GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 21, 2024

Kelly Devereaux
Mentors Of Michigan, Inc.
3812 Finch
Troy, MI 48084

RE: License #: AS630273674
Investigation #: 2024A0612013
Briarwood

Dear Ms. Devereaux:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan. 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.

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,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630273674
Investigation #:	2024A0612013
Complaint Receipt Date:	01/26/2024
Investigation Initiation Date:	01/29/2024
Report Due Date:	03/26/2024
Licensee Name:	Mentors Of Michigan, Inc.
Licensee Address:	3812 Finch Troy, MI 48084
Licensee Telephone #:	(248) 632-3534
Administrator:	Kelly Devereaux
Licensee Designee:	Kelly Devereaux
Name of Facility:	Briarwood
Facility Address:	10140 Curtis Lane White Lake, MI 48386
Facility Telephone #:	(248) 360-1714
Original Issuance Date:	03/17/2005
License Status:	REGULAR
Effective Date:	03/19/2022
Expiration Date:	03/18/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 01/24/2024, Home Manager, Crystal Diehl transported Resident A to the hospital emergency room (ER) due to bruising on Resident A's chest and abdominal wall. Resident A was examined in the ER and her injuries caused concern for possible abuse, neglect, and/or sexual assault.	Yes

III. METHODOLOGY

01/26/2024	Special Investigation Intake 2024A0612013
01/29/2024	Special Investigation Initiated - Telephone Telephone call to APS worker, Angelique Evans to coordinate.
01/29/2024	APS Referral Referral received from Adult Protective Services (APS).
01/29/2024	Contact - Document Sent Referral made to Recipient Rights Specialist, Katie Garcia via email.
01/30/2024	Contact - Document Received I received an email from APS Worker, Angelique Evans.
01/30/2024	Contact - Document Received I received an email from Recipient Rights Specialist, Katie Garcia.
01/30/2024	Contact - Document Received Copy of Resident A's Individual Plan of Service and Crisis Plan.
01/31/2024	Contact - Document Received I received an email from Recipient Rights Specialist, Katie Garcia.
01/31/2024	Contact - Document Received I received an email with a copy of Open Arms case manager, Jamie Spring case note dated, 01/29/24.
02/05/2024	Contact - Document Received I received an email from APS worker, Estelita Horton.

02/06/2024	Inspection Completed On-site I completed an unscheduled, onsite investigation in collaboration with Recipient Rights Specialist, Katie Garcia. I interviewed home manager Crystal Diehl, direct care staff Melissa McCovery, Resident B, C, D, E, and F.
02/06/2024	Contact - Document Received I received the following documentation via email: prescription for hospital bed with full bedrails, picture of bruising, Incident Report dated 01/23/24, January 2024 staff scheduled and January 2024 Community living support logs (CLS).
02/08/2024	Contact - Telephone call made Telephone interview with Open Arms case manager, Jamie Spring.
02/19/2024	Contact - Document Received I received an email from Recipient Rights Specialist, Katie Garcia.
02/23/2024	Contact - Telephone call made In collaboration with APS worker, Estelita Horton and Recipient Rights Specialist Katie Garcia I conducted telephone interviews with Harmony Care Nurse Practitioner, Shirley Vicente and home manager, Crystal Diehl.
02/23/2024	Contact - Document Sent Request for medical records sent via fax.
02/26/2024	Contact - Telephone call made In collaboration with APS worker, Estelita Horton and Recipient Rights Specialist Katie Garcia I conducted telephone interviews with direct care staff Lashanda Mansfield, Danyal Martinez, Leroy Topp, Alton Davis, home manager Crystal Diehl, and Resident A’s Guardian.
02/26/2024	Contact - Document Received I received two photos sent via text message of hospital beds.
02/26/2024	Contact - Document Received I received a copy of Resident C’s Individual Plan of services and Crisis Plan.
03/05/2024	Contact - Document Received Email received from APS worker, Ms. Horton.

03/05/2024	Contact – Telephone call made Telephone interview completed with Oakland County Medical Examiner, Dr. Richmond.
03/06/2024	Contact – Document Received I exchanged emails back and forth with Detective Snow.
03/13/2024	Contact – Document Sent I exchanged emails back and forth with Detective Snow and Oakland County Medical Examiner, Dr. Richmond.
03/13/2024	Exit Conference I placed a telephone call to licensee designee, Kelly Devereaux to conduct an exit conference.
03/19/2024	Contact – Document Received I received an email from Detective Snow.

ALLEGATION:

On 01/24/2024, Home Manager, Crystal Diehl transported Resident A to the hospital emergency room (ER) due to bruising on Resident A's chest and abdominal wall. Resident A was examined in the ER and her injuries caused concern for possible abuse, neglect, and/or sexual assault.

INVESTIGATION:

On 01/29/24, I received a referral from Adult Protective Services (APS). The referral indicated Resident A has a history of mental illness, cognitive impairment, physical disability and uses a wheelchair as she is not ambulatory. Resident A resides at Briarwood. On 01/24/24 at 8:55 p.m., Home Manager, Crystal Diehl transported Resident A to the hospital emergency room (ER) due to bruising to Resident A’s chest and abdominal wall. Resident A was examined in the ER and her injuries caused concern for possible abuse. Resident A was diagnosed with a collapsed lung and multiple rib fractures. Resident A could not have caused these injuries herself due to her disability. On 02/20/24, I received another intake from APS that contained additional allegations. The referral indicated on 01/24/24, Resident A was taken to hospital and died on 02/18/24. It was found that Resident A had multiple rib fractures and there is suspected abuse, neglect, and/or sexual assault. APS denied the referral for investigation.

On 01/29/24, I initiated my investigation by placing a telephone call to assigned APS worker, Angelique Evans. There was no answer. I left a voicemail requesting a return call to coordinate. On 01/29/24, I made a referral via email to Oakland Community Health Network (OCHN) – Office of Recipient Rights (ORR). Recipient Rights Specialist,

Katie Garcia was already aware of the allegations. Ms. Garcia and I scheduled a date to conduct an unscheduled onsite investigation.

On 01/30/24, I received an email from APS Worker, Angelique Evans, she stated that she is going on leave and the case will be reassigned. On 02/05/24, I received an email from APS worker, Estelita Horton. Ms. Horton stated that the case was reassigned to her.

On 01/30/24, I received an email from Recipient Rights Specialist, Katie Garcia that indicated she interviewed licensee designee, Kelly Devereaux. Ms. Devereaux stated Resident A has a hospital bed with bedrails and she will throw herself into her bedrails. Ms. Devereaux stated that there was a picture sent on 01/21/24 to home manager, Crystal Diehl from a staff reporting the bruise. Ms. Devereaux did not see the bruise until after this incident. Ms. Devereaux said if she would have witnessed it at the time, she would have asked staff to gently touch it and if there were no concerns to continue to monitor. Ms. Devereaux saw a picture of the bruise on 01/24/24, and that is when she instructed the staff to take Resident A to the hospital. Ms. Devereaux stated this home has long term staff. They do not use fill in staff because of the medically fragile individuals who live here. Ms. Devereaux stated that she cannot understand when or how the injury occurred, as Resident A did not have any big falls, accidents, or anything unusual happening.

On 01/31/24, I received an email from Recipient Rights Specialist, Katie Garcia that indicated she interviewed Open Arms case manager, Jamie Spring. Ms. Spring was at the hospital on 01/30/24, Resident A is currently in the Intensive Care Unit (ICU) sedated. Ms. Spring implied that she may not make it. Resident A has a MRSA blood infection, that she is "touch and go" and has a long way to recovery. Ms. Spring further stated that she spoke with the physician, who reported that Resident A’s ribs are "shattered”, and the injuries appear to be one to two weeks old. The injuries are consistent with "high velocity trauma." The physician said the injuries that Resident A has are like something they would see from a person who was in a car accident, high velocity trauma. The physician stated that she has pockets of "puss" in the injuries and ribs 4-11 are "shattered."

I reviewed Open Arms case manager, Jamie Spring case notes dated, 01/29/24. The following is a summary of relevant information:

> The surgical resident came by to give a report on how the surgery went. Resident A had a left side thoracotomy. Ribs 4, 5, 6, 7, 8, 9, 10, 11 are reported to have been shattered and they were unable to plate and stabilize them because she also has sepsis & a MRSA infection in her blood. Her left lung was compressed and surrounded by inflammatory disease. The doctor explained that there was empyema which he explained is fluid (pus) encased in a rind (like a rotting orange) which indicates that the injury was not new. When asked if he could approximate how old the injury is he stated 1-2 weeks. He did indicate that the lung was re-inflated and that the ribs should fuse back together but will take them

longer. He also reports that there is no air leak in the lung and her chest tube is draining nicely. He went on to report that the diaphragmatic hernia was able to be repaired. The bowel was not perforated and looked healthy. The bowel was placed back in the abdominal cavity. They will do a small bowel contrast follow thru tomorrow to make sure that everything is moving through properly. The doctor reports that the shattered ribs along with the diaphragmatic hernia is "consistent with a motor vehicle accident or a forceful trauma with high velocity." The left side of her torso was observed to be slightly caved in. The doctor estimates that if all goes well and she does not have any setbacks, she will spend another 2-3 days in ICU then 4-5 days in a general bed and will have the chest tube for 4-5 days. He stressed that this was the plan if everything continues to go well and there are not any complications or setbacks.

On 02/06/24, in collaboration with Recipient Rights Specialist, Katie Garcia I completed an unscheduled, onsite investigation I interviewed home manager Crystal Diehl, direct care staff Melissa McCovery, Resident B, Resident C, Resident D, Resident E, and Resident F.

On 02/06/24, I interviewed Resident C. Resident C was observed sitting in the kitchen at the table. Resident C was appropriately dressed and well groomed. Resident C answered all interview questions with the phrase, “existence exists.”

On 02/06/24, I interviewed Resident B. Resident B was observed sitting at the kitchen table in her wheelchair. She was appropriately dressed and well groomed. Resident B was minimally verbal. When asked if she knew how Resident A sustained her injuries she remarked, “I don’t know.”

On 02/06/24, I interviewed Resident F. Resident F was observed sitting in the living room in a chair. She was appropriately dressed. Resident F is nonverbal and made minimal eye contact, she was unable to be interviewed for this investigation.

On 02/06/24, I interviewed Resident D. Resident D was observed sitting in the living room watching a movie. Resident D spoke about an incident when Resident F fell however had no information regarding Resident A and how she sustained her current injuries.

On 02/06/24, I interviewed Resident E. Resident E was observed sitting in the living room. Resident E is Deaf and has autism. He was unable to be interviewed for this investigation.

On 02/06/24, I interviewed home manager, Crystal Diehl. In collaboration with APS Worker, Ms. Horton, and Recipient Rights Specialist, Ms. Garcia I interviewed Ms. Diehl again on 02/23/24, and 02/23/24 via telephone. Ms. Diehl stated that she has worked at this home for four years. On Sunday, 01/21/24, direct care staff Melissa McCovery texted her a picture of a bruise that she observed on Resident A’s left side. Ms. Diehl did not receive the text message until Monday, 01/22/24, because she was experiencing issues with her phone. Ms. Diehl stated when she observed the picture of

the bruise it was small and appeared black and yellow. When she arrived to work on Wednesday, 01/24/24, she observed that the bruise had tripled in size and looked dark purple. Ms. Diehl took Resident A to the emergency room. Ms. Diehl stated Resident A could not communicate pain, she only made noises. Resident A was not making noises and did not seem to be in pain during the days leading up to her hospitalization.

Ms. Diehl stated approximately two to three months ago, Resident A was prescribed a hospital bed with full bedrails. On Monday, 01/22/24, after the bruising on Resident A's side as first observed, during a bed check she found Resident A sitting up in her bed. Resident A had taken the bedrails off her bed. Ms. Diehl stated Resident A did not have any additional injuries, there were no changes to the bruise on her left side. Ms. Diehl completed an Incident Report. Ms. Diehl stated Resident A's hospital bed with bedrails was delivered and installed by the medical supply company. To remove the bedrails, you must pull up on the rails and press a button. Ms. Diehl said she does not know how Resident A's injuries were caused, but she suspects she could have injured herself on the bedrails. Although Resident A uses a wheelchair, and does not walk, she is able to use her upper body and pull herself up. Resident A tosses and turns in her bed and sometimes puts her head at the foot of the bed. Ms. Diehl stated she has never witnessed Resident A fall or lean over the bedrails.

Ms. Diehl stated before she requested a prescription for a hospital bed with full bedrails she contacted Open Arms case manager, Jamie Springs. Ms. Springs suggested that Resident A's bed be moved to the ground as opposed to getting bedrails because Resident A is known to get herself out of her bed. Ms. Diehl chose to request the prescription for a hospital bed with full bedrails despite the conversation she has with Ms. Spring. Ms. Diehl explained Resident A was prescribed a hospital bed with full bedrails however when the bed was delivered, they received a hospital bed with partial bedrails. She accepted the delivery, and the bed was put into Resident A's bedroom. Resident A continued to get out of her bed with the partial bedrails. The home had a previous resident, Resident G who died in August 2023. Resident G had a hospital bed with full bedrails, his bed was still at the home. Ms. Diehl put Resident G's prescribed hospital bed with full bedrails into Resident A's bedroom. Ms. Diehl stated the hospital bed raised up and down, it was kept in an elevated positioned while Resident A was in bed. Resident A was using Resident G's hospital bed with full bedrails at the time she removed the rails and was found by Ms. Diehl during the evening bed check. When Resident A was hospitalized, the hospital bed with full bedrails was removed from her bedroom and her bed was lowered to the ground.

Ms. Diehl stated Resident A goes to New Gateway in Waterford, MI on Mondays, and Wednesdays from 9:00 am – 3:00 pm. However, Resident A was on winter break and did not go to New Gateway from December 2023 to January 2024. Ms. Diehl stated Resident A does not go out of the house with anyone other than staff and she has not gone out on any outings recently. Ms. Diehl denies that any of the residents who live in the home are aggressive. She does not suspect that another resident caused harm to Resident A. Ms. Diehl stated Resident A receives full assistance with bathing. She is

never alone while in the bathroom. Resident A did not sustain any injuries while being bathed. Ms. Diehl denied that she physically and/or sexually abused Resident A.

On 02/06/24, I interviewed direct care staff, Melissa McCovery. Ms. McCovery stated she has worked with this company for five years however, she just started working at this home in November 2023. Ms. McCovery works 24-hour shifts, twice a week, 12:00 pm – 12:00 pm. On Sunday, 01/21/24, Ms. McCovery observed a small bruise on Resident A's left side. The bruise looked new; it was blue. Ms. Covery informed home manager, Ms. Diehl of the injury. Ms. McCovery stated she does not know how Resident A sustained this injury however, she suspects that Resident A may have injured herself on her bedrails. Resident A is known to toss and turn and try to get herself out of bed. Ms. McCovery stated she does not suspect that another resident or any staff caused Resident A's injuries. Ms. McCovery denied that she physical and/or sexually abused Resident A. Ms. McCovery stated Resident A has not been in any car accidents, she does not leave the home often. Resident A is assisted while bathing. She did not experience any accidents or injuries while bathing. Resident A uses a wheelchair. Ms. McCovery has not witnessed Resident A fall or injury herself while in her wheelchair.

On 02/19/24, I received an email from Recipient Rights Specialist Katie Garcia. Ms. Garcia stated she was informed that Resident A died in the hospital on 02/18/24. An autopsy was completed, the results are unknown. Resident A's cause of death is "pending." Ms. Garica further reported that she spoke to Open Arms case manager, Jamie Spring who indicated Resident A's Guardian told her that a bone density test was completed, and Resident A was found to have very brittle bones. Resident A's Guardian informed her that a physician spoke with her and said that Resident A's injuries could have been caused by a fall, given how fragile her bones appear to be.

On 02/08/24, I completed a telephone interview with Open Arms case manager, Jamie Spring. Ms. Spring has worked with Resident A since 1996. Ms. Spring stated during Resident A's individual planning meeting it was discussed that she was getting herself in and out of bed and staff would come to complete bed checks and find that she had gotten out of bed. Bedrails were discussed however it was decided that bed rails could potentially be dangerous as she could hurt herself on them. Home manager Ms. Diehl attended the individual planning meeting, and she was a part of this discussion. Ms. Spring stated she was not aware that a prescription for bedrails was obtained. Ms. Spring stated while she was at the hospital she spoke to Resident A's physician and inquired if the bedrails could have caused Resident A's injuries, he said no. Ms. Spring stated she is familiar with all the residents in the home except Resident C. She does not believe that any of the residents caused Resident A' s injuries. Ms. Spring stated Resident A has a high pain tolerance. She has a history of self-harm which includes beating herself in the head with a closed fist and biting herself. If Resident A had been injured for a long time, it is likely she would not have shown any signs of pain.

On 02/23/24 and 02/26/24, in collaboration with APS worker, Estelita Horton and Recipient Rights Specialist Katie Garcia I conducted the following telephone interviews:

On 02/23/24, I interviewed Harmony Care Nurse Practitioner, Shirley Vicente via telephone. Ms. Vincente stated Resident A had cerebral palsy. She completed a visit to the home two weeks ago however, she was unable to meet with Resident A during this visit because she was in the hospital. A week later she was notified by the Harmony Care Nurse Case Manager, Jamie that Resident A died. The notification Harmony Care received indicated that Resident A had multiple rib fractures, injury to her diaphragm, and suspected sexual abuse. As a result of this notification an APS referral was completed. Ms. Vincente stated Harmony Care will not receive the hospital medical records and therefore she is unaware of the results of any tests completed while Resident A was hospitalized. Ms. Vincente stated she worked with Resident A since November 2022. She completed in home visits almost monthly. She never observed any concerns or issues with the care Resident A received. Ms. Vincente wrote the prescription for Resident A’s hospital bed with a full bedrail. Ms. Vincente does not think the bedrails could have caused Resident A’s injuries. Ms. Vincente was asked if Resident A could have independently removed her bedrails. Ms. Vincente does not believe that Resident A would have been strong enough to remove her bedrails unless they were installed incorrectly. To remove bedrails, you would need to be standing outside of the bed and click the buttons that keep the rails secure and in place. Ms. Vincente stated it would be more likely that Resident A could get caught in the bedrails if she was trying to get herself out of bed. Ms. Vincente stated Resident A did not have any indication of brittle bones she was not diagnosed with osteoporosis. Ms. Vincente’s last visit with Resident A was on January 2, 2024. There were no noted concerns during the appointment. Resident A weighted 94 lbs., which was normal for her. Ms. Vincente stated Briarwood staff were generally helpful. Ms. Vincente did not conduct full body scans of Resident A. However, she notes that there was no medical reason that Resident A would bruise easily.

On 02/26/24, I completed a telephone interview with direct care staff, Lashanda Mansfield. Ms. Mansfield began her employment in June 2022. Ms. Mansfield denied the allegation stating that she did not physically and/or sexually abuse Resident A. Ms. Mansfield further stated she does not believe Resident A’s injuries were caused by any of the other residents who reside in the home. Ms. Mansfield stated she worked on Sunday, 01/21/24, with direct care staff, Melissa McCovery. She observed a small bruise on Resident A’s side, and she completed an Incident Report. On Monday, 01/22/24, the bruise had gotten bigger, it was on Resident A’s left side underneath the side of her bra. Ms. Mansfield informed home manager, Crystal Diehl. Ms. Diehl asked if she had completed an Incident Report and she told her that she did. On Tuesday, 01/23/24, the bruise looked worse, it looked swollen. On Wednesday, 01/24/24, Ms. Diehl took Resident A to the hospital. Ms. Mansfield stated Resident A did not appear to be in pain. Ms. Mansfield is not aware of how Resident A sustained the injury however

she suspects that she could have injured herself on her bedrails. Ms. Mansfield explained when she started working in the home, she was told that Resident A could get herself out of bed and she would walk to the living room. This did not happen on every shift but there were times when staff were completing bed checks during the night and Resident A would be found on her bedroom floor. Home manager, Ms. Diehl was aware of this ongoing issue, and she got bedrails for Resident A. Initially, Resident A had a hospital bed with partial bedrails. However, Resident A continued to get out of her bed at night. Ms. Mansfield stated she never witnessed Resident A getting out of her bed, but Resident A had to have been climbing over the rails. Approximately two weeks prior to Resident A's hospitalization, Ms. Diehl switched Resident A's bed to another bed that they had at the home. This bed belonged to a former resident; Resident G. Resident G is now deceased. Resident G's hospital bed had full bedrails. The bed raised up and down and it was in a raised position during the night while Resident A was sleeping. Ms. Mansfield stated Resident A continued to get out of the bed even with the full bedrails. Ms. Mansfield further stated the bed with partial bedrails that was delivered for Resident A was moved to Resident C's bedroom. He is currently using that bed.

On 02/26/24, I completed a telephone interview with direct care staff, Danyal Martinez. Ms. Martinez began her employed three years ago. Ms. Martinez stated she worked on Sunday, 01/21/24, and she got Resident A ready for bed. While doing so she did not observe any bruising to her body. When she returned to work on Thursday, 01/25/24, she was informed that Resident A was in the hospital. Ms. Martinez denied the allegation and stated she did not physically and/or sexually abuse Resident A. Ms. Mansfield stated she does not believe Resident A's injuries were caused by any of the other residents who reside in the home. Ms. Martinez stated when she began her employment, she was told that Resident A was known for getting herself in and out of bed. Although she has never observed her doing it, she has found Resident A on her bedroom floor during the night. Home manager, Ms. Diehl requested a hospital bed with bedrails to assist with keeping Resident A in bed. The bed that was delivered had half bedrails and Resident A continued to get out of her bed. Ms. Martinez explained the home had a resident who is now deceased, Resident G. Resident G used a hospital bed with full bedrails. Ms. Diehl put Resident G's hospital bed with full bedrails into Resident A's bedroom. Ms. Martinez stated at the time the bruising was initially observed on Resident A's left side she was using Resident G's hospital bed with full bedrails. Resident A's hospital bed with partial bedrails was given to Resident C.

On 02/26/24, I interviewed Direct Care Staff, Leroy Topp via telephone. Mr. Topp has worked at this company since 2011. He is a floating staff, he works at this facility on Saturday – Sunday, his shift is 24 hours. Mr. Topp stated on Sunday morning (date unknown) he assisted Resident A with getting dressed, while dressing her he did not observe any bruising or redness on her body. Mr. Topp was informed later that week, on Tuesday (date unknown) that Resident A was taken to the hospital due to a bruise on her side. He was surprised to learn of this as he did not see any bruising to her body while on his shift just a few days prior. Mr. Topp stated since he has worked at the home Resident A has always gotten herself out of bed. During bed checks staff would

sometimes find her on the floor in her bedroom and she would need to be assisted back into bed. The home obtained a hospital bed with bedrails to assist Resident A with staying in bed. Mr. Topp stated the hospital bed was slightly elevated off the floor at medium height. Mr. Topp stated he does not know how Resident A's injuries were caused however, he does not suspect that Resident A was physical and/or sexual abused by any staff. Mr. Topp denied that he physically and/or sexually abused Resident A. Mr. Topp stated he does not believe Resident A's injuries were caused by any of the other residents who reside in the home. Mr. Topp stated he does not assist Resident A with bathing, the women staff shower Resident A. However, he did not witness and/or hear about any incidents of Resident A being injured while bathing.

On 02/26/24, I completed a telephone interview with direct care staff, Alton Davis. Mr. Davis begin his employment in 2022. Mr. Davis denied the allegation stating that he has never physically and/or sexually abused Resident A. Mr. Davis stated Resident A has always been able to get herself out of bed. He has never witnessed her do it, but he has found her on her bedroom floor during the night shift. Mr. Davis stated Resident A received a hospital bed with partial bedrails, she continued to get out of bed. She then got a hospital bed with full bedrails. The bed raised up and down and it was kept in a slightly lifted position off the floor. Mr. Davis stated he did not directly see Resident A's injuries however on Monday, 01/22/24, or Wednesday, 01/24/24, direct care staff, Lashanda Mansfield was showing home manager, Ms. Diehl the bruise and he oversaw a bruise on Resident A's left side, it was red in color.

On 02/26/24, I interviewed Resident A's Guardian via telephone. Resident A's Guardian stated she is unaware of how Resident A's injuries were caused, and she did not request the hospital medical records. Resident A's Guardian stated in summary, Resident A had sepsis and MRSA in her lungs, shattered ribs, injury to her diaphragm, lung damage, and her bowel moved into her chest. Resident A's Guardian was surprised by Resident A's injuries as she stated whenever she visited the home, Resident A always looked very nice, she was clean, and she always smiled. Resident A's Guardian last visited the home before Christmas 2023. She did not go inside, but Resident A's stepfather went inside and said everything looked good. Resident A's aunt also visited the home often and never noted any issues or concerns.

Resident A's Guardian stated she was always present for Resident A's individual planning meeting; however, she could not attend this year's meeting as she was ill. She discussed the plan with Open Arms case manager, Jamie Spring. Ms. Spring has worked with Resident A since 1996 and she knows her well. Resident A's Guardian stated during the conversation, Ms. Spring suggested lowering Resident A's bed to the floor as she would frequently get herself out of bed. Resident A's Guardian stated she was later contacted by home manager, Crystal Diehl who suggested getting a hospital bed with bedrails for Resident A. Resident A's Guardian agreed. Resident A's Guardian stated she received a telephone call from Ms. Diehl who informed her that she found Resident A in her bedroom, and she had removed her bedrail. Resident A's Guardian stated Resident A has a long history of self-injurious behavior including hitting herself in

the head and banging her body against the bedrail. Resident A's Guardian stated she felt that the Briarwood staff were providing care that was within Resident A's best interest. The staff were attentive and loving. Resident A's Guardian does not suspect that any Briarwood staff caused or contributed to Resident A's injuries.

On 03/05/24, I completed a telephone interview with Oakland County Medical Examiner, Dr. Richmond. Dr. Richmond stated Resident A's Death Certificate is pending as a manner of death has not yet been determined, the investigation is ongoing. Dr. Richmond explained that Resident A's death was the result of a severe infection, she went septic, and the infection spread to her abdomen. Resident A also had numerous rib fractures. The cause of the fractures is currently unknown. Dr. Richmond was not aware of any allegations of sexual abuse, she did not complete a rape kit. Dr. Richmond completed an external exam of Resident A's genitalia, there were no frank injuries.

On 03/05/24, I received an email from APS worker, Ms. Horton. Ms. Horton stated her case is closed. She did not substantiate for physical abuse.

On 03/06/24, I exchanged emails back and forth with Detective Snow with the White Lake Police Department. Detective Snow stated the police investigation is ongoing. The hospital medical records have not yet been received. Detective Snow was advised by the records department that they were still finalizing the records and they will be mailed due to size.

On 03/13/24, I emailed Detective Snow requesting a status update on the police investigation. Detective Snow stated the hospital medical records have not yet been received. She will notify me when she obtains the documentation.

On 03/13/24, I emailed Oakland County Medical Examiner, Dr. Richmond requesting a status update on the death certification and/or manner of death. Dr. Richmond stated she is still working on her case and reviewing the microscopic slides and the medical records. Currently, she does not have an update to provide. The death certificate is not available at this time.

On 03/19/24, I received an email from Detective Snow who stated she received Resident A's medical records. There are 4,900 pages. Detective Snow has transferred the files onto a USB and is sending them for my review via US Mail.

I reviewed the following relevant documentation:

- Resident A's Individual Plan of Service (IPOS) dated 09/11/23.
  Resident A's IPOS states "looking into getting her a lower bed and possibly a concave mattress to help her to not roll out of bed. Bed rail discussion was had, and (Resident A) can get in and out of bed so potentially bedrails could be restrictive and cause her to get tangled in them and hurt herself."
- Resident A's Crisis Plan dated 09/11/23.

Resident A's Crisis Plan in summary sates, Resident A has a history of getting up out of bed, sleeping on the floor or in her roommate's bed. Resident A has experienced falls related to getting out of bed on her own. Resident A requires full assistance when bathing due to her inability to shower herself, being unaware of dangers, and risk of falling due to her unsteady gait.

- Resident A's prescription dated 09/28/2023 for a hospital bed with full bedrails.
- A picture taken by direct care staff Melissa McCovery sent via text message on 01/21/24, to home manager, Crystal Diehl. In the picture the bruise on Resident A's left side is small, and purple/ blue.
- Incident Report (IR) written on 01/23/24, by home manager Crystal Diehl. In summary, the IR indicates during a bed check Ms. Diehl found that Resident A had removed her bedrails. The bedrails were put back on her bed and Resident A was monitored until she fell asleep.
- Resident A's January 2024 Community living support logs (CLS). The CLS logs noted no falls, injuries, accidents, outings, etc., that may have caused or contributed to Resident A's injuries.
- Briarwood January 2024 staff scheduled.
- Resident C's Individual Plan of services dated 11/20/2023. There is no recommendation for a hospital bed and/or bedrails.
- Resident C's Crisis Plan dated 07/24/23. There is no recommendation for a hospital bed and/or bedrails.
- Two pictures of hospital beds, one with partial bedrails and the other with full bedrails. The bed with partial bedrail is in Resident C's bedroom.

On 03/13/24, I placed a telephone call to licensee designee, Kelly Devereaux to conduct an exit conference and review my findings. Ms. Devereaux acknowledged the recommendation of a provisional license and verbally agreed to complete a corrective action plan and accept the provisional license. Ms. Devereaux stated unfortunately, she was not aware until after the incident that Resident A's individual plan of service stated her bed should be lowered to the ground as opposed to a hospital bed with bedrails. Ms. Devereaux further stated the hospital bed has been removed from Resident C's bedroom. He is now in a standard bed. Leadership is completing daily checks to the home during the day and night. Home manager Ms. Diehl has increased her communication with the leadership team. As a result of this investigation, Ms. Diehls position/ employment status will be assessed, and additional training will be provided. Ms. Devereaux also acknowledged that she understands pending the police investigation, if relevant information is received based on the outcome of the police case, this investigation may be reopened.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**

	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the information gathered through my investigation there is sufficient information to determine that supervision, protection, and personal care as specified in Resident A's written assessment was not followed. Resident A's Individual plan of Service (IPOS) and her Crisis Plan consistently indicate Resident A has a history of getting up out of bed, sleeping on the floor or in her roommate's bed. Resident A has experienced falls related to getting out of bed on her own. Resident A's IPOS specifically documents that lowering her bed and possibly getting a concave mattress to help her to not roll out of bed was discussed. Bedrail discussion was had, but Resident A could get in and out of bed so potentially bedrails could be restrictive and cause her to get tangled in them and hurt herself. Home manger, Crystal Diehl, who was present for Resident A's IPOS meeting requested a prescription for a hospital bed with full bedrails. Before doing so she contacted Open Arms case manager, Jamie Springs. Ms. Springs suggested that Resident A's bed be moved to the ground as opposed to getting bedrails because Resident A is known to get herself out of her bed. Home manager, Ms. Diehl chose to request the prescription for a hospital bed with full bedrails despite the conversation she had with Ms. Spring and the risk of harm discussed during the IPOS meeting which was documented in Resident A's written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 determine Resident A's personal needs including protection and safety were not attended to at all times. Resident A sustained serious injuries.

	Resident A had a left side thoracotomy, ribs 4, 5, 6, 7, 8, 9, 10, 11 were shattered, she had sepsis & a mrsa infection in her blood. Her left lung was compressed and surrounded by inflammatory disease. Home manager Crystal Diehl, direct care staff Melissa McCovery, Lashanda Mansfield, Danyal Martinez, Leroy Topp, Alton Davis, Residents B, C, D, E, and F were interviewed, and no one was able to say with certainty how Resident A sustained these injuries.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	Based on the information gathered through my investigation there is sufficient information to determine Resident C's written assessment plan does not specify the use of a hospital bed with full and/or partial bedrails. It was consistently reported by direct care staff interviewed that Resident C is currently using the hospital bed with partial bedrails that was delivered to the home for Resident A. I observed a picture of the hospital bed with partial bedrail set up in Resident C's bedroom.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	Based on the information gathered through my investigation there is sufficient information to determine that although Resident A had a prescription for a hospital bed with full bedrails the bed that was delivered for her was not the bed that she was sleeping in. Home manager, Crystal Diehl explained Resident A was prescribed a hospital bed with full bedrails however when

	the bed was delivered, they received a hospital bed with partial bedrails. She accepted the delivery, and the bed was put into Resident A's bedroom. Resident A continued to get out of her bed with the partial bedrails. The home had a previous resident, Resident G who died in August 2023. Resident G had a hospital bed with full bedrails, his bed was still at the home. Ms. Diehl put Resident G's prescribed hospital bed with full bedrails into Resident A's bedroom. At the time of Resident A's injuries, she was sleeping in Resident G's hospital bed that was not authorized for her use. There was an incident on Monday, 01/22/24, after the bruising on Resident A's side was first observed, where Ms. Diehl found Resident A sitting up in her hospital bed with full bedrails, Resident A had taken the bedrails off. Harmony Care Nurse Practitioner, Shirley Vicente stated Resident A would not have had the ability to remove her bedrails unless they were installed incorrectly. As this bed Resident A was using was not delivered to the home and installed in Resident A's bedroom for her use it cannot be confirmed that the hospital bed with full bedrails was assembled correctly. Moreover, after the bed was put back together by Ms. Diehl it cannot be confirmed that it was assembled correctly to prevent injury to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Based on the information gathered through my investigation there is insufficient information to determine any form of physical force was used against Resident A. All staff interviewed denied physical abuse against Resident A. Other than the APS referral there were no reports of concern that Resident A's injuries were caused by Briarwood staff or any residents who resides in the Briarwood home. APS worker, Ms. Horton did not substantiate for physical abuse. Resident A's Guardian felt that the

	Briarwood staff were providing care that was within Resident A's best interest. The staff were attentive and loving. Resident A's Guardian does not suspect that any Briarwood staff caused or contributed to Resident A's injuries. Harmony Care Nurse Practitioner, Shirley Vicente did not observe any concerns that Resident A was being physically abused. Ms. Vincente stated Briarwood staff were generally helpful, she noted no concerns during her monthly visits to the home.
CONCLUSION:	VIOLATION NOT 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 the information gathered through my investigation there is insufficient information to determine that Resident A was mistreated including any intentional action or omission which exposes her to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means. All staff interviewed consistently denied the allegation stating they have not physically and/or sexually abused Resident A. There were no reports of mistreatment, physical, or emotional harm. Oakland County Medical Examiner, Dr. Richmond was not aware of any allegations of sexual abuse, she did not complete a rape kit however, an external exam of Resident A's genitalia, showed there were no frank injuries.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

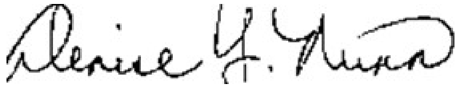
Contingent upon recipient of an acceptable corrective action plan, issuance of a provisional license is recommended.

However, due to the pending police investigation, if relevant information is received based on the outcome of White Lake Police Department's investigation, this investigation may be reopened.

03/19/2024

Johnna Cade Date
Licensing Consultant

Approved By:



03/21/2024

Denise Y. Nunn Date
Area Manager