GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 6, 2023

Andre Marable
Marable Specialized Care Inc
#265
13335 15 Mile Road
Sterling Heights, MI 48312-4271

RE: License #: AS820381006
Investigation #: 2023A0992027
Marable Specialized Care Inc. II

Dear Mr. Marable:

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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820381006
Investigation #:	2023A0992027
Complaint Receipt Date:	05/11/2023
Investigation Initiation Date:	05/15/2023
Report Due Date:	07/10/2023
Licensee Name:	Marable Specialized Care Inc
Licensee Address:	#265 13962 Renfrew Court Sterling Heights, MI 48312
Licensee Telephone #:	(313) 289-9730
Administrator:	Andre Marable
Licensee Designee:	Andre Marable
Name of Facility:	Marable Specialized Care Inc. II
Facility Address:	32823 Comanche Street Westland, MI 48185
Facility Telephone #:	(734) 326-7642
Original Issuance Date:	04/06/2016
License Status:	REGULAR
Effective Date:	10/06/2022
Expiration Date:	10/05/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A tried to get off the toilet and fell; she sustained a black eye. The concern is a lack of supervision in the home as it pertains to Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/11/2023	Special Investigation Intake 2023A0992027
05/15/2023	Special Investigation Initiated - Telephone Rosalyn Johnson, Resident A's supports coordinator with Wayne Center.
05/15/2023	Inspection Completed On-site Staff A, Staff B, Resident A and B
05/16/2023	Contact - Document Received Resident A’s Individual Plan of Service (IPOS)
05/16/2023	Contact - Document Received Incident reports
05/17/2023	Contact - Telephone call received Staff B, direct care staff
05/22/2023	Contact - Telephone call made Staff C
05/22/2023	Contact - Telephone call made Gary Marable, home manager
06/05/2023	Contact - Telephone call made Andre Marable, licensee designee.
06/23/2023	Contact - Document Received Staff C employee file/training
06/28/2023	Contact - Telephone call made Relative A, Resident A’s guardian.

06/28/2023	Contact - Telephone call made Andre Hardrick, Office Of Recipient Rights (ORR)
06/28/2023	Contact - Telephone call made Ms. Johnson
06/28/2023	APS Referral
06/28/2023	Exit Conference Ms. Marable

ALLEGATION: Resident A tried to get off the toilet and fell; she sustained a black eye. The concern is a lack of supervision in the home as it pertains to Resident A.

INVESTIGATION: On 05/15/2023, contacted Rosalyn Johnson, Resident A's supports coordinator with Wayne Center regarding the reported allegation, which Ms. Johnson confirmed. She further stated she called the home to schedule an appointment with Resident A and was made aware Resident A was hospitalized. Ms. Johnson said she did not receive an incident report and did not have any knowledge of Resident A being in the hospital. Ms. Johnson said Resident A is a fall risk and she requires 1:1 staffing at all times. I requested a copy of Resident A's IPOS. Ms. Johnson agreed to provide the IPOS. Ms. Johnson expressed concerns regarding Resident A receiving adequate supervision and Staff C's ability to provide care as outlined in Resident A's IPOS. She stated Resident A has been in and out of the hospital multiple times due to health issues in last year.

On 05/15/2023, I completed an unannounced on-site inspection; Staff A and B were present. I interviewed Staff A and B regarding the allegations, both of which denied they were on shift when Resident A fell. Staff A said Staff C was on shift. I asked if an incident report was completed and Staff A confirmed an incident report was completed but she was unable to locate it, Staff A contacted Gary Marable, home manager, regarding the incident report. While on the telephone with Mr. Marable, Staff A said Mr. Marable has the physical incident report with him because the Office of Recipient Rights (ORR) and Adult Protective Services (APS) requested a copy. I requested a copy of the incident report.

Staff B confirmed Staff C was on shift when the incident occurred. She said although she was not on shift, she received a call from Staff C regarding Resident A falling. She said Staff C said Resident A dropped her weight on her while assisting her with toileting, causing them to both fall. She further stated Staff C said Resident A hit her face which caused a small abrasion, swelling and bruising above her right eye. She said Staff C said she applied ointment to the injury, and ice due to the swelling. Staff

B said once she arrived at the home the following day, Resident A was yelling out in pain and her lips were starting to change color, so she called 911 and Resident A was transported to the hospital.

Resident A was observed, she has limited verbal skills and was unable to be interviewed.

On 05/16/2023, I received a copy of Resident A's IPOS from Ms. Johnson. According to the IPOS, Resident A requires the following, "Needs to be monitored due to her seizures. She is to wear her helmet at all times. Her eyesight is deteriorating, and she does not wear glasses. She has incontinence night and day and seems to be disoriented or confused at times. She is ambulatory but walks slowly, must be arm in arm due to risk of falling, wears helmet at all times and a gait belt. She has an extensive medical history. "It is important that her staff provide services based on the recommendations of her medical doctors. The home provider must inform the support coordinator and her guardian when she goes into the hospital or other facility outside of the home and submit an incident report to all required parties. It is also important for the home provider to have staff that is knowledgeable of her conditions and needs to meet with the support coordinator for all monthly visits and IPOS meetings." Resident A requires 1:1 staffing as described in her behavior treatment plan and IPOS. If the home is short staffed the supports coordinator must be made aware immediately.

On 05/17/2023, I received incident reports regarding the reported allegation. On 04/20/2023, an incident report was completed by Staff C, stating the following "[Resident A] was using the toilet. As I tried to help her off the toilet, she dropped her weight on me and hit the side of my knee as I was trying to hold her up. Once I got her to a seated position, I noticed a dark red spot by her right eye, and I applied first aid." As far as the action taken by staff, first aid was applied and notified supervisor. No corrective measures noted. On 04/21/2023, an incident report was completed by Staff B, stating the following, "Staff called stating [Resident A] was weak and dropped her weight while getting her off the toilet. [Resident A] hit her face which caused swelling and bruising above her right eye. She also has a small abrasion." Action taken by staff, staff monitored Resident A and put antibiotic ointment on her scrape. Resident A's right eye began to swell and change colors. Staff applied ice to her eye. As far as the corrective measures take, "I received a call today stating [Resident A] was acting weird. I came to the home and [Resident A] began yelling in pain and her lips started turning blue. 911 was called and she was transported to the hospital. On 04/21/2023 her doctor sent someone out to do a chest x-ray and electrocardiogram (ekg).

On 05/17/2023, I was contacted by Staff B regarding Resident A. Staff B expressed concerns regarding Staff C's ability to provide adequate care for Resident A. Staff B said Resident A always sustains some form of injury when Staff C is on shift. She said she is concerned Staff C is not properly trained to care for Resident A. She said Resident A is a fall risk and she cannot stand by herself. Staff B said Resident A

requires 1:1 staffing, and she is typically assigned to work with her as her 1:1. However, she said there are times when Staff C is assigned as her 1:1 and Resident A is always agitated and combative following Staff C's shift. She said there was a time when Resident A would say "she hit me" but she never says a name. Staff B said she has never witnessed Staff C or anyone else hit or abuse Resident A. She said currently Resident A is confused and not able to articulate well.

On 05/22/2023, I contacted Staff C and interviewed her regarding the reported allegation. Staff C confirmed she was on shift when the incident occurred. She said there were three residents, and she was working alone. Staff C said she was assisting Resident A with toileting when the incident occurred. She said when transferring Resident A from the toilet to her wheelchair, she dropped her weight causing her knee to buckle. Staff C said both she and Resident A fell. She said Resident A either hit her head on the wheelchair or the toilet. She said once she got her positioned, she noticed a dark red mark above Resident A's right eye. Staff C said she applied first aid and contacted her supervisor/medication coordinator, Staff B. Staff C said typically she uses a gait-belt, but Resident A was very agitated at the time. I asked if Resident A's injury required medical attention and she said no. She said Resident A was transported to the hospital days later due other medical issues. I asked if she was aware Resident A requires 1:1 staffing, and she said yes. She said another staff was scheduled to work with her, but she was a no-show. I asked if she has been properly trained to use a gait belt and transfer Resident A, she said she is familiar with how to use a gait-belt from her previous employment. I referenced the incident report she completed and made her aware that it did not include details as she just explained, specifically how Resident A sustained the head injury.

On 05/22/2023, contact Gary Marable, home manager, and interviewed him regarding the allegation. He confirmed he was aware of the allegation. I made him aware that an incident report was not initially received by the Department and a copy was not available at the time of inspection on 05/15/2023. I also made him aware of the lack of detail in the incident report specifically how Resident A sustained the head injury. I suggested in-service training on properly completing an incident report. I referenced the fact that Staff C was working alone, and Resident A requires 1:1 staffing. He stated Staff D was scheduled to work but called off and he was unable to secure coverage. Mr. Marable said typically, when staff call off, another staff covers the shift. I asked about Staff C's training and requested a copy of her file, which he agreed to provide. Mr. Marable was uncertain how long Staff C has been working for the company but said she has been there for a couple months.

On 06/05/2023, I contacted Andre Marable, licensee designee, and interviewed him regarding the allegations, which he was aware. I also referenced the fact that Staff C was working alone when the incident occurred, and Resident A requires 1:1 staffing. I made Mr. Marable aware that I requested to review Staff C's file to determine if she has been in-serviced regarding Resident A having an unsteady gait and proper use of a gait-belt. I explained although an incident report was completed it was not faxed to the Department and a copy was not available at the time of inspection. I made him aware

that once Staff C's file is received and reviewed, I will follow-up with him to discuss the findings.

On 06/23/2023, I received a copy of Staff C's employee file/training. Although Staff C's application stated she applied for the direct care worker position on 04/04/2023, the last page of the application is dated 03/02/2022. Staff C's file contained training to meet the requirements direct care health (DCH) group home training curriculum part I which includes support plans, recipient rights and working with individuals with disabilities, and emergency preparedness, medication administration, CPR and First Aid. Staff C's file did not contain verification of criminal background check or fingerprints.

On 06/28/2023, I contacted Relative A, Resident A's guardian regarding the reported allegation. Relative A said he has never received an incident report. He said he has often expressed his concerns regarding Resident A's supervision to the staff and he has spoken to Gary Marable once. He said historically Resident A has always required 1:1 staffing but the last couple years she has not received it in that home. He said Gary Marable confirmed 1:1 staffing was assigned to Resident A, but it is unlikely. Relative A said Resident A is currently at a different facility and he is working with Ms. Johnson so that Resident A does not have to return to the home.

On 06/28/2023, I contacted Andre Hardrick, Office of Recipient Rights (ORR) regarding the reported allegation. Mr. Hardrick confirmed he received several complaints regarding Resident A. He explained the ORR investigative process. He said if more than one maltreatment is reported, the investigations are done separately. He said although multiple complaints were received, he only substantiated for failure to report the incident and failure to provide sufficient staffing. He said there was also a contract action due to Staff C being on shift alone on several days. Mr. Hardrick said as a course of action, in-service training was provided on incident reporting.

On 06/28/2023, I made follow-up contact with Ms. Johnson. Ms. Johnson made me aware that Resident A is currently at a different facility and does not intend to return to Marable Specialized Care Inc, II. She said Relative A is not interested in Resident A returning to the home as well. Ms. Johnson said up until Resident A left the home there continued to be concerns regarding supervision and multiple incident reports were received.

On 06/28/2023, I completed an exit conference with Mr. Marable regarding the investigative findings. I referenced our previous conversation regarding Resident A requiring 1:1 staffing and Staff C being on shift alone, resulting in insufficient staffing. I explained although an incident report was completed it was not faxed to the Department and a copy was not available at the time of inspection. I further made him aware that due to the violations identified in the report, a written corrective action plan is required. Mr. Marable agreed to review the report and submit the corrective action plan as required. He denied having any questions.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	During this investigation, I interviewed Andre Marable, licensee designee; Gary Marable, home manager; Staff A, DCS; Staff B, DCS; Staff C, DCS; Rosalyn Johnson, Resident A's Supports Coordinator; Andre Hardrick, ORR; and Relative A, Resident A's brother/guardian regarding the allegations, all of which confirmed the reported allegation. Resident A was observed, she has limited verbal skills and was unable to be interviewed. I reviewed Resident A's IPOS. Resident A requires 1:1 staffing as described in her behavior treatment plan and IPOS. If the home is short staffed the supports coordinator must be made aware immediately. She is ambulatory but walks slowly, must be arm in arm due to risk of falling, wears helmet at all times and a gait belt. Based on the investigative findings, there is sufficient evidence that Andre Marable, licensee designee, failed to provide sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/23/2023, I received a copy of Staff C employee file/training. Staff C's file did not contain verification of criminal background check or fingerprints or verification of communicable tuberculosis testing and results.

On 06/28/2023, I contacted LARA workforce background check unit to see if they have a record of fingerprints. I was informed the applicant has not been fingerprinted to work at that license number.

On 06/28/2023, I completed an exit conference with Mr. Marable regarding the additional findings. I made Mr. Marable aware upon review of Staff C's employee file, the file did not contain verification of a criminal history check/fingerprinting documentation or verification of communicable tuberculosis testing and results. Mr. Marable asked for assistance with completing the criminal history background check. I provided technical assistance and provided him with a PowerPoint including instruction on how to register his staff for fingerprinting obtain a copy of the employee eligibility form. Mr. Marable denied having any questions. He agreed to review the report and submit the corrective action plan as required.

APPLICABLE RULE	
400.734(b)(4)	**Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(4) Upon receipt of the written consent and identification required under subsection (3), the adult foster care facility that has made a good faith offer of employment or independent contract shall make a request to the department of state police to conduct a criminal history check on the individual and input the individual's fingerprints into the automated fingerprint identification system database, and shall make a request to the relevant licensing or regulatory department to perform a check of all relevant registries established according to federal and state law and regulations for any substantiated findings of abuse, neglect, or misappropriation of property. The request shall be made in a manner prescribed by the department of state police and the relevant licensing or regulatory department or agency. The adult foster care facility shall make the written consent and identification available to the department of state police and the relevant licensing or regulatory department or agency. If the department of state police or the federal bureau of investigation charges a fee for conducting the initial criminal history check, the charge shall be paid by or reimbursed by the department. The adult foster care facility shall not seek reimbursement for a charge imposed by the

	department of state police or the federal bureau of investigation from the individual who is the subject of the initial criminal history check. The department of state police shall conduct an initial criminal history check on the individual named in the request. The department of state police shall provide the department with a written report of the criminal history check conducted under this subsection that contains a criminal record. The report shall contain any criminal history record information on the individual maintained by the department of state police.
ANALYSIS:	At the time of inspection, Staff C's employee file did not contain verification of a criminal history check or fingerprinting documentation.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(4) A licensee shall provide the department with written evidence that he or she and the administrator have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken. The results of subsequent testing shall be verified every 3 years thereafter.
ANALYSIS:	At the time of inspection, Staff C's employee file did not contain verification of communicable tuberculosis testing and results before Staff C's employment, and assumption of duties in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend that the status of the license remains the same

07/06/2023

_____

Denasha Walker Date
Licensing Consultant

Approved By:

07/06/2023

_____

Ardra Hunter Date
Area Manager