GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 29, 2022

Marlene Burgess
Alternative Community Living, Inc.
P. O. Box 190179
Burton, MI 48519

RE: License #: AS630237226
Investigation #: 2022A0612001
Fox River

Dear Ms. Burgess:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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,

Johnna Cade, Licensing Consultant
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630237226
Investigation #:	2022A0612001
Complaint Receipt Date:	05/31/2022
Investigation Initiation Date:	06/01/2022
Report Due Date:	07/30/2022
Licensee Name:	Alternative Community Living, Inc.
Licensee Address:	P. O. Box 190179 Burton, MI 48519
Licensee Telephone #:	(586) 206-8869
Licensee Designee:	Marlene Burgess
Name of Facility:	Fox River
Facility Address:	4693 Pontiac Lake Road Waterford, MI 48328
Facility Telephone #:	(248) 683-9908
Original Issuance Date:	10/18/2001
License Status:	REGULAR
Effective Date:	12/12/2020
Expiration Date:	12/11/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Per incident reports, Resident A was transported to the hospital after complaining her side was hurting. While at the hospital, Resident A reported that she threw pop in staff's face and staff pushed her down. She was diagnosed with fractured ribs.	Yes

III. METHODOLOGY

05/31/2022	Special Investigation Intake 2022A0612001
05/31/2022	APS Referral Adult Protective Services (APS) referral, call made to Centralized Intake
06/01/2022	Special Investigation Initiated - On Site Unannounced onsite inspection completed
06/01/2022	Inspection Completed On-site I interviewed Resident B, Resident C and direct care worker, Shenellie Peters
06/09/2022	Contact - Telephone call made Coordination with Adult Protective Services (APS) worker, Heather Stickel
06/09/2022	Contact - Telephone call made Coordination with Recipient Rights Specialist, Briana Squibb
06/09/2022	Contact - Telephone call made Interview completed with direct care worker, Kenyatta Williams
06/09/2022	Contact - Telephone call made Interview completed with home manager, Jennifer Callaghan
06/10/2022	Contact - Telephone call made Voicemail left for direct care worker, Martika Cunningham. Return call requested

06/13/2022	Contact - Telephone call made Voicemail left for direct care worker, Martika Cunningham. Return call requested
06/17/2022	Contact - Telephone call made Interview completed with direct care worker, Martika Cunningham
06/27/2022	Exit Conference Completed Exit Conference with licensee designee, Marlene Burgess via telephone

ALLEGATION:

Per incident reports, Resident A was transported to the hospital after complaining her side was hurting. While at the hospital, Resident A reported that she threw pop in staff's face and staff pushed her down. She was diagnosed with fractured ribs.

INVESTIGATION:

On 05/31/22, I received a complaint from Adult Protective Services (APS), indicating on Saturday, 05/28/22, Resident A was upset with a staff member, Kenyatta Williams. Resident A was in the shower and Ms. Williams walked into the bathroom to ask her about her medication. Resident A sprayed Ms. Williams with the water hose. Later in the day, Resident A walked from the dining room to the living room and poured her pop on Ms. William's face. Resident A then threw a coffee mug at Ms. Williams and hit her. Resident A slipped and fell on the pop but did not want medical attention. On Sunday,05/29/22, Resident A complained of pain in her right side. Resident A was taken to St. Joseph Hospital and had three fractured ribs. Resident A was admitted to the hospital. Resident A stated to hospital staff that she did not slip in the pop, Ms. Williams pushed her causing her to fall. While in the hospital, on 06/04/22, Resident A died.

I initiated my investigation on 06/01/22, by conducting on unannounced onsite inspection at the Fox River Home. While at the home I interviewed Resident B, Resident C and direct care worker, Shenellie Peters.

On 06/01/22, I conducted an unannounced onsite inspection at the Fox River Home. I interviewed direct care worker, Shenellie Peters. Ms. Peters stated she has been employed with this company for five years. She picks up shifts at the Fox River home and usually works the morning shift with the home manager from 9:00 am – 3:00 pm. Ms. Peters said that she heard from the home manager, there was an incident over the weekend that involved Resident A and Resident A is currently in the hospital, but she has no further details.

Ms. Peters stated Resident A uses a walker. She has never witnessed Resident A fall. Resident A at times becomes upset and acts out, saying she wants to move however, she has never witnessed Resident A become physically aggressive. Ms. Peters does not work with Ms. Williams; however, she does interact with her during passing and at shift change. Ms. Peters stated Ms. Williams does not speak to other staff and she does not like Ms. Williams' attitude or her demeanor. Ms. Peters stated she has never witnessed Ms. Williams push Resident A.

On 06/01/22, I observed Resident C sleeping in a recliner chair in the living room. Resident C was prompted to wake up to be interviewed. Resident C refused to participate in this investigation.

On 06/01/22, I interviewed Resident B. Resident B stated, "(Resident A) put pop in (Ms. Williams) eye." Resident B said it happened in the kitchen at the kitchen table. Resident B remarked, "I watched her do it." Resident B stated all of a sudden Resident A fell, "I think she pushed her." Resident B was asked if she saw Ms. Williams push Resident A. Resident B said, "Yep."

On 06/06/22, I reviewed an Incident Report (IR) written by the home manager, Jennifer Callaghan, dated 06/04/22. The IR stated on 06/04/22, Resident A died in St Joseph Mercy Oakland Hospital. She was admitted to the hospital on 05/29/22, for fractured ribs and chronic obstructive pulmonary disease (COPD.)

On 06/09/22, I interviewed Adult Protective Service (APS) worker, Heather Stickel. Ms. Stickel stated her case is substantiated for physical abuse of Resident A by Kenyatta Williams. Ms. Stickel stated that she interviewed Resident A on 05/31/22, at Royal Oak Beaumont Hospital prior to her death. Resident A said that she threw pop in the face of Ms. Williams and hit her with a cup. Resident A said Ms. Williams then pushed her from the back, causing her to fall on the floor on her side, hitting herself on something on the way down.

Ms. Stickel stated that she coordinated with the Recipient Rights Specialist, Briana Squibb who received a verbal summary of Resident A's discharge paperwork from Resident A's hospital social worker (name unknown.) Ms. Stickel explained, because Resident A is deceased and she did not have a guardian St. Joseph Hospital was unable to release Resident A's medical records therefore, a verbal summary was provided. Ms. Stickel stated she was informed from Ms. Squibb that Resident A was diagnosed with acute traumatic rib fractures of 7 and 8 on the right side. At the time of Resident A's death, she had multiple closed fractures of ribs on the right side. Resident A had COPD. She experienced complications due to her inability to clear secretions and

poor respiratory functioning. Ms. Stickel was further informed by Ms. Squibb that on 5/30/22, an X-ray technician noted in Resident A's chart that Resident A refused to cough up secretions due to pain in right side which caused mucus plugging to worsen plural effusion (fluid buildup in the lining of the lungs.)

Ms. Stickel stated on 06/09/22, she coordinated with Waterford Police Department (PD) Sergeant White and, despite declining to investigate initially, prior to Resident A's death, Waterford PD will be conducting interviews. Per Ms. Stickel, Waterford PD Sergeant White spoke to the Medical Examiner's Office and Resident A's death was ruled an accident.

On 06/09/22, I received an email from APS worker Ms. Stickel providing her interview with Resident A. Relevant portions are quoted below:

> "Adult Protective Service worker interviewed Resident A on 05/31/2022 at 1:05pm at RO Beaumont." "Nurse Joslyn advised (Resident A) has no discharge date as of yet as she is currently on IV antibiotics for pneumonia and her oxygen level is low. She stated (Resident A) is very tired and it is unknown why but is not from any medications."
>
> "(Resident A) was very groggy for the duration of the visit and was, at times, difficult to understand as she was slurring her words. (Resident A) stated she met earlier today with the Office of Recipient Rights and informed them of what happened to her. She stated a couple of days ago she was naked in the shower and Kenyatta (last name unknown), a staff member at the home (Resident A) resides in, barged into the bathroom, and began to yell at (Resident A.) (Resident A) denied knowing what Kenyatta was yelling at her about and stated she sprayed Kenyatta with shower head. She stated later on she was in the kitchen, and she was still mad at Kenyatta, so she threw pop on Kenyatta's face. (Resident A) advised Kenyatta is very bossy and unkind to the residents in the home. She stated when she threw the pop at Kenyatta and also tried to hit her in the face with the cup, Kenyatta got upset and pushed (Resident A) with both hands on her shoulders from the back. (Resident A) stated she fell to the tile ground on her side. She stated she did not realize she had injured herself until yesterday when she was in pain and diagnosed with three broken ribs. (Resident A) denied slipping on the wet floor and was insistent that Kenyatta pushed her, causing the injury…"

On 06/09/22, I interviewed Recipient Rights Specialist, Briana Squibb. Ms. Squibb confirmed the details provided by Ms. Stickel. Ms. Squibb stated during her investigation she determined the two staff who worked the afternoon shift on 05/28/22, are related. Ms. Williams is Ms. Cunningham's mother. Ms. Squibb stated she will be substantiating her investigation.

On 06/09/22, I conducted a telephone interview with home manager, Jennifer Callaghan. Ms. Callaghan stated on 06/04/22, she was informed by Resident A's family member that Resident A died. Ms. Callaghan stated she is unaware of Resident A's cause of death.

Ms. Callaghan said according to Ms. Williams, on Saturday, 05/28/22, Resident A had a cup of pop in her hand, walked into the living room and threw the pop at Ms. Williams. Resident A slipped on the pop and fell landing on her walker. Ms. Callaghan stated Resident A uses a walker with wheels, the walker has a seat. Ms. Callaghan was told Resident A declined assistance getting up off the floor. Once she got herself up, Resident A sat down in a recliner chair in the living room.

Ms. Callaghan stated on 05/28/22, Resident A denied medical assistance. Resident A does not have a guardian and therefore makes her own medical decisions. Ms. Callaghan stated Resident A was checked for injuries, none were observed. Ms. Callaghan took Resident A to St. Joseph Hospital on Sunday, 05/29/22 after she reported pain in her side. While at the hospital, Resident A reported she fell because a staff pushed her. Per Ms. Callaghan, Resident A did not provide a name of the staff person who pushed her.

Ms. Callaghan stated Resident A had a history of COPD and was a smoker. Resident A was not ill and had not experienced any recent COPD flair up. Ms. Callaghan described Resident A as pleasant and happy. Resident A moved into the Fox River home on December 28, 2021. Since living in the home Resident A has not exhibited physical aggression towards others. Ms. Callaghan stated Resident A typically sat at the kitchen table and drank her pop without issue and without leaving the table. The behavior displayed by Resident A on 05/28/22, was unusual.

Ms. Callaghan stated Ms. Williams has worked at this home for ten years. She has no concerns about the care she provides to the residents. Ms. Callaghan stated per the direction of Macomb County Office of Recipient Rights, Ms. Williams is currently off the schedule at Fox River pending the investigation.

On 06/10/22, I conducted a telephone interview with Kenyatta Williams. Ms. Williams has been employed with this company for 18 years as a direct care worker. Ms. Williams stated on Saturday, 05/28/22, she worked a double shift. She worked from 7:00 am – 3:00 pm with the home manager, Ms. Callaghan. Then, from 3:00 pm – 11:00 pm with Martika Cunningham.

Ms. Williams stated after lunch on 05/28/22, Resident A said that she wanted to go outside to smoke then take a shower. Ms. Callaghan assisted Resident A with showering. Ms. Williams stated that Resident A is prescribed a pain patch that she

wears on her back. The patch is good for 12 hours. Ms. Williams applied the pain patch to Resident A's back earlier that morning. While Resident A was in the shower, Ms. Williams overheard Ms. Callaghan asking Resident A where her pain patch was, because it was not on her back. Ms. Williams went into the bathroom to tell Ms. Callaghan that she applied the patch to Resident A's back earlier, Resident A became upset. Ms. Williams stated Resident A sprayed her with the shower hose. Ms. Williams exited the bathroom and "gave (Resident A) her space," not directly working with her for the remainder of the morning shift. Ms. Williams stated during the afternoon shift Resident A made phone calls to her case manager leaving voicemails saying that she wanted to move from the home. Ms. Williams said she informed the other staff on shift, Ms. Cunningham that she was giving Resident A her space because she attacked her earlier.

Ms. Williams stated she was sitting on the couch and "out of the blue" Resident A walked up to her holding a cup of pop. Ms. Williams described the cup as "a soup bowl with a handle." Ms. Williams stated Resident A approached her slowly then splashed pop in her face. Then, Resident A started swinging at her and hit her in the head two times with the cup. Ms. Williams stated Resident A hit her on her left forearm and above her right eyebrow leaving a knot on her head. Ms. Williams stated then, Resident A "tripped or stumbled" causing her to fall onto the tile floor in the kitchen near the kitchen table. Ms. Williams said she had pop in her eye and therefore was unable to explain exactly how Resident A fell. Ms. Williams said Resident A uses a walker, the walker was behind Resident A when she fell. Ms. Williams stated she does not know which way Resident A was facing when she fell to the ground. Ms. Williams remarked, Resident A "could have hit the walker when she fell." Ms. Williams stated after Resident A fell, she observed Resident A on the floor. Ms. Williams stated, "she was on her butt laying down, but getting up." Ms. Williams left the room and went into the office to remove herself from the situation. Ms. Cunningham told Ms. Williams that Resident A got herself up independently and sat in her lazy boy chair in the living room.

Ms. Williams stated she has never known Resident A to become physically aggressive as such, this behavior was unusual. Ms. Williams denied that she pushed and/or became physically aggressive with Resident A. Ms. Williams denied witnessing anyone push and/or become physically aggressive with Resident A. Ms. Williams said Resident B and Resident C were in the living room when this incident occurred. When asked if Ms. Williams knew how Resident A fractured her ribs she remarked, "it had to be from the fall."

On 06/17/22, I conducted a telephone interview with Martika Cunningham. Ms. Cunningham has been employed with the company since October 2021 as a direct care worker. Ms. Cunningham stated she worked on Saturday, 05/28/22, from 3:00 pm – 11:00 pm with Kenyatta Williams. Ms. Williams is Ms. Cunningham's mother. Ms. Cunningham stated at shift change she was informed by Ms. Williams that Resident A attacked her earlier in the day. As a result, she agreed to provide care to Resident A during the shift.

Ms. Cunningham stated Ms. Williams was in the living room, she did not see Resident A approach Ms. Williams. When she looked over Resident A splattered pop in Ms. Williams face then began swinging her cup towards Ms. Williams. Ms. Williams looked shocked, she screamed. Ms. Cunningham tried to verbally redirect Resident A. Resident A hit Ms. Williams in the head with the cup one to two times. Ms. Cunningham said she continued to try and verbally redirect Resident A asking her to stop, she did not comply. Then, Resident A fell over. Resident A's walker was behind her when she fell. Ms. Cunningham stated Resident A fell onto the floor landing on her butt. Resident A got herself up and sat in her recliner chair in the living room. Ms. Cunningham stated that she asked Resident A if she was okay. Resident A indicated she was fine and declined medical attention. Ms. Williams went into the staff office and called the home manager to report what had occurred. Ms. Cunningham stated she recalls Resident B being in the living room when this incident occurred.

Ms. Cunningham described Resident A as "a very nice lady," and further indicated physical aggression is unusual for Resident A. Ms. Cunningham denied that she pushed and/or became physically aggressive with Resident A. Ms. Cunningham denied witnessing anyone push and/or become physically aggressive with Resident A. Ms. Cunningham stated she believes Resident A's injuries were a result of her falling.

On 06/17/22, I reviewed an additional complaint with the same allegations. The complainant indicated that Resident A's death was a result of being pushed by a staff.

On 06/21/22, I interviewed Relative A via telephone. Relative A said Resident A told her that a staff came into the bathroom while she was showering and started yelling at her. Resident A sprayed the staff with water. Later that day, the same staff person pushed Resident A from behind and she fell. Resident A did not provide any further details, nor did she say the name of the staff person who pushed her. Resident A's death certificate states her cause of death is broken ribs. Relative A was asked to provide a copy of the death certificate.

On 06/21/22, I reviewed Resident A's death certificate. Her date of death was 06/04/22. Her death was due to or a consequence of a fracture of the bony chest cage and complications thereafter. The manner of death was ruled an accident. The date of injury was 05/29/22, as a result of a fall at the group home.

I completed an exit conference with licensee designee, Marlene Burgess, on 06/27/2022. I informed her of the violation found and that a copy of the special investigation report would be e-mailed once approved. I also informed her that a corrective action plan would be requested, and a provisional license was recommended.

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: (b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that direct care worker Kenyatta Williams used physical force against Resident A on 05/28/22. Prior to her death, Resident A consistently reported in the hospital, when interviewed by APS, and to Relative A that on 05/28/22, she threw pop in the face of Ms. Williams and hit her with a cup. Then, Ms. Williams pushed her, causing her to fall. Ms. Williams denied pushing Resident A however, Resident B corroborated the information provided by Resident A stating she witnessed Ms. Williams push Resident A on 05/28/22. Resident A died on 06/04/22, due to or as the consequence of the injuries she sustained from being pushed.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 the information gathered through my investigation, there is sufficient information to conclude that the home did not provide adequate protection and safety for Resident A. On 05/28/22, Resident A threw pop in Ms. Williams face and hit her with a cup. Then, Ms. Williams pushed Resident A resulting in Resident A fracturing ribs on her right side.
CONCLUSION:	**VIOLATION ESTABLISHED**

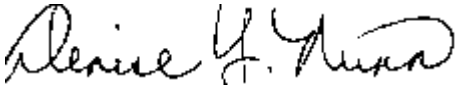
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend modification of the license to a six-month provisional license.

06/27/2022

Johnna Cade — Date
Licensing Consultant

Approved By:



06/29/2022

Denise Y. Nunn — Date
Area Manager