GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 14, 2022

Diane Ciric
AHS Community Services Inc
35518 Park St.
Wayne, MI 48184

RE: License #: AS820013621
Investigation #: 2022A0121007
Parkgrove Home

Dear Ms. Ciric:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 01/12/22, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

K. Robinson

K. Robinson, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820013621
Investigation #:	2022A0121007
Complaint Receipt Date:	12/15/2021
Investigation Initiation Date:	12/16/2021
Report Due Date:	02/13/2022
Licensee Name:	AHS Community Services Inc
Licensee Address:	35518 Park St. Wayne, MI 48184
Licensee Telephone #:	(734) 722-4580
Administrator:	Diane Ciric, Designee
Name of Facility:	Parkgrove Home
Facility Address:	34638 Parkgrove Westland, MI 48185
Facility Telephone #:	(734) 525-7731
Original Issuance Date:	06/20/1983
License **Status:**	REGULAR
Effective Date:	04/13/2020
Expiration Date:	04/12/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Per incident report, on 12/11/21, a chair was observed to have restraints on it. Staff said a resident had been tied up as punishment.	Yes

III. METHODOLOGY

12/15/2021	Special Investigation Intake 2022A0121007
12/16/2021	Special Investigation Initiated - On Site Interviewed Home Manager, Arlena Nwugo and Resident A
12/17/2021	Referral - Recipient Rights Online complaint form
01/10/2022	Contact - Telephone call made Phone interview with direct care worker, Monique Johnson
01/10/2022	Contact - Telephone call made Follow up call to Arlena Nwugo
01/10/2022	Exit Conference Diane Ciric, licensee designee
01/12/2022	Corrective action plan received and approved
01/12/2022	Contact - Telephone call received Adult Protective Services investigator, Serlibrity Good-Giles

ALLEGATION: Per incident report, on 12/11/21, a chair was observed to have restraints on it. Staff said a resident had been tied up as punishment.

INVESTIGATION: I conducted an unannounced onsite inspection at the facility on 12/16/21. I interviewed home manager, Arlena Nwugo and observed Resident A who is non-verbal. Mrs. Nwugo reported direct care worker, Erica Allen told her she stopped by the home over the weekend to pick up some paperwork. While at the facility, Erica said she observed one of the dining room chairs with what appeared to be restraints tied to the chair. Mrs. Nwugo said she checked the Staff schedule to

determine who was working when Erica stopped by. Mrs. Nwugo determined direct care workers, Sheila Brewer and Monique Johnson were on duty. Mrs. Nwugo conducted an internal investigation by calling Monique first to ask, “Who was tied up?” According to Mrs. Nwugo, Monique confessed that Sheila tied Resident A to the chair as punishment for his bad behavior. Mrs. Nwugo reported it is in Resident A's treatment plan for Staff to administer medication when he exhibits unacceptable behavior.

I reviewed Resident A’s, Community Living Services, Inc (CLS) personal plan dated 6/8/21. It is not documented in his plan that medication is to be administered as needed. I also reviewed Resident A’s medication records. He is prescribed Ativan “every day for aggression/agitation.” According to Mrs. Nwugo, the Ativan is what they use to calm him.

On 1/10/22, I interviewed Monique by phone. Monique indicated she’s a newer employee; she was hired on 11/22/21 as a direct care worker. Per Monique, she wasn’t fully trained when the incident occurred. Monique acknowledged Sheila used restraints to tie Resident A to a dining room chair. Monique explained Sheila put Resident A in “time-out” because he was trying to pull on Sheila’s arm. Monique described the object used to restrain Resident A as a belt-like, strap. Moniques also reported seeing Sheila restrain Resident A “twice” during the week they worked together.

On 1/10/22, I completed an exit conference with Diane Ciric, licensee designee. Ms. Ciric informed me that both Sheila and Monique were terminated from employment pursuant to this investigation. Ms. Ciric indicated Sheila and Monique minimized the incident. Sheila admitted to restraining Resident A with the “shower chair belt”, but Sheila argued the restraint only lasted 5 minutes. Although Monique didn’t utilize the restraint tactic, she failed to report the incident to Management. Ms. Ciric provided the department with an acceptable plan of correction on 1/12/22.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.**

ANALYSIS:	• Erica Allen came to the home unannounced and saw physical restraints in the home. • Mrs. Nwugo's internal investigation revealed Sheila Brewer was responsible for tying Resident A to the dining room chair as punishment for bad behavior. • Monique Johnson failed to report the abuse. • Sheila acknowledged to Diane Ciric that she had indeed restrained Resident A with a shower chair belt. • Ms. Ciric subsequently fired both Sheila and Monique for negligence of their work duties.
CONCLUSION:	**VIOLATION ESTABLISHED**

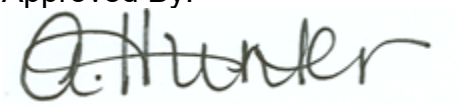
IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend the status of this license remain unchanged.

02/09/22

Kara Robinson Date
Licensing Consultant

Approved By:



02/14/22

Ardra Hunter Date
Area Manager