



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 29, 2022

Tanisha Johnson
Victory AFC INC
14 Victory Court
Saginaw, MI 48602

RE: License #: AS730362423
Investigation #: 2022A0576049
Victory AFC INC

Dear Ms. Johnson:

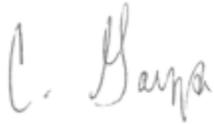
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,

A handwritten signature in cursive script that reads "C. Garza".

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730362423
Investigation #:	2022A0576049
Complaint Receipt Date:	08/02/2022
Investigation Initiation Date:	08/02/2022
Report Due Date:	10/01/2022
Licensee Name:	Victory AFC INC
Licensee Address:	14 Victory Court, Saginaw, MI 48602
Licensee Telephone #:	(989) 971-9333
Administrator:	Tanisha Johnson
Licensee Designee:	Tanisha Johnson
Name of Facility:	Victory AFC INC
Facility Address:	2525 Mackinaw Street, Saginaw, MI 48602
Facility Telephone #:	(989) 971-9333
Original Issuance Date:	05/05/2015
License Status:	REGULAR
Effective Date:	11/05/2021
Expiration Date:	11/04/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, ALZHEIMERS, DEVELOPMENTALLY DISABLED, MENTALLY ILL AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 07/29/22, law enforcement was called to the AFC home due to Resident B slapping Resident A on the hand. Resident A lost control of his body and fell over his wheelchair causing his leg to get stuck. Resident A suffered a femur break to his right leg.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/02/2022	Special Investigation Intake 2022A0576049
08/02/2022	APS Referral
08/02/2022	Special Investigation Initiated - Letter Reviewed Incident Report (IR)
08/16/2022	Inspection Completed On-site Interviewed Licensee Designee, Tanisha Johnson
08/16/2022	Contact - Document Received Reviewed Police Report
09/22/2022	Contact - Telephone call made Interviewed Staff, Tanisha Ship
09/22/2022	Contact - Telephone call made Interviewed Staff, Bernice Anglin
09/22/2022	Contact - Telephone call made Interviewed Resident A
09/22/2022	Contact - Telephone call made Interviewed Resident C
09/23/2022	Contact - Document Received Reviewed Incident Reports and Resident B AFC Assessment Plan
09/29/2022	Contact - Telephone call made Interviewed Guardian B
09/29/2022	Contact - Telephone call made

	Interviewed A & D Case Manager, Cadaccee Sullivan
09/29/2022	Exit Conference Exit Conference conducted with Licensee Designee, Tanisha Johnson

ALLEGATION:

On 07/29/22, law enforcement was called to the AFC home due to Resident B slapping Resident A on the hand. Resident A lost control of his body and fell over his wheelchair causing his leg to get stuck. Resident A suffered a femur break to his right leg.

INVESTIGATION:

On August 2, 2022, I reviewed 2 AFC Licensing Division – Incident / Accident Reports (IR). The first IR was dated for July 28, 2022, and authored by Licensee Designee, Tanisha Johnson. The IR documented that on July 27, 2022, Resident C was attempting to get passed Resident B while Resident B was blocking the door. Resident B punched Resident C in the arm. Corrective measures indicated that Resident B’s guardian, Guardian B was notified, and he and Resident B’s case manager are looking for another AFC home for Resident B to reside. The 2nd IR was dated for July 29, 2022, and authored by Tanisha Johnson. The IR documented that on July 29, 2022, Resident A was in his motorized wheelchair coming down the hallway. Resident B smacked Resident A’s hand causing him to lose his balance in his chair. Resident A did not fall to the floor, but his half of his body was out of the chair and his right leg was caught in the chair. Staff assisted Resident A back to his chair and 911 was contacted. Corrective measure indicated that on July 27, 2022, the Licensee Designee contacted Resident B’s guardian to find him another placement due to his combative behaviors. The IR documented that Resident B was moved from the home.

On August 16, 2022, I completed an unannounced on-site inspection at Victory AFC and interviewed Licensee Designee, Tanisha Johnson who reported Resident A has lived at the home since June 15, 2021, and does not have a guardian. Ms. Johnson explained that Resident A has muscular dystrophy and has “no motion of body”. Resident A cannot move his arms or legs and utilizes a wheelchair. Resident A’s wheelchair is motorized, and Resident A can operate the chair with his hand. Regarding the allegations, Resident A was coming out of his bedroom, down the hall in his chair, and Resident B slapped Resident A’s hand. Ms. Johnson did not know why Resident B slapped Resident A’s hand. Resident A lost his balance and his leg got caught in between the seat and arm of the chair causing the injury to Resident A’s leg. Resident A was assisted to his bed and explained he heard a “pop”. Resident A was taken to the hospital about 20 minutes after the injury occurred and was diagnosed with a broken femur. Resident A required surgery to repair the broken bone. Ms. Johnson does not think Resident B meant to harm Resident A intentionally and afterward said he

was sorry. The police were contacted regarding this incident and the prosecutor called Ms. Johnson however she is not certain Resident B will be prosecuted.

Resident B no longer lives at the home and was moved immediately after the incident involving Resident A. Resident B has limited comprehension and limited verbal skills. Resident B had surgery about 3 months ago to remove a kidney and since that time has been more agitated according to Ms. Johnson. Ms. Johnson explained that she believed things were progressing with respect to Resident B's combative behavior. Resident B has lived at the home since July 2021, and has a guardian, Guardian B.

Ms. Johnson reported that the incident involving Resident A and Resident B occurred on Friday, July 27, 2022, and on Wednesday July 25, 2022, she contacted Guardian B to have Resident B moved due to him punching Resident C in the arm. Ms. Johnson advised Guardian B that Resident B was too combative, and Guardian B agreed to move him from the home.

Ms. Johnson reported that in February 2022, there was an incident between Resident A and Resident B. Resident B shut the front door on staff and Resident A directed Resident B to open the door. Resident B hit Resident A in the arm and opened the door. Ms. Johnson contacted Guardian B who came out and spoke to the residents and Resident A said to "give Resident B another chance" and he did not have to move from the home. Subsequently, Resident B remained at the home at that time.

On August 16, 2022, I went to the City of Saginaw Police Department and obtained the police report (#2271704220) involving Resident A and Resident B. The report was dated for July 29, 2022, and authored by Officer Jordan Bady. The report documented Resident A as the victim and Resident B as the suspect. Officer Bady was dispatched to St. Mary's Hospital for an assault report. Resident A has muscular dystrophy and was backhanded out of his power chair by Resident B. Resident A's relative, Relative A provided a statement to Officer Bady and said Resident A was punched in the face approximately 2 months ago by Resident B. Resident A reported he was in his powered wheelchair going to get coffee. Resident B was sitting at a table and backed away from the table and backhanded him. Resident A said he fell out of his chair and hung by his leg. Resident A was picked up by staff and taken to his room. Resident A reported his leg is broken. Resident A reported he was assaulted by Resident B in the past because he told him to open a door for staff. Resident B also assaulted another resident in the home in the past. Guardian B was interviewed and advised Resident B had a stroke many years ago and is wheelchair bound. Resident B has no function of his lower extremities and is nonverbal.

On September 22, 2022, I interviewed Staff, Tanisha Ship who reported she was working at the time of allegations. Ms. Ship explained she assisted Resident A out of bed, and he came out of his room. She was in the kitchen along with her coworker, Bernice Anglin and heard Resident A screaming. Ms. Ship heard Resident A yelling "help, help!" and she came out of the kitchen to find Resident A "dangling" over his chair. Ms. Ship picked up Resident A and took him to his bed. Resident A said

Resident B punched him, he fell from his chair, and complained of his leg hurting. According to Ms. Ship, Resident B cannot speak well however he said, "why me?" Resident B also utilizes a wheelchair as he is paralyzed on his right side, per Ms. Ship. Ms. Ship explained that both residents "mess with each other" and she has heard them arguing before. Staff would try to keep the residents separated when they were arguing with each other. Resident A is a 25-year-old Caucasian male and Resident B is a 71-year-old African American male. Ms. Ship reported Resident A has told Resident B to "shut the fuck up" and calls him the "N-word". Resident A has never hit Resident B and Resident B has hit Resident A on at least 2 other occasions, once in the face and once in his leg. Ms. Ship reported Resident A's leg has since healed and staples were taken out 2 weeks ago. Resident B no longer resides at the home.

On September 22, 2022, I interviewed Staff, Bernice Anglin who reported she has worked at the facility for 4 months. Ms. Anglin was working at the time of the allegations, and she did not see what happened however heard Resident A yell. Resident A reported Resident B punched him and he fell over in his wheelchair. Staff, Tanisha Ship got Resident A to his bed and 911 was contacted. Resident B was in his chair saying, "Why me, why me?" Ms. Anglin reported to her knowledge this incident was the first time Resident B hit Resident A. Since the time she has worked at the facility, she has never known Resident B to hit anyone however she heard Resident B hit Resident C in the past.

On September 22, 2022, I interviewed Resident A who reported he has lived at his home since June 2021, and he does not have a guardian. Regarding the allegations, Resident A reported he was driving out of his bedroom and Resident B struck him in the hand causing him to fall over and break his leg. Resident A did not know why Resident B hit him in the hand and this was the 4th time Resident B hit him. Resident A did not remember the dates when Resident B hit him and the most recent was because Resident B locked a staff person out of the home. Resident A told Resident B to open the door and Resident B punched Resident A in the face. Resident A almost fell out of his chair and when the staff person was let in the home, she helped him back in his chair. This incident occurred in June or July 2022. There were 2 other times when Resident B slugged Resident A in the arm with his fist. Resident A did not know why Resident B hit him and explained that Resident B has "fits of rage" when he does not have cigarettes. According to Resident A, staff did not do anything to keep Resident B from hitting him. Resident B has also hit Resident C in his arm and tried to trip him however he did not fall.

On September 22, 2022, I interviewed Resident C who reported he has lived at his home for about 3 years and "it's alright". Regarding the allegations, Resident C reported he saw Resident B hit Resident A while Resident A was in his motorized wheelchair. Resident B hit Resident A in his arm with his fist and Resident A went over sideways. Resident B also hit Resident C in his arm with his fist a couple weeks before the incident with Resident A. Resident C did not know why Resident B hit him and he had never hit him before. Resident C is happy that Resident B no longer lives at the home, and no one is hitting him.

On September 29, 2022, I interviewed Guardian B who reported that Licensee Designee, Tanisha Johnson contacted him to report that Resident A and Resident B did not get along. Resident B was exhibiting aggressive behavior and there were some incidents between the two residents. Guardian B went to the home to speak with Resident B and explained he needed to display better behavior and to get along with the other residents, or he would have to move. Resident B did not want to move and although Resident B is nonverbal, Guardian B believes Resident B knew what the consequences would be if he continued to act out. Guardian B denied any concerns regarding the home and stated the home is small and felt the staff did their best to keep the 2 residents apart.

On September 23, 2022, I reviewed Resident B's AFC Assessment Plan which revealed Resident B does not control aggressive behavior. It is documented that Resident A gets angry when needs are misunderstood / staff will redirect. It is also noted that Resident B does not get along with others and is very aggressive. Resident B does not like to share and takes other's belongings / staff will redirect.

On September 23, 2022, I received and reviewed an IR dated for June 8, 2022, and authored by Tanisha Johnson. The IR lists "date of incident" as "5/31/22". The IR documented the following: "1-2-22 Resident A was in Resident B's room watching tv with Resident B's roommate. Resident B appeared to want Resident A out of his room and struck him on the leg. 2nd incident. 6-3-22 Resident B was guarding the door when Resident A was trying to open it (living room). Resident B struck Resident A on the side of the head." Corrective measures taken by staff indicate that on June 8, 2022, Guardian B came to visit Resident B about the incidents. Guardian B also spoke to Resident A. Resident A stated he would give Resident B one more chance and if it happens again, he will request him to be removed.

On September 29, 2022, I interviewed Resident A's Case Manager, Cadaccee Sullivan from A & D Waiver who reported she has been Resident A's case manager for 1 year. Ms. Sullivan reported she was told that another resident slapped Resident A's hand causing him to sustain an injury. Resident A reported to her that the same resident had hit him before however it was not a big deal as it did not hurt. According to Ms. Sullivan, it was explained to her that the resident hit Resident A because Resident A was in his bedroom. Ms. Sullivan spoke to Ms. Johnson about what occurred between the two residents and Ms. Johnson spoke to the residents about not going in other resident bedrooms.

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:	<p>It was alleged that Resident A was hit by Resident B causing him to lose balance in his wheelchair. Resident A's leg became caught in his chair resulting in a broken leg. After completion on investigative interviews with residents and staff, and a review of documentation, there is a preponderance of evidence to conclude a rule violation.</p> <p>Resident A reported Resident B hit him in his hand causing him to lose balance in his chair resulting in a significant injury. Resident B fell over and his leg became stuck in the chair resulting in a broken femur. Resident A reported he had been hit by Resident B three times prior to this incident.</p> <p>Resident C was interviewed and reported he was hit by Resident A. Resident A hit Resident C in his arm with his fist.</p> <p>Incident Reports were reviewed, and they indicated Resident B was assaultive with Resident C and Resident A on multiple occasions. Resident B's guardian was contacted however no significant corrective measures were taken to ensure the safety of the residents in the home.</p> <p>Licensee Designee, Tanisha Johnson was interviewed and stated that Resident B's had become more agitated and he displayed increasingly combative behavior over the past 3 months at the home.</p> <p>There is a preponderance of evidence to conclude Resident A's safety and protection was not attended to at all times. Resident B had a history of assaultive behaviors, and no meaningful corrective or safety measures were enacted to ensure resident safety.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On September 23, 2022, I received and reviewed an IR dated for June 8, 2022, and authored by Tanisha Johnson. The IR lists "date of incident" as "5/31/22". The IR documented the following: "1-2-22 Resident A was in Resident B's room watching tv with Resident B's roommate. Resident B appeared to want Resident A out of his room and struck him on the leg. 2nd incident. 6-3-22 Resident B was guarding the door when

Resident A was trying to open it (living room). Resident B struck Resident A on the side of the head.” Corrective measures taken by staff indicate that on June 8, 2022, Guardian B came to visit Resident B about the incidents. Guardian B also spoke to Resident A. Resident A stated he would give Resident B one more chance and if it happens again, he will request him to be removed.

APPLICABLE RULE	
R 400.14311	Investigation and reporting of incidents, accidents, illnesses, absences, and death.
	<p>(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following:</p> <p>(c) Incidents that involve any of the following:</p> <ul style="list-style-type: none"> (i) Displays of serious hostility. (ii) Hospitalization. (iii) Attempts at self-inflicted harm or harm to others. (iv) Instances of destruction to property.
ANALYSIS:	<p>There is a preponderance of evidence to conclude a rule violation in that the licensee did not provide adult foster care licensing a written report within 48 hours displays of hostility and attempts of harm to others by Resident B.</p> <p>On September 23, 2022, I reviewed an incident report (IR) dated for June 8, 2022, and authored by licensee designee, Tanisha Johnson. The IR documented 2 separate incidents of combative behavior by Resident B toward Resident A that took place on January 2, 2022, and June 3, 2022, respectively. These incidents were not reported in writing to adult foster care licensing within 48 hours.</p>
CONCLUSION:	VIOLATION ESTABLISHED

On September 29, 2022, I conducted an Exit Conference with Licensee Designee, Tanisha Johnson. I advised Ms. Johnson I would be requesting a corrective action plan with respect to the cited rule violations.

IV. RECOMMENDATION

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



9/29/2022

Christina Garza
Licensing Consultant

Date

Approved By:



9/29/2022

Mary E. Holton
Area Manager

Date