GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 25, 2023

Monica Flagg
Elite Alternatives, Inc.
3330 Primary Rd.
Auburn Hills, MI 48326

RE: License #: AS630274298
Investigation #: 2023A0991025
Avon Group Home

Dear Ms. Flagg:

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,

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630274298
Investigation #:	2023A0991025
Complaint Receipt Date:	06/12/2023
Investigation Initiation Date:	06/12/2023
Report Due Date:	08/11/2023
Licensee Name:	Elite Alternatives, Inc.
Licensee Address:	3330 Primary Rd Auburn Hills, MI 48326
Licensee Telephone #:	(248) 852-2065
Licensee Designee:	Monica Flagg
Name of Facility:	Avon Group Home
Facility Address:	275 Lesdale Troy, MI 48085
Facility Telephone #:	(248) 879-6120
Original Issuance Date:	10/10/2005
License Status:	REGULAR
Effective Date:	04/10/2022
Expiration Date:	04/09/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident J was admitted to Beaumont Hospital on 06/02/23 with bruising and swelling all over his body that was not consistent with a fall.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/12/2023	Special Investigation Intake 2023A0991025
06/12/2023	Special Investigation Initiated - Telephone Call to Adult Protective Services (APS) worker, Brad Edwards
06/12/2023	APS Referral Referral received from adult protective services (APS).
06/12/2023	Referral - Recipient Rights Sent referral to Alanna Honkanen at Office of Recipient Rights (ORR)
06/12/2023	Contact - Telephone call made To assigned ORR worker, Katie Garcia
06/12/2023	Contact - Document Received Images of injuries
06/13/2023	Inspection Completed On-site Unannounced onsite inspection with APS worker, Bradley Edwards
06/13/2023	Contact - Document Received Health care chronological, hospital discharge paperwork, body chart
06/13/2023	Contact - Document Received Plan of service and crisis plan
06/27/2023	Contact - Document Received Email from APS worker, Bradley Edwards

07/20/2023	Contact - Face to Face With APS worker- substantiated for neglect, Resident J passed away
08/02/2023	Contact - Face to Face Unannounced onsite inspection- interviewed home managers
08/03/2023	Contact - Telephone call made Interviewed staff, Novella Jackson
08/03/2023	Contact - Telephone call made Interviewed staff, Donta Easley
08/03/2023	Contact - Telephone call made Left message for case manager
08/03/2023	Contact - Telephone call made Left message for previous home manager, Lakesha Smith
08/03/2023	Exit Conference Via telephone with licensee designee, Monica Flagg

ALLEGATION:

Resident J was admitted to Beaumont Hospital on 06/02/23 with bruising and swelling all over his body that was not consistent with a fall.

INVESTIGATION:

On 06/12/23, I received a complaint from Adult Protective Services (APS) alleging that Resident J was admitted to Beaumont Hospital in Troy on 06/02/23 with bruising and swelling all over his body that was not consistent with a fall. Resident J is nonverbal and was unable to communicate what happened to him.

I initiated my investigation on 06/12/23 by contacting the assigned APS worker, Bradley Edwards. Mr. Edwards stated that Resident J was discharged back to the home today, but they are looking into moving him to another home within the company. He stated that the medical team at the hospital had concerns because Resident J's injuries were not consistent with a fall, which was the explanation provided by the staff from the home. This was the first time Resident J was seen at Beaumont Hospital.

I reviewed photographs from Beaumont Hospital, which showed a large scrape and several smaller bruises and wounds on Resident J's back, bruising and wounds on Resident J's knees and thighs, an open wound on Resident J's right elbow, large

bruises on Resident J's right hip and thigh, and a large bruise on Resident J's right shoulder.

I reviewed a copy of an incident report dated 06/02/23, which notes that staff, Donta Easley, was doing a safety check on Resident J and was assisting him to the bathroom with his walker when Resident J lost his balance and fell to the ground. Donta noticed that Resident J's hands were swollen and looked like there was fluid buildup, so staff took him to Beaumont Hospital. Resident J was diagnosed with broken hands and ribs.

I reviewed a copy of Resident J's Easter Seals/MORC crisis prevention and safeguard plan effective 04/01/23-06/30/23. It notes that special attention needs to be given when Resident J ambulates around his home environment as he has an unsteady gait. Resident J uses his walker at home and in the community. He requires supervision at home and in the community. He has limited safety skills and safety awareness and has the potential to fall. Caregivers should know Resident J's whereabouts and check on him frequently throughout the day and night as Resident J is very curious and impulsive. The crisis plan notes that due to Resident J having an unsteady gait, his staff/caregivers need to provide close supervision when he is walking on uneven, potentially slippery surfaces, up or down stairs, and long distances. Resident J does a good job of ambulating at a safe pace most of the time. He may require assistance to exit the building in an emergency due to his unsteady gait. Resident J is taking baby aspirin. He bruises easily and caregivers need to be aware of this. Any bruises need to be documented. He needs to be monitored for any falls as well and document any bruises or abrasions as a result of a fall.

On 06/13/23, I conducted an unannounced onsite inspection at Avon Group Home. I interviewed the home manager, Kim Daniel. Ms. Daniel stated that she has worked in the home for two years. She stated that Resident J moved into the home on 04/01/23. When Resident J moved into the home, he had broken fingers. He went to the doctor about these injuries when he first moved into the home, but he has not had any other medical appointments until his hospitalization. They are in the process of getting Resident J set up with the visiting physician. Ms. Daniel stated that she was off work when Resident J fell and was taken to the hospital. On 06/02/23, direct care worker, Donta Easley took Resident J to the hospital for injuries after he fell. He had injuries to his hands and back. Ms. Daniel stated that Resident J has a history of falls and is always falling in the home. Staff check on him every fifteen minutes during waking hours. Staff assist Resident J with bathing. He can go to the bathroom on his own, but he needs assistance with wiping. Ms. Daniel stated that she was not aware of Resident J having any open wounds or sores. She typically works in the home during the day, but the other staff on shift usually assist Resident J with his personal care. Ms. Daniel stated that there are always two staff on shift. She did not have any concerns about staff being abusive and never witnessed anyone being physically aggressive towards Resident J.

On 06/12/23, I interviewed the assistant home manager, Keyon Jones. Mr. Jones stated that he has worked for the company for eight years and has worked at Avon Group

Home since December 2022. He stated that on 06/02/23, he was at the table completing his logs between 8:00am-9:00am. Resident J got up to use the bathroom and staff, Donta Easley, was assisting him. Resident J lost his balance and fell backwards. Resident J was in the hallway when this happened. Mr. Jones stated that he heard Resident J fall, but he could not see him from where he was sitting at the table. Mr. Easley helped Resident J up and noticed that his hands were swollen. Mr. Easley took Resident J to the hospital, but they gave Resident J a shower before he went to the hospital. Mr. Jones stated that when he was showering Resident J, he saw that Resident J's hands were swollen. Resident J also had marks, a scab, and a bruise on his back from an older injury. He had scuffs on his right knee and a bruise on his lower stomach, which looked old. The bruise on his stomach was from a previous incident in which he broke the strap on his shower chair while trying to get out of the chair. He had marks on his knees that looked new. He had marks on his feet from rubbing his feet on the floor. Mr. Jones did not notice any bruising or wounds on Resident J's elbows or shoulders. Resident J's left hand was broken when he moved into the home in April. Mr. Jones stated that Resident J falls frequently and will sometimes fall to his knees when staff give him showers. He also falls against the wall. Resident J goes to the bathroom on his own and requires staff assistance with showers. He is showered every day. There are always two staff on shift. Staff document falls in the health care chronological and document marks and bruises on a daily body injury check sheet. The check sheet has a body diagram on it, and staff circle any areas that have a new injury. Mr. Jones stated that he did not have any concerns about any staff being physically aggressive towards Resident J.

On 06/12/23, I observed Resident J at Avon Group Home. Resident J had numerous marks and bruises on his legs, arms, body, and hands. Resident J was fixated on getting a bag from under his bed and would not answer any questions or participate in an interview. The other residents in the home could not participate in an interview due to limited cognitive and verbal abilities.

On 07/20/23, I spoke with the assigned APS worker, Bradley Edwards. Mr. Edwards stated that he completed his investigation and substantiated for neglect. He stated that Resident J passed away recently while on a visit at a new home where his previous home manager, Lakesha Smith, whom he was very close with, worked.

On 08/02/23, I conducted an unannounced onsite inspection at Avon Group Home for an unrelated investigation. The home managers, Kim Daniel and Keyon Jones, confirmed that Resident J passed away on 07/11/23 while on a visit for a potential new placement with Lakesha Smith. The cause of death was a heart attack. Staff found him non-responsive in his room after he had been active all night. Ms. Daniel stated that Resident J had known heart issues. They had not yet received a copy of Resident J's death certificate.

On 08/03/23, I interviewed direct care worker, Donta Easley, via telephone. Mr. Easley stated that on 06/02/23, he arrived to work around 7:15am. Most of the residents were already up and ready for the day. He was at the table documenting in the residents'

books, when he heard Resident J get up. He went to assist Resident J who was walking in the hallway with his walker. Mr. Easley was right behind Resident J when Resident J fell backwards. He hit the wall and fell to the ground. Mr. Easley stated that Resident J usually gets up with no problem, but on this occasion, he was not trying to get up. Staff assisted him and noticed that his hands were swollen, so they decided to take him to the doctor. Mr. Easley stated that the other staff on shift gave Resident J a shower before he took him to the hospital. Mr. Easley stated that the hospital reported that Resident J had a fractured hand and fractured ribs following his fall on 06/02/23. This is the first time Resident J went to the hospital following a fall at Avon Group Home.

Mr. Easley stated that Resident J had a lot of marks and bruises on his body prior to his hospitalization. Resident J had a hand injury when he moved into the home. He had bruises from snapping the belt on the shower chair, a mark or “gouge” on his back from falling and hitting his back weeks earlier, and bruises all over his legs. Mr. Easley stated, “All he does is fall.” He stated that staff document big bruises in the health care chronological and they document new marks and bruises on the body check sheet. They do not document marks and bruises that were previously noted by staff, only new marks. Mr. Easley stated that Resident J only lived in the home for a few weeks, and he did not come with a fall prevention plan. They were told that Resident J could walk on his own. He went to the bathroom on his own, and he was constantly getting up to use the bathroom. Mr. Easley stated that he did not have any concerns about staff being abusive towards Resident J.

On 08/03/23, I interviewed direct care worker, Novella Jackson, via telephone. Ms. Jackson stated that she has worked at Avon Group Home for two years. She was not working on the day that Resident J fell and was taken to the hospital. She stated that Resident J fell frequently. Whenever Resident J got up, staff would assist him and walk behind him as he walked with his walker, but Resident J gets weak and does not like to be touched, so it was difficult to assist him. He would frequently fall when trying to open cabinets or when going into the bathroom. Staff document his falls in the book and have a chart that they use if they see any marks. Only new marks are documented on the chart. Ms. Jackson stated that Resident J was a very busy man, and he would get bruises any time he bumped into something. He would scrape his arm on the wall or counter, and he scraped his ankles in bed. She stated that he was bruised up when he moved into the home. She stated that Resident J used a walker and wanted to be independent, but she felt he should not be walking at all because he was too weak and fell frequently. Ms. Jackson stated that Resident J had not been to the hospital for any falls prior to falling on 06/02/23. She did not have any concerns about any staff being physically abusive or aggressive towards Resident J.

I reviewed a copy of Resident J’s health care chronological and noted the following pertinent information:

- On 04/03/23, staff from another home took Resident J to a medical appointment. He returned to the home with his left hand and fingers wrapped up. Staff were told that Resident J broke his fingers.

- On 04/06/23, Resident J was walking to the bathroom and fell backwards, pulling his walker on him, and hitting his legs and feet. He was cut and bruised.
- On 04/12/23, Resident J was getting an Ensure and lost his balance, falling and scraping his back on the fireplace in the middle of his lower back.
- On 04/19/23, Resident J fell back while trying to open the bathroom door.
- On 05/16/23, Resident J was walking from the bathroom and fell backwards pulling his walker on the cut on the bottom.
- On 05/26/23, staff was assisting Resident J with a shower. While in the shower chair with the safety straps on, Resident J leaned over trying to get up and out of the chair. He broke the shower chair strap and staff noticed a bruise on his stomach where the strap was around his stomach.
- On 06/02/23, staff was assisting Resident J to the bathroom when he lost his balance and fell to the ground backwards. As staff was helping him up, they noticed that both of his hands were swollen and took him to the hospital.
- On 06/02/23, Resident J was admitted to the hospital at 2:30pm.
- On 06/12/23, Resident J was discharged from the hospital with three medication changes and staff are to make a follow-up appointment with his primary care physician.

I reviewed copies of Resident J's daily body injury check sheets, and noted the following falls and injuries, which were not recorded in the health care chronological:

- On 04/26/23, while assisting Resident J to the bathroom, he was walking and fell straight back and hit his back on the wall. Staff noticed bruising in two spots (diagram shows circles on left shoulder and left side of back).
- On 05/02/23, Resident J was in his room when staff heard him fall. He gets up whenever he wants and does not care to be touched. (Diagram shows circles on back of left elbow and back of right wrist/hand).
- On 05/06/23, while being assisted to the dinner table, Resident J fell. When staff helped him into the chair, they noticed bruising on his knee and a scratch on the back of his elbow. (Diagram shows circles on front of left knee and back of right elbow).
- On 05/08/23, staff came in and saw bruises. (Diagram shows circles on front of right hip, front of left arm, and back of left heel).
- On 05/09/23, staff noticed bruising. (Diagram shows circles on back of left arm and back of right thigh).
- On 05/11/23, staff were assisting Resident J to the bathroom when he hit his right hand on the corner of the wall. Staff noticed a bruise on the right hand. (Diagram shows circle on back of right hand).
- On 05/17/23, staff noticed that Resident J had swelling in both of his hands. (Diagram shows circles on front of right and left hands).
- On 05/18/23, Resident J was being assisted to the bathroom and as he was getting up, he fell back. (Diagram shows circles on front of right arm, back of right and left elbows, and back of left hand).

- On 05/23/23, staff noticed a small scratch. (Diagram shows circle on back of right heel).

I reviewed Resident J's after visit summary from Beaumont Hospital. It notes that Resident J was in the hospital from 06/02/23-06/12/23. His diagnosis was falls frequently, hypotension, anemia, thrombocytopenia (low blood platelet count, which can cause easy or excessive bruising), closed fracture of transverse process of lumbar vertebra L3, multiple closed fractures of ribs of left side, closed fractures of multiple sites of phalanx of left hand, closed displaced fracture of shaft of third metacarpal bone of right hand, compression fracture of L4 vertebra, and unspecified intellectual disabilities.

On 08/03/23, I conducted an exit conference via telephone with the licensee designee, Monica Flagg. Ms. Flagg stated that Resident J resided in a private residence with Elite Alternatives for nearly 30 years before being transferred to Avon Group Home. She stated that his health was deteriorating, and it was very difficult to prevent falls, as he could not be restrained. Aside from having a one-on-one staff assigned to him, there was not much staff could do to prevent Resident J from falling. Resident J would wander constantly from morning until the middle of the night. She felt staff did the best they could to assist him and prevent falls.

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:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff did not ensure Resident J's safety and protection at all times. Resident J's crisis plan notes that special attention needs to be given when Resident J ambulates around his home environment as he has an unsteady gait and is prone to falls. Staff documented over ten falls during the time Resident J was residing at Avon Group Home from 04/01/23-06/02/23. Resident J had numerous wounds, scrapes, and bruises on his body when he was seen at Beaumont Hospital on 06/02/23, as well as fractures to his hands, ribs, and vertebra. Resident J was not seen by a doctor following any of his previous falls and there was no clear fall prevention plan in place to ensure Resident J's safety in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite inspection on 06/13/23, I requested to review a copy of Resident J's health care appraisal that was completed upon his admission to Avon Group Home. The home manager, Kim Daniel, stated that Resident J had a physical in March 2023, but there was no completed physical or health care appraisal form on file. The only medical documentation on file was Resident J's hospital discharge paperwork and a medical examination assessment dated 08/09/22, which was prior to Resident J moving into the home.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Based on the information gathered through my investigation, Resident J did not have a written health care appraisal form on file that was completed within the 90-day period before his admission to the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection on 06/13/23, one of the smoke detectors in the home was chirping, indicating that the batteries or smoke detector needed to be replaced. During a subsequent onsite inspection at the home on 08/02/23, I noted that the smoke detector was still chirping.

On 08/03/23, I conducted an exit conference via telephone with the licensee designee, Monica Flagg. Ms. Flagg stated that she would submit a corrective action plan to address the violations identified in the investigation.

APPLICABLE RULE	
R 400.14505	**Smoke detection equipment; location; battery replacement; testing, examination, and maintenance; spacing of detectors mounted on ceilings and walls; installation requirements for new construction, conversions and changes of category.**
	(4) Detectors shall be tested, examined, and maintained as recommended by the manufacturer.
ANALYSIS:	During onsite inspections at the home on 06/13/23 and 08/02/23, one of the smoke detectors in the home was chirping, indicating that the batteries or smoke detector needs to be replaced.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/03/2023

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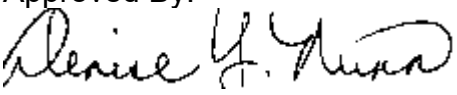
Kristen Donnay Date
Licensing Consultant

Approved By:



08/25/2023

_____

Denise Y. Nunn Date
Area Manager