GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 11, 2023

Roger Covill
North-Oakland Residential Services Inc
P. O. Box 216
Oxford, MI 48371

RE: License #: AS630339744
Investigation #: 2023A0605027
Edgar Home

Dear Mr. Covill:

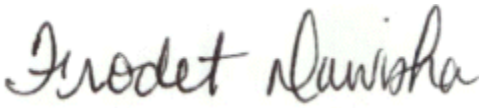
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630339744
Investigation #:	2023A0605027
Complaint Receipt Date:	04/17/2023
Investigation Initiation Date:	04/17/2023
Report Due Date:	06/16/2023
Licensee Name:	North-Oakland Residential Services Inc
Licensee Address:	106 S. Washington Oxford, MI 48371
Licensee Telephone #:	(248) 969-2392
Administrator/Licensee Designee:	Roger Covill
Name of Facility:	Edgar Home
Facility Address:	8740 Andersonville Road Clarkston, MI 48347
Facility Telephone #:	(248) 625-4273
Original Issuance Date:	06/13/2013
License Status:	REGULAR
Effective Date:	03/13/2022
Expiration Date:	03/12/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was in the hospital on 04/13/2023 and was diagnosed with a broken femur. It is unknown how long femur has been broken and what was the cause of this injury.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/17/2023	Special Investigation Intake 2023A0605027
04/17/2023	Special Investigation Initiated - Telephone Discussed allegations with Office of Recipient Rights (ORR) Sarah Rupkus
04/17/2023	Contact - Telephone call made Discussed allegations with Resident A's guardian/father
04/17/2023	APS Referral Adult Protective Services (APS) referral made by ORR
04/18/2023	Contact - Telephone call made Confirmed with McLaren Oakland Hospital in Pontiac that Resident A was still there.
04/18/2023	Contact - Telephone call made Left message for Adult Protective Services (APS) worker Tina Edens.
04/18/2023	Contact - Face to Face I met with Resident A, Resident A's guardian/father and stepmom and ORR worker Sarah Rupkus and Dr. Mason at McLaren Oakland Hospital in Pontiac regarding the allegations.
04/18/2023	Inspection Completed On-site I conducted an unannounced on-site investigation. I interviewed the home manager (HM) Tiffany Cooper, direct care staff (DCS) Krystal Milton, Resident B, Resident C, and Resident D. I reviewed Resident A's medical information records and staff schedule.

04/18/2023	Contact - Telephone call received Message from the area supervisor Adrienne Doelle regarding the allegations.
04/18/2023	Contact - Telephone call made Discussed allegations with area supervisor Adrienne Doelle, Life Skills Focus program manager Sarah Lueck, Life Skills Focus staff members Della Nard and Taevin Johnson.
04/18/2023	Contact - Document Received Email received from area supervisor Adrienne Doelle.
04/18/2023	Contact - Document Sent Emails sent to ORR worker Sarah Rupkus and APS worker Tina Edens.
04/20/2023	Contact - Document Received Email from HM.
04/24/2023	Contact - Telephone call made I interviewed Resident A's sister regarding the allegations.
04/24/2023	Contact - Telephone call made I interviewed Life Skills Focus staff members Cynthia Williams and Terry Croskey and Edgar Home DCS RoShawnda Williams and DCS DeMechia Sanders regarding the allegations.
04/25/2023	Contact - Telephone call made Left message for DCS Tina McFadden to return call.
05/01/2023	Exit Conference Telephone call with licensee designee Roger Covill with my findings.

ALLEGATION:

Resident A was in the hospital on 04/13/2023 and was diagnosed with a broken femur. It is unknown how long femur has been broken and what was the cause of this injury.

INVESTIGATION:

On 04/17/2023, intake #194609 was referred by Oakland County Office of Recipient Rights (ORR) regarding Resident A has a broken right femur and it is unknown how long the femur has been broken and what caused the injury.

On 04/17/2023, I initiated my special investigation via telephone with ORR worker Sarah Rupkus. Ms. Rupkus is investigating these allegations. She agreed to meet with me at McLaren Oakland Hospital in Pontiac on 04/18/2023 to meet with Resident A. On 04/17/2023, I contacted via telephone Resident A's father/guardian regarding the allegations. Resident A's father received a telephone call from the home manager (HM) Tiffany Cooper on 04/13/2023 saying that Resident A has a broken femur, and he was at McLaren Oakland Hospital in Pontiac. The HM told Resident A's father, "I don't know how it happened." Resident A's father will be visiting with Resident A tomorrow at the hospital. He is concerned that no one can tell him how his son broke his femur but reported that Resident A's sister was visiting with Resident A at the hospital and Resident A told the physical therapist, "both my legs are broken and my ribs too." Resident A's father does not know if this is true, but he will be speaking with the doctor's tomorrow at the hospital. I advised Resident A's father I will be coming up to the hospital tomorrow to meet with him and Resident A. He acknowledged.

On 04/18/2023, I along with ORR worker Sarah Rupkus met with Resident A and Resident A's father at McLaren Oakland Hospital in Pontiac. Upon arrival, the attending physician Dr. Jeffrey Mason was in the room with Resident A and Resident A's father. Resident A was lying in bed and both Resident A's father and stepmother were present. Resident A's surgery of his right femur went well, and he will be discharged back to Edgar Home today. Dr. Mason advised he was not part of the trauma department but will have the doctor come up to Resident A's room to discuss the broken femur. Dr. Mason reviewed Resident A chart notes and reported no documentation of a "spiral fracture," but again will have the trauma team provide additional information on their findings.

Resident A was interviewed regarding the allegations. Resident A stated, "I fell out of the bed at home. A guy picked me up." He was sleeping when he fell out of bed and there were no witnesses. Resident A was unable to provide any further information. Resident A has a very high pain tolerance and would not report his pain to anyone unless someone asked him "are you in pain?" Resident A's stepmother advised that Edgar Home does not have any male staff; however, Resident A shares a bedroom with a young male. She described this young male as being "in your face," but is not violent or aggressive in any manner." The young male is ambulatory, but she does not think the young male caused harm to Resident A. Resident A's father advised that Resident A attends workshop four days out of the week. He is unsure if this injury occurred at workshop or at Edgar Home. Resident A is wheelchair bound and requires a two-person transfer or one-person with the Hoyer lift so it's unclear if Resident A was dropped on the floor by a staff member at the workshop or at Edgar Home or if Resident A rolled out of his bed because his bedrails were not up. Resident A's father advised that he and the stepmother were caring for Resident A at their home, but due to Covid, the caregivers quit and both Resident A's father and stepmother were unable to provide 24/7 care. Resident A's father advised Resident A must return to Edgar Home because there is no other place he can go at this time. I advised Resident A's father I will be investigating these allegations and provide him with an update once it is available. He acknowledged.

On 04/18/2023, I conducted an unannounced on-site investigation at Edgar Home. Present were the HM Tiffany Cooper, direct care staff (DCS) Krystal Milton and Resident B, Resident C, and Resident D. Resident E was at school.

I interviewed the HM Tiffany Cooper regarding the allegations. Ms. Cooper has been with North-Oakland Residential Services (NORS) for seven years. She works the morning shift from 7AM-3PM. There are three shifts and two-DCS per shift. Resident A and Resident C are both a two person assist. On 04/12/2023, she was working second shift from 3PM-11PM with DCS DeMechia Sanders. Around 8:30AM, Ms. Sanders transferred Resident A from his wheelchair to the bed using the Hoyer lift. Ms. Sanders undressed Resident A to get him ready for bed when Ms. Sanders noticed Resident A's right thigh was "swollen the size of a mini football." Ms. Sanders called the HM into Resident A's bedroom where the HM observed Resident A's thigh. The HM advised Ms. Sanders that no staff member reported anything to her about Resident A's thigh nor was an incident report (IR) completed regarding the thigh. The HM contacted the area supervisor Adrienne Doelle who requested the HM to send her pictures of the swelling which the HM did. Ms. Doelle advised the HM to take Resident A to urgent care. The HM called the midnight staff DCW RoShawnda Williams and Tina McFadden who arrived at their shifts early. Around 10PM, the HM transported Resident A to McLaren Hospital in Clarkston. Resident A was checked in the ER and told by one of the physicians that "it was nothing," and to "follow-up with Resident A's doctor in the morning." The HM transported Resident A back to Edgar Home.

On 04/13/2023, the HM called Resident A's doctor who advised the HM that they do not have access to an X-ray machine and to return to McLaren Hospital in Clarkston and request an X-ray of Resident A's leg. The HM transported Resident A back to the hospital, an X-ray was taken of the leg and determined it was a broken femur. Resident A was then transported to McLaren Hospital in Pontiac where he underwent surgery. The HM reported that Resident A was never dropped by her or any DCS at Edgar Home. She reported that according to Resident A, he fell at workshop (Life Skill Focus in Pontiac). The HM never received any IR's or calls from workshop stating that Resident A fell. The HM called Life Skill Focus and was informed by their staff (name unknown) that Resident A never fell there either. Resident A has a high pain tolerance and has never expressed any pain to staff on 04/12/2023 or any time prior to that day. Ms. Cooper advised that all staff have been through the Hoyer lift training, and she provided me with the in-service sign-in sheet.

I interviewed DCS Krystal Milton regarding the allegations. Ms. Milton has been with NORS for about two years. She too works the morning shift from 7AM-3PM. On 04/12/2023 when Ms. Milton arrived at her shift, Resident A was already in his wheelchair. The midnight staff are responsible for getting all the residents up and ready for the day. Around 8AM, she began loading residents up for their workshops. She dropped Resident A at Life Skills Focus between 8:30AM-9AM. When she arrives at Life Skills Focus, she drops Resident A off at the ramp and pushes him to the door. Opens the door for him and he goes inside. Ms. Milton does not see or talk to anyone in the

morning during drop-offs. Ms. Milton reported no incidents during the drop-off. At 2PM, she arrived at Life Skills Focus to pick Resident A up. When she arrived, she went into the building and asked for Resident A. Resident A was brought to Ms. Milton. Ms. Milton stated she was not informed by any Life Skills Focus staff that there was an incident with Resident A on that day or the day before on 04/11/2023. Ms. Milton reported that she was not responsible for Resident A on 04/12/2023 because she was responsible for transporting. She stated that the HM was responsible for Resident A; however, she did not see the HM drop Resident A nor did she witness Resident A fall. When Ms. Milton is responsible for Resident A's care, she uses a Hoyer lift to transfer him onto the bed to change him. She pulls down his pants and changes his briefs. If Resident A soils his shift, she takes that off too and changes it. Ms. Milton does not complete a body assessment of Resident A day but stated that Resident A is showered every morning by the midnight staff. Ms. Milton was not informed by the midnight staff on 04/11/2023 or 04/12/2023 that Resident A had fallen or that his leg was observed to be swollen. Ms. Milton stated that DCS Tina McFadden told Ms. Milton that Resident A informed Ms. McFadden that "I fell out of my bed and a man picked me up." There are no male staffs at Edgar Home and Ms. Milton stated that Resident B who is Resident A's roommate would never pick Resident A up off the floor if Resident A had fallen. Ms. Milton believes Resident A fell at Life Skills Focus because there is a male staff there.

I attempted to interview Resident B, but he is non-verbal. However, Resident B is very hyper. He was in and out of his bedroom and pacing in an out of the laundry room. He did not sit the entire time I was at the visit and kept busy.

I interviewed Resident C regarding the allegations. Resident C reported that Resident A went to the hospital, but Resident C does not know why. Resident C has never witnessed Resident A fall nor has he observed any staff member drop Resident A. Resident C had no additional information regarding Resident A.

I interviewed Resident D regarding the allegations. Resident D did not have much to say. He did not see Resident A fall nor has he observed any staff member drop Resident A.

Note: I observed Resident A's bedroom. He has a hospital bed with bedrails on both sides of the bed. There is no gap between the bedrails and the mattress. I reviewed the doctor's order for the hospital bed and railings.

Note: During my on-site visit, I observed DCS Krystal Milton on her personal cell phone twice. The first time was in the living/dining room area where she was sitting on the couch on her cell phone while Resident C was eating lunch. Then again, before I left, I observed Ms. Milton sitting in the front room by herself on her personal cell phone on social media. In addition, the HM was in her office when I arrived and throughout the visit too while the residents were either in their rooms or pacing around the home.

On 04/18/2023, I interviewed Adrienne Doelle, NORS area supervisor. Ms. Doelle has been working for the corporation for about 15 years. On 04/12/2023, Ms. Doelle

received a telephone call from the HM around 8:19PM regarding Resident A's leg is swollen. Ms. Doelle requested a picture of the leg, which the HM took and sent to Ms. Doelle. After receiving the picture, Ms. Doelle advised the HM to take Resident A to the hospital. Initially, Resident A was sent back to Edgar Home by McLaren Hospital in Clarkston to follow-up with Resident A's doctor, but on 04/13/2023, the doctor advised to return Resident A back to the hospital, which the HM did. It was discovered that Resident A had a broken femur. Resident A was then transferred to McLaren Hospital in Pontiac where he underwent surgery. Ms. Doelle asked the HM, "What happened?". The HM told Ms. Doelle that Resident A was reporting to staff that he "fell at workshop and a man picked him up." Resident A is a two-person transfer or a one-person with the Hoyer lift. She advised that all staff at Edgar Home have been trained on proper transfers of Resident A using a Hoyer lift. Ms. Doelle will send the training guide used to in-service staff on transfers. Ms. Doelle does not believe that Resident A fell at Edgar Home because Resident A is reporting to staff that he fell at workshop and a man picked him up. There are no male staff at Edgar Home. Resident A's hospital bed has bedrails, so if the bedrails were not put up and Resident A fell out of bed at Edgar Home, the staff would have written an IR regarding the fall and contacted her; however, no IRs were written, and no calls were made to Ms. Doelle. Ms. Doelle does not believe that Resident B would pick Resident A off the floor because Resident B's disability, he would not think to pick Resident A up off the floor. I advised Ms. Doelle of my observations regarding DCS Krystal Milton being on her cell phone during my on-site visit. Ms. Doelle stated NORS has a no cell phone policy and she will be addressing the issue with Ms. Milton.

On 04/18/2023, I interviewed the Program Manager Sarah Lueck with Life Skills Focus regarding the allegations. On 04/12/2023, Resident A arrived at Life Skills Focus around 8:30AM and was in the building until 11:30AM. At 11:30AM, Resident A was in the community at Friend Park until his pickup time of 2PM which is when the transport van brought Resident A back to Life Skills Focus. At 2PM, staff from Edgar Home was already at Life Skills Focus waiting for Resident A. Resident A never entered the building. He got off the Like Skills Focus van and right into Edgar Home transport van. The only time Resident A is out of his wheelchair at Life Skills Focus is when he is being changed. Resident A is a two-person transfer and one of the two people who transfer Resident A is a male staff member, Taevin Johnson. That day, Taevin and Della Nard were responsible for Resident A. Ms. Lueck advised she conducts all transfer trainings with her staff and both Taevin and Della completed the training. The transfer training consists of watching a video and then Ms. Lueck observes staff demonstrating the transfers. Ms. Lueck did not observe Taevin and Della on 04/12/2023 when they transferred Resident A onto the changing table. Life Skills Focus does not have a Hoyer lift; therefore, there must be two-people always to transfer Resident A when he needs to be changed. Ms. Lueck received a telephone call on 04/12/2023 from the HM asking Ms. Lueck if Resident A had "fallen." Ms. Lueck advised the HM that no staff member reported that Resident A had fallen and nor did Ms. Lueck observe Resident A fall.

On 04/18/2023, I interviewed Life Skills Focus staff member Della Nard via telephone. Della has been working at Life Skills Focus for about seven years. She completed her

training on transfers. On 04/12/2023, she was responsible for Resident A. Resident A was only changed once, right before he left for the community around 11:30AM. She and staff member Taevin transferred Resident A from the wheelchair onto the changing table and then back to the wheelchair. Della explained when she and Taevin transfer Resident A, Taevin grabs Resident A underneath his arms and she grabs Resident A's legs close to his knees then count 1, 2, 3 and then they lift him out of the wheelchair and place him on the changing bed. Taevin leaves as she changes Resident A. She rolls Resident A side to side to pull his pants down and then his adult brief. On this day, she noticed his right leg was swollen near his thigh. It was the size of a quarter. She was informed by Ms. Lueck that Resident A had been in the hospital prior and that the quarter size swelling was probably due to the IV he was given. Della did not question it and continued to change Resident A's soiled brief. Della asked Resident A, "Are you ok?" and Resident A said, "Yes." Della always asks Resident A "if he is ok," to know that he is not in pain because Resident A has a high pain tolerance. Della then called Taevin to return to the room and both transferred him back to the wheelchair the same way, Taevin grabbed Resident A underneath his arms and Della grabbed his legs and put him into the wheelchair. Della denied that she or Taevin dropped Resident A and she denied leaving Resident A unattended on the changing table and Resident A rolling off the changing table onto the floor. Resident A was only changed by Della once on 04/12/2023. She was not responsible for Resident A on 04/11/2023.

On 04/18/2023, I interviewed Taevin Johnson via telephone regarding the allegations. Taevin has worked for Life Skills Focus for six years. Taevin completed his training on transfers. On 04/12/2023, he assisted Della in transferring Resident A from his wheelchair onto the changing table. He grabbed Resident A from underneath his armpits while Della grabbed his legs, count 1, 2, 3 and then they lifted him off his wheelchair and transferred him onto the changing bed. Taevin left the room and Della continued to change his brief. Soon after, Della called him to assist her in transferring Resident A back to his wheelchair. Again, he grabbed underneath Resident A's armpits while Della grabbed his legs. They lifted him off the changing table and back into his wheelchair without any incident. On 04/11/2023 Taevin was responsible for Resident A's care. He changed Resident A twice on 04/11/2023 and was assisted by Life Skills Focus staff member Cynthia. He nor Cynthia dropped Resident A on the floor during their transfer. He transferred Resident A the same way he did with Della. Taevin did not see any swelling or redness on Resident A's right leg when he changed his brief twice on 04/11/2023. Taevin denied leaving Resident A unattended on the changing table and denied picking Resident A up off the floor that day or any other day.

On 04/24/2023, I interviewed Cynthia Williams a staff member at Life Skills Focus via telephone regarding the allegations. Cynthia has worked for Life Skills Focus since July 2022. She completed her in-service training for transfers by her manager Sarah Lueck. Cynthia worked on 04/11/2023 with Taevin and assisted Taevin in transferring Resident A from the wheelchair onto the changing table. She grabbed Resident A by his legs near his thighs while Taevin grabbed Resident A underneath his armpits. They count 1, 2, 3 and lift him out of his wheelchair onto the changing table. They did the same after changing his brief. Cynthia denied dropping Resident A and denied that she witnessed

Taevin drop Resident A. She also denied witnessing Resident A on the floor or witnessing Taevin ever pick Resident A up off the floor. Cynthia has never tried transferring Resident A by herself nor has she witnessed another Life Skills Focus staff transfer Resident A without a two-person assist. Cynthia denied observing any redness or swelling on Resident A's legs on 04/11/2023 when she assisted Taevin with changing Resident A.

On 04/24/2023, I interviewed Resident A's sister via telephone regarding the allegations. Resident A's sister visited with Resident A once or twice last year. When she visited, the staff at Edgar Home were very attentive and there were no concerns with staff. However, her only concern was Resident A's roommate, Resident B. Resident A's sister described Resident B as being "hyper," which concerned her because Resident A is very mellow and quiet. Although Resident B was hyper, there were no incident during the visit. Resident A's sister was at McLaren Hospital in Pontiac visiting with Resident A. She asked Resident A several times, "What happened?" and Resident A kept repeating, "I fell." She was unable to gather any additional information from Resident A, but stated that the physical therapist (PT) at the hospital came into to meet with Resident A. The PT told Resident A's sister that "Resident A has sustained extensive fractures to his body," and that "the fractures to his ribs and legs do not appear to be from a fall." Resident A's sister is concerned about Resident A and how Resident A sustained these injuries.

On 04/24/2023, I interviewed Life Skills Focus staff member Cynthia Williams regarding the allegations. Cynthia has been working for Life Skills Focus since July 2022. On 04/10/2023, she assisted Taevin in transferring Resident A from his wheelchair onto the changing table. She grabbed Resident A by his legs and Taevin grabbed him from underneath his armpits, they counted 1, 2, 3 and lifted Resident A from his wheelchair onto the table. She assisted Taevin in changing Resident A's brief and stated she did not observe any redness or swelling of his legs. Cynthia denied that she or Taevin dropped Resident A that day and denied witnessing any Life Skills Focus staff drop Resident A. She also denied leaving Resident A unattended on the changing table and Resident A rolling off the table onto the floor. Cynthia completed an in-service training on transfers from her manager Sarah Lueck.

On 04/24/2023, I interviewed Life Skills Focus staff member Terry Croskey via telephone. Terry has been with Life Skills Focus for 12 years. On 04/10/2023, she was working but she did not assist any staff member with Resident A. Terry did not observe any staff member drop Resident A nor did she witness Resident A on the floor. She did not have any other information to provide.

On 04/24/2023, I interviewed Edgar Home DCS RoShawnda Williams via telephone regarding the allegations. Ms. Williams has been with NORS since 04/17/2022. She works the midnight shift from 11PM-7AM. On 04/11/2023, she began her shift at 11PM and Resident A was sleeping. His bedrails were both up and he his bed was inclined appropriately. Ms. Williams reported no concerns that night. She conducted her bed checks every 15 minutes and never found Resident A on the floor. Around 6:30AM on

04/12/2023, she washed Resident A's face, brushed his teeth, and got him ready. She did not shower him that morning because he was already clean the night before. She changed his brief and did not observe any redness or swelling on his legs. She and DCS Tina McFadden transferred him onto his wheelchair using the Hoyer lift. Ms. Williams waited for the HM to arrive and then Ms. Williams left her shift. Ms. Williams received a telephone call from the HM around 8PM which woke Ms. Williams up from her sleep. The HM asked Ms. Williams, "Did Resident A fall last night?" Ms. Williams stated, "No, what are you talking about." The HM stated, "Resident A said he fell." Ms. Williams replied, "he didn't fall with me." The HM hung up. Ms. Williams called Ms. McFadden asking her if the HM called her regarding Resident A. Ms. McFadden told Ms. Williams she was sleeping too and that she had missed calls from the HM. Ms. McFadden told Ms. Williams she called the HM back and the HM asked Ms. McFadden if "Resident A said he fell." Ms. McFadden told the HM, "no, he never fell with us." The HM called Ms. Williams again asking her to come in early to her shift so she can take Resident A to urgent care. Ms. Williams arrived at Edgar Home at 10PM on 04/12/2023. The HM was sitting in her office and Resident A was in his bed, which Ms. Williams found to be strange since the HM told Ms. Williams she was going to be transporting Resident A to urgent care. Ms. Williams went into Resident A's bedroom and looked at his leg. She stated that Resident A's leg, "didn't look good. It was swollen and red." Ms. Williams and the HM transferred Resident A onto his wheelchair. At this time, Ms. McFadden arrived at her shift. The HM told both Ms. Williams and Ms. McFadden that Resident A was transported to workshop around 8:30AM this morning and then transported back to Edgar Home around 3PM. DCS DeMechia Sanders was putting Resident A to bed at 8PM when she discovered that his right thigh was swollen and red. Ms. Williams then said, "I'm not sure why the injury was not caught before 8PM since Resident A had been home since he was home around 3PM. Did anyone change him between 3PM-8PM?

Ms. Williams advised that Resident A needs to be checked every two hours, so it is concerning that he had not been changed five hours after returning from workshop. The HM returned and transported Resident A to urgent care, but then returned with Resident A soon after stating that urgent care advised to follow-up with Resident A's doctor. Ms. Williams stated she and Ms. McFadden were extremely concerned about Resident A's leg and to her, the leg appeared to be broken. Ms. Williams asked the HM three times to take Resident A to the hospital, but the HM declined stating that urgent care told her to follow up with Resident A's doctor. Ms. Williams texted Adrienne Doelle, the area supervisor regarding Resident A's leg "looked bad," and possibly being broken. Ms. Williams asked to take Resident A to the hospital, but Ms. Doelle advised to ask the HM. Ms. Williams reported she asked the HM who said, "No, to wait until 04/13/2023." Ms. Williams asked Resident A, "Did you fall?" Resident A stated, "Yes." Ms. Williams asked Resident A, "Who picked you up?" Resident A said, "a young man." Ms. Williams advised there are no male staff at Edgar Home. Ms. Williams does not believe Resident B would have picked Resident A up and that she would have seen Resident A on the floor because she conducted all her 15-minute checks. Ms. Williams denied dropping Resident A and denied observing Resident A on the floor. She also denied observing any DCS drop Resident A.

On 04/24/2023, I interviewed Edgar Home DCS DeMechia Sanders via telephone regarding the allegations. Ms. Sanders has worked for NORS since March 2023. She completed all her trainings except for her medication training. Ms. Sanders stated she does not administer medications to any of the residents. On 04/12/2023, Ms. Sanders worked the afternoon shift with the HM from 3PM-11PM. She arrived at work around 3PM and Resident A was sitting in his wheelchair. Around 8PM, she put Resident A to bed using the Hoyer lift. She pulled down his pants and that is when she noticed his right thigh looked like “a swollen mini football.” She went to get the HM who was sitting in her office. The HM came into Resident A’s bedroom, looked at his leg and took pictures to send to the area supervisor. The HM asked Ms. Sanders, “what happened.” Ms. Sanders stated, “I don’t know.” The HM called the midnight staff to come to work early and then transported Resident A to urgent care. Ms. Sanders stated, “I didn’t drop anybody.” Before Ms. Sanders transferred Resident A onto his bed, Resident A told Ms. Sanders, “I fell.” She asked him when and he said, “I don’t know.” Ms. Sanders stated she finished her shift and left at 11PM. Ms. Sanders stated that she never changed Resident A’s brief from 3PM-8PM; however, she reported that “she checked him by putting her hands on his pants to see if he was wet,” but never changed his brief. Ms. Sanders also reported that when she works with the HM, that the HM is “usually sitting in the office.” Ms. Sanders does not know what the HM is doing in her office. Ms. Sanders reported that during her shift, she is responsible for Resident A and two other residents and that the HM is then responsible for Resident D and another resident. Ms. Sanders stated she has never witnessed Resident A on the floor, nor has she observed any DCS drop Resident A.

Note: On 04/12/2023, Resident A’s brief had not been changed from 11:30AM-8PM by anyone from Life Skills Focus nor Edgar Home.

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:	Resident A’s adult brief had not been changed on 04/12/2023 from 2:30PM-8PM as reported by DCS DeMechia Sanders. Staff member Della Nard at Life Skills Focus stated she changed Resident A’s adult brief at 11AM and then Resident A was out in the community from 11:30AM-2PM. Resident A then returned from the community around 2PM, which then Resident A was transferred from Life Skills Focus transport van to Edgar Home transport van. Resident A returned to Edgar Home between 2:30-3PM. Ms. Sanders only checked Resident A by

	putting her hands on his pants to see if he was soiled which she determined he was not just by placing her hands on the pants. Ms. Sanders did not change Resident A's adult brief until she got him ready for bed around 8PM, which then she discovered that above Resident A's right knee was swollen the size of a mini football. Ms. Sanders reported that Resident A does not get toileted; therefore, he had been sitting in his briefs for five hours before getting changed.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 my investigation and information gathered, I was unable to determine the cause of Resident A's right femur fracture because staff members at both Life Skills Focus and Edgar Home denied dropping Resident A and denied that Resident A fell on 04/12/2023. Resident A was interviewed and stated he fell out of bed and a "guy," picked him up, but was unable to provide any further details. Edgar Home does not have any male staff.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

During my on-site investigation on 04/18/2023, I observed DCS Krystal Milton on her personal cell phone twice. The first time was in the living/dining room area where she was sitting on the couch on her cell phone while Resident C was eating lunch. Then

again, before I left, I observed Ms. Milton sitting in the front room by herself on her personal cell phone on social media. In addition, the HM was in her office when I arrived and also throughout the visit while the residents were either in their rooms or pacing around the home.

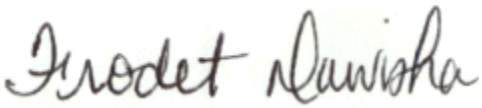
On 04/18/2023, area supervisor Adrienne Doelle was advised of my observations during my on-site visit on 04/18/2023. I advised Ms. Doelle that during my visit, I observed DCS Krystal Milton on her cell phone more than once during my on-site visit and one of those times, Ms. Milton was sitting in the front room by herself on social media while the residents were in their bedrooms or pacing around the home. Ms. Doelle was also informed that the HM was in her office most of the time I was there leaving the residents unsupervised. Ms. Doelle stated NORS has a no cell phone policy and she will be addressing the issue with Ms. Milton.

On 05/01/2023, I conducted the exit conference via telephone with licensee designee Roger Covill with my findings. Mr. Covill acknowledged and did not have any questions or comments regarding the findings.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on my investigation, DCS Krystal Milton and the HM Tiffany Cooper did not provide supervision to Residents B, C, and D on 04/18/2023. During my on-site investigation on 04/18/2023, I observed DCS Krystal Milton on her personal cell phone twice. The first time was in the living/dining room area where she was sitting on the couch on her cell phone while Resident C was eating lunch. Then again, before I left, I observed Ms. Milton sitting in the front room by herself on her personal cell phone on social media and the HM was in the office. The HM was in her office when I arrived and also throughout the visit while the residents were either in their rooms or pacing around the home. Residents B, C, and D require supervision to ensure their safety due to their developmental disability.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

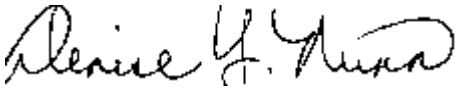
Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



05/01/2023

Frodet Dawisha — Date
Licensing Consultant

Approved By:



05/11/2023

Denise Y. Nunn — Date
Area Manager