GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 26, 2021

Zad White
Caring Hands AFC, LLC
PO Box 37618
Oak Park, MI 48237

RE: License #: AS820378117
Investigation #: 2021A0119024
Caring Hands - Normandy

Dear Mr. White:

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 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,

Shatonla Daniel, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-3003

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820378117
Investigation #:	2021A0119024
Complaint Receipt Date:	06/02/2021
Investigation Initiation Date:	06/04/2021
Report Due Date:	08/01/2021
Licensee Name:	Caring Hands AFC, LLC
Licensee Address:	24270 Ithaca Oak Park, MI 48237
Licensee Telephone #:	(248) 670-9787
Administrator:	Zad White
Licensee Designee:	Zad White
Name of Facility:	Caring Hands - Normandy
Facility Address:	16596 Normandy Detroit, MI 48221
Facility Telephone #:	(248) 670-9787
Original Issuance Date:	11/03/2015
License Status:	REGULAR
Effective Date:	05/11/2020
Expiration Date:	05/10/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL DEVELOPMENTALLY DISABLED ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Per incident report, Resident B's face was bleeding and left eye was injured due to an altercation with Resident A. Resident A reportedly used a bicycle chain lock in the altercation.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/02/2021	Special Investigation Intake 2021A0119024
06/04/2021	Special Investigation Initiated - Telephone Licensee Designee/ Administrator- Licensee Designee
06/10/2021	Inspection Completed On-site Licensee Designee and Residents B- D
07/15/2021	Contact - Telephone call made Staff- Barbara Green and Donna Dixon
07/20/2021	Contact - Telephone call made Resident B's guardian, Left message
07/22/2021	APS Referral Made
07/23/2021	Exit Conference Zad White, Licensee Designee

ALLEGATION: Per incident report, Resident B's face was bleeding and left eye was injured due to an altercation with Resident A. Resident A reportedly used a bicycle chain lock in the altercation.

INVESTIGATION: On 06/04/2021, I telephoned and interviewed Licensee Designee/ Administrator- Zad White regarding the above allegation. Mr. White stated Resident C sold Resident A a bicycle chain lock, which Resident A used to assault Resident B. He stated Resident B did not want to file charges on Resident A. Mr. White stated one staff called upstairs for Residents A and B to stop fighting. Mr. White stated there were two staffing working at the time of the assault.

On 06/10/2021, I completed an onsite inspection and interviewed Zad White (Administrator) and Residents B, C and D regarding the above allegation. Mr. White

stated Resident A is always verbally aggressive and could be having multi-conversations with himself in a very loud manner. He stated Resident A's behaviors could be mistaken for arguing and staff would not have known initially if he was fighting with another resident. He stated Resident A was discharged from the facility after the assault.

Resident B stated he did not understand why Resident A attacked him. Resident B stated Resident A just started hitting him. Resident B stated he did know exactly what Resident A was hitting him with, but he thought it was a belt or a fist. Resident B stated Resident A got tired and just stopped hitting him. Resident B stated no one came to actually help him and he does not remember anything after Resident A stopped hitting him.

Resident C stated he sold Resident A the bicycle chain lock. He stated Resident A told him that the chain lock was to be going to Resident A's mother's house. Resident C stated he had the chain lock for protection. Resident C stated Resident A was assaulting Resident B in the bathroom. Resident C stated Resident B was laying in the bathtub with a swollen eye and had blood mixed with glass all over the bathroom. Resident C stated when the assault was happening none of the staff came upstairs to help Resident B. Resident C stated Resident A was always attacking other residents.

Resident D stated Resident B was upstairs and Resident A ran upstairs. Resident D stated Resident A attacked Resident B with a large chain. Resident D stated the assault started in the hallway and then they went into the bathroom. Resident D stated the assault was very loud and Resident A was beating against the bathroom walls. Resident D stated Resident A was yelling that he was going to get put out the facility and then ran downstairs. Resident D stated Resident B was covered in blood and ran outside. Resident D stated no one cleaned Resident B and he walked downstairs on his own. Resident D stated "staff Donna" called emergency personnel. Resident D stated no one came upstairs to help Resident B and he walked downstairs on his own. Resident D stated Resident A fights everyone.

On 07/15/2021, I telephoned and interviewed staff Donna Dixon and Barbara Green regarding the above incident. Ms. Dixon stated she could hear Resident A yelling but did not feel it was anything out of the ordinary. Ms. Dixon stated she became alarmed when she heard Resident A yell out "I'm going to kill you." She stated she had no idea that anyone was being physically assaulted. Ms. Dixon stated she was waiting in her car from 6:30pm to 7:00pm because she did not start her shift until 7:00pm. Ms. Dixon stated she came into the house for her shift and heard a noise that sounded like a gunshot. She stated when she went upstairs and Resident A ran outside the house. She stated she also noticed Resident B badly injured. She stated she immediately yelled out Resident B's name and saw blood all over the bathroom. She stated Resident B was laying down in the bathroom tub. She stated she had no idea what type of object Resident A used to assault Resident B. Ms. Dixon stated she called the police and went upstairs. Ms. Dixon stated when she

saw Resident B, she called for emergency medical assistance. Ms. Dixon stated another resident told her that Resident A used a bicycle chain lock. Ms. Dixon stated she did not know Resident A had a bicycle chain lock.

Ms. Green stated she was working at the time of the altercation but did not see the altercation between Resident A and B. She stated Resident A speaks loudly all of the time and she did not think anything was going on upstairs. Ms. Green stated she also assumed Resident B was outside because she did not see him re-enter the facility. Ms. Green stated she heard what sounded like a gunshot. She stated she asked her co-worker to come inside of the facility to see what is going on upstairs. Ms. Green stated her co-worker- Ms. Dixon was outside waiting before her shift was to start. Ms. Green stated Ms. Dixon entered the house and was too scared to go upstairs to investigate the commotion. Ms. Green stated Ms. Dixon contacted the police and they waited until the police arrived to check out the commotion upstairs. She stated they learned that Resident B had been beaten with a bicycle chain lock by Resident A. Ms. Green stated she has no knowledge of where or when Resident A got the bicycle lock chain. Ms. Green stated after the police arrived, then emergency medical personnel came shortly afterwards. Ms. Green was unable to provide the time frame for the arrival of the police.

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:	Ms. Dixon and Ms. Green heard sounds coming from upstairs. Residents B, C and D stated no staff came upstairs to intervene while Resident A was assaulting of Resident B. Residents B, C and D stated Resident A was always attacking and fighting with other residents. In consideration of the above information, it is determined that Resident B was not protected and safe at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: (d) Personal care, supervision, and protection.
ANALYSIS:	Staff Barbara Green was working at the time Resident A was assaulted. Ms. Green acknowledged that she asked another staff (Ms. Dixon) to go upstairs to investigate what was taking place when she heard loud sounds. She failed to provide supervision of all the residents during the assault. Therefore, Ms. Green did not show competency while performing her job duties as a direct care worker.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 07/15/2021, I telephoned and interviewed staff Barbara Green regarding the above incident. Ms. Green stated she did not witness Resident B assault Resident A. Ms. Green stated, “I don’t do the stairs and I used a walker”, after falling in January. She stated she asked her co-worker to come inside the facility to determine what was the commotion happening upstairs.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: (a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident. (b) Be capable of appropriately handling emergency situations.
ANALYSIS:	Staff- Barbara Green reported that she uses a walker and is unable to physically walk up the stairs in the facility. Therefore, she is not suitable to handle emergency situations on the second floor of the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/23/2021, I completed an exit conference with Licensee Designee- Zad White in regard to the above findings. Mr. White stated that he understood the findings

and did not have any questions or have anything to add to the report. Mr. White did inquire about how to properly handle a disabled employee. I informed him that she may be suited for another facility without stairs or possibly having another staff work in conjunction with her to provide support. Mr. White stated he would complete a corrective action plan.

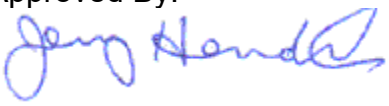
IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend that the license remains the same.

07/26/2021

Shatonla Daniel Date
Licensing Consultant

Approved By:



07/26/2021

Jerry Hendrick Date
Area Manager