GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 10, 2022

Shannon White-Schellenberger
Angels' Place
29299 Franklin Road
Suite 2
Southfield, MI 48034

RE: License #: AS630307091
Investigation #: 2022A0991032
R.C. Mahon Home

Dear Ms. White-Schellenberger:

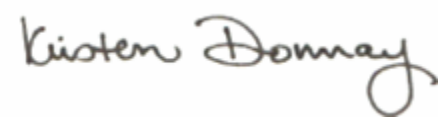
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630307091
Investigation #:	2022A0991032
Complaint Receipt Date:	06/29/2022
Investigation Initiation Date:	06/29/2022
Report Due Date:	08/28/2022
Licensee Name:	Angels' Place
Licensee Address:	29299 Franklin Road Suite 2 Southfield, MI 48034
Licensee Telephone #:	(248) 350-2203
Licensee Designee:	Shannon White-Schellenberger
Name of Facility:	R.C. Mahon Home
Facility Address:	4765 Tullamore Bloomfield Hills, MI 48304
Facility Telephone #:	(248) 594-0264
Original Issuance Date:	08/18/2010
License Status:	REGULAR
Effective Date:	02/09/2021
Expiration Date:	02/08/2023
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 06/24/22, Resident J broke his right hip, which required surgery. Staff were unaware of how this injury occurred.	Yes

III. METHODOLOGY

06/29/2022	Special Investigation Intake 2022A0991032
06/29/2022	Special Investigation Initiated - Telephone Call to Office of Recipient Rights (ORR) worker
06/29/2022	APS Referral Denied for investigation by Adult Protective Services (APS)
06/29/2022	Referral - Recipient Rights Received from recipient rights
06/30/2022	Contact - Telephone call received From ORR worker, Aaron Winston
07/05/2022	Inspection Completed On-site Unannounced onsite inspection- interviewed program manager
07/05/2022	Contact - Document Received Resident J's plan of service/crisis plan
07/06/2022	Contact - Telephone call made Interviewed direct care worker, Eboni Knott
07/06/2022	Contact - Telephone call made Interviewed direct care worker, Darryl Crosby
08/01/2022	Contact - Telephone call made To ORR worker, Aaron Winston
08/01/2022	Contact - Document Received Hospital discharge paperwork
08/03/2022	Exit Conference Via telephone with licensee designee, Shannon White-Schellenberger

ALLEGATION:

On 06/24/22, Resident J broke his right hip, which required surgery. Staff were unaware of how this injury occurred.

INVESTIGATION:

On 06/29/22, I received a complaint alleging that sometime between the evening of 06/23/22 and the morning of 06/24/22, Resident J broke his hip. It is unknown how Resident J sustained this injury. When staff discovered that Resident J was not walking very well, he was taken to urgent care and then to the emergency room at Beaumont Hospital Royal Oak. Resident J had surgery on his hip on 6/27/22. There is concern that staff have no knowledge as to how Resident J sustained such an injury, despite receiving 24-hour care and supervision. I initiated my investigation on 06/29/22, by contacting the assigned Office of Recipient Rights (ORR) worker, Aaron Winston. The complaint was referred to Adult Protective Services (APS), but it was denied for investigation.

On 06/30/22, I interviewed the assigned ORR worker, Aaron Winston. Mr. Winston stated that he spoke with the home manager who informed him that there were two staff working during the timeframe when the injury likely occurred, Eboni Knott and Darryl Crosby. The home manager stated that Resident J might have fallen, but staff did not witness a fall or find him on the floor. Mr. Crosby was working the midnight shift. Mr. Crosby told the home manager that when he did a bed check, Resident J was lying on the edge of the bed, facing the door of the room. He usually faces the wall when he sleeps.

On 07/05/22, I conducted an unannounced onsite investigation at R.C. Mahon Home. I interviewed the program manager, Marcia Stewart. Ms. Stewart stated that she worked on Thursday, 06/23/22, from 7:00am-6:30pm. Nothing out of the ordinary happened during her shift and Resident J was acting normal. Direct care worker, Eboni Knott, worked from 3:00pm-11:00pm. Ms. Knott was the only staff person on shift from 6:30pm-11:00pm. Ms. Knott did not report any concerns and stated that she did not witness Resident J fall. Direct care worker, Darryl Crosby, worked the midnight shift from 11:00pm-7:00am. Mr. Crosby told Ms. Stewart that he completed a walk through when he started his shift and checked on all the residents. Mr. Crosby noticed that Resident J was lying near the edge of his bed, so he moved him back further into his bed. Mr. Crosby told Ms. Stewart that Resident J did not fall during his shift. He did not see or hear anything that would indicate Resident J fell. When Resident J woke up on 06/24/22, staff noticed that he was favoring his left leg and was having difficulty bearing weight on his right leg.

Ms. Stewart stated that Resident J has arthritis, so they initially attributed it to his arthritis. The assistant manager, Naquille Wales, checked over Resident J and found that he had some abrasions on his right elbow. Ms. Wales and Ms. Knott transported

Resident J to urgent care, where they were instructed to take him to the emergency room. Resident J was transported to Beaumont Hospital. It was determined that Resident J had a fracture in his right hip, which required surgery. The hospital stated that the injury was due to a fall. Ms. Stewart stated that Resident J could not tell staff what happened. He did not say anything about a fall. Ms. Stewart did not have any concerns about staff being physically aggressive towards Resident J. She stated that all of the staff love the residents and spoil them. She did not have any concerns about staff sleeping on shift. She has done pop-in visits at the home and never observed staff sleeping. Mr. Crosby told Ms. Stewart that he did bed checks every hour. He stated that he was in one of the empty back bedrooms ironing clothes for most of his shift. Ms. Stewart stated that Resident J has his own bedroom, which has an attached bathroom. He will get up from time to time to use the bathroom. He can walk to the bathroom on his own. Resident J sometimes shuffles when he walks, which is usually an indication that his arthritis is flaring up. Resident J has a high pain tolerance. He will not verbalize that he is in pain. Ms. Stewart stated that the other residents sleep through the night and did not witness anything. Ms. Stewart expressed frustration that Resident J had a broken hip and staff did not have any idea how it happened.

On 07/06/22, I interviewed direct care worker, Eboni Knott. Ms. Knott stated that she has worked in the home since October 2021. Ms. Knott stated that she worked from 3:00pm-11:00pm on 06/23/22. When Ms. Knott came on shift, she began preparing for dinner and was assisting another resident in the shower. A short while later, she noticed that Resident J had his pants down. He had some feces on his underwear. Resident J does not like being messy, so Ms. Knott took him to the bathroom and helped him clean up. Resident J did art therapy and then ate dinner around 5:30pm. Ms. Knott asked Resident J to put up his dishes, but he refused and walked back to his bedroom. Ms. Knott checked on Resident J around 6:40pm and gave him his medications at 7:00pm. At that time, Resident J was in bed, so she walked him to his chair, as Resident J has to sit up after taking his medications.

Ms. Knott stated that she assisted Resident J to bed 30-40 minutes later, after she finished passing medications to the other residents. Ms. Knott checked on Resident J at 8:45pm and he was sleeping. She did bed checks every 45-60 minutes after that, around 9:45pm and 11:00pm. Resident J was sleeping in bed during all of her checks. There was nothing unusual about how he was sleeping. Ms. Knott did not hear Resident J get out of bed or fall. She did not believe that Resident J fell during her shift. Ms. Knott stated that Resident J has arthritis in his right leg. He was shuffling a little bit while walking during her shift, but this was not out of the ordinary. Resident J did not appear to be in any pain. Ms. Knott stated that she was working the next day when the assistant manager noticed a mark on Resident J's elbow, and Resident J was having difficulty standing on his right side. They took Resident J to urgent care and then transported him to the emergency room. At the hospital, it was discovered that Resident J had a broken hip. Ms. Knott stated that they assumed Resident J was having difficulty standing due to his arthritis. She was surprised that he had a broken hip, as Resident J did not seem to be in any pain. Ms. Knott stated that she did not have any concerns about anyone being physically aggressive towards Resident J.

On 07/06/22, I interviewed direct care worker, Darryl Crosby, via telephone. Mr. Crosby stated that he has worked in the home since August 2021. He was working the midnight shift on 06/23/22 from 11:00pm-7:00am. When Mr. Crosby arrived on shift, he discussed the happenings of the day with the staff person he was relieving, Eboni Knott. Ms. Knott did not report that anything unusual happened during her shift. Mr. Crosby stated that he always checks on the residents when he first comes in for his shift. Resident J was in bed sleeping when Mr. Crosby checked on him on 06/23/22. Mr. Crosby stated that he checked on Resident J every hour throughout the night. They do not use a bed check sheet or chart, but it is documented in the community living supports (CLS) log. When Mr. Crosby first checked on Resident J, he was close to the edge of the bed and facing the door. Mr. Crosby moved him back further in the bed. Resident J was sleeping in the same position the entire night. He did not get up at any point during the night. Mr. Crosby did not hear Resident J get up or fall at any point during the night. He never found him out of bed or on the floor.

Mr. Crosby stated that he was cleaning up the house throughout his shift. He typically cleans the front of the home when he first comes in and then stays towards the back of the house for the rest of the shift so that he can be closer to Resident J's bedroom. Mr. Crosby does not sleep or watch tv during his shift. Resident J sometimes gets up on his own to use the bathroom during the night. Mr. Crosby stated that he always hears Resident J getting up. He did not hear anything on 06/23/22. When Mr. Crosby was getting Resident J up the following morning, Resident J did not want to walk. Mr. Crosby stated that Resident J has episodes where he does not want to walk due to his arthritis. Mr. Crosby assumed Resident J's arthritis was acting up. He helped Resident J to the chair in his room with a gait belt. He gave Resident J his medications and changed his clothes in his room. He did not see anything unusual and did not notice any marks on Resident J's arm at that time. The marks on Resident J's elbow were later discovered by the assistant manager. Mr. Crosby asked Resident J what happened, and he was unable to answer. Resident J never said that he fell or that anything happened to him. Mr. Crosby stated that Resident J was not flinching, yelling out, or showing any signs of pain. The hospital reported that Resident J's hip was broken due to a fall, and that he would not have been able to get up due to the way the hip was broken. Mr. Crosby did not know how the injury occurred. He did not have any concerns about staff being physically aggressive and stated that all of the staff in the home are good.

I reviewed a copy of Resident J's CLS log from 06/23/22. It notes that from 3:00pm-11:00pm Resident J's pm hygiene was completed. Resident J had art therapy. He relaxed and slept throughout the day. From 11:00pm-7:00am, the log notes that Resident J was monitored during the night every hour. Staff tried to get Resident J to use the restroom, but he did not want to. When it was time to get dressed, Resident J could not walk on his right leg. He urinated on the edge of the bed.

I reviewed a copy of Resident J's individual plan of service (IPOS) and crisis plan dated 04/01/22. The crisis plan notes that Resident J must be within arm's reach at all times when walking through the home due to his decline in mobility. Resident J has a walker/

wheelchair but does not use it all the time. Caregivers are to use Resident J's gait belt when walking with him throughout the home. Resident J will sometimes get confused as to where he is going. Resident J needs assistance and holding his arm or hand from staff when walking through the home or in the community. Resident J is unable to sleep on his back any longer due to aspiration concerns. Resident J must sleep on his side every night. Staff is to check on Resident J every 30 minutes while in the home. The crisis plan notes that staff are to check on Resident J every 30 minutes when he is in bed or sleeping.

I reviewed a copy of the after-visit summary from Beaumont Hospital Royal Oak. The discharge paperwork shows that Resident J was admitted to Beaumont Hospital from 06/24/22-07/01/22. The primary diagnosis was a closed displaced fracture of the right femoral neck. On 06/26/22, Resident J had a right hip hemiarthroplasty (a surgical procedure where half the hip is replaced). Resident J was discharged to an extended care facility with orders for occupational therapy, physical therapy, and skilled nursing.

On 08/01/22, I interviewed the assigned ORR worker, Aaron Winston. Mr. Winston indicated that he was still working on his investigation, but he would likely be substantiating against the midnight staff, as Resident J's plan states bed checks should be completed every 30 minutes and staff were conducting bed checks every hour. Mr. Winston stated that Resident J is still in the rehabilitation facility. Mr. Winston attempted to interview Resident J, but Resident J was not responsive and was unable to provide any information about what happened. He stated that Resident J pulled the blanket over his head and went back to sleep.

On 08/03/22, I conducted an exit conference via telephone with the licensee designee, Shannon White-Schellenberger. Ms. White-Schellenberger indicated that they already have an in-service scheduled with staff to review the plans of service for the residents. She did not have any additional information to share regarding the investigation and stated that she would submit a corrective action plan to address the violations.

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:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff did not provide supervision and protection as specified in Resident J's written assessment plan. Resident J's crisis plan notes that staff must complete bed checks every 30 minutes while Resident J is sleeping. Direct care workers, Eboni Knott and Darryl Crosby, were both working shifts during which Resident J was sleeping on 06/23/22-06/24/22. Both workers completed bed checks

	hourly, rather than every 30 minutes as required by Resident J's plan.
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 the information gathered through my investigation, there is sufficient information to conclude that staff did not attend to Resident J's protection and safety at all times. Staff were completing bed checks every hour instead of every 30 minutes as required by Resident J's plan. Resident J broke his hip sometime during the night between 06/23/22-06/24/22. Resident J also had abrasions on his right elbow, indicating that Resident J likely fell during the night. Staff were not aware of how the injuries occurred and had no knowledge of Resident J falling.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

Kristen Donnay 08/03/2022

Kristen Donnay Date
Licensing Consultant

Approved By:

Denise Y. Nunn 08/10/2022

Denise Y. Nunn Date
Area Manager