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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 15, 2021

Andrew Akunne
Homestead Residences, Inc.
Suite A
3879 Packard
Ann Arbor, MI 48108

RE: License #: AM820010073
Investigation #: 2021A0116020
Beechwood Living Center

Dear Mr. Akunne:

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 #:	AM820010073
Investigation #:	2021A0116020
Complaint Receipt Date:	05/20/2021
Investigation Initiation Date:	05/21/2021
Report Due Date:	07/19/2021
Licensee Name:	Homestead Residences, Inc.
Licensee Address:	Suite A 3879 Packard Ann Arbor, MI 48108
Licensee Telephone #:	(734) 973-7764
Administrator:	Andrew Akunne
Licensee Designee:	Andrew Akunne
Name of Facility:	Beechwood Living Center
Facility Address:	10470 Beech Daly Road Taylor, MI 48180
Facility Telephone #:	(313) 292-6690
Original Issuance Date:	N/A
License Status:	REGULAR
Effective Date:	03/07/2021
Expiration Date:	03/06/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED AGED

	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 3/10/21, Resident A was brought to the hospital for a bruised right hand. It was found she had a fracture right pinky and ring finger.	Yes

III. METHODOLOGY

05/20/2021	Special Investigation Intake 2021A0116020
05/21/2021	Special Investigation Initiated - Telephone Interviewed assigned adult protective services (APS) worker.
06/02/2021	Inspection Completed On-site Interviewed home manager Sandra Brown, Resident A and Staff (1), Staff (2) and Staff (3).
06/08/2021	Contact - Telephone call made Interviewed staff Edna Elbra.
06/08/2021	Contact - Telephone call made Interviewed staff Cacoyyia Powell.
06/08/2021	Contact - Telephone call made Interviewed Guardian (1).
06/08/2021	Inspection Completed-BCAL Sub. Compliance
06/11/2021	Exit Conference With licensee designee Andrew Akunne.

ALLEGATION:

On 3/10/21, Resident A was brought to the hospital for a bruised right hand. It was found she had a fracture right pinky and ring finger.

INVESTIGATION:

I interviewed assigned APS investigator Eryn Sherman on 05/21/21. Ms. Sherman reported that Resident A is bed bound and suffers from Alzheimer's. Ms. Sherman reported that her right pinky and ring finger was fractured, and the home is unaware of how Resident A sustained the injury. Ms. Sherman reported that there is suspicion from some of the staff in the home that a new staff to the home (Edna Elbra) may have caused the injury, however, they do not have proof of it. Ms. Sherman reported that she attempted to interview Resident A on 05/20/21 but due to her diagnosis and altered mental state she was unsuccessful. Ms. Sherman reported that she is substantiating her complaint for physical abuse and neglect. Ms. Sherman reported that Resident A's fingers are healed, and she is doing well at the present. Ms. Sherman forwarded pictures of Resident A's right hand and I observed her hand covered in purple bruises and swollen.

I conducted an unscheduled onsite inspection at the home on 06/02/21 and interviewed home manager Sandra Brown, Staff (1), (2) (3), and Resident A. Ms. Brown reported that the incident occurred in March of this year and reported that on Monday 03/08/21 when she completed her shift at around 3:00 p.m. Resident A was fine, was in no pain and did not have any bruises to her hands. Ms. Brown reported that Resident A is 91 years old, is bed bound and depends on staff for total care.

Ms. Brown reported that she did not work on Tuesday 03/09/21 and returned to work on Wednesday 03/10/21 and while in Resident A's room checking on her, she observed the bruising and swelling to her right hand. Ms. Brown reported that she completed a visual assessment of Resident A's entire body to see if she had any other bruises to her body, and she did not. Ms. Brown reported she immediately sent Resident A to the hospital for evaluation and treatment. Ms. Brown reported Resident A returned later the same day with both fingers in a cast. Ms. Brown reported she began an internal investigation by interviewing all of the staff that had worked on Monday 03/08/21 and Tuesday 03/09/21 and reviewed documentation logs where staff are supposed to document about each of the residents, especially if they observed anything concerning. Ms. Brown reported she was upset that there was no documentation regarding Resident A's hand and reported that as bruised and swollen as it was there is no way staff did not see it. Ms. Brown reported that nothing like this has happened in the 17 years that she has worked in the home and reported she does not tolerate abuse or mistreatment of the residents. Ms. Brown reported that although she cannot prove what or who harmed Resident A, she reported that Edna Elbra started working in the home in March of 2021 and shortly after Resident A was injured. Ms. Brown reported all of the other staff employed in the home has been there for a while and know how to handle Resident A when she

is being combative. Ms. Brown reported that Ms. Elbra is no longer working in the home.

I interviewed Staff (1) (2) and (3) they asked not to be identified for fear of retaliation.

Staff (1) reported that she worked on 03/08/21 and did not observe any marks or bruises to Resident A during her shift. Staff (1) reported that she provided care to Resident A and reported that if her hand would have been bruised and swollen, she would have immediately sent her out to the hospital. Staff (1) reported that she was off on Tuesday 03/09/21 and returned to work on 03/10/21 and observed Resident A's hand to be severely bruised and swollen. Staff (1) reported Ms. Brown had Resident A sent to the hospital.

Staff (1) reported that in her observation of staff Edna Elbra, she found her to be impatient and aggressive with the residents. Staff (1) reported that she spoke to Ms. Elbra about how she was interacting with the residents, especially Resident A but she did not listen and continued to use a loud tone of voice with them. Staff (1) reported that Resident A can be very combative at times and will hit staff. Staff (1) reported that because all of the other staff have worked with Resident A for a while, they all know what to do to deescalate the behaviors. Staff (1) reported she attempted to share that knowledge with Ms. Elbra to no avail.

I interviewed Staff (2) and she reported that she worked midnight shift (11:00 p.m. - 7:00 a.m.) on 03/08/21 and reported that the residents are normally changed every 2 -3 hours even during the midnight shift. Staff (2) reported that if she sees anything concerning, she would document it and if needed would seek medical treatment. Staff (2) reported that she remembers changing Resident A during the night (03/08/21) and early a.m. hours on 03/09/21 and denied observing any marks or bruises on Resident A. Staff (2) also reported that Resident A did not appear to be in any pain or discomfort.

Staff (2) reported that she had worked a few shifts with Ms. Elbra and reported she had a different way of handling and dealing with the residents. Staff (2) reported that when she observed Ms. Elbra doing things that she thought were aggressive or not right she would correct her and show her the right way. Staff (2) reported that she does not know if this was a cultural thing or if Ms. Elbra is intentional in her aggressive manner. Staff (2) reported that this work is not for everyone and that she is glad that Ms. Elbra will not be working in the home anymore.

I interviewed Staff (3) and she reported working 03/09/21 on the afternoon shift from 3:00 p.m. to 11:00 a.m. but was not responsible for the care of Resident A. Staff (3) reported that staff are each assigned a hallway and are responsible to care for the residents in their respective hallways but will help out with the residents on the other hallway when needed. Staff (3) reported that Ms. Elbra was responsible for Resident A during this shift. Staff (3) reported that she remembers peeking in to speak to Resident A but did not provide any direct care to her and did not come in close

enough contact with her to observe any marks or bruises. Staff (3) denied hearing any noises or altercations between Resident A and Ms. Elbra, but reported the home is large and she was focused on the care of the residents she was directly responsible for. Staff (3) reported that she has observed Ms. Elbra to be verbally and physical aggressive with the residents but reported she did not address it with Ms. Elbra or her supervisor.

I attempted to interview Resident A. Resident A said hello. I asked Resident A if she remembered what happened to her hand and she did not respond. I attempted to ask additional questions, however, Resident A stopped responding. I observed Resident A to be clean and nicely dressed and observed her hand to be healed with no cast and no bruising or swelling was present.

I interviewed Ms. Elbra on 06/08/21 and she reported that she worked the afternoon shift (3:00p.m.-11:00 a.m.). on 03/09/21 and was responsible for the care of Resident A. Ms. Elbra denied that she did anything to harm Resident A and denied observing any marks or bruises on her right hand. Ms. Elbra reported Resident A did not appear to be in any pain and did not verbalize that she was hurting. Ms. Elbra reported she did not observe Resident A's hand until 03/10/21 when she returned to work and saw that her two fingers were in a cast.

Ms. Elbra reported that she does not know why the staff is trying to blame her for Resident A's injury. Ms. Elbra reported that she is 69 years old and has worked in the field for 16 years and has never had any issues. Ms. Elbra denied yelling at the residents and reported that she talks loud and direct and that staff are misconstruing that as her yelling or being aggressive. Ms. Elbra denied being physically aggressive with the residents. Ms. Elbra reported that she is not working in the home at this time.

I interviewed Ms. Powell on 06/08/21 and she reported that she worked the day shift (7:00 a.m. – 3:00 p.m.) on 03/09/21 and remembers assisting her co-worker with changing Resident A. Ms. Powell reported that Resident A was having a good day, was not exhibiting any signs of pain or discomfort and did not have any visible marks or bruises to her hands or body. Ms. Powell reported that Resident A can be very combative and aggressive with staff, however, denied that she is self-harming and reported it is unlikely that she caused the injury to herself. Ms. Powell reported she was surprised when she returned to work on 03/11/21 and observed the swelling and bruising to Resident A hand and saw that her ring and pinky fingers were casted.

Ms. Powell reported that she is not familiar with Ms. Elbra or her interactions with the residents as she has never worked a shift with her.

I interviewed Guardian (1) on 06/08/21 and she reported that she was aware of the incident and was concerned that Resident A sustained an injury that no one was certain how it occurred. Guardian (1) reported that Resident A has been in the home

for about five years, and she has not had any major concerns regarding the care provided. Guardian (1) reported she lives a couple thousand miles away and she does not see Resident A. She reported that she depends on the staff and outside professionals as her eyes and ears as it pertains to the care of Resident A. Guardian (1) reported that prior to this incident, medical staff, hospice nurses (when Resident was on Hospice) had always reported to her that Resident A was being properly cared for and that although she was bed bound, she never had any skin break down or bedsores. Guardian (1) reported that this was reassuring to her as this meant the staff was rotating her as required and taking very good care of her.

Guardian (1) reported that she spoke with the nurse at the hospital, during the time that Resident A sustained the injury and reported that although they could not provide any additional information as to how the injury occurred, they shared with her that Resident A looked good, her skin was in great condition and there were no visible signs on the rest of her body that were consistent with abuse/neglect. Guardian (1) reported that she has decided to allow Resident A to remain in the home.

I conducted the exit conference with Mr. Akunne on 06/11/21 and informed him of the findings of the investigation. Mr. Akunne reported an understanding of the findings but reported that he does not believe any of the staff intentionally harmed Resident A. Mr. Akunne was unable to provide any plausible explanation has to how Resident A sustained two fractured fingers. Mr. Akunne reported that although he believes that Ms. Elbra is a good staff, he has removed her from the home.

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 findings of the investigation, which included interviews of Ms. Sherman, Ms. Brown, Staff (1), (2), (3), visual observation of Resident A, Ms. Elbra, Ms. Powell, and Guardian (1), I am able to corroborate the allegations. Resident A sustained a fractured right ring and right pinky finger. Ms. Brown, Staff (1), (2), (3) Ms. Elbra, and Ms. Powell all denied observing Resident A with any marks or bruises on 03/08/21 and 03/09/21. Ms. Brown reported observing the injury the morning of 03/10/21 and immediately sent Resident A to the hospital. Resident A is 91 years old and does not ambulate and does not self-harm. No one in the home could provide an explanation as to how the injury occurred. Violation established as Resident A's 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

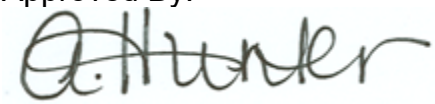
Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

06/14/21

Pandrea Robinson
Licensing Consultant

Date

Approved By:



06/15/21

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Ardra Hunter
Area Manager

Date