GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 15, 2023

Angela Joquico
Resilire Neurorehabilitation, LLC
Suite 2
16880 Middlebelt Road
Livonia, MI 48154

RE: License #: AS500407470
Investigation #: 2023A0602009
Chesley Drive

Dear Ms. Joquico:

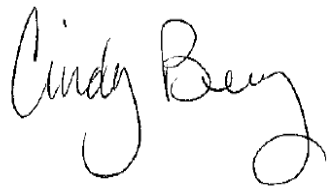
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS500407470
Investigation #:	2023A0602009
Complaint Receipt Date:	12/02/2022
Investigation Initiation Date:	12/02/2022
Report Due Date:	01/31/2023
Licensee Name:	Resilire Neurorehabilitation, LLC
Licensee Address:	7200 Challis Rd. Brighton, MI 48116
Licensee Telephone #:	(734) 239-1937
Administrator:	Angela Joquico
Licensee Designee:	Angela Joquico
Name of Facility:	Chesley Drive
Facility Address:	2640 Chesley Drive Sterling Heights, MI 48310
Facility Telephone #:	(586) 979-2740
Original Issuance Date:	07/01/2021
License Status:	REGULAR
Effective Date:	01/01/2022
Expiration Date:	12/31/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff member Veronica Anderson shoved Resident A to the ground when he tried to get out of his room.	Yes

III. METHODOLOGY

12/02/2022	Special Investigation Intake 2023A0602009
12/02/2022	Special Investigation Initiated - Telephone Call made to complainant.
12/02/2022	APS Referral Adult Protective Services (APS) referral received.
12/08/2022	Inspection Completed On-site Interviewed Resident A and staff member Rashaunda Knox.
12/13/2022	Contact – Telephone call received Spoke to the assigned Aps worker, Ciera Collins.
01/10/2023	Contact – Telephone call made Message left for staff member, Veronica Anderson. C
02/06/2023	Contact – Telephone call made Message left for staff member, Veronica Anderson
02/06/2023	Contact – Telephone call made Message left for staff member, Denise Anderson.
02/06/2023	Contact – Telephone call made Spoke with the licensee designee, Angela Joquico.
02/06/2023	Contact – Telephone call received Spoke with the administrator, Geoffrey Rantala and the home manager Erina Lici.
02/07/2023	Contact – Telephone call made Message left for staff member, Denise Anderson.

02/07/2023	Contact – Telephone call made Message left for staff member, Veronica Anderson.
02/08/2023	Contact – Telephone call made Message left for the home manager, Erina Lici.
02/08/2023	Contact – Telephone call made Spoke with the assistant home manager, LaToya Carruth.
02/08/2023	Exit Conference Held with the licensee designee, Angela Joquico by telephone.
02/09/2023	Contact – Telephone call received Spoke with the home manager, Erina Lici.

ALLEGATION:

Staff member Veronica Anderson shoved Resident A to the ground when he tried to get out of his room.

INVESTIGATION:

On 12/02/2022, a complaint was received and assigned for investigation alleging that staff member Veronica Anderson shoved Resident A to the ground when he tried to get out of his room.

On 12/08/2022, I conducted an unannounced on-site investigation at which time I interviewed Resident A and staff member Rashunda Knox. Resident A stated one evening he was in his room watching television when he felt like he was becoming dehydrated and wanted to get some water from the bathroom. When he attempted to leave his bedroom, the staff member told him to stay in his room. Resident A informed the staff that he wanted some water, but she insisted that he remain in his room. She began arguing with him and told him to go back to bed. When he refused, the staff pushed him (causing him to fall to the floor) and left him there without assisting him up from the floor. Resident A stated the other residents were asleep or in their rooms at the time the incident occurred and did not witness the incident. He did not remember the exact date or the staff member's name but knew it was a female staff and the incident occurred during the night shift.

On 12/08/2022, I interviewed staff member, Rashunda Knox while at the facility. Ms. Knox stated she has worked in the home about four years and works the day shift between the hours of 6:30 am and 2:30 pm. Ms. Knox was not working at the time the incident occurred and had no information to report.

On 12/13/2022, I spoke with the assigned APS worker, Cierra Collins. Ms. Collins stated she interviewed staff member Veronica Anderson and she denied that she pushed Resident A. However, based on the information she received from Resident A; she will be substantiating the allegation of abuse.

On 02/06/2023, I spoke with the licensee designee, Angela Joquico by telephone. Ms. Joquico stated she was aware of the incident but advised that I speak with the administrator, Geoffrey Rantala as he was the person who conducted the internal investigation regarding the allegations.

On 2/06/2023, I interviewed the home manager, Erina Lici and the administrator, Geoffrey Rantala by telephone (three-way call). Mr. Rantala stated he and Ms. Lici interviewed staff members Veronica Anderson, Denise Anderson and Resident A. On 11/30/2022 Veronica Anderson and Denise Anderson worked the midnight shift together. Veronica Anderson denied that she pushed Resident A. She said Resident A was acting aggressive and came at her. She was defending herself when Resident A tripped and fell. Denise Anderson and Resident A's account of what occurred were very similar as Denise Anderson stated she witnessed Veronica Anderson push Resident A. Veronica Anderson was immediately suspended and terminated two days later.

On 02/08/2023, I called the group home and spoke with the assistant home manager, LaToya Carruth. I informed Ms. Carruth that I had been trying to reach staff member Denise Anderson and left her a couple of messages requesting a return call but have not received a response from her. Ms. Carruth stated Denise Anderson no longer works for the company.

On 02/08/2023, I conducted an exit conference with the licensee designee, Angela Joquico by telephone. I informed Ms. Joquico of the investigative findings and recommendation documented in this report. Ms. Joquico stated she agrees that something occurred between Resident A and staff member Veronica Anderson but cannot say with certainty that Veronica Anderson pushed Resident A down. Veronica Anderson was terminated, and Denise Anderson no longer works for the company. Ms. Joquico agreed to submit a corrective action plan upon receipt of this report.

On 2/09/2023, I received a return phone call from the home manager, Ms. Lici. I informed Ms. Lici that I spoke with Ms. Carruth yesterday and was informed that Denise Anderson no longer works for the company. Ms. Lici stated Denise Anderson was terminated about a month after Veronica Anderson was terminated for an issue unrelated to the incident regarding Resident A.

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 from Ms. Collins, Resident A, Mr. Rantala and Ms. Lici, there is sufficient information to determine that on 11/30/2022 there was some sort of altercation between Resident A and staff member, Veronica Anderson. According to Resident A, he wanted to get a drink of water and Veronica Anderson wanted him to remain in his room. When he refused, she pushed him causing him to fall to the floor. According to Mr. Rantala and Ms. Lici, they believe that something did in fact occur between Resident A and staff member Veronica Anderson on 11/30/2022. Resident A and Denise Anderson's account of the incident were very similar in that Veronica Anderson pushed Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: (b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Based on the information obtained during the investigation, there is sufficient information to determine that on 11/30/2022 staff member, Veronica Anderson pushed Resident A. According to Resident A, Veronica Anderson pushed him causing him to fall to the floor and left him there without assisting him up. According to Mr. Rantala and Ms. Lici, Resident A and staff member Denise Anderson both reported that staff member Veronica Anderson did in fact push Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

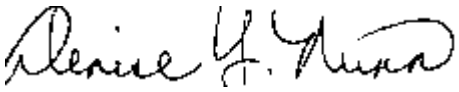
IV. RECOMMENDATION

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

02/10/2023

Cindy Berry — Date
Licensing Consultant

Approved By:



02/15/2023

Denise Y. Nunn — Date
Area Manager