GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 10, 2022

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

RE: License #: AS630012521
Investigation #: 2022A0991030
Lakeville Home

Dear Mr. Covill:

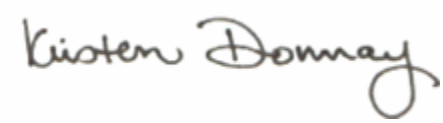
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS630012521
Investigation #:	2022A0991030
Complaint Receipt Date:	06/15/2022
Investigation Initiation Date:	06/15/2022
Report Due Date:	08/14/2022
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:	Lakeville Home
Facility Address:	3060 Rochester Road Leonard, MI 48367
Facility Telephone #:	(248) 628-4969
Original Issuance Date:	11/20/1987
License **Status:**	REGULAR
Effective Date:	10/08/2020
Expiration Date:	10/07/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff scrubbed Resident A's face too hard, causing corneal abrasions. Resident A had bruising of an unknown origin on his left eye and right arm.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/15/2022	Special Investigation Intake 2022A0991030
06/15/2022	Special Investigation Initiated - Telephone Call to Rishon Kimble, Office of Recipient Rights (ORR)
06/15/2022	APS Referral Received from Adult Protective Services - denied for investigation
06/15/2022	Referral - Recipient Rights Call to ORR- resident is not receiving services through Oakland County
06/17/2022	Inspection Completed On-site Unannounced onsite inspection- interviewed assistant home manager and observed Resident A
06/17/2022	Contact - Document Received Incident reports, discharge paperwork, health care chronological, staff log
06/29/2022	Contact - Document Received Additional allegations received from Adult Protective Services
06/30/2022	Contact - Telephone call made To assistant home manager
06/30/2022	Contact - Telephone call made To APS worker, Gene Evans
06/30/2022	Contact - Document Received Incident report and urgent care paperwork

07/01/2022	Contact - Telephone call made To direct care worker, Angelica Kowalski
07/25/2022	Contact - Telephone call made To direct care worker, Misty Metzger
07/25/2022	Contact - Telephone call made To APS worker, Gene Evans
07/27/2022	Exit Conference Via telephone with licensee designee, Roger Covill

ALLEGATION:

Staff scrubbed Resident A's face too hard, causing corneal abrasions. Resident A had bruising of an unknown origin on his left eye and right arm.

INVESTIGATION:

On 06/15/22, I received a complaint from Adult Protective Services (APS) alleging that Resident A was brought to the hospital for abrasions around his eye and drainage from his eye. It was alleged that a staff member was cleaning his face and scrubbed his face too hard. Resident A was treated for a corneal abrasion on his eye as well. APS denied the complaint for investigation. On 06/29/22, I received an additional complaint from APS alleging that Resident A had bruising around his left eye and right upper arm from staff, Angelica, but it was unknown what she did to him. This complaint was assigned to APS worker, Gene Evans, for investigation. I initiated my investigation on 06/15/22 by contacting the Office of Recipient Rights (ORR).

On 06/17/22, I conducted an unannounced onsite inspection at Lakeville Home. I interviewed the assistant home manager, Melissa Kinnick. Ms. Kinnick stated that she has worked in the home for a year, and she is currently filling in while the home manager is on leave. On Thursday, 06/09/22, she came in for her shift around 7:00am. Direct care worker, Angelica Kowalski, asked Ms. Kinnick to look at Resident A’s face. Ms. Kowalski told Ms. Kinnick that she was using a washcloth and scrubbed Resident A’s face too hard. Ms. Kinnick stated that Resident A's eye was really red and the area around his eyelid was red. Ms. Kinnick flushed Resident A’s eye and put a cold compress on it. Ms. Kinnick stated that she video chatted with the area manager, Kris Hodge, who instructed her to take Resident A to urgent care the following day if his eye looked worse. Ms. Kinnick left the home at 3:00pm and came back to work another shift at 11:00pm. Resident A’s eye was beginning to look worse. She took pictures of the injury that evening and put cold compresses on it throughout the night. Ms. Kinnick left at 7:00am on Friday morning and returned to work again at 5:00pm on Friday. She

stated that Resident A's eye looked "nasty" at that point and was beginning to look infected, so she contacted the area manager again. The area manager instructed staff to take Resident A to McLaren Clarkston Emergency Department. Direct care worker, Misty Metzger, transported Resident A to McLaren Clarkston later that night. Resident A was diagnosed with corneal and facial abrasions. He was prescribed Ciprofloxacin Ophthalmic eye drops and Naproxen 500mg tablets. The doctor at the hospital told Ms. Metzger and Ms. Kinnick that the abrasions were due to excessive scrubbing.

Ms. Kinnick stated that Angelica Kowalski is a good worker most of the time. She felt that Ms. Kowalski might have been "trying to prove a point" by cleaning Resident A's face excessively. Ms. Kinnick stated that earlier that week she showed staff how to properly wash Resident A's face, because she did not want him going to workshop with crusty eyes. Resident A has entropion eyelids, causing his bottom eyelids to flip inwards and making him prone to infections. Ms. Kinnick showed Ms. Metzger and Ms. Kowalski how to pull Resident A's eyelid down until it flips out and demonstrated how to clean his eyes with baby shampoo and a washcloth. She stated that she texted staff on Wednesday night, letting them know that the residents should be ready to go the following morning, with their faces clean, smelling good, and lunches made. Ms. Kinnick stated that she felt Ms. Kowalski had to scrub very hard in order to cause the abrasions around Resident A's eye.

During the onsite inspection, I observed Resident A sitting in his wheelchair in the living room. Resident A is nonverbal and was unable to be interviewed. I observed abrasions on the upper eyelid of his left eye, which were in the process of healing. I observed the pictures that Ms. Kinnick took of Resident A's eye on Friday, 06/10/22. In the pictures, there are abrasions above and below Resident A's left eye. The skin around his eye appears to be red and raw.

I reviewed a copy of an incident report completed by the assistant home manager, Melissa Kinnick, dated 06/09/22. The incident report notes that Ms. Kinnick came into work and Angelica let her know that she rubbed Resident A's face too hard when cleaning his face. Angelica then informed her that she put triple antibiotic ointment on it and did not inform the medication passer that she was doing this. Ms. Kinnick flushed Resident A's eye and used a washcloth with cold water to clean the surface area around the eye. She informed staff that they cannot use ointment on Resident As eyes and flushed his eyes until the redness was gone.

I reviewed a copy of an incident report completed by Ms. Kinnick dated 06/10/22. The incident report notes that yesterday, Resident A's eye was red and swollen after Angie washed his face in the morning. Through the evening it was less red and swollen with a cold compress. On the evening of 06/10/22, it looked like Resident A rubbed it and scratched it raw, so he was taken to the emergency room in Clarkston. The corrective actions to prevent recurrence of the incident note that training will be provided on washing Resident A's face and eyes properly.

I reviewed a copy of the discharge paperwork from the McLaren Clarkston Emergency Department. The discharge paperwork notes that Resident A was seen on 06/10/22 for skin problems and a swollen/red left eye. The final diagnosis was a corneal abrasion on his left eye and facial abrasions. Resident A was prescribed Ciprofloxacin eye drops, apply one drop in both eyes four times a day for 5 days and Naproxen 500mg tablets, take twice a day for 15 days.

On 06/30/22, I interviewed the home manager, Melissa Kinnick, regarding the allegations that Resident A had bruising around his eye. Ms. Kinnick stated that she was not working when the alleged incident occurred. She received a text message from direct care worker, Misty Metzger, on the morning of 06/29/22, stating that she was trying to pass medications to Resident A, but Angelica Kowalski was in Resident A's bedroom and had a wheelchair blocking the door, so she could not get in to pass medications. Ms. Metzger then told Ms. Kinnick to look at Resident A's face when she arrived at the home. Ms. Kinnick came to the home around 7:00am on 06/29/22. Angelica Kowalski met her at the office door and told her that Resident B's hand was swollen. Resident B has self-injurious behaviors, so this was not that unusual. Ms. Kowalski also told Ms. Kinnick that Resident A had some redness and black spots around his eye. Ms. Kinnick stated that she did a physical exam of Resident A and noticed that he had some bruising developing between his eye and cheekbone. Ms. Kowalski reported that the bruising was not there when she was doing her bed checks. Ms. Kinnick stated that she called the area manager, who instructed them to take Resident A to urgent care due to the injuries being on his face. Resident A was taken to urgent care by Misty Metzger, where they found he had bruising on his left eye and a small circular bruise on the inside of his right arm. Ms. Kinnick stated that Resident A cannot move his right arm. She stated that she does not know what caused the bruising. Angelica Kowalski was removed from the schedule pending the investigation.

On 07/01/22, I interviewed direct care worker, Angelica Kowalski. Ms. Kowalski denied the allegations that she caused abrasions or bruising around Resident A's eye. She stated that workshop had been complaining about Resident A's face not being clean. Resident A has a disease in his eyes, so they are difficult to clean. Ms. Kowalski denied ever scrubbing Resident A's face too hard while washing his face. She does not scrub his face. She wets a washcloth with warm water and places it over Resident A's eye to loosen up the crust around his eyes and let it dissolve. She stated that Resident A will bat at you if you try to scrub his face, as he does not like his face being touched. Ms. Kowalski stated that the assistant home manager, Melissa Kinnick, showed them how to clean Resident A's face by pulling down his eyelid. She stated that she was not going to do it like that, because she did not feel comfortable lifting his eyelids. Ms. Kowalski stated that when she left on the morning of 06/09/22, Resident A's eye was red. It looked like he had pink eye. Resident A sometimes pokes his own eye. Ms. Kowalski was not scheduled to work for the next few days. Approximately four days later, she

received a text from Ms. Kinnick with pictures of Resident A's face. Ms. Kinnick told her that there was an APS case open because of her scrubbing Resident A's eye. Ms. Kowalski stated that in the pictures it looked like Resident A had chemical burns on his face. This is not how it looked when she left the home. Ms. Kowalski denied telling Ms. Kinnick that she scrubbed Resident A's face too hard. She stated that she did not put antibiotic ointment on Resident A's eye. She did not do anything other than place a washcloth on Resident A's face to clean his eye.

Ms. Kowalski stated that on 06/29/22, she was doing bed checks and noticed that Resident A had black circles around his eye. She showed her co-worker who agreed that it looked like black circles. When Ms. Kinnick came in, she showed her Resident A's eye. Ms. Kinnick indicated that it looked like a bruise. Ms. Kowalski stated that she did not know what caused the bruising, but it seemed to get worse as the night progressed. She denied being physically aggressive towards Resident A and never noticed anyone else being physically aggressive towards him. She stated that Resident A is combative at times. He will swat his arm and lock up. Ms. Kowalski stated that she did not notice any bruises on Resident A's arm. Ms. Kowalski stated that she did not intentionally lock staff out of Resident A and Resident B's bedroom when she was getting them ready for the day. She had the wheelchair positioned by the closet door and the footrests were next to the bedroom door. She stated that she had to take the footrests off the wheelchair in order to get Resident B situated. She was just trying to get her residents situated and ready for the day.

On 07/25/22, I interviewed direct care worker, Misty Metzger. Ms. Metzger stated that she came in for her shift around 7:00am on 06/09/22. When she came in, direct care worker, Angelica Kowalski, was in a panic because she scrubbed Resident A's face too hard. Ms. Kowalski did not tell her this directly, but she heard her telling the assistant home manager, Melissa Kinnick. Ms. Metzger stated that Resident A's eye and the surrounding area were a little red at first, but it progressively got worse throughout the day. Ms. Metzger was working a double shift, so they put cold compresses on Resident A's eye throughout the day. Resident A's eye continued to get worse and by Friday afternoon, it was determined that he needed to go to the emergency room. Ms. Metzger transported Resident A to McLaren Hospital on Friday evening. The treating physician determined that Resident A had an abrasion on his eye. He stated that it was from staff scrubbing Resident A's face too hard. The doctor indicated that he would be calling to make a report to APS, as he did not believe that Resident A could have caused the injuries himself.

Ms. Metzger reported that Resident A does sometimes swing his arm up when he is ornery, but she has never witnessed Resident A scratching his eye. She stated that she has worked with Resident A frequently, and she did not believe he could have caused injuries to that extent himself. Ms. Metzger stated that Ms. Kinnick gave them

instructions on how to clean Resident A's eye two days prior to the incident. She demonstrated how to roll out his eyelid and clean it with a warm washcloth and baby shampoo. Ms. Metzger stated that she felt Ms. Kowalski just went too far and scrubbed too much. She stated that Ms. Kowalski also told Ms. Kinnick that she applied triple antibiotic ointment near Resident A's eye, which is not permitted in Resident A's standing medical orders.

Ms. Metzger stated that she was also working when Resident A was taken to urgent care for bruising around his eye. She was working the midnight shift with Angelica Kowalski on 06/28/22. Ms. Metzger stated that Ms. Kowalski was moody and was being argumentative with staff throughout the shift. The following morning, on 06/29/22, Ms. Metzger was preparing to pass medications to Resident A. Ms. Metzger stated that Ms. Kowalski was in Resident A's bedroom with the door shut for a long time, approximately 25-30 minutes. Ms. Metzger felt this was a long time to get one resident ready for the day. She texted the assistant home manager to let her know that Ms. Kowalski was in the room with the door shut and she needed to pass medications. The assistant home manager told her to enter the room to pass medications, but the door was blocked, and she could not get into the room. Ms. Kowalski told her that she would be right out. When Ms. Kowalski came out, she wrote an incident report because Resident B's hand was swollen, and Resident A's eye was bruised. Ms. Metzger did not know what happened and did not witness Ms. Kowalski being physically aggressive towards the residents. Ms. Kowalski told her that Resident A was being vocal throughout the night and was swinging on himself during brief changes.

Ms. Metzger stated that she did not hear Resident A being vocal or agitated at any point during the night. When the assistant manager arrived that morning, she had Ms. Metzger take Resident A to urgent care, where they found he had bruising of an unknown cause around his left eye and a small bruise on the inside of his right arm. Resident A is not able to move his right arm. Ms. Metzger stated that the doctor made a referral to APS due to Resident A having bruises of an unknown cause. The doctor did not feel that Resident A caused the bruising himself. Ms. Kowalski was removed from the schedule. Ms. Metzger stated that Resident A is non-verbal and cannot answer questions. He does vocalize. She stated that Resident A seems slightly more anxious when Ms. Kowalski is around him. He is not as vocal around her and appears to be stiffer.

On 07/25/22, I interviewed the assigned APS worker, Gene Evans. Mr. Evans indicated that he conducted an onsite inspection on 06/29/22. He observed a small bruise, about the size of a quarter, on the inner part of Resident A's right arm above his elbow. Resident A does not move his right arm. Resident A also had some bruising around his left eye. Mr. Evans stated that it was unclear whether this was new bruising or residual from the previous injuries which were healing. Resident A was unable to answer any

questions. Mr. Evans suggested the staff person involved, Angelica Kowalski, be moved to another home pending the investigation. He stated that he was still working on his investigation, but he would likely be substantiating.

I reviewed copies of the discharge paperwork from Rochester Urgent Care dated 06/29/22. It notes that Resident A came in for bruising. The exam found that Resident A had mild ecchymosis (discoloration of the skin resulting from bleeding underneath, typically caused by bruising) on his left orbit and scattered soft tissue bruising. It notes that a referral was made to APS for further investigation into the group home and staff concerns.

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 gathered through my investigation, there is sufficient information to conclude that staff did not attend to Resident A's protection and safety at all times. Resident A was treated at the emergency room on 06/10/22 for abrasions around his eye and a corneal abrasion on his left eye. The treating physician made a referral to Adult Protective Services (APS) and indicated to staff that the injury was caused from staff scrubbing Resident A's face excessively. Direct care worker, Angelica Kowalski, denied scrubbing Resident A's face; however, this contradicts the information provided by the assistant home manager, Melissa Kinnick, and direct care worker, Misty Metzger. According to Ms. Kinnick and Ms. Metzger, Ms. Kowalski said she scrubbed Resident A's face too hard while cleaning his face on 06/09/22. Resident A was also treated at urgent care on 06/29/22 for bruising around his left eye and a bruise on his right arm, which he cannot move. The cause of the bruises could not be determined, but the urgent care doctor made a referral to APS as they did not feel the bruises were self-inflicted by Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the investigation, I reviewed a copy of Resident A's discharge paperwork from his visit to the McLaren Clarkston Emergency Department on Friday, 06/10/22. The discharge paperwork notes that Resident A was prescribed Ciprofloxacin eye drops, apply one drop in both eyes four times a day for 5 days, and Naproxen 500mg tablets, take twice a day for 15 days for his corneal abrasion. I reviewed Resident A's medication log, which showed that the eyedrops were first administered at 4:00pm on Tuesday, 06/14/22. The Naproxen was first administered at 8:00pm on Tuesday, 06/14/22. The assistant home manager, Melissa Kinnick, stated that the pharmacy was closed over the weekend, and they could not get the medications delivered. Resident A's health care chronological (HCC) notes that Ms. Kinnick contacted Genoa Pharmacy on 06/13/22. The pharmacy stated that they received the prescriptions, and the medications would be delivered that day. The medications were not delivered until 06/14/2022, four days after his visit to the emergency room on 06/10/22 when the medications were prescribed.

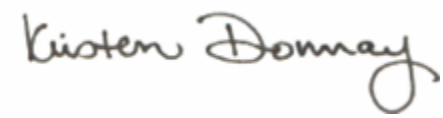
On 07/27/22, I conducted an exit conference via telephone with the licensee designee, Roger Covill. Mr. Covill indicated that Angelica Kowalski was removed from the schedule pending the outcome of the APS investigation. He stated that he felt the bruising under Resident A's eye was not the result of anyone being physically aggressive towards Resident A but was related to the abrasions that were healing. Mr. Covill stated that they do have a process in place to have prescriptions filled on the weekend or in case of an emergency, but staff did not follow this procedure. Mr. Covill agreed to submit a corrective action plan to address the violations.

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: (a) Medications.
ANALYSIS:	Based on the information gathered through my investigation, staff did not follow the instructions and recommendations of the emergency room physician regarding the medications that were prescribed. On 06/10/22, Resident A was prescribed Ciprofloxacin eye drops, apply one drop in both eyes four times a day for 5 days, and Naproxen 500mg tablets, take twice a day for 15 days for his corneal abrasion. The prescriptions were not filled until 06/14/22, four days after his emergency room visit.

CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

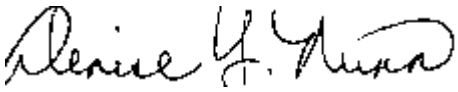
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



07/27/2022

Kristen Donnay Date
Licensing Consultant

Approved By:



08/10/2022

Denise Y. Nunn Date
Area Manager