back into the facility. Resident A stated Mr. McCowan hit him in his stomach and it still hurts today. After the incident, Mr. McCowan contacted Resident A's guardian (and daughter). She came over and took him to the hospital. The police were called as well.

While interviewing Resident A, I observed a large purplish bruise on the upper area of Resident A's stomach. I also observed multiple lacerations on Resident A's right arm.

On 06/20/2019, I conducted a telephone interview with staff Jimmie McCowan and Vickie Sumner. Mr. McCowan verified the incident occurred on 06/04/2019. He was not scheduled work in the facility at the time of the incident. Instead Ms. Sumner was working. Mr. McCowan verified Ms. Sumner asked for his assistance after Resident A told her to "f*ck off." Mr. McCowan denied throwing Resident A into his bedroom. Instead, he escorted him to his bedroom to calm down. Resident A came out his bedroom and left out of the facility in attempts of running away. Mr. McCowan ran after him. Mr. McCowan stated he grabbed Resident A and redirected him back into the facility. Mr. McCowan denied pulling or dragging Resident A up the ramp. He also denied punching Resident A in his stomach. According to Mr. McCowan, Resident A was fighting him the entire time he redirected him back into the facility. However, he did not observe the lacerations or that Resident A was bleeding until he got back into the facility. After the incident, he contacted Resident A's guardian (and daughter) to inform her of the incident. She transported Resident A to the hospital for treatment.

Ms. Sumner verified she was working in the facility during the incident between Mr. McCowan and Resident A on 06/04/2019. According to Ms. Sumner, Resident A had been agitated all day. He asked for a cigarette. She told Resident A she could not give it to him at that present moment. Resident A began screaming "f-you, f-you, f-you." She called Mr. McCowan. McCowan told Resident A to go to his bedroom. Mr. McCowan waited in the living room for a few minutes and then left. As soon as Mr. McCowan left, Resident A ran out of the front door. Mr. McCowan went after him and tried to redirect him back into the facility. Mr. McCowan scooped Resident A from behind and guided him up the ramp into the facility. Resident A was fighting him the entire way. Once in the facility, Mr. McCowan called Resident A's guardian (and daughter) and informed her of the incident. She called 911 and later transported him to the hospital. Ms. Sumner denied observing Mr. McCowan punch Resident A in his stomach or beating and squeezing Resident A. Ms. Sumner acknowledged Resident A sustained multiple lacerations on his arm; however, she stated she assumes Resident A sustained them from the ramp.

On 06/25/2019, I reviewed a copy of the Oakland County Sheriff's Office police report. Per the report, the sheriff's office was dispatched to the facility on 06/04/2019 for assault upon Resident A by Mr. McCowan. The sheriff's office is investigating the allegations.

On 07/24/2019, I conducted an announced onsite investigation. I requested a copy of Resident A's assessment plan. There was no verification that an assessment plan was complete at the time of admission. Instead, I received and reviewed a form entitled Addendum to Assessment Plan." The form noted Resident A "has wandered from homes in the past." The level of supervision required for Resident A was not documented. The actions that staff should take if Resident A wandered away from the facility also was not documented.

On 07/30/2019, I conducted an exit conference with licensee designee Kathy McCowan. I informed her of the findings. She agreed to submit a corrective action plan.

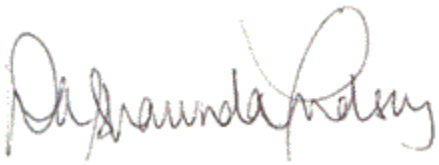
APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	On 07/24/2019, during the onsite, there was no verification that an assessment plan was complete at the time of admission. Instead, I received and reviewed a form entitled Addendum to Assessment Plan." The form noted Resident A "has wandered from homes in the past." The level of supervision required for Resident A was not documented. The actions that staff should take if Resident A wandered away from the facility also was not documented.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.** **4**

ANALYSIS:	Resident A attempted to run away from the facility on 06/04/2019. Mr. McCowan used excessive force to get Resident A back into the facility. Resident A sustained lacerations on his right arm. He also sustained a bruise on his stomach.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

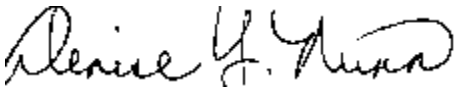
Contingent upon receipt of a corrective action plan, I recommend no change in the license status.



07/30/2019

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



08/01/2019

Denise Y. Nunn — Date
Area Manager