GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 6, 2022

Betty Mackie
Bowers Adult Foster Care Inc
PO Box 19286
Detroit, MI 48219

RE: License #: AS820303642
Investigation #: 2022A0121001
Bowers AFC on Winston

Dear Ms. Mackie:

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 (313) 456-0380.

Sincerely,

K. Robinson, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820303642
Investigation #:	2022A0121001
Complaint Receipt Date:	10/06/2021
Investigation Initiation Date:	10/07/2021
Report Due Date:	12/05/2021
Licensee Name:	Bowers Adult Foster Care Inc
Licensee Address:	1929 Chalmers Drive West Rochester Hills, MI 48309
Licensee Telephone #:	(313) 910-2951
Administrator:	Shelia Hawkins, Administrator
Licensee Designee:	Betty Mackie, Designee
Name of Facility:	Bowers AFC on Winston
Facility Address:	19440 Winston Detroit, MI 48219
Facility Telephone #:	(313) 387-4079
Original Issuance Date:	09/19/2011
License **Status:**	REGULAR
Effective Date:	03/21/2020
Expiration Date:	03/20/2022
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident is a fall risk. The facility will not provide her with a wheelchair and she fell when Staff made her walk. Staff also fell when the ramp broke with them on it.	Yes
The wheelchair ramp is broken and the licensee has failed to repair it.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/06/2021	Special Investigation Intake 2022A0121001
10/07/2021	Special Investigation Initiated - Telephone Scheduled onsite with the Administrator, S. Hawkins
10/08/2021	Inspection Completed On-site Interviewed Sirethia Kennedy, Home Manager and Resident A
10/12/2021	Contact - Telephone call made Follow up call to Mrs. Hawkins
10/13/2021	Contact - Document Received Received copy of Individual Plan of Service (IPOS), AFC assessment plan and hospital discharge report
10/22/2021	Referral - Recipient Rights (ORR)
10/26/2021	Contact - Telephone call received Rights Investigator, Linda Hicks
12/14/2021	Contact - Telephone call made Interview with direct care worker (DCW), Jerisha Hill
12/14/2021	Contact - Telephone call received Ms. Hicks with ORR
12/17/2021	Contact - Telephone call made

	Mrs. Hawkins
12/27/2021	Contact - Telephone call made Mrs. Hawkins
01/05/2022	Exit conference Betty Mackie, licensee designee

ALLEGATION: Resident is a fall risk. The facility will not provide her with a wheelchair and she fell when Staff made her walk. Staff also fell when the ramp broke with them on it.

INVESTIGATION: On 10/8/21, I conducted an onsite inspection at the facility. According to Home Manager, Sirethia Kennedy, Resident A has dementia, she's blind in the left eye, she has no light reception in the right eye, and her mobility is declining. Ms. Kennedy further explained Resident A was originally prescribed a seated walker to help her get around, but unfortunately, Resident A didn't know how to use it properly, so the doctor discontinued its use. Per Ms. Kennedy, Resident A's primary care physician provided a new order on 8/27/21 for her to receive a wheelchair. The wheelchair was delivered during the commencement of my onsite inspection.

Prior to receiving the wheelchair, Resident A had fallen several times at the facility. I reviewed the incident reports which documented each fall. On 7/26/21, it is reported that Resident A "attempted to sit in the chair, she missed the chair and fell to the floor, staff tried to catch her but was too late, she stated her hand was hurting." On 8/2/21, it is reported Resident A "was coming in the house and tripped over her walker." On 8/3/21, it is reported Resident A "was coming in the house and fell. Her wheelchair/walker was on top of her. Her chin was bleeding. She stated her arms hurt." All incident reports were drafted and signed by Ms. Kennedy. Administrator, Sheila Hawkins was made aware of each incident as denoted by her signature on the reports.

I interviewed Resident A while at the facility. Resident A said she doesn't remember how she fell, but she stated, "I'm tired of falling." Resident A reported she had to wear casts on her forearms after one of the falls. I reviewed a medical order from Hart Medical Equipment dated 7/26/21. Resident A's diagnosis on the report is "right hand, wrist fracture". According to Ms. Kennedy, Resident A was prescribed hand braces to aid in her healing, but she kept taking them off. So, the doctor opted to put casts on both forearms to assist in the healing process. Ms. Kennedy reported Resident A wore the casts for approximately 2 weeks. I also reviewed Resident A's, After Visit Summary from Henry Ford Health Systems to verify she received medical treatment for her injury; the report is dated 7/26/21. Resident A was treated and released with an initial fall encounter (closed fracture of right hand). Mrs. Hawkins indicated Resident A did not require medical treatment for the fall on

8/2/21. On 8/3/21, Resident A was taken to Henry Ford Fairlane Emergency for treatment and evaluation. The After Visit Summary records Resident A's initial encounter as "left hand pain and chin laceration". Resident A's medical diagnosis on 8/3/21 was "closed fracture of left hand". Ms. Kennedy reported the two were heading out to get Resident A's nails clipped. When exiting the facility, Ms. Kennedy said she turned away briefly to close the front door and Resident A "fell within a split second." Ms. Kennedy explained Resident A fell "face first", injuring her chin. Resident A was taken to a local urgent care facility for treatment. Ms. Kennedy reported the urgent care center gave Resident A four (4) stitches to treat the chin laceration. Per Ms. Kennedy, the urgent care center directed that Resident A be taken to the hospital for an x-ray of her hand. Follow up care is recommended with an orthopedic specialist.

I reviewed Resident A's current AFC assessment plan dated 2/2/21. I also reviewed Resident A's Integrated BioPsychosocial Assessment developed by Ms. Regina Thompson with Development Centers, Inc. It has been assessed that Resident A cannot go in the community without Staff. Resident A also requires assistance with her activities for daily living (ADLs), including eating, bathing, grooming, personal hygiene, mobility, and stair climbing.

On 1/5/22, I completed an exit conference with Betty Mackie. Ms. Mackie reported Resident A does not have a 1:1 staffing assignment. She indicated the contract agencies are moving away from granting 1:1 staffing assignments, so she and her Staff are doing the best they can to care for residents under these circumstances. Ms. Mackie said the incidents involving Resident A are unfortunate. Ms. Mackie acknowledged Resident A could benefit from a more restrictive placement to care for her current needs.

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 A had a known history of falls. - As Home Manager, Ms. Kennedy was well aware of Resident A's fall history, yet she turned her attention away from Resident A when Resident A fell on 8/3/21. - Resident A fell 3 times within a week span, all while at the facility under the care of Staff. - Resident A's injuries after 2 of 3 falls required medical attention, with the third fall being the most severe. - Therefore, Resident A's needs, including protection and safety were not attended to at all times.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The wheelchair ramp is broken and the licensee has failed to repair it.

INVESTIGATION: On 10/8/21, I inspected the wheelchair ramp at the front of the house. I did not observe anything unusual or in disrepair with respect to the ramp. Both Mrs. Hawkins and Ms. Kennedy denied the wheelchair ramp had been broken. I also interviewed direct care worker, Inell Burrell. Ms. Burrell stated she does not recall the ramp being broken either.

I did however, observe the porch steps were severely cracked and worn. The steps were in inoperable condition. I observed the steps had been purposely blocked off with a wooden rail to prevent its use (photo available). Mrs. Hawkins acknowledged they installed a barrier to prevent anyone from accessing the steps out of an abundance of caution. Mrs. Hawkins recognized the current condition of the steps presented a safety hazard. I asked Ms. Kennedy how long the steps had been in disrepair. Ms. Kennedy reported she estimates the steps broke at the end of 2020 or early 2021. She indicated Ms. Mackie hadn't been able to get the steps repaired due to staffing and supply shortages caused by the Covid-19 pandemic.

On 12/27/21, I reported these findings to Mrs. Hawkins. Mrs. Hawkins has agreed to get the concrete stairs repaired by 3/20/22 (weather permitting).

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	• On 10/8/21, I observed the porch steps in disrepair. They are inoperable at this time. • Therefore, the home has not been maintained to provide adequately for the health, safety, and well-being of occupants.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: Upon review of Resident A's medical records, I was able to determine she is no longer suitable for adult foster care. Dr. Rachel Karmally with Henry Ford Health Systems has recommended "she be placed in a higher level of care such as a long-term care facility/skilled nursing facility." Dr. Karmally provided written recommendations for Resident A's care on 9/9/21 and 9/13/21. It is also written in Resident A's BioPsychosocial Assessment that "consumer be referred to a nursing facility." This BioPsychosocial Assessment was completed and signed by Regina A. Thompson, LLPC on 7/19/21.

Mrs. Hawkins reported they have started the process to have Resident A relocated. Mrs. Hawkins indicated plans were delayed because Resident A is her own guardian. Plans are in place to have Resident A's adult son become her guardian. Ms. Mackie insisted Resident A hasn't been discharged from the home because the case manager has failed to secure a new placement. I asked Ms. Mackie if Resident A had been provided a 30-day discharge notice; Ms. Mackie was unclear if a written notice had been completed.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(1) A licensee shall not accept, retain, or care for a resident who requires continuous nursing care. This does not preclude the accommodation of a resident who becomes temporarily ill while in the home, but who does not require continuous nursing care. **(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions:**

	(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home. **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.** **(c) The resident appears to be compatible with other residents and members of the household.**
ANALYSIS:	• Internal medicine doctor, Rachel Karmally provided Ms. Mackie with clear instructions for Resident A to be relocated to a setting that offers continuous nursing home care. • The recommendation for Resident A to receive nursing home care was made nearly 6 months ago. • To date, Resident A has not been discharged from the facility. • Therefore, the licensee has maintained a resident in care who requires continuous nursing home care on a long-term basis.
CONCLUSION:	**VIOLATION ESTABLISHED**

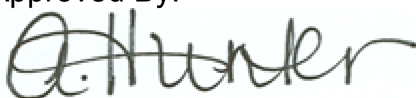
IV. RECOMMENDATION

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

01/06/22

Kara Robinson   Date
Licensing Consultant

Approved By:



01/06/22

Ardra Hunter   Date
Area Manager