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STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 10, 2019

Enzo Addari
St. Louis Center for Exceptional Children & Adults
16195 Old US-12
Chelsea, MI 48118

RE: License #: AL810007467
Investigation #: 2019A0122032
Fr Guanella Hall

Dear Fr. Addari:

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) 284-9720.

Sincerely,

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL810007467
Investigation #:	2019A0122032
Complaint Receipt Date:	09/12/2019
Investigation Initiation Date:	09/12/2019
Report Due Date:	11/11/2019
Licensee Name:	St. Louis Center for Exceptional Children & Adults
Licensee Address:	16195 Old US-12 Chelsea, MI 48118
Licensee Telephone #:	(734) 475-8430
Administrator:	Enzo Addari
Licensee Designee:	Enzo Addari
Name of Facility:	Fr Guanella Hall
Facility Address:	16195 Old US-12 Chelsea, MI 48118
Facility Telephone #:	(734) 475-8430
Original Issuance Date:	02/01/1991
License Status:	REGULAR
Effective Date:	10/21/2018
Expiration Date:	10/20/2020
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 09/07/2019, Kristie Jordan, staff member, changed Resident A's diaper in the facility living room.	Yes
On 09/10/2019, Resident B fell out of his wheelchair and received injury as staff members failed to provide protection and safety while assisting him with personal hygiene tasks.	Yes

III. METHODOLOGY

09/12/2019	Special Investigation Intake 2019A0122032 Adult Protective Services referral made on 09/11/2019 (documented on incident report)
09/12/2019	Special Investigation Initiated - Telephone Completed interview with Sheryl Mohr, Social Worker
09/13/2019	Inspection Completed On-site Files reviewed. Completed interviews with Resident C and D.
09/18/2019	Contact – Telephone Call Made Completed interviews with staff members Kristie Jordan and Jessica Osborne.
09/23/2019	Exit Conference Discussed findings with Fr. Enzo Addari, Licensee Designee

ALLEGATION:

- **On 09/07/2019, Kristie Jordan, staff member, changed Resident A's diaper in the facility living room.**
- **On 09/10/2019, Resident B fell out of his wheelchair and received injury as staff members failed to provide protection and safety while assisting him with personal hygiene tasks.**

INVESTIGATION:

On 09/12/2019, Sheryl Mohr, Social Worker affiliated with St. Louis Center for Exceptional Children & Adults, submitted a copy of a Recipient Rights Complaint dated 09/11/2019 stating the following: Resident B "was in the living room on Saturday evening at my home when a staff member changed another resident's," Resident A, "diaper …where all of us was watching T.V. I didn't like that and it was embarrassing…"

On 09/13/2019, I completed interviews with Residents B and C. Both reported that on 09/07/2019 a female staff member changed Resident A's diaper in the living room while other residents were present. Both Residents B and C have lived at Fr Guanella Hall for at least 5 years and accurately identified other residents in the facility. Both Residents B and C were upset and felt uncomfortable that the incident happened.

Sheryl Mohr stated that due to cognitive delays Resident A is nonverbal and unable to participate in an interview.

I reviewed Resident A's Individual Person-Centered Plan of Support dated 11/01/2018 and it states that Resident A is diagnosed with Down's Syndrome and Severe Mental Retardation. The plan also states that Resident A "wears adult incontinence products at all times and depends upon caregivers for all toileting needs."

On 09/18/2019, Krystie Jordan confirmed that she was assigned to work and provide care to the residents of Fr Guanella Hall between the hours of 2:30 p.m. – 10:00 p.m. Ms. Jordan denied twice that she had changed Resident A's diaper in the facility living room with other resident's present even though two individuals, Residents B and C, reported that she had.

I reviewed Ms. Jordan's New Hire Orientation Scheduled dated June 2019 which outlines different topics that she received training in. On 06/18/2019, 06/19/2019 and 06/20/2019 respectively Ms. Jordan received training on Recipient Rights, Blood borne Pathogens and Personal Care and Hygiene.

On 09/11/2019, I received an incident/accident report documenting that Resident D fell out of his wheelchair and sustained injury on 09/10/2019.

Resident D's After Visit Summary dated 09/11/2019-09/12/2019 from University of Michigan documents that he received treatment on those dates, and he had a CT Head Scan. The summary informs what behaviors/signs to look out for and to seek additional medical treatment, however, does not state the reason for his medical visit.

On 09/13/2019, I observed Resident D seating in his wheelchair while attending his day program. He was appropriately dressed and appeared to be comfortable and content with staff member sitting next to him. He was leaning towards the left as he sat in the

wheelchair. He had a bruised (black and blue) right eye with a small cut above his eyebrow on the same eye. Resident D is nonverbal and therefore unable to participate in an interview.

Resident D's wheelchair was observed to be in good repair, however there was no seatbelt or safety device as part of the wheelchair. Pictures were taken and are included as part of this report.

On 09/13/2019, I completed an interview with Debra Markiewicz, Registered Nurse, on staff. Ms. Markiewicz confirmed that she was working the evening of 09/10/2019 and received a phone call stating that Resident D had fallen out of his wheelchair and was injured. Per Ms. Markiewicz upon arrival to the facility bathroom she observed Resident on the floor with a huge hematoma and bleeding from a cut on the right eye. Ms. Markiewicz provided medical care to Resident D until emergency personnel arrived and transported him to the hospital.

Ms. Markiewicz further reported that she had observed Resident D leaning forward all day. She stated he typically leans to the side but on 09/10/2019 she observed him leaning so far forward that his head almost touched his knees. Ms. Markiewicz stated that Resident D needs assistance for all hygiene tasks and he is a two person assist with bathing and toileting.

Resident D's Assessment Plan dated 03/15/2019 documents that he needs assistance with toileting, bathing, and personal hygiene tasks. He must also have assistance with walking/mobility and requires a wheelchair for long distances. His Individualized Plan of Service Meeting Report dated 03/15/2019 documents that Resident D requires 1:1 assistance with bathing, personal hygiene, toileting, etc.

On 09/18/2019, I interviewed staff members, Krystie Jordan and Jessica Osborne, both confirm that they provided care to Resident D on 09/10/2019 and were assisting him in the bathroom. Ms. Jordan stated that she was on the side of the wheelchair while Ms. Osborne was positioned behind the wheelchair. They had placed him back in the wheelchair when they took their eyes off him, Ms. Jordan stated she was grabbing a towel and Ms. Osborne stated she was looking at Ms. Jordan. As they looked back at him, they observed him falling out of the wheelchair and couldn't prevent the fall.

They observed that he sustained injury from the fall. They provided assistance and contacted Debra Markiewicz, nurse on duty, to report the injury and provide further assistance. Eventually emergency personnel arrived, and Resident D was taken to the University of Michigan hospital to receive medical treatment. Both Ms. Joran and Ms. Osborne confirmed that they had observed Resident D leaning forward earlier in the day and that he requires assistance with toileting and personal hygiene tasks.

I reviewed Ms. Jordan and Ms. Osborne's training record. Both have been trained in the topics of personal care and hygiene.

On 09/23/2019, I completed an exit conference with Fr. Enzo Addari, Licensee Designee. Fr. Addari stated he understood my findings and would submit a corrective action plan to address rule non-compliance found.

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:	On 09/12/2019, a copy of a Recipient Rights Complaint was received stating on 09/07/2019 a female staff member, Krystie Jordan, changed Resident A's diaper in the facility living room with resident's present. On 09/18/2019, Ms. Jordan denied changing Resident A's diaper in the facility living room on 09/07/2019. On 09/13/2019, Residents B and C reported they observed Krystie Jordan change Resident A's diaper in the facility living room. On 09/11/2019, an incident report was received documenting that Resident D fell out of his wheelchair and sustained injury due to staff members, Krystie Jordan and Jessica Osborne, failing to provide protection and safety while assisting him with personal hygiene tasks. On 09/18/2019, both Ms. Jordan and Ms. Osborne reported that they had observed Resident D leaning forward in his wheelchair earlier in the day on 09/10/2019. Both reported they took their eyes off him while providing him assistance with personal hygiene tasks. Both reported once they looked back at him and observed him falling out of the wheelchair, they were unable to prevent the fall. Based upon my investigation I find that Resident A was not treated with dignity as staff member, Krystie Jordan changed her diaper in the facility living room on 09/07/2019. Resident D received injury on 09/10/2019 as he fell out of his wheelchair due to staff members, Krystie Jordan and Jessica Osborne, not attending to his protection and safety as they observed him leaning forward in his wheelchair earlier in the day but failed to observe him properly while assisting with his personal hygiene tasks.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan I make no changes to the status of the license.

Vanita C. Bouldin
Licensing Consultant

Date: 09/23/2019

Approved By:

Ardra Hunter
Area Manager

Date: 10/10/2019