GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 25, 2021

Roland Higgs
Family Living Center Inc.
Suite 101
132 Franklin Blvd
Pontiac, MI 48341

RE: License #: AS630012322
Investigation #: 2021A0605049
Dawn Lane House

Dear Mr. Higgs:

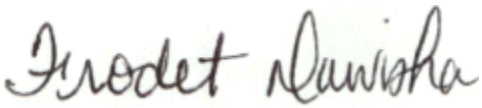
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012322
Investigation #:	2021A0605049
Complaint Receipt Date:	09/08/2021
Investigation Initiation Date:	09/08/2021
Report Due Date:	11/07/2021
Licensee Name:	Family Living Center Inc.
Licensee Address:	Suite 101 132 Franklin Blvd Pontiac, MI 48341
Licensee Telephone #:	(248) 334-5330
Administrator/Licensee Designee:	Roland Higgs
Name of Facility:	Dawn Lane House
Facility Address:	4112 Dawn Lane West Bloomfield, MI 48323
Facility Telephone #:	(248) 626-0276
Original Issuance Date:	01/22/1981
License Status:	REGULAR
Effective Date:	07/11/2021
Expiration Date:	07/10/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 09/0420/21, the home manager (HM) Leanna Peterson was so loud that the physical therapist (PT) from Atlas Home Help refused to return to the home if Ms. Peterson is working. Resident A has physically declined as the exercises she needs to do are not being done. Are these allegations related? If not please separate	Yes

III. METHODOLOGY

09/08/2021	Special Investigation Intake 2021A0605049
09/08/2021	Special Investigation Initiated - Telephone I contacted Office of Recipient Rights (ORR) worker, Dawn Krull regarding the allegations.
09/13/2021	Inspection Completed On-site I conducted an unannounced on-site investigation. I interviewed the assistant home manager Patricia Odigie and observed Resident A only as Resident A was unable to communicate due to her developmental disability.
10/07/2021	Contact - Telephone call made I interviewed the home manager Leanna Peterson and licensing consultant DaShawnda Lindsey regarding the allegations. I left a voice mail message for direct care staff (DCS) Ramia Temple and ORR worker Dawn Krull.
10/07/2021	Contact - Document Sent I emailed the home manager Leanna Peterson requesting staff schedules for 08/2021 and 09/2021.
10/07/2021	Contact - Document Received The home manager Leanne Peterson emailed me the staff schedule, Resident A's 2021 e-score, tornado drills, OT script, appointment information record and discharge papers from Henry Ford West Bloomfield Hospital.
10/14/2021	Exit Conference

	I conducted the exit conference via telephone with licensee designee Roland Higgs with my findings.

ALLEGATION:

On 09/0420/21, the home manager (HM) Leanna Peterson was so loud that the physical therapist (PT) from Atlas Home Help refused to return to the home if Ms. Peterson is working. Resident A has physically declined as the exercises she needs to do are not being done.

INVESTIGATION:

On 09/08/2021, intake #181890 was received from Oakland County Office of Recipient Rights (ORR) regarding Resident A declined physically due to staff at Dawn Lane House not completing Resident A's exercises provided by the physical therapist.

On 09/08/2021, I contacted ORR worker Dawn Krull who stated she will be investigating these allegations.

On 09/13/2021, I conducted an unannounced on-site investigation. I observed Resident A, but due to Resident A's developmental disability, I was unable to complete the interview. Resident A was sitting on the couch rocking back and forth and shouting out random words. I interviewed the assistant home manager Patricia Odigie regarding the allegations. Ms. Odigie stated that the other four residents were at their workshops and that she was the only staff on shift. Ms. Odigie stated that the home manager Leanne Peterson is on vacation and that I needed to call licensee designee, Roland Higgs for Ms. Peterson's contact information.

Ms. Odigie stated on 09/04/2021, the physical therapist (PT) Ehab Abdullah with Atlas Home Help was at the home as Ms. Odigie arrived to begin her shift. The PT was about to leave, but before he left, Ms. Odigie overheard that the next appointment being scheduled for the following week which was this past Saturday 09/11/2021. Ms. Odigie stated that PT never showed up and then Resident A's sister called the home saying, "PT cancelled the appointment." Ms. Odigie stated that the sister never provided them with the reason why PT cancelled. Ms. Odigie stated when she was present on 09/04/2021, she did not hear Ms. Peterson speak loudly or in a loud manner nor did the PT provide any exercises for the home to complete as that was PT's initial assessment of Resident A.

Ms. Odigie stated that Resident A was in the hospital in 03/2021 and after Resident A was discharged, Resident A went to stay with her sister due to COVID-19. Ms. Odigie stated that Resident A remained at her sister's house for a few months and then returned to Dawn Lane House on 06/09/2021. Ms. Odigie stated since Resident A returned here, her health has declined physically. Resident A has difficulty climbing up and down the stairs. Ms. Odigie stated this is an issue since Resident A's bedroom is

upstairs. Ms. Odigie stated it is difficult to get Resident A to go upstairs because Resident A refuses and complains of leg pains and when Resident A does go upstairs, a staff must assist her. However, Resident A does not want to come down the stairs standing, so then Resident A sits on the steps and tries to slide down, which is a safety issue. Ms. Odigie stated sometimes she is on shift by herself with all five Residents. She stated that Resident B continues to require a one-to-one staff and now Resident A is physically declining, she too sometimes requires a one-to-one assist when trying to get her to walk to the bathroom. Ms. Odigie stated she does not have the staff schedule and that I would need to request these documents from Mr. Higgs.

Note: I observed Ms. Odigie having to assist Resident A out of her seated position on the couch and assist her hand-to-hand to the restroom.

On 10/07/2021, I contacted Dawn Lane House and the home manager Leanne Peterson answered the phone. Ms. Peterson was interviewed regarding the allegations. Ms. Peterson stated Resident A had a heart attack in 03/2021. She was hospitalized for 10 days and during Resident A's hospitalization, the staff were refused access to Resident A by the sister. Ms. Peterson stated then Resident A was discharged to Resident A's sister where Resident A stayed at her sister's house until Resident A returned on 06/09/2021. Ms. Peterson stated when Resident A returned to Dawn Lane House, the sister did not provide any paperwork other than the hospital discharge papers. Ms. Peterson stated the discharge papers were vague; therefore, Ms. Peterson was unable to learn any new information regarding Resident A's health. Ms. Peterson stated that the sister did not provide any paperwork or exercises for PT.

After Resident A returned to Dawn Lane House, Ms. Peterson and the staff observed a decline in her physical state. Resident A was refusing to walk to the van or climb the stairs to go to her bedroom, which is located upstairs. Ms. Peterson stated it has been difficult caring for Resident A since her return home. In addition, Ms. Peterson stated that Resident A is refusing to conduct fire and tornado drills, complaining of leg pain. Ms. Peterson stated sometime in 07/2021, she and Mr. Higgs completed their renewal inspection with their assigned licensing consultant, DaShawnda Lindsey. During that time, Ms. Peterson stated she along with Mr. Higgs discussed Resident A with Ms. Lindsey. Ms. Peterson stated she recalls Ms. Lindsey telling Mr. Higgs, "If Resident A is no longer able to climb the stairs and there is no bedroom on the first floor, then Resident A is no longer a good fit and would then need to be issued a 30-day discharge." Ms. Peterson stated as of today, Mr. Higgs has not issued Resident A a 30-day discharge. Ms. Peterson stated currently, Resident A has been sleeping on the couch in the living room because Resident A refuses to climb the stairs and cannot climb the stairs without staff assist. When Resident A climbs the stairs with staff assist, Resident A then refuses to come down the stairs and wants to slide down the stairs.

Ms. Peterson stated a PT order was put in and on 09/04/2021, PT Ehab Abdullah arrived at the home to complete the initial assessment with Resident A. Resident A was refusing to climb the stairs or complete the exercises. PT advised Ms. Peterson that Resident A will require a staff to assist Resident A in climbing the stairs due to Resident

A having difficulty in doing so. Ms. Peterson told PT that there is currently a staff shortage at Dawn Lane House, so it will be difficult in assisting Resident A with the exercise of going up and down the stairs and that “Resident A is no longer a good fit, and this home is now unsafe for her.” Ms. Peterson stated she was not loud nor yell during this visit. She stated that Resident A’s sister was present and that Resident A’s sister was yelling because Ms. Peterson stated that Resident A was no longer a good fit at Dawn Lane. Ms. Peterson stated that PT then scheduled the next PT appointment for 09/11/2021 at Dawn Lane but PT never showed up. Resident A’s sister called saying that PT cancelled the appointment but did not say why.

Ms. Peterson stated she is concerned about Resident A’s safety and that Resident A has been sleeping on the couch because Resident A refuses to climb the stairs. Ms. Peterson stated since Resident A returned home, there has been a rapid decline in her physical health. Resident A becomes “dead weight,” when she refuses to go into the van when they are all in an outing and Ms. Peterson stated she must call a male staff from another home to help get her up and into the van. Ms. Peterson stated this is a safety issue and Resident A is no longer safe at Dawn Lane. Ms. Peterson stated she has been in contact with Resident A’s supports coordinator Alexis Smith with Macomb-Oakland Regional Center (MORC) who has been actively searching for placement even though Resident A was not given a discharge notice. Ms. Peterson stated Resident A will be sent for occupational therapy (OT) which Ms. Smith is currently working on.

On 10/07/2021, Ms. Peterson emailed me the 2021 fire drills, OT script, staff schedule, Resident A’s hospital discharge papers, Resident A’s appointment information records, and fire drills for 2021. I reviewed the fire drills and beginning June 2021 after Resident A returned to Dawn Lane House, the evacuation time increased from about two minutes to five minutes. I reviewed the OT referral, and an OT script was sent to the OT supervisor on 09/29/2021 for approval.

I reviewed the staff schedule from 08/16/2021-10/10/2021; residents are in workshop Mondays and Fridays from 8AM-3PM except from 09/13/2021-10/10/2021 when the residents did not attend workshop. There are three shifts: first shift 7AM-3PM, second shift 3PM-11PM and third shift 11PM-7AM. There was only one DCS during the first and second shift on 08/17/2021, first shift on 08/18/2021, first shift and part of second shift on 08/19/2021-08/20/2021, part of first and second shift on 08/21/2021 and 08/22/2021, first shift on 08/24/2021, 08/25/2021, 08/26/2021, part of first shift and entire second shift on 08/28/2021, part of second shift on 08/29/2021, 08/30/2021, first and second shift on 09/01/2021, part of first and second shift on 09/02/2021, first and second shift on 09/03/2021, second shift on 09/06/2021, part of first and second shift on 09/07/2021, 09/08/2021, 09/09/2021, 09/10/2021, 09/11/2021, 09/13/2021, first shift and second shift on 09/14/2021, 09/15/2021, 09/16/2021, part of first shift on 09/17/2021, first shift on 09/18/2021, 09/20/2021-09/24/2021, second shift on 09/25/2021, part of first shift on 09/27/2021, 09/28/2021, first and second shift on 09/29/2021, 09/30/2021, 10/01/2021, second shift on 10/02/2021, part of first shift on 10/04/2021, first and second shift on 10/07/2021, first shift and part of second shift on 10/08/2021, 10/09/2021 and part of second shift on 10/10/2021.

I reviewed Resident A's appointment information records signed by her physician on 09/04/2021 and 09/22/2021 regarding Resident A's leg pains, weakness and diagnosis of bilateral leg pain resulting in inability to walk. Resident A's discharge papers from Henry Ford Hospital dated 03/26/2021 did not have specific aftercare other than to follow-up with Resident A's physician in one week.

On 10/07/2021, I contacted via telephone licensing consultant DaShawnda Lindsey regarding the on-site renewal inspection she conducted on 07/13/2021. Ms. Lindsey stated licensee designee Roland Higgs and the home manager Leanna Peterson were present. Mr. Higgs and Ms. Peterson expressed concerns regarding Resident A's mobility. Ms. Lindsey stated she informed Mr. Higgs that due to all the bedrooms being located upstairs, if Resident A is unable to climb the stairs or her mobility is impacted in any way, then Resident A would no longer be a good fit for Dawn Lane House. Ms. Lindsey stated she discussed with Mr. Higgs discharging Resident A due to no bedrooms being on the main floor of this home. Ms. Lindsey stated that Mr. Higgs stated he understood.

On 10/07/2021, I contacted DCS Ramia Temple via telephone regarding the allegations. Ms. Temple has worked for this corporation over 10 years. She stated on 09/04/2021, PT Ehab Abdullah arrived, and Resident A's sister was present. Ms. Temple stated that the sister was saying to Ms. Peterson, "Resident A is not getting better because you're not doing the PT exercises." Ms. Temple stated that Ms. Peterson replied, "We're not trained to do PT so we can't take that responsibility." Ms. Temple stated that Ms. Peterson was extremely calm during this visit and that the sister was screaming and slamming her hands on the table because Ms. Peterson was telling the PT and the sister that it is no longer safe for Resident A to live at Dawn Lane House. Ms. Temple stated that concerns regarding Resident A's inability to walk up and down the stairs were discussed and the PT observed Resident A climb two steps and then sat down on the step refusing to get up. Resident A was complaining of leg pain. Then Resident A began sliding down the steps, which the PT discouraged as Resident A will injure her tailbone and/or back. Ms. Temple stated that the upstairs bathroom was being remodeled and the residents were going to stay in a hotel; therefore, the sister agreed for PT to be completed at the sister's home. The PT scheduled the next appointment for 09/11/2021, so Resident A was going to get dropped at her sisters, but PT cancelled the appointment.

Ms. Temple stated since Resident A returned from her sister's home after three months being discharged from the hospital in March 2021, Resident A has physically declined. She stated that Resident A is unable to climb the stairs, so she has been sleeping on the couch in the living room. Ms. Temple stated that Ms. Peterson has discussed concerns regarding Resident A to Mr. Higgs and to MORC's support coordinator Alexis Smith, but nothing is getting done. Resident A remains not a good fit in this home and now also requires a one-to-one when she is ambulating. Ms. Temple stated Dawn Lane House is short staffed and Resident B continues to be a one-to-one. She stated there are some shifts where there is only one DCS to five residents. Ms. Temple stated, "it's

labor-intensive caring for Resident A, especially with only one staff." Ms. Temple stated another safety concern regarding Resident A is that Resident A is refusing to conduct any of the fire drills complaining again of leg pain and inability to stand or walk.

On 10/07/2021, I interviewed MORC support coordinator Alexis Smith via telephone regarding the allegations. Ms. Smith stated Resident A had a heart attach in March 2021 and since then her health has declined. Resident A's sister has been taking Resident A frequently to doctor appointments because of leg pain. The most recent appointment was going to be an MRI of the legs to determine if Resident A has blood clots which is attributing to her inability to climb up and down the stairs. Ms. Smith stated that staff at Dawn Lane House have informed her that Resident A is refusing to climb the stairs because of leg pain. Ms. Smith stated currently Resident A is a one-to-one during mobility only and due to this new information, Ms. Smith has been looking for alternative placement. Although, Mr. Higgs has not discharged Resident A or Resident B from Dawn Lane House. Ms. Smith stated whenever she has been to Dawn Lane House, there have been two DCS there; however, her appointments are always scheduled. Ms. Smith also confirmed that Resident B continues to be a one-to-one DCS too.

On 10/07/2021, I contacted via telephone ORR Dawn Krull updating her on my investigation. I advised Ms. Krull that Resident A has been sleeping on the couch due to Resident A's inability to climb the stairs because of leg pain. Ms. Krull stated she was aware there is insufficient staff at Dawn Lane House but was not aware the Resident A was sleeping on the couch or refusing to conduct fire drills. Ms. Krull stated she will be investigating the allegations regarding Resident A's mobility concerns.

On 10/07/2021, I interviewed PT Ehab Abdullah with Atlas Home Help regarding the allegations. Mr. Abdullah stated he only met Resident A once on 09/04/2021 at Dawn Lane House as that was the initial evaluation. He stated a treatment plan was created; however, Resident A's sister told PT to "wait for Resident A's transfer to the sister's house," before he began PT. Therefore, he cancelled the appointment on 09/11/2021 as Resident A was still residing at Dawn Lane House. The PT stated this transfer was because of Resident A's inability to climb up and down the stairs and there was no bedroom on the main floor, only upstairs of Dawn Lane House. The PT observed Resident A trying to climb the stairs, but then Resident A refused to come down the stairs so Resident A "slid down," which the PT advised that this was "dangerous," for Resident A as Resident A will "be injured." The PT advised Dawn Lane House that due to Resident A's mobility issues, Resident A should sleep on the main floor. He stated that there were no concerns with Ms. Peterson other than Ms. Peterson told the sister that "Resident A needs to be moved because it's now a safety issue for Resident A." The PT told the sister that the issue is not with Dawn Lane House not following the exercises but that Resident A's disability of not understanding what the exercises are and refusing to do them is the issue. The PT told Ms. Peterson that Resident A will require one-to-one assistance during mobility only and Ms. Peterson advised PT that they were short staffed and sometimes this is impossible for staff.

On 10/14/2021, I conducted the exit conference with licensee designee Roland Higgs via telephone with my findings. Mr. Higgs acknowledged that Resident A is no longer a good fit for this home as Resident A's mobility has been impacted and she is now sleeping on the couch. Mr. Higgs stated he has not issued a discharge notice to Resident A, but that MORC is actively searching for a new placement. Mr. Higgs acknowledged he is short staffed and stated he is looking to hire additional people to meet coverage. Mr. Higgs agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on my investigation, there is insufficient DCS on duty at all times for the supervision, personal care, and protection of Resident A and Resident B. Resident A's physical health has declined as of July 2021, due to her inability to ambulate up and down the stairs. As of 09/04/2021, it was recommended by PT that Resident A requires a one-to-one during mobility only; however, according to the home manager, Leanna Peterson, they are short staffed. In addition, Resident B continues to be a one-to-one due to her significant aggressive behaviors. I reviewed the staff schedule from 08/16/2021-10/10/2021 and there are numerous shifts that there is only one DCS on shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: (a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.

ANALYSIS:	Based on my investigation and information gathered, Dawn Lane House does not have the amount of personal care, supervision, and protection that is required for Resident A and Resident B. Resident A currently requires a one-to-one during mobility only and Resident B requires a one-to-one during waking hours and during transport to workshop, but due to Dawn Lane House being understaffed, both Resident A and Resident B should have been discharged. According to MORC's support coordinator, there was no discharge notice provided for Resident A or Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 my investigation and information gathered, Resident A's and Resident B's protection and safety are not attended to at all times due to insufficient DCS at Dawn Lane House. The home manager, Leanna Peterson and DCS Ramia Temple stated it is extremely difficult ensuring the safety and protection of both Resident A and Resident B with only one DCS on shift. They stated that Resident A's physical health has declined and sometimes sits down and becomes "dead weight," making it difficult to move her. In addition, Resident A is refusing to conduct fire drills as she complains of leg pain.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: (d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.

ANALYSIS:	Based on my investigation and information gathered, Resident A did not have any PT instructions after returning to Dawn Lane House from her sister's home in June 2021. The PT completed the initial evaluation on 09/04/2021, and it was determined by Resident A's sister that PT will continue after the sister transfers Resident A back to the sister's home due to Resident A's inability to climb up and down the stairs to get to her bedroom. However, Resident A continues to reside at Dawn Lane House now awaiting an OT assessment.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

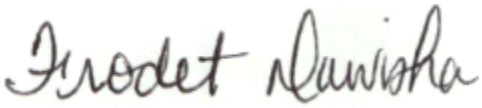
APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(2) A living room, dining room, hallway, or other room that is not ordinarily used for sleeping or a room that contains a required means of egress shall not be used for sleeping purposes by anyone.
ANALYSIS:	Based on my investigation and information gathered, the couch in the living room not ordinarily used for sleeping is being used for sleeping purposes for Resident A. Resident A's mobility has been impacted and she can no longer climb up and down the stairs to get to her bedroom; therefore, DCS have been using the living room couch for sleeping purposes.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(9) A resident who has impaired mobility shall not sleep in or be assigned a bedroom that is located above the street floor of the home.

ANALYSIS:	Based on my investigation and information gathered, Resident A's bedroom is located above the street floor of Dawn Lane House and due to Resident A's impaired mobility, she can no longer access her upstairs bedroom and there are no bedrooms on the main floor of Dawn Lane House. Therefore, Resident A is no longer a good fit for Dawn Lane House.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

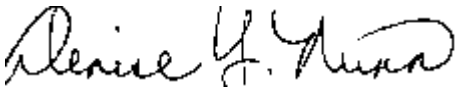
Contingent upon receiving an acceptable corrective action plan, I recommend this investigation be closed and no change to the status of the license.



10/25/2021

Frodet Dawisha Date
Licensing Consultant

Approved By:



10/27/2021

Denise Y. Nunn Date
Area Manager