GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 3, 2020

Angela Joquico
Apple Tree Lane LTD dba Special Tree NeuroCare Ctr
Suite 2
16880 Middlebelt Road
Livonia, MI 48154

RE: License #: AL820313042
Investigation #: 2020A0116012
NeuroCare Center South

Dear Ms. Joquico:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820313042
Investigation #:	2020A0116012
Complaint Receipt Date:	02/10/2020
Investigation Initiation Date:	02/10/2020
Report Due Date:	04/10/2020
Licensee Name:	Apple Tree Lane LTD dba Special Tree NeuroCare Ctr
Licensee Address:	39000 Chase Road Romulus, MI 48174
Licensee Telephone #:	(734) 239-1937
Administrator:	Angela Joquico
Licensee Designee:	Angela Joquico
Name of Facility:	NeuroCare Center South
Facility Address:	39000 Chase Road Romulus, MI 48174
Facility Telephone #:	(734) 239-1937
Original Issuance Date:	08/07/2012
License Status:	REGULAR
Effective Date:	06/10/2018
Expiration Date:	06/09/2020
Capacity:	15
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Incident report received stated that employee Jauron Grantham witnessed staff, DeJuan LeBlanc, slap Resident A.	Yes

III. METHODOLOGY

02/10/2020	Special Investigation Intake 2020A0116012
02/10/2020	Special Investigation Initiated - Telephone Telephone call from licensee designee Angela Joquico on 02/07/20 regarding allegations.
02/11/2020	Inspection Completed On-site Interview attempted with Resident A. Interviewed housekeeping employee Jauron Grantham and assistant to the administrator Alesa Bray.
02/11/2020	Contact - Document Received Received copies/verification that Mr. LeBlanc was fully trained.
02/14/2020	Contact - Telephone call made Interviewed former staff DeJuan LeBlanc.
02/24/2020	Contact - Telephone call made Interviewed assigned Adult Protective Services (APS worker Shevon Jackson.
02/24/2020	Inspection Completed-BCAL Sub. Compliance
02/26/2020	Exit Conference With licensee designee, Angie Joquico.

ALLEGATION:

Incident report received stated that employee Jauron Grantham witnessed staff, DeJuan LeBlanc, slap Resident A.

INVESTIGATION:

On 02/07/20, I received a call from licensee designee, Angie Joquico, with regard to the incident report sent to me on 02/06/20 involving the alleged abuse to a resident by a staff. Ms. Joquico reported that the facility was conducting an internal investigation and would update me with the findings. Ms. Joquico reported that Resident A was assessed by the facility nurse and no marks or bruises were observed in the shoulder area where it was alleged that Resident A was slapped.

On 02/11/20, I conducted an unscheduled onsite inspection and interviewed Ms. Bray. Ms. Bray reported that on 02/05/20 housekeeping staff Mr. Grantham reported that he witnessed staff Mr. LeBlanc slap Resident A with an open hand across his left shoulder. Ms. Bray reported that an internal investigation commenced, and Mr. LeBlanc was interviewed regarding the allegations. Ms. Bray reported that Mr. LeBlanc denied that he slapped Resident A and reported that he had a witness that was with him during the time he was with Resident A. Ms. Bray reported that during the internal investigation, they interviewed three other employees who saw Mr. LeBlanc alone in Resident A' s room, the hallway and as he entered the shower room with Resident A. Ms. Bray reported that Mr. LeBlanc was not being truthful and that no other staff person was with him as reported. Ms. Bray reported that Mr. LeBlanc has been terminated. Ms. Bray reported that Resident A is very combative and bruises easily; however, reported visually assessing Resident A and not observing any marks or bruises on either of his shoulder areas but reported that there were marks/scratches on both of his lower arms.

I interviewed Mr. Grantham and he reported that he was in the hallway area cleaning up and heard Resident A and Mr. LeBlanc going back and forth arguing. Mr. Grantham reported that Resident A is a very combative resident and "will strike you in a minute." Mr. Grantham reported that in spite of his behaviors he does not deserve to be hit or mistreated. Mr. Grantham reported that on 02/05/20 he observed Mr. LeBlanc slap Resident A across his left shoulder with an open hand and then proceeded to take him into the shower room alone. Mr. Grantham reported his belief that the abuse continued in the shower room as he heard the two arguing back and forth and heard Resident A say something like "is that all you've got?" Mr. Grantham reported he was really bothered by what he observed and heard. He reported at the end of his shift he reported it. I advised Mr. Grantham that in the future if he observes mistreatment/abuse/neglect of a resident that he needs to report it immediately so that management can ensure the continued safety and well-being of that resident. Mr. Grantham reported an understanding.

I attempted to interview Resident A, however, due to his level of cognitive function he was unable to articulate anything regarding the incident. I did observe some red marks/bruises on both of Resident A's lower arms below his elbows.

On 02/11/20, I received and reviewed Mr. LeBlanc's training transcript which documented that Mr. LeBlanc was fully trained and aware of his job responsibilities and prohibitions, specifically as it relates to residents.

On 02/14/20, I interviewed Mr. LeBlanc and he denied the allegations. Mr. LeBlanc reported that Resident A is always combative, so he usually always has another staff assist him. Mr. LeBlanc reported that on 02/05/20 while he was preparing to shower Resident A he was yelling and kicking him. Mr. LeBlanc reported that Resident A calmed down a little and he was able to wheel him down to the shower room to be showered. Mr. LeBlanc reported that during the entire ordeal from the time he was in Resident A's bedroom to the shower room and throughout the shower another staff was present with him. Mr. LeBlanc denied ever being alone with Resident A. According to Ms. Bray, their internal investigation determined this statement to be untrue and that Mr. LeBlanc was in fact working alone with Resident A.

On 02/24/20, I interviewed APS worker Ms. Jackson and she reported that she will be substantiating the case. Ms. Jackson reported that her co-worker commenced the investigation at the facility on 02/06/20 @ 11:20 a.m. and observed a slight red mark on Resident A's left shoulder that was consistent with being hit/slapped, she also reported that marks/bruises were observed on both of Resident A's lower arms.

On 02/26/20, I conducted the exit conference with Ms. Joquico and informed her of the findings of the investigation and the rule violation. I informed Ms. Joquico that in my contact with APS the worker documented observing a mark/bruise in the shoulder area where it was alleged that Resident A was slapped. Ms. Joquico reported that she was present when APS came to the facility and when staff lifted Resident A's shirt up so that his shoulder could be observed. Ms. Joquico reported there were no marks, bruises, scratches visible. I advised Ms. Joquico to address this with the assigned APS worker when she makes contact with her. Ms. Joquico reported that she would. Ms. Joquico reported that marks/bruises were observed on both of Resident A's lower arms so that along with the inconsistences in the story provided by Mr. Leblanc and the credibility of Mr. Grantham, Mr. Leblanc was terminated immediately. I informed Ms. Joquico that the report was forthcoming and that it would include a request to a corrective action plan. Ms. Joquico reported an understanding.

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 findings of the investigation, which included interviews of Ms. Joquico, Ms. Bray, Mr. Grantham. Mr. LeBlanc and Ms. Jackson, I am able to corroborate the allegations. Although Mr. LeBlanc denied the allegations, Mr. Grantham's observation of Resident A being slapped coupled with APS observation of the mark to Resident A's shoulder area and consultant observation of the marks to both of Resident A's lower arms, I am able to conclude that Resident A was not treated with dignity and his personal needs including protection and safety were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

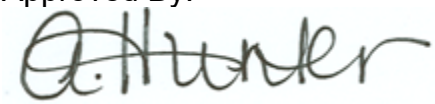
Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

02/26/2020

Pandrea Robinson
Licensing Consultant

Date

Approved By:



03/03/2020

Ardra Hunter
Area Manager

Date