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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 24, 2020

Michelle Helmuth-Charles
LADD, Inc.
300 Whitney Dr.
Dowagiac, MI 49047

RE: License #: AS630082322
Investigation #: 2019A0989030
Adams Home

Dear Ms. Helmuth-Charles:

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,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630082322
Investigation #:	2019A0989030
Complaint Receipt Date:	12/19/2018
Investigation Initiation Date:	12/20/2018
Report Due Date:	02/17/2019
Licensee Name:	LADD, Inc.
Licensee Address:	300 Whitney Dr. Dowagiac, MI 49047
Licensee Telephone #:	(269) 240-1473
Administrator:	Julia Jeffreys
Licensee Designee:	Gloria Mitzelfeld
Name of Facility:	Adams Home
Facility Address:	4609 Butler Troy, MI 48098
Facility Telephone #:	(248) 524-1275
Original Issuance Date:	01/22/1999
License **Status:**	REGULAR
Effective Date:	07/24/2017
Expiration Date:	07/23/2019
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 12/17/18, Resident A was taken to ER with bruises. X-rays indicate she has a clavicle fracture.	Yes

III. METHODOLOGY

12/19/2018	Special Investigation Intake 2019A0989030
12/20/2018	Special Investigation Initiated – Telephone Filed complaint with Centralized Intake for APS referral.
12/20/2018	Contact - Telephone call made Vociemail message left for Beaumont Hospital Social Worker Theresa Vrij.
12/21/2018	Contact - Telephone call received Telephone call received from Theresa Vrij, Beaumont Hospital Social Work Dept. Resident A was released from the hospital and returned to the group home per the request of the legal guardian. Legal guardian feels Resident A is well cared for and has no safety concerns. Legal guardian believes the incident that led to the injury occured in the day program.
12/11/2019	Inspection Completed On-site On 12/11/19, Licensing Consultant Kristine Donnay conducted an onsite inspection at Adams Home. She interviewed the program administrator, Vivian Rheaves and the assistant home manager Elfrida Sims.
01/31/2020	Exit Conference Held with the program administrator, Vivian Rheaves

ALLEGATION:

On 12/17/18, Resident A was taken to ER with bruises. X-rays indicate she has a clavicle fracture.

INVESTIGATION:

A complaint was received regarding Adams Home which indicated that Resident A was brought to the Emergency Center at Beaumont Hospital Troy with a bruise on the left side of her face, near her left eye, and a rather large bruise on her left shoulder. According to the complaint, Resident A has medical history of mental retardation, cerebral palsy, high blood pressure, diabetes, and frequent falls. Resident A is unable to speak. Adams House assistant manager, Elfrida Sims, states the bruise on patient's face and shoulder were noticed after patient returned from Lahser Pre-Vocational Center where patient attends weekdays. According to Elfrida, a call was made to Lasher Pre-Vocational Center who reported Resident A did not fall while in their care. Adams House staff also report that Resident A did not fall in their care. Resident A was taken to a local urgent care for evaluation on 12/17/18, but as the x-ray equipment was not working, no x-rays were taken. Staff brought Resident A back to Adams House. This afternoon, 12/18/18, assistant manager, Elfrida, saw the bruise on Resident A's shoulder and noted it to be rather large, which Elfrida states she was not informed of the severity of the bruise on her shoulder on 12/17/18. Elfrida brought Resident A to the hospital for evaluation and x-rays which indicate Resident A has a clavicle fracture. Elfrida states if she had been made aware the extent of Resident A's bruising yesterday, she would have instructed Adams House staff to take patient to Beaumont Hospital. Elfrida stated staff first became aware of Resident A's shoulder injury when Resident A began holding her shoulder Monday after returning to Adams House from Lasher Pre-Vocational Center. Bruising was not noted until after return from Lasher Pre-Vocational Center on Monday.

On 12/21/18, Telephone call received from Theresa Vrij, Beaumont Hospital Social Work Dept. Resident A was released from the hospital and returned to the group home per the request of the legal guardian. Legal guardian feels Resident A is well cared for and has no safety concerns. Legal guardian believes the incident that led to the injury occurred in the day program.

On 12/11/19, Licensing Consultant Kristine Donnay conducted an onsite inspection at Adams Home. She interviewed the program administrator, Vivian Rheaves and the assistant home manager Elfrida Sims. Ms. Rheaves and Ms. Sims did not know how Resident A sustained the injuries to her collarbone/shoulder. They stated that they believed the injuries occurred while Resident A was at workshop. They were not aware of Resident A falling in the home. Ms. Rheaves and Ms. Sims stated that Danielle Huddleston took Resident A to urgent care on 12/17/18, but their x-ray machine was not working, and they sent Resident A home. Staff took Resident A to the hospital the following day, 12/18/18, where it was discovered that she had a broken clavicle. Ms. Rheaves and Ms. Sims could not explain why staff waited until the next day to take Resident A to the hospital. The health care chronological indicates that the x-ray machine was down at urgent care on 12/17/18 and the doctor ordered staff to take Resident A to the hospital to get an x-ray done on her left clavicle. It also notes that Resident A was in pain.

Exit conference held on 01/31/20 with the program administrator Vivian Rheaves. The findings of the investigation were reviewed with Ms. Rheaves. I explained that she has 15 days from the day the report is sent to submit a corrective action plan for the substantiated violations.

APPLICABLE RULE	
R 400.14305	**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:	There is not enough information to determine how Resident A sustained her injuries. The facility states that Resident A did not fall under their supervision and Resident A's vocational education institution states the same.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14310	**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:	The health care chronological indicates that the x-ray machine was down at urgent care on 12/17/18 and the doctor ordered staff to take Resident A to the hospital to get an x-ray done on her left clavicle. It also notes that Resident A was in pain. Ms. Rheaves and Ms. Sims could not explain why staff waited until the next day to take Resident A to the hospital.
CONCLUSION:	**VIOLATION ESTABLISHED**

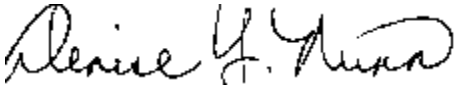
IV. RECOMMENDATION

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

1/31/20

Eric Johnson Date
Licensing Consultant

Approved By:



02/14/2020

Denise Y. Nunn Date
Area Manager