GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 7, 2021

Michael Farrell
Wellspring Assisted Living LLC
45989 Greenridge Dr.
Northville, MI 48167

RE: License #: AS820362904
Investigation #: 2022A0901001
Southworth Elder Care

Dear Mr. Farrell:

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.

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,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820362904
Investigation #:	2022A0901001
Complaint Receipt Date:	10/08/2021
Investigation Initiation Date:	10/12/2021
Report Due Date:	12/07/2021
Licensee Name:	Wellspring Assisted Living LLC
Licensee Address:	9476 Southworth Ave. Plymouth, MI 48170
Licensee Telephone #:	(734) 589-3225
Administrator:	Michael Farrell
Licensee Designee:	Michael Farrell
Name of Facility:	Southworth Elder Care
Facility Address:	9476 Southworth Ave. Plymouth Twp, MI 48170
Facility Telephone #:	(734) 589-3225
Original Issuance Date:	02/09/2015
License Status:	REGULAR
Effective Date:	08/09/2021
Expiration Date:	08/08/2023
Capacity:	6

Program Type:	AGED ALZHEIMERS

I. ALLEGATION(S)

	Violation Established?
Resident A reported that she was pushed by a staff.	No
Additional Findings	Yes

II. METHODOLOGY

10/08/2021	Special Investigation Intake 2022A0901001
10/08/2021	APS Referral
10/12/2021	Special Investigation Initiated - Telephone Complainant
10/12/2021	Contact - Telephone call made Licensee Designee, Michael Farrell
10/12/2021	Contact - Telephone call made Home Manager, Ciara Cooney
10/14/2021	Inspection Completed On-site Resident A Licensee Designee, Michael Farrell
10/15/2021	Contact - Telephone call made Staff, Dominique Hall
10/15/2021	Contact - Telephone call made Resident A's daughter
10/15/2021	Contact - Telephone call made Home Manager, Ciara Cooney
10/28/2021	Contact - Telephone call made APS, Samantha Smith

11/30/2021	Exit Conference Licensee Designee, Michael Farrell
12/01/2021	Contact - Telephone call received Licensee Designee, Michael Farrell
11/30/2021	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A reported that she was pushed by a staff.

INVESTIGATION:

On 10/12/2021, I made a telephone call to the complainant and left a voice message, but the call was not returned.

On 10/12/2021, I made a telephone call to the licensee designee, Michael Farrell, and left a voice message. He later called back and agreed to meet me at the facility on 10/14/2021 to show me a video of the incident.

On 10/12/2021, I made a telephone call to the facility and spoke with the home manager, Ciara Cooney. She sated staff, Dominique Hall, was working at the time of the incident and was the only staff on duty. During her shift, Dominique called Ciara complaining about Resident A's defiant behavior and her not listening. When Resident A gets like that, they give her Ativan to help calm her down, but she refused to take it from Dominique. Ciara went to the home to help calm Resident A down and gave her the Ativan. Later, after she left, she got another call from Dominique regarding Resident A's behavior and her trying to enter another resident's room. Dominique indicated that Resident A had a flashlight in her hand and while she was trying to take it, Resident A fell. Ciara did not know if Resident A was trying to hit Dominique, but stated Resident A had the tendency to be physically aggressive. She also said she reviewed the video and could not tell if Resident A was pushed or not.

On 10/14/2021, I conducted an onsite inspection at the facility. Mr. Farrell was present and showed me the video. The video showed Dominique trying to take the flashlight out of Resident A's hand. Resident A seemed to be resisting and lost balance and fell backwards. Dominique immediately helped her up. She did not appear to have been pushed. Mr. Farrell also indicated that he could not confirm that Resident A was pushed when he watched the video.

During the onsite inspection on 10/14/2021, I interviewed Resident A. She could not remember the incident. She stated she only remembers losing balance and falling.

She did not recall how she lost balance or having a flashlight. She also indicated her hip and back was still hurting from the fall.

On 10/15/2021, I made a telephone call to Dominique. She denied pushing Resident A. She stated the incident happened on 09/25/2021. During her shift Resident A was very agitated and defiant. She kept trying to go into another resident's room, who did not want her in there. Whenever Dominique would try to redirect her, Resident A kept trying to hit her with her walker. Due to feeling uncomfortable and needing help, Dominique said she texted Mr. Farrell. She did not get a response so she called Ciara. Ciara came to the home and tried to calm Resident A down. She gave her an Ativan and took her to her room, but the Ativan never kicked in. After Ciara left, Resident A came out of her room and kept trying to hit Dominique with her walker. The other residents were in their rooms trying to sleep. The lights in the dining room area and in most of the house were off. Resident A came out her room again with a flashlight trying to go into another resident's room. As Domonique was trying to redirect her back to her room, Resident A tried to hit her with the flashlight. Therefore, Dominique attempted to take the flashlight. Resident A resisted giving it to her and as Resident A was trying to pull it away from Dominique, she lost balance and fell backwards into the cabinet. Dominique stated she assisted her up and helped her back to her room. As she walked Resident A back to her room, she was still trying to hit her with the walker.

On 10/15/2021, I made a telephone call to Resident A's daughter, who is also her Power of Attorney. She stated Resident A told her that her and Dominique fought. She fell backwards and her walker was on top of her. She watched the video and saw that Resident A fell and there was not a fight.

On 10/28/2021, I made a telephone call to Samantha Smith, from APS. She stated she reviewed the video and did not see any wrongdoing on behalf of Dominique. She stated it appeared Domonique was trying to take the flashlight from Resident A. She was refusing to give it to her and lost balance and fell. Ms. Smith stated she did not plan to substantiate the referral.

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 obtained during this investigation, there is a lack of evidence to support the allegations. There is no indication that Resident A's protection and safety was not adhered to. Everyone interviewed who watched the video, including myself, could not confirm that Resident A was pushed. In addition to this, Dominque denied pushing Resident A and Resident A could not recall the incident.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/14/2021, I conducted an onsite inspection at the facility and interviewed Resident A. She could not recall the details of the incident but remembered falling and hurting her back and hip. She stated she was still sore.

On 10/15/2021, I made a telephone call to staff, Dominique Hall. She stated when Resident A fell, she was yelling "ouch," as if she was in pain, and was screaming out for help. She assisted her up and back to her room.

On 10/15/2021, I made a telephone call to Resident A's daughter, who is also her Power of Attorney. She was displeased with the way the situation was handled. She stated she was not notified of the incident right away and Resident A did not receive any medical care until she notified the hospice nurse on 09/28/2021, who gave her pain medication. Resident A's daughter felt that considering her mother is aged and fragile, she should have received medical care sooner.

On 10/15/2021, I made a telephone call to the home manager Ciara Cooney. She confirmed that Resident A did not get medical care after the fall. She also confirmed that since the fall, Resident A was complaining about pain and continues to complain.

On 11/30/2021, I made a telephone call to the licensee designee, Michael Farrell, and left a detailed voice message regarding my investigative findings.

On 12/01/2021, I received a telephone call from the licensee designee, Mr. Farrell. He confirmed Resident A was not treated medically after the fall. He stated he did not know she was in pain until after she complained about back pain on 09/27/2021 and she told her daughter about it on 09/28/2021.

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 obtained during this investigation, Resident A did not receive immediate medical care after an incident occurred in the home, in which she fell backwards into a cabinet. Staff, Dominique, was present and indicated that when the incident happened, Resident A was yelling “ouch” as if she was in pain and had to be helped up. Ms. Cooney also indicated that she had been complaining about pain since falling. The incident happened on 09/25/2021 and despite staff knowledge of the fall and her being in pain, medical care was not obtained until 09/28/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 10/15/2021, I made a telephone call to staff, Dominique Hall. She stated on 09/25/2021, Resident A was being aggressive towards her. In addition to trying to hit her with the flashlight, she kept trying to hit her with her walker during the shift. When asked if she completed an incident report regarding the details of that night, she stated no and that she did not know she needed to.

On 10/15/2021, I made a telephone call to Resident A’s daughter, who is also her Power of Attorney. She was displeased with the way the situation was handled. She stated she never saw an incident report and no one from the home informed her of the incident. She stated she did not know until Resident A mentioned it to her days later.

On 11/30/2021, I made a telephone call to the licensee designee, Michael Farrell, and left a detailed voice message regarding my investigative findings.

On 12/01/2021, I received a telephone call from Mr. Farrell. He explained that an incident report was not completed and sent because Ms. Hall never told him about the aggression she claimed Resident A was exhibiting. I informed him that although she may not have told him, since she claimed it happened and witnessed it, as his employee, she was supposed to document it.

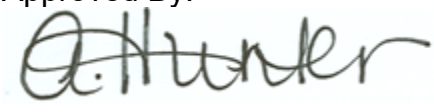
APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.**
ANALYSIS:	Based on the information obtained during this investigation, as reported by Ms. Hall, Resident A attempted to hit her with her walker and a flashlight. Attempted harm towards others is required to be reported to this Department within 48 hours. An incident report was never completed.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

_____12/03/2021
Regina Buchanan Date
Licensing Consultant

Approved By:



_____12/7/2021
Ardra Hunter Date
Area Manager