GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 22, 2022

Rochelle Greenberg
Medical Alternatives Inc
#120
24301 Catherine Ind. Dr
Novi, MI 48375

RE: License #: AS630397262
Investigation #: 2022A0605032
Ripple Creek

Dear Mrs. Greenberg:

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,

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630397262
Investigation #:	2022A0605032
Complaint Receipt Date:	05/09/2022
Investigation Initiation Date:	05/09/2022
Report Due Date:	07/08/2022
Licensee Name:	Medical Alternatives Inc
Licensee Address:	#120 24301 Catherine Ind. Dr Novi, MI 48375
Licensee Telephone #:	(248) 473-1139
Administrator/Licensee Designee:	Rochelle Greenberg
Name of Facility:	Ripple Creek
Facility Address:	23839 Ripple Creek Novi, MI 48375
Facility Telephone #:	(248) 473-1139
Original Issuance Date:	08/28/2019
License Status:	REGULAR
Effective Date:	02/28/2022
Expiration Date:	02/28/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Incident report (IR) received regarding Resident A fell at 9.55PM on 05/08/2022 and instead of calling 911, direct care staffs (DCS) Felicia Williams and Jamilia Twyman picked up Resident A and placed her in her wheelchair. Resident A was transported to the hospital via the group home transport van at 10:55PM. Resident A sustained a broken fracture and requires surgery. DCS Felicia Williams and Jamilia Twyman did not seek immediate medical attention per company protocol.	Yes

III. METHODOLOGY

05/09/2022	Special Investigation Intake 2022A0605032
05/09/2022	APS Referral Adult Protective Services (APS) referral made.
05/09/2022	Special Investigation Initiated – Telephone Telephone call with Quality Improvement Manager Sherry Lynn Navarro regarding allegations.
05/10/2022	Contact - Document Received The Quality Improvement Manager, Sherry Lynn Navarro emailed the policy on transfers, gait belt, and how to safely get someone up.
05/11/2022	Contact - Face to Face I conducted face-to-face interviews with staff at Medical Alternatives, Inc, office at 24301 Catherine Drive, Ste 120, Novi 48375. I interviewed the following staff Jamilia Twyman, Felecia Williams, Brandon Porcaro, Demaria Wynn and Executive Director/Registered Nurse Daniel Eaton regarding the allegations. I also interviewed occupational therapist Nicole Garcia. I reviewed training documents for gait belt, transfers, and falls and staff meeting agenda and sign-in sheet.

05/11/2022	Inspection Completed On-site I conducted an on-site at the group home and observed the bathroom where Resident A fell.
06/01/2022	Contact - Document Received The Quality Improvement Manager, Sherry Lynn Navarro emailed the policy on when to call 911 and staff meeting minutes, staff meeting sign-in sheet and safe handling training for DCS Jamilia Twyman and Felicia Williams.
06/07/2022	Contact - Document Received Adult Protective Services (APS) worker Ra'Shawnda Robertson is investigating these allegations.
06/22/2022	Exit Conference Left detailed message for licensee designee Rochelle Greenberg with my findings.

ALLEGATION:

Incident report (IR) received regarding Resident A fell at 9.55PM on 05/08/2022 and instead of calling 911, direct care staffs (DCS) Felicia Williams and Jamilia Twyman picked up Resident A and placed her in her wheelchair. Resident A was transported to the hospital via the group home transport van at 10:55PM. Resident A sustained a broken fracture and requires surgery. DCS Felicia Williams and Jamilia Twyman did not seek immediate medical attention per company protocol.

INVESTIGATION:

On 05/09/2022, I received a telephone call from the Quality Improvement Manager Sherry Lynn Navarro regarding allegations. Ms. Navarro stated DCS Felicia Williams and DCS Jamilia Twyman did not follow Medical Alternative's Inc., protocol regarding Resident A after Resident A fell. Ms. Navarro stated the protocol/procedure for Resident A is that if Resident A has a fall and Resident A cannot assist in getting herself up, then staff must call 911. Ms. Navarro stated that DCS have been trained not to lift Resident A up off the floor if Resident A cannot assist in getting up. Ms. Navarro stated it was over an hour before Resident A was transported to Providence Hospital by DCS Yvette Blackwell. I scheduled a face-to-face interview for 05/11/2022 with all the DCS that were involved with Resident A's fall on 05/08/2022.

On 05/10/2022, I received an email from Sherry Lynn Navarro with a corrective action plan (CAP) that was implemented regarding Resident A's fall. The CAP is as follows: DCS Felicia Williams, DCS Jamilia Twyman, manager on duty Brandon Pocaro, case coordinator Demaria Wynn and RN Daniel Eaton to review the 911 memo and protocol, and complete refresher handling training with the Occupational Therapist Nicole Garcia

or Kelley Lee. In addition, Ms. Williams, Ms. Twyman, and Mr. Porcaro received a written warning, Ms. Wynn received a conversation recording and coaching and Mr. Eaton received a verbal warning. Ms. Navarro included the training that all the staff completed as part of the CAP.

On 05/11/2022, I conducted face-to-face interviews with staff at Medical Alternatives, Inc, office at 24301 Catherine Drive, Ste 120, Novi, MI 48375. I interviewed the following staff: Jamilia Twyman, Felecia Williams, Brandon Porcaro, Demaria Wynn and Executive Director/Registered Nurse Daniel Eaton regarding the allegations. I also interviewed occupational therapist Nicole Garcia.

On 05/11/2022 I interviewed direct care worker (DCW) Jamilia Twyman. Ms. Twyman stated she has been employed with this company since 07/13/2022. She typically works on the midnight shift from 11:00 pm – 7:00 am. Ms. Twyman stated on Sunday, 05/08/22, she worked with Felecia Williams. Ms. Twyman stated at 9:20 pm Ms. Williams was sitting at the table charting in book. She completed a bed check; all the residents were in bed. After finishing the bed check she went outside to smoke a cigarette. Ms. Twyman after she finished smoking, she came inside and went to the bathroom. Ms. Twyman stated while she in the bathroom, Ms. Williams yelled out for her stating Resident A fell. Ms. Twyman stated she ran out of the bathroom and observed Resident A laying on the bathroom floor. Resident A's wheelchair was near the toilet. Ms. Twyman explained Resident A was laying on her side, she had fell onto the floor and her body was positioned partially in the walk-in shower. Ms. Twyman stated she asked Resident A if she hit her heard and she said no. Ms. Twyman stated she and Ms. Williams assisted Resident A up off the floor and sat her back into her wheelchair. Ms. Twyman stated she looked Resident A over for injuries, no injuries were observed. Ms. Twyman stated when Resident A falls the policy states, she is to not assist her up. Staff should call 911 and assess her for injuries. Ms. Twyman explained Resident A should not be assisted up after a fall as it can cause injury to her and/or staff. Ms. Twyman stated Resident A does not fall frequently. She wears a gait belt and when she fell on 05/08/2022, she was wearing the gait belt which was used to assist her up. Ms. Twyman stated when she helped Resident A up off the floor as Resident A was unable to assist herself up. Resident A held onto to her, and the gait belt was used to aid in the transfer. Ms. Twyman stated she asked Ms. Williams to call the manager on duty, Brandon Porcaro. Mr. Porcaro told Ms. Williams to call Resident A's case coordinator, Deemaria Wynn. Ms. Twyman called Ms. Wynn, but Ms. Wynn did not answer. Ms. Twyman stated she believes Mr. Porcaro called and informed Ms. Wynn of the incident because when Ms. Wynn returned her call and stated she (Ms. Wynn) was already informed of what happened. Ms. Twyman was directed to contact Dan Eaton, RN/Executive Director. Mr. Eaton indicated that Resident A needed to be taken to the hospital. Ms. Twyman stated Mr. Porcaro called her and said he was going to come to the home and transport Resident A to the hospital. Ms. Twyman stated she and Ms. Williams began to get Resident A dressed and ready for the hospital. Ms. Twyman stated Mr. Porcaro arrived at the home around the same time as the midnight manager on duty, Yvette Blackwell. Ms. Twyman stated, Ms. Blackwell transported Resident A to

the hospital. Ms. Twyman stated she was never directed to call 911 to transport Resident A to the hospital.

On 05/11/2022, I interviewed DCS Felecia Williams. Ms. Williams stated she has been employed with this company for six months. She typically works the afternoon shift from 3:00PM–11:00PM. Ms. Williams stated on Sunday, 05/08/2022, she worked with Jamilia Twyman. Ms. Williams stated at 9:00 pm she was charting in the resident books at the table. At 9:15 pm Resident A came out of her bedroom and asked her to assist her with hanging a picture on the wall. Ms. Williams told Resident A she would come and help her after she finished writing in the books. Ms. Williams stated Resident A left to go back into her bedroom then she heard a scream. Ms. Williams stated she jumped up and walked towards Resident A's bedroom when she found Resident A in the bathroom on the floor. Ms. Williams stated Resident A was laying on her back near the toilet, half of her body was in the walk-in shower. Ms. Williams asked Resident A if she was hurt, and Resident A said her right thigh was sore. Ms. Williams called out for Ms. Twyman. Ms. Williams stated she and Ms. Twyman used Resident A's gait belt to lift her up and sit her back in her wheelchair. Ms. Williams explained, Resident A was not wearing her gait belt when she fell. Staff obtained the gait belt to assist Resident A up. Resident A did not appear to be in pain however she stated she was having pain in her right leg. Ms. Williams reports Ms. Twyman began making calls to report the fall and she wrote an IR. Ms. Williams called Mr. Porcaro and Ms. Twyman was handling all other calls. She does not know what was discussed during those calls. Yvette Blackwell, midnight manager on duty arrived at the home and transported Resident A to the hospital. Ms. Williams stated the protocol when Resident A falls is to call 911 and not assist her up. Ms. Williams has never seen Resident A fall before and when she fell, she was shocked. Ms. Williams stated she reacted first without thinking and assisted Resident A off the floor. Ms. Williams explained Resident A usually asks staff for assistance when she needs to use the bathroom and staff help to transfer her. Ms. William further stated Resident A was toileted just before this incident and she was wearing an adult brief.

On 05/11/2022, I interviewed DCS, Brandon Porcaro. Mr. Porcaro stated he has worked for this company since 2016. He typically works the afternoon shift from 3:00 pm–11:00 pm. Mr. Porcaro stated he is the manager on duty. Which means staff contact him with questions and report any issues to him as they occur. Mr. Porcaro stated on 05/08/2022, he received a call from Ms. Twyman who indicated Resident A fell and stated her right leg was sore. Mr. Porcaro directed Ms. Twyman to contact the Case Coordinator, Deemaria Wynn. Mr. Porcaro stated Ms. Twyman ended the call with him and contacted Ms. Wynn. Mr. Porcaro received a return call from Ms. Twyman asking for Mr. Eaton's phone number which he provided. Mr. Porcaro stated at 10:16 pm he received a call from Brad who stated Resident A needed to be taken to the Emergency Room. Mr. Porcaro went to the home to transport Resident A. When Mr. Porcaro arrived, Ms. Twyman and Ms. Williams were preparing Resident A for transport. Yvette Blackwell, midnight manager on duty also arrived at the home at this time. Mr. Porcaro stated Ms. Blackwell transported Resident A to the hospital. Mr. Porcaro stated all staff received training on 04/21/2022, that indicated when Resident A falls, 911 should be

called and she is not to be assisted up. Mr. Porcaro stated he did not advise the staff on shift to call 911.

On 05/11/2022 I interviewed Executive Director & RN, Daniel Eaton. Mr. Eaton stated on 05/08/2022, at 10:00 pm he noticed that he had a missed call from Ms. Twyman. Mr. Eaton tried calling her back three times, there was no answer. Mr. Eaton called the house phone, there was no answer. Mr. Eaton then called Ms. Wynn who informed him that Resident A fell. Ms. Wynn further stated Resident A was back in her wheelchair and was reporting pain in her right leg. Mr. Eaton advised that Resident A be taken to the Emergency Room. Mr. Eaton stated he did not direct any staff to call 911. Mr. Eaton was not aware until the following day that staff assisted Resident A up after she fell. Mr. Eaton stated the procedure when Resident A falls is to call 911 and not assist her up. Mr. Eaton stated all staff were trained on this procedure by OT, Nicole Garcia.

On 05/11/2022, I interviewed Case Coordinator, Demaria Wynn. Ms. Wynn has worked for this company for 30 years. Ms. Wynn stated the company policy if someone falls, and they cannot get themselves up, is to call 911 and not assist them up. Ms. Wynn stated Resident A does not fall frequently, but she is at high risk of falls. Ms. Wynn stated OT, Nicole Garcia trained staff two weeks ago on the procedure for falls. Ms. Wynn stated on 05/08/2022, at 9:30 pm she received a call from Ms. Twyman who informed her that Resident A fell, and she was back in her wheelchair. She was informed that Resident A was reporting pain in her right leg. Ms. Wynn stated she indicated that Resident A needed to be taken to the Emergency Room. Ms. Wynn stated she spoke to Mr. Porcaro, and he arranged for Ms. Blackwell to transport Resident A to the hospital.

On 05/11/2022, I conducted an on-site inspection at the group home and observed the bathroom where Resident A fell. I also observed Resident A’s wheelchair in Resident A’s bedroom. I was unable to interview Resident A as she was still in the hospital.

On 06/01/2022, the Quality Improvement Manager, Sherry Lynn Navarro emailed the policy on when to call 911 and staff meeting minutes, staff meeting sign-in sheet and safe handling training for DCS Jamilia Twyman and Felicia Williams. I reviewed training documents for gait belt, transfers, and falls and staff meeting agenda and sign-in sheet completed on 08/26/2021 regarding “When to call 911 - Medical Emergency.” I reviewed the Universal Training Document dated 07/16/2020 for both DCS Felicia Williams and Jamilia Twyman that was completed and signed by Ms. Williams and Ms. Twyman regarding specific protocol on gait belt, transfers using sliding board and falls.

On 06/07/2022, APS worker Ra'Shawnda Robertson sent an email indicating she is investigating these allegations.

On 06/22/2022, I conducted the exit conference via telephone with licensee designee Rochelle Greenberg with my findings. Ms. Greenberg stated Ms. Navarro has already implemented the training with all the staff involved and has already forwarded the CAP compliance verification to me. However, Ms. Greenberg will submit a CAP to reflect what was implemented with the staff.

APPLICABLE RULE	
R 400.14310	**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 my investigation and information gathered, DCS Felicia Williams and DCS Jamilia Twyman did not obtain needed medical care immediately after Resident A fell. Resident A had an unwitnessed fall in the bathroom on 05/08/2022. Instead of Ms. Williams and Ms. Twyman following Medical Alternative, Inc., protocol regarding Resident A, to call 911 immediately if a resident has an unseen fall and the resident is unable to get themselves up, Ms. Williams and Ms. Twyman began contacting staff members within Medical Alternatives, Inc. Ms. Twyman contacted the manager on duty Brandon Porcaro, case coordinator Demaria Wynn, and RN Daniel Eaton regarding Resident A's fall; however, no one advised Ms. Twyman to call 911. According to the Quality Improvement Manager Sherry Lynn Navarro, all staff members have been trained since 2020 regarding the protocol/procedure specifically for Resident A if she falls. The protocol for Resident A is to call 911 immediately especially if the fall is unwitnessed. In addition, the OT Nicole Garcia stated she has conducted several trainings with all staff members of Medical Alternatives, Inc., regarding the protocol on falls, specifically Resident A, but 911 was never contacted. Resident A was transported by another manager on duty over an hour later to the hospital. Resident A had a fractured right femur resulting in surgery.
CONCLUSION:	**VIOLATION ESTABLISHED**

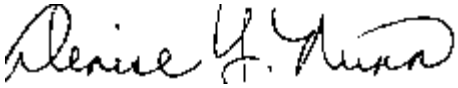
IV. RECOMMENDATION

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

06/22/2022

Frodet Dawisha — Date
Licensing Consultant

Approved By:



06/22/2022

Denise Y. Nunn — Date
Area Manager