GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 18, 2024

Holly Heath
Community Opportunity Center NPHC
14147 Farmington Rd
Livonia, MI 48154

RE: License #: AS820067419
Investigation #: 2024A0992024
Milburn II House

Dear Holly Heath:

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 #:	AS820067419
Investigation #:	2024A0992024
Complaint Receipt Date:	03/13/2024
Investigation Initiation Date:	03/15/2024
Report Due Date:	05/12/2024
Licensee Name:	Community Opportunity Center NPHC
Licensee Address:	14147 Farmington Road Livonia, MI 48154
Licensee Telephone #:	(734) 838-0536
Administrator:	Holly Heath
Licensee Designee:	Holly Heath
Name of Facility:	Milburn II House
Facility Address:	19415 Milburn Livonia, MI 48152
Facility Telephone #:	(248) 615-7569
Original Issuance Date:	10/16/1995
License Status:	REGULAR
Effective Date:	10/10/2023
Expiration Date:	10/09/2025
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
On 3/11, Resident A fell while getting into the van and hurt her leg. She was unattended and unsupervised. She laid on the ground for an unknown amount of time.	Yes

III. METHODOLOGY

03/13/2024	Special Investigation Intake 2024A0992024
03/13/2024	APS Referral denied
03/13/2024	Referral - Recipient Rights
03/15/2024	Special Investigation Initiated - On Site Sheanell Horton, home manager; Kelsey Bartlett, medical coordinator; Marchelle Huntley, direct care staff and Resident A.
03/18/2024	Contact - Telephone call made Holly Heath, licensee designee was not available; message left.
03/18/2024	Contact - Telephone call made Monica Walker, direct care staff. Ms. Walker was unable to discuss the allegations and agreed to call me back.
03/18/2024	Contact - Telephone call made Guardian A, Resident A's guardian.
03/19/2024	Contact - Telephone call received Ms. Walker
03/19/2024	Contact - Telephone call received Exit Conference with licensee designee, Holly Heath

ALLEGATION: On 3/11, Resident A fell while getting into the van and hurt her leg. She was unattended and unsupervised. She laid on the ground for an unknown amount of time.

INVESTIGATION: On 03/15/2024, I completed an unannounced onsite inspection. I interviewed Sheanell Horton, home manager; Kelsey Bartlett, medical coordinator; Marchelle Huntley, direct care staff and Resident A regarding the allegation. I interviewed Resident A, she confirmed she fell while trying to get in the van. She said they were going to a Saint Patrick's Day dance. I asked Resident A if she could recall which staff was on shift and she said she believes it was "Kelsey," Resident A was unsure of Kelsey's last name. When asked if there was another staff working along with Kelsey, she said yes but could not recall the staff's name. She said she believes it was Kelsey that told her to go to the van which was in the garage. Resident A said she proceeded to the van. She said she put her left foot up to get in the van and her right foot slipped and went under the van. Resident A said she slipped on some water. She said she was on the ground yelling out for help, but no one responded. Resident A said she is not sure how long she was on the ground. She said Resident B was in the van, but there was no staff in the garage with her. Resident A said she hit her head, but her helmet protected her from injuring her head. She said she hurt her right leg. I observed bruising on her right leg near her shin area. Resident A said she was transported to the hospital by the ambulance and examined.

I Interviewed Kelsey Bartlett, medication coordinator. Kelsey denied she was on shift. She said on the day the incident occurred she worked from 7:30 a.m. to 3:00 p.m. She said based on the incident report and case notes, the incident occurred around 6:15 p.m. and she was not on shift. She said at the time direct care staff Moncia Walker and Marchelle Huntley were on shift. Ms. Bartlett said Resident A gets her days and times confused. Ms. Bartlett said from her understanding Resident A attempted to get into the van by herself without staff. I asked if Resident A requires staff assistance when getting in and out of the van, and she said yes. Typically when transporting, the residents and staff leave out at the same time. She said as it relates to Resident A, staff should always assist her when getting in and out of the van due to her unsteady gait and fall history. Ms. Bartlett said it is also outlined in Resident A's individual plan of services (IPOS). Ms. Bartlett said Resident A was transported the hospital and Ms. Walker accompanied her and Ms. Huntley remained at the home with the other residents.

I interviewed Sheanell Horton, home manager; she confirmed the allegation. She said she received a call at approximately 8:34 p.m. from Ms. Walker stating Resident A fell and she is complaining of leg pain. Ms. Horton said she instructed Ms. Walker to call 911 and Resident A was transported to the hospital. She said Ms. Walker went to the hospital with Resident A and she was later relieved by the midnight staff. Ms. Horton said as it pertains to Resident A falling, from what she gathers Ms. Walker told Resident A to go to the van and she fell. Ms. Horton said Ms. Walker is aware Resident A needs assistance when getting in and out of the van. Ms. Horton

said Resident A's IPOS clearly indicates she needs assistance due to her unsteady gait and fall risk. She said both staff are familiar with Resident A's IPOS, and they signed acknowledging they read the IPOS. I asked about the whereabouts of Ms. Huntley at the time the incident occurred. Ms. Horton said Ms. Huntley was eating her dinner. She further explained that there are 4 residents in the home and the staff are assigned 2 residents per staff. She said on the day in question, Resident A was assigned to Ms. Walker. I explained that although the residents are assigned to a specific staff, both staff are responsible for the supervision, protection, and personal care of all the residents while on shift. I asked about the regular practice when transporting residents. Ms. Horton said when it is time for transport, the residents and staff leave out at the same time. She said if for any reason a resident is running behind, one staff is to remain with that resident and the other staff can assist the other residents with getting in or out the van.

I interviewed Marchelle Huntley. Ms. Huntley said she was sitting at the counter eating her food before they transported the residents to the dance. She said Ms. Walker told the residents to get ready to leave. She said some of the residents went to the bathroom and some went and grabbed their coats. She said once all the residents were ready, Ms. Walker told them to go to the van. She said Resident A and B proceeded to go to the van. Ms. Huntley said she wrapped her food up and proceeded to go to the van and when she opened the door, she heard a squealing noise. Ms. Huntley said she asked what is going on as she walked towards the van and Resident B said Resident A fell. Ms. Huntley said she ran back to the door and notified Ms. Walker and went to help Resident A. She said Resident A was on the ground. Ms. Huntley explained that Resident A was assigned to Ms. Walker. I explained that although the residents are assigned to a specific staff, both staff are responsible for the supervision, protection, and personal care of all the residents while on shift.

While onsite, Ms. Horton provided me with a copy of Resident A's progress notes, incident report, Resident A's IPOS and Resident A's hospital discharge documents. According to Resident A's progress notes Ms. Walker documented Resident A was assisted with getting in the van during transport. According to Resident A's IPOS "Staff will be in arms reach of Resident A 100% of the time when she is walking outside of her home. Staff will offer hands on assistance getting in and out of any vehicle." Per Resident A's IPOS log, Ms. Huntley signed and acknowledged she was trained on Resident A's needs on 02/04/2024 and Ms. Walker signed on 03/04/2024. Per Resident A's hospital discharge documents, she was diagnosed with a foot sprain.

On 03/18/2024, I contacted Guardian A, Resident A's guardian and interviewed her regarding the allegation. Guardian A confirmed she was previously made aware of the reported allegation by the staff. She said the staff also provided her a copy of the incident report. Guardian A denied having any questions or concerns about the allegation.

On 03/19/2024, I received a return call from Ms. Walker; I interviewed her regarding the allegation. Ms. Walker said the residents and staff were getting ready to go because the residents were going to a Saint Patrick's Day dance. Ms. Walker said when she was not paying attention, Resident A left out of the home and went to the van. She said there was water on the ground, and Resident A fell while trying to get into the van. I referenced Resident A's IPOS and asked if she is familiar with Resident A's needs and she said yes. However, Ms. Walker said Resident A is very rebellious. She said Resident A is familiar with her goals and limitations. She said she left out the home without staff knowing. I explained that staff is responsible for the supervision, protection, and personal care of the residents while on shift. Ms. Walker insisted on blaming Resident A for falling. I asked her if she assisted Resident A with getting into the vehicle as indicated in the progress notes and she said the progress notes were completed prematurely. She said Resident A often refuses help and she does what she wants to do. I explained that based on the documentation I reviewed, Resident A did not refuse help; she was not offered help. Ms. Walker said she was distracted with cutting the television off, grabbing the keys and making sure everything was off because they were leaving the house.

On 03/19/2024, I received a return call from Holly Heath, licensee designee. I interviewed her regarding the allegation. Ms. Heath confirmed the allegation, she said she was aware of the incident. She said Resident A is very smart and tends to be defiant at times. However, she said the staff is very seasoned and familiar with Resident A's behaviors. She said the staff should be more strategic when dealing with the residents. I explained that during my interview with Ms. Walker seemed to blame Resident A and did not accept accountability for failing to provide adequate supervision which resulted in Resident A being injured. I also made Ms. Heath aware that although the staff are assigned residents at the beginning of their shift, it is ultimately the staff's responsibility to provide supervision, protection, and personal care of all the residents while on shift, which Ms. Heath said she understands. I proceeded to conduct an exit conference. I made Ms. Heath aware that based on the findings, there is sufficient evidence to support the allegation. I referenced Resident A's IPOS which states that the staff is responsible for providing hands on assistance when Resident A is getting in and out of any vehicle. Ms. Heath said they are currently developing a plan to better address the residents needs. I explained that as a result of the violation, a written corrective action plan is required, and she can provide details regarding the plan they are developing as a corrective measure. Ms. Heath agreed to submit a corrective action plan as required.

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 Holly Heath, licensee designee; Sheanell Horton, home manager; Kelsey Bartlett, medication coordinator; Marchelle Huntley and Monica Walker, direct care staff; Guardian A, Resident A's guardian; all of which confirmed staff failed to provide hands on assistance when Resident A is getting in and out of any vehicle. I reviewed Resident A's IPOS which states, "Staff will be in arms reach of Resident A 100% of the time when she is walking outside of her home. Staff will offer hands on assistance getting in and out of any vehicle." Resident A was injured and sustained a foot sprain. Based on the investigative findings, there is sufficient evidence to support the allegation. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

04/18/2024

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Denasha Walker Date
Licensing Consultant

Approved By:

04/18/2024

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Ardra Hunter Date
Area Manager