GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 2, 2021

Nicole Deneweth
Homes of Opportunity Inc
Suite C
23420 Greater Mack Ave.
St. Claire Shores, MI 48080

RE: License #: AS630294018
Investigation #: 2021A0617020
Christian Hills

Dear Ms. Deneweth:

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 dates 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 licensee or licensee designee and a date.

A 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,

Eric Johnson
Adult Foster Care Licensing Consultant
Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630294018
Investigation #:	2021A0617020
Complaint Receipt Date:	08/03/2021
Investigation Initiation Date:	08/03/2021
Report Due Date:	10/02/2021
Licensee Name:	Homes of Opportunity Inc
Licensee Address:	Suite C 23420 Greater Mack Ave. St. Claire Shores, MI 48080
Licensee Telephone #:	(586) 627-0024
Administrator:	Nicole Deneweth
Licensee Designee:	Nicole Deneweth
Name of Facility:	Christian Hills
Facility Address:	1788 Crooks Rochester Hills, MI 48309
Facility Telephone #:	(248) 375-0910
Original Issuance Date:	05/19/2009
License Status:	REGULAR
Effective Date:	11/28/2019
Expiration Date:	11/27/2021
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was at the ER with first and second degree burns on her thighs.	**Yes**

III. METHODOLOGY

08/03/2021	Special Investigation Intake 2021A0617020
08/03/2021	Special Investigation Initiated - Letter Email received with Incident Report from Licensee Designee Nicole Deneweth
08/03/2021	Contact - Document Received Email received from Mr. Matthew McCormick- Email included an Incident Report
08/03/2021	APS Referral Adult Protective Services (APS) Referral received - assigned worker is Candid Jamerson
08/05/2021	Contact - Document Sent Email sent to Ms. Deneweth
08/05/2021	Contact - Document Received Email received from Ms. Deneweth
08/05/2021	Contact - Document Sent Email sent to Ms. Deneweth
08/05/2021	Contact - Document Received Email received from Ms. Deneweth
08/05/2021	Contact - Telephone call made I interviewed Ascension Providence Hospital social worker Olivia
08/09/2021	Contact - Document Sent Email sent to Ms. Deneweth and Ms. Lotus
08/09/2021	Contact - Document Received Email received from Ms. Lotus

08/10/2021	Contact - Document Sent Email sent to Ms. Deneweth
08/11/2021	Contact - Document Received Email received from Ms. Deneweth
08/11/2021	Inspection Completed On-site I conducted an unannounced onsite investigation at the Christian Hills home. I interviewed home manager Queen Lotus, Detective Wiegmann of the Oakland County Sheriff's office and Resident A.
08/11/2021	Contact - Telephone call made TC made to Ms. Raina Buckner
08/13/2021	Contact - Document Received Email Received from Ms. Deneweth
08/13/2021	Contact - Telephone call made TC made to Ms. Raina Buckner
09/10/2021	Contact - Telephone call made TC to Ms. Jamerson
09/20/2021	Contact - Telephone call made TC made to Ms. Raina Buckner
09/30/2021	Contact - Document Sent Email sent to Adult Protective Service Worker Candid Jamerson
10/04/2021	Contact - Telephone call made I interviewed Ms. Candid Jamerson Adult Protective Service Worker.
10/04/2021	Contact - Document Sent Email sent to Ms. Jamerson
10/04/2021	Contact - Document Sent Email sent to Ms. Kimble
10/04/2021	Contact - Document Sent Email sent to Detective Wiegmann
10/04/2021	Contact - Document Received Email received from Detective Wiegmann

10/05/2021	Contact - Telephone call made I conducted a phone interview with Rishon Kimble from Office Recipient Rights.
10/05/2021	Exit Conference I conducted an exit conference with Licensee designee Nicole Deneweth.
10/15/2021	Contact – Document Received I received a redacted copy of the Oakland County Sheriff's case report #210165985.
10/25/2021	Inspection Completed On-site I conducted an unannounced onsite investigation at the Christian Hills facility. I interviewed Resident B, Resident C, and staff Dreaunna Harrison.
11/02/2021	Exit Conference I conducted an exit conference with Licensee designee Nicole Deneweth.

ALLEGATION:

Resident A was at the ER with first and second degree burns on her thighs.

INVESTIGATION:

On 08/03/21, a complaint was received regarding the Christian Hills home. The complaint indicated on 8/02/21, APS received a referral with the following allegations: Resident A is a 62-year-old female and resides at an adult foster care facility. Resident A is a quadriplegic, and she came into the emergency room with first and second degree burns on her thighs. Resident A is not a good historian, but she stated that Rena spilled hot water on her. Rena is a staff member who works at the AFC home. It is unknown when this occurred. Resident A is unable to report if the incident was accidental. Resident A looked disheveled and has an odor. Resident A appears that she hasn't been taken care of and is in need of a shower.

On 08/02/21, I received an email from licensee designee Ms. Nicole Deneweth. The email stated that Resident A from the Christian Hills home was taken to Ascension Providence Hospital in Rochester this morning due to appearing red/swollen from the waist to the knees. The staff assisted her up this morning and noted that she was red from the waist to the knees and had a blister in the abdominal area. The hospital has admitted her for evaluation as they don't know if this is caused by the time she has spent in her wheelchair.

On 08/03/21, I received an incident report completed by staff Dreaunna Harrison. The incident report indicated that on August 2, 2021, at 08:00 AM upon my arrival I did my daily bed checks to make sure everybody was in home. Resident A was laying in bed at the time and as I was preparing to get her up, I discovered that her eyes were red, she had red bruises on both upper legs and around her lower stomach area. She also had blisters on her right leg. We instantly decided to take Resident A to the hospital. Resident A was taken to Ascension Providence Hospital in Rochester. The incident report indicates that staff Raina Buckner was involved.

On 08/05/21, I interviewed Ascension Providence Hospital social worker Olivia. Ms. Olivia stated that Resident A should be released from the hospital this weekend. She stated that Resident A has intellectual delays and cannot communicate effectively. According to Ms. Olivia, Resident A is currently diagnosed with second degree burns to her legs. I was unable to visit Resident A in the hospital at the time due to COVID-19 restrictions.

On 08/11/21, I received an email from Ms. Deneweth that indicated Resident A was discharged from the hospital on the evening of 08/10/21. The email also included discharge documents and a written evaluation completed by hospital staff. The discharge documents indicated that Resident A was treated for second degree burns on her legs. The written evaluation indicated that Resident A is a 62-year-old female with cerebral palsy, bipolar disorder, neurogenic bladder and osteoporosis presenting with a burn. Resident A is minimally communicative. According to the evaluation, Resident A told hospital staff that while at her group home, she was burned with hot water on her thighs. She believed this was intentional and mentioned that “Rayna did it”. Resident A had distinct band-like distribution of erythema across the anterior proximal thighs, approximately 4 cm wide, right lower abdominal and right proximal thigh erythema and blistering.

On 08/11/21, I conducted an unannounced onsite investigation at the Christian Hills home. I interviewed home manager Queen Lotus, Detective Wiegmann of the Oakland County Sheriff’s office and Resident A.

During the onsite investigation, I interviewed Ms. Lotus. Ms. Lotus stated that on 08/01/21, she was on vacation. According to Ms. Lotus, on 08/01/21, Raina Buckner worked the midnight shift until 8 AM on 08/02/21. On 08/02/21, at 8 AM, staff Dreauanna Harrison arrived at the facility and conducted her morning bed checks. When Ms. Harrison checked Resident A, she observed her to be disorientated. Resident A’s eyes were very big and swollen like she hadn’t slept. Ms. Harrison pulled the covers back from Resident A and she noticed Resident A’s thighs were extremely red and blistered. Staff immediately decided to transport Resident A to the hospital. Ms. Buckner was questioned but was unable to provide an explanation on what occurred. Ms. Buckner was supposed to work on 08/02/21 from 4 PM to 8 AM on 08/03/21 but she did not show for her shift. Ms. Lotus stated that this was Ms. Buckner’s fifth no call no show. Ms. Lotus took Ms. Buckner off the schedule indefinitely. Ms. Lotus notified Ms. Buckner that she needed to meet with her in person before she could be put back

on the schedule. Ms. Buckner ignored Ms. Lotus attempts to contact her from 08/03/21 to 08/08/21. On 08/08/21, Ms. Buckner showed up to the facility and attempted to work the afternoon shift. Ms. Buckner was told to leave because she would not be put back on the schedule until she met face to face with Ms. Lotus. On 08/10/21, Ms. Buckner quit via text message.

During the onsite investigation, I interviewed Detective Wiegmann of the Oakland County Sheriff's office. Detective Wiegmann stated that he is just starting his investigation, but he would be in touch with me as he gathers more information.

During the onsite investigation, I interviewed Resident A. Resident A had issues effectively communicating due to her delays and disabilities, but she stated that Raina Buckner put hot water on her in the shower. Resident A stated that Ms. Buckner left her in the shower alone.

During the onsite investigation I reviewed the staff schedule for August 2021. According to the staff schedule, Raina Buckner worked on 08/01/21 from 4 PM to 8 AM on 08/02/21.

On 10/04/21, I interviewed Ms. Candid Jamerson Adult Protective Service Worker. Ms. Jamerson stated that she interviewed Resident A on 08/04/21 at the hospital. The attending physician told Ms. Jamerson that Resident A sustained second degree burns from hot water. The Doctor stated that they could tell that hot liquid was poured on her thighs. Resident A told Ms. Jamerson that Raina did it but she was unable to tell her when or how this happened. Ms. Jamerson was unable to reach Ms. Buckner for questions. However, Ms. Jamerson was able to speak with Detective Wiegmann and he stated that Ms. Buckner told him that the injuries to Resident A were due to a seatbelt malfunction. Detective Wiegmann followed up with the hospital medical staff and they stated that it was not possible for a seatbelt to cause those injuries.

On 10/04/21, I received an email from Detective Wiegmann. The email indicated that Ms. Buckner is scheduled to complete a polygraphy on 10/05/21. Detective Wiegmann stated he would have a completed report for my review by the end of the week.

On 10/05/21, I conducted a phone interview with Rishon Kimble from Office Recipient Rights. Ms. Kimble stated that she was unable to reach Ms. Buckner for an interview. Ms. Kimble also stated that she interviewed Resident B and Resident B told her that Raina had been sick all day, she put Resident A in the shower but then started throwing up. Resident A started screaming because the water was too hot, but Ms. Buckner did not assist her right away. Ms. Buckner eventually got Resident A out of the shower and put her to bed. Resident B told Ms. Kimble that Resident A could be heard screaming in pain throughout the night. Ms. Buckner did not check on Resident A or get her medical attention. Ms. Kimble interviewed Resident A and she told Ms. Kimble that Raina put her in the shower and the water was too hot. Resident A told Raina that the water was hot, but she did not care and left her in there.

I attempted multiple times to interview Ms. Raina Buckner, but I was unsuccessful as well.

On 10/05/21, I conducted an exit conference with Licensee designee Nicole Deneweth. The findings of the investigation were discussed.

On 10/15/21, I received a redacted copy of the Oakland County Sheriff's case report #210165985. The report indicated that Detective Wiegmann interviewed Resident A at the Christian Hills facility. Resident A told the detective that Raina did it. When he asked when it happened, Resident A told him in the shower. According to the report, when the detective asked additional questions, he either didn't get an answer or the answer didn't seem to match the context of the question. It was not clear to him how much of the incident Resident A understands or can explain. Detective Wiegmann observed burns to Resident A's lower abdomen and thighs. The report indicates that Detective Wiegmann interviewed former staff Raina Buckner. Ms. Buckner explained to the detective that she was scheduled to work a 16-hour, overnight shift on 08/1/21 into 08/2/21. She would be working the shift alone. Prior to the shift, she reported feeling ill and contacted her employer with the intent of calling in sick. There was no one else to work the position and she found herself stuck working. During the shift, feeling ill progressed into being very ill and she reported that she vomited numerous times. Ms. Buckner found herself unable to care for the patients in the group home as a result. At certain times, Ms. Buckner believes she was potentially incapacitated.

Ms. Buckner reported calling her supervisor multiple times to obtain relief, but no one was available. Ms. Buckner reported that due to her illness and strength level she was unable to move Resident A from her wheelchair until about 5 AM when another resident helped her move Resident A into the bed. Ms. Buckner stated that she was aware of the burns at the end of her shift, and they did not pre-exist her shift. Ms. Buckner stated that she believes that the seatbelt that was securing Resident A in the wheelchair is what caused the burns. Ms. Buckner reported that she did not shower or attempt to shower Resident A because that is not her responsibility to do so. She stated that showers happen at different times of the day from when her 16-hour shift occurred. Ms. Buckner indicated that she nor any other resident provided Resident A with any hot beverages that could have spilled. Ms. Buckner provided the detective with hospital paperwork from McLaren Oakland Hospital in Pontiac showing that she received treatment on 08/02/21 at 08:09 hours. The paperwork indicated that the reason for treatment was nausea/vomiting in conjunction with abdominal pain. According to the report, Detective Wiegmann interviewed Dr. Mohammad Fityan M.D., who was the attending physician that treated Resident A in the emergency room at the time of the incident. Dr. Fityan stated that the injuries were likely caused by a hot liquid. Dr. Fityan stated that the burns could not have been a result of friction from a seatbelt.

On 10/25/21, I conducted an unannounced onsite investigation at the Christian Hills facility. I interviewed Resident B, Resident C, and staff Dreaunna Harrison.

During the onsite, Resident B stated that she was on the couch when Raina put Resident A in the shower. The water was hot and burned Resident A's legs. Resident A screamed for help. Raina got Resident A out of the shower and put her to bed. Resident B could not tell me how long Resident A was left in the shower or screamed for help.

During the onsite, I interviewed Resident C. Resident C stated that Raina was sick all day. Raina put Resident A in the shower and then put her into the bed with burns. Resident C said she did not see anything, but she heard Resident A saying, "Help, Help, Help".

During the onsite, I interviewed staff Ms. Harrison. Ms. Harrison stated that she was working at the time of the incident. She stated that she came in the next morning at 8 AM. When she arrived at the facility, Raina was sitting on the porch with red eyes. Raina was crying and stated that she didn't feel well. Ms. Harrison went into the home and completed her morning bed checks. She saw that Resident A's eyes were very swollen and red. Ms. Harrison then discovered the blisters on Resident A's thighs and immediately called the home manager and sent Resident A to the emergency room. Resident A was not given a shower or had her daily hygiene routine completed due to the severity of the injuries discovered.

On 11/2/21, I conducted another exit conference with Licensee designee Nicole Deneweth. The findings of the investigation were discussed and licensee designee was informed on the recommendation of a six month provisional license.

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:	Based on the information gathered through my interviews and documentation reviews, the Christian Hills facility failed to protect and properly care for Resident A. Resident A sustained second degree burns to her lower abdominal and her thighs. Resident A informed Adult Protective Services, Office of Recipient Rights, Adult Foster Care Licensing and The Oakland County Sheriff's department that staff Raina Buckner burned her with hot water in the shower. Resident A's account of the incident is consistent with the diagnosis from the hospital staff. Resident A was not supervised and protected while in care of this licensee.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Based on the information gathered through my interviews and documentation reviews, the Christian Hills facility failed to obtain needed medical care immediately. Resident A sustained second degree burns to her lower abdominal and her thighs. Resident A informed Adult Protective Services, Office of Recipient Rights, Adult Foster Care Licensing and The Oakland County Sheriff's department that staff Raina Buckner burned her with hot water in the shower. Resident A's account of the incident is consistent with the diagnosis from the hospital staff. Resident A was not provided immediate care for the injuries she sustained during Raina Buckner's shift. Ms. Buckner admitted that the injuries were not present prior to her shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Based on the information gathered through my interviews and documentation reviews, the Christian Hills facility failed to provide proper hygiene care for Resident A. Resident A arrived at the hospital looking disheveled and had an odor. Resident A appeared that she hasn't been taken care of and was in need of a shower. Ms. Buckner informed Detective Wiegmann that she did not shower or attempt to shower Resident A because that is not her responsibility to do so. She said that showers happen at a different time of day from when her 16-hour shift occurred. According to Ms. Harrison, Resident A was not given a shower or had her daily hygiene routine completed due to the severity of the injuries discovered.
CONCLUSION:	**VIOLATION ESTABLISHED**

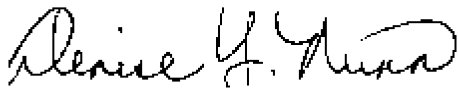
IV. RECOMMENDATION

Contingent upon receipt of an acceptable CAP, I recommend a six-month provisional license.

11/02/21

Eric Johnson | Date
Licensing Consultant

Approved By:



11/02/2021

Denise Y. Nunn | Date
Area Manager