GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 4, 2022

Rashalle Austin
Unity Group LLC
163 N. Fiske Road
Coldwater, MI 49036

RE: License #: AS130325127
Investigation #: 2022A0578014
Unity Group LLC

Dear Ms. Austin:

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 (517) 284-9727.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS130325127
Investigation #:	2022A0578014
Complaint Receipt Date:	01/07/2022
Investigation Initiation Date:	01/07/2022
Report Due Date:	03/08/2022
Licensee Name:	Unity Group LLC
Licensee Address:	163 N. Fiske Road, Coldwater, MI 49036
Licensee Telephone #:	(517) 617-9591
Administrator:	Rashalle Austin
Licensee Designee:	Rashalle Austin
Name of Facility:	Unity Group LLC
Facility Address:	1861 B Case Drive, Union City, MI 49094
Facility Telephone #:	(517) 741-4227
Original Issuance Date:	10/16/2012
License Status:	REGULAR
Effective Date:	04/16/2021
Expiration Date:	04/15/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Whenever Resident A is incontinent direct care staff will throw her on to her bed. As a result, Resident A sustained a bruise on her left wrist and this bruise is still visible.	No
Staff use filthy language and were observed being disrespectful to Resident A.	Yes

III. METHODOLOGY

01/07/2022	Special Investigation Intake 2022A0578014
01/07/2022	Special Investigation Initiated - Telephone With Complainant
01/07/2022	APS Referral Completed.
01/14/2022	Special Investigation Completed On-site. -Interview with Resident A, Resident B, and Resident C. Interview with staff member Candie Jenkins, staff member Grace Smith, Staff A.
01/14/2022	Contact-Document Reviewed. -*Behavior Treatment Plan* for Resident A, dated 08/14/2021.
01/21/2022	Contact-Telephone -Interview with licensee designee, Ms. Rashalle Austin.
01/21/2022	Exit Conference -With licensee designee, Ms. Rashalle Austin.
02/14/2022	Contact-Telephone -Interview with staff member Mandy Orozco.

ALLEGATION:

- **Whenever Resident A is incontinent direct care staff will throw her on to her bed. As a result, Resident A sustained a bruise on her left wrist and this bruise is still visible.**

- **Staff use filthy language and were observed being disrespectful to Resident A.**

INVESTIGATION:

On 01/07/2022, I received this complaint through the BCHS on-line complaint system. Complainant alleged that Resident A was thrown by direct care staff on to her bed after being incontinent. Complainant reported that as a result, Resident A had a bruise on her left wrist and this bruise is still visible. Complainant added that direct care staff will swear at Resident A and use “filthy language.”

On 01/07/2022, I reviewed the details of the allegations with adult protective services worker Jennifer Stockford. Ms. Stockford reported observing a bruise on Resident A’s left wrist that was in the healing stage. Ms. Stockford confirmed observing staff member Mandy Orozco being disrespectful towards Resident A when Ms. Stockford responded to the facility.

Equipped with personal protective equipment, on 01/14/2022, I completed an unannounced investigation on-site at this facility and interviewed staff member Candie Jenkins regarding the allegations. Ms. Jenkins reported working for the licensee for four years and working at this facility for over two years. Ms. Jenkins reported serving at this facility as the home manager. Ms. Jenkins reported that she was the staff member that allegedly picked up Resident A and threw Resident A across the room but denied this event occurred, clarifying that Resident A had a history of making false allegations as documented in Resident A’s behavior plan and that Resident A had fallen independently**.** Ms. Jenkins also clarified that she was incapable of picking up Resident A and throwing her. Ms. Jenkins stated that after making the allegations, Resident A reported to her that she was wrong for “lying.” Ms. Jenkins reported Resident A was doing better and that her behavior may have been related to a urinary tract infection that had since been treated and resolved. Ms. Jenkins also stated Resident A receives regular care from the Bronson Wound Clinic for an open and infected wound on her leg which she was receiving care for prior to being admitted to this facility. Ms. Jenkins added Resident A requires the use of a walker. Ms. Jenkins identified direct care staff Grace Smith and direct care staff Dawn Mills as the two direct care staff that were present when Resident A fell.

While at the facility, I interviewed direct care staff Grace Smith regarding the allegations. Ms. Smith reported working at this facility for the last six months. Ms. Smith acknowledged working with direct care staff Dawn Mills when Resident A fell. Ms. Smith stated Resident A takes the medication Trazadone at night which makes

her tired. Ms. Smith reported that Resident A usually takes her Trazadone medication and staff prompt her to go to bed and Resident A complies. Ms. Smith reported on this particular night, Resident A had taken her Trazadone medication but refused to go to bed, instead insisting she remain on the couch. Ms. Smith reported that when attempting to go to bed a short time later, Resident A stood up from this couch and immediately fell asleep while standing with the assistance of her walker. Ms. Smith reported that she went to get assistance from Ms. Mills when Resident A's walker pushed out from underneath Resident A, resulting in Resident A falling on the floor face first. Ms. Smith reported she attempted to provide Resident A with assistance, but she was "not fast enough."

While at the facility, I interviewed Resident A regarding the allegations. Resident A reported living at this facility for the last four months. Resident A acknowledged falling independently and clarified that after she had taken her medications, she had tried using her walker, but it was too far ahead of her and the walker went out from underneath and resulted in Resident A falling "flat" on her face. Resident A reported shortly thereafter she was provided assistance from staff. Resident A denied having any significant injury but reported having slight pain in her elbow and attributed the bruising that was reported on her wrist to this fall. I observed Resident A with no bruising but with a bandaged wound on her left leg. Resident A clarified that she is diabetic and receives ongoing treatment for a wound that is slow to heal prior to her placement at this facility.

Resident A acknowledged reporting staff had picked her up and thrown her on the bed and acknowledged this was not accurate. When asked why Resident A initially made these allegations, she responded that she did not know. Resident A reiterated that staff use vulgar and profane language and used a whispered tone and discretely pointed at staff member Candie Jenkins. Resident A did not verbally respond to questions about when the last occurrence of vulgar or profane language was used by staff. When asked if she felt safe at this facility, Resident A denied feeling safe anywhere.

While at the facility, I interviewed Resident B regarding the allegations. Resident B reported living at this facility for over three years. Resident B denied ever seeing any staff being verbally or physically aggressive with any resident or Resident A. Resident B denied ever hearing staff using any kind of vulgar or profane language. Resident B reported that she is happy at the facility and that staff take good care of her.

While at the facility, I interviewed Resident C regarding the allegations. Resident C reported living at this facility for over one year. Resident C used a lowered tone and acknowledged that staff use vulgar and profane language and reported that on one occasion, staff told Resident A to "shut the fuck up." Resident C reported she could not identify which staff had made this comment as the comment was heard and not directly observed by Resident C. Resident C reported that staff member Mandy

Orozco does most of the yelling and swearing in this facility. Resident C reported that she felt safe at this facility.

While at the facility, I interviewed Staff A regarding the allegations. Staff A stated that it was “sometimes true” that staff will use verbally aggressive language. Staff A clarified staff sometimes use foul language around residents and do not necessarily direct this language at residents. Staff A reported that Candie Jenkins and Resident A will sometimes engage in argumentative behavior and that Ms. Jenkins will become frustrated. Staff A reported that on one occasion, Ms. Jenkins commented to Resident A, “this is getting fucking ridiculous, [Resident A], you’re a fucking grown adult.” Staff A denied having any additional concerns but expressed concern over retaliation and reported that staff would know that she cooperated with an investigation. Resident A was advised to follow any type of personnel policies regarding retaliation and mandatory reporting requirements.

While at the facility, I reviewed the *Behavior Treatment Plan* for Resident A. The *Behavior Treatment Plan* for Resident A identified Resident A’s target behaviors as “Verbal aggression” and “False reporting of emergencies”. The *Behavior Treatment Plan* for Resident A indicated that Resident A will report to any agency that her rights have been violated or that she is a victim of a crime when no such occurrence has taken place. The *Behavior Treatment Plan* for Resident A indicated that when Resident A is verbally aggressive, staff should keep a neutral voice, stance, and facial expression and should not show a negative or judgmental reaction.

On 01/21/2022, I interviewed licensee Ms. Rashalle Austin regarding the allegations. Ms. Austin acknowledged being aware of the allegations and reported that direct care staff Mandy Orozco was having a bad day when adult protective services responded to the facility and Ms. Orozco was “short” with adult protective services and Resident A. Ms. Austin reported that before adult protective services coming to the facility, Resident A had not reported any of the allegations. Ms. Austin reported that Ms. Orozco was removed from the schedule pending any investigations. Ms. Orozco denied ever observing any direct care staff using vulgar or profane language in front of her.

On 02/14/2022, I interviewed former direct care staff Mandy Orozco regarding the allegations. Ms. Orozco reported working at this facility for approximately four years before being removed from the schedule and finding a different job. Ms. Orozco denied every yelling or using vulgar or profane language with Resident A or any other resident for any reason.

Ms. Orozco acknowledged knowing that Resident A had fallen and reported Resident A fell on her own but denied being present when Resident A’s fall occurred. Ms. Orozco denied ever being physically aggressive with Resident A or any other resident and denied observing any other staff member being physically aggressive with Resident A or any other resident.

Ms. Orozco acknowledged making some errors in the presence of adult protective services, and when asked to clarify, Ms. Orozco reported making a comment about Resident A's bedroom "stinking" in the presence of adult protective services and Resident A.

On 02/24/2022, I reviewed the details of the allegations with adult protective services worker Jennifer Stockford. Ms. Stockford acknowledged citing this facility for physical abuse. Ms. Stockford clarified this was because of Resident A's visible but healing bruising on her wrist when she observed Resident A at the facility. Ms. Stockford reported that Resident A identified Ms. Mandi Orozco as the staff responsible and that Ms. Orozco no longer worked at the facility. Ms. Stockford reported that Ms. Orozco made disrespectful and embarrassing comments about Resident A in front of Resident A and other residents and said that Resident A's bedroom smelled like urine because Resident A likes to "piss the bed." Ms. Stockford reported that she did smell urine in Resident A's bedroom, but this was not overwhelming. Ms. Stockford reported that Ms. Orozco's demeanor changed once Ms. Stockford identified being with adult protective services. Ms. Stockford reported that during an interview, Resident A reported that Ms. Orozco makes comments to Resident A such as "fuck you" and "you are no good." Ms. Stockford reported the licensee designee for this facility, Ms. Rashalle Austin, was very responsive and concerned for Resident A and terminated one staff members employment and suspended another staff member as well.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	During an unannounced investigation on-site, Resident A denied being thrown on her bed by staff and receiving a bruise on her wrist as a result. Resident A clarified that she had fallen independently after taking her nighttime medications which was corroborated during interviews with staff member Candie

	Jenkins and direct care staff Grace Smith. Adult protective services worker Jennifer Stockford reported that during her interview, Resident A reported being pushed by former direct care staff Mandie Orozco. In an interview, Ms. Orozco, Ms. Smith, and Ms. Jenkins denied ever being physically aggressive with Resident A or any other resident or observing any other staff member being physically aggressive with any resident. During an unannounced investigation on-site, Staff A, Resident A, and Resident C acknowledged that staff use vulgar and profane language with residents and identified staff members Candie Jenkins and Mandie Orozco as the staff members responsible. During interviews, staff members Candie Jenkins and Mandie Orozco denied using any type of verbally aggressive or profane language with any resident. Adult protective services worker Jennifer Stockford reported that when she was in the facility, direct care staff Mandie Orozco was rude and disrespectful to Resident A until Ms. Stockford identified herself. Ms. Stockford noted that Resident A had reported that staff had used profane or vulgar language when addressing Resident A. While Resident A has a documented history of false reporting as indicated by her *Behavior Treatment Plan,* there is a preponderance of evidence based on interviews with Staff A, Resident A, Resident C, and adult protective services worker Jennifer Stockford that staff at this facility have used profane or vulgar language with residents, and the resident's right to be treated with consideration and respect was not safeguarded by the licensee designee.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status

02/25/2022

Eli DeLeon Date
Licensing Consultant

Approved By:

03/04/2022

Dawn N. Timm Date
Area Manager