GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 16, 2023

Holly Heath
Community Opportunity Center NPHC
14147 Farmington Rd
Livonia, MI 48154

RE: License #: AS820013941
Investigation #: 2023A0101009
Redford Opportunity House

DearMs. Heath:

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 (313) 456-0380.

Sincerely,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820013941
Investigation #:	2023A0101009
Complaint Receipt Date:	12/27/2022
Investigation Initiation Date:	12/28/2022
Report Due Date:	02/25/2023
Licensee Name:	Community Opportunity Center NPHC
Licensee Address:	14147 Farmington Road Livonia, MI 48154
Licensee Telephone #:	(734) 422-1020
Administrator:	Holly Heath
Licensee Designee:	Holly Heath
Name of Facility:	Redford Opportunity House
Facility Address:	17360 Beech Daly Redford, MI 48239
Facility Telephone #:	(313) 531-3411
Original Issuance Date:	11/08/1984
License **Status:**	REGULAR
Effective Date:	04/01/2021
Expiration Date:	03/31/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 11/20/2022, staff Angela Fuqua yelled at Resident A and told him to sleep in the recliner. She told him to sleep in the recliner, because she didn't want to take him to the hospital. Ms. Fuqua also slammed Resident A into the lazy boy chair. Ms. Fuqua repeatedly thumped Resident A in the forehead and told him not to tear things up.	Yes

III. METHODOLOGY

12/27/2022	Special Investigation Intake 2023A0101009
12/28/2022	Special Investigation Initiated - Telephone Home manager Angela Fuqua
01/06/2023	Inspection Completed On-site
01/19/2023	Contact - Telephone call made DCS Kelly Craig
01/24/2023	Contact - Telephone call made Resident A's Guardian
01/24/2023	Contact - Telephone call received ORR advisor Ms. Moore
01/25/2023	Contact - Telephone call made Ms. Moore

ALLEGATION: On 11/20/2022, staff Angela Fuqua yelled at Resident A and told him to sleep in the recliner. She told him to sleep in the recliner because she didn't want to take him to the hospital. Ms. Fuqua also slammed Resident

A into the lazy boy chair. Ms. Fuqua repeatedly thumped Resident A in the forehead and told him not to tear things up.

INVESTIGATION: On 12/28/2022, I spoke with the home manager Angela Fuqua. Ms. Fuqua became very emotional and started to cry. Ms. Fuqua stated she had worked 80 hours that week and Resident A's behaviors caused her to become frustrated. According to Ms. Fuqua, Resident A frequently violates personal boundaries by touching others, he intentionally aggravates others, and he engages in self injurious behaviors. Ms. Fuqua stated Resident A has Down Syndrome and he was recently diagnosed with dementia. According to Ms. Fuqua Resident A's problematic behaviors have increased drastically. Ms. Fuqua stated, "I would never abuse a resident." Ms. Fuqua stated she used firm and immediate redirections because Resident A was "hitting staff and chasing staff." Ms. Fuqua stated "I made Resident A sit down by using hands on assistance. Ms. Fuqua stated she only thumped Resident A on his shoulder once. Ms. Fuqua was very remorseful throughout the conversation, she was crying and repeatedly stated, "I would never abuse a resident." Ms. Fuqua stated she was also concerned Resident A's acting out behaviors was going to lead to him pulling his catheter out. Ms. Fuqua stated her interaction with Resident A was to de-escalate the situation and to prevent Resident A from harming himself or others.

On 01/06/2023, I interviewed the licensee designee, Holly Heath. Ms. Heath stated Ms. Fuqua is a "good person who would never abuse a resident." Ms. Heath stated Ms. Fuqua's tone is loud which can be interpreted as yelling. Ms. Heath stated Ms. Fuqua needs to work on her tone of voice. Ms. Heath stated Ms. Fuqua is an excellent employee and she cares about the residents. Ms. Heath stated during the pandemic when they could not get staff to work Ms. Fuqua would work. Ms. Heath stated that is the reason why Ms. Fuqua was working 80 hours a week. Ms. Heath also expressed concern as to why the second staff on duty waited 12 days to report what was alleged.

I also interviewed direct care staff (DCS) Tracy Bounty on 01/06/2023. Ms. Bounty stated she has worked at Redford Opportunity Home for three years. Ms. Bounty stated in the past she and Ms. Fuqua did not get along. Ms. Bounty contends Ms. Fuqua is rude and she is like that with everyone. Ms. Bounty stated she and Ms. Fuqua were able to resolve their differences. Ms. Bounty stated Ms. Fuqua would never mistreat or abuse a resident.

On 01/06/2023, I interviewed DCS Ezanjolo Drapper. Mr. Drapper stated he has worked at Redford Opportunity Home for three years and he has never observed Ms. Fuqua being abusive or mistreating a resident. Mr. Drapper stated Ms. Fuqua is loud.

On 01/06/2023, I reviewed Resident A's resident record. "[Resident A's] diagnoses are Down's Syndrome, mile intellectual disabilities, anxiety state unspecified, conduct disorder, esotropia, esophageal reflex, urinary catheter. [Resident A] is

experiencing memory loss. [Resident A] requires 24/7 supports to assure that activities of daily living are completed thoroughly, and that health and safety is maintained." According to Resident A's Behavior Treatment Plan when Resident A is having a behavioral episode staff members are to "provide firm and immediate redirection."

I spoke with Relative 1 on 01/24/2023, who is also Resident A's Power of Attorney. Relative 1 stated she does not believe Ms. Fuqua would abuse Resident A. She stated, "[Resident A] is not afraid of Ms. Fuqua because Ms. Fuqua is his buddy." Relative 1 stated Ms. Fuqua brings Resident A to family visits, and she stays there for the duration of the visits. During those visits Ms. Fuqua interacts with her entire family. Relative 1 stated, "I know my brother and he can be a "hand full." Relative 1 stated Resident A was discharged from many homes due to is challenging behaviors.

On 01/24/2023, I spoke with Kelly Craig. Ms. Craig worked with Ms. Fuqua on 11/20/2022. Ms. Craig stated Ms. Fuqua thumped Resident A because he kept tearing things up. Ms. Craig stated Resident A was falling asleep in a chair at the dining room table and Ms. Fuqua yelled at Resident A. She told him to sleep in the recliner, because she didn't want to take him to the hospital. Ms. Craig stated Ms. Fuqua was not being abusive. She stated, "Ms. Fuqua was being disrespectful, and would you want someone you love to be treated like that." Ms. Craig also stated she failed to report what she observed on 11/20/2022, because she had to think about it.

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: (1) (a) Use any form of punishment. (11)(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:	The home manager used a form of punishment with Resident A. Ms. Fuqua admitted she thumped Resident A because he was displaying a problematic behavior. Ms. Fuqua confined Resident A to a chair. Ms. Fuqua admitted she made Resident A sit in the recliner.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION:

Contingent upon submission of an acceptable corrective action plan I recommend the status of the license remains unchanged.

02/15/2023

Edith Richardson — Date
Licensing Consultant

Approved By:

02/16/2023

Ardra Hunter — Date
Area Manager