GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 20, 2024

Rebecca Nyinawabeza
Adventure USA Consultancy, LLC
814 W. Ionia St
Lansing, MI 48915

RE: License #: AS330418099
Investigation #: 2025A1029005
Lenox Hill Living

Dear Ms. Nyinawabeza:

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.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330418099
Investigation #:	2025A1029005
Complaint Receipt Date:	11/04/2024
Investigation Initiation Date:	11/04/2024
Report Due Date:	01/03/2025
Licensee Name:	Adventure USA Consultancy, LLC
Licensee Address:	814 W. Ionia St, Lansing, MI 48915
Licensee Telephone #:	(574) 326-7334
Administrator:	Rebecca Nyinawabeza
Licensee Designee:	Rebecca Nyinawabeza
Name of Facility:	Lenox Hill Living
Facility Address:	814 W Ionia St, Lansing, MI 48915
Facility Telephone #:	(574) 481-3391
Original Issuance Date:	05/09/2024
License Status:	REGULAR
Effective Date:	11/09/2024
Expiration Date:	11/08/2026
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A requires 1:1 staffing coverage and there are not enough direct care staff members working to provide adequate supervision to her.	Yes
On October 31, 2024 direct care staff member Samantha Farquharson fell asleep and Resident A was not supervised during this time.	Yes
On October 31, 2024 Resident A was bound in her bedroom because direct care staff member Samantha Farquharson put kitchen mitts on her hands so she could not open the door and had her helmet slid down her face so she could not see.	Yes
Resident A was physically abused while residing at Lenox Hill Living.	No
Resident B was confined in his room with the door locked causing him to urinate and defecate on himself because he could not leave his room.	No
Resident A was supposed to have a helmet to wear at all times and licensee designee Rebecca Nyinawabeza did not provide her with one.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/04/2024	Special Investigation Intake 2025A1029005
11/04/2024	APS Referral - APS is investigating the concerns. Shonna Simms-Rosa is the assigned worker.
11/04/2024	Special Investigation Initiated – Letter to Shonna Simms Rosa APS
11/04/2024	Contact - Document Sent -Email to Sparrow Aimee Fitzpatrick
11/06/2024	Contact - Document Received Aimee Fitzpatrick, RN
11/07/2024	Contact - Telephone call received RN Aimee Fitzpatrick
11/19/2024	Inspection Completed On-site - Face to Face with Resident C, direct care staff member Elia Joe Rutamu, licensee designee Rebecca Nyinawabeza, Resident D
12/03/2024	Contact - Telephone call received APS Liberty Yako

12/04/2024	Contact - Telephone call made to APS Liberty Yako
12/10/2024	Contact – Email to Jessica Martin, LMSW, Lansing Police Department
12/11/2024	Contact – Document sent - email to Cheryl Cass, Pathways CMH and Ashley Shayter, Pathways Behavioral Psychology Services. Email received from Melissa Misner, Lansing PD Community Services Unit, Telephone call to Guardian A1, former direct care staff member Samantha Farquharsen
12/13/2024	Contact – Email received from Dr. Shayter, Pathways Behavioral Psychological Services.
12/16/2024	Contact – Teams meeting with Dr. Shayter, Pathways
12/17/2024	Exit conference with licensee designee Ms. Nyinawabeza.

ALLEGATION:

- **Resident A requires 1:1 staffing coverage and there are not enough direct care staff members working to provide adequate supervision to her.**

- **On October 31, 2024 direct care staff member Samantha Farquharson fell asleep and Resident A was not supervised during this time.**

INVESTIGATION:

On November 4, 2024, a complaint was received via Bureau of Community and Health Systems online complaint system with allegations there were not enough direct care staff members to provide care and supervision to Resident A because she required 1:1 staffing coverage. There was an additional allegation stating that on October 31, 2024, Resident A was not provided supervision because direct care staff member Ms. Farquharson fell asleep during her shift and there was no one available to provide supervision to Resident A.

On November 19, 2024, I conducted an unannounced on-site investigation at Lenox Hill Living and met with direct care staff member Elia “Joe” Rutamu and licensee designee Rebecca Nyinawabeza. Mr. Rutamu stated he has worked almost every day since May 2024. Mr. Rutamu stated Resident A moved out at the beginning of November 2024. Mr. Rutamu stated there is always at least one staff working because there are only two residents currently. Mr. Rutamu stated when Resident A lived there in October 2024, there were four residents and one direct care staff member at all times. Mr. Rutamu stated Resident A needed 1:1 staffing coverage 24 hours per day because she “had a

lot of special needs" and was very demanding. Mr. Rutamu stated Resident A harmed herself by banging her head on the wall and she had wounds on her head from this. Ms. Nyinawabeza stated there was always a direct care staff member assigned to Resident A however there were times when there was only one direct care staff member working to provide care to all four residents. I explained to Ms. Nyinawabeza if Resident A required 1:1 staffing coverage, there should have been an additional direct care staff member working to provide care to the other residents.

During the onsite investigation, I reviewed Resident A's resident record which included the following documentation regarding supervision guidelines:

1. *Discharge Plan* from October 18, 2024 from Schoolcraft Memorial Hospital stated she requires "1:1 sitter, at times requiring further staff members."
2. According to Resident A's *Assessment Plan for AFC Residents* signed by Guardian A1 on October 19, 2024, she is visually impaired and needs constant supervision. Exhibits self-injurious behavior with head banging when she cannot get her way. Can be overly aggressive when she doesn't get her way. Under additional comments "constant supervision."
3. According to Resident A's *Pathways Individualized Plan of Service* "[Resident A] is approved for 1:1 staffing 24 hours daily starting October 15, 2024. The medical necessity of 1:1 staffing will continue until a mutual agreement with Pathways and Lenox Hill Living has been made that a reduction of 1:1 staffing is appropriate. Documentation needs to be clearly stated and documented to support the medical necessity of 1:1 staffing."

On November 19, 2024 I interviewed Resident C. Resident C stated usually Mr. Rutamu was the only direct care staff member working at Lenox Hill Living. Resident C stated there were other direct care staff members but they all quit because they could not handle Resident A and her behaviors.

On November 19, 2024 I interviewed Resident D who stated there was usually two direct care staff members working when Resident A was living there but he did not believe there was a direct care staff member assigned to work with her at all times.

On December 11, 2024, I interviewed Guardian A1. Guardian A1 stated she did not know until after Resident A moved out there was only one person assigned at a time to provide supervision for all the residents. Guardian A1 stated Resident A required 1:1 staffing coverage which Ms. Nyinawabeza knew before Resident A moved in. Guardian A1 stated Pathways CMH is very strict on their rules and Resident A's 1:1 supervision guideline is documented in her *Individualized Plan of Service.* Guardian A1 stated it was mostly Ms. Farquharson working when she visited Lenox Hill Living. Guardian A1 stated she did see Ms. Nyinawabeza and Mr. Rutamu but they were training with Dr. Shayter from Pathways when she was there visiting. Guardian A1 stated when she spoke to Ms. Farquharson she complained about being alone with all the residents. Guardian A1 was worried Ms. Farquharson was going to become overwhelmed due to Resident A's behaviors.

On December 11, 2024, I interviewed former direct care staff member Ms. Farquharson. Ms. Farquharson stated she worked at Lenox Hill Living for about one month. Ms. Farquharson stated when she worked she worked alone with the four residents. Ms. Farquharson stated Resident A required 1:1 staffing coverage but she could not always provide it. Ms. Farquharson stated Ms. Nyinawabeza would come by to drop off food or visit when Guardian A1 was at the facility. Ms. Farquharson stated she could not take a break because Resident A was always in need of assistance.

Ms. Farquharson stated she did fall asleep while working on October 31, 2024. Ms. Farquharson stated she contacted Ms. Nyinawabeza who informed her Mr. Rutamu would be there for his shift “in a little bit”, so she went upstairs to take her shower. Ms. Farquharson stated she fell asleep, woke up in the morning and realized that Mr. Rutamu was working. Ms. Farquharson stated Mr. Rutamu informed her the television was on the ground because Resident A woke up and was not supervised.

On December 16, 2024, I interviewed Pathways Behavioral Analyst, Dr. Shayter. Dr. Shayter stated there were only three direct care staff members, Ms. Nyinawabeza, Mr. Rutamu, and Ms. Farquharson, and she was worried about staff burnout due to Resident A’s behaviors. Dr. Shayter stated as the behavior analyst she determined Resident A’s risk of harm and determined that she should be within eyesight, because of her self-injuries behavior and she is very quick so direct care staff member should be able to intervene if she is running toward a wall or door to try to hit her head. Dr. Shayter stated Resident A is also legally blind and needs assistance navigating a new environment. Dr. Shayter stated she was informed by Ms. Nyinawabeza that Ms. Farquharson was a 24-hour live-in staff which was concerning because of Resident A’s significant support needs.

Dr. Shayter sent me Resident A’s *Functional Behavioral Assessment* which included the following documentation about Resident A’s supervision levels:

1. “[Resident A] had visual impairment that limits her acuity and requires supervision for health and safety.”
2. Resident A was diagnosed with Unspecified Intellectual disability, autism spectrum disorder, OCD, hydrocephalus visual impairment, VP Shunt disruption / repair in 2013, jaw fracture in 2024, and constipation.
3. *Behavior Description* – According to “[Guardian A1], [Resident A] often becomes aggressive (hitting, kicking, head-butting others) and engages in self-injurious behavior. Self-injury included more mild forms (e.g., pinching) as well as more significant forms that require first aid or urgent medical treatment. She is known for diving into walls, furniture, doors, and throwing herself to the ground to hit her head.”

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:	Based on interviews with licensee designee Ms. Nyinawabeza, direct care staff member Ms. Farquharson, Guardian A1 and behavioral analyst Dr. Shayter there was not 1:1 staffing coverage for Resident A while she lived at Lenox Hill Living. Licensee designee Ms. Nyinawabeza did not have a direct care staff schedule verifying 1:1 staffing for Resident A was provided. Ms. Nyinawabeza stated Resident A was not provided 1:1 staffing for an unknown period of time when Ms. Farquharson fell asleep until Mr. Rutamu arrived to work.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **On October 31, 2024 Resident A was bound in her bedroom because direct care staff member Samantha Farquharson put kitchen mitts on her hands so she could not open the door and had her helmet slid down her face so she could not see.**

- **Resident A was physically abused while residing at Lenox Hill Living.**

INVESTIGATION:

On November 4, 2024, a complaint was received via Bureau of Community and Health Systems online complaint system with allegations that On October 31, 2024 Resident A was bound in her bedroom because direct care staff member Samantha Farquharson put kitchen mitts on her hand so she could not open the door. The complaint also stated Resident A's helmet had slid down her face so she could not see. Additional allegations were also received with concerns Resident A was physically abused while residing at Lenox Hill Living.

On November 7, 2024, I received a call from Sparrow forensic nurse, Aimee Fitzpatrick, RN who stated anytime there is an assault she is called to assist. RN Fitzpatrick stated she was informed by Guardian A1 while Resident A was at the hospital that Resident A was assaulted by an unknown direct care staff member at the AFC. RN Fitzpatrick witnessed that she had injuries on her including scattered bruising up and down her legs, marks on her neck, scabs on her forehead, red inflamed lip, black eye as well as the bridge of her nose was red with a mark. Ms. Fitzpatrick stated on her right leg

looked like a handprint or the tips of someone's fingers. Ms. Fitzpatrick stated Resident A had other bruising on the top of her left food, left axillary area, and bruising on her legs. Ms. Fitzpatrick stated Guardian A1 informed her that it "looked like she was held down" but she was not there when it occurred. Ms. Fitzpatrick stated Resident A is verbal but cognitively impaired and was not able to complete an interview regarding what occurred. RN Fitzpatrick stated the injuries on her head could be from hitting her head on the wall repeatedly however the other injuries are unexplained.

On November 19, 2024 I conducted an unannounced on-site investigation at Lenox Hill Living and met with direct care staff member Elia "Joe" Rutamu. Mr. Rutamu stated there was an incident where Resident A was found in her room with mittens taped on her hands which prevented her from opening her bedroom door even though her door did not lock. Mr. Rutamu stated her door was closed and typically she did not close her door so when he went into the room after arriving to work early at 9 PM instead of 10 PM on October 31, 2024, he found Resident A with mittens on her hands and her helmet over her eyes. Mr. Rutamu stated when he arrived the home was quiet which was rare and Resident A's room was dark. Mr. Rutamu stated Resident A had dropped her tv while being in her bedroom in this condition. Mr. Rutamu stated Ms. Farquharson was the direct care staff member working at the time and she was the direct care staff member who put the kitchen mittens on Resident A's hand and then went upstairs to sleep leaving Resident A unsupervised and unable to leave her bedroom. Mr. Rutamu stated he contacted Ms. Nyinawabeza and informed her about this, took off the mittens, and tended to a cut Resident A had on her face. Mr. Rutamu stated he spoke with Ms. Farquharson about this incident but she denied that she was asleep or that she put kitchen mittens on Resident A. Mr. Rutamu stated he has never observed Ms. Farquharson to cause harm to Resident A or physically hurt her. Mr. Rutamu stated when she went to the hospital, she did have a black eye and a bruise on her head. Mr. Rutamu stated Resident A never expressed to him another direct care staff member was hurting her.

On November 19, 2024 I interviewed Resident C and Resident D. Resident C stated Resident A was locked in her bedroom because she was unruly but he does not know when this occurred or who locked her in the room. Resident C stated he knew it was not Mr. Rutamu or Ms. Nyinawabeza because it was an unknown direct care staff member. Resident D stated he was not aware of anyone being locked in their room or anyone being physically abused. Resident D stated Ms. Farquharson did not physically harm Resident A at any time.

On November 19, 2024 I interviewed licensee designee Ms. Nyinawabeza. Ms. Nyinawabeza stated she learned from Mr. Rutamu that Ms. Farquharson closed Resident A into her room and did not allow her to come out. Ms. Nyinawabeza stated that Resident A had a history of behaviors and had to be restrained even in the hospital but there was no reason for Ms. Farquharson to close her in the bedroom. Ms. Nyinawabeza stated Resident A resided at Lenox Hill Living from October 18, 2024-November 2, 2024 and after going to the hospital, she did not return to Lenox Hill Living. Ms. Nyinawabeza stated Resident A was not in the right place for the care and

supervision she required. Ms. Nyinawabeza stated Lansing Police Department also responded to this incident. Ms. Nyinawabeza stated Ms. Farquharson was working with Resident A when she banged her head and taped the kitchen mittens on her hands so she could not get them off. Ms. Nyinawabeza stated she does not know why Ms. Farquharson put kitchen mittens on Resident A or what happened before Ms. Farquharson did this to Resident A. Ms. Nyinawabeza stated Ms. Farquharson had talked to her about using kitchen mittens to control Resident A however Ms. Nyinawabeza stated she informed Ms. Farquharson no resident could be restrained and any type of restraint would need to be approved in the residents' *Person Centered Plan*. Ms. Nyinawabeza stated Resident A could not have opened the door in her condition if there was a fire or some other emergency. Ms. Nyinawabeza stated it was not possible for Resident A to successfully leave her room in that condition because she could not see due to her helmet over her eyes and hands being covered and taped with kitchen mittens. Ms. Nyinawabeza stated she does not believe Ms. Farquharson physically abused Resident A or any of the residents. Ms. Nyinawabeza showed me a picture of Resident A with kitchen mitts secured on her hands with tape standing in the middle of her room with a helmet that is down over her eyes. In the picture, you can see her television has been knocked over as well.

I reviewed the *AFC Incident / Accident Report* for the incident written by Ms. Nyinawabeza:

> *"Explain what happened: On October 31, 2024 when Joe walked in [Resident A] was found with gloves on her hands and was wearing a helmet that is different from what she is prescribed in her IPOS. Direct care staff member Samantha had applied these items on [Resident A]. She was also found to have an alcoholic beverage in her room.*
>
> *These items were removed and once Joe notified Ms. Nyinawabeza I explained to Samantha that what she did was restraining [Resident A] and I fired her."*

On December 11, 2024, I received an email from Lansing Police Department Social Worker Melissa Misner who stated there were three calls to the home for welfare checks between November 1-2, 2024 and the police responded to the incident. Ms. Misner stated there was an employee who was terminated who was making allegations and refusing to leave the property when asked. The report numbers were 24-0202921, 24-0203366, 24-0203298.

On December 11, 2024, I received an email from Resident A's Pathways Community Mental Health case manager, Cheryl Cass with the following documentation:

"I did not suspect that [Resident A] was being confined to her room and/or being physically abused in the home until I received a call from Rebecca on 11/4. Rebecca reported she had a staff member, Sam, who put mittens and a different helmet (that was not [Resident A] helmet) on [Resident A]. Rebecca told Sam she could not restrict her in that way. Rebecca then stated she had fired Sam; Sam did call APS to report

allegations of [Resident A] being locked in her room. One this same day guardian, [Guardian A1] was in communication with Sam and Sam was voicing her concerns about [Resident A] being locked in her room. Once arriving at Lenox Hill Living, [Guardian A1] said [Resident A] had looked very beat up, her head wound was large and open, and she had bruises and cuts on her body. [Guardian A1] took [Resident A] to Sparrow Hospital, where she still is."

On December 11, 2024, I interviewed Guardian A1. Guardian A1 stated she visited with Resident A and found Resident A with multiple injuries so she decided to take her to the hospital. Guardian A1 stated Resident A's condition made it clear she was physically harmed by someone, although Guardian A1 did not know who had harmed Resident A. Guardian A1 stated Ms. Farquharson has a calm demeanor and Resident A was bonded to Ms. Farquharson while she was employed at Lenox Hill Living. Guardian A1 stated Ms. Farquharson told her she could not find the helmet for Resident A so Ms. Farquharson bought Resident A a different one online and Ms. Farquharson put the kitchen mittens on her because she wanted to prevent her from hurting herself. Guardian A1 stated she believes Resident A was locked in her room because she had shredded foam all over the room which she would not have been able to do if she was supervised. Guardian A1 stated Ms. Farquharson informed her she had put kitchen mitts on Resident A to protect Resident A. Guardian A1 stated there is negligence from Ms. Nyinawabeza and Ms. Farquharson because Ms. Nyinawabeza should have made sure Resident A was taken to the hospital when she had the bruises on her body. Guardian A1 stated "did anyone hit you?" and she said "Joe" but she did not give any details. Guardian A1 stated while she was on her way to Lansing, she started to receive calls from Ms. Farquharson who was upset and crying. Guardian A1 stated when she arrived and saw Resident A she had a black eye. Guardian A1 stated Ms. Nyinawabeza did not take Resident A to the hospital for evaluation because she said, "I didn't know I was supposed to." Guardian A1 stated she is sure Resident A did not cause all the marks on her body because typically her self-injurious behavior causes marks on her head. Guardian A1 stated there were marks on Resident A's neck which looked like she was scratched, all over her legs, and arms which she would not have been able to do that to herself. Guardian A1 stated when she was at her previous facility direct care staff members terminated their employment because they could not provide care for Resident A or keep her safe due to her extensive behaviors.

On December 11, 2024, I interviewed former direct care staff member Ms. Farquharson. Ms. Farquharson stated she bought a onesie for Resident A that she could wear so she would stop stripping in front of the men. Ms. Farquharson stated she did put kitchen mittens on Resident A but denied initially that she went to sleep at that time. Ms. Farquharson stated Ms. Nyinawabeza locked the residents in their room, but she did not do this. Ms. Nyinawabeza stated there are locks that were bought and purchased for the outside of the doors so the residents could not get out. Ms. Farquharson stated Ms. Nyinawabeza bought mattresses at Walmart so she could have them on the walls and Resident A ripped them all off so there was foam all over the room while she was locked in her room. Ms. Farquharson stated she left Resident A without supervision because Resident A was sleeping and Mr. Rutamu would be at the facility soon. Ms.

Farquharson stated she does not know what time he was getting there but he said he would be there soon. Ms. Farquharson stated she went upstairs to take a shower and then fell asleep while Resident A was in her room asleep. Ms. Farquharson stated she did not know what time Mr. Rutamu arrived at the facility but when he did, she was informed that Resident A was in her room and had knocked her television off the stand. Ms. Farquharson then stated Resident A was in the room sleeping with the mitts on but the door was not locked, it was just slightly closed so the television in the living room would not wake her up. Ms. Farquharson stated she left her television on with calming music to play while she was sleeping. Ms. Farquharson stated there is nothing in Resident A's *Plan of Service* to use taped kitchen mittens on Resident A's hands. Ms. Farquharson stated Ms. Nyinawabeza did not want to call the ambulance for Resident A and she allowed her to put kitchen mittens on Resident A. Ms. Farquharson stated the mittens were attached with gauze and that didn't not bruise up her hand. Ms. Farquharson stated she did not physically hit or harm Resident A at any time. Ms. Farquharson stated she did not see Ms. Nyinawabeza or Mr. Rutamu physically restrain Resident A during that weekend.

Ms. Farquharson and Guardian A1 both sent me pictures of the locking mechanism that was used over the door handles. I was able to use reverse Google search to locate these locking mechanisms on Amazon. According to the Amazon search these locks are called Prime Line EP 4180 Doorknob lock out device which blocks access to the keyhole and fits round doorknobs. According to the Amazon description, it's a doorknob lock out device which can be placed over the doorknob to block access to the keyhole and will keep keyholders out and is often used in evictions, rentals, home sales, or on job sites. The description also states it prevents the turning of the doorknobs.

On December 16, 2024, I interviewed Pathways Behavior Analyst, Dr. Shayter. Dr. Shayter stated the helmet Resident A had on her in the picture with the kitchen mitts is not the helmet she was prescribed. Dr. Shayter stated at no given time should Resident A been locked in the room for any given time. Dr. Shayter stated there is nothing regarding kitchen mitts in her Safety Care training or behavioral assessment. Dr. Shayter stated there is no way the kitchen mitts or locks would be anything Pathways would support. Dr. Shayter stated she does not know why Ms. Nyinawabeza or Ms. Farquharson thought this would be an appropriate choice no matter behaviors Resident A had exhibited.

On December 17, 2024, I interviewed licensee designee Ms. Nyinawabeza about the door locks. Ms. Nyinawabeza stated the pictures of the door locks were also sent to Ms. Nyinawabeza by Ms. Farquharson. Ms. Nyinawabeza stated Ms. Farquharson informed her she was going to report that Resident B was left in his room and the next time she heard about it was when Guardian A1 showed her the picture of the locks and asked if she knew where they were from. Ms. Nyinawabeza stated she "would never do such a thing" to lock the residents in the room and has never seen those locks in person. Ms. Nyinawabeza stated Ms. Farquharson was making accusations about her locking residents in their rooms but this did not happen.

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: **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.**
ANALYSIS:	Based on the interviews with licensee designee Ms. Nyinawabeza, Mr. Rutamu, and Ms. Farquharson, Resident A was restrained in her bedroom with kitchen mitts taped on her hands. Due to the kitchen mitts taped on Resident A's hands she was not able to lift her helmet after it had slid over her eyes. Also, Resident A would not have been able to leave her bedroom in case of an emergency whether the door was propped open or closed. Ms. Farquharson stated Ms. Nyinawabeza used locks on the door and both Guardian A1 and Ms. Farquharson sent pictures of these locks which I verified on Amazon would prohibit the door from opening. however Ms. Nyinawabeza states these were never used in the facility. In this situation, even if Resident A was not locked in her room, the kitchen mitts and helmet were not prescribed restraints and restricted Resident A's movement by binding and immobilizing her.
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 interviews with licensee designee Ms. Nyinawabeza, Mr. Rutamu, and Ms. Farquharson there is not enough evidence to determine if Ms. Farquharson used physical force on Resident A. Resident A did have a large head wound, however there is documentation she came with this wound and although it increased drastically in size, it appears she was not wearing her helmet consistently and was engaging in self-injurious behaviors. Resident A did have several bruises and injuries on her body however, there is not enough evidence to determine she was physically abused or if this was caused by self-injurious behaviors.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident B was confined in his room with the door locked causing him to urinate and defecate on himself because he could not leave his room.

INVESTIGATION:

On November 4, 2024 a complaint was received via Bureau of Community and Health Systems online complaint system with allegations Resident B was confined in his room with the door locked causing him to urinate and defecate on himself because he could not leave his room.

On November 19, 2024 I conducted an unannounced on-site investigation at Lenox Hill Living and met with direct care staff member Elia “Joe” Rutamu. Mr. Rutamu stated there were no incidents when Resident B was locked in his room because he was able to open his door on his own. Mr. Rutamu stated Resident B spent most of his time in the common areas of the house if he was not sleeping. Mr. Rutamu stated Resident B never urinated on himself because of being locked in his room.

On November 19, 2024 I interviewed Resident C and Resident D. Resident C stated Resident B was a previous resident at Lenox Hill Living and he has never observed him to be locked in his room. Resident D stated he did not recall a time when Resident B was ever locked in his room. Resident D stated he resides in the room Resident B used to be in so I observed the lock and it was equipped with a non-locking against egress lock. If this was the same lock during the time Resident B resided in the bedroom, Resident B would have been able to leave his room at any time.

On November 19, 2024 I interviewed licensee designee Ms. Nyinawabeza. Ms. Nyinawabeza stated Resident B would have incontinence at times and would have feces on his pants and not clean up after himself, however, none of these accidents were because he was locked in his room or unable to use the restroom. Ms. Nyinawabeza stated Resident B was “very busy” and was always outside his room. Ms. Nyinawabeza showed me text messages between she and Ms. Farquharson from

October 23, 2024 describing a smell in Resident B's room and troubleshooting how to resolve this issue.

On December 11, 2024, I interviewed former direct care staff member Ms. Farquharson. Ms. Farquharson stated there was a lock on Resident B's door and he was unable to get out of his room. Ms. Farquharson stated Ms. Nyinawabeza told her the "government does not want the doors locked."

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: **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.**
ANALYSIS:	Based on the interviews with Resident C, Mr. Rutamu, and Ms. Nyinawabeza there is no indication Resident B was locked in his room. Ms. Nyinawabeza stated Resident B did have incontinence issues, however none of these incidents were due to being locked in a room.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A was supposed to have a helmet to wear at all times and licensee designee Rebecca Nyinawabeza did not provide her with one.

INVESTIGATION:

On November 4, 2024 a complaint was received via Bureau of Community and Health Systems online complaint system with allegations Resident A was supposed to wear a helmet at all times and Ms. Nyinawabeza did not provide Resident A with a helmet.

On November 19, 2024 I conducted an unannounced on-site investigation at Lenox Hill Living and met with direct care staff member Elia "Joe" Rutamu. Mr. Rutamu stated Resident A did have a helmet she wore during the day but she did not sleep with it on. Mr. Rutamu stated she arrived to Lenox Hill Living with the helmet and it was in her *Person Centered Plan* but he did not know if there was a physicians order for the helmet.

On November 19, 2024 I interviewed Resident C. Resident C stated Resident A did have a helmet but she would take it off sometimes and not want to wear it which was dangerous because she was always hitting her head on the walls and she would have

seizures at times. Resident C stated direct care staff members reminded Resident A to wear her helmet.

On November 19, 2024 Ms. Nyinawabeza sent Resident A's inventory list and Discharge Plan from Schoolcraft Hospital. I reviewed the Discharge Plan from October 18, 2024 from Schoolcraft Memorial Hospital which stated she had a non-suicidal self-inflicted head wound with no active bleeding and no evidence of infection. The Discharge Plan stated to apply Resident A's helmet as Resident A allows. Resident A's Inventory of Valuables listing from her move in date of October 18, 2024, documented she came with one helmet and it was returned to her on November 3, 2024.

On December 11, 2024, I received an email from Resident A's Pathways Community Mental Health case manager, Cheryl Cass with the following documentation:

> *"[Resident A] did move into the home with a safety helmet. The helmet needs some repairs, so Dr. Shayter sent the home some new helmet suggestions for her PCP to review/write a script for. The original helmet was still fine to use in the time being. As per review of Lenox Hill residential progress notes, there were occasions that [Resident A] accepted wearing her helmet, and other occasions she refused to wear it."*

On December 11, 2024, I interviewed Guardian A1. Guardian A1 stated Resident A came with a helmet she was supposed to wear but 99% of the time she would take it off even though direct care staff members would encourage her to put it on. She would keep it on for a short time and then take it off. Guardian A1 stated they were in the process of getting an updated helmet for Resident A because the other one needed repair.

On December 11, 2024, I interviewed former direct care staff member Ms. Farquharson. Ms. Farquharson stated Resident A did have a helmet she could wear but she kept taking it off and not keeping it on.

On December 16, 2024, I interviewed Pathways Behavioral Psychological Services, Dr. Shayter. Dr. Shayter stated Resident A's helmet was prescribed in March 2023 and it was a durable medical helmet but her strap was broken at her previous placement and it was hand sewn together using fishing line. Dr. Shayter stated this was a dense foam helmet with a vinyl outside. Dr. Shayter stated she provided licensee designee Ms. Nyinawabeza a list of specific helmets which required measurements and the helmet price would be covered by Medicaid. Dr. Shayter stated she had sent emails to Ms. Nyinawabeza regarding the helmets but she did not receive a response so a new one could be ordered. Dr. Shayter stated when Resident A arrived to Lenox Hill Living she had the correct helmet but she does not know when Resident A stopped wearing the helmet or how long she was wearing the incorrect helmet. Dr. Shayter stated she provided Ms. Nyinawabeza with behavioral data sheets which have included this information. Dr. Shayter stated Ms. Nyinawabeza never returned any of these data sheets the entire time Resident A was residing at Lenox Hill Living. Dr. Shayter stated

there were also no AFC Incident / Accident Reports sent in regarding behavioral concerns in the home. Dr. Shayter stated when Resident A moved in she had a head injury the size of a silver dollar that was scabbed over and healing because it was treated at Schoolcraft Hospital and wearing the helmet was protecting her from additional damage. Dr. Shayter stated when she arrived it was a weeping wound but it was the same size as a sliver dollar. I showed Dr. Shayter the picture of the injury sent by Guardian A1 and she stated the wound was double or triple of the size of when Resident A arrived at Lenox Hill Living.

Dr. Shayter emailed me Resident A's *Pathways Functional Behavioral Assessment* which included the following documentation about Resident A's helmet use:

- *"After an incident involving significant self-injury at her previous facility, [Resident A] had a persistent open wound and eventually contracted MERSA. Ongoing instances of self-injurious behavior (SIB) resulted in the wound reopening. At the time of this assessment (10/15/2024), this wound was still present but was healing better with routine helmet wear constituted by SCMH.*
- *[Resident A] was also prescribed a protective helmet. She previously could request to wear it and staff could encourage her to do so, however [Resident A] did not ever historically request to wear her helmet independently. She was also likely to decline use or escalate further if requests were made to wear it if she was already engaging in self-harm. Additionally, staff were allowed to assist her with putting the helmet on but could not force her to wear/prevent her from removing it. It was recommended that staff use pillows or other soft items to minimize SIB attempts if this occurred. However, [Resident A] historically engaged in significant self-injury suddenly which requested in bleeding injuries. These wounds had not been able to heal properly because of continued self-injury. Since her stay at the hospital and consistent use of her helmet, these wounds have started to heal.*
- *[Resident A] should wear her helmet any time she is not seated or laying down (see restrictive plan). She should be encouraged to wear her helmet any time she is moving throughout the home (i.e., outside of her bedroom) even while seated as episodes of SIB can occur quickly and/or take place while seated/laying on furniture within common areas (e.g., couches)."*

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and**

	recommendations shall be recorded in the resident's record.
ANALYSIS:	On November 19, 2024 Ms. Nyinawabeza sent an inventory list which included Resident A's helmet. Although Resident A had a helmet there, at one point Ms. Farquharson could not find it and ordered another helmet which was not prescribed. Based on the worsening condition of her wound when she left Lenox Hill Living, it appears she was not wearing a helmet regularly. According to her *Pathways Functional Behavioral Assessment*, Resident A had an open wound in the past on her head from her self injurious behavior, however it was healing because of the consistent helmet use. A picture I reviewed showed the wound on Resident A's head which had opened and according to Dr. Shayter was two to three times larger than when she first arrived at Lenox Hill Living. When this incident occurred, Resident A was wearing a helmet which was not prescribed to her and Dr. Shayter was able to confirm this helmet was purchased off Amazon.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On November 19, 2024 I interviewed licensee designee Ms. Nyinawabeza at Lenox Hill Living. Ms. Nyinawabeza stated she found out two days before Resident A arrived that she needed to have a training to work with her behaviors through Pathways CMH. Ms. Nyinawabeza stated she completed this training but not all direct care staff were able to complete the training before working with Resident A. Licensee designee Ms. Nyinawabeza did have verification she signed off on Resident *A's Person-Centered Plan* but she did not have verification that Mr. Rutamu or Ms. Farquharson signed off on Resident A's *Person-Centered Plan* or *Individual Plan of Service* indicating they understood how to provide personal care and supervision to Resident A.

On December 11, 2024, I interviewed former direct care staff member Ms. Farquharson. Ms. Farquharson stated she received training on how to restrain Resident A but she did not feel comfortable doing so. Ms. Farquharson stated she did not read Resident A's *Person Centered Plan* but she was taught about Resident A by speaking with Ms. Nyinawabeza. Ms. Farquharson stated they were taught how to manage her behaviors but Ms. Farquharson stated she would distract her by sitting outside with Resident A.

On December 16, 2024, I interviewed Pathways Behavioral Analyst, Dr. Shayter who stated she went to Lenox Hill Living to complete the Safety Care training with Ms. Farquharson, Mr. Rutamu, and Ms. Nyinawabeza. Dr. Shayter stated Ms. Nyinawabeza did participate in most of the training however, Ms. Nyinawabeza had to leave at 5:00

PM the second day which is when the bulk of the physical management techniques were delivered. Dr. Shayter stated part of the email correspondence to Ms. Nyinawabeza stated there was lecture portions of the training which were supposed to be done but those were not done by Ms. Nyinawabeza so she could not sign off on the training as completed. Dr. Shayter stated she reached out to Ms. Nyinawabeza three times to get this training completed by direct care staff members and herself however she never responded to these attempts. Dr. Shayter stated there are no records of completion or a certificate for Ms. Nyinawabeza for the Safety Care training because they technically did not complete the entire training so she is not comfortable signing off. Dr. Shayter stated while she was there, she was embedding her behavior support programing as well, how to interact, deescalate behaviors and they did see observe her model some of those behaviors with Resident A once she arrived at Lenox Hill Living. Dr. Shayter stated there was no documentation verifying the Person-Centered Plan was reviewed because she also requested this information from Ms. Nyinawabeza but they never received that back either even after several email attempts.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(2) All staff who work independently and staff who function as lead workers with clients shall have successfully completed a course of training which imparts basic concepts required in providing specialized dependent care and which measures staff comprehension and competencies to deliver each client's individual plan of service as written. Basic training shall address all the following areas: **(a) An introduction to community residential services and the role of direct care staff.** **(b) An introduction to the special needs of clients who have developmental disabilities or have been diagnosed as having a mental illness. Training shall be specific to the needs of clients to be served by the home.** **(c) Basic interventions for maintaining and caring for a client's health, for example, personal hygiene, infection control, food preparation, nutrition and special diets, and recognizing signs of illness.** **(d) Basic first aid and cardiopulmonary resuscitation.** **(e) Proper precautions and procedures for administering prescriptive and nonprescriptive medications.** **(f) Preventing, preparing for, and responding to, environmental emergencies, for example, power failures, fires, and tornados.** **(g) Protecting and respecting the rights of clients, including providing client orientation with respect to the written policies and procedures of the licensed facility.**

	(h) Nonaversive techniques for the prevention and treatment of challenging behavior of clients.
ANALYSIS:	Ms. Nyinawabeza could not provide verification that Mr. Rutamu or Ms. Farquharson signed off on Resident A's Person Centered Plan indicating they understood how to provide personal care and supervision to Resident A. According to Dr. Shayter, Ms. Nyinawabeza did not complete the required Safety Care training to learn how to handle Resident A's challenging self-injurious. Ms. Farquharson stated she did not read Resident A's Person Centered Plan, but instead just spoke with Ms. Nyinawabeza about Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On November 19, 2024 I interviewed licensee designee Ms. Nyinawabeza. Ms. Nyinawabeza stated Ms. Farquharson would work 16-hour days 6 days per week and the other shifts were filled in by Mr. Rutamu or herself. Licensee designee Ms. Nyinawabeza did not have a direct care staff schedule showing who was working for the month of October 2024 however she did have a schedule for November 2024.

On December 11, 2024, I interviewed former direct care staff member Ms. Farquharson. Ms. Farquharson stated there was no schedule when she was supposed to work because she was there for 24 hours per day as a live in direct care staff member. Ms. Farquharson stated she never saw a schedule detailing when she was supposed to work.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**

ANALYSIS:	Licensee designee Ms. Nyinawabeza did not have a schedule showing who was working for the month of October 2024. Ms. Farquharson stated she never saw a schedule showing the hours she was required to work because she was expected to be there at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

_____12/19/2024_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

12/20/2024

_____

Dawn N. Timm
Area Manager

Date