STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

June 30, 2021

Janet Patterson
Advocates for Self Determination, LLC
Suite 102
28237 Orchard Lake Rd.
Farmington Hills, MI 48334

RE: License #: AS630402110
Investigation #: 2021A0993023
St. Marys Home

Dear Ms. Patterson:

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:

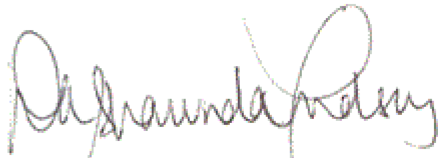
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

A continued six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630402110
Investigation #:	2021A0993023
Complaint Receipt Date:	04/27/2021
Investigation Initiation Date:	04/27/2021
Report Due Date:	06/26/2021
Licensee Name:	Advocates for Self Determination, LLC
Licensee Address:	Suite 102 28237 Orchard Lake Rd. Farmington Hills, MI 48334
Licensee Telephone #:	(248) 723-7152
Administrator:	Janet Patterson
Licensee Designee:	Janet Patterson
Name of Facility:	St. Marys Home
Facility Address:	24156 St. Marys Farmington, MI 48336
Facility Telephone #:	(248) 987-6169
Original Issuance Date:	04/21/2020
License Status:	1st PROVISIONAL
Effective Date:	11/25/2020
Expiration Date:	05/24/2021
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED AGED

II. ALLEGATION(S)

	Violation Established?
• On 04/12/2021, Resident B was transported to the hospital. Per the physician, Resident B came to the emergency room (ER) with altered mental status and was “minimally responsive. His pupils were small and only mildly responsive. His blood glucose is 50 and his temperature is 84” degrees Fahrenheit. • Resident B went from being a healthy adult to being severely malnourished, sores over his whole body, lacerations to his face and barely holding on to life.	Yes

III. METHODOLOGY

04/27/2021	Special Investigation Intake 2021A0993023
04/27/2021	Special Investigation Initiated - Telephone Telephone call made to Beaumont Farmington social worker Colleen Knurek
04/27/2021	Inspection Completed On-site Conducted an unannounced onsite investigation
04/27/2021	Contact - Face to Face Interviewed Beaumont Farmington social worker Colleen Knurek. Attempted to interview Resident A at Beaumont Farmington
04/28/2021	Contact - Document Received Received additional allegations
04/28/2021	Referral - Recipient Rights Forwarded allegations to recipient rights Alanna Honkanen
04/28/2021	Contact - Document Sent Requested medical records from Beaumont Farmington
04/28/2021	Contact - Document Sent Requested documentation from licensee designee Janet Patterson
04/28/2021	Contact - Telephone call made Telephone call made to Resident A's sister

04/28/2021	Contact - Telephone call made Telephone call made to Resident A's guardian (and mother)
05/06/2021	Contact - Document Received Received documentation
05/24/2021	Contact - Telephone call received Telephone call received from recipient rights advocate Alanna Honkanen
05/25/2021	Inspection Completed On-site Conducted an announced onsite inspection
06/24/2021	Contact - Telephone call made Telephone call made to recipient rights advocate Alanna Honkanen
06/24/2021	Contact - Document Received Received documentation from recipient rights advocate Alanna Honkanen
06/24/2021	Contact - Telephone call made Telephone call made to support coordinator Dana Abbamonte. Left a message.
06/24/2021	Contact - Telephone call made Telephone call made to home manager Laporches Welch
06/24/2021	Contact - Telephone call made Telephone call made to staff Valentine Reeves. Left a message.
06/24/2021	Contact - Telephone call made Telephone call made to staff Corey Daniels Jones
06/24/2021	Contact - Telephone call made Telephone call made to staff Raven Rand
06/24/2021	Contact - Telephone call received Telephone call received from staff Valentina Reeves
06/28/2021	Contact - Telephone call made Telephone call made to support coordinator Dana Abbamonte. Left a message.

06/28/2021	Contact - Telephone call received Telephone call received from support coordinator Dana Abbamonte
06/28/2021	Contact - Telephone call made Telephone call made to Dr. Faiz Mansour. There was no option to leave a message.
06/28/2021	Contact - Documentation Received Received documentation
06/28/2021	Contact - Telephone call made Telephone call made to Dr. Faiz Mansour
06/29/2021	Contact - Telephone call made Recipient rights advocate Alanna Honkanen attempted to conduct a follow up call with home manager Laporches Welch. Left a message.
06/29/2021	Contact - Telephone call made Recipient rights advocate Alanna Honkanen attempted to conduct a follow up call with staff Valentina Reeves. Left a message.
06/29/2021	Contact - Telephone call made Recipient rights advocate Alanna Honkanen conducted a telephone interview with staff Corey Daniels Jones
06/29/2021	Contact - Telephone call made Recipient rights advocate Alanna Honkanen conducted a telephone interview with staff Raven Rand
06/29/2021	APS Referral Forwarded allegations to adult protective services (APS). The assigned APS specialist is Darlene Thompson.
06/29/2021	Contact - Telephone call made Telephone call made to licensee designee Janet Patterson. Left a message.
06/30/2021	Exit Conference Attempted to conduct an exit conference with licensee designee Janet Patterson. Left a message.

ALLEGATION:

- **On 04/12/2021, Resident B was transported to the hospital. Per the physician, Resident B came to the emergency room (ER) with altered mental status and was “minimally responsive. His pupils were small and only mildly responsive. His blood glucose is 50 and his temperature is 84” degrees Fahrenheit.**
- **Resident B went from being a healthy adult to being severely malnourished, sores over his whole body, lacerations to his face and barely holding on to life.**

INVESTIGATION:

On 04/27/2021, I received the allegations from Bureau of Child and Adult Licensing Online Complaints.

On 04/27/2021, I conducted a telephone interview with Beaumont Farmington social worker Colleen Knurek. Ms. Knurek confirmed Resident B was transported to the hospital on 04/12/2021. She stated the emergency room (ER) physician documented Resident B was came to “the ER with altered and minimally responsive. His pupils were small and only mildly responsive. His blood glucose is 50 and his temperature is 84” degrees Fahrenheit. The physician stated Resident B was extremely malnourished when he came into the hospital.

On 04/27/2021, I conducted an unannounced onsite investigation. I interviewed home manager Laporches Welch. Ms. Welch stated Resident B was transported to the hospital on 04/12/2021 after falling in the facility twice. He is still admitted into the hospital. Ms. Welch stated Resident B has had low weight and fragile since moving into the facility on 05/14/2021. Ms. Welch stated Resident B ate a lot, but they were told most of his food and liquids were going into his lungs. Due to his low weight, he was prescribed Ensure daily at 8am and 8pm. Per Ms. Welch, Resident B had a chewing assessment with Macomb Oakland Regional Center (MORC) last month and was prescribed a puree diet and simply thick/pudding thick.

While at the facility, I observed Resident B’s medication administration record (MAR) for April 2021, weight chart, health care appraisal, appointment information record and adult foster care assessment plan. Per the MAR, Resident B is prescribed Ensure daily at 8am and 8pm. Resident B was supposed to begin getting Ensure at 8am on 04/12/2021 but did not receive it due to being hospitalized. Staff initialed the MAR for all other medications to show administration of the medications to Resident B as prescribed.

Per Resident B’s weight chart, Resident B weighed 102 lbs. when he was admitted into the facility on 05/14/2020. Resident B’s weights from May 2020 to April 2021 are as followed:

Month	Weight
May 2020	102 lbs.
June 2020	102 lbs.
July 2020	102 lbs.
August 2020	102.5 lbs.
September 2020	103 lbs.
November 2020	105 lbs.
December 2020	100.5 lbs.
January 2021	103.8 lbs.
February 2021	101 lbs.
March 2021	101 lbs.
April 2021	98.5 lbs.

Resident B’s health care appraisal was completed by Dr. Faiz Mansour, on 05/28/2021. Per the appraisal, Resident B was 111 lbs., and his body mass index (BMI) was 17. The appraisal documented Resident B was in good hygiene and well nourished. Resident B was full ambulatory and was prescribed a regular varied diet.

The appointment information record documented Resident B saw a MORC speech pathologist on 03/31/2021 due to increased coughing when drinking and chewing concerns. Resident B was prescribed a simple thick gel for pudding thick liquids and pureed solids. In addition, Resident B was to have a modified Barium Swallow Study to be done outpatient.

Resident B’s assessment plan, dated 04/16/2021, documented Resident B has a history of choking. Food should be pureed. Resident B required assistance as needed with toileting, bathing, grooming, and dressing. Resident B required verbal prompts to attend to personal hygiene.

On 04/27/2021, I interviewed Beaumont social worker Colleen Knurek at Beaumont Hospital. Ms. Knurek stated Resident B had marks on his back. Resident B was referred for hospice services. His family is signing him up for Heart-to-Heart Hospice. When Resident B arrived at the hospital, he weighed 85 pounds (lbs.), was not able to talk, but he could ambulate and feed himself. Today, he weighs 102 lbs. and is bedridden. Resident B may be possibly discharged from the hospital. Ms. Knurek suggested I interview Resident B’s sister and guardian.

While at the hospital, I attempted to observed Resident B. However, Resident B was having an electroencephalogram (EEG). His nurse Alivia (last name unknown) was also off the floor.

On 04/28/2021, I received additional allegations. Per the complainant, Resident B went from being a healthy adult to being severely malnourished, sores over his whole body, lacerations to his face and barely holding on to life. The complainant stated this facility needs to be investigated for the safety of the other residents and it need to be shut down as soon as possible.

On 04/28/2021, I forwarded the allegations to recipient rights advocate Alanna Honkanen. She confirmed she is also investigating the allegations.

On 04/28/2021, I conducted a telephone interview with Resident B's sister. Resident B's sister stated Resident moved into the facility on 05/14/2021. During his last emergency room (ER) visit on 04/12/2021, he weighed either 99 or 102 lbs. She stated Resident B was extremely malnourished, had sores up and down his legs, bruising throughout his body, a laceration over his eye, and a kidney infection. Supposedly, this occurred from a fall due to being weak. Resident B's sister stated the hospital is experiencing trouble with regulating Resident B's blood pressure, heart rate and body temperature. He was put on a breathing tube. Per Resident B's sister, Resident B went from the ER to the intensive care unit (ICU). Resident B was not expected to make it, but now he is on the medical floor being monitored. Resident B's sister expressed concerns with Resident B being sent to the hospital in June 2020, July 2020, January 2021, and April 2021. She expressed concerns about the care Resident B received in the facility. Resident B's sister stated Resident B has always been mobile, and it is concerning that he is no longer mobile. In addition, she stated Resident B weighed significantly more when he was first admitted into the facility. Resident B's sister was not sure of Resident B's exact weight when he was admitted.

On 04/28/2021, I conducted a telephone interview with Resident B's guardian (and mother). Resident B's guardian stated she was unsure how much Resident B weighed when he was admitted into the facility. Recently, he weighed between 101-102 lbs. Resident B's guardian stated she made Resident B's sister the contact person. She suggested I contact her to answer any additional questions.

On 05/06/2021, I reviewed Resident A's, Resident B's, Resident C's, Resident H's, and Resident J's health care chronological, health care appraisal, April's medication administration record (MAR) incident reports, assessment plan and weight chart. I observed the following:

Resident A

- Health care appraisal completed on 10/02/2020 by Dr. Kelly Hobson. Resident A's weight was 256lbs. He was described as "well-groomed "and "well-nourished".
- Had a well visit on 10/14/2020
- Received flu shot on 10/15/2020
- Had podiatry services on 11/03/2020, 01/14/2021, and 04/20/2021
- Had an appointment primary care physician (PCP) on 11/04/2020
- Received first Moderna COVID vaccine on 03/25/2021.
- Staff did not initial the MAR at 8pm from 04/28/2021 to 04/30/2021 to show administration of Melatonin 10mg. Staff initialed the MAR for all other medications to show administration of the medications to Resident A as prescribed.
- Per IR, Resident A had a behavior and became very aggressive. Staff tried to redirect him, and he started throwing things in the office. After speaking with his mother on the phone, Resident A became more aggressive.
- Per assessment plan, Resident B requires assistance when necessary, with toileting, bathing, grooming, and dressing. He also requires verbal prompts to attend to personal hygiene.
- From December 2020 to May 2021, Resident A's weight decreased from 256 lbs. to 241 lbs.

Resident B

- Had a physical with Dr. Manzour on 05/28/2020.
- Went to Beaumont hospital on 06/01/2020 due to colostomy complications
- Received a flu shot on 10/15/2020
- Had podiatry services on 11/03/2020 and 01/14/2021
- Had follow up appointment with Dr. Manzour on 11/09/2020
- Follow up appointment with Dr. Manzour on 12/23/2020 due to Generalized Pruritus
- Went to Beaumont hospital on 01/04/2021 due to aggressive behaviors
- Received the first Moderna COVID vaccine on 02/25/2021 and the second shot on 03/25/2021
- Per IR, Resident B hit his head against wall and hit and bit staff on 12/23/2020
- Per IR, Resident B seem agitated. Staff showered him. He hit his head into the wall on 02/22/2021
- Per IR, staff observed a graze over Resident B's eye on 04/10/2020
- Per IR, Resident B fell twice in the facility on 04/12/2021. He had an appointment scheduled with Dr. Manzour the next day (04/13/2021), but he was taken to the hospital on 04/12/2021.

Resident C

- Health care appraisal completed on 05/28/2020 by Dr. Faiz Mansour. Resident C's weight was 136 lbs. He was described as to have "good hygiene" and be "well-nourished".
- Taken to Beaumont hospital for trimmers on 07/13/2020. Observed overnight, but not admitted
- Had a follow up call via Zoom with Dr. Manzour on 07/15/2020
- Had a follow up call with support coordinator via Zoom on 07/16/2020
- Had a wellness follow up with MORC support coordinator on 07/24/2020
- Received a flu shot on 10/15/2020
- Had podiatry services on 11/03/2020, 01/14/2021, and 04/20/2021
- Seen by PCP doctor on 11/04/2020
- Seen by Dr. Manzour for constipation on 11/09/2020. Prescribed Miralax
- Had a follow up appointment with Dr. Manzour on 02/22/2021. Dr. Manzour sent him to the hospital, and he was admitted to St. Joseph Mercy Hospital.
- Discharged from hospital on 02/25/2021. Sent home with wound care and a medication change
- Had a post hospital visit with Dr. Manzour on 03/02/2021
- Saw wound care doctor on 03/09/2021 and 03/19/2021
- Received the first Moderna COVID vaccine on 03/25/2021 and the second shot on 04/22/2021.
- Staff initialed the MAR for all other medications to show administration of the medications to Resident C as prescribed.
- Per IR, staff noticed an insect bite on Resident C's leg and contacted Dr. Manzour on 02/18/2021. Bite appeared infected, appeared an antibiotic ointment. An appointment scheduled with Dr. Manzour for 02/22/2021.
- Per IR, Resident C had an appointment with Dr. Manzour, and he sent him to the hospital on 02/22/2021.
- Per assessment plan, Resident C requires his food to be cut into 1-inch by 1-inch pieces. In addition, he requires assistance when necessary, with toileting, bathing, grooming, and dressing. He also requires verbal prompts to attend to personal hygiene.
- From December 2020 to May 2021, I did not observe any significant weight loss concerns.

Resident H

- Had an eye exam on 08/12/2020
- Had a doctor appointment on 10/01/2020
- Had a doctor appointment on 11/02/2020
- Health care appraisal completed on 11/17/2020 by Dr. Bana Antonios. Resident H weighed 171 lbs. It was documented that "no acute distress was observed".
- Had a preventative dental appointment on 01/27/2021
- Had a doctor's appointment on 02/03/2021
- Received the first Moderna COVID vaccine on 02/25/2021 and the second shot on 03/25/2021

- Had a doctor's appointment on 04/16/2021 for Diabetes management
- Staff initialed the MAR for all other medications to show administration of the medications to Resident H as prescribed.
- Per IR, Resident H had mild behavior and received podiatry services on 04/22/2021
- Per the assessment plan, staff are to cut up Resident H's food in 1-inch by 1-inch pieces and monitor and assist him with eating as needed. In addition, staff are to guide and prompt him with toileting, assist and remain with him while bathing, and assist when necessary, when dressing and grooming. He also requires verbal prompts to attend to personal hygiene.
- From December 2020 to May 2021, I did not observe any significant weight loss concerns.

Resident J

- Health care appraisal completed on 05/28/2020 by Dr. Faiz Mansour. Resident J's weight was 146 lbs. He was described as to have "good hygiene" and be "well-nourished".
- Had a Zoom video conference with support coordinator on 05/29/2020
- Received flu shot on 10/15/2020
- Had podiatry services on 11/03/2020, 01/14/2021, and 04/20/2021
- Follow up appointment with doctor on 11/09/2020
- Hospitalized from 01/04/2021 to 01/13/2021 for Status Epilepticus
- Went to the hospital after a seizure on 02/14/2021
- Seen by Dr. Mansour on 02/22/2021
- Seen by the neurologist on 03/09/2021
- Received the first Moderna COVID vaccine on 02/25/2021 and the second shot on 03/25/2021
- Staff initialed the MAR for all other medications to show administration of the medications to Resident J as prescribed.
- Per IR, Resident J collapsed in the facility on 02/14/2021 and was transported to the hospital
- Per the assessment plan, resident has a history of choking. Staff are to cut up Resident J's food in 1-inch by 1-inch pieces. In addition, staff are to guide and prompt him with toileting, assist and remain with him while bathing, and assist when necessary, when dressing and grooming. He also requires verbal prompts to attend to personal hygiene.
- From December 2020 to January 2021, Resident J's weight decreased from 152 lbs. to 132 lbs. Resident J's weight increased to 140 lbs. in February 2021. As of May 2021, Resident J weighs 142 lbs.

On 05/24/2021, I conducted a follow up call with recipient rights advocate Alanna Honkanen. Ms. Honkanen stated Resident B was referred to hospice on 04/29/2021. Resident B died on 05/02/2021. Ms. Honkanen interviewed Resident B's primary care physician (PCP) Dr. Faiz Manzour on 05/19/2021. Mr. Mansour stated Resident B's weight was always low. Resident B had a BMI of 17. Resident B had Crohn's Disease and colitis. According to Dr. Manzour, whatever Resident B ate, he lost it. Resident B's last visit with Dr. Mansour was on 12/23/2020. Dr. Manzour stated Resident B's weight had not been more than 116 lbs. since 2019. Per Dr. Manzour, Resident B's weight being within the range of 98 to 102 lbs. was not an unexpected range considering Resident B's weight history and underlying medical conditions. To address Resident B's low weight, Resident B was given supplements such as Ensure. Ensure was given "to maintain weight, not necessarily to gain". Dr. Manzour was not aware of any history of abuse towards Resident B.

On 05/25/2021, I conducted an announced onsite investigation. I observed Resident A, Resident C, Resident H, and Resident J. I was unable to interview them due to their limited cognitive abilities. I did not observe any signs of abuse or neglect.

While at the facility, I reviewed Resident C's and Resident P's May's medications and MAR. Staff did not administer Memantine HCL 5mg to Resident C at 8am on 05/16/2021. I observed the pill in the bubble pack. Staff initialed the MAR for all other medications to show administration of the medications to Resident C as prescribed. Staff also initialed the MAR to show administration of medications to Resident P as prescribed.

On 06/24/2021, I received an email from Ms. Honkanen. Ms. Honkanen documented the following:

- Ms. Honkanen interviewed Beaumont social worker Colleen Knurek. Ms. Knurek stated when Resident B arrived at the hospital, he weighed 99lbs. His weight further declined to 76 lbs. (on 04/14/2021). He was placed on IV fluids and his weight increased to 84lbs (on 04/16/2021) and to 102 lbs (by 04/21/2021). Ms. Knurek stated the physician observed "horizontal lines on his back". Ms. Knurek did not have any other information about these "lines" and/or if they were suspected to be the result of abuse/neglect. Ms. Knurek did not observe the lines herself.
- Ms. Honkanen interviewed Macomb Oakland Regional Center (MORC) registered dietician Angela Neagu. Resident B had a "history of medical issues, including that he is underweight and has a colostomy bag". When Resident B moved into the facility, he weighed 103 lbs. She did not conduct onsite visits due to COVID, she but completed telehealth meetings to discuss Resident B's diet and weight on a quarterly basis. She did not have concerns about Resident B's food intake as it was reported to her that Resident B "was always eating and drinking supplements". She stated staff was supposed to notify her if Resident B's weight went below 115lbs or if he lost more than two pounds in between the monthly weigh-ins. In April 2021, she learned there was an issue with the facility's scale not being calibrated right and learned that Resident B was not

making any progress. At that point, staff was instructed to weigh Resident B on a weekly basis. Ms. Neagu stated the last time she saw Resident B, on 04/02/2021, he was “standing and walking” and appeared “normal”.

- Ms. Honkanen interviewed Macomb Oakland Regional Center (MORC) speech pathologist Kerri Gonda who verified Resident B had a swallow study on 03/31/2021 due to concerns with Resident B’s swallowing function. She recalled Resident B being thin during the in-person visit. Ms. Gonda “did not have any reason to suspect neglect, nor did she have reason to suspect physical abuse, noting that she observed no physical signs of this”.

On 06/24/2021, I conducted a telephone interview with home manager Laporches Welch. Ms. Welch stated staff were providing care to Resident A, Resident B, Resident C, Resident H, and Resident J according to each resident’s assessment plan. She stated Resident B was always small (or had a low weight) while living in the facility. An assessment was completed on him and staff was informed Resident B did not gain weight due to his medical conditions. When staff observed noticeable changes in Resident B, an appointment was scheduled with Dr. Mansour. When he fell in the facility twice on 04/12/2021, he was transported to the hospital for evaluation. Ms. Welch denied any abuse or neglect concerns. All residents were well taken care of. Ms. Welch did not have knowledge of the alleged horizontal lines on Resident B’s back. She stated she was only aware of an abrasion Resident B had over one of his eyes. Ms. Welch denied ever observing staff hit, abuse or doing anything to mistreat Resident B or any of the other residents.

On 06/24/2021, I conducted a telephone interview with staff Corey Daniels Jones. Mr. Jones stated he began working in the facility in or around September 2020. Per Mr. Jones, in the last two months Resident B resided in the facility he appeared to have been aspirating. He had a swallow study. His diet was switched to a mechanical soft diet, and he required thicken with his liquids. Mr. Jones stated he personally observed staff Valentina Reeves makings big meals, and Resident B ate a lot. He had a big appetite. Mr. Jones stated Resident B has always been on the “thin side” since he started working with him. Mr. Jones did not have knowledge of red marks/lines on Resident B’s back. He was only aware of the graze above Resident B’s eye, that he assumed he sustained when he fell in the facility. Mr. Jones denied ever observing staff hit, abuse or doing anything to mistreat Resident B or any of the other residents. Per Mr. Jones, staff were providing care to Resident A, Resident B, Resident C, Resident H, and Resident J according to each resident’s assessment plan.

On 06/28/2021, I conducted a telephone interview with staff Raven Rand. Ms. Rand stated she worked in the in the facility on and off since about October 2020. She transferred to another facility about two to three weeks ago. She stated Resident B’s weight has always been 99-100 lbs. That was a baseline weight for him since she began working with him. Per Ms. Rand, Ms. Reeves cooked big, hearty meals and Resident B ate a lot. He was given seconds. In addition, he was given an Ensure to drink after breakfast and dinner. Ms. Rand stated she observed a bruise near Resident B’s rib area as well as a graze over his eye prior to him going to the hospital on

04/12/2021. Ms. Rand did not know how Resident B sustained the injuries. Ms. Rand stated Resident B had behaviors where he hit his face (or forehead) on a wall or window. Ms. Rand denied ever observing staff hit, abuse or doing anything to mistreat Resident B or any of the other residents. Ms. Rand stated staff were providing care to Resident A, Resident B, Resident C, Resident H, and Resident J according to each resident's assessment plan.

On 06/24/2021, I conducted a telephone interview with staff Valentina Reeves. Ms. Reeves stated she worked in the facility from September 2020 until May 2021. Ms. Reeves stated Resident B has always been around 100 lbs. since she began working with him. She stated she cooked a lot of the meals in the facility, and Resident B ate a lot. She was told that due to Resident B's colostomy bag, food was going into his lungs. This was the reason he did not gain weight. Ms. Reeves stated Resident B was regularly seen by a physician. He was weighed monthly. He was administered his medications as prescribed. Ms. Reeves stated she observed a graze over his eye. She informed Ms. Welch. Ms. Welch came to the facility, washed his face, and put ointment on it. Ms. Reeves denied knowledge on how Resident B sustained the graze. Ms. Reeves denied observing bruising on Resident B's back. Ms. Reeves denied ever observing staff hit, abuse or doing anything to mistreat Resident B or any of the other residents. Ms. Reeves stated staff were providing care to Resident A, Resident B, Resident C, Resident H, and Resident J according to each resident's assessment plan.

On 06/28/2021, I conducted a telephone interview with Macomb Oakland Regional Center (MORC) support coordinator Dana Abbamonte. Ms. Abbamonte verified she was Resident B's support coordinator. She is also Resident A's, Resident C's, Resident H's, and Resident J's support coordinator. Ms. Abbamonte stated due to the pandemic she did not conduct onsite visits last year. She conducted weekly virtual visits, mainly with Ms. Welch. Ms. Abbamonte assumed staff followed each resident's assessment plan as there was nothing that alerted to staff not following them. Ms. Abbaomonte described Resident B as "a pretty good eater". He received double meals as well as supplements. Per Ms. Abbamonte, Resident B was "always thin". She stated he was seen by a dietician as well as his primary care physician. Staff took him to the doctor or hospital whenever they observed concerns. Ms. Abbamonte mentioned that there were some discrepancies with Resident B's weight chart, but staff informed her there was some problems with the scale. Ms. Abbamonte denied any abuse or neglect concerns for any of the residents. She conducted an onsite visit on 06/14/2021 and 06/23/2021. She stated she did not observe any physical care concerns.

On 06/28/2021, I reviewed Resident B's death certificate and medical records. Per the death certificate, Resident B died on 05/02/2021. The cause of death was Myoneural disorder with complications. It is noted that the time between the onset of this medical condition and death is "years". The other condition contributing to his death was Systemic Sarcoidosis. The manner of death was natural.

I reviewed Resident B's medical record. The record documented Resident B was transported to the hospital via an ambulance on 04/12/2021. Resident B has "a past

history significant for intellectual disability from birth, nonverbal at baseline, questionable psychiatric history, Crohn's disease, history of colostomy placement". During the ER physician's examination, Resident B was nonverbal and withdrew "all extremities to noxious stimuli". The ER physician spoke with Resident B's guardian and the home manager who stated Resident B "was noted to have progressive worsening weakness with inability to eat for the past 4 days. At baseline, [Resident B] is dependent on all activities of daily living but is able to ambulate without any assistance. For the past several days, patient has required increased assistance with ambulation with frequent falls". She denied "any head trauma or loss of consciousness and attributes the falls to increased weakness". She denied "any fevers, chills, nausea, vomiting, abdominal pain, diarrhea, constipation". Resident B was found to have a large right tension pneumothorax, a Wayne catheter was placed, and patient was sent to intensive care unit (ICU). The studies' findings were consistent with dehydration. Chest x-rays (CXR) showed "multiple old and new rib fractures as well as R pneumothorax with L shift concerning for tension pneumothorax requiring needle decompression and chest tube insertion". Resident B was noted to have multiple open leg wounds. There was a concern raised for abuse/neglect. Resident B required a course of dopamine drip for maintenance of heart rate (HR). Resident B had a seizure on 04/27/2021. Resident B's guardian and Resident B's sister stated Resident B had not had a seizure in the past, to their knowledge. Resident B was discharged from the hospital on 04/29/2021.

On 06/28/2021, I conducted a telephone interview with Dr. Mansour. Dr. Mansour verified he seen and provided treatment to Resident A, Resident B, Resident C, and Resident J. Dr. Mansour stated Resident H is not one of his patients. Per Dr. Mansour, Resident B had a history of having a low weight. The most he weighed was about 118 lbs. in 2019. He verified he completed a wellness visit with Resident B in May 2020. In November 2020, he recommended Resident B begin drinking Ensure with every meal; however, the insurance company denied the claim. Dr. Mansour saw Resident B again on 12/23/2020. At that time, Resident B weighed 109 lbs. Dr. Mansour stated he had not seen Resident B since the December visit. Dr. Mansour denied any concerns regarding the care Resident B received in the facility. He stated staff maintained regular contact with him and brought him in for his visits. Dr. Mansour did not have knowledge of old or new rib fractures or open legs wounds on Resident B. Regarding Resident A, Resident C and Resident J, he confirmed he saw Resident A on 10/14/2020 for a wellness visit. He last saw Resident A and Resident J on 05/19/2021. Dr. Mansour denied any abuse or neglect concerns for these residents.

On 06/28/2021, I reviewed additional medical records for Resident B. Resident B was taken to Beaumont ER due to colostomy complication on 06/01/2020. Per the record, Resident B had "purulent discharge from ostomy site". Staff stated "2-3 days ago tissue surrounding ostomy looked irritated and erythematous. Yesterday, ostomy began leaking thick, brown liquid". Staff denied Resident B had a fever or was vomiting. The record documented Resident B was a "chronically ill-appearing male". Resident B was discharged back to the facility the same day. No abuse or neglect concerns were noted.

Resident B was transported to Beaumont ER due to tremors and a rapid heart rate on 07/22/2020. The group home manager (name not listed in the record) stated Resident B was agitated, acting differently. Resident B was not violent, but he would not sit still. In addition, his eyes were wider than normal, his heart rate was 102 while at the facility, and his hands were shaking. The group home manager informed ER staff that Resident B had not received his past two doses of Ativan at night. Resident B was discharged back to the facility the same day. No abuse or neglect concerns were noted.

Resident B was transported to Beaumont ER due to aggressive behaviors on 01/04/2021. He was diagnosed with a laceration on his nose. Per the record, Resident B exhibited aggressive and violent behaviors towards staff. He was found with a laceration to the nose which was covered with a bandage to prevent him from picking it. The laceration was treated, and Resident B was discharged back to the group home the same day. No abuse or neglect concerns were noted.

Resident B was transported to Beaumont ER due to altered mental status on 04/12/2021. He was admitted to the hospital. The record noted multiple knee and shin bilateral abrasions was observed on Resident B. He also had six different skin tears/wounds to the left elbow and forearm. Resident B was described as “very fragile and ill appearing”. Beaumont social work Marisa Anderson documented she spoke with Resident B’s guardian who denied concerns about the care he received in the facility. She stated she received frequent updates from staff and staff always notified her any incidents. She stated she was aware Resident B went to the hospital with wounds and upon discharged she wanted Resident B to return to the group home. Beaumont pulmonary disease physician Dr. Kathryn Heal documented Resident B was “confused. Trying to sit up at times. Scabs and abrasions in many areas: elbows, lower legs, knees, right eyebrow area. Likely self-inflicted, dry, not draining. Left open to air”. Resident B was discharged from the hospital on 04/29/2021 and admitted to inpatient hospice with Heart-to-Heart the same day.

On 06/29/2021, recipient rights advocate Alanna Honkanen and I conducted a follow up interview with Mr. Jones. Mr. Jones stated he did not have knowledge of Resident B having multiple old and new rib fractures. He stated aside from sustaining them from the falls, he did not know how Resident B sustained the fractures. Regarding wounds on Resident B’s legs, Mr. Jones stated he observed that Resident B’s legs were scarred up, but he did not observe any open wounds or injuries on him. Mr. Jones stated he informed management about changes in Resident B’s behaviors around September 2020. Resident B was beginning from not want to walk or stand up and was laying around all day. He was also tipping off the couch onto the floor. Mr. Jones stated there were no changes in Resident B’s appetite. Despite those behavioral changes, he still ate. He may have eaten slower, but he ate.

On 06/29/2021, recipient rights advocate Alanna Honkanen and I conducted a follow up interview with Ms. Rand. Ms. Rand stated she did not work in the facility for about four or five days in April 2021. When she returned to the facility on 04/11/2021, she worked from 4pm to midnight. She did not observe any changes in Resident B besides a graze

over one of his eyes. She was informed he sustained the graze from a fall. Per Ms. Rand, Resident B was walking around and eating and drinking with no concerns. She worked the next day (on 04/12/2021). When she arrived at the facility, Resident B was laying in the hallway. He refused to eat and drink. While Ms. Reeves was cleaning Resident B to getting him ready to go to the hospital, she observed bruising on Resident B's rib area. She pointed it out to Ms. Rand. Ms. Rand did not know how Resident B sustained the bruising. Ms. Rand confirmed Resident B had healed scars all over his body, but she denied any knowledge of fresh, open wounds on Resident B.

On 06/30/2021, I attempted to conduct an exit conference with licensee designee Janet Patterson. I left a message.

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:	I reviewed Resident A's, Resident B's, Resident C's, Resident H's, and Resident J's assessment plans which indicated that staff were to assist as necessary with toileting, bathing, grooming, dressing. They required verbal prompts to attend to personal hygiene. Resident B, Resident, C, Resident H, and Resident J required assistance with eating. According to Ms. Welch, Ms. Reeves, Mr. Jones, and Ms. Rand, staff were providing care to Resident A, Resident B, Resident C, Resident H, and Resident J according to each resident's assessment plan. On 05/25/2021, I observed Resident A, Resident C, Resident H, and Resident J. I was unable to interview them due to their limited cognitive abilities. I did not observe any signs of abuse or neglect.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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:	Resident B was admitted to the hospital on 04/12/2021 and discharged to hospice on 04/29/2021. While at the hospital, the

	ER physician indicated Resident B appeared malnourished. CXR showed “multiple old and new rib fractures as well as R pneumothorax with L shift concerning for tension pneumothorax requiring needle decompression and chest tube insertion”. Resident B was noted to have multiple open leg wounds. Dr. Heal later documented Resident B was “confused. Trying to sit up at times. Scabs and abrasions in many areas: elbows, lower legs, knees, right eyebrow area. Likely self-inflicted, dry, not draining. Left open to air”. The rib fractures were not further addressed. Ms. Welch, Ms. Reeves, Mr. Jones, and Ms. Rand did not have knowledge of Resident B having rib fractures and/ or on how Resident B sustained them. They denied observing any fresh, open wounds on Resident B. They denied ever observing staff hit, abuse or doing anything to mistreat Resident B or any of the other residents. Resident B died on 05/02/2021. The cause of death was Myoneural disorder with complications. It is noted that the time between the onset of this medical condition and death is "years". The other condition contributing to his death was Systemic Sarcoidosis. The manner of death was natural.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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:	Resident B was admitted to the facility on 05/14/2021. At the time of admission, he weighed 102. Per the weight chart, staff weighed Resident B monthly. From May 2020 to April 2021, Resident B’s weight was within the range 98.5 lbs. and 105 lbs. According to Dr. Mansour, Resident B’s weight was always low. Resident B had a BMI of 17. Resident B had Crohn’s Disease and Colitis. Whatever Resident B ate, he lost it. Per medical records, Resident B was taken to the ER on 06/01/2020, 07/22/2020, 01/14/2021 for treatment. He was evaluated and discharged back to the facility the same day. No signs of abuse or neglect were noted.

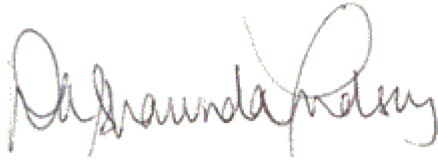
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 05/25/2021, I observed that staff did not administer Memantine HCL 5mg to Resident C at 8am on 05/16/2021. I observed the pill in the bubble pack.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR 2020A0993020 dated 10/20/2020 and CAP dated 11/25/2020** **REPEAT VIOLATION ESTABLISHED** **Reference SIR #2020A0993038 dated 09/02/2020 and CAP dated 09/28/2020.**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medications, which shall be entered at the time the medication is given.**
ANALYSIS:	I reviewed Resident A's, Resident B's, Resident C's, Resident H's, Resident J's April MAR. Staff did not initial the MAR at 8pm from 04/28/2021 to 04/30/2021 to show administration of Melatonin 10mg to Resident A.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR 2020A0993020 dated 10/20/2020 and CAP dated 11/25/2020** **REPEAT VIOLATION ESTABLISHED** **Reference SIR #2020A0993038 dated 09/02/2020 and CAP dated 09/28/2020.**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend continued issuance of a continued six-month provisional license.



06/30/2021

DaShawnda Lindsey Date
Licensing Consultant

Approved By:

06/30/2021

Denise Y. Nunn Date
Area Manager