STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

June 29, 2021

Samantha Nieuwenbroek
Life Center Inc
Ste. 100
36975 Utica Rd.
Clinton Twp., MI 48038

RE: License #: AS500379039
Investigation #: 2021A0617009
Mile End

Dear Ms. Nieuwenbroek:

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 #:	AS500379039
Investigation #:	2021A0617009
Complaint Receipt Date:	05/03/2021
Investigation Initiation Date:	05/07/2021
Report Due Date:	07/02/2021
Licensee Name:	Life Center Inc
Licensee Address:	Ste. 100 36975 Utica Rd. Clinton Twp., MI 48038
Licensee Telephone #:	(586) 739-9220
Administrator:	Samantha Nieuwenbroek
Licensee Designee:	Samantha Nieuwenbroek
Name of Facility:	Mile End
Facility Address:	50171 Mile End Utica, MI 48317
Facility Telephone #:	(586) 726-9693
Original Issuance Date:	12/12/2016
License Status:	REGULAR
Effective Date:	03/28/2021
Expiration Date:	03/27/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was found to have an injured leg on 5/1/2021 during midnight shift. She has a spiral fracture of unknown cause.	No

II. METHODOLOGY

05/03/2021	Special Investigation Intake 2021A0617009
05/03/2021	APS Referral Adult Protective Services (APS) referral received. Emily Poley is the assigned specialist.
05/07/2021	Special Investigation Initiated – Letter Email sent to Adult Protective Services Specialist Emily Poley.
05/14/2021	Inspection Completed On-site I conducted an onsite investigation at Mile End facility and interviewed Staff Shartisa Crawford and observed Resident A. I reviewed the staff schedule for the months of April and May 2021. I also reviewed Resident A's Health Care Chronological.
05/19/2021	Contact - Document Received Email from Adult Protective Services Specialist Emily Poley
06/16/2021	Contact - Telephone call made I conducted a phone interview with home manager Angel McCoy
06/16/2021	Contact - Telephone call made I conducted a phone interview with staff Ahjanae Wade
06/16/2021	Contact - Telephone call made I conducted a phone interview with staff Nicole Stewart
06/16/2021	Contact - Telephone call made I conducted a phone interview with staff Victoria Bartkowski
06/16/2021	Contact - Telephone call made I reinterviewed Ms. Stewart via telephone
06/16/2021	Contact - Document Sent Email sent to Office of Recipient Rights Specialist Susan Feld.

06/16/2021	Contact - Document Received Email received to Office of Recipient Rights Specialist Susan Feld.
06/17/2021	Contact - Document Received I received and reviewed Resident A's Emergency Medical Form, IRs, Hospital Discharge documents, Individualize Plan of Service, Health Care Appraisal Health Care Chronological and Staff schedule.
06/18/2021	Contact - Telephone call made TC to Melissa from Elara Care Home Nursing
06/18/2021	Contact - Telephone call made I conducted a phone interview with home health care nurse Curtis Ward from Elra Care Home Nursing.
06/18/2021	Exit Conference I held an exit conference with licensee designee Samantha Nieuwenbroek
06/22/2021	Contact – Telephone call made I conducted a phone interview with Dr. Abdellatif from Beaumont Hospital
06/23/2021	Exit Conference I held a second exit conference with licensee designee Samantha Nieuwenbroek

ALLEGATION:

Resident A was found to have an injured leg on 5/1/2021 during midnight shift. She has a spiral fracture of unknown cause.

INVESTIGATION:

On 05/03/21, a complaint was received regarding the Mile End facility. The complaint indicated that Resident A has a developmental non-verbal disorder, cerebral palsy, and a seizure disorder. Resident A is wheelchair bound at baseline. On 05/01/21, midnight staff went to change Resident A around 4:00 AM. Resident A winced when her left leg was touched. The leg was swollen. Resident A was brought to Beaumont Hospital. Resident A is being prepped for surgery. Resident A has a spiral fracture proximal to the left femoral shaft. Also, on 04/28/21, Resident A was discharged from Beaumont Hospital after her peg tube malfunctioned. It is typical for Resident A that every 3-4 months the peg-tube is fixed. There were no noted concerns to Resident A’s leg at

discharge. Resident A has cerebral palsy and does not have any sign of muscle spasticity.

On 05/14/21, I conducted an onsite investigation at Mile End facility. I interviewed Staff Shartisa Crawford and observed Resident A. Resident A was unable to communicate verbally or in any capacity due to her disabilities. I reviewed the staff schedule for the months of April and May 2021. I also reviewed Resident A's Health Care Chronological.

During the onsite investigation, Ms. Crawford stated that she worked from 8 AM to 3 PM on Friday 4/30 and returned to work on 5/1 at 12 AM for the midnight shift. According to Ms. Crawford, when she returned to the facility, Resident A had recently been changed and was not wet. Ms. Crawford stated that Resident A has to be checked on every two hours, even during sleeping hours to see if she is in need of a Depends diaper change. Ms. Crawford checked on Resident A again at 2 AM and she was still dry and did not require a change. Ms. Crawford checked on her again at 4 AM, and Resident A was still dry. Ms. Crawford stated that Resident A is fed through a peg tube four times a day starting at 6 AM. Prior to starting the feeding process, Ms. Crawford began to change Resident A when she noticed her leg was swollen. Ms. Crawford stated that Resident A's leg was swollen around the thigh area and it appeared limp. According to Ms. Crawford, Resident A did not show any signs of pain. Ms. Crawford then called for staff Ahjanae Wade to come and observe Resident A's leg. According to Ms. Crawford, Ms. Wade agreed that Resident A's leg appeared to be broken and called the assistant manager Tracey Dunlap to see what they should do next. While Ms. Wade called Ms. Dunlap, Ms. Crawford felt something was really wrong with Resident A's leg, so she decided to call 911 for help. Ms. Crawford stated that EMS showed up and transported Resident A to Troy Beaumont Hospital. Ms. Crawford followed the ambulance to the hospital to be with Resident A as she is non-verbal. Ms. Crawford stated that the doctors diagnosed Resident A with a fractured upper femur. Ms. Crawford does not know how the injury could have happened. Ms. Crawford worked the day before (4/30/21) and there were no issues with Resident A's leg. According to Ms. Crawford, staff Victoria Bartkowski and Nicole Stewart worked the afternoon shift. Ms. Crawford asked Ms. Bartkowski about Resident A's condition during her shift, but Ms. Bartkowski was unaware of how the injury could have happened.

During the onsite investigation, I observed Resident A laying in her bed. Resident A is non-verbal and was unable to communicate with me in any form. Resident A is not able to ambulate without assistance.

On 05/19/21, I interviewed Adult Protective Services specialist, Emily Poley. According to Ms. Poley, she did not substantiate the allegations against the facility. Ms. Poley stated that the hospital staff informed her that the cause of Resident A's injury was undetermined. According to Ms. Poley, all of the staff at the Mile End facility denied harming Resident A. Resident A has osteoporosis and hospital staff stated that the injury could have been accidental, but they were unable to know exactly what happened based on the injury.

On 06/16/21, I conducted a phone interview with home manager Angel McCoy. According to Ms. McCoy, she worked on 04/30/21 from 8 AM to 4 PM and Resident A did not have any issues or complications. Ms. McCoy stated that when she arrived to work on 4/30, Resident A was already out of bed and in her wheelchair. Resident A spends the majority of the day in her wheelchair so that she doesn't lay in bed all day. When Resident A is not in her wheelchair, she is either in bed, being changed or showered. Ms. McCoy stated that she fed Resident A at 10 AM and changed her at 1 PM but she did not observe or notice any issues with Resident A. Ms. McCoy stated that she did not notice any issues with Resident A when she left work at 4 PM. According to Ms. McCoy, the afternoon shift is responsible for bathing the residents and putting them to bed daily. The facility does not track showers or changing.

On 06/16/21, I conducted a phone interview with staff Ahjanae Wade. Ms. Wade stated that on 05/01/21 at approximately around 6 AM, staff were getting the residents up and ready for the day. According to Ms. Wade, she was in the kitchen when Ms. Crawford came and got her because she believed there was something wrong with Resident A's leg. When Ms. Wade observed Resident A's leg, it appeared to be swollen, bruised and limp. Ms. Wade stated that when staff touched or tried to move Resident A's leg, she would wince in pain. According to Ms. Wade, Ms. Crawford called emergency and they transported her to the hospital. Ms. Wade stated that she did not have any contact with Resident A prior to the incident and she does not know how the injury could have happened.

On 06/16/21, I conducted a phone interview with staff Nicole Stewart. Ms. Stewart stated that Resident A is a two person assist or they have to use the Hoyer lift. According to Ms. Stewart on 04/30/21 around 9 PM, she and staff Victoria used the Hoyer lift to get Resident A out of the wheelchair and into bed. Ms. Stewart did not notice any issues with Resident A while getting her into bed. Ms. Stewart stated that Resident A was changed prior to being put to bed. According to Ms. Stewart, Resident A did not receive a shower that day, as residents are showered every other day.

On 06/16/21, I conducted a phone interview with staff Victoria Bartkowski. Ms. Bartkowski stated that on 04/30/21, she worked the afternoon shift with staff Nicole Stewart. According to Ms. Bartkowski, she fed Resident A around 4 PM. Around 6 PM Ms. Stewart changed and showered Resident A prior to putting her to bed. Ms. Bartkowski stated that she checked on Resident A around 7:30 PM and she appeared to be fine. Ms. Bartkowski passed Resident A's medication at 8 PM and she still appeared to be okay. Ms. Bartkowski likes to check on the residents every 30 minutes to be sure they are okay. At 10 PM, Ms. Bartkowski gave Resident A her last feeding for the day and Resident A did not show any signs of pain or injury. Ms. Bartkowski stated that Ms. Stewart changed Resident A's depends around 10:15 PM. According to Ms. Bartkowski, Resident A is a two person assist or one person with the assistance of a Hoyer lift. Ms. Bartkowski was adamant that Resident A received a shower on 04/30/21 by Ms. Stewart. Ms. Bartkowski stated that Ms. Stewart was the only one to shower, change and put Resident A in bed during that shift.

On 06/16/21, I reinterviewed Ms. Stewart via phone. Ms. Stewart was asked about showering Resident A on 04/30/21. Ms. Stewart stated that she did not shower Resident A on that day, however, after being notified of the conflicting information from her home manager and peers, she changed her story. Ms. Stewart then stated that she in fact did give Resident A a shower on 04/30/21. Ms. Stewart stated that she and Ms. Bartkowski gave Resident A a shower together around 5 or 5:30 PM on 04/30/21. Ms. Stewart was once again made aware of the conflicting information and she again changed her story to she gave Resident A a shower by herself with the use of a Hoyer lift and shower chair. Ms. Stewart remained adamant that Resident A showed no signs or pain or injury.

On 06/18/21, I conducted a phone interview with home health care nurse Curtis Ward from Elra Care Home Nursing. Mr. Ward stated that he had no concerns on the care that Resident A is receiving from the facility and believes that it is one of the best facilities he has seen.

I reviewed the staff schedule for the months of April and May 2021, Resident A's Health Care Chronological, Emergency Medical Form, IRs, Hospital Discharge documents, Individualize Plan of Service, and Health Care Appraisal.

According to the staff schedule on 04/30/21, Angel McCoy worked from 8 am to 4 PM, Victoria Bartkowski worked from 3 PM to 11 PM, Nicole Stewart worked from 4 PM to 12 AM on 05/01/21, Ahjanae Wade worked from 11 PM to 8 AM on 05/01/21. Also, according to the staff schedule Shartisa Crawford worked from 12 AM to 7 AM and 7 AM to 3 PM on 05/01/21.

According to Resident A's Individualized Plan of Service, she has lived at the Mile End Group home since February of 2011. Resident A is diagnosed with profound intellectual disabilities, Paraplegia, epilepsy, and chronic gingivitis. Resident A does not possess the necessary skills to live independently in the community and requires 24-hour daily support and monitoring to ensure her health and safety. Resident A requires assistance with her activities of daily living. She is non-verbal and non-ambulatory and requires full staff support with all of her ADL's. She relies on staff to assist with all of her medical needs as well. Resident A wears Depends and should be changed every two hours. She should be positioned at a 45-degree angle at all times due to aspiration precautions. Resident A is on a feeding tube and receives all of her medications through her feeding tube. According to Resident A's hospital discharge documents from Beaumont Troy Hospital, she was diagnosed with a closed displaced spiral fracture of shaft of left femur with malunion. It also indicates that Resident A had Open Reduction Internal Fixation Left Femur surgery on 05/02/21 at 10:40 AM.

On 06/18/21, I held an exit conference with licensee designee Samantha Nieuwenbroek informing her of the findings of the investigation.

On 06/22/21, I interviewed Dr. Abdellatif, who is Resident A's attending doctor from Beaumont Hospital. Dr. Abdellatif stated that he is unable to determine how Resident A's injury occurred. According to Dr. Abdellatif, Resident A could have sustained the

injury herself while moving around in bed or it could have been caused by staff while caring for her.

On 06/23/21, I held a second exit conference with licensee designee Samantha Nieuwenbroek informing her of the new findings of the investigation.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the information gathered through my interviews and documentation reviews, the Mile End facility failed to protect and properly care for Resident A. According to Resident A's hospital discharge documents from Beaumont Troy hospital, she was diagnosed with a closed displaced spiral fracture of shaft of left femur with malunion. The injury required Resident A to have open reduction internal fixation left femur surgery on 05/02/21. Resident A was not supervised and protected while in care of this licensee.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

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

06/23/21

Eric Johnson — Date
Licensing Consultant

Approved By:

06/28/2021

Denise Y. Nunn — Date
Area Manager