GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 25, 2021

Angella Hamm
Orchard AFC Home
43 Batavia Street
River Rouge, MI 48218

RE: License #: AS820381240
Investigation #: 2021A0992024
Stoner AFC Home

Dear Ms. Hamm:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (313) 456-0380.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820381240
Investigation #:	2021A0992024
Complaint Receipt Date:	07/15/2021
Investigation Initiation Date:	07/16/2021
Report Due Date:	09/13/2021
Licensee Name:	Orchard AFC Home
Licensee Address:	73 Orchard Ecorse, MI 48229
Licensee Telephone #:	(734) 512-6294
Administrator:	Angella Hamm
Licensee Designee:	Angella Hamm
Name of Facility:	Stoner AFC Home
Facility Address:	28 Stoner River Rouge, MI 48218
Facility Telephone #:	(734) 512-6294
Original Issuance Date:	12/22/2016
License Status:	REGULAR
Effective Date:	06/22/2021
Expiration Date:	06/21/2023
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 7/15/2021 Resident A was found at a liquor store naked. Staff Rogeta Parks has a broken foot and cannot keep track of the residents. There is a lack of supervision.	No

III. METHODOLOGY

07/15/2021	Special Investigation Intake 2021A0992024
07/16/2021	Special Investigation Initiated - Telephone Rosie Rice, home manager
07/16/2021	Contact - Telephone call made Angella Hamm, licensee designee; she was not available. Message left
07/16/2021	Contact - Telephone call made Rogeta Parks, direct care staff
07/21/2021	Inspection Completed On-site Residents B and C.
08/10/2021	Contact - Telephone call made Ms. Hamm was not available, message left.
08/11/2021	Contact - Telephone call made Ms. Hamm was not available, message left.
08/12/2021	Contact - Telephone call received Ms. Hamm
08/12/2021	Contact - Telephone call made Ms. Rice
08/12/2021	Contact - Document Received Resident assessment plans
08/12/2021	Contact - Telephone call made Regina Rhoden, designated representative was not available, message left.
08/12/2021	Contact - Telephone call received Ms. Rhoden

08/23/2021	Contact - Telephone call received Marcella Harris, Faith Connection.
08/23/2021	Contact - Telephone call received Ms. Hamm
08/23/2021	Contact - Document Received Ms. Parks return to work notice
08/23/2021	Exit Conference Ms. Hamm

ALLEGATION: On 7/15/2021 Resident A was found at a liquor store naked. Staff Rogeta Parks has a broken foot and cannot keep track of the residents. There is a lack of supervision.

INVESTIGATION: It should be noted that an adult protective services complaint was generated at intake and denied.

On 7/16/2021, I contacted Rosie Rice, home manager and interviewed her regarding the allegation, which she denied. Ms. Rice said Rogeta Parks, direct care staff sprained her ankle but denied her ankle is broken. She said physically Ms. Parks is not handicapped and she can fulfill her direct care duties. Ms. Rice said as far as Resident A is concerned, she is combative and aggressive. She said that on the day of this most recent incident, Resident A backed Ms. Parks into the corner and attacked her. She said she slapped her twice and spit in her face. Ms. Rice said Ms. Parks tried to verbally redirect Resident A, but she refused to listen, became aggressive and left the home. Ms. Rice said the police were called and Resident A was petitioned. Ms. Rice said the social worker at the hospital is familiar with Resident A and said she needs more of a long-term care facility or controlled environment. Ms. Rice also mentioned that Resident A attacked the security guard while at the hospital. I asked if Resident A requires 1:1 staffing, and she said not to her knowledge. She said none of the residents in the home require 1:1 staffing. She explained that Resident A was admitted into the home on 7/1/2021 from Pontiac Hospital and they have not received a copy of her individual plan of services (IPOS) yet, however she said the adult foster care (AFC) assessment was completed at the time of admission. I explained to Ms. Rice that Resident A should be re-assessed due to her behaviors, and her AFC assessment plan should be updated to reflect as such. As far as Resident A being in the community independently, Ms. Rice said based on Resident A's behaviors and violent tendencies she doesn't think she should be in the community independently and typically she wouldn't, but she has "elopement issues". She said in this instance, Resident A attacked the staff and left. Ms. Rice said she hasn't received any documentation stating Resident A can't be in the community independently. Ms. Rice further explained that since Resident A has been exhibiting violent behaviors, she contacted her previous placement (which is

also in the community) to gather some additional information and apparently there have been some changes with her medications which might explain why she's acting out. Ms. Rice said the neighbors in the community are tired of her behaviors and the police are too. Ms. Rice identified Resident A's diagnosis as fragile X and developmentally disabled. Ms. Rice explained that Faith Connections did have guardianship of Resident A, but she is uncertain of the status. I requested a copy of the following documents: Resident A's placement packet and her AFC assessment plan. I also asked about the staffing ratio, Ms. Rice said the staffing ratio is 1:4 because no one requires 1:1 staffing, and the home is typically very calm.

On 7/16/2021, I contacted Ms. Parks and interviewed her regarding the allegation. Ms. Parks confirmed she was the staff on shift when Resident A was found at the store. Ms. Parks said on the day in question, the residents had just finished eating and Resident A said she was going upstairs to lay down. Ms. Parks said moments later Resident A came back downstairs with her purse and said she was leaving. Ms. Parks said she tried to verbally redirect her but Resident A wasn't capable of being redirected. Ms. Parks said Resident A cornered her and started attacking her, she said she hit her twice and spit in her face. Ms. Parks said Resident A left the house and started running. Ms. Parks said she contacted Ms. Rice and the police. She said the police arrived and she explained what happened. Ms. Parks said Resident A was escorted to the hospital by the emergency medical services (EMS) and petitioned. I asked if there were other residents present when this incident occurred and she said yes, Resident B and C. Ms. Parks said Resident A has made it clear that she is not happy at the home and doesn't want to be there. I asked Ms. Parks about the condition of her ankle, and she said she sprained it a week or so ago, but it is not broken. Ms. Parks said she is still capable of performing her direct care duties.

On 7/21/2021, I arrived onsite to find Ms. Rice, Resident B and C present. Ms. Rice made me aware that there was another incident involving Resident A and this time Resident A picked up one of the landscaping bricks and threw it at the glass screen door, causing the screen door to shatter. I observed the screen door glass had been broken. Ms. Rice said the police were called again due to Resident A's behaviors. Ms. Rice provided me with a copy of Resident A's AFC assessment plans (2), her emergency discharge notice and multiple incident reports. As far as Resident A's AFC assessment plans, both indicated that she moves in the community independently and that she doesn't control her aggressive behaviors, in which the staff will verbally redirect.

I proceeded to interview Resident B and C regarding the allegation. Both residents said they witnessed the entire incident. Resident B said Resident A was trying to go out the door and Ms. Parks was talking to her trying to stop her from going out. She said Resident A cornered Ms. Parks and slapped her in the face. She said Resident A tried to slap Ms. Parks again, but she fell. She said Resident A started pinching and scratching Ms. Parks legs. Resident B said Ms. Parks bent over to try and stop Resident A from scratching her and help her up but Resident A slapped Ms. Parks in her face again. Resident B said once Resident A got up, she spit in Ms. Parks face.

Resident B said somehow Resident A managed to spit on her too because she was trying to stop Resident A from attacking Ms. Parks. She said Resident A went upstairs gathered her belongings and was screaming “I don’t want to live here.” Resident B said Ms. Parks called Ms. Rice and she called the police.

Resident C said out of nowhere Resident A started hitting Ms. Parks and pinching her, she said she wouldn’t stop. Resident C said they were yelling “stop” but Resident A just kept hitting her. She said Resident A slapped Ms. Parks in the face, and she spit in her face. Resident C said Ms. Parks didn’t hit her back, she just called the police. Resident C said Resident A was “nuts”. She said Resident A picked up a brick and busted out the glass in the front door this past weekend.

On 8/12/2021, I made contact with Ms. Hamm. Ms. Hamm made me aware that she was currently in the hospital, and she been there a week and a half because she had to have surgery. Ms. Hamm identified Regina Rhoden as the designated representative at this time.

On 8/12/2021, I contacted Ms. Rhoden regarding the allegation. I explained that due to the concern regarding a lack of supervision, I need to review the IPOS and/or assessment plans of the other residents in the home to confirm none of the residents require 1:1 supervision. Ms. Rhoden agreed to provide me with copies of the requested documents.

On 8/12/2021, I received copies of Resident B, C and D’s assessment plans. Upon review of Residents B, C and D’s assessment plan all require 24-hour supervision but none require 1:1 staffing.

On 8/23/2021, I contacted Marcella Harris with Faith Connection regarding Resident A. Ms. Harris said at this time Faith Connections is not Resident A’s guardian. She said based on her records Faith Connections was her guardian at one point in time, but that guardianship has since expired.

On 8/23/2021, I made a follow-up contact with Ms. Hamm regarding the allegation. I explained that there was concern regarding Ms. Parks ability to perform her direct care duties considering her foot was injured. Ms. Hamm explained that although her foot was injured, she was cleared by a physician to return to work, and it was a sprained ankle. Ms. Hamm also agreed to provide me with a copy of Ms. Parks’ return to work notice. She said as far as staffing, there is always adequate staffing; she said the ratio is 1:4 and that the home is a very calm home.

On 8/23/2021, I received a copy of Ms. Parks’ return to work notice, which indicates she was seen at “Get Well Urgent Care Downriver” on 6/25/2021 and is able to return to work on 6/26/2021. Her diagnosis was a right ankle sprain.

On 8/23/2021, I conducted an exit conference with Ms. Hamm. I explained to Ms. Hamm that upon review of the residents’ assessment plans and Ms. Parks’ return-to-

work notice, I have determined there is insufficient evidence to support the allegation and the allegation is unsubstantiated. Ms. Hamm did not have any additional questions.

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:	During this investigation, I interviewed Angella Hamm, licensee designee; Rosie Rice, home manager; Rogeta Parks, direct care staff; and Residents B and C regarding the allegation. All of which denied the allegation. Resident A was issued an emergency discharge and her current whereabouts are unknown, as a result she was not interviewed. I reviewed the assessment plans and IPOS's of all the residents in the home and none require 1:1 staffing. I also reviewed Ms. Parks return to work notice, stating she was eligible to return to work on 6/26/2021. Evidence was not discovered through this investigation that would support the allegation that Resident A or other residents of the home are inadequately supervised. Therefore, the allegation is unsubstantiated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

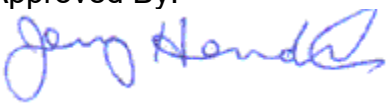
IV. RECOMMENDATION

I recommend the status of the license remain unchanged.

08/25/2021

Denasha Walker Date
Licensing Consultant

Approved By:



08/25/2021

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Jerry Hendrick Date
Area Manager