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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 21, 2021

Roger Covill
North-Oakland Residential Services Inc
P. O. Box 216
Oxford, MI 48371

RE: License #: AS630402011
Investigation #: 2021A0988012
Dunwoodie

Dear Mr. Covill:

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,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 860-4475

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
CAUTION: THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS630402011
Investigation #:	2021A0988012
Complaint Receipt Date:	02/24/2021
Investigation Initiation Date:	02/26/2021
Report Due Date:	04/25/2021
Licensee Name:	North-Oakland Residential Services Inc.
Licensee Address:	106 S. Washington Oxford, MI 48371
Licensee Telephone #:	(248) 969-2392
Administrator:	Roger Covill
Licensee Designee:	Roger Covill
Name of Facility:	Dunwoodie
Facility Address:	1781 Dunwoodie Ortonville, MI 48462
Facility Telephone #:	(248) 793-3066
Original Issuance Date:	03/27/2020
License Status:	REGULAR
Effective Date:	09/27/2020
Expiration Date:	09/26/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff member Derrick Harris refused to change the bandage on Resident G's arm. Mr. Harris roughly changed Resident G and left him laying slightly off the bed. Resident G could not adjust himself for fear of falling out of bed.	Yes

III. METHODOLOGY

02/24/2021	Special Investigation Intake 2021A0988012
02/26/2021	Special Investigation Initiated - Telephone Call made to the Office of Recipient Rights.
03/23/2021	Inspection Completed On-site Interviewed the home manager and Resident G.
04/20/2021	Exit Conference Held with the licensee designee Roger Covill by telephone.

ALLEGATION:

Staff member Derrick Harris refused to change the bandage on Resident G's arm. Mr. Harris roughly changed Resident G and left him laying slightly off the bed. Resident G could not adjust himself for fear of falling out of bed.

INVESTIGATION:

On 2/24/2021, a complaint was received and assigned for investigation alleging that staff member Derrick Harris refused to change the bandage on Resident G's arm. Mr. Harris roughly changed Resident G and left him laying slightly off the bed. Resident G could not adjust himself for fear of falling out of bed.

On 3/23/2021, I conducted an unannounced on-site investigation at which time I interviewed the home manager Vanessa Jones and Resident G. Ms. Jones stated on 2/22/2021 she and staff member Derrick Harris were working the third shift between the hours of 11 pm and 7 am (2/23/2021). Another resident got up twice during the night and Mr. Harris assisted him. After the resident got up for the second time, Mr. Harris said he would go ahead and get the other residents up. He went into Resident G's bedroom somewhere between 4 am and 5 am. Ms. Jones said she could hear Resident

G informing Mr. Harris that his bandage came off and needed to be replaced. Mr. Harris said, “I’m not changing it. Whoever the ‘fuck’ changed it needs to change it.” Ms. Jones told Mr. Harris it was his job to change the bandage if it needed changing or replacing. Mr. Harris then called her a ‘bitch’. Ms. Jones said she could hear Resident G crying while Mr. Harris was in his room. She assumed he was being rough with Resident G but did not witness this as she was in another room. Ms. Jones instructed Mr. Harris to go home if he was unable to do his job. Mr. Harris left the home and staff member Shania Robinson was called in to finish his shift. When she went into Resident G’s bedroom, his knee was touching the wall and his head was slightly hanging off the bed. Ms. Jones stated once Mr. Harris left the home, he never returned (ultimately quitting).

On 3/23/2021, I interviewed Resident G at the facility. Resident G stated the bandage on his arm came off during the night (exact date unknown) and he informed Mr. Harris that it needed to be replaced. Mr. Harris said, “I’m not changing your ‘fucking’ bandage. It’s not my job.” He then changed his brief but was very rough while doing so. Ms. Jones told Mr. Harris it was his job and he called her a ‘bitch’. Mr. Harris left the home and Ms. Jones changed his bandage. Resident G said Mr. Harris no longer works in the home.

On 4/20/2021, I conducted an exit conference with the licensee designee, Roger Covill by telephone. Mr. Covill was informed of the investigative findings and recommendation of the investigation. He agreed to submit a corrective action plan upon receipt of the report.

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:	Based on the information obtained from Ms. Jones and Resident G, there is sufficient information to determine that Mr. Harris did not treat Resident G with dignity or attend to his personal needs by disregarding his request to change the bandage on his arm.
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. (f) Subject a resident to any of the following: (ii) Verbal abuse.
ANALYSIS:	Based on the information obtained from Ms. Jones and Resident G, there is sufficient information to determine that Mr. Harris handled Resident G roughly while changing his brief, cursed at him and refused to change the bandage on his arm.
CONCLUSION:	**VIOLATION ESTABLISHED**

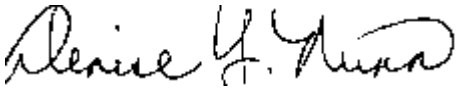
IV. RECOMMENDATION

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

04/20/2021

Cindy Berry — Date
Licensing Consultant

Approved By:



04/21/2021

Denise Y. Nunn — Date
Area Manager