GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 9, 2022

Sonia McKeown
JARC Suite 100
6735 Telegraph Rd
Bloomfield Hills, MI 48301

RE: License #: AS630246169
Investigation #: 2022A0602010
Grosberg

Dear Ms. McKeown:

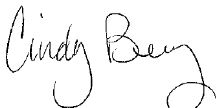
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630246169
Investigation #:	2022A0602010
Complaint Receipt Date:	12/07/2021
Investigation Initiation Date:	12/08/2021
Report Due Date:	02/05/2022
Licensee Name:	JARC
Licensee Address:	Suite 100 - 6735 Telegraph Rd Bloomfield Hills, MI 48301
Licensee Telephone #:	(248) 403-6013
Administrator:	Sonia McKeown
Licensee Designee:	Sonia McKeown
Name of Facility:	Grosberg
Facility Address:	32146 Staman Circle Farmington Hills, MI 48336
Facility Telephone #:	(248) 478-2566
Original Issuance Date:	03/14/2002
License Status:	REGULAR
Effective Date:	12/14/2020
Expiration Date:	12/13/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A alleged he was bitten by staff member Kelechi Onweneme.	No
Additional Findings	Yes

III. METHODOLOGY

12/07/2021	Special Investigation Intake 2022A0602010
12/07/2021	APS Referral Adult Protective Services (APS) referral received.
12/08/2021	Special Investigation Initiated - Telephone Call made to the home.
12/14/2021	Inspection Completed On-site Interviewed the assistant home manager, staff member and Resident A.
12/15/2021	Contact – Telephone call made Call made to APS – message left.
02/09/2022	Contact – Telephone call made Interviewed staff member Kelechi Onweneme.
02/09/2022	Contact – Telephone call made Interviewed staff member Rowena Taylor-Mills.
02/09/2022	Contact – Telephone call made Message left for staff member, Tamika Finley.
02/10/2022	Contact – Telephone call made Message left for staff member, Tamika Finley.
02/10/2022	Contact – Telephone call made Spoke with the home manager, Pam Hoskin. Requested that she have Ms. Finley give me a call.

02/11/2022	Contact – Telephone call received Interviewed staff member, Tamika Finley.
02/11/2022	Exit Conference Held with the licensee designee, Sonia McKeown by telephone.

ALLEGATION:

Resident A alleged he was bitten by staff member Kelechi Onweneme.

INVESTIGATION:

On 12/07/2021, a complaint was received and assigned for investigation alleging that Resident A was bitten by staff member Kelechi Onweneme.

On 12/14/2021, I conducted an unannounced on-site investigation at which time I interviewed the home manager, Pam Hoskin, the assistant home manager, Doris Moore, and Resident A. Ms. Hoskin stated on 12/02/2021 Ms. Moore informed her that when she arrived for her shift (around 8 am), Mr. Onweneme and Resident A were coming out of Resident A's bedroom. Ms. Hoskin stated she was not in the home at the time and Ms. Moore would be able to speak to what she witnessed. She went on to state that she spoke with Resident A after the incident occurred and he said he asked Mr. Onweneme for some milk, he told him no, and this made him mad, so he threw his iPad. Resident A said Mr. Onweneme bit him. Ms. Hoskin said it is documented in Resident A's crisis plan not to use the word no when Resident A asks for anything. This will only agitate him more. Staff should give him choices.

Ms. Moore stated she has worked for the company for 10 years and in the Grosberg Home for the past five years. On 12/02/2021, Ms. Moore was scheduled to work the day shift (8 am-4 pm) with staff member Tamika Finley. Ms. Finley had arrived at the home before Ms. Moore. When Ms. Moore arrived Ms. Finley met her outside in a panic. She said Resident A hit Resident B in the head with his iPad. Ms. Moore entered the home and observed Resident A and Mr. Onweneme coming out of Resident A's bedroom. Mr. Onweneme informed her that Resident A hit Resident B with his iPad. The iPad was not broken but was not in its case. Ms. Moore observed that Resident A had punched holes in the wall near the kitchen and the hallway. She asked Mr. Onweneme what happened, and he said staff member Rowena Taylor-Mills told Resident A he could not have any milk. Mr. Onweneme then said Resident A asked him for milk and he told him to wait. Ms. Moore checked Resident B for any marks or bruises and did not observe any. Resident A was transported to his workshop and his mother was informed of the incident. Resident A's mother picks him up from the workshop every Thursday. She contacted the home on 12/02/2021 after picking Resident A up from his workshop and noticed a reddish colored mark on his back. Resident A told his mother that Mr. Onweneme bit him. When Resident A arrived back to the group home Ms. Moore checked his back and noticed a small red area at the top of his back. The area did not

look like a bite mark, but it appeared as if his skin was irritated or had been pinched. Ms. Moore showed me a picture of Resident A’s back. I observed a red mark between his shoulder blades. There were no teeth marks and it appeared as if Resident A's skin was irritated.

On 12/14/2021, I attempted to interview Resident A and observed Resident B. Resident A was in his bedroom and refused to answer any questions. Ms. Moore stated Resident A does not talk to people he is unfamiliar with. I was unable to interview Resident B due to his cognitive impairment.

On 12/14/2021, I received and reviewed Resident A’s Crisis Prevention and Safeguard Plan. According to the plan, staff should avoid using the word no or any negative responses as it often causes immediate frustration and anger and lead to escalation, or more demands. Resident A should be given choices instead. Staff should never identify Resident A’s negative behaviors. If Resident A is extremely upset, and not calming down, the best strategy is to minimize verbal redirection and interaction as this may further agitate him.

On 2/09/2022, I interviewed staff member Kelechi Onweneme by telephone. Mr. Onweneme stated he has worked for the company for nine years and in the home for the past 9 months. On 12/02/2021 near the end of his shift he was assisting a resident in the bathroom with a shower when Resident A asked him for some milk. Mr. Onweneme told Resident A to wait because he was busy assisting another resident. The other midnight staff, Rowena Taylor-Mills had gone for the day and the day shift staff member Tamika Finley had arrived. Ms. Findley was an untrained new staff member and was unable to assist Mr. Onweneme with Resident A. After Mr. Onweneme finished assisting the other resident, he offered Resident A some milk, but he refused. Resident A began punching holes in the walls. He asked him if he wanted to go outside for a walk and he refused. Resident A went into his bedroom and Mr. Onweneme heard a loud noise. When he entered the bedroom, Resident A was sitting on the floor and his dresser was flipped over with clothing and other items on the floor as well. Mr. Onweneme attempted to assist Resident A up from the floor, but he refused. He told him to leave him alone. Ms. Moore entered the home and said she would take over. Mr. Onweneme stated that Resident A wants what he wants when he wants it and if he does not get it, he will act out. When asked why he didn’t ask Ms. Finley to take over with showering the other resident or to give Resident A the milk if he is aware that Resident A will have a behavior if he does not get what he wants, Mr. Onweneme said Ms. Finley was not trained and was unable to assist him.

On 2/10/2022, spoke with Ms. Hoskin by telephone. I informed Ms. Hoskin that I have left two messages for Ms. Finley and have not received a return call. She agreed to have Ms. Finley return the call tomorrow morning. Ms. Hoskin stated Ms. Finley is a new staff member to the Grosberg Home but she is not a new staff member to the company. She was fully trained at the time the incident occurred except for medication administration.

On 2/11/2022, I interviewed staff member Tamika Finley by telephone. Ms. Finley stated on 12/02/2021 she was scheduled to work the day shift between the hours of 8 am and 4 pm. When she arrived for her shift, (prior to 8 am) she spoke to Ms. Taylor-Mills before she left the home and Resident A said hello to her as he usually does. Mr. Onweneme was not in the bathroom assisting a resident with showering, he was cleaning up the home. The residents had already been showered. There were no issues or concerns at that time. Ms. Finley said she went to use the bathroom. After being in the bathroom a few minutes, she heard a loud noise. Resident A then knocked on the door and asked her if she could fix his iPad because Mr. Onweneme had taken it. She told him that she was using the bathroom and would fix it as soon as she was done. Resident A said okay. A few minutes later she heard more loud noises. Resident A knocked on the bathroom door again and said, "He's not giving me my stuff back." Ms. Finley exited the bathroom and saw a hole in the wall near the bathroom and near the kitchen. She asked Mr. Onweneme what happened, and he said Resident A threw his iPad at Resident B and punched holes in the wall. By this time, Ms. Moore had arrived for her shift and was in the driveway. Mr. Onweneme told Resident A to go to his room and Resident A said, "No I'm not going." Ms. Finley went outside to inform Ms. Moore what was going on. When she came back in the home, she asked Mr. Onweneme again what caused Resident A to have a behavior. This is when he said, "It was all over some milk." Ms. Finley had no knowledge about Mr. Onweneme biting Resident A on his back.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on the information obtained during the investigation, there is insufficient information to determine that Mr. Onweneme bit Resident A on his back. Although there was a red mark on Resident A's upper back between his shoulder blades, it appeared as if his skin was irritated rather than bitten. On 12/14/2021, I attempted to interview Resident A, but he refused to answer any questions.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 2/09/2022, I interviewed staff member Kelechi Onweneme by telephone. Mr. Onweneme stated on 12/02/2021 he worked the midnight shift with staff member Rowena Taylor-Mills. Ms. Taylor-Mills had left for the day as her relief staff, Tamika Taylor had arrived. Mr. Onweneme was in the bathroom assisting a resident with showering when Resident A asked him for some milk. He told Resident A to wait a minute. Resident A became angry, punched holes in the wall and threw his iPad hitting Resident B in the head. Mr. Onweneme stated Resident A wants what he wants when he wants it and will have a behavior if he does not get what he wants. Mr. Onweneme was asked if he knew that about Resident A, why would he tell him to wait rather than request assistance for Ms. Finley. Mr. Onweneme said Ms. Finley is an untrained staff member and was unable to assist him.

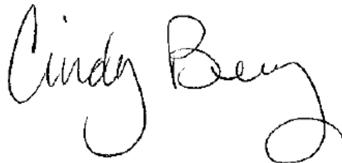
On 2/11/2022, I interviewed staff member Tamika Finley by telephone. Ms. Finley stated she did not witness the actual incident as she was in the bathroom when it occurred. There were no issues or concerns when she initially arrived for her shift just before 8 am on 12/02/2021. Ms. Finley said she went to use the bathroom. After being in the bathroom a few minutes, she heard a loud noise. Resident A then knocked on the door and asked her if she could fix his iPad because Mr. Onweneme had taken it. She told him that she was using the bathroom and would fix it as soon as she was done. Resident A said okay. A few minutes later she heard more loud noises. Resident A knocked on the bathroom door again and said, “He’s not giving me my stuff back.” Ms. Finley exited the bathroom and saw a hole in the wall near the bathroom and near the kitchen. She asked Mr. Onweneme what happened, and he said Resident A threw his iPad at Resident B and punched holes in the wall. By this time, Ms. Moore had arrived for her shift and was in the driveway. Mr. Onweneme told Resident A to go to his room and Resident A said, “No I’m not going.” Ms. Finley went outside to inform Ms. Moore what was going on. When she came back in the home, she asked Mr. Onweneme again what caused Resident A to have a behavior. This is when he said, “It was all over some milk.” Ms. Finley stated she has worked for the company since June 2021 and is trained in everything except for medication administering. She is familiar with Resident A’s plan and aware that if he is not given choices when he asks for something he will act out. If she would have known that he wanted some milk, she would have given it to him.

On 2/11/2022, I conducted an exit conference with the licensee designee Sonia McKeown by telephone. I informed Ms. McKeown of the investigative findings and recommendation documented in this report. She agreed to submit a corrective action plan upon receipt of the report.

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(1) A licensee shall ensure that methods of behavior intervention are positive and relevant to the needs of the resident.
ANALYSIS:	According to Resident A's crisis plan, staff should avoid using the word no or any negative responses as it often causes immediate frustration and anger and leads to escalation, or more demands. Resident A should be given choices instead and staff should never identify Resident A's negative behaviors. Resident A asked Mr. Onweneme for milk and he told him to wait. Based on this information, Mr. Onweneme failed to follow Resident A's crisis plan which caused Resident A to become angry and act out.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

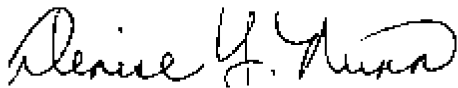
Contingent upon receipt of an acceptable corrective action plan, I recommend that the license remain unchanged.



02/15/2022

Cindy Berry Date
Licensing Consultant

Approved By:



03/09/2022

Denise Y. Nunn Date
Area Manager