GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 14, 2022

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

RE: License #: AS630283823
Investigation #: 2022A0991025
Horseshoe East Home

Dear Mr. Covill:

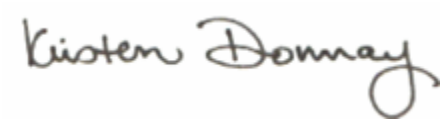
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630283823
Investigation #:	2022A0991025
Complaint Receipt Date:	05/09/2022
Investigation Initiation Date:	05/09/2022
Report Due Date:	07/08/2022
Licensee Name:	North-Oakland Residential Services Inc
Licensee Address:	106 S. Washington Oxford, MI 48371
Licensee Telephone #:	(248) 969-2392
Licensee Designee:	Roger Covill
Name of Facility:	Horseshoe East Home
Facility Address:	1649 Ray Road Oxford, MI 48371
Facility Telephone #:	(248) 236-8649
Original Issuance Date:	09/19/2006
License Status:	REGULAR
Effective Date:	06/15/2021
Expiration Date:	06/14/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A dislocated both of his elbows in November 2021. He did not receive follow up care until May 2022.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/09/2022	Special Investigation Intake 2022A0991025
05/09/2022	APS Referral Received from Adult Protective Services (APS)
05/09/2022	Referral - Recipient Rights Referred to Office of Recipient Rights (ORR) worker, Rishon Kimble
05/09/2022	Special Investigation Initiated - Telephone To ORR worker, Rishon Kimble
05/11/2022	Inspection Completed On-site Unannounced onsite inspection - interviewed staff and home manager
05/11/2022	Contact - Document Received Appointment records, health care appraisal
05/11/2022	Contact – Telephone Call Made To ORR worker, Rishon Kimble
05/13/2022	Contact - Telephone Call Made Left message for McLaren Orthopedics
05/17/2022	Contact - Document Received Individual plan of service and crisis plan
05/26/2022	Contact - Face to Face With licensee designee, Roger Covill
06/10/2022	Exit Conference Via telephone with licensee designee, Roger Covill

ALLEGATION:

Resident A dislocated both of his elbows in November 2021. He did not receive follow up care until May 2022.

INVESTIGATION:

On 05/09/22, I received a complaint from Adult Protective Services (APS), alleging that Resident A fell and dislocated both of his elbows in November 2021. Resident A did not receive any follow up care until 05/05/22. These types of injuries require follow up every two weeks, but this did not happen. The complaint noted that the injuries worsened over time, and Resident A was likely in a significant amount of pain, although he could not verbalize it. I initiated my investigation on 05/09/22, by contacting the assigned Office of Recipient Rights (ORR) worker, Rishon Kimble. On 05/10/22, I spoke with the assigned APS worker, Taneisha Sims. Ms. Sims indicated that Resident A moved into the Horseshoe East home on 12/22/21. He sustained the injuries prior to moving into the home, but staff at Horseshoe East did not follow through with getting him care after he moved into the home.

On 05/11/22, I conducted an unannounced onsite inspection at Horseshoe East Home. I interviewed direct care worker, Stacy Harrington. Ms. Harrington stated that she began working in the home in November 2021. Resident A moved into the home on 12/22/21. Ms. Harrington stated that when Resident A moved in, his previous provider indicated that Resident A's left elbow was broken. However, it was apparent that both Resident A's right and left elbows were broken. Ms. Harrington explained that Resident A was unable to move and/or bend both of his arms. When Resident A moved into the home, he did not have a sling for his right or left arm. Ms. Harrington stated that Resident A had an appointment scheduled for his broken elbows on 12/23/21. Resident A did not go to the scheduled appointment, because the home manager, Phelon Hodge, did not know about it until a week later when he found the appointment reminder card in Resident A's medical book. In January 2022, most of the residents and staff at Horseshoe East tested positive for Covid-19. As a result, Resident A's orthopedic appointment was not rescheduled. Ms. Harrington stated that last week, on 05/05/22, Resident A was taken to the doctor.

On 05/11/22, I interviewed the home manager, Phelon Hodge. Mr. Hodge stated that he has been the home manager since October 2021. Resident A moved into the Horseshoe East home on 12/22/21. At that time, a transfer meeting was conducted. Mr. Hodge was informed at the transfer meeting that Resident A's right and left elbows were broken. Mr. Hodge was told Resident A had a scheduled appointment with an orthopedic surgeon regarding these injuries, but he was not informed of the date of the appointment. Mr. Hodge discovered the appointment was scheduled for 12/23/21 when he found an appointment card in the front pocket of Resident A's medical book one week after the scheduled appointment date. Mr. Hodge stated that in January 2022 several residents and staff had Covid-19. Resident A was not tested for Covid-19; however, he had symptoms. Mr. Hodge stated that he did not reschedule Resident A's

orthopedic appointment amid the chaos with Resident A moving in and everyone having Covid-19. Resident A had at least four visits with his primary care physician since January 2022. Mr. Hodge stated Resident A's primary care physician was aware that both of Resident A's elbows were broken and told him that he needed to follow up with Resident A's orthopedic surgeon. Mr. Hodge stated Resident A cannot bend his arms. When Resident A moved into the home, he did not have a sling. On one occasion, Mr. Hodge tried to assess Resident A's range of motion by bending his arms. This caused Resident A to "yelp" in pain, so he stopped and has not done so since. Mr. Hodge knew he needed to reschedule Resident A's orthopedic appointment, but he "didn't get around to it until last week." Mr. Hodge stated, "there is no good reason that (Resident A) did not go sooner." Mr. Hodge stated Resident A was taken to the orthopedic surgeon on 05/05/22. Resident A is scheduled to have surgery on both of his elbows on 05/25/22 at 4:00pm.

On 5/11/22, I observed Resident A asleep in a recliner chair in the living room. Resident A is nonverbal and was unable to engage in an interview. Resident A was not observed wearing a sling on either arm.

I reviewed a copy of Resident A's individual plan of service (IPOS) and crisis plan dated 12/17/21. The crisis plan indicates that Resident A was recently hospitalized with a diagnosis of a broken left elbow. The discharge paperwork indicated to wear a sling. Resident A refuses to wear the sling, but staff should encourage it. It was discussed that Resident A will not wear the sling after daily attempts to keep it on. The cast was removed from Resident A's right elbow on 12/17/2021. Staff should not grab any of Resident A's elbows when transferring due to a tender elbow.

I reviewed an addendum to the IPOS, which was completed on 12/21/21 when Resident A moved into the Horseshoe East home. It indicates that over the past six months, Resident A has had an overall decline in his medical status. He dislocated his right elbow and then months later his left elbow. He has been having increased behaviors. Resident A's doctor continues to try different medications to meet his needs. However, it is recommended to follow up with an orthopedic doctor and neurologist to assess Resident A's overall functioning and brain function.

I reviewed a copy of an appointment record form from Resident A's previous placement dated 12/17/21, which indicates that Resident A dislocated his right elbow on 11/26/21. Resident A was still experiencing right elbow pain and reduced range of motion, as well as swelling and bruising. The appointment form indicates an x-ray was needed, but was unable to be completed, so they will retry at the next appointment. The appointment record notes that Resident A should elevate his right arm, ice it three times a day for 20 minutes, and use a sling with range of motion done four times a day.

I reviewed an appointment card from McLaren Medical Group which indicates that Resident A had an appointment scheduled with the orthopedic surgeon on December 23 at 11:00am.

I reviewed an appointment record form from Dr. Yambo with the Visiting Physician Association dated 01/18/22. It indicates that Resident A has broken elbows and a displaced fracture. It indicates that Resident A should have a follow up with the orthopedic doctor for a closed displaced fracture of the right ulna coronoid process.

On 05/11/22, I interviewed the Office of Recipient Rights (ORR) worker, Rishon Kimble. Ms. Kimble stated that she was still working on her investigation, but she would likely be substantiating for Neglect III against the home manager, as he knew about the missed appointment and did not reschedule it for several months.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A did not receive the personal care and protection outlined in his written assessment plan. Resident A's plan of service dated 12/21/21 indicates that Resident A requires follow up with an orthopedic doctor due to having fractured both of his elbows. This information was also shared during the transition meeting that took place when Resident A moved into the home. Staff did not take Resident A for follow up care until 05/05/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: (d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff did not follow the recommendation of Resident A's physician, as they did not obtain follow up care with an orthopedic surgeon for over four months after Resident A moved into the home with two broken elbows. Resident A missed a scheduled appointment with the orthopedic doctor on 12/23/21. The home manager did not reschedule the appointment until 05/05/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my unannounced onsite inspection on 05/11/22, I observed Resident B sitting in his wheelchair in the living room. Resident B had a gait belt around his waist that also went around the back of the wheelchair and was fastened in the back. Resident B was unable to remove the gait belt. The home manager, Phelon Hodge, stated that Resident B would fall forward in his wheelchair without the gait belt. He stated that a new wheelchair with a seatbelt was ordered for Resident B in October 2021, but it was on back order and has not yet arrived. Mr. Hodge indicated that Resident B's plan does not specify the use of a gait belt in this manner.

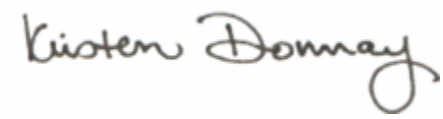
On 06/10/22, I conducted an exit conference with the licensee designee, Roger Covill, via telephone. Mr. Covill stated that a new wheelchair was never ordered for Resident B, but they have obtained a seat belt for his current wheelchair. Mr. Covill stated he would submit a corrective action plan to address the violations identified during the investigation.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident B was restrained with a gait belt during my onsite inspection on

	05/11/22. I observed Resident B secured to his wheelchair with a gait belt tied around his waist and fastened behind the wheelchair, preventing him from getting up or removing the belt.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



06/10/2022

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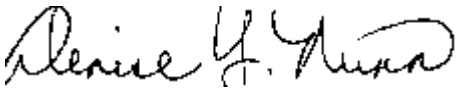
Kristen Donnay Date
Licensing Consultant

Approved By:



06/14/2022

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Denise Y. Nunn Date
Area Manager