RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

June 16, 2017

Cheryl Thomas-Hardy
PO Box 4317
Saginaw, MI 48606

RE: License #:	AS730354102
Investigation #:	2017A0872034
	Iowa's Place

Dear Ms. Thomas-Hardy:

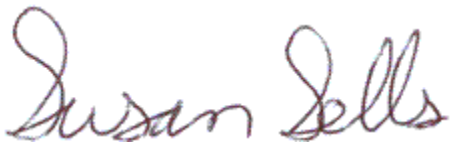
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (810) 787-7031.

Sincerely,



Susan Sells, Licensing Consultant
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730354102
Investigation #:	2017A0872034
Complaint Receipt Date:	04/07/2017
Investigation Initiation Date:	04/10/2017
Report Due Date:	06/06/2017
Licensee Name:	Cheryl Thomas-Hardy
Licensee Address:	4462 E. Lakecress Drive Saginaw, MI 48603
Licensee Telephone #:	(989) 737-4010
Administrator:	Cheryl Thomas-Hardy
Licensee Designee:	Cheryl Thomas-Hardy
Name of Facility:	Iowa's Place
Facility Address:	2308 Iowa Saginaw, MI 48601
Facility Telephone #:	(989) 737-4010
Original Issuance Date:	05/14/2014
License **Status:**	REGULAR
Effective Date:	11/14/2016
Expiration Date:	11/13/2018
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

	PHYSICALLY HANDICAPPED

II. ALLEGATION(S)

	Violation Established?
Resident A has a large contusion and cut on her hand. She alleges that staff, Diamond Thomas hit her.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/07/2017	Special Investigation Intake 2017A0872034
04/07/2017	APS Referral This complaint was referred by APS
04/10/2017	Special Investigation Initiated - Letter
04/11/2017	Contact - Document Received I exchanged emails with APS Worker, Katrice Humphrey
04/26/2017	Contact - Telephone call made I spoke to Ms. Humphrey about this complaint
04/27/2017	Inspection Completed On-site Unannounced
05/01/2017	Contact – Telephone call received I spoke to Ms. Humphrey about this complaint
05/02/2017	Contact – Document Received I received an Incident/Accident Report from Ms. Thomas-Hardy
05/04/2017	Contact - Document Received I received documentation from Ms. Humphrey
06/01/2017	Contact - Document Received I exchanged emails with Ms. Humphrey

06/02/2017	Contact - Telephone call made I spoke to the licensee, Cheryl Thomas-Hardy
06/02/2017	Contact - Telephone call made I interviewed Resident A
06/05/2017	Contact - Telephone call made I interviewed staff, Diamond Thomas
06/05/2017	Inspection Completed-BCAL Sub. Compliance
06/16/2017	Exit Conference I conducted an exit conference with Mrs. Thomas-Hardy via telephone

ALLEGATION:

Resident A has a large contusion and cut on her hand. She alleges that staff, Diamond Thomas hit her.

INVESTIGATION:

On 4/11/17, I exchanged emails with Adult Protective Services Worker, Katrice Humphrey. Ms. Humphrey stated that on 4/07/17, she interviewed Resident A and observed a bruise and contusion on her hand. Resident A told Ms. Humphrey that the injury occurred when staff, Diamond Thomas pushed her and she fell. Resident A also said that Ms. Thomas hit her on the back. Resident A said that she told the licensee, Cheryl Thomas-Hardy and her husband, Jonathon what happened. Resident A stated that Mr. Hardy told Ms. Thomas “this is your last time and keep your hands off her.” Resident A said that Mrs. Thomas-Hardy did not say anything to her about the injury.

Ms. Humphrey said that she interviewed Mr. Hardy who stated that he was not aware of Resident A’s injury until two days after the injury occurred. Mr. Hardy said that Ms. Thomas told him that Resident A fell while getting the shower chair out of the tub. Mr. Hardy said that Resident A did not receive medical treatment and a report was not made to AFC Licensing.

Ms. Humphrey interviewed Mrs. Thomas-Hardy who said that Ms. Thomas told her that Resident A fell which is how she received the injury. Ms. Humphrey advised Mrs. Thomas-Hardy to seek medical treatment for Resident A.

On 4/27/17, I conducted an unannounced inspection of Iowa's Place AFC facility. I interviewed Mrs. Thomas-Hardy and Mr. Hardy. Mrs. Thomas-Hardy said that Resident A was admitted to her facility on 10/10/14 but was moved to another facility within the past couple of weeks. Mrs. Thomas-Hardy said that Diamond Thomas is her daughter.

Mrs. Thomas-Hardy said that on or around 4/02/17, Ms. Thomas called her and told her that Resident A had fallen. Mrs. Thomas-Hardy said that Ms. Thomas did not tell her that Resident A had received an injury.

On 4/04/17, Resident A's Support Coordinator called and told Mrs. Thomas-Hardy that Resident A presented to her Day Program with a bruise on her hand, stating that Ms. Thomas had pushed her down. Mrs. Thomas-Hardy said that she asked Resident A what happened but she only cried and said that she did not remember.

Mrs. Thomas-Hardy said that she asked Ms. Thomas about the injury. Ms. Thomas told her that she found Resident A on the floor in the bathroom. Ms. Thomas denied hitting or pushing Resident A. Mrs. Thomas-Hardy said that she was interviewed by APS Worker, Katrice Humphrey and as a result of the investigation, Ms. Thomas has been taken off the work schedule.

Mrs. Thomas-Hardy said that she took Resident A to MedExpress on 4/08/17. I examined the discharge paperwork from the treating physician. An x-ray was done on Resident A's hand and it was negative for any fractures. The treating physician recommended Tylenol and ice.

On 5/01/17, I spoke to Ms. Humphrey about this complaint. Ms. Humphrey said that initially, Ms. Thomas told her that she was in the bathroom with Resident A when she fell but later said that she was in the living room watching television when Resident A fell.

Ms. Humphrey said that she is concerned about Ms. Thomas's suitability. She said that during her interview with Ms. Thomas, she did not always seem to understand the questions asked of her and her responses were not always clear. Ms. Humphrey said that Ms. Thomas did not know her address and had to look on her phone even though she said she'd been living at this address for approximately one year. Ms. Humphrey said that due to Ms. Thomas's apparent delays, she asked her about her income. Ms. Humphrey said that she discovered that Ms. Thomas is on SSI and that she has a case manager through Community Mental Health.

On 5/02/17, I received an Incident/Accident Report from Ms. Thomas-Hardy via fax. The report was dated 4/02/17 at 6:30pm and was completed by Diamond Thomas.

According to the report "I was watching tv and [Resident A] was going to take a shower. She went into the bathroom to get into the shower and I heard her fall so I went to the bathroom. She was on the floor. I asked her was she ok. She said she was ok but she said she hit her hand on the tub but she was ok then she got into the shower with my

help. I told her I will help her get out." Under the section "action taken by staff/treatment given" the area was blank. Under the section "corrective measures taken…" the report stated "The staff will help her get in and out the shower." The Incident/Accident Report was signed by Mrs. Thomas-Hardy on 4/07/17.

On 6/02/17, I interviewed Resident A. Resident A stated that she has a "scar" on her hand from Ms. Thomas hurting her. She said that she was trying to get in the shower but Ms. Thomas got angry at her for not taking the shower chair out of the shower. Resident A said that Ms. Thomas pushed her and she fell. Ms. Thomas then stepped on her hand, causing the injury. Resident A said that Ms. Thomas told her "don't tell my mom and dad what I did." Resident A stated "but I did anyway. I told them what she did."

On 6/02/17, I again spoke to Mrs. Thomas-Hardy. I asked Mrs. Thomas-Hardy about Ms. Thomas receiving SSI. She said that Ms. Thomas had a "club foot" which is why she is on SSI. I asked her if Ms. Thomas has a case manager through CMH and she said that she used to due to "learning disabilities." Mrs. Thomas-Hardy said that Ms. Thomas lives on her own but does not have a driver's license.

On 6/05/17, I interviewed Diamond Thomas. Ms. Thomas stated "I heard something in the bathroom" so she went in the bathroom and found Resident A on the floor. Ms. Thomas said "she must have slipped and fell." Initially, Ms. Thomas said that she saw a bruise on Resident A's hand but then said she did not see a bruise or injury. Ms. Thomas then said that she was trying to help Resident A up "and she had hit her hand on the shower chair and that's how she hurt her hand."

Ms. Thomas said that she told Mrs. Thomas-Hardy the next day about the bruise to Resident A's hand. She said that she did not tell Mrs. Thomas-Hardy about it the day it happened because she was cleaning up another resident's bowel movement and she forgot. Initially, she said that she filled out an Incident/Accident Report the day of the incident but then said it was three days later.

Ms. Thomas stated that she is on SSI "because I had a club foot." She said that she used to have a case manager through CMH because she was "trying to help me find a job." She reported that she has not had a CMH case manager for two years. Ms. Thomas said that she moved into her own apartment on 3/28/17. She said that she lives by herself.

I asked Ms. Thomas if she has ever hurt any of the residents. She said "I'm not no fighter and I don't hurt nobody." I asked her if she ever got frustrated caring for the residents and initially she said no. Then she said that she does get frustrated "but I don't hit nobody." Ms. Thomas said that Resident A was her friend and she does not know why Resident A said that she hit her. Ms. Thomas said that she was mad when she found out what Resident A said. During my interview with Ms. Thomas, her speech was very slow and she seemed confused by my questions at times.

According to the Adult Protective Services Report completed by Ms. Humphrey, she substantiated abuse by Ms. Thomas to Resident A. Ms. Humphrey also made a referral to law enforcement regarding the incident.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	On 4/02/17, Resident A received an injury to her hand which resulted in a bruise. Resident A said that staff Diamond Thomas hit her, causing her to fall and resulting in the injury to her hand. Resident A said that Ms. Thomas told her "don't tell my mom and dad what I did." Ms. Thomas gave several different accounts as to how the injury occurred, where she was when the injury occurred, whether she knew Resident A received an injury, and when she notified Ms. Thomas-Hardy about the injury. I conclude that there is sufficient evidence to substantiate the allegations that Ms. Thomas caused the injury to Resident A's hand which is a direct violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.** **(b) Be capable of appropriately handling emergency situations.**

ANALYSIS:	Resident A received an injury to her hand which she says was a result of Ms. Thomas pushing her and her falling to the ground. Resident A said that Ms. Thomas was angry with her when this incident occurred and told her “don’t tell my mom and dad what I did.” APS Worker, Katrice Humphrey and I interviewed Ms. Thomas and found that she seemed easily confused by our questions, her responses were not always clear, and her speech was very slow. Ms. Thomas gave several different accounts of what happened to Resident A and how she received the injury. I conclude that Ms. Thomas is not suitable to meet the physical, emotional, intellectual, and social needs of the residents which is a direct violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 4/04/17, Mrs. Thomas-Hardy said that she was told that Resident A had a bruise and an injury to her hand. However, she did not seek medical attention for Resident A until 4/08/17.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident’s physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	On 4/04/17, Mrs. Thomas-Hardy said that she was told that Resident A had a bruise and an injury to her hand. However, she did not seek medical attention for Resident A until 4/08/17 which is a direct violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Ms. Thomas said that on or around 4/02/17, Resident A fell and sustained a bruise to her hand. Ms. Thomas said that she did not tell Mrs. Thomas-Hardy about the injury

until the next day and did not complete an Incident/Accident Report until three days later because she “forgot.”

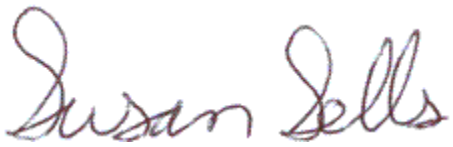
I received an Incident/Accident Report from the licensee on 5/02/17 which was dated 4/07/17.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(2) An immediate investigation of the cause of an accident or incident that involves a resident, employee, or visitor shall be initiated by a group home licensee or administrator and an appropriate accident record or incident report shall be completed and maintained.
ANALYSIS:	Ms. Thomas said that on or around 4/02/17, Resident A fell and sustained a bruise to her hand. Ms. Thomas said that she did not tell Mrs. Thomas-Hardy about the injury until the next day and did not complete an Incident/Accident Report until three days later because she “forgot.” I received an Incident/Accident Report from the licensee on 5/02/17 which was dated 4/07/17. I conclude that staff did not complete an Incident/Accident Report at the time of the incident which is a direct violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/16/17, I conducted an exit conference with the licensee, Cheryl Thomas-Hardy via telephone. I discussed the findings of my investigation and explained which rule violations I will be substantiating. She agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

IV. RECOMMENDATION

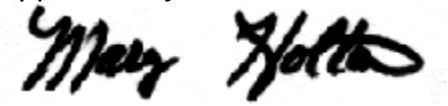
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



June 16, 2017

Susan Sells Licensing Consultant	Date

Approved By:



June 16, 2017

Mary E Holton Area Manager	Date