GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 7, 2021

Joy Mbelu
Blessed Manor LLC
5517 Starflower Dr.
Haslett, MI 48840

RE: License #: AS330272015
Investigation #: 2022A0582005
Blessed Manor LLC

Dear Ms. Mbelu:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9727.

Sincerely,

Derrick Britton, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-9721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330272015
Investigation #:	2022A0582005
Complaint Receipt Date:	10/11/2021
Investigation Initiation Date:	10/13/2021
Report Due Date:	12/10/2021
Licensee Name:	Blessed Manor LLC
Licensee Address:	5517 Starflower Dr. Haslett, MI 48840
Licensee Telephone #:	(517) 402-3952
Administrator:	Joy Mbelu
Licensee Designee:	Joy Mbelu
Name of Facility:	Blessed Manor LLC
Facility Address:	716 Wisconsin Ave. Lansing, MI 48915
Facility Telephone #:	(517) 267-0976
Original Issuance Date:	01/07/2005
License Status:	REGULAR
Effective Date:	02/04/2020
Expiration Date:	02/03/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATIONS

	Violation Established?
Staff did not seek medical attention for Resident A, who was fully ambulatory when admitted, but now she cannot walk, talk, toilet herself, sit herself up, or feed herself.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/11/2021	Special Investigation Intake 2022A0582005
10/12/2021	Contact - Telephone call made With Guardian A1
10/13/2021	Special Investigation Initiated - Telephone With Penny Howard, Adult Protective Services
10/14/2021	Inspection Completed On-site
10/14/2021	Contact - Face to Face With Direct Care Worker Lakisha Washington
10/14/2021	Contact - Face to Face With Resident C
10/27/2021	Contact - Telephone call made With Guardian A1
10/27/2021	Contact - Telephone call made With Mindy Farison, CEICMH Case Manager
11/17/2021	Contact - Document Received Documentation from Sparrow Hospital
11/22/2021	Inspection Completed On-site With DCW Lakisha Washington and Resident B
11/23/2021	Contact - Telephone call made With Resident A
11/23/2021	Contact - Telephone call made

	With Joy Mbelu, Licensee Designee
11/29/2021	Contact - Telephone call made With DCW Lakisha Washington
11/29/2021	Exit Conference With Joy Mbelu, Licensee Designee
11/29/2021	Inspection Completed-BCAL Sub. Non-Compliance

ALLEGATION:

Staff did not seek medical attention for Resident A, who was fully ambulatory when admitted, but now she cannot walk, talk, toilet herself, sit herself up, or feed herself.

INVESTIGATION:

I received this Adult Protective Services referral on 10/11/2021, and contacted Penny Howard, Adult Protective Services on 10/13/2021. Ms. Howard stated Resident A was admitted to the home due to behavioral/developmental issues on 09/22/2021 but was completely functioning physically. Ms. Howard stated that when Resident A was admitted, she began having tremors at the home on the same day. Ms. Howard stated it appeared prior to Resident A's admission, she was possibly admitted with medications that should have been discontinued. Ms. Howard stated Resident A told relatives she wanted to leave the home and wanted to be hospitalized, but relatives told staff to ignore Resident A because the hospital is a "safe place" for her. Ms. Howard stated Resident A grabbed a knife and threatened a staff member while at the home. Ms. Howard stated Resident A had a rapid decline in functioning to the point where she could not walk without her legs buckling. Ms. Howard stated other residents were assisting staff in the home with Resident A. Ms. Howard stated Resident A was admitted to the hospital with blood clots, brain swelling, and put on a feeding tube.

On 10/12/2021, I interviewed Guardian A2, who stated she feels there was negligence in the care of Resident A while Resident A was at the AFC facility. Guardian A2 stated that Resident A was supposed to received proper care "24-7," but she did not. Guardian A2 stated that the staff at the home should have taken the proper steps to get Resident A medical attention when her condition was worsening. Guardian A2 stated that Resident A moved into the home on 09/22/21 and was having some side effects from the medications she was prescribed. Guardian A2 stated that CMH was notified on 09/27/2021, and there was a meeting with the CMH psychiatrist, CMH case manager, Guardian A1, and Direct Care Worker Lakeisha Washington. Guardian A2 stated that the plan according to the case manager was to

adjust Resident A's medications and monitor her for two weeks for improvements. Guardian A2 stated Resident A continued to decline and had numerous falls and other injuries. Guardian A2 stated that at no point did AFC direct care staff members take initiative to send Resident A to the hospital or communicate with Guardian A1 or CMH about Resident A's decline. Guardian A2 stated that at some point before Resident A's most recent hospitalization, Resident A was sent to Sparrow Hospital by Guardian A2, but Sparrow Hospital medical personnel only looked at her injuries, not her baseline abilities. Guardian A2 stated that the hospital was not informed that Resident A was outside of her baseline functioning and needed additional medical attention. Guardian A2 stated that Resident A continued to decline and she later learned that the owner, Joy Mbelu, told staff not to send Resident A back to the hospital because they would just send her back. Guardian A2 stated that at the facility, Direct Care Worker Lakeisha Washington was seeking assistance from other residents to help with Resident A, such as moving her and helping her upstairs. Guardian A2 stated that Resident A had serious injuries on her arm and face that no one was made aware of. Guardian A2 stated that today, Resident A is in a vegetative state with swelling on the brain, spinal injury, and blood clots. Guardian A2 questioned why Resident A's rapid decline was not taken seriously and why staff waited to send her back to the hospital.

On 10/13/2021, I received an email from APS Specialist Ms. Howard, who spoke with Guardian A1, which documented the following:

> "[Resident A] was having behavioral issues at [previous home], throwing and smashing things. She attacked staff and keyed the owner's car. Law Enforcement was called, and she was taken to Sparrow for evaluation. It was determined that she needed inpatient treatment and was transferred to Samaritan Psychiatric Hospital in Detroit. She was there about a week and then taken to Blessed Manor. Blessed Manor was getting extra amounts of payment due to [Resident A's] behavioral issues. She was fully functioning when she arrived except for a few tremors. [Resident A] right away called [Guardian A1] after arriving at Blessed Manor and said, "this place isn't going to work." She didn't like the place and said she was going to walk out. [Guardian A1] got a call about [Resident A] throwing dishes and threaten staff with a butter knife. Days after that there was a group call with Lakisha (Direct Care Worker), [Guardian A1], Mindy (CMH), and psychiatrist. [Resident A] was beginning to fall. Medication list was reviewed, and it was discovered that [Resident A] was being given all the old meds and the new meds as well. Meds were corrected but her functioning continued to decline. She was taken to the ER but sent home as they only checked for a UTI. It should have been explained that this was not [Resident A's] base line functioning. Another week passed by before it was finally reported how bad [Resident A] had gotten. Lakisha was threatening to walk out because she could not care for [Resident A]. Joy (Licensee Designee) was against sending [Resident A] to ER as she believed that she would just be sent home. [Guardian A2] insisted that she be taken to ER. The wound on her elbow from falling had become infected and she was sepsis."

On 10/14/2021, I conducted an unannounced, onsite inspection at the facility. I interviewed Direct Care Worker Lakisha Washington. Ms. Washington stated Resident A moved into the home on 09/22/2021 from a rehabilitation center. Ms. Washington stated Resident A's belongings were moved in 10 days prior to 09/22/2021 by family members. Ms. Washington stated she thought something was not right with Resident A on the first day. Ms. Washington stated she spoke with Guardian A1, who informed her that Resident A was possibly having complications from the new medications she was prescribed. Ms. Washington stated Guardian A1 informed her Resident A would lie and do anything to get attention. Ms. Washington stated on the first day moving in, Resident A was having "tremors" with her hands shaking. Ms. Washington stated Resident A's family was aware of her tremors when she moved in. Ms. Washington stated it was only Resident A's hands that were shaking, and her legs were fine on the first day. Ms. Washington stated on the second day in the home, Resident A was having problems walking and almost falling when moving around. Ms. Washington stated on her second day in the home, Resident A was having behavioral problems, breaking dishes, threatening her with a butter knife, and wanting to go to the hospital. Ms. Washington stated on the third day, Resident A insisted and was sent to the hospital after complaining of pain, nausea, and tremors. Ms. Washington stated Resident A was sent back home because she was being disruptive at the hospital and being impatient. Ms. Washington stated she did not have a hospital *After Visit Summary* or *Incident Report* for this hospital visit. Ms. Washington stated Resident A went to the hospital on 09/24/2021 and was seen for a urinary tract infection. Ms. Washington stated the next time Resident A was sent to the hospital was on 10/08/2021. Ms. Washington stated that in between these two hospital evaluations, Resident A went from shaking/legs buckling to almost falling/falling with her assisting Resident A to the ground. Ms. Washington stated Resident A got to the point where she could not walk without assistance. Ms. Washington stated Resident A developed a bruise on her face and cheek discoloration because she would spend her time laying on the couch with her face on the hard wood part. Ms. Washington stated Resident A had marks on her body from her previous placement. Ms. Washington stated that she spoke with Guardian A1 everyday about Resident A's condition. Ms. Washington stated Guardian A1 suggested to her that she discontinues giving medications to Resident A. Ms. Washington stated she also spoke with the CMH case manager as well about Resident A's declining condition. Ms. Washington stated Resident A's bedroom was upstairs in the home, and at some point, it became difficult to get Resident A upstairs. Ms. Washington stated she had other residents assisting her with transferring Resident A because she could not walk on her own and she was heavy. Ms. Washington stated eventually she made a pad for Resident A on the first floor living room floor for Resident A to sleep on floor through the night, so that Ms. Washington could hear and assist Resident A when needed. Ms. Washington stated that Resident A also slept on the living room chair at night. Ms. Washington stated that Resident A's face would be propped up against the chair all night. Ms. Washington stated that Resident A would moan every night in pain, and she would give Resident A pain pills. Ms. Washington stated that Resident A continued to sleep

in the living room area (chair or pad on the floor) until her hospitalization on 10/07/2021. Ms. Washington stated that she had to assist Resident A with eating, as her hand shaking had become worse. Ms. Washington stated that she participated in a virtual meeting to discuss Resident A's health issues with Dr. Riviera, CMH psychiatrist, CMH case manager, and Guardian A1. Ms. Washington stated that at that time, some of Resident A's medications were discontinued, and she was instructed to observe Resident A for any changes. Ms. Washington stated that a follow up appointment for Resident A was scheduled for 10/12/2021 to see if the medication changes would make a difference in Resident A's condition. Ms. Washington stated Guardian A2 made the decision to send Resident A to the hospital on 10/08/2021. Ms. Washington stated that she had a conversation with Joy Mbelu, Licensee Designee regarding Resident A's health and sending her to the hospital. Ms. Washington stated that Ms. Mbelu told her that the hospital would just send Resident A back after checking her out, and they should wait until the follow up appointment on 10/12/2021. Ms. Washington stated that the follow up appointment date was changed to 10/13/2021.

On 10/27/2021, I interviewed Guardian A1 who stated that she lives in Texas and has not seen Resident A in person as of late. Guardian A1 stated that before Resident A was admitted to the home, she was informed the AFC facility was contracted through CMH to provide specialized services. Guardian A1 stated the AFC facility did not seem to function as a contracted home. Guardian A1 stated that upon admission to the home, Resident A could walk, talk, and could do things on her own. Guardian A1 stated that as Resident A began having difficulties with her health, she did not receive the appropriate attention. Guardian A1 stated she was informed that Resident A was having falls, and the other residents in the home were assisting DCW Lakisha Washington instead of having an additional trained worker assist with Resident A's care. Guardian A1 stated that she was only informed Resident A was having difficulty walking, but her condition was much worse. Guardian A1 stated she spoke with DCW Lakisha Washington, who stated taking care of Resident A was "too much" for her to handle. Guardian A1 stated Resident A was sent to the hospital for a UTI and sent back to the home, without looking at the actual problems that were occurring with her. Guardian A1 stated the next time Resident A was sent to the hospital was because she was having difficulty walking and fell on her face. Guardian A1 stated she had to tell Ms. Washington to send Resident A to the hospital. Guardian A1 stated Joy Mbelu, Licensee Designee, told her that the hospital would send Resident A back from the hospital. Guardian A1 stated she participated in a conference call with Ms. Washington, Mindy Farison-CMH Case Manager, and CMH psychiatrist Dr. Riviera to discuss Resident A's health. Guardian A1 stated Resident A's medications were cut down, and an appointment was scheduled two weeks out to see if any changes occurred in her health. Guardian A1 stated that when Resident A went to the hospital, they did not look at her baseline health. Guardian A1 stated that the second time Resident A went to the hospital, she called and told them that her current health status was not her baseline. Guardian A1 stated that although Resident A had behavioral problems in previous placements, she was a healthy 21-year-old who could do things on her own. Guardian A1 stated

that Resident A is convalescing at the hospital after arriving at the home only two weeks prior.

I reviewed Resident A's *Health Care Appraisal* dated 09/10/2021, which documented that she had developmental delay, dyspepsia, morbid obesity, poor self-care/disheveled, moody, uncooperative with staff at times, frequently refusing exam, and fully ambulatory. I reviewed Resident A's *Assessment Plan for AFC Residents* dated 09/10/2021, which documented that Resident A required no assistance with self-care skills (eating, toileting, bathing, walking, stair climbing) and needing reminders/prompting with grooming, dressing, and personal hygiene.

I reviewed an *After-Visit Summary* from Sparrow Hospital dated 09/23/2021, which documented that Resident A went to the hospital for leg pain and abdominal pain, with diagnoses of pain in both lower extremities and "shaky." The *After-Visit Summary* included information on "tremors" and "pain without a known cause." I reviewed another *After- Visit Summary* dated 09/25/2021, which documented Resident A was seen for "weakness" and "UTI symptoms" with a diagnosis of occasional tremors.

I reviewed an *AFC Incident/Accident Report* date 09/23/2021, which documented the following:

Date: 09/23/2021
Time: 10:15 AM
Explain What Happened: [Resident A] came down to eat breakfast. She was in a bad mood. She stated she wanted to go the hospital. While preparing her breakfast she came in the kitchen telling me to hurry up. While I reached in the fridge for milk, [Resident A] was behind me holding a butter knife and threatening to hurt me.
Action Taken by Staff: I went into my room, closed the door, I called 911 and called my supervisor and [Resident A's] case manager. We talked about her treatment plan and the cops brought [Resident A] to Sparrow.

I reviewed an *AFC Incident/Accident Report* date 09/23/2021, which documented the following:

Date: 10/07/2021
Time: 6:17 PM
Explain What Happened: [Resident A] stated her back and legs were hurting. I called 911/Ambulance. I called my supervisor and also her guardian. I stayed by [Resident A] until the ambulance arrived.
Action Taken by Staff: Made [Resident A] comfortable until the ambulance arrived. The ambulance arrived and asked for [Resident A's] medication records.

On 10/27/2021, I interviewed Mindy Farison, CMH case manager. Ms. Farison stated that Resident A was admitted to the home and "highly functioning" on 09/21/2021 but "decompressed really fast." Ms. Farison stated that she was not receiving a clear picture and information from the home staff on what was going on

happening with Resident A. Ms. Farison stated that on 09/28/2021, she participated in a conference call with Dr. Riviera, Resident A, and Guardian A1 to discuss medication changes. Ms. Farison stated that Resident A was admitted to Blessed Manor with medications from two previous placements. Ms. Farison stated Resident A was over medicated, and Dr. Riviera said “oh my God” when referring to the amount of medications that Resident A was taking. Ms. Farison stated medications were discontinued, and Resident A was supposed to be monitored for any changes.

On 11/17/2021, I received and reviewed Sparrow Emergency Department notes for Resident A, dated 10/07/2021, which documented the following:

> **“HISTORY OF PRESENT ILLNESS:** [Resident A] 20-year-old developmentally delayed female from an adult foster care. She was sent in further evaluation of a red face and elbow. On initial evaluation it appears that she may have a septic elbow/bursitis, so I activated a sepsis alert. Her history and physical exam are limited due to her mental state. She does appear to be very uncomfortable she is moaning and trembling which I believe is Ace pain response. Does answer basic yes and no questions. Upon attempts to palpate or move her left elbow her moans and pain response increases. There is a surrounding erythematous and warm area primarily posterior lateral consistent with infection. Her tachycardia and source and initiated a sepsis alert to speed up her care while complaining and the rest of her workup.
>
> **Elbow Pain**: This is a new problem. The current episode started more than 2 days ago. The problem occurs constantly. The problem has been gradually worsening. Pertinent negatives include no chest pain, no abdominal pain, no headaches, and no shortness of breath. The symptoms are aggravated by bending and twisting. The symptoms are relieved by rest. She has tried nothing for the symptoms.
>
> **Clinical Impression:** Diagnoses that are still under consideration: Sepsis without acute organ dysfunction, due to unspecified organism (HCC) Final diagnoses: Septic bursitis of elbow, left arm cellulitis.
>
> **Subjective:** 20-year old female comes in from her AFC home. She is moaning about her LEFT arm, especially when palpated. When pain seems to go up, she has noticeable tremors. There is redness around the elbow expending down the forearm in patchy pattern as well. She is unable to verbalize any HPI data. She will moan that her "arm hurts" but that is really about it. Nothing else obtained from the patient.
>
> **Nursing Note, 10/08/21:** Call received from [Guardian A2] legal guardian, who expressed concerns of patient’s mental status. [Guardian A2] states that the patient was placed into her AFC in mid-September. At that time pt was ambulatory, able to feed herself, bathe, and toilet herself. She states pt is currently unable to perform these tasks and is total care. [Guardian A2] suspects

that this could be due to psych medications changes and requests these to be looked at. Dr. Li notified of family concerns, consult placed to case management and PTA med list requested from AFC home.

Chart reviewed and pt examined 20 YO F with a PMH of developmental delay, PTSD/depression who presented from AFC for cellulitis of left forearm failed attempted joint aspiration. Recent stay in psych unit with psych med adjustment. Started on vanco and rocephin on admission Physical exam: Altered. Pupils are very dilated, reactive, and symmetric. Tremors with limb rigidity. Confused, not answering questions or open eyes. Grimace with pain stimuli. Left upper am swollen and warm. Pulse present on left radial."

Procedure date: 10/21/2021, Preoperative Diagnosis: Left upper extremity swelling and pain, possible myositis

I reviewed Sparrow Psychiatry Consult for Resident A, dated 10/09/2021, which documented the following:

"History of Present Illness: Patient is a 20-year-old female with PMH of intellectual disability and behavioral problems, who lives in an AFC and was admitted for cellulitis of left arm or possible sepsis on 10/7. Psychiatry is consulted for psychiatric problems. Patient is well known to our service. She has hx of intellectual disability, PTSD, poor impulse control with multiple episodes of intentional overdose on chemicals or attempt. Finally, she was placed in an AFC home this summer. She is moaning and mumbling, with poor eye contacts. She said her left arm hurts. In May, she was seen by psychiatry for suicidal attempt, and was given Abilify Susitna, Lexapro and doxepin on discharge. She said she was recently (~2 months ago) discharged from inpatient psychiatry of Harbor Oaks in Detroit, on lithium, Depakote, Lexapro, Seroquel, Lexapro, and Doxepin. The staff manages her medications. Lithium level was 0.4, no valproic acid level, elevated AST, and ALT (tripled), ammonia. During the interview, she is oriented to place and year, complaining of left arm pain. She said she fell at the facility. She has passive suicidal ideation, not active suicidal thoughts, and plan. Denies visual or auditory hallucinations. Per IM, patient has dilated pupils, rhabdo, rigidity and tremor, tachycardia and AMS, pt may have mild serotonin syndrome from polypharmacy. Her home medications were held."

On 11/22/2021, I conducted an unannounced, onsite inspection at the facility. I interviewed Direct Care Worker Lakisha Washington. Ms. Washington stated that it was about the fourth day of Resident A's stay at the facility that she began having Resident A sleep downstairs in the living room to keep her safe from falling when trying to help Resident A upstairs to her bedroom, and this continued until Resident A was hospitalized on 10/07/2021. Ms. Washington stated that she had to turn Resident A when she as laying down to prevent her from being hurt. Ms. Washington stated that Resident A was heavy, and she had to call the fire department at least three times to help get Resident A out of the bathtub. Ms.

Washington stated that Resident A would slide off the shower chair if she leaned/slumped over. Ms. Washington stated that she had a walker for Resident A to use, but it was difficult for her.

On 11/22/2021, I interviewed Resident B at the facility, who stated that he helped assist Resident A everyday because she could not walk. Resident B stated that when Resident A was seated, he would assist Ms. Washington in getting her out of the chair by grabbing her underneath her arms and guiding her to where she needed to go. Resident B stated that Resident A would fall “all the time,” so they started “bedding her downstairs.” Resident B stated that Resident A was heavy and could not move around on her own. Resident B stated that Resident A tried to use a walker but was not able to use it for a long time.

On 11/23/2021, I interviewed Resident A who was still hospitalized at Sparrow Hospital. Resident A stated that while living at the home, she had to get help walking because she was falling. Resident A stated that she was fine before coming to the home and then got much worse. Resident A stated that she went to the hospital because she was hurt. Resident A stated that she slept in the living room on a chair or on the floor because she could not walk upstairs, and she would have falls. Resident A stated that DCW Lakisha Washington hit her with a broom. Resident A stated that this occurred in the living room of the home. Resident A stated that she did not know the circumstances that caused Ms. Washington to hit her. Resident A stated that no one else was around at the time to see Ms. Washington hit her with a broom.

On 11/23/2021, I interviewed Joy Mbelu, Licensee Designee. Ms. Mbelu stated that before Resident A was admitted to the facility, she had an appointment to meet with her and her family. Ms. Mbelu stated that Resident A went to rehabilitation at the time of the appointment, but she accepted Resident A for admittance to the home after completing admission documents and an assessment with Guardian A2. Ms. Mbelu stated Resident A was young, mobile, and they only had to work with mental health issues at the time of admission. Ms. Mbelu stated that the day Resident A moved in, she was shaking with a lot of tremors throughout her whole body. Ms. Mbelu stated that she first met Resident A on the second day she was in the home. Ms. Mbelu stated she observed Resident A in the living room shaking with tremors in her hands. Ms. Mbelu stated that she was told by the case manager that the tremors were a side effect of new medications that Resident A was prescribed. Ms. Mbelu stated that she and staff administered medications as they were prescribed, and the case manager Mindy Farison told her that she should get better and the tremors would go away. Ms. Mbelu stated Resident A had a behavior issue where she pulled a knife on Ms. Washington and she told Ms. Washington to contact 911. Ms. Mbelu stated that at some point, caring for Resident A became difficult, as her tremors increased. Ms. Mbelu stated Ms. Washington had to assist Resident A with walking, toileting, and feeding her. Ms. Mbelu stated she told Ms. Farison about the situation, but she just said that Resident A would get better. Ms. Mbelu stated she asked Ms. Farison if they could get a home health aide for Resident A because caring for her

was becoming too much but was told that since she had a CMH contracted home, there was nothing she could do. Ms. Mbelu stated there was a scheduled virtual meeting to see if medication changes had made a difference in her functioning. Ms. Mbelu stated she and facility direct care staff members did the best they could in providing care for Resident A; she was being fed, taken to the bathroom, and assisted with care. Ms. Mbelu stated they decided to keep Resident A downstairs so she was accessible, and they could keep track of her, because she could not climb the stairs. Ms. Mbelu stated she did not know that Ms. Washington had Resident A sleeping on the floor in the living room. Ms. Mbelu stated Resident A could walk with support, and she provided her a walker to use. Ms. Mbelu stated Resident B would assist with helping Resident A move around. Ms. Mbelu stated the day before Resident A was hospitalized, she observed redness on her cheek. Ms. Mbelu stated that when Resident A falls asleep, she would slouch to one side on the couch and her face would be pressed against it. Ms. Mbelu stated she put some cushioning for Resident A to rest her face on so that it would be softer. Ms. Mbelu stated she and direct care staff would try to lift Resident A, but more than one person was needed because she was “wobbling and shaking.” Ms. Mbelu stated that on the day of Resident A’s hospitalization, she was at the home. Ms. Mbelu stated that she left the home to run some errands, and Ms. Washington called her to ask if she could send Resident A to the hospital. Ms. Mbelu stated that she asked Ms. Washington if anything happened to Resident A since she left the home, and Ms. Washington said “no.” Ms. Mbelu stated that if they took Resident A to the hospital, she would be sent right back. Ms. Mbelu stated that shortly after receiving a call from Ms. Washington, she received a call from Guardian A1, stating that she needed Resident A to be taken to the hospital immediately, because Resident A could previously walk on her own and function on her own, but now needed help. Ms. Mbelu stated she was not trying to prevent Resident A from going to the hospital. Ms. Mbelu stated she told Guardian A1 that she would call Ms. Washington to have Resident A sent to the hospital. Ms. Mbelu stated that she felt like they were going above and beyond for Resident A. Ms. Mbelu stated that had planned to talk with the case manager Ms. Farison to discuss a discharge.

On 11/29/2021, I interviewed DCW Lakisha Washington. Ms. Washington denied hitting Resident A with a broom. Ms. Washington stated that she recalls sweeping and vacuuming the floor when Resident A was sleeping on the floor, but she did not hit her with the broom.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Resident A's *Health Care Appraisal* and *Assessment Plan for AFC Residents* documented that Resident A was fully ambulatory and did not need assistance with walking/mobility or stair climbing when she was admitted to the facility on 09/22/2021. Based on interviews with Penny Howard, Guardian A2, Guardian A1, DCW Lakisha Washington, Mindy Farison, Resident A, Resident B, and Joy Mbelu, Resident A had a change in her physical condition that required immediate care. Interviews indicated Resident A's physical health decline included that she could not walk without assistance or eat on her own due to tremors and she could no longer climb the stairs to her bedroom. DCW Washington indicated Resident A was having hand tremors on her first day, which progressed to leg tremors. An *After-Care Summary* from Sparrow Hospital documented that Resident A was seen on 09/23/2021 for tremors and 09/25/2021 for weakness and UTI symptoms. Between 09/25/2021 and her hospitalization on 10/07/2021, Resident A continued to have medical issues that required assistance with mobility, toileting, and eating. Resident A was hospitalized on 10/07/2021 after prompting by Guardian A1, as Ms. Mbelu felt that Resident A would only be sent back home after being seen. Sparrow Hospital documentation did not indicate a spinal injury or brain bleed. Resident A was scheduled for surgery on 10/21/2021 for "left upper extremity swelling and pain and possible myositis."
CONCLUSION:	**VIOLATION 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 interviews with DCW Lakisha Washington, Resident A, Resident B, and Joy Mbelu, although Resident A had a bedroom upstairs in the home, the living room was used by Resident A for sleeping due to the change in her physical condition and inability to walk up and down stairs.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	Based on interviews with DCW Lakisha Washington and Resident B, Resident A was given a walker to assist with her mobility, although she did not have a walker prescribed to her by a physician. There was no documentation in Resident A's *Assessment Plan* that she required a walker.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based on interviews with DCW Lakisha Washington, Resident A, and Resident B, Resident A's dignity and privacy were not considered when it was decided by staff that that she would sleep in the living room on the floor.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**
	(1) An administrator and direct care staff shall be persons who are not residents.

ANALYSIS:	Based on interviews with DCW Lakisha Washington, Ms. Mbelu, and Resident B, Resident B was performing the duties of a direct care staff by assisting Resident A with mobility. Resident B admitted to lifting Resident A underneath her arms and guiding her, because she would fall all the time.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 interviews with DCW Lakisha Washington, Ms. Mbelu, and Resident B, there was not enough direct care staff members on duty to provide care to Resident A, who had a change in condition. This resulted in Resident B assisting Ms. Washington with transferring Resident A. Additionally, Ms. Washington admitted to calling the fire department to assist with getting Resident A out of the bathtub on multiple occasions.
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 interviews with Resident A and Ms. Washington, there is not sufficient evidence to confirm that Ms. Washington hit Resident A with a broom. There were no other witnesses to the alleged event by Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/14/2021 at approximately 11 AM, I conducted an unannounced, onsite inspection at the facility. The door was answered by Resident C, who identified himself as a resident. I asked Resident C if he could get the staff person in the home. Resident C stated that she (DCW Lakisha Washington) was asleep, and once I wake her up to let her know that he was hungry. Resident C stated that Ms. Washington was awake for breakfast but went back to sleep afterwards. I asked Resident D if he could get Ms. Washington. Resident D knocked on Ms. Washington's door, and she came out after about five minutes. Ms. Washington was dressed in a nightgown and looked as if she had just awakened. Ms. Washington stated that she was taking a nap.

On 11/29/2021, I interviewed Joy Mbelu, Licensee Designee. Ms. Mbelu stated that Ms. Washington has been working for her for about four years, and she will be looking for someone to replace her.

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:	Based on my observations at the facility on 10/14/2021, live-in staff Lakisha Washington was not available to meet the needs of residents in the home due to being in her room behind closed doors and asleep. Ms. Washington was not capable of handling an emergency during this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/29/2021, I conducted an Exit Conference with Joy Mbelu, Licensee Designee. Ms. Mbelu stated that she was not given the total picture of Resident A when she admitted her. Ms. Mbelu stated that she was under the impression that Resident A's condition would improve, because she was told by Case Manager Mindy Farison and Guardian A1 that the new medications were causing Resident A's issues. Ms. Mbelu stated that she thought that Resident A's condition would improve, and she would be back to walking, so she did not act immediately. Ms. Mbelu stated that prior to Resident A's admittance, she was in rehabilitation. Ms. Mbelu stated that she did Resident A's Assessment Plan with Guardian A2, but Resident A arrived at the facility with tremors.

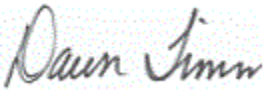
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend modification of the license to provisional.

11/30/2021

Derrick Britton Date
Licensing Consultant

Approved By:



12/02/2021

Dawn Timm Date
Area Manager