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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 04, 2022

Sharon Cuddington
Trinity Continuing Care Services
Suite 200
17410 College Parkway
Livonia, MI 48152

RE: License #: AL810261123
Investigation #: 2022A0122043
St. Joseph's Village #2

Dear Ms. Cuddington:

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) 284-9720.

Sincerely,

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL810261123
Investigation #:	2022A0122043
Complaint Receipt Date:	09/28/2022
Investigation Initiation Date:	09/28/2022
Report Due Date:	11/27/2022
Licensee Name:	Trinity Continuing Care Services
Licensee Address:	Suite 200 17410 College Parkway Livonia, MI 48152
Licensee Telephone #:	(810) 989-7492
Administrator:	Sharon Cuddington
Licensee Designee:	Tori Dober
Name of Facility:	St. Joseph's Village #2
Facility Address:	2nd Floor 5341 McAuley Dr. Ypsilanti, MI 48197
Facility Telephone #:	(734) 712-1600
Original Issuance Date:	03/31/2005
License **Status:**	REGULAR
Effective Date:	10/10/2021
Expiration Date:	10/09/2023
Capacity:	19
Program Type:	PHYSICALLY HANDICAPPED

	AGED

II. ALLEGATION(S)

	Violation Established?
On 09/06/2022, staff member, Shantina Shelly, struck Resident A on the arm.	Yes

III. METHODOLOGY

09/28/2022	Special Investigation Intake 2022A0122043 APS Referral
09/28/2022	Special Investigation Initiated - On Site Completed interviews and resident file review.
09/30/2022	Contact – Document received Received requested information Tori Dober via email.
10/03/2022	Contact – Telephone call made Completed interview with Shantina Shelly, staff member.
10/03/2022	Contact – Telephone call made Completed interview with Relative A.
10/03/2022	Exit Conference Discussed findings with Sharon Cuddington, Licensee Designee.

ALLEGATION: On 09/06/2022, staff member, Shantina Shelly, struck Resident A on the arm.

INVESTIGATION: On 09/28/2022, I completed an interview with Tori Dober, Administrator of St. Joseph's Village #2 adult foster care group home. Mr. Dober stated he was made aware of the allegation two days later 09/08/2022. Once he received the information, he made a police report with the Washtenaw Sheriff's Department. He took Ms. Shelly off the staff schedule and completed an internal investigation. Per Mr. Dober, it was reported that Ms. Shelly grabbed Resident A's wrist to help her up rather than use the gait belt that is an approved assistive device for that purpose.

On 09/28/2022, I completed an interview with Resident A. Resident A reported that staff member Shantina Shelly was "kinda rough" while giving her assistance but "don't think she meant to hurt me." Resident A further stated that "the skin on my

body is really thin and doesn't matter where you touch me it will get blue." Resident A stated Ms. Shelly grasped my wrist and that was how she was injured.

On 10/03/2022, I completed an interview with staff member, Shantina Shelly. Ms. Shelly confirmed that she assisted Resident A with getting dressed on 09/06/2022 which also included assistance with transferring positions from sitting, standing, and walking. Ms. Shelly stated while assisting Resident A with changing her shirt, Resident A made the statement that it was painful. Once Ms. Shelly heard this she stopped and assisted Resident A with removing her undergarments and pants.

Per Ms. Shelly, She assisted Resident A without further incident and was informed later of the allegation made that involved her. Ms. Shelly denied striking Resident A. She stated that she assisted Resident A with transferring to different positions by holding her under the arms. Ms. Shelly stated she did not use an assistive device, a gait belt, when assisting Resident A when transferring from one position to another.

On 10/03/2022, I completed an interview with Relative A. Relative stated she had been informed about the incident on 09/06/2022 involving Resident A and staff member, Shantina Shelly. Relative A reported that she believes that Ms. Shelly may have grabbed Resident A too tight while trying to assist her unintentionally hurting her. Relative A stated she had no problems and/or concerns with the care that Resident A is receiving and believes that this issue will be addressed appropriately through staff training.

On 10/03/2022, I reviewed documents from Resident A's file. Resident A's information sheet states the following: "please be careful when doing care for this resident she has very thin skin and it is easily injured as well as bruised. Gait belt is to be used with all transfers." Resident A's Assisted Living Assessment dated 06/04/2022 states, "Resident always uses gait belt with all transfers."

On 10/03/2022, I completed an exit conference with Sharon Cuddington, Licensee Designee. Ms. Cuddington was in agreement with my findings and stated she would submit a corrective action plan to address the rule violation found.

APPLICABLE RULE	
R 400.15308	**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:	On 09/06/2022, it was alleged that Resident A was struck on the arm by staff member, Shantina Shelly. On 09/28/2022, Resident A reported that staff member, Shantina Shelly, grasped her wrist while giving her assistance unintentionally causing her pain. On 09/28/2022, Mr. Dober reported that Ms. Shelly grabbed Resident A's wrist to help her up rather than use the gait belt that is an approved assistive device for that purpose. On 10/03/2022, Shantina Shelly denied striking Resident A on the arm but stated she gave assistance with transferring from different positions without using a gait belt, an approved assistive device. Based upon my investigation I find that no physical was used when staff member, Shantina Shelly, was providing assistance to Resident A on 09/06/2022. Ms. Shelly provided assistance without using the approved assistive device thereby unintentionally causing harm to Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(1) An assistive device shall only be used to promote the enhanced mobility, physical comfort, and well-being of a resident.

ANALYSIS:	On 09/28/2022 Mr. Dober, reported that Shantina Shelly grabbed Resident A's wrist to help her up rather than use the gait belt that is an approved assistive device for transferring assistance. On 10/03/2022, Shantina Shelly denied striking Resident A on the arm but stated she gave assistance with transferring from different positions without using a gait belt, an approved assistive device. On 10/03/2022, I reviewed documents from Resident A's file. Resident A's information sheet states the following: "…Gait belt is to be used with all transfers." Resident A's Assisted Living Assessment dated 06/04/2022 states, "Resident always uses gait belt with all transfers." Based upon my investigation I find that on 09/06/2022 staff member Shantina Shelly did not use the approved gait belt when transferring Resident A into different positions therefore the assistive device was not used to promote the physical comfort, and well-being of a resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan I recommend no change in the status of the license.

Vanita C. Bouldin
Licensing Consultant
Date: 10/03/2022

Approved By:

Ardra Hunter
Area Manager
Date: 10/04/2022