GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 8, 2021

Roger Covill
North-Oakland Residential Services Inc
P. O. Box 216
Oxford, MI 48371

RE: License #: AS630339744
Investigation #: 2021A0611030
Edgar Home

Dear Mr. Covill:

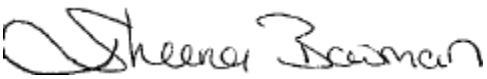
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630339744
Investigation #:	2021A0611030
Complaint Receipt Date:	09/23/2021
Investigation Initiation Date:	09/23/2021
Report Due Date:	11/22/2021
Licensee Name:	North-Oakland Residential Services Inc
Licensee Address:	106 S. Washington Oxford, MI 48371
Licensee Telephone #:	(248) 969-2392
Administrator:	Roger Covill
Licensee Designee:	Roger Covill
Name of Facility:	Edgar Home
Facility Address:	8740 Andersonville Road Clarkston, MI 48347
Facility Telephone #:	(248) 625-4273
Original Issuance Date:	06/13/2013
License Status:	REGULAR
Effective Date:	03/13/2020
Expiration Date:	03/12/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident J has right leg swelling, ecchymosis and bruising. The x-ray shows a right femur fracture on 9/22/2021 with no explanation for injury.	Yes

III. METHODOLOGY

09/23/2021	Special Investigation Intake 2021A0611030
09/23/2021	APS Referral The assigned Adult Protective Service (APS) worker is Ra'Shawnda Robertson.
09/23/2021	Special Investigation Initiated - Letter I contacted the APS worker, Ms. Robertson via email regarding the allegations. Ms. Robertson shared her conversation with Resident J's guardian. Ms. Robertson stated she is having trouble locating Resident J at the hospital.
09/29/2021	Inspection Completed On-site I completed an unannounced onsite. I received a copy of Resident J's assessment plan. I also received a phone number for Resident J's guardian.
10/06/2021	Contact - Telephone call made I made a telephone call to the home manager, Tiffany Cooper. The allegations were discussed.
10/06/2021	Contact - Telephone call made I made a telephone call to Resident J's guardian. The allegations were discussed.
10/06/2021	Contact - Telephone call made I left a message for staff member, Xavier Willis requesting a call back.
10/06/2021	Contact - Document Received I received an email from APS worker, Ra'Shawnda Robertson. Ms. Robertson stated she will be substantiating her investigation.

10/06/2021	Exit Conference I completed an exit conference with the licensee designee, Roger Covill.

ALLEGATION:

Resident J has right leg swelling, ecchymosis and bruising. The x-ray shows a right femur fracture on 9/22/2021 with no explanation for injury.

INVESTIGATION:

On 09/23/21, I contacted the APS worker, Ra'Shawnda Robertson via email. Ms. Robertson stated she is trying to locate Resident J at McLaren-Pontiac hospital. However, the hospital indicated Resident J is not there.

Ms. Robertson forwarded a copy of her conversation with Resident J's guardian. A copy of that conversation is below.

> "A phone call was received from Resident J's brother and legal guardian, Individual 1. He confirmed being aware of Resident J's hospitalization. He denied having any concerns for abuse or neglect. Individual 1 reported Resident J is a very fragile and sick individual. He stated Resident J has been this way his whole life. Individual 1 reported Resident J has severe spina bifida and he never advanced beyond the development of a 9-month-old baby. He reported Resident J has never walked or talked. He stated Resident J weighs under 100 pounds and it is nearly impossible to keep weight on him. Individual 1 advised Resident J sleeps in a hospital bed and he uses a wheelchair which he can maneuver himself around with his feet. He stated he believes Resident J rolled over in bed and caused the femur fracture himself. Individual 1 reported Resident J's physical health has been deteriorating over the last few years. He stated Resident J has been living at Edgar Home since the 1980's and he denied having any concerns with the care Resident J receives. He mentioned there has been some staff shortages lately. He reported "Tiffany" runs the home and is the staff who took Resident J in for treatment. He stated "Tiffany" took Resident J to urgent care then to McLaren Clarkston. He stated she stayed with Resident J all night at the hospital and she is just as concerned as he is. Individual 1 advised Resident J was transferred from McLaren Clarkston to McLaren Pontiac and he consulted with the surgeon this morning. He stated tests are being ran to see if Resident J can even withstand going under anesthesia for surgery. He stated he will be speaking with the surgeon again this afternoon to determine the next steps. APS advised the assigned specialist will be visiting Resident J".

On 09/29/21, I completed an unannounced onsite. Staff member, Xavier Willis stated Resident J was not present as he is still in the hospital. I received a copy of Resident J's assessment plan. I also received a phone number for Resident J's guardian. According to the assessment plan, Resident J is diagnosed with Sturge Weber Syndrome.

On 10/06/21, I made a telephone call to the home manager, Tiffany Cooper. Regarding the allegations, Ms. Cooper stated she had just returned from vacation prior to observing Resident J's swollen right leg during her midnight shift. Ms. Cooper stated she was working with staff member, Tina McFadden and asked her if she knew what happed to Resident J's leg. Ms. McFadden stated she did not know what could have happened to Resident J's leg. Ms. Cooper transported Resident J to the hospital. Ms. Cooper stated Resident J had never suffered an injury like this before. Resident J has Spina Bifida and he has a history of bruising easily. Ms. Cooper stated Resident J is not taking any medications that cause him to bruise easy.

Ms. Cooper stated she was informed by the licensee designee, Roger Covill that Resident J will not be returning to the AFC group home per his guardian's request. Resident J was discharged from the AFC group home on 10/06/21 and; he will be moving to Dunwoodie AFC group home tomorrow following his discharge from the hospital.

On 10/06/21, I made a telephone call to Resident J's guardian, Individual 1. Regarding the allegations, Individual 1 stated Resident J will be discharged from the hospital tomorrow and will be moving to Dunwoodie AFC group home. Resident J resided at Edgar home for over 20 years however; Individual 1 requested for Resident J to be moved to a different home because he is no longer familiar with the staff at Edgar home. Individual 1 stated Ms. Cooper is great and she loves Resident J as much as he does. Individual 1 stated he use to know the staff at Edgar home however; they now have a high turnover with staff. Individual 1 stated the staff at Dunwoodie are more stable.

Individual 1 stated he does not know if the staff at Edgar home, did anything negligent to cause Resident J injury. However, he would like to err on the side of caution. Individual 1 does not have any concerns regarding Ms. Cooper. Resident J has Spina Bifida and his entire body is fragile as he has never built muscle due to never being able to walk. Individual 1 stated Resident J's surgery on his femur was a success.

On 10/06/21, I completed an exit conference with the licensee designee, Roger Covill. Regarding the allegations, Mr. Covill was informed by staff member, Xavier Willis that he observed Resident J's right leg to be swollen two days before he was taken to the hospital. Mr. Willis did not complete an incident report and he did not seek medical attention because Resident J's leg was not bruised. Mr. Covill was informed by Mr. Willis that he wrote a note in the log book for Ms. Cooper regarding Resident J's leg. However, Ms. Cooper was on vacation during this time. Mr. Cooper instructed Mr. Willis to complete an incident report however; Mr. Willis did not complete the incident report

on the actual date Resident J's injury was observed. Mr. Willis observed Resident J's swollen leg on 09/20/21 however; he dated the incident report on 09/22/21 which is the date he was taken to the hospital by Ms. Cooper. Mr. Covill was advised that the investigation will be substantiated and a corrective action plan will be required. Mr. Covill stated Mr. Willis will receive disciplinary action.

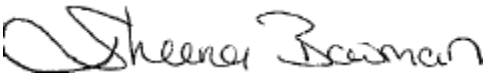
On 10/06/21, I received an email from APS worker, Ra'Shawnda Robertson. Ms. Robertson stated she will be substantiating her investigation.

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:	Staff member, Xavier Willis failed to meet Resident J's personal needs, nor did he ensure his protection and safety as he did not seek medical attention after he observed his swollen right leg.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	According to the licensee designee, Roger Covill, staff member Xavier Willis admitted to observing Resident J's swollen right leg on 09/20/22. Mr. Willis did not seek immediate medical attention for Resident J. Resident J was not taken to the hospital until 09/22/21 when Ms. Cooper observed Resident J's swollen leg following her return from vacation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

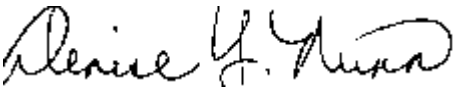


10/06/21

Sheena Bowman
Licensing Consultant

Date

Approved By:



10/08/2021

Denise Y. Nunn
Area Manager

Date