GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 3, 2023

Karon Lee
Michigan Community Services, Inc.
PO Box 317
Swartz Creek, MI 48473

RE: License #:	AS090010214
Investigation #:	2023A0123035
	Candlestick CLF

Dear Ms. Lee:

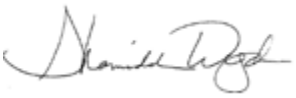
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (517) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS090010214
Investigation #:	2023A0123035
Complaint Receipt Date:	04/11/2023
Investigation Initiation Date:	04/13/2023
Report Due Date:	06/10/2023
Licensee Name:	Michigan Community Services, Inc.
Licensee Address:	5239 Morrish Rd. Swartz Creek, MI 48473
Licensee Telephone #:	(810) 635-4407
Administrator:	Karon Lee
Licensee Designee:	Karon Lee
Name of Facility:	Candlestick CLF
Facility Address:	3123 Candlestick Lane Bay City, MI 48706
Facility Telephone #:	(989) 667-0829
Original Issuance Date:	07/15/1986
License Status:	REGULAR
Effective Date:	01/11/2023
Expiration Date:	01/10/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff Shelly Narvais forced Resident A to shower. Staff Narvais told her to stop screaming and yelling for help. Staff Narvais put Resident A in the shower chair and was being aggressive jerking Resident A's clothes off. Resident A had socks on in the shower. When out of the shower, Staff Narvais put Resident A's nightgown on while she was still soaking wet. Staff Narvais didn't put a brief or pants on Resident A. Staff Narvais pushed Resident A in her room in the shower chair and shut the door.	Yes

III. METHODOLOGY

04/11/2023	Special Investigation Intake 2023A0123035
04/13/2023	Special Investigation Initiated - On Site I conducted an unannounced on-site at the facility.
04/28/2023	Contact - Telephone call made I made a call to the assigned APS investigator Sarah LaBarge.
04/28/2023	APS Referral Information received regarding APS referral.
05/02/2023	Contact - Document Sent I sent an email to Resident A's public guardian.
05/02/2023	Contact - Document Received I received an email response from Resident A's public guardian.
05/02/2023	Contact - Telephone call made I interviewed staff Julie Green.
05/02/2023	Contact - Telephone call made I interviewed staff Shelly Narvais.
05/03/2023	Exit Conference I spoke with licensee designee Karon Lee via phone.

ALLEGATION: Staff Shelly Narvais forced Resident A to shower. Staff Narvais told her to stop screaming and yelling for help. Staff Narvais put Resident A in the shower chair and was being aggressive jerking Resident A's clothes off. Resident A had socks on in the shower. When out of the shower, Staff Narvais put Resident A's nightgown on while she was still soaking wet. Staff Narvais didn't put a brief or pants on Resident A. Staff Narvais pushed Resident A in her room in the shower chair and shut the door.

INVESTIGATION: On 04/07/2023, I conducted an unannounced on-site at the facility. I interviewed assistant home manager Trina Popp at the facility. Resident A was present as well. Resident A is limited verbally and was unable to be interviewed. Staff Popp stated that Staff Narvais is off of the schedule. She heard that Resident A was in her recliner. Staff Julie Green asked Resident A if she wanted a shower. Resident A refused. Staff Green told her okay, then staff Shelly Narvais said, “no she’s just showing her ass” and got Resident A into her wheelchair and to the bathroom. Resident A was yelling “No! Help me! Help me!” Staff Narvais had her in the shower washing Resident A’s hair while Resident A was still wearing her socks. Staff Narvais then got Resident A in her room and put her night gown on without drying her off. She left Resident A in her room and told Staff Green that Resident A needed to stay in her room until she calmed down.

Home manager Kim Nadolny was interviewed as well. She stated that per Staff Green, Staff Narvais threw Resident A in her wheelchair forcefully. Staff Narvais was not Resident A’s assigned staff. She stated that if Resident A tells staff “later” she means later, not that she won’t shower at all. She stated that Staff Narvais threw Resident A pajamas on her while Resident A was soaking wet and told Staff Green not to go into Resident A’s room, but Staff Green went in anyway and got Resident A situated.

During this on-site I obtained Resident A’s *Assessment Plan for AFC Residents* dated 01/02/2023. The assessment plan states that Resident A requires full assistance with showers and grooming needs and requires assistance with personal hygiene.

During this on-site, I observed all six residents in the home. They all appeared clean and appropriately dressed. No issues were noted.

On 04/18/2023, I received an *AFC Licensing Division- Incident/Accident Report* via email with the date of incident noted as 04/07/2023. In summary, the incident report states that staff had asked Resident A if she was ready for a shower. Resident A said “no, not right now.” The other staff said that she’s showing her ass and grabbed Resident A out of the recliner, put her in her wheelchair forcefully, then took her into the bathroom. Staff gave Resident A a shower with her socks on. After the shower, the staff person pushed her to her room, left her soaked, and put her pajamas on her wet body. Staff did not put pants or a brief on Resident A, then she slammed Resident A’s door and told the other staff not go help Resident A until she acts right.

Resident A was screaming and hitting herself the whole time. The other staff person went into Resident A's room, dried her off, put on a brief, assisted her to bed, and turned on a tv show Resident A wanted to see. Staff informed management on 04/10/2023. In the corrective measures, it states that staff was instructed to call management immediately.

On 04/28/2023, I spoke with adult protective services investigator Sarah LaBarge. Ms. LaBarge confirmed that she is investigating the allegations. She stated that she conducted an on-site, and that Resident A is unable to say what happened, but per Guardian 1, Resident A is happy living in the facility.

On 05/02/2023, I interviewed staff Julie Green via phone. She stated that she works second shift from 2:00 pm to 10:00pm. On 04/07/2023, she was the staff assigned to Resident A. She stated that she asked Resident A if she wanted to get in the shower, and Resident A said no. She stated that she told Resident A that she could shower later. She stated that staff Shelly Narvais said "*no she's not going to act like this today. She's getting in the shower*." She stated that Staff Narvais forced Resident A to shower and was being aggressive with Resident A. Staff Narvais put Resident A in the shower with her socks on, as Resident A was screaming for help. Staff Green stated that she went into the bathroom and removed Resident A's socks. She stated that Staff Narvais wheeled Resident A in her shower chair, into her room wearing only a night gown without drying Resident A off. She stated that Resident A was not wearing a brief or anything. She stated that after Staff Narvais wheeled Resident A into her room, Staff Narvais locked the shower chair wheels and closed the door. Staff Narvais then told Staff Green not to go into Resident A's room until Resident A stopped screaming.

On 05/02/2023, I interviewed staff Shelly Narvais via phone. She stated that she is an emergency relief staff person. She stated that she gave Resident A shower. She stated that Resident A screams when she feels like it. She stated that she had Resident A in the shower chair, with the seat belt buckled, and had something over her so her bottom was not showing. She stated that she did leave Resident A in her room after the shower, because she had to walk away. She stated that she put the safety breaks on, and closed Resident A's bedroom for privacy. She denied getting Resident A in the shower with her socks on. When asked if she was aggressive at any point with Resident A, she stated "*I spoke to her sternly, but not aggressive*." She stated that she does not remember if Staff Green asked Resident A if she was ready to shower. She stated that Staff Green was Resident A's assigned staff, but she took over to shower Resident A because she felt that she had more experience working with Resident A. She denied jerking Resident A's clothing off of her. She stated that she dried Resident A off to the best of her ability, and that she put a night gown and a towel over Resident A to cover her bottom area. She stated that she was fired on April 18, 2023.

On 05/02/2023, I emailed Resident A's public guardian, Guardian 1, inquiring if she was aware of the allegations, and if there's any concerns regarding Resident A's

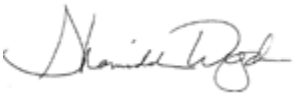
care. Guardian 1 replied back stating that she is aware of the allegations and has no concerns regarding care.

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:	An *AFC Licensing Division- Incident/Accident Report* for an incident dated 04/07/2023, was reviewed and detailed the mistreatment Resident A received from Staff Shelly Narvais. Home manager Kim Nadolny and assistant home manager Trina Popp stated that they were informed of the incident. Guardian 1 reported that she was aware of the incident but denied having any care concerns. Resident A could not be interviewed due to her limited verbal skills. Staff Julie Green was interviewed and reported that she witnessed Staff Narvais mistreat Resident A by forcefully making Resident A take a shower and shutting her in her bedroom. Staff Shelly Narvais was interviewed and admitted to shutting Resident A in her bedroom. She denied being aggressive but stated that she spoke to Resident A “sternly.” There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/03/2023, I conducted an exit conference with licensee designee Karon Lee. I informed her of the findings and conclusion.

IV. RECOMMENDATION

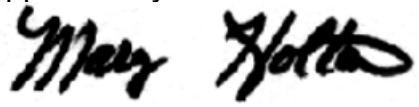
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 1-6).



05/03/2023

Shamidah Wyden Date
Licensing Consultant

Approved By:



05/03/2023

Mary E. Holton Date
Area Manager