GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 20, 2024

Aniema Ubom
Care First Group Living & In-Home Services, Inc.
24111 Southfield Road
Southfield, MI 48075

RE: License #: AS630411027
Investigation #: 2024A0611023
The Winchester Residence

Dear Mr. Ubom:

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,

Sheena Worthy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630411027
Investigation #:	2024A0611023
Complaint Receipt Date:	08/29/2024
Investigation Initiation Date:	08/30/2024
Report Due Date:	10/28/2024
Licensee Name:	Care First Group Living & In-Home Services, Inc.
Licensee Address:	24111 Southfield Road Southfield, MI 48075
Licensee Telephone #:	(248) 331-7444
Administrator:	Leslie Ubom
Licensee Designee:	Aniema Ubom
Name of Facility:	The Winchester Residence
Facility Address:	5522 Winchester Drive Troy, MI 48085
Facility Telephone #:	(248) 480-4162
Original Issuance Date:	08/10/2022
License Status:	REGULAR
Effective Date:	02/10/2023
Expiration Date:	02/09/2025
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 08/26/2024, an unknown employee at the group home body slammed Resident V to the wall.	No
Additional Findings	Yes

III. METHODOLOGY

08/29/2024	Special Investigation Intake 2024A0611023
08/30/2024	Contact - Telephone call made I left a voice message for the assigned Adult Protective Services worker Bradley Edwards requesting a call back.
08/30/2024	APS Referral The assigned Adult Protective Services (APS) worker is Bradley Edwards.
08/30/2024	Special Investigation Initiated - Telephone I made a telephone call to the reporting source. The allegations were discussed.
08/30/2024	Contact - Telephone call made I made a telephone call to Resident V guardian. The allegations were discussed.
09/03/2024	Contact - Telephone call made I made a return phone call to Resident V guardian. Additional information was discussed.
09/03/2024	Contact - Telephone call made I made a telephone call to a social worker at Troy Beaumont Hospital regarding Resident V.
09/03/2024	Contact - Telephone call made I made a telephone call to Resident V's case manager Julie Tezler. The allegations were discussed.
09/03/2024	Contact - Telephone call made I made a telephone call to the Adult Protective Services worker Bradley Edwards. The allegations were discussed.

09/04/2024	Contact - Telephone call made I made a telephone call to medical records at Troy Beaumont. I was provided with an email address to send a request for Resident V's medical records.
09/10/2024	Contact - Document Received On 09/10/24, I received a copy of Resident V’s medical records from Corewell Health Beaumont Troy Hospital.
09/11/2024	Inspection Completed On-site I made an unannounced onsite with the Adult Protective Services worker Brad Edwards. There was no answer at the door. I contacted Chief Engineering Officer, Ime Ubom. Ms. Ubom agreed to meet us at the home; however, after waiting for an hour, Mr. Edwards and I left the home. I spoke to Ms. Ubom shortly after and we Facetime each other in order for me to review records.
09/11/2024	Contact - Document Received I received a copy of Resident V's incident reports and 30-day discharge notice.
09/12/2024	Contact - Document Received I received a copy of the staff schedule for 08/25/24 and a copy of Resident V's MAR for the month of July through September.
09/12/2024	Contact - Telephone call made A voice message was left for staff member Donovan Harper requesting a call back.
09/12/2024	Contact - Telephone call made I made a telephone call to staff member Sarah Miller. The allegations were discussed.
09/12/2024	Contact - Document Received I received a copy of Mr. Edwards interview with staff member Donovan Harper via email.
09/12/2024	Contact - Document Received I received a copy of Mr. Edwards interview with staff member Etim Obong via email.
09/13/2024	Contact - Telephone call made A voice message was left for the administrator Leslie Ubom requesting a call back.

09/13/2024	Contact - Telephone call made A voice message was left for Resident V's case manager requesting contact information for Dr. Lager.
09/13/2024	Contact - Telephone call made A voice message was left for staff member Donovan Harper requesting a call back.
09/13/2024	Contact - Telephone call made I left a voice message for Dr. Ruza requesting a call back.
09/13/2024	Contact - Telephone call made I received a return phone call from Dr. Ruza. The allegations were discussed.
09/17/2024	Contact – Telephone call made I made a telephone call to the AFC group home. I interviewed Resident J regarding the allegations.
09/17/2024	Exit Conference I completed an exit conference with the licensee designee Aniema Ubom via telephone.

ALLEGATION:

On 08/26/2024, an unknown employee at the group home body slammed Resident V to the wall.

INVESTIGATION:

On 08/29/24, a complaint was received and assigned for investigation alleging that on 08/26/2024 an unknown employee at the group home body slammed Resident V to the wall. Resident V is experiencing left shoulder soreness. He has no marks or bruises. There is a concern that Resident V is being overly medicated at the group home as he has been slurring his speech. Since June and July, Resident V has been in the hospital due to being assaulted by employees at the group home and other residents. He is currently at the hospital for his injuries today.

On 08/30/24, I made a telephone call to the reporting source. Regarding the allegations, the reporting source stated she spoke with Resident V on 08/27/24, and he told her that an employee body slammed him into a wall. Resident V also said an employee used a hose and sprayed water on him. Resident V told the reporting source this was the second time an employee has put their hands on him within the last couple of weeks. The reporting source is unsure if Resident V was referring to more than one employee. The reporting source initially thought Resident V was being harmed by other residents

as well; however, he did not say he was hurt by any of the residents in the AFC group home. Resident V does not have any marks or bruises on him. Resident V complained about soreness on his left shoulder. Resident V was admitted into the hospital with a chief complaint of back pain and being verbally aggressive and threatening to spit on the staff at the AFC group home. Resident V was seen by a psychiatrist at the hospital on 08/27/24. Resident V was aggressive while speaking with the psychiatrist and he told the psychiatrist he was going to strangle the MF's at the AFC group home.

The reporting source stated Resident V has been in and out the hospital since he has been at the AFC group home. Resident V was admitted into the hospital on 06/15/24, 07/14/24, 07/23/24, 07/31/24, 08/06/24, 08/11/24, and 08/26/24. Resident V hospital admissions have all been due to him being aggressive at the AFC group home.

The reporting source stated another AFC group home in Kalamazoo is willing to admit Resident V when he is discharged from the hospital. It is expected for Resident V to be discharged from the hospital on 09/03/24. The reporting source stated Resident V's case manager from his insurance company thinks Resident V is being overly medicated at the AFC group home. The reporting source stated currently Resident V is fine, alert, and making jokes. Resident V does not have any more issues with pain.

On 08/30/24, I made a telephone call to Resident V's guardian. Regarding the allegations, the guardian stated Resident V is hospitalized due to being aggressive towards staff. Resident V admitted to spitting on staff member Donovan because Donovan had him on the ground and Resident V was fighting him off. The incident ensued when Resident V became upset when he was told he could not smoke a cigarette inside the home. The staff proceeded to give Resident V a PRN (valium). Resident V's PRN is crushed and mixed in with food for Resident V to swallow. Resident V asked a staff member to feed him his PRN like a baby and he became upset when the staff refused to do so. The guardian stated what was told to her doesn't make sense because Resident V is independent and doesn't like anyone touching him or feeding him. Resident V told the guardian that staff member Donovan also provoked him by saying he has a small penis and that he pees on himself. The guardian stated the AFC group home has cameras in the home and she has requested to see the footage of the incident but, it has not been provided as of yet. Resident V told his aunt that he does have a mark on him. Resident V has resided at the AFC group home since the end of April 2024. The guardian stated Resident V has only displayed aggression at this AFC group home.

The guardian confirmed that Resident V will not be returning to the AFC group home as he is being moved to Progressive Alternatives in Kalamazoo, MI on 09/03/24. Resident V's belongings will be picked up by Progressive Alternatives. The guardian received a 30-day discharge notice on 08/28/24. The guardian stated Resident V is being discharged from the home due to her not complying with doctor's orders pertaining to Resident V's medications. The guardian stated Resident V is prescribed Valium 5mg in the morning and 10mg at night. Resident V is also prescribed Valium as a PRN. The guardian has informed the AFC group home to not give Resident V his PRN if he does

not need it. The guardian stated when Resident V was initially prescribed Valium, he could not form a word. The guardian stated the last time she spoke to Resident V he sounded much better.

On 09/03/24, I made a return phone call to Resident V guardian. The guardian stated she was contacted by Dr. Lager in Kalamazoo who informed her that he observed a fracture in Resident V's spine after reviewing his X-rays. The guardian received a phone call from the hospital today. The guardian does not know the name of the doctor from the hospital; however, the doctor confirmed that Resident V does have a fracture in his spine. The doctor could not say how long Resident V has had the fracture in his spine or how he received the fracture. The doctor also stated Resident V has arthritis in his spine.

The guardian stated Resident V resided at another AFC group home under the same company when he was hospitalized prior to this current hospitalization. The guardian could not remember the name of the previous home. The guardian stated there was an incident that took place at the previous AFC group home either at the end of June or early July. The guardian stated she requested to view the video footage of this incident; however, she was told that the footage was deleted because it was more than 30 days old. The guardian stated she was informed Resident V that staff picked him up by the back of this shirt and shorts and put him on the couch. The staff then put his forearm on the back of Resident V's neck and said can you breathe. Resident V called the police. The police came to the home; however, the guardian stated the staff had deleted the video footage before the police arrived to the home.

The guardian stated the second incident occurred in July and she was able to view the video footage. The guardian saw Resident V arguing with a staff member and another resident got out of his wheelchair and tried to hit Resident V. This other resident grabbed Resident V ankle and tried to pull Resident V to the ground. The staff took Resident V to his room. Resident V went to the hospital following this incident.

On 09/03/24, I made a telephone call to Resident V's case manager Julie Tezler. Ms. Tezler works for Skyview which is an independent company. Ms. Tezler coordinates everything pertaining to Resident V's auto accident. Regarding the allegations, Ms. Tezler stated Dr. Lager is Resident V's Endocrinologist. Dr. Lager reviewed Resident V's X-rays from July and observed that he has a L1 fracture in his spine. Dr. Lager is unable to determine when the fracture took place. Ms. Tezler stated Resident V was admitted into the hospital on 07/23/24 for back pain. Resident V has low testosterone which can cause low bone density. Resident V has had multiple falls in the last four weeks. Ms. Tezler stated Resident V gait is unsteady. Ms. Tezler speculates that Resident V falls are due to him being prescribed Valium. Ms. Tezler stated Resident V's speech has been slurred since he started taking Valium. Ms. Tezler is not accusing anyone of sedating Resident V.

Ms. Tezler described an instance where she was speaking to Resident V on the telephone and his speech was slurred. Ms. Tezler contacted the administrator Mrs.

Ubom and requested that a staff be present on the phone with Resident V to observe his slurred speech. Mrs. Ubom told Ms. Tezler that this was a part of Resident V's persona to get her attention as his speech is clear when he talks to staff.

Ms. Tezler stated on 08/26/24, she attended Resident V's appointment in Kalamazoo with Dr. Radowski who is a physiatrist. Dr. Radowski recommended Resident V to follow up with Dr. Lager regarding his testosterone. Dr. Radowski was concerned about Resident V's slurred speech. Dr. Radowski also recommended the psychiatrist to decrease Resident V's Valium as it is not good for him to take due to his brain injury. Ms. Tezler stated Resident V is being discharged from the hospital today. Resident V's belongings at the AFC group home was moved out by the new AFC group home in Kalamazoo earlier today.

On 09/03/24, I made a telephone call to Troy Beaumont hospital and spoke with social worker Amanda Kralisz. Ms. Kralisz stated she is no longer Resident V's social worker as he was moved to a different unit. I asked Ms. Kralisz if she could send me Resident V's medical records. Ms. Kralisz provided me with the number to medical records. Ms. Kralisz stated she did hear a nurse mention that Resident V had a fracture in his spine. I left a voice message requesting the medical records for Resident V.

On 09/03/24, I made a telephone call to the Adult Protective Services worker Bradley Edwards. Regarding the allegations, Mr. Edwards stated he investigated similar allegations in July when Resident V was residing at The Tutbury Residence (AS630406615, SIR #2024A0605032). Mr. Edwards investigation and the licensing investigation was unsubstantiated. Mr. Edwards stated his previous investigation alleged that staff member Etim put Resident V's face in the couch and said "you can't breathe, how does that feel". Mr. Edwards reviewed video footage of Resident V having a verbal dispute with Resident D. Resident D got out of his wheelchair and attempted to swing on Resident V. Resident D fell to the ground. Resident V moved his foot out of the way from Resident D. The video did not have any sound. Mr. Edwards stated he did not receive any video footage regarding the allegations against staff member Etim Obong as he was told that footage had expired.

Mr. Edwards stated when the police arrived to the AFC group home regarding the incident between Resident V and Resident D, they did not review the video footage. The police did not observe any marks or bruises on Resident V. Mr. Edwards stated the police closed their investigation.

Mr. Edwards stated regarding this current investigation, he interviewed Resident V in the hospital. A summary of Mr. Edwards interview with Resident V is below:

"APS asked Resident V why he was in the hospital, and he stated that one of the workers at the home named Donovan said to him "his d**k is so small that when he pees, he pees on his balls." Resident V stated that after he called Donovan the N word, Donovan grabbed him, and body slammed him on the fireplace and then chocked him and then pulled his shirt over his head. APS then asked what occurred after that and he

stated that he got up and walked out of the home and Big E followed him outside telling him to come back into the home. APS asked if he had any marks or bruises on him now and he stated no, and APS asked if he had any on him after the incident and he stated no. APS asked who was present for the incident to which he stated he did not know but he knows that Big E, Donovan and the lady who owns the place was there and it is on video".

On 09/10/24, I received a copy of Resident V's medical records from Corewell Health Beaumont Troy Hospital. Resident V was admitted on 08/26/24 at 7:25pm. According to the medical records, Resident V's chief complaint was listed as back injury and aggressive behavior. The medical records also indicates that staff was supposed to petition Resident V for "attacking staff". Resident V complained of back pain after he states he was "body slammed" by group home staff member. Resident V reported he became upset when a staff member was being verbally aggressive toward him, and he was then "body slammed". Per the medical records, on 08/30/24, Ms. Tezler spoke to a nurse to inquire about a "fractured vertebra". Ms. Tezler stated Resident V's team noticed he had a compression fracture. The nurse informed Ms. Tezler that they were unaware of this. Ms. Tezler expressed concerns over how Resident V obtained this fracture. "Per the 7/23 visit it is undetermined if this is an old fracture or new". Ms. Tezler stated this is a new fracture and she will inform Resident V's guardian.

Under the section entitled History of present illness, it states Resident V was complaining of lower back pain and pain in the back of his left shoulder. Resident V denied any other symptoms. Resident V denied any head trauma or loss of consciousness. Resident V stated he was able to ambulate afterwards. According to the staff at the group home, there was no altercation with the resident today. Staff stated Resident V had been increasingly aggressive, violent, and threatening with the staff. Resident V had spit on a staff member the day before. Resident V threw his medication at other residents. Resident V also makes aggressive and threatening remarks to staff members. Per group home staff, patient was brought to the emergency room to be evaluated by a social worker or psychiatrist.

A copy of Resident V's physical exam results is provided below:

> Resident V is a 48-year-old male presenting with back pain and aggressive behavior. He has normal vital signs and normal exam. X-rays of his lumbar spine and his left shoulder will be obtained. Resident V's labs show mild AKI, imaging is negative. He will be placed in emergency center for observation.

On 09/11/24, I made an unannounced onsite with the Adult Protective Services worker Brad Edwards. There was no answer at the door. I contacted Chief Engineering Officer, Ime Ubom. Ms. Ubom agreed to meet us at the home however; after waiting for an hour, we left the home. I spoke to Ms. Ubom shortly after and we Facetime each other in order for me to review records. I also viewed Resident V's former bedroom. The bedroom was empty including the closet and dresser. Ms. Ubom confirmed that the bed and dresser in the bedroom belonged to the AFC group home.

Ms. Ubom stated Resident V was admitted on 07/10/24 and discharged on 09/03/24. Ms. Ubom did not have any direct contact with Resident V. Ms. Ubom stated there are currently three residents living in the AFC group home. The residents attend workshop daily and usually does not return to the home until around 4:00pm. Resident V's file did not include the MAR for the month of August. The MAR for July was in the file. Ms. Ubom did not see Valium listed on the July MAR. Ms. Ubom stated she will email me the MAR for the month of July and August. Ms. Ubom stated the August MAR has not been printed off from Quick MAR as of yet. Ms. Ubom reviewed Resident V's incident reports pertaining to hospitalizations. An incident report was completed when Resident V was hospitalized on 07/6/24, 7/22/24, and 08/22/24 through 08/26/24. Ms. Ubom stated she will obtain the full names and contact information for staff member Donovan and Etim Obong. Ms. Ubom will send me the contact information for the administrator Leslie Ubom as well.

On 09/12/24, I received a copy of the staff schedule for 08/25/24 and a copy of Resident V's MAR for the month of July through September. Resident V is prescribed Diazepam which is equivalent to Valium. According to the MAR for July 2024, Resident V was prescribed Diazepam 10mg one tab daily at bedtime. This medication was prescribed on 07/31/24. Resident V was also prescribed Diazepam 5mg twice a day starting on 07/16/24. This medication was discontinued on 07/31/24. Resident V was prescribed Diazepam 5mg on 07/31/24 once in the morning.

According to the MAR for August 2024, Resident V was prescribed Diazepam 10mg once at bedtime. Resident V was also prescribed Diazepam 5mg in the morning however; this medication was discontinued on 08/24/24. Resident V was prescribed Diazepam 5mg starting 8/24/24 once in the morning. Based on the documentation and the staff initials it appears that Resident V was being administered his Diazepam as prescribed.

According to the staff schedule, the following staff worked during the time of the incident:

Reshawnda Click 7:00 AM 7:30 PM
Sarah Miller 7:00 AM 7:30 PM
Leroy Harris 7:00 AM 3:30 PM
Donavan Harper 8:30 AM 5:15 PM

On 09/12/24, I received video footage from the day in question. The video is dated 08/25/24 and it is 11 minutes and 1 second long. There is no audio in the video footage. At the onsite of the video, I observed staff member Donavan Harper sitting in a chair near the side sliding door in the living area. Mr. Harper is looking at his cell phone. Staff member Sarah Miller is sitting at a desk in the living area with her back facing Mr. Harper and the side door. Resident V is observed entering the AFC group home from the side sliding door. There is no interaction or eye contact observed between Resident V and Mr. Harper. Resident V walks directly over to the desk where Ms. Miller is sitting. It appears he is trying to use the house phone and Ms. Miller is either assisting him and/or re-direct him. Mr. Harper gets up from his chair and starts to walk towards

Resident V. Before Mr. Harper can get close to Resident V, Resident V is observed throwing the phone receiver at Ms. Miller. Mr. Harper proceeded to grab Resident V's arms in an attempt to de-escalate him. Resident V is resisting. Ms. Miller gets up from her chair and calls someone on a cell phone.

Mr. Harper is holding onto Resident V's wrist and forces him to sit down on the brick bench connected to the fireplace. A second staff member (later identified as Reshawnda Click) is observed walking into the kitchen area. Ms. Harper continues to hold Resident V's wrist while Resident V is resisting. Another resident is observed entering the living area in a wheelchair. This resident quickly leaves the living area and is no longer visible. Ms. Miller is still observed on the phone and watching Mr. Harper and Resident V. Resident V is now on his back while Mr. Harper continues to hold his wrist. Ms. Miller is observed grabbing Mr. Harpers cell phone out of his pocket and calls someone. Ms. Click enters the living room and quickly leaves the living area without providing Mr. Harper with any assistance.

Mr. Harper maneuvers Resident V onto the floor onto his back. It appears Resident V starts spitting at Mr. Harper. Mr. Harper uses one of his hands to turn Resident V's face sideways. Mr. Harper then pulls Resident V's shirt from behind his back and pulls it over Resident V's face. Resident V's face is completely covered by his shirt. Resident V is trying to get up from the floor. At this time, Mr. Harper lifts Resident V up from the floor and landed him on his back. Resident V's face is still covered by his shirt. Mr. Harper has both of Resident V's arms spread out on the floor. Ms. Miller continues to watch Mr. Harper and Resident V while she has a cell phone in her hand. Mr. Harper is sitting on the floor with his hands holding down Resident V's wrist. Resident V tries to get up from the floor and his shirt is moved off his face. Mr. Harper gets on his knees and places Resident V's arms in a criss cross position as he holds them on top of his chest.

Ms. Click enters the living again while Ms. Miller leaves the area and is no longer visible. Resident V proceeds to try to get Mr. Harper to let him go. At this point, Resident V's legs are observed in the air facing the brick bench connected to the fireplace and; Mr. Harper is on his knees with his chest on top of Resident V's chest. Resident V's face is not visible. Ms. Click is standing over Mr. Harper with a cell phone in her hand and it appears Mr. Harper is talking into the cell phone. The police arrive into the living area with Ms. Miller. The police officer appears to be talking to either Mr. Harper or Resident V. Mr. Harper releases Resident V and walks into the kitchen area. Resident V sits up and is talking to the police officer. The video ends.

On 09/12/24, I made a telephone call to staff member Sarah Miller. Regarding the allegations, Ms. Miller stated she was the staff member watching Resident V when he was outside. Resident V started walking towards a neighbors pool and took off his shirt. Ms. Miller asked Resident V to come back into the home. Resident V fell down to the ground on purpose. Ms. Miller stated she and staff member Reshawnda Click convinced Resident V to go back inside the home as they told him they would make him some tea. Ms. Miller stated Resident V became upset when he was told that he could not return his pop cans for a deposit as he was placed on a restriction. Ms. Miller stated Resident

V went in and out the home two more times. The last time Resident V went outside, Mr. Harper was sitting in a chair in the living area and was able to see Resident V while he was outside near the side sliding door. Ms. Miller was sitting at the desk in the living area.

When Resident V entered the home, he asked Ms. Miller for a favor. Resident V wanted Ms. Miller to call 911. Ms. Miller informed Resident V that she could not call 911. Resident V picked up the phone and started to dial 911. Mr. Harper advised Ms. Miller to unplug the phone. Ms. Miller stated she did unplug the phone. Resident V was still holding the phone receiver. Mr. Harper started walking towards Resident V. Resident V then threw the phone and the phone hit the computer screen. Mr. Harper grabbed Resident V after he threw the phone to make sure he didn't hit Ms. Miller. Resident V started spitting and kicking at Mr. Harper. Ms. Miller made several attempts to call Cheynne Turner who is a manager. Ms. Miller stated she is expected to never call the police without speaking to Ms. Turner first. Ms. Miller stated she grabbed Mr. Harper's phone out of his pocket as she needed the phone numbers to try to reach other staff members for assistance. Ms. Miller stated she eventually called the police, as she was unsuccessful with reaching anyone else.

Ms. Miller identified the resident that was seen in the video footage in the wheelchair. Ms. Miller stated she is not CPI trained which is why she did not assist Mr. Harper with physically managing Resident V. Ms. Miller stated she does not think Ms. Click is CPI trained either. Ms. Miller stated Resident V calmed down when the police arrived. When the police left, Resident V went to his bedroom. Ms. Turner arrived to the home after the police left. Ms. Miller confirmed that the only staff present during this incident was herself, Mr. Harper, and Ms. Click. Ms. Miller stated the following day (08/26/24), Resident V told Ms. Turner that he was having back pain and he wanted to go to the hospital.

On 09/12/24 I received a copy of Adult Protective Services worker Brad Edwards Interview with Donovon Harper. A summary of the interview is below:

> "A phone call was made to Donovan. APS then asked what occurred with him and Resident V on the day that things got physical. Donovan stated that when he got to work Resident V was upset about not being able to take bottles to the store but that is up to his sister to do. Donovan stated that Resident V was outside yelling obscenities to him and neighbors and other workers, so he was able to calm him down and walked him back into the home. Donovan stated that once he came into the home Resident V threw his cell phone at a computer and broke the monitor. Donovan stated that Resident V then attempted to punch a female staff (Sara - last name unknown) and he blocked his punch and then grabbed both of his wrists and held him down on the step of the fireplace. Donovan stated that Resident V then began to spit on him and in his mouth and that is when he pulled his shirt over his head to keep him from spitting and then Resident V started to head butt him and he asked for staff to contact 911. APS then asked if there was a male staff named Etim or Big E working with him and he stated that he came on site after he left so they did not work together that day.

> APS then provided the allegations to Donovan as well as what Resident V reported, and Donovan stated that what he is reporting did not happen. Donovan stated that he is 6 foot 4 and if he was to slam someone then there would be injuries".

On 09/12/24 I received a copy of Adult Protective Services worker Brad Edwards Interview with Etim Obong. A summary of the interview is below:

> "A phone call was made to Etim who stated that he was not present the day that the altercation occurred and stated that he cannot speak to that day, but he was told about the altercation between Resident V and Donovan. APS asked what he was told, and he stated that he was told that Resident V had one of his outbursts and threw a phone at a worker and spit on a worker and had to be restrained until the police came that was it. APS then asked if he worked later that day, and he stated that he did not. APS asked if he was aware of Donovan ever provoking Resident V or being physical with him in the past and he stated no".

On 09/13/24, I received a return phone call from Dr. Ruza. Regarding the allegations, Dr. Ruza confirmed that Resident V's Valium was not prescribed as a PRN but, it was prescribed as a morning and bedtime medication. Dr. Ruza met with Resident V about two time. Dr. Ruza stated Resident V's guardian and case manager participated in the meetings between him and Resident V. Dr. Ruza does not believe that Resident V's speech was slurred or altered by taking Valum. Dr. Ruza stated he will call me back once he is able to review his notes.

On 09/17/24, I made a telephone call to the AFC group home. I interviewed Resident J. Resident J has lived at the AFC group home for five months. Regarding the allegations, Resident J stated he likes living at the AFC group home but, the food is not that good. Resident J stated he is cool with the staff members and denied any issues with them. Resident J denied witnessing any staff member mistreat any residents. Resident J stated Resident V "was a trip". Resident J stated he heard that Resident V has lived at three different homes. Resident J witnessed a male staff member hold Resident V down because Resident V threw a phone at a female staff member. Resident J stated it's a good thing the male staff was able to hold Resident J down because the female staff member could have gotten hurt. Resident J stated the male staff held Resident V down to keep him from hurting himself or the female staff member.

On 09/17/24, I completed an exit conference with the licensee designee Aniema Ubom via telephone. The video footage was discussed. It was suggested to encourage staff to assist each other when CPI is being utilized especially when a resident is spitting on a staff member. The requirement for completing an incident report was discussed. Mr. Ubom was informed that a corrective action plan will be required based on required incident reports not being completed and/or the required form not being used.

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 video footage that was reviewed from the day in question, Mr. Harper did not use excessive or unnecessary force while he was applying crisis prevention and intervention (CPI) with Resident V. Mr. Harper used physical restraint by holding down Resident V's wrist after Resident V threw a phone receiver at Ms. Miller. There were no marks or bruises observed on Resident V.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS

INVESTIGATION:

On 09/11/24, I received a copy of Resident V's incident reports and 30-day discharge notice. I received an incident report dated 07/06/24 that was not completed on the BCAL licensing form. This incident took place at an outpatient rehab clinic. This incident report was about Resident V becoming agitated because he was not allowed to have a cigarette. It is noted on the incident report form that a State of Michigan form was not used as this incident occurred outside of the AFC group home. Resident V was transported to Beaumont Royal Oak hospital.

An incident report dated 08/25/24, was not completed on the required BCAL licensing form. This incident is regarding the day in question. Resident V walked out of the residence and went to sit on the front lawn. Resident V called out to neighbors as they walked by. Resident V was redirected by staff. Resident V was using derogatory language towards the staff and neighbors. Shortly after, Resident V re-entered the residence. Resident V was using his cell phone but, he grew angry after his call was unanswered. Resident V went to the staff and demanded that she call 911 for him. Resident V behavior escalated as he grabbed the residential phone and proceeded to call 911. Resident V threw the phone at the staff's head. The staff was able to avoid getting hit by the phone. Resident V continued to threaten her and tried to swing his hands towards her. Another staff was able to block Resident V by using safety strategies/techniques learned from CPI in order to avoid further physical aggression towards the staff. Community and crisis support was deployed to the residence. Health and safety strategies were continuously implemented to secure Resident V until support

arrived. Resident V's behavior deescalated, and he retired for the rest of the evening. It is also noted on the incident report that on 08/26/24, Resident V was taken to the hospital for psychiatric services. On 08/27/24, a discharge notice was issued.

On the second page of this form, it states Resident V indicates he is well aware that his speech was not really slurred but, conducted himself this way to manipulate his guardian and case manager. Resident V has been doing something similar when he stops using his assistive devices such as a walker to walk then deliberately falls. Thereafter he requests that 911 be called.

It should be noted that an incident report was not completed for Resident V's hospitalization on 08/26/24. Furthermore, the dates (07/6/24, 7/22/24, 08/22/24-08/26/24) provided by Ms. Ubom regarding the incident reports that were completed for when Resident V was hospitalized does not coincide with the incident reports that were provided. Based on the incident reports that were received and described above, an incident report was not received for 07/22/24 and the incident report dated 08/22/24-08/26/24 does not pertain to a hospitalization. According to the medical records, Resident V was hospitalized on 07/23/24 as opposed to 07/22/24.

According to the discharge notice, it was issued on 08/27/24. The reasons for discharge were uncooperative with treatment, insurer refuses to acknowledge responsibility, violent behavior, misrepresentations by servicing insurer or other responsible parties, and unproductive partnership with guardian/case manager.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (ii) Hospitalization.
ANALYSIS:	Based on my investigation and the information gathered, Resident V was hospitalized on 07/06/24, 07/14/24, 07/23/24, 07/31/24, 08/06/24, 08/11/24, and 08/26/24. However, an incident report was not completed for Resident V's hospitalization on 07/14/24, 07/23/24, 07/31/24, 08/06/24 or 08/26/24.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(7) A copy of the written report that is required pursuant to subrules (1) and (6) of this rule shall be maintained in the home for a period of not less than 2 years. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Resident V was hospitalized on 07/06/24. However, this incident was not documented on the required department form as the AFC group home opted to record this incident on an internal form. The day in question occurred on 08/25/24, which commenced when Resident V attempted to inflict harm on Ms. Miller by throwing a phone at her. Therefore, an incident report should have been completed on the required department form; however, it was recorded on an internal form.
CONCLUSION:	**VIOLATION ESTABLISHED**

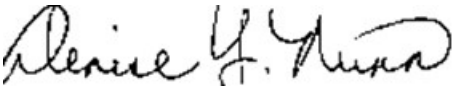
IV. RECOMMENDATION

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

09/17/24

Sheena Worthy
Licensing Consultant
Date

Approved By:



09/20/2024

Denise Y. Nunn
Area Manager
Date