RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

May 3, 2018

Cynthia White
Neighborhood Residential Inc. (Life Center Inc.)
15419 Middlebelt
Livonia, MI 48154

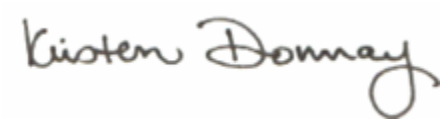
RE: License #: AS630312997
Investigation #: 2018A0991014
Terova Home

Dear Ms. White:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 296-2783

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630312997
Investigation #:	2018A0991014
Complaint Receipt Date:	02/13/2018
Investigation Initiation Date:	02/13/2018
Report Due Date:	04/14/2018
Licensee Name:	Neighborhood Residential Inc. (Life Center Inc.) (Operated by: Integrated Living)
Licensee Address:	15419 Middlebelt Livonia, MI 48154
Licensee Telephone #:	(586) 799-9220
Licensee Designee:	Cynthia White (Karen Harris- Integrated Living)
Name of Facility:	Terova Home
Facility Address:	2448 Terova Troy, MI 48098
Facility Telephone #:	(248) 689-7572
Original Issuance Date:	02/29/2012
License Status:	1ST PROVISIONAL
Effective Date:	09/19/2017
Expiration Date:	03/18/2018
Capacity:	3
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
The home manager, Ashley Buchanan, hit Resident A multiple times in the arm in response to Resident A being physically aggressive towards her.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/13/2018	Special Investigation Intake 2018A0991014
02/13/2018	Special Investigation Initiated - Telephone Call to Katie Garcia, Office of Recipient Rights (ORR)
02/13/2018	APS Referral Referral made to Adult Protective Services (APS) by recipient rights, assigned to Gene Evans
02/13/2018	Contact - Telephone call made Left message for Gene Evans
02/13/2018	Referral - Recipient Rights Referral received from recipient rights
02/13/2018	Contact - Telephone call made To Jeff Swanson, Integrated Living quality manager
02/20/2018	Inspection Completed On-site
04/11/2018	Exit Conference Via telephone with Integrated Living licensee designee, Karen Harris, and quality assurance manager, Jeff Swanson
04/23/2018	Contact – Telephone call made To Jeff Swanson re: updated recommendation
04/23/2018	Exit conference Via telephone with Cynthia White, licensee designee from Neighborhood Residential Inc. (Life Center Inc.)

ALLEGATION:

The home manager, Ashley Buchanan, hit Resident A multiple times in the arm in response to Resident A being physically aggressive towards her.

INVESTIGATION:

On 02/13/18, I received a complaint alleging that the home manager at Terova Home, Ashley Buchanan, hit Resident A multiple times in the arm in response to Resident A being physically aggressive towards her. I initiated my investigation by contacting the assigned Office of Recipient Rights (ORR) worker, Katie Garcia. I also left a message for the assigned Adult Protective Services worker, Gene Evans. On 02/20/18, Ms. Garcia and I completed an onsite inspection at Terova Home.

On 02/20/18, I interviewed the home manager, Ashley Buchanan. Ms. Buchanan stated that the alleged incident happened on a Tuesday, but she could not recall the exact date. She was completing her 20-minute checks on Resident A. When she entered Resident A's room, she noticed there was urine on the floor. She was on the floor cleaning up the urine and asked Resident A for his compact disc (CD) back, as he can only have CDs for a short period of time or he will break and destroy them. Resident A became upset and started hitting Ms. Buchanan on the arm. She put her arm out to block him from hitting her anywhere else. She stated that she did not hit him back, but her hand was open when she put her arm out. As she attempted to stand up, she swung her arm out, but she was not sure if she hit Resident A or not. Ms. Buchanan told Resident A, "I am the wrong one for you to attack." She indicated that she said this because she was trying to convey to Resident A that she is the one who normally transports him on outings, so if he attacks her she will no longer feel safe transporting him. Ms. Buchanan stated that direct care worker, Eric McCormick, was standing behind her when the incident occurred, but he did not attempt to intervene or provide assistance.

On 02/20/18, I interviewed direct care worker, Eric McCormick. Mr. McCormick stated that on 02/06/18 Resident A was in his bedroom when he entered the room with the home manager, Ashely Buchanan. Ms. Buchanan asked Resident A for his CD back, because Resident A is only allowed to have CDs for an hour at a time or he will become destructive. Resident A was still listening to the CD and said no. Ms. Buchanan entered the room to try to get the CD and Resident A hit her in the arm. Ms. Buchanan returned the blows, hitting Resident A with a closed fist and open hand. She hit him approximately 5 or 6 times in the arm. Ms. Buchanan grabbed Resident A by the wrist so he would stop punching. Resident A then started kicking Ms. Buchanan and she hit him a few more times. She then said to Resident A, "You picked the wrong person to hit." Mr. McCormick stated that this was the first and only time he ever witnessed any

staff being physically aggressive towards a resident. None of the residents in the home have ever said anything to him about being mistreated by staff.

On 02/20/18, I interviewed direct care workers, Deondrae Porter, Takela Whitlock, and Takisha Mitchell. They all indicated that Resident A has a history of being physically aggressive towards staff; however, they have never witnessed any staff person being physically aggressive or inappropriate towards Resident A or any other resident in the home. They did not have any concerns with regards to Ms. Buchanan's interactions with the residents in the home.

On 02/20/18, I attempted to interview Resident A, but he refused to speak to me.

On 02/20/18, I interviewed Resident B. He stated that staff treat the residents well and he did not have any complaints with regards to Ms. Buchanan.

On 03/08/18, I received and reviewed copies of written statements completed by Ms. Buchanan and Mr. McCormick. The written statements reflect the same information that was provided during their interviews.

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 information gathered through my interviews and onsite inspection, there is sufficient information to conclude that the home manager, Ashley Buchanan, used physical force and hit Resident A after he was being physically aggressive towards her. This was witnessed by direct care worker, Eric McCormick, who provided a consistent and detailed account of the incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 02/20/18, I interviewed the home manager, Ashley Buchanan, and direct care worker, Eric McCormick. Ms. Buchanan and Mr. McCormick both stated that Resident A's individual plan of service (IPOS) states that they are supposed to have pillows in the area that can be used as a buffer to prevent Resident A from hitting and injuring staff.

There were no pillows in the area when Resident A became aggressive towards Ms. Buchanan on 02/06/18.

On 02/20/18, I received and reviewed a copy of Resident A's IPOS. The plan indicates that for the prevention of injury, staff are to calmly place a pillow or cushion between Resident A and the point of contact. They are to have plenty in the environment in case he tosses it. If Resident A is grabbing or flailing at caregivers (instead of himself), staff should keep a safe distance while placing a barrier such as pillows or cushions until he is ready to accept staff into his space.

The plan also indicates that staff should avoid lectures, debates, or power struggles when Resident A is upset. Caregivers need to suspend the temptation to correct the situation and should not verbally correct him, try to rationalize with him, or debate, threaten negative consequences, intimidate, bribe, or instruct. Staff should try to subdue their verbal statements and allow Resident A to decompress or calm down. During the incident on 02/06/18, Ms. Buchanan told Resident A, "I am the wrong one for you to attack." She said this because she was trying to convey to Resident A that she is the one who normally transports him on outings, so if he attacks her she will no longer feel safe transporting him.

Ms. Buchanan and Mr. McCormick also stated that Resident A is only allowed to have CDs for an hour and then they must take them back so that he will not destroy them. Resident A's IPOS does not mention restricting use of CDs to one hour. The plan does indicate that staff should have flexible demands. Staff should understand Resident A's emotional needs and adjust their demands accordingly, depending on Resident A's tolerance.

It should also be noted that Terova Home is currently on a provisional license and being operated by Integrated Living, Inc. (43133 Schoenherr Rd., Sterling Heights, MI 48313). An application was submitted on 11/14/17 and the new enrollment is still pending (AS630391421).

On 04/11/18, I conducted an exit conference via telephone with the Integrated Living licensee designee, Karen Harris, and the quality assurance director, Jeff Swanson to review my findings. Ms. Harris and Mr. Swanson indicated that they understood the citations and were taking the necessary actions to ensure compliance with the licensing rules. They stated that Ms. Buchanan was no longer the home manager at Terova Home. She was moved to a different position in another home. Ms. Harris and Mr. Swanson also indicated that Resident A's behaviors have escalated and they submitted a 30 day discharge notice due to concerns for his own safety and the safety of staff and the other residents in the home.

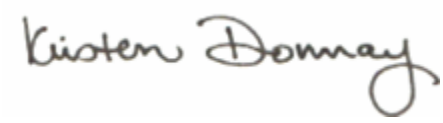
On 04/23/18, I conducted an exit conference with Cynthia White, the licensee designee from Neighborhood Residential Inc., which has merged with Life Center Inc. I informed Ms. White that since the home was on a provisional license and there were additional quality of care violations, revocation of the license is being recommended. Ms. White

did not have any additional information to share. On 04/23/18, I informed Jeff Swanson from Integrated Living of the updated recommendation for revocation and he indicated that he would share the information with the licensee designee, Karen Harris.

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:	Based on the information gathered through my interviews and onsite inspection, there is sufficient information to conclude that care was not provided as specified in Resident A's written assessment plan. Ms. Buchanan failed to follow Resident A's individual plan of service when he was being physically aggressive, as there were no pillows in the area to use as a barrier. Ms. Buchanan also told Resident A, "I am the wrong one for you to attack," which contradicts Resident A's plan which states that staff should not verbally correct Resident A, try to rationalize with him, or debate, threaten negative consequences, intimidate, bribe, or instruct. Staff also tried to limit Resident A's access to his CDs, which is not specified in his individual plan of service.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend revocation of the license due to quality of care violations while the license was on provisional status.



04/23/18

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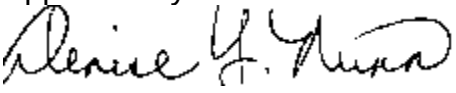
Kristen Donnay Date
Licensing Consultant

Approved By:



04/24/2018

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Denise Y. Nunn Date
Area Manager