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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 21, 2021

Elva Steward
Berrys AFC Homes Inc
3640 McDougall
Detroit, MI 48207

RE: License #: AM820010100
Investigation #: 2021A0992033
Berry Adult Foster Care

Dear Ms. Steward:

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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM820010100
Investigation #:	2021A0992033
Complaint Receipt Date:	09/14/2021
Investigation Initiation Date:	09/14/2021
Report Due Date:	11/13/2021
Licensee Name:	Berry's AFC Homes Inc
Licensee Address:	3640 McDougall Detroit, MI 48207
Licensee Telephone #:	(313) 579-1881
Administrator:	Elva Steward
Licensee Designee:	Elva Steward
Name of Facility:	Berry Adult Foster Care
Facility Address:	3640 McDougall Detroit, MI 48207
Facility Telephone #:	(313) 220-7363
Original Issuance Date:	07/15/1991
License Status:	REGULAR
Effective Date:	09/23/2020
Expiration Date:	09/22/2022
Capacity:	11
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Per incident report, Resident A was upset, and staff attempted to redirect her with cleaning her room. Resident A snatched a bottle of bleach and drank a small amount before staff could get the bottle from her.	Yes

III. METHODOLOGY

09/14/2021	Special Investigation Intake 2021A0992033
09/14/2021	Special Investigation Initiated - Telephone Shatonla Daniels, licensing consultant
09/22/2021	Contact - Telephone call made Elva Carson, licensee designee was not available; message left.
09/22/2021	Contact - Telephone call made Facility, no answer; message left.
09/22/2021	Contact - Telephone call received Ms. Carson
09/22/2021	Contact - Telephone call made Relative A
09/22/2021	Contact - Face to Face Veronica Newell, direct care staff; Angela Cooper, direct care staff; Residents A and B
09/22/2021	Contact - Document Received Resident A's individual plan of service and crisis plan
10/06/2021	APS Referral
10/07/2021	Contact - Telephone call made Lorraine Moore, Resident A’s supports coordinator
10/07/2021	Contact - Telephone call received Cheryl Scott, Resident A’s psychologist

10/07/2021	Exit Conference Ms. Carson
10/15/2021	ORR Referral

ALLEGATION: Per incident report, Resident A was upset, and staff attempted to redirect her with cleaning her room. Resident A snatched a bottle of bleach and drank a small amount before staff could get the bottle from her.

INVESTIGATION: On 09/14/2021, I made contact with Shatonla Daniels, licensing consultant regarding the allegations. Ms. Daniels confirmed an incident report was received regarding the reported allegations. She further explained that although the incident report states Resident A ingested bleach it doesn't explain how she gained access to the bleach when all caustics should be safeguarded.

On 09/22/2021, I received a return call from Elva Carson, licensee designee; I proceeded to interview her regarding the allegations. Prior to addressing the allegations, Ms. Carson provided some history regarding Resident A. She said Resident A was involved in a domestic violence relationship and her family doesn't want her communicating with the man she was involved with in fear of him finding out where she lives and causing trouble. She said apparently Resident A has been communicating with the man on the internet and on the day in question, it was discovered that Resident A told the man where she lives. She said Relative A was upset and she made Resident A aware that she was not pleased with her actions, which triggered her behaviors. Ms. Carson said as it pertains to the incident, she was not present when it occurred. However, she said after reading the incident report and speaking with Angela Cooper, direct care staff it appears Resident A was having behaviors after speaking with Relative A. She said in attempt to redirect her, Ms. Cooper encouraged her to engage in cleaning her room, which is apart of her individual plan of services (IPOS) and crisis plan. She said at some point, Resident A grabbed the bottle of bleach and ingested a small amount before Ms. Cooper was able to take the bottle away. Ms. Carson said there was no intentional act of harm. She said Resident A was transported to the hospital where she was examined and discharged back to the facility and there has not been any further issues. I requested the following documents to further assist with the investigation: Resident A's IPOS and behavior/crisis plan, in which she agreed to provide. Ms. Carson said Resident A doesn't have a guardian at this time, but Relative A is actively involved and supports Resident A. She also mentioned Resident A has 1:1 staffing, which was Ms. Cooper at the time the incident occurred.

On 09/22/2021, I contacted Relative A and discussed the allegations. Relative A explained that she is not Resident A's guardian but is in the process of obtaining guardianship. Relative A said she is very active in Resident A's life, and she assists her in any way she can. Relative A said she is familiar with the allegations, she said

she was contacted by the staff and made aware of the situation. She said from her understanding once the incident occurred, Resident A was immediately transported to the hospital and examined. Relative A said she doesn't believe there was any ill will or neglect on behalf of the staff, she said it seems as though it was an isolated incident. Relative A said Resident A is well taken care of by the staff at the facility.

On 09/22/202, I completed an unannounced onsite inspection and interviewed Residents A and B; Veronica Newell, direct care staff and Angela Cooper, direct care staff, regarding the allegations. Resident A said the bleach was in the bathroom when she grabbed it and started drinking. I asked her if she recalls where the bleach was in the bathroom, and she said it was said sitting out. I asked her if staff was present when this happened, and she said, "No." I asked her where was staff and she was shrugged her shoulders and said, "I don't know." I asked her if anyone saw her drinking the bleach and she said Resident B; she said Resident B told staff. Resident A was very soft spoken and appeared very shy and/or uncomfortable discussing the allegations.

I interviewed Resident B regarding the allegations, in which she initially denied having any knowledge of the allegations. Resident B said, "Well there was some Lysol in our room." She further said Resident A wets the bed and staff must constantly clean her bed. She said sometimes it stinks and they spray Lysol. I asked Resident B if staff uses bleach to clean her bed and she said she's not sure. I asked her if she witnessed Resident A drinking bleach and she said, "No." She said Resident A had something in her hand, but she wasn't sure if it was bleach. I asked her if she told any of the staff Resident A was drinking bleach and she said she couldn't recall.

I interviewed Ms. Newell, she confirmed she was on shift the day the incident occurred but denied witnessing the incident. She said she was on the main floor of the home when she was informed by Resident B what happened; she said Residents A and B were upstairs when the incident occurred. Ms. Newell said Residents A and B are roommates. I asked Ms. Newell if she knew where Resident A was at upstairs, and she said she believes she was in her room. Ms. Newell said from her understanding Resident A got the bleach out of the upstairs bathroom but she's not sure. However, she said she believes Ms. Cooper was Resident A's 1:1 staff at the time.

I interviewed Ms. Cooper, she confirmed she was Resident A's 1:1 staffing on the day in question. Ms. Cooper explained Resident A was having behaviors as a result of a conversation she had with Relative A. She said in attempt to redirect her she suggested they clean her room. Ms. Cooper said she took the Lysol and Odoban spray bottle with her; she said the Odoban bottle has bleach in it. She said she had the spray bottle in one hand, and she was removing the linen from Resident A's bed with the other hand. She said Resident A snatched the spray bottle out her hand and was threatening to hit her with it while she was unscrewing the top. She said once the top was off, she thought she was going to throw it at her because she has a

history of throwing things. However, Ms. Cooper said Resident A took two sips from the bottle. Ms. Cooper said she asked her why she did that and she said “if she can’t talk to him, she don’t want to live.” I reiterated that Resident A requires 1:1 staffing, in which Ms. Cooper confirmed. I asked her if she must be in arm’s length, eyesight etc.; and she said in arm’s length.

On 09/22/2021, I received a copy of Resident A's individual plan of service and crisis plan to determine Resident A’s needs, the specifics of her 1:1 and her behavior plan. Upon review of Resident A’s IPOS 1:1 staffing is not included in her plan. As far as steps used to minimize or prevent crisis, the following is outlined: talking to her family, listening to music and/or going for a walk. Although cleaning her room is one of Resident A’s objectives, it is not included in her crisis plan.

On 10/07/2021, I contacted Lorraine Moore, Resident A’s supports coordinator regarding Resident A receiving 1:1 staffing. Ms. Moore explained that the psychologist included 24-hour supervision in Resident A’s treatment plan which translates to 1:1 staffing. I explained to Ms. Moore that 24-hour supervision is a component of adult foster care, in which most residents require. However, 24-hour supervision doesn’t necessarily mean 1:1 staffing. I told her that I have reviewed some treatment plans that are specific as to the resident must be in eyesight or arm’s reach and Resident A’s IPOS doesn’t include 1:1 at all. Ms. Moore said Resident A does require 1:1 staffing and that was in place prior to her drinking bleach. She said she will contact her psychologist and request her to include 1:1 staffing language. Ms. Moore said although she doesn’t believe the staff deliberately let Resident drink bleach, she was concerned as to how she got ahold of bleach.

On 10/07/2021, I received a call from Cheryl Scott, Resident A’s licensed psychologist. Ms. Scott explained that Resident A is new to Michigan Community Mental Health as she recently relocated to Michigan from Mississippi; Ms. Scott said she is equally new to her caseload. However, she said based on Resident A’s history ingesting bleach was not a past behavior of hers, so there was no mention of preventing her from having access to caustics in her IPOS or treatment plan. I explained to Ms. Scott that although it wasn’t in Resident A’s documents, it is a licensing rules that all caustics should be safeguarded in nonresident areas. I explained to her that my reason for contacting Ms. Moore was because I understand Resident A requires 1:1 staffing but it is not in her IPOS or crisis plan. Ms. Scott explained that there is 1:1 staffing language outlined in her residential planning guide and treatment plan, which Ms. Scott agreed to provide me with a copy. She said after being notified that Resident A ingested bleach, she has revised her treatment plan to include language that she should not have access to caustics or other dangerous materials. She said her treatment plan also includes her participating in the cleaning process when she urinates and/or defecate in her bed.

On 10/07/202, I received a copy of Resident A’s psychological evaluation and her residential assessment both of which outlines 1:1 staffing within arm’s length within the facility and in the community.

On 10/07/2021, I conducted an exit conference with Ms. Carson. I explained that according to Ms. Cooper while providing arm's length 1:1 staffing and assisting Resident A with cleaning her bedroom, Resident A snatched the bleach from her hand, twisted off the top of the bottle while she stood there suspecting Resident A was going to spray her with bleach but instead, she ingested the bleach. I explained that the issue here is Resident A gained access to bleach while Ms. Cooper was within arm's length as her 1:1 staffing. I made her aware that Ms. Cooper failed to provide the supervision necessary to prevent Resident A from ingesting bleach. I further informed Ms. Carson that due to the violation identified, a written corrective action plan is required; in which Ms. Carson agreed to review the report and respond accordingly.

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:	During this investigation, I interviewed Licensee Designee, Elva Carson; Direct Care Staff, Veronica Newell and Angela Cooper; Lorraine Moore, Resident A's Supports Coordinator; Residents A and B regarding the allegations. I also reviewed Resident A's IPOS, psychological evaluation, residential assessment and crisis plan. Resident A gained access to bleach while Ms. Cooper was within arm's length as her 1:1 staffing. Ms. Cooper failed to provide the supervision necessary to prevent Resident A from ingesting bleach. Based on the investigative findings, there is sufficient evidence to support the allegations. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/18/2021

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Denasha Walker Date
Licensing Consultant

Approved By:

10/21/2021

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Ardra Hunter Date
Area Manager