GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 16, 2024

Shannon White-Schellenberger
Angels' Place
Suite 2
29299 Franklin Road
Southfield, MI 48034

RE: License #: AS500094696
Investigation #: 2024A0617029
Van Elslander, Mary Ann

Dear Mrs. White-Schellenberger:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days.

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,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd.
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500094696
Investigation #:	2024A0617029
Complaint Receipt Date:	08/14/2024
Investigation Initiation Date:	08/15/2024
Report Due Date:	10/13/2024
Licensee Name:	Angels' Place
Licensee Address:	Suite 2 - 29299 Franklin Road Southfield, MI 48034
Licensee Telephone #:	(248) 350-2203
Administrator:	Shannon White-Schellenberger
Licensee Designee:	Shannon White-Schellenberger
Name of Facility:	Van Elslander, Mary Ann
Facility Address:	18900 Cheyenne Street Clinton Township, MI 48036
Facility Telephone #:	(586) 463-0789
Original Issuance Date:	01/10/2001
License Status:	REGULAR
Effective Date:	08/24/2023
Expiration Date:	08/23/2025
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 8/11/2024, a bruise on Resident A's back was discovered by midnight staff that was unreported by daytime staff.	Yes

III. METHODOLOGY

08/14/2024	Special Investigation Intake 2024A0617029
08/14/2024	APS Referral Adult Protective Services (APS) referral received- not assigned
08/15/2024	Special Investigation Initiated – Telephone TC to Complainant
08/20/2024	Inspection Completed On-site I conducted an unannounced onsite investigation at the Van Elsander, Mary Ann. I interviewed Director Latrice Toney, Home manager Carla Thomas, Resident A and Resident B.
08/20/2024	Inspection Completed-BCAL Sub. Compliance
08/20/2024	Contact - Telephone call made TC to Ms. Candy Forbes
09/30/2024	Contact - Telephone call made TC to Ms. Shawana Jackson
09/30/2024	Contact - Telephone call received TC with Ms. Candy Forbes
09/30/2024	Exit Conference I held an exit conference with licensee designee Shannon White-Schellenberger informing her of the findings of the investigation. She did not answer and a voicemail was left.

ALLEGATION:

On 8/11/2024, a bruise on Resident A's back was discovered by midnight staff that was unreported by daytime staff.

INVESTIGATION:

On 08/14/24, I received a complaint on the Van Elsander, Mary Ann AFC home. The complaint indicated that Resident A is a 41-year-old male with Downs Syndrome, seizures, anxiety, Autism and verbal OCD. Resident A resides at Mary Ann Van Elslander, AFC home. On 8/11/2024, a bruise on Resident A's back was discovered by midnight staff that was unreported by daytime staff. Resident A reported that a resident had pushed him and he fell. Resident A was brought to the hospital for the bruising, and he was also diagnosed with a hairline fracture in his left arm. Resident A requires 24-hour supervision and staff are denying they saw Resident A fall, nor did they see the bruise on his back when he was showering which is a supervised task as well. Staff sent Resident A into the bathroom to shower by himself so that is why the bruise was not seen by daytime staff.

On 08/20/24, I conducted an unannounced onsite investigation at the Van Elsander, Mary Ann. I interviewed Director Latrice Toney, Home manager Carla Thomas, Resident A and Resident B.

During the onsite inspection, I reviewed Resident A's assessment plan, Incident report, Shower logs, Hospital records and staff schedule. According to Resident A's assessment plan, he requires support for showering. According to the shower logs, Resident A received a shower on 8/11/24 by staff Candy Forbes. According to the incident report, on 8/12/24, at 6:40am Resident A went to staff Uniqua Clemons and asked for medication for his arm because it was in pain. Ms. Clemons checked his arm and noticed a huge bruise on his shoulder, neck and upper left back. Ms. Clemons contacted management and Resident A's guardian. According to the hospital records, Resident A had a collarbone fracture. According to the staff schedule, on 8/11/24, the following staff worked: Allen Smith worked from 7am to 3pm, Shawana Jackson from 11am to 7pm, Candy Forbes from 3pm to 11pm and Uniquka Clemons from 11pm to 7am.

According to Ms. Toney, she received a call on the morning of 8/12/24, that Resident A had a large bruise on his back. Ms. Toney stated that staff Uniqua Clemmons called the home manager Carla Thomas and notified her that Resident A had a large bruise on his back and was complaining of pain. Ms. Toney stated that she conducted an interview with staff, and nobody knows how Resident A sustained the injury. Ms. Toney stated that Resident a told her that Resident B pushed him. Resident B told her that Resident A kept banging on Resident B's bedroom door and Resident B pushed Resident A. Staff Candy Forbes was supposed to shower Resident A on that day, but she did not go into the bathroom with him. Therefore, she did not notice the injury to Resident A. When Ms. Toney asked Ms. Forbes why she didn't go into the bathroom with Resident A, Ms. Forbes stated to her that it was because she was the only staff home and she had to assist other residents. Ms. Toney stated that she instructed home manager Ms. Thomas to take Resident A to the hospital, where it was discovered that he sustained a hairline

fracture in his left collarbone. According to Ms. Toney, Ms. Forbes and Ms. Jackson are suspended.

During the onsite investigation, I interviewed Resident A. According to Resident A, he was pushed into the wall by Resident B. During the onsite investigation, I observed Resident A in visible pain.

During the onsite investigation, I interviewed Resident B. According to Resident B, Resident A kept coming into his room without his permission and messing with his trash can. Resident B got upset and yelled at him multiple times to get out of his room. Staff never came to intervene. Resident B stated as Resident A was leaving his room, he tripped and fell into the wall by the bathroom. Resident B stated that Ms. Forbes was the only staff home and she saw what happened.

During the onsite investigation, I interviewed home manager Ms. Carla Thomas. According to Ms. Thomas, she did not work on 8/11/24. She received a call around 6:45 am on 8/12/24 from Ms. Clemons, notifying her of Resident A's injury. Ms. Thomas stated that Ms. Clemons told her that at 6:40am Resident A went to staff Uniqua Clemons and asked for medication for his arm because it was in pain. Ms. Clemons checked his arm and noticed a huge bruise on his shoulder, neck and upper left back. Ms. Thomas stated she got to the facility around 8:30am and took Resident A to the hospital herself. Resident A was diagnosed with a hairline fracture on his collarbone. According to Ms. Thomas, originally Resident A told her he fell but later told her that Resident B pushed him. When Ms. Thomas questioned staff on what happened, they all stated that they did not know.

On 09/30/24, I interviewed staff Ms. Shawana Jackson. According to Ms. Jackson, on 8/11/24, she took Resident A and another resident to Dairy Queen, and they got back to the home around 3pm. She didn't witness or hear anything in regard to the incident. Ms. Jackson stated that Resident A did not complain of any pain or make her of aware of any incident. When she left the home at 7pm, Resident A had not showered. She returned the next day 8/12/24, at 8am. Her and Ms. Thomas asked Resident A what happened, and he originally stated that he didn't know what happened. Resident A's father came to the home and questioned Resident A alone in his room and Resident A told him that Resident B pushed him. Resident A's father then questioned Resident B about the incident and Resident B told him that he pushed Resident A and demonstrated how it happened. According to Ms. Jackson, Resident B stated that staff Candy Forbes was the only staff member in the home, and she witnessed what happened and helped Resident A off of the floor.

On 09/30/24, I interviewed staff Candy Forbes. According to Ms. Forbes, on 8/11/24, she worked from 3pm to 11pm. Ms. Forbes stated that she began giving showers around 8:30pm and she was the only staff in the home. Ms. Forbes stated that she went into Resident A's room and laid out his clothes, while he undressed but his back was not facing her, so she did not notice any injury. Resident A did not complain of pain or mention any incident to her. Resident A has an attached bathroom in his bedroom and

he entered the shower alone because Ms. Fobes had to assist another resident in another bathroom. Ms. Forbes stated that she never went into the bathroom with Resident A and did not assist him with his shower. Ms. Forbes stated that Resident A requires assistance showering but she could not help due to having to care for multiple residents at the same time by herself. Ms. Forbes denied seeing or hearing any incident and she does not believe the injury occurred on her shift.

On 09/30/24, I held an exit conference with licensee designee Shannon White-Schellenberger informing her of the findings of the investigation. She did not answer and a voicemail was left.

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 interviews and documentation reviews, the facility did not treat and care for Resident A with dignity and his personal needs, including protection and safety, have not been attended to at all times in accordance with the provisions of the act. Resident A requires 24-hour supervision and staff denied seeing or hearing Resident A fall. Staff Candy Forbes did not assist Resident A with his shower and therefore she did not see the bruise on Resident A's back when he was showering which is a supervised task according to his assessment plan. Resident A stated that he was pushed by Resident B. Staff was not present to intervene or stop the alleged assault from happening. The extent of Resident A's injuries led him to be sent to the hospital. Resident A has a fractured collarbone, large bruise and cut on his back from the incident. During the onsite investigation, I observed Resident A in visible pain.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	During the onsite inspection, I reviewed Resident A's assessment plan, Incident report, Shower logs, Hospital records and staff schedule. According to Resident A's assessment plan, he requires support for showering. According to the shower logs, Resident A received a shower on 8/11/24 by staff Candy Forbes. Resident A requires 24-hour supervision and staff denied seeing or hearing Resident A fall. Staff Candy Forbes did not assist Resident A with his shower and therefore she did not see the bruise on Resident A's back when he was showering which is a supervised task according to his assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

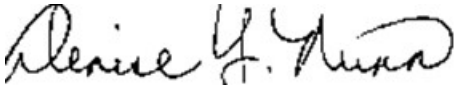
IV. RECOMMENDATION

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

09/30/24

Eric Johnson Date
Licensing Consultant

Approved By:



10/16/2024

Denise Y. Nunn Date
Area Manager