GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 28, 2022

Hope Lovell
LoveJoy Special Needs Center Corporation
17141 New Jersey Street
Southfield, MI 48075

RE: License #: AS330297845
Investigation #: 2022A0577038
Michigan Ave. Residential Care

Dear Ms. Lovell:

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 June 2, 2022, 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.

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 (231) 922-5309.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0561

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330297845
Investigation #:	2022A0577038
Complaint Receipt Date:	05/13/2022
Investigation Initiation Date:	05/13/2022
Report Due Date:	07/12/2022
Licensee Name:	LoveJoy Special Needs Center Corporation
Licensee Address:	17141 New Jersey Street Southfield, MI 48075
Licensee Telephone #:	(517) 574-4693
Administrator:	Hope Lovell
Licensee Designee:	Lesley Benson
Name of Facility:	Michigan Ave. Residential Care
Facility Address:	1204 W. Michigan Ave. Lansing, MI 48915
Facility Telephone #:	(517) 367-8172
Original Issuance Date:	12/11/2009
License **Status:**	REGULAR
Effective Date:	02/23/2022
Expiration Date:	02/22/2024
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
• Resident A went to the hospital unsupervised by staff when Resident A is supposed to be supervised while in the community. • Resident A is supposed to be supervised while taking medications and when checking her blood sugars. Resident A was unsupervised and swallowed two lancets.	Yes Yes
Addition Finding:	Yes

III. METHODOLOGY

05/13/2022	Special Investigation Intake 2022A0577038
05/13/2022	Special Investigation Initiated – Letter- Email to and from Complainant.
05/13/2022	APS Referral- Amanda Dixon filed APS.
05/20/2022	Contact - Document Received- Resident A's BTP and POC.
05/24/2022	Inspection Completed On-site- Interviewed staff and review resident files.
05/25/2022	Inspection Completed-BCAL Sub. Compliance
05/25/2022	Exit Conference with licensee designee Lesley Benson.

ALLEGATION:

- **Resident A went to the hospital unsupervised by staff when Resident A is supposed to be supervised while in the community.**
- **Resident A is supposed to be supervised while taking medications and when checking her blood sugars. Resident A was unsupervised and swallowed two lancets.**

INVESTIGATION:

On May 13, 2022, a complaint was received alleging that on May 11, 2022, Resident A walked three miles by herself to Sparrow hospital from the AFC facility and Resident A does not have independent community access per her behavioral treatment plan. It is

being alleged Resident A has had multiple trips to the emergency room unaccompanied by any direct care staff member.

On May 17, 2022, a second complaint was received with additional information to this investigation. The department received an *AFC Licensing Division-Incident/Accident Report* on May 15, 2022, documenting that on May 11, 2022 at 4:00pm Resident A asked for glucose monitor and was given the monitor by direct care staff Camille Owens. Ms. Owens then proceeded to assist another resident leaving Resident A unsupervised with the monitor. The *AFC Licensing Division-Incident/Accident Report* documented Resident A in turn swallowed two lancets. Ms. Owens called the crisis unit, called for an ambulance, and Resident A was taken to the hospital.

On May 13, 2022, I contacted Amanda Dixon, Office of Recipient Rights (ORR) with North Country Community Mental Health (NCCMH), who reported she currently has an open investigation for the same allegations. Ms. Dixon reported Resident A was placed at the facility on April 11, 2022 and since being placed has been to the emergency room on 12 separate occasions. Ms. Dixon reported per Resident A's behavioral treatment plan Resident A is supposed to be supervised while in the community including the emergency room. Ms. Dixon reported Resident A has been to the emergency room multiple times over the past few months unsupervised as direct care staff members cannot bill Resident A's responsible agency for the direct care staff time spent supervising Resident A at the hospital. Ms. Dixon reported she was unsure at this time of the exact dates due to incident reports not being uploaded into their system. Ms. Dixon reported she will provide copies of Resident A's Care Plan, *Plan of Service*, and *Behavioral Treatment Plan*.

On May 20, 2022, I received copies of Resident A's Care Plan, *Plan of Service*, and *Behavioral Treatment Plan* from Amanda Dixon ORR-NCCMH which documented the following information:

- *Plan of Service* completed on December 01, 2021, by NCCMH documented: "[Resident A] has a history of self-harm and needs to be monitored for her safety. [Resident A] has poor boundaries and can be impulsive, supervision for safety at home and in the community. Access Limitations: Within the home-15-minute visual checks for safety, not allow in others bedrooms; Outside of home (porch-yard) 15 minute visual checks for safety; Community-1:1staffing per behavior plan. Locks are required: Sharps; Access Limitations: 1:1 supervision in the community."
- *Care Plan* completed on October 04, 2021, by NCCMH documented: "[Resident A] Behavioral Plan for health and safety monitoring due to [Resident A] saying she has medical conditions with no diagnosis and then want to increase medications if felt they are not working. AFC will dispense medications. [Resident A] often misunderstands what she is being told during medical appointments so staff will need to attend medical appointments."
- *Behavior Assessment Plan and Support Plan* completed on October 05, 2021, by NCCMN documented: "[Resident A] has a long history of psychiatric

hospitalizations related to her anxiety and depression, which leads her to self-harming behaviors. [Resident A] often cuts herself to release tension and anxiety. [Resident A] has gone 33 days without cutting herself, however, she has begun ingesting nonedible items that will cause harm to her bodily system. Staff should always know where [Resident A] is both in the home and community. [Resident A] should always be supervised with eyes on in the community as she has been known to use sharps to cut herself at stores. Due to [Resident A] 's history of self-harm, staff should ensure that all sharps are locked and secured away from her access, as well as items smaller than a bennis ball and harmful chemicals. [Resident A] has been known to hide sharps in her bedroom. Staff will need to provide supervision when [Resident A] needs to use items smaller than a tennis ball, staff will provide direct supervision (visual observation within sic fee of Behavior Assessment Plan and Support Plan to interrupt any attempt to ingest objects. If [Resident A] swallowed an item staff should report this immediately to her clinician, home manager and guardian. Staff should contact Poison Control and follow their direction."

- *Behavior Assessment Plan and Support Plan Modification* completed on January 05, 2022, by NCCMH: "[Resident A] has significant anxiety and exhibits self-harming behavior regularly; [Resident A] uses self-harm as a coping mechanism when upset and has started ingesting small items and possible harmful chemicals, this is occurring on a daily basis. Restrictive/Intrusive: Line of sight supervision in the community and in the home; All sharps are to be locked and away from [Resident A]; all items smaller than a tennis ball to be locked up as well as harmful chemicals. [Resident A] can only use sharps with adult supervision."

On May 24, 2022, I completed an unannounced onsite investigation and interviewed direct care staff with Amanda Dixon, Office of Recipient Rights (ORR) with North Country Community Mental Health (NCCMH) joining by telephone. We interviewed direct care staff member (DCS) Jamila McCoy who reported she has worked at the facility for just over one year and last week was promoted to home manager. Ms. McCoy reported since Resident A moved to the facility in April 2022, Resident A has made many trips to the emergency room. Ms. McCoy reported Resident A will call for an ambulance and be transported to the hospital by ambulance. Ms. McCoy reported direct care staff does not accompany Resident A when going to the emergency room. Ms. McCoy reported if Resident A is being discharged from the emergency room, the emergency room will call the facility and the facility will contact public transportation, Uber, or medi-cab to bring Resident A back to the facility. Ms. McCoy reported there was one occasion where Resident A went to the hospital, was discharged, walked to the pharmacy to fill her prescription, and then walked to another hospital. Ms. McCoy reported direct care staff was not with Resident A during this event. Ms. McCoy reported she was aware of Resident A currently being hospitalized due to swallowing lancets, but Ms. McCoy was not aware of the specifics of the incidents due to not working at the time of the incident.

On May 24, 2022, we interviewed DCS Camille Owens who reported Resident A calls for an ambulance on her own and has been to the hospital many times since being admitted to the facility in April 2022. Ms. Owens reported direct care staff does not go to the hospital with Resident A, due to Resident A being under the supervision of the medical staff on the ambulance and at the hospital. Ms. Owens reported on May 11, 2022, Ms. Owens was working by herself and Resident A asked for her blood sugar levels to be check. Ms. Owens reported she took the glycosometer into Resident A's bedroom, gave Resident A the glycosometer to check levels and then heard a loud noise from another room and left Resident A in her bedroom by herself with the glycosometer. Ms. Owens reported Resident A came to Ms. Owens and reported she swallowed two lancets. Ms. Owens stated, "it is my fault, I know she cannot be left unsupervised while checking her blood sugar level." Ms. Owens reported emergency services were contacted and Resident A was taken to the hospital by ambulance.

On May 24, 2022, I was unable to interview Resident A during my onsite investigation due to Resident currently being hospitalized.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Resident A's *Care Plan and Behavior Assessment Plan and Support Plan Modification* documented Resident A's need for enhanced supervision, including line-of-sight supervision, while in the community and while in the home due to Resident A's self-injurious behaviors and safety. Resident A's plans also document direct care staff should ensure that all sharps are locked and secured away from her access, as well as items smaller than a tennis ball and harmful chemicals. Resident A's *Care Plan and Behavior Assessment Plan and Support Plan Modification* plans also documented direct care staff need to provide visual observation within six feet to interrupt any attempt to ingest objects. It has also been found on May 11, 2022, Resident A was left alone by direct care staff Camille Owens while taking her blood sugar levels and during this time Resident A swallowed two lancets. Lastly, Resident A's plans documented how Resident A often misunderstands what she is being told during medical appointments but direct care staff did not attend any emergency medical visits with Resident A. The investigation also found direct care staff have not been supervising Resident A while in the community, specifically during the times in which Resident A was taken to the hospital by ambulance. It has been determined direct care were not providing supervision and protection according to Resident A's *Care Plan, Behavior Assessment Plan and Support Plan Modification.*
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On May 13, 2022, Amanda Dixon, ORR-NCCMH, reported Resident A has been to the emergency room or hospitalized 12 time since being admitted on April 11, 2022. Ms. Dixon reported per their case management system, Resident A was taken to the emergency room or hospitalized on April 11, 16, 17, 19, 23, 28, 2022 and May 07, 08, 11, and 12, 2022. Ms. Dixon reported NCCMH received *AFC Licensing Division-Incident/Accident Reports* (IRs) for April 11, 14, 17 2022 and May 07, 11, 2022, but did not receive IRs for the other dates.

During my onsite investigation on May 24, 2022, I requested and reviewed IRs for Resident A and found copies of IRs for Resident A's emergency room/hospitalizations for April 11, 2022, and May 07, 2022, only.

On May 24, 2022, DCS Jamila McCoy reported she was aware IRs needed to be completed when a resident is taken to the emergency room. Ms. McCoy reported she has completed two IRs pertaining to Resident A going to the emergency room during her shifts and had submitted them to the home manager at the time. Ms. McCoy reported she is not aware of what happens with the IR's once she submits them or where they are at currently.

On May 24, 2022, DCS Camille Owens reported IRs should be completed when a resident goes to the emergency room. Ms. Owens reported she completed IRs regarding Resident A and her emergency room visits when Ms. Owens was working. Ms. Owens reported she completes the IR, put the IR under the office door for the administrator to sign when they come to work and then the administrator is supposed to distribute the IR to the appropriate parties.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.**
ANALYSIS:	Through the investigation it has been found Resident A has been hospitalized or taken to the emergency room on at least 12 separate occasion and *AFC Licensing Division-Incident/Accident (IR) Reports* were completed on April 11, 2022, and May 07, 2022, but were not submitted on the additional hospitalization dates of April 16, 17, 19, 23, 28, 2022 and May 08, 11, and 12, 2022. It has been determined the facility is not making reasonable attempts to contact Resident A's completing IR's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of a hospitalization.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the current status of the license remains unchanged.

06/28/2022

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

06/28/2022

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Dawn N. Timm Date
Area Manager