GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 23, 2020

Ryan Goleski
The Haworth Center
30301 W. 13 Mile Road
Farmington Hills, MI 48334

RE: License #: AH630236793
Investigation #: 2020A1019063

Dear Mr. Goleski:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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 authorized representative and a date.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630236793
Investigation #:	2020A1019063
Complaint Receipt Date:	06/15/2020
Investigation Initiation Date:	06/15/2020
Report Due Date:	08/15/2020
Licensee Name:	Detroit Baptist Manor
Licensee Address:	30301 W 13 Mile Rd. Farmington Hills, MI 48334
Licensee Telephone #:	(810) 626-6100
Administrator and Authorized Representative:	Ryan Goleski
Name of Facility:	The Haworth Center
Facility Address:	30225 13 Mile Road Farmington Hills, MI 48334
Facility Telephone #:	(248) 539-3131
Original Issuance Date:	05/09/1999
License Status:	REGULAR
Effective Date:	11/18/2019
Expiration Date:	11/17/2020
Capacity:	59
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was assaulted.	No
Additional Findings	Yes

III. METHODOLOGY

06/15/2020	Special Investigation Intake 2020A1019063
06/15/2020	Comment Complaint was forwarded to LARA from APS, APS denied the referral and did not assign it for investigation.
06/15/2020	Special Investigation Initiated - Telephone Phone interview conducted with complainant
06/18/2020	Inspection Completed On-site
06/18/2020	Inspection Completed-BCAL Sub. Compliance
06/18/2020	Exit Conference

ALLEGATION:

Resident A was assaulted.

INVESTIGATION:

On 6/15/20, the department received a complaint reporting an assault allegation involving Resident A. A telephone interview was conducted with the complainant on 6/15/20. The complainant stated that she was contacted by the resident's daughter, informing her that she saw a bruise on her mom's head on the same day the complaint was filed and that Resident A stated that another resident hit her a few days prior. The complainant stated that the resident's daughter reported that she went up to the facility to take a picture of the bruise on the same date that she reported seeing the bruising (6/15/20), but was unable to locate it. The complainant stated that she contacted the facility and spoke with nurse "Kathy", who reported that she had assessed Resident A and didn't see any bruising or marks to indicate that

she was hit. The complainant stated that Resident A has dementia and is a poor historian. The complainant stated that she isn't alleging the facility did anything wrong but stated that she "Is a mandated reporter and felt someone should know."

On 6/18/20, an onsite inspection was conducted. I interviewed administrator and authorized representative Ryan Goleski at the facility. Mr. Goleski reported that on 6/12/20, Resident A made accusations that a man had punched her in the face three times. Mr. Goleski stated that the resident was immediately evaluated by nurse Christine Robinson, in the presence of two other staff. Mr. Goleski stated that the assessment did not indicate the assault took place, as there were no marks, bruising, swelling, redness, pain, etc. Mr. Goleski stated that video surveillance was reviewed and observed the following:

> 2:56pm – [Resident B] walking in Hallway, turns and looks into [Resident A's] room. Decides to walk into doorway. Can't see [Resident B] once he enters doorway.
>
> 2:59pm – [Resident B] leaves [Resident A's] room and begins to walk down to the end of the hallway. Never returns to her room.
>
> 3:00-3:14pm – [Resident B] wanders around the end of the hallway trying to get out of the end door.
>
> 3:14pm – [Resident B] enters the vestibule at end of hallway and stares out the windows. Never leaves vestibule until staff removes him at 3:23pm.
>
> 3:22pm - Staff is called down by [Resident A] yelling "HELP!!". Resident [Resident B] hadn't been near [Resident A] for 23 minutes at this point.
>
> 3:23pm - Staff walk down to attend to [Resident B] who is stuck in between the double doors.
>
> 3:24pm - Staff interview and audit [Resident A] for injuries. No marks, redness, scratches, or signs of struggle are noted. Staff as stated that [Resident A] seemed calm and normal in terms of behavior.

Mr. Goleski stated that Resident B have severe dementia, has no history of physical aggression and does not believe that any altercation took place. Mr. Goleski stated "If he hit her, why didn't she react right away? She didn't call for help until 20 minutes after he left her room. It just doesn't add up." Mr. Goleski stated that on 6/15/20, Resident A went out to a doctor's appointment and while out, her daughter called the facility reporting that she noticed a bruise on Resident A's head. Mr. Goleski stated that upon her return from the facility. Resident A was assessed again and staff could not locate any bruising. Mr. Goleski stated that he allowed Resident A's daughter to come into the facility to show staff the bruising she reported to have observed, however she could not locate it in person.

On 6/18/20, I interviewed administrator of clinical services Kathy Ogden at the facility. Ms. Ogden's knowledge of the incident was consistent with Mr. Goleski's report. Ms. Ogden reported that she was not present during the incident on 6/12/20 but evaluated Resident A on the morning of 6/15/20 before she went out to her doctor's appointment. Ms. Ogden stated that Resident A told her that a man came into her room and punched her in the face three times. Ms. Ogden stated that Resident A pointed to a few spots on her face as to indicate where she was hit. Ms. Ogden stated that she did not observe any markings, tenderness, bruising or anything unusual on Resident A's face or head. Ms. Ogden stated that while Resident A was out of the facility at her appointment, her daughter contacted the facility reporting that she saw a bruise on the back of her head. Ms. Ogden stated that after Resident A returned to the facility from her doctor's appointment, resident A's daughter came up to the facility wanting to take a picture of the bruise. Ms. Ogden reported that she re-evaluated Resident A in the presence of her daughter and two other staff members and did not locate any bruising. Ms. Ogden stated that there was nothing in the area that Resident A's daughter indicated she saw the bruising.

On 6/18/20, I interviewed house supervisor Latosha Moore at the facility. Ms. Moore was also not present during the incident on 6/12/20 but was working on 6/15/20 when Resident A's daughter came to the facility after reporting she saw bruising on her head. Ms. Moore reported that she and two other staff ("Joy" and "Adjuan") were looked Resident A over in front of her daughter in an attempt locate the bruising and reported that there was nothing there.

On 6/18/20, I interviewed shift supervisor Adjuan Monroe. Ms. Monroe reported that she was present on 6/12/20 and responded to Resident A's calls for help. Ms. Monroe stated that Resident A alleged that a man had hit her in the head. Ms. Monroe stated that at the time Resident A was calling for help, Resident B was observed at the end of the hallway in the vestibule. Ms. Monroe stated that she witnessed Ms. Robinson assess Resident A and that there were no marks on her. Ms. Monroe stated that Resident A "Makes a lot of accusations and says things that aren't accurate because of her dementia." Ms. Monroe stated that she was also present when Resident A's daughter came up to the facility to show staff the bruising on her head. Ms. Monroe stated that she, along with two other staff attempted to locate the site of the bruising but were unable to find anything. Ms. Monroe stated that Resident A's daughter was not able to find the bruising either.

On 6/18/20, I interviewed Resident A at the facility. Resident A stated "A man knocked me in my head three times." Resident A stated she did not know the man who hit her. When asked to point out where she was hit, Resident A lifted her shirt and exposed her left breast. She pointed to her breast as to indicate that was the spot she was hit. I asked her if that was where the man struck her, and she replied "yes". I then asked her to clarify how many times she was hit, and she replied "once".

Due to Resident B's cognitive limitations, he was unable to be interviewed and did not respond to questioning.

A signed statement completed by nurse Christine Robinson read:

> During shift change from days to afternoons, the caregivers were walking down the hallways towards the end of the hall with the door there was a man [Resident B] in between the two doors staring out the window. As the caregivers were approaching down the hallway, they began to hear someone yelling out. When they entered the resident's room [Resident A] she stated that a man was just in her room and "beat her in the head three times." The afternoon caregiver immediately came out and got writer while the day shift caregiver stayed with the resident. upon entering the room, nurse observed resident sitting in her recliner chair calm, no evidence of redness, no bruising, no scrapes, no cuts, no trembling in her voice and no evidence of trauma. Resident wanted to call son [name omitted]. Nurse explained that camera footage was being reviewed to see if the man was near her room.
>
> Upon reviewing camera footage, the man was in her room from 1456-1500. Resident was not yelling out during this time or pushing call pendant. It was not until 1519 when caregivers heard resident yelling as they were rounding and the man had already been seen on camera in between the doors for 18-19 minutes by this time.
>
> Both caregivers were interviewed at the time of incident and both stated they saw the man in between the double doors as they were approaching the resident's room during shift rounds.

Ms. Robinson also completed an "unusual occurrence report" in which she documented that no injuries were located.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff.

	Patients or residents shall be treated in accordance with the policy.
ANALYSIS:	Resident A alleged that a man assaulted her. Attestations from multiple staff who either responded to Resident A's calls for help or were present immediately following the alleged incident do not report having any evidence that an assault took place. Staff examined Resident A for injuries on more than one occasion without any findings and an interview with Resident A reveals inconsistent information pertaining to the allegations. At this time, there is insufficient evidence to determine an assault took place and it cannot be concluded that there was any wrongdoing on behalf of the facility. Based on this information, the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

While onsite, bed rails were observed attached to the bedframes of twenty resident beds. Most of the devices were loose, contained gapping large enough to pose an entrapment risk and did not have proper covers to enclose the gaps. Ms. Ogden reported that the facility has covers for the devices and is unsure why they weren't installed on all of the rails. Ms. Ogden also reported that some of the residents that have the bed rails attached to their beds do not need the devices at all.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference R 325.1906	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety,

	and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	The facility did not ensure the safe use of bedside assistive devices used within the home. Additionally, the facility reported that not all the residents with the devices had a necessity for them and didn't benefit from their use. Therefore, the facility also lacked a regimented program of assessing residents' needs in a safe and timely manner. Based on this information, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/18/20, I shared the findings of this report with authorized representative Ryan Goleski.

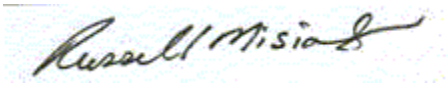
IV. RECOMMENDATION

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

6/23/20

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:



6/23/20

Russell B. Misiak Date
Area Manager