GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 27, 2022

Phebe Holston
Moore Non Profit Housing Corp
5900 Executive Dr.
Lansing, MI 48911

RE: License #: AL330007014
Investigation #: 2022A1033013
Moore Living Connections 1

Dear Ms. Holston:

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) 284-9730.

Sincerely,

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330007014
Investigation #:	2022A1033013
Complaint Receipt Date:	06/09/2022
Investigation Initiation Date:	06/10/2022
Report Due Date:	08/08/2022
Licensee Name:	Moore Non Profit Housing Corp
Licensee Address:	5900 Executive Dr. Lansing, MI 48911
Licensee Telephone #:	(517) 894-9324
Administrator:	Phebe Holston
Licensee Designee:	Phebe Holston
Name of Facility:	Moore Living Connections 1
Facility Address:	1401 Georgetown Blvd Lansing, MI 48911
Facility Telephone #:	(517) 887-6964
Original Issuance Date:	03/06/1980
License **Status:**	REGULAR
Effective Date:	03/26/2022
Expiration Date:	03/25/2024
Capacity:	16
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff members Talisa Greer and Marqweisha Oglesby physically restrained Resident A. Resident B may have witnessed the incident.	No
Additional Findings	Yes

III. METHODOLOGY

06/09/2022	Special Investigation Intake 2022A1033013
06/10/2022	Special Investigation Initiated - On Site Interview Resident A, Resident B, LD Phebe Holston, Developmental Disabilities Specialist, Andrea Belanger, direct care staff, Christina Conrad. Review of employee records initiated. Requested staff records be emailed to consultant.
06/10/2022	Contact - Telephone call made- Adult Protective Services referral made for Resident A.
07/07/2022	Contact - Telephone call made- Interview with Program Director, Michelle Young, via telephone.
07/07/2022	Contact - Telephone call made- Interview with direct care staff, Olivia Summers, via telephone.
07/07/2022	Contact - Telephone call made- Interview with direct care staff, Marqweisha Oglesby, via telephone.
07/07/2022	Contact - Telephone call made- Interview with direct care staff, Talisa Greer, via telephone.
07/08/2022	Contact - Face to Face- Interviews with Residents C, D, & E.
07/11/2022	Inspection Completed-BCAL Sub. Compliance
07/27/2022	Exit Conference – Telephone call with Licensee Designee, Phebe Holston.

ALLEGATION:

Direct care staff members Talisa Greer and Marqweisha Oglesby physically restrained Resident A. Resident B may have witnessed the incident.

INVESTIGATION:

I received a complaint, based upon an *AFC Licensing Division - Incident/Accident Report* (IR) received on 6/9/2022. The IR noted, "[Resident A] was having behavior problems. Staff asked her to go to her room. [Resident A] became more aggressive. Consumer [Resident B] witnessed staff M.O. and T.G. physically restrain consumer against the wall. Consumer presented with bruises on her left arm and left hip." This IR was completed by Program Director, Michelle Young. Date of the incident was noted to be 6/8/22.

On 6/10/22 I completed an on-site investigation at Moore Living Connections 1 facility (the facility). I interviewed Licensee Designee, Phebe Holston. Ms. Holston reported she was informed of the alleged incident with Resident A and direct care staff members, Talisa Greer and Marqweisha Oglesby, through verbal reports from other direct care staff in the facility. Ms. Holston reported the alleged incident occurred on 6/8/22 and Ms. Greer and Ms. Oglesby have been placed on a leave of absence from their current positions while an investigation takes place. Ms. Holston reported Resident A does have bruising on her left arm and left side of her abdomen. Ms. Holston reported Resident A has a history of self-harm and has been noted to be aggressive with staff on numerous occasions. Ms. Holston further reported Resident A has injured Ms. Holston on more than one occasion. She reported Resident A has bitten her and broken several pairs of her glasses. Ms. Holston reported Ms. Greer and Ms. Oglesby have been asked to provide written statements of the incident that occurred with Resident A on 6/8/22, and they have agreed to comply. Ms. Holston reported the Lansing Police Department was contacted and have made a visit to the home to begin an investigation into the incident. Ms. Holston reported Guardian A1 was informed about the incident and has, at this time, decided to not press charges, pending the outcome of the police investigation. Ms. Holston reported direct care staff members at the facility are not CPI trained and are not allowed to place hands on any resident who is exhibiting aggressive behaviors. Ms. Holston reported direct care staff members have been trained to walk away from Resident A and give her space when she is displaying aggressive behaviors. Ms. Holston reported she has worked with Ms. Greer and Ms. Oglesby for an extended period, and she does not feel that they are capable of harming Resident A, or any of the residents at the facility. Ms. Holston reported Resident A was not taken for a medical examination following the incident.

On 6/10/22 I attempted to interview Resident A however Resident A is primarily nonverbal but does know some sign language and communicates with staff who are trained in American Sign Language (ASL). I asked Resident A if the staff at the facility are kind to her. Resident A replied, "yes." I asked Resident A if any of the

staff at the facility have hurt her. Resident A replied, “no.” I asked Resident A if anyone at the facility has grabbed her. Resident A replied, “no.” I did a visual inspection of Resident A’s injuries. Resident A was noted to have bruising and scratches going up her left arm from her wrist to just above the elbow. She was noted to have a large bruise on her lower left side of her abdomen, beginning on her hip, extending up several inches and across the entire left side from her back to her pelvis area. The bruising on her left hip was dark purple in color.

On 6/10/22 I interviewed Resident B who reported she witnessed the alleged incident that occurred on 6/8/22 with Resident A, Ms. Greer, and Ms. Oglesby. Resident B reported Resident A had started throwing CDs and video tapes off a shelf in the common area. Resident B reported direct care staff members then asked Resident A to go upstairs but she continued to throw objects and scratch herself. Resident B reported Resident A began pinching and hitting Ms. Oglesby. Resident B reported Ms. Greer pulled on Resident A’s arm to get her away from Ms. Oglesby. She reported Ms. Greer pulled Resident A by the wrist. Resident B reported Ms. Greer and Ms. Oglesby did not hit Resident A. Resident B reported Resident A’s behaviors did not stop, and Ms. Greer and Ms. Oglesby pushed her against the wall and then down to the ground. Resident B reported after the incident Resident A stomped up the stairs and went to her room. Resident B reported Ms. Greer looked at her and said, “what are you looking at?” and went back to work. Resident B reported she has never seen Ms. Greer and Ms. Oglesby use this kind of force with a resident in the facility before this date.

On 6/10/22, during on-site investigation, I interviewed Resident A’s Developmental Disabilities Specialist, Andrea Belanger, with Community Mental Health Clinton, Eaton, Ingham counties. Ms. Belanger reported that she is the Developmental Disabilities Specialist for 11 of the 12 residents in this facility. Ms. Belanger reported she has never heard of physical altercations happening among residents and direct care staff members in this facility. Ms. Belanger reported she has heard residents complain of verbal altercations with staff members at the facility, in the past. Ms. Belanger reported Resident A does self-harm and she has been known to leave scratches and marks on her arms from this behavior. Ms. Belanger reported she has never witnessed bruising on Resident A to the extent that can be seen today. Ms. Belanger reported she has a working relationship with Resident B as well. She reported Resident B can be a good historian provided she is not asked leading questions. She reported Resident B, sometimes responds how she thinks the interviewer wants her to respond, if the questions appear to be leading in a particular direction. Ms. Belanger reported she did not feel I asked leading questions when I interviewed Resident B today as she remained present for the interview.

On 6/10/22, during on-site investigation, I interviewed direct care staff, Christina Conrad (Medical Coordinator). Ms. Conrad reported that on 6/9/22 Resident A came to her and said, “ow” and pointed to her left side. Ms. Conrad reported that she saw a large bruise on Resident A’s side. Ms. Conrad reported that there is a direct care staff member, Olivia Summers, who works at a neighboring facility, and she

understands and communicates with ASL. Ms. Conrad reported she had Ms. Summers come to the facility and talk to Resident A. Ms. Conrad reported Resident A indicated to Ms. Summers that “the workers hurt me.” Ms. Conrad reported this was then reported to management of the facility and an incident report was completed. Ms. Conrad reported that Resident A does exhibit behaviors of self-harm, but she has not seen her injuries to the extent that they are today. Ms. Conrad reported she believes it is possible Resident A could have caused the injuries on her left arm but not the injuries on her left side. Ms. Conrad reported she has never been aware of complaints related to Ms. Greer or Ms. Oglesby before this incident. Ms. Conrad reported medical attention was not sought for Resident A after the injuries were discovered.

On 7/7/22 I interviewed Ms. Summers via telephone. Ms. Summers reported she does work at the neighboring facility and is not a current direct care staff at this facility. Ms. Summers reported Ms. Young had come to her on 6/9/22 for assistance with communicating with Resident A. Ms. Summers reported Resident A is mostly nonverbal but does use some ASL. Ms. Summers reported she went to the facility and spoke with Resident A, using ASL. Ms. Summers reported Resident A signed, “I’m bleeding.” Ms. Summers reported she asked Resident A, “Did someone hurt you?” She reported that Resident A replied, “yes,” and then showed her the large bruise on her left side. Ms. Summers reported that she then asked, “Did a worker hurt you?” and Resident A replied, “yes.” Resident A was not able to identify which worker injured her.

On 7/7/22 I interviewed Ms. Young via telephone. Ms. Young reported that on 6/9/22 she arrived to work at the neighboring facility and received a phone call from Ms. Conrad at the facility. She reported that Ms. Conrad had asked her to come look at Resident A’s injuries. Ms. Young came to the facility and observed bruising on Resident A’s left arm and left side. She reported Resident B was present and Resident B stated, “Marqweisha and Talisa slammed her up against the wall.” Ms. Young reported she took pictures of the injuries and then called her supervisor, Kathy Hockey, for guidance. Ms. Young reported she was instructed, by Ms. Hockey, to write and IR, call licensing, call the guardian, call the police, call Community Mental Health and suspend Ms. Greer and Ms. Oglesby. Ms. Young reported Resident A was not seen by a physician after the injuries were noticed and documented. Ms. Young reported the procedure in the facility is to use daily log sheets to document when a resident is exhibiting aggressive behaviors. She reported Ms. Greer and Ms. Oglesby had noted Resident A to be having “bad” behaviors on 6/8/22 but did not account for the injuries sustained or any event that could have caused these injuries. Ms. Young reported the residents in the home have complained that Ms. Greer and Ms. Oglesby have been mean to them. Ms. Young reported that since the two staff have been placed on a leave of absence Resident A’s behaviors have been more positive.

On 7/7/22 I interviewed Ms. Greer regarding the alleged incident on 6/8/22. Ms. Greer reported she has worked for this facility for around 2.5 years. Ms. Greer

reported that on the date of 6/8/22 she was working with Ms. Oglesby. Ms. Greer reported Resident A was upset because she wanted the direct care staff to do her hair. Ms. Greer reported she was doing medication administration at the time and Ms. Oglesby had just finished cleaning and was preparing to start a load of laundry. Ms. Greer reported Resident A began, yelling, screaming, and scratching herself and then signed the word, “phone” and said, “mom.” Ms. Greer reported she knew Resident A wanted to call her mother and told her that her mother was working and not available at this time. Ms. Greer reported Resident A then started knocking things off the shelves. Ms. Greer reported Ms. Oglesby then asked Resident A to go to her bedroom. She reported Resident A stated, “no,” and then proceeded to throw items off the shelf and tried to pull the shelf over. Ms. Greer reported Resident A then tried to knock the shelf over and fell to the floor, hitting the wall as she went down. Ms. Greer reported at this time Resident A began attacking Ms. Oglesby. Ms. Greer reported Ms. Oglesby asked her for assistance as Resident A was trying to bite her and grab at her crotch, so she went to aid Ms. Oglesby. She further reported by the time she reached Ms. Oglesby she had been able to back away from Resident A. Ms. Greer reported Resident A then got up, started crying and retreated to her bedroom. Ms. Greer reported no physical assessment was completed for Resident A to check for injuries after the incident. Ms. Greer reported Resident B did observe the incident. She further reported this is typical behavior for Resident A but they are not allowed to defend themselves and do not lay hands on Resident A when she is demonstrating these behaviors. Ms. Greer reported that later on this date, 6/8/22, Resident A became upset during dinner and broke her dinner plate. Ms. Greer reported she is aware she did not update the resident behavior log after this incident occurred.

On 7/7/22 I interviewed Ms. Oglesby, via telephone. Ms. Oglesby reported she has worked for this facility for around 5 years. Ms. Oglesby reported that on 6/8/22 she was working at the facility with Ms. Greer. She reported Resident A wanted her hair done and she asked her to wait a minute as she had just finished cleaning and was going to start a load of laundry. Ms. Oglesby reported at this time Resident A became agitated and started throwing items, spitting, scratching, and ripping her clothing. Ms. Oglesby reported she asked Resident A to go to her room and Resident A said, “no.” Ms. Oglesby reported then Resident A had asked to call her mom, by using sign language for “phone.” Ms. Oglesby reported she and Ms. Greer had to tell Resident A that her mom was at work. Ms. Oglesby reported Resident A began throwing items off the shelf and then she fell and hit the wall. Ms. Oglesby reported that while Resident A was on the floor, she tried to pull the shelf over. Ms. Oglesby reported she grabbed the shelf to stop it from falling. Ms. Oglesby reported Resident A then started grabbing at her, tried to bite her ankle, and grabbed at her crotch. Ms. Oglesby reported she then asked Ms. Greer for assistance but by the time Ms. Greer was able to assist, Ms. Oglesby was able to back away from Resident A. Ms. Oglesby reported at that time Resident A had started crying and got up from the floor. She reported Resident A went to her room after the incident. Ms. Oglesby reported that if Resident A suffered any injuries during this incident, they were self-inflicted. Ms. Oglesby reported this is typical behavior for Resident A. She

reported Resident A has previously bit another resident in the neck, causing that resident to be taken for emergency medical attention. She further reported Resident A has broken the glasses of Ms. Holston on several occasions. Ms. Oglesby reported, “I never touched her” and noted Resident A is legally blind and does have some balance issues, which is probably why she fell. Ms. Oglesby reported neither she nor Ms. Greer performed a physical assessment on Resident A following this incident.

On 7/8/22 I completed an on-site investigation and interviewed Resident C. Resident C reported that she is familiar with Ms. Greer and Ms. Oglesby. She reported she has never seen these two staff members being verbally or physically abusive with any residents of the facility. Resident C reported Resident A does have a history of scratching and biting others.

On 7/8/22 I completed an on-site investigation and interviewed Resident D. Resident D reported that she has lived at the facility for about one year. Resident D reported she is familiar with Ms. Greer and Ms. Oglesby. Resident D reported Ms. Greer and Ms. Oglesby have always been kind to her, and she has never heard or witnessed them being verbally or physically abusive with any residents in the facility.

On 7/8/22 I completed an on-site investigation and interviewed Resident E. Resident E reported she has lived at the facility for about one year. Resident E reported being familiar with Ms. Greer and Ms. Oglesby. Resident E reported Ms. Greer is “pretty good.” She reported Ms. Oglesby is “good.” Resident E reported she has never witnessed Ms. Greer or Ms. Oglesby being verbally or physically abusive with any residents at the facility.

On 6/10/22 I reviewed the employee records for Ms. Greer and Ms. Oglesby. Both records included evidence of completed background checks, fingerprinting, reference checks, and required trainings. There were no documented incidents of disciplinary action in either record related to abuse/neglect issues or resident rights issues.

On 6/10/22 I reviewed the resident behavior log for Resident A, dated 6/8/22, and initialed by Ms. Greer. Under the Section, *What was the behavior – check below,* The following boxes were checked, “Physical Aggression, Hitting, Kicking, Spitting, Crying, Self Injury, Property Destruction.” The following notation was written under the subsection, *What was happening before – Describe*, “[Resident A] was crying staff ask her to go to her room to calm down after staff said that she started throwing stuff at staff.” There were further notations stating, “She was spitting, at staff hitting staff. She started injurying her self kicking at staff then she started property destruction things and crying.” Further documentation on this log stated, “When staff tried to assist her she was physical aggression with staff.” Under the subsection, *Was there anything else that could of occurred to assist [Resident A] in the situation?,* was written, “nothing!”

On 6/10/22 I reviewed the document, *Initial Assessment and Positive Support Plan,* dated 2/23/22, found in Resident A's file. Under section *B. Reason for Referral,* it states, "[Resident A] has been having increased behaviors over the past months and has been hitting, spitting, and biting others. [Resident A] is non-verbal but does understand some sign language. Staff are looking for additional assistance in supporting [Resident A] when she is extremely upset." In this same document on page 3, section, *Functional Assessment of Behavior,* subsection *2. Intermittent Explosive Disorder,* it reads, "[Resident A] is known to have sudden outbursts, aggressive and violent behaviors."

On 6/10/22 I reviewed the *Assessment Plan for AFC Residents* form dated, 9/3/19, found in Resident A's record. Under section *I. Social/Behavioral Assessment,* subsection, *I. Controls Aggressive Behavior,* was written, [Resident A] needs verbal redirection when exhibiting aggression. History of spitting, hitting, and scratching others. History of scratching own arms and chest. History of throwing items." Continued in section I, under subsection, *L. Exhibits Self Injurious Behavior,* is written, "Will scratch her arm or chest – nails should be kept short. Random emotional crying – often frustrated or not getting her way." In section, *III. Health Care Assessment,* under subsection, *E. Other Difficulties (Vision, Weight, Allergies, etc.),* is written "Has to have glasses – legally blind without."

On 6/10/22 I reviewed the IRs in Resident A's record. There was an IR dated for 8/11/21, signed by Phebe Holston, that referenced an incident when Resident A bit another resident in the neck, breaking the skin.

APPLICABLE RULE	
R 400.15305	**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 interviews with Residents A, B, C, D, E, Ms. Holston, Ms. Belanger, Ms. Conrad, Ms. Summers, Ms. Young, Ms. Greer, Ms. Oglesby, review of employee files, Resident A's behavior log for 6/8/22, Resident A's, *Initial Assessment and Positive Support Plan,* Resident A's *Assessment Plan for AFC Residents,* and review of IRs for Resident A, there is not adequate evidence to find that direct care staff members Ms. Greer and Ms. Oglesby did not provide for Resident A's protection and safety. Neither direct care staff member has any history of inappropriately physically managing any resident and there was not enough evidence it happened in this case either.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 6/10/22 during on-site investigation I interviewed Ms. Holston. Ms. Holston reported that Resident A has new bruising on her left arm and left side of her abdomen, above her hip. She reported that this bruising was first discovered on 6/9/22 by Ms. Conrad. Ms. Holston reported that medical treatment was not sought for Resident A following discovery of the injuries.

On 6/10/22 during on-site investigation I interviewed Ms. Conrad. Ms. Conrad reported that she was first made aware of the extensive bruising on Resident A's left arm and left side of her abdomen, above her hip, on 6/9/22, when Resident A self-reported the injuries. Ms. Conrad reported that medical treatment was not sought for Resident A at this time.

On 7/7/22 I interviewed Ms. Young, via telephone. Ms. Young reported that she was made aware of the extent of the bruising on Resident A's left arm and her left side of her abdomen, above her hip, on 6/9/22. Ms. Young reported that she contacted her supervisor, Kathy Hockey, who instructed her to contact the licensing consultant, the guardian, Community Mental Health and the police. She further reported she completed an IR and the two direct care staff being accused of allegedly injuring Resident A were placed on a leave of absence from their position. She reported that Resident A did not go to a doctor for the injuries to be evaluated and the bruising has since diminished.

On 7/7/22 I interviewed Ms. Greer related to the alleged incident with Resident A on 6/8/22. Ms. Greer reported Resident A did fall while exhibiting aggressive behaviors toward Ms. Greer and Ms. Oglesby. Ms. Greer reported she did not have a chance to document the fall on Resident A's behavior log and she did not physically assess Resident A for injuries after the fall.

On 7/7/22 I interviewed Ms. Oglesby related to the alleged incident with Resident A on 6/8/22. Ms. Oglesby reported Resident A fell and hit the wall as she was throwing items off a shelf at Ms. Greer and Ms. Oglesby. She further reported Resident A was spitting, scratching, and ripping her own clothing. Ms. Oglesby reported that after this incident had resolved, she did not perform a physical assessment of Resident A to assess for potential injuries she may have sustained when she fell.

APPLICABLE RULE	
R 400.15310	**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 interviews with Ms. Holston, Ms. Conrad, Ms. Young, Ms. Greer, and Ms. Oglesby, Resident A experienced an incident at the facility on 6/8/22 that resulted in significant bruising to her left arm and left side of her abdomen, above her hip, however medical attention was not sought to rule out any potential for a more serious injury.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 6/10/22 I completed an on-site investigation at the facility. I reviewed Resident A's record. The *Assessment Plan for AFC Residents* form was dated 9/3/19. I interviewed Ms. Holston to inquire whether there was an available updated form and she noted the file was complete at this time.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.

ANALYSIS:	The *Assessment Plan for AFC Residents* form located in Resident A's file was dated for 9/3/19, indicating the form has not been updated, at least, annually as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 6/10/22 I completed an on-site investigation at the facility. I reviewed Resident A's record. The *AFC – Resident Care Agreement* form was dated for 10/8/19. There was no supporting documentation to indicate that this form had been reviewed with Guardian A1 since 10/8/19.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.
ANALYSIS:	The *AFC – Resident Care Agreement* form located in Resident A's file was dated for 10/8/19. There was no supporting documentation available to indicate this form had been reviewed with Guardian A1 since 10/8/19 as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the results of ongoing police investigation and receipt of an approved corrective action plan, I recommend no change to the status of the license at this time.

07/19/2022

_____

Jana Lipps — Date
Licensing Consultant

Approved By:

07/27/2022

_____

Dawn N. Timm — Date
Area Manager