GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 20, 2022

Renee Ostrom
Residential Alternatives Inc
P.O. Box 709
Highland, MI 48357-0709

RE: License #: AS630012764
Investigation #: 2022A0612012
Timber Hill AIS

Dear Ms. Ostrom:

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,

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 #:	AS630012764
Investigation #:	2022A0612012
Complaint Receipt Date:	08/16/2022
Investigation Initiation Date:	08/16/2022
Report Due Date:	10/15/2022
Licensee Name:	Residential Alternatives Inc
Licensee Address:	14087 Placid Dr Holly, MI 48442
Licensee Telephone #:	(248) 369-8936
Administrator:	Renee Ostrom
Licensee Designee:	Renee Ostrom
Name of Facility:	Timber Hill AIS
Facility Address:	555 Timber Hill Dr Ortonville, MI 48462
Facility Telephone #:	(248) 369-8936
Original Issuance Date:	10/28/1992
License Status:	REGULAR
Effective Date:	07/03/2021
Expiration Date:	07/02/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 08/13/22, Resident A was diagnoses with a humerus fracture of the upper arm. Resident A alleged that direct care staff, Robert Johnson hurt him.	Yes

III. METHODOLOGY

08/16/2022	Special Investigation Intake 2022A0612012
08/16/2022	APS Referral Recipient Rights Specialist, Sarah Rupkus stated that this incident was reported to Adult Protective Services (APS)
08/16/2022	Special Investigation Initiated – Telephone I called Recipient Rights Specialist, Sarah Rupkus to coordinate
08/16/2022	Contact - Telephone call received I completed a telephone interview with area manager, LaShonda Lindsey
08/23/2022	Contact - Document Received Recipient Rights Specialist, Darlita Paulding emailed me a copy of Resident A's Individuals Plan of Service (IPOS) and Crisis Plan
08/24/2022	Inspection Completed On-site In collaboration with Recipient Rights Specialist Darlita Paulding, I completed an onsite investigation. I interviewed licensee Renee Ostrom, Resident B, Resident C, home manager Rosalind Alexander, area manager, LaShonda Lindsey, direct care staff Robert Johnson, Melita Jurick and MaChristina Quick
08/24/2022	Contact - Document Received Area manager, LaShonda Lindsey provided me with a copy of Resident A's McLaren Clarkston Emergency Room discharge paperwork, Resident A's Royal Oak Beaumont Hospital discharge paperwork, two pictures of Resident A's left arm, and a copy of Timber Hills August 2022 staff schedule

08/25/2022	Contact - Document Received Recipient Rights Specialist, Darlita Paulding emailed me five Incident Reports (IR's) for review
08/25/2022	Contact - Telephone call made I completed a second interview via telephone with home manager Rosalind Alexander and direct care staff Melita Jerick. I also interviewed Resident A's guardians (father & step- mother) via telephone
08/25/2022	Contact - Document Received Adult Protective Services (APS) worker, Tamiesha Williams emailed me her interview with Resident A
08/29/2022	Contact - Telephone call made I completed a telephone interview with direct care staff, Ebony Jones
08/29/2022	Exit Conference I held an exit conference via telephone with licensee, Renee Ostrom

ALLEGATION:

On 08/13/22, Resident A was diagnoses with a humerus fracture of the upper arm. Resident A alleged that direct care staff, Robert Johnson hurt him.

INVESTIGATION:

On 08/16/22, I received a complaint from the Office of Recipient Rights which indicates, on 08/13/22, Resident A was taken to the emergency room because of a bruised and swollen upper arm. An x-ray determined that Resident A had a "humerus fracture of the upper arm." Home manager, Rosalind Alexander, stated that she spoke to Resident A and asked him if the male staff who was on shift hurt him and he said, yes. The staff that was on shift at that time was Robert Johnson and MaChristina Quick. I initiated my investigation with a call to Recipient Rights Specialist, Sarah Rupkus to coordinate. Ms. Rupkus informed me that the case had been transferred to Recipient Rights Specialist Darlita Paulding. On 08/24/22, Ms. Paulding and I completed an onsite investigation. I interviewed area manager, LaShonda Lindsey, home manager, Rosalind Alexander, direct care staff, Robert Johnson, direct care staff, Melita Jurick, direct care staff, MaCristina Quick, licensee, Renee Ostrom, Resident B, and Resident C.

On 08/16/22, I received a telephone call from area manager, LaShonda Lindsey. Ms. Lindsey stated Adult Protective Services (APS) completed a home visit on 08/16/22, regarding this allegation. Ms. Lindsey provided the name and contact information for the assigned APS worker. Ms. Lindsey stated Resident A moved into the home on April 1,

2022. Resident A answers yes to any question that he is asked. Resident A has pathologic bones, which means his bones break and he bruises easily. Ms. Lindsey denied that Resident A was physical abused by any Timber Hill staff.

On 08/23/22, Recipient Rights Specialist, Darlita Paulding emailed me a copy of Resident A's Individual Plan of Service (IPOS) and Crisis Plan. Resident A's IPOS indicates that he is mostly nonverbal. Resident A utilizes a wheelchair with seat belt, gait belt, glasses, and Ankle/foot orthotis (AFO's) for his legs. Resident A wears a BioSleeve five days per week for seven to eight hours. The Left Upper Extremity BioSleeve Muscle Stimulation System is a rehabilitation tool for the left arm to manage muscle atrophy and muscle spasms.

On 08/24/22, I completed a second interview with area manager, LaShonda Lindsey. Ms. Lindsey stated she has worked in this home for three years. On 08/13/22, she worked 11:00 pm – 8:00 am. At 8:00 am she went into Resident A's bedroom to get him up for the day. Resident A sat up in his bed but refused to get up and did not want to eat breakfast. Ms. Lindsey stated she did not observe bruising on Resident A's left arm at that time. Ms. Lindsey was relieved from shift by direct care staff, Melita Jurick. She told Ms. Jurick that Resident A did not want to get out of bed, and he did not have breakfast. Ms. Lindsey then ended her shift.

At 1:30 pm, Ms. Jurick called Ms. Lindsey and said Resident A still would not get out of bed or eat. She advised Ms. Jurick to continue to encourage Resident A to get up and eat and to keep monitoring him. During this phone call, Ms. Jurick informed Ms. Lindsey that she observed a bruise on Resident A's right thigh. Ms. Jurick was directed to document the injury and Ms. Lindsey would take Resident A to urgent care the following day, 08/14/22. Per Ms. Lindsey, Ms. Jurick did not observe the bruising on Resident A's left arm and therefore, never mentioned it to her during this phone call.

At 9:00 pm, Ms. Lindsey received a phone call from direct care staff, MaChristina Quick. Ms. Quick informed her that Resident A's left arm was bruised and swollen. Ms. Quick took pictures of the injury and sent them to Ms. Lindsey. Ms. Lindsey stated there were two direct care staff on shift, MaChristina Quick and Robert Johnson. She asked that Mr. Johnson take Resident A to the emergency room. Mr. Johnson took Resident A to McLaren emergency room. They diagnosed Resident A with a broken arm and stated he needed to go to Beaumont Hospital for further treatment. Mr. Johnson took Resident A to Beaumont where he stayed until 4:00 pm on 08/14/22. Beaumont X- rayed Resident A's arm and provided him with a sling. Resident A was sent home with a referral for an orthopedic surgeon and advised to follow up to scheduled surgery. Ms. Lindsey consulted with Resident A's guardian who advised that Resident A has an orthopedic surgeon who he has worked with in the past. Ms. Lindsey followed up with Resident A's guardians' preferred surgeon. Resident A had surgery on 08/24/22, at Royal Oak Beaumont Hospital. Ms. Lindsey stated she was informed that Resident A had the same surgery on his right arm prior to moving into the Timber Hill AFC in April 2022. Ms. Lindsey stated Resident A has a medical diagnosis of pathological fracture which causes his bones to break easily.

Ms. Lindsey stated she was informed by APS worker, Tamiesha Williams, that while in the hospital Resident A reported direct care staff, Robert Johnson hurt him. Ms. Lindsey stated Resident A is minimally verbal and answers yes to most questions that he is asked. Ms. Lindsey stated she asked Resident A how he hurt himself and further asked if he fell. Resident A took her into the bathroom. She assumed Resident A was suggesting that he fell in bathroom but could not verbalize this. Ms. Lindsey stated when Resident A was interviewed by APS worker, Ms. Williams he was asked a string of questions about how he sustained the injury. Resident A answered yes to every question that he was asked. Ms. Lindsey stated APS worker, Ms. Williams asked Resident A if Robert hurt him. Resident A said, “yeah.” APS worker, Ms. Williams then asked Resident A if the person who hurt him was in the home right now. Resident A said, “yeah.” Ms. Lindsey stated direct care staff, Robert Johnson was not in the home at that time of his interview with APS.

On 08/24/22, I completed an interview with direct care staff Robert Johnson. Mr. Johnson stated he has been employed with this company for a year and a half. He worked on 08/13/22, from 9:00 pm – 8:00 am with direct care staff, MaChristina Quick. Mr. Johnson stated Ms. Quick observed bruising on Resident A’s left arm. He was asked by area manager, Ms. Lindsey to take Resident A to the emergency room. Mr. Johnson took Resident A to McLaren emergency room, they diagnosed him with a left arm fracture and advised that he go to Beaumont Hospital for further treatment. Mr. Johnson took Resident A to Beaumont Hospital, they completed x-rays and stated the injury appeared to be a result of a fall. Mr. Johnson stated Resident A is very active he crawls, gets out of his bed, and his wheelchair. However, he has not observed Resident A fall or have any accidents recently. Mr. Johnson denied physical abuse against Resident A. Mr. Johnson further denied that any Timber Hill staff was physically abusive to Resident A. Mr. Johnson stated Resident A has not had any physical contact with any of his housemates that could have resulted in this injury. Mr. Johnson stated he was informed by Resident A’s surgeon that Resident A has fragile bones that break easily. Resident A had the same injury to his right arm prior to moving into Timber Hill AFC.

On 08/24/22, I completed an interview with direct care staff MaChristina Quick. Ms. Quick stated she has been employed with this company for 10 months. She worked on 08/13/22, from 9:00 pm – 9:00 am with direct care staff, Robert Johnson. Ms. Quick stated when she arrived on shift, she relieved direct care staff Melita Jurick. She was informed by Ms. Jurick that Resident A had not gotten out of bed today and was refusing to eat. Ms. Quick went into Resident A’s bedroom, and he was sleeping which is unusual for Resident A because he is very active. Ms. Quick woke up Resident A and asked him if he was okay. Resident A stared at her. Ms. Quick began assisting Resident A with sitting up in bed. At that time, she observed the bruising and swelling to his left arm. Ms. Quick called area manager, Ms. Lindsey and was advised to have direct care staff, Mr. Johnson take Resident A to the emergency room. Ms. Quick stated she has no idea how Resident A sustained an injury to his arm. Ms. Quick denied physical abuse against Resident A. Ms. Quick further denied that any Timber Hill staff was physically abusive to Resident A. Ms. Quick stated Resident A is very active and crawls

around the house a lot. Ms. Quick has not witnessed Resident A fall or have any accidents recently. Ms. Quick stated she regularly works with Mr. Johnson and she has never seen him being aggressive towards the residents in the home. She stated Mr. Johnson is very helpful and she has no concerns with the care he provides the residents.

On 08/24/22, I completed an interview with direct care staff Melita Jurick. Ms. Jurick stated she has worked for this company for three years. On 08/13/22, she worked from 8:00 am – 9:00 pm with direct care staff, Ebony Jones. Ms. Jurick stated when she arrived on shift, she was informed by area manager, Ms. Lindsey, and direct care staff, Ms. Quick that Resident A was still in bed, he was refusing to get up and did not want to eat. Ms. Jurick stated around 10:00 am she went into Resident A's bedroom and encouraged him to get up and eat he said, no. She came back at 10:30 am and tried again, Resident A again refused. Ms. Jurick asked Resident A if he would drink some water. He agreed and sipped some water through a straw. She then asked Resident A if he wanted to get up and go to the bathroom. Resident A chose to use his bedside urinal. Ms. Jurick stated she pulled the blankets back to allow Resident A to sit up and us the urinal at which time she observed a bruise on his left thigh. Ms. Jurick called area manager, Ms. Lindsey to inform her of the bruising. Ms. Jurick stated she never observed bruising to Resident A's left arm because his arms were under the blankets. Ms. Jurick stated when her shift ended, she informed the next staff on shift, Ms. Quick that Resident A had not gotten out of bed or eaten. Ms. Jurick stated she does not work on shift with Mr. Johnson so she cannot speak to the way he interacts with the residents in the home. Ms. Jurick denied that she physically abused Resident A. Ms. Quick stated she did not observe Resident A fall or have any accidents in the home that could have resulted in this injury.

On 08/24/22, I completed an interview with home manager, Rosalind Alexander. Ms. Alexander stated she has worked for this company since June 2022. On 08/12/22, she worked 8:00 am – 12:00 pm. She was off on 08/13/22 and 08/14/22. She returned to work on 08/15/22, she worked 8:00 am – 6:00 pm with direct care staff Ebony Jones. Ms. Alexander stated when she arrived at work on 08/15/22, she noticed that Resident A's arm was in a sling. She asked Resident A if anyone hurt him and he said, "yeah." She then asked Resident A if it happened last night, he said, "yeah." She asked Resident A if it was a guy or a girl who hurt him, he said "yeah." She asked if it was Robert and he said, "yeah." Ms. Alexander stated, Robert Johnson is the only male staff at Timber Hill. Ms. Alexander does not know if Mr. Johnson hurt Resident A, but this is what Resident A reported to her. Resident A cannot communicate fully however, when he is asked a question if the answer is no, Resident A will not respond. If the answer is yes, Resident A will say "yeah." Ms. Alexander stated area manager, Ms. Lindsey "blows (Resident A) off" because Ms. Lindsey believes Resident A answers yes to any question that he is asked. Ms. Alexander has never worked on shift with direct care staff Mr. Johnson, but she has observed him interacting with the residents in the home. She has never witnessed Mr. Johnson being aggressive or physically abusive to any resident. She remarked, he is always kind.

Ms. Alexander stated the staff who work in the home are great with the residents. Ms. Alexander denied that she was physically abusive to Resident A. Ms. Alexander stated she has not witnessed Resident A fall or have any accidents that may have caused this injury. Ms. Alexander stated on Friday, date unknown, Resident A broke the back of the toilet which he has done before. This occurred while she was on shift with direct care staff, Melita Jurick.

On 08/24/22, I completed an interview with Resident B. Resident B stated he has lived in the home for one year. Resident B stated the staff do a good job with him. Resident B stated he likes working with Mr. Johnson. Mr. Johnson treats him and Resident A good. Resident B stated he is not sure how Resident A broke his arm.

On 08/24/22, I observed Resident C sitting in his wheelchair in the dining room at his home. Resident C is nonverbal and was unable to be interviewed for this investigation. Resident C appeared appropriately groomed, dressed, and comfortable. He smiled and acknowledged me.

On 08/24/22, I completed an interview with licensee designee, Renee Ostrom. Ms. Ostrom stated she assumes the injury was caused by a fall. Resident A is very active he transfers himself out of his wheelchair and crawls around the house. Ms. Ostrom stated Resident A is fairly new to the home, his Individual Plan of Service (IPOS) did not detail all of his behaviors and abilities. Ms. Ostrom stated she does not have any concerns about direct care staff, Robert Johnson, and the care he provides to the residents in the home.

On 08/24/22, I reviewed the Timber Hill staff schedule for August 2022. All staff who worked from 08/12/22 – 08/14/22, were interviewed.

On 08/24/22, I reviewed Resident A's McLaren Clarkston Emergency Department discharge paperwork. The paperwork is dated 08/14/22, and in summary indicates Resident A was diagnosed with a left humerus arm fracture. This condition may be caused by a fall, a hard direct hit to the arm, or a car accident.

On 08/24/22, I reviewed Resident A's Royal Oak Beaumont Hospital discharge paperwork. The paperwork is dated 08/14/22, and in summary, states, Resident A was diagnosed with a left arm fracture. He was referred to an orthopedic surgeon. Resident A's medical history includes a pathological fracture of right humerus.

On 08/24/22, I observed two photos of Resident A's left arm. These photos were sent to me from area manager, Ms. Lindsey. In the photos Resident A's left arm is swollen and black and blue.

On 08/25/22, I completed a telephone interview with Resident A's father/ guardian. Resident A's guardian stated Resident A is not a reliable source of information. He can answer yes or no questions however, if he were to identify a person it would be

unknown if he was suggesting that person was with him that day or if that person hurt him, it would be speculation. Resident A's guardian stated he was informed that Resident A fell in the bathroom on 08/12/22, but staff were not aware of the fall. He stated Resident A has the ability to transfer himself in and out of his wheelchair and onto the toilet which he does often and has done his whole life. Resident A's guardian stated this does not appear to be an issue of abuse, but one of inadequate supervision/ protection as there should have been staff with Resident A while he was in the bathroom.

On 08/25/22, I completed a telephone interview with Resident A's stepmother/guardian. Resident A's guardian stated Resident A moved into the home in April 2022. Since living in the home he has started to unbuckle the seatbelt on his wheelchair and transfer himself out. Living in a licensed AFC has been a change for Resident A as there are different rules and regulations that are less restrictive than the rules/ boundaries that he has had in previous settings. Resident A's guardian stated Resident A is more active than the other residents who live in the home. On 08/13/22, she received a call from area manager, Ms. Lindsey who said Resident A fell in the bathroom, staff were unaware of the fall. The bruising to Resident A's body was not observed until 9:00 pm on 08/13/22. Resident A has fell in the bathroom once before. Resident A has a high threshold for pain therefore, it is possible that he attempted to transfer himself out of his wheelchair onto the toilet, fell and injured himself, then got back into his wheelchair. Resident A's guardian stated she would be surprised if no one heard this happen however, there are other residents in the home, and they keep the TV volume very high. Resident A's guardian stated Resident A has intensive bruising on his chest, stomach, shoulder, and his arm. Resident A had surgery on 08/24/22. He is still in the hospital. Resident A's guardian and his treatment team are working with the Behavioral Treatment Team Committee to explore the option of using a locking push button seat belt for his wheelchair. This will limit his ability to unbuckle himself and transfer out of his wheelchair.

On 08/25/22, I completed a second interview via telephone with home manager Rosalind Alexander and direct care staff Melita Jerick. Ms. Jerick and Ms. Alexander stated Resident A did not fall in the bathroom the week that he fractured his arm. This incident occurred previously (date unknown.) Ms. Jerick and Ms. Alexander stated when Resident A fell in the bathroom he was taken to the urgent care as he had a bruise under his chin. There was no further medical attention required.

On 08/25/22, APS worker, Tamiesha Williams sent her interview with Resident A via email. In summary, the interview indicates, Ms. Williams completed a face-to-face interview with Resident A. Resident A was observed to be alert however not oriented to place or time. Resident A is non-verbal, but he can understand when someone is speaking with him. He can also respond with head nods or say "yeah." Resident A was observed sitting in his wheelchair. He was wearing a wrap on his left arm. He did not have any visible marks or bruises. Due to Cerebral Palsy and Autism, Resident A was unable to follow the interview process. Ms. Williams spoke with Resident A briefly due to his limited communication skills. Ms. Williams asked Resident A how he was doing

today, and he responded “yeah.” Ms. Williams asked Resident A if his arm was injured, and he relied “yeah.” Ms. Williams asked was it injured by another person, and he stated “yeah.” Ms. Williams asked if the person was there, and he stated “yeah.” Ms. Williams asked if it was Robert and he stated “yeah.” Ms. Williams asked him if he felt safe there and he responded “yeah.” The interview was concluded at that time. Ms. Williams stated direct care staff Robert Johnson was not in the home at the time of her interview.

On 08/25/22, I received an email from Recipient Rights Specialist, Darlita Paulding that included the following Incident Reports (IR’s):

- IR dated 06/03/22, written by direct care staff, Melita Jurick in summary indicates, while assisting Resident A with transferring to the toilet he fell. While falling he grabbed the toilet cover, it broke. Resident A had a scratch on his butt. Resident A’s guardian took him to the doctors.
- IR dated 08/09/22, written by direct care staff, MaChristina Quick in summary indicates, Resident A has a bruise on his right shoulder, left leg, scratch on his face, and his chin. It is unknown how he sustained these injuries.
- IR dated 08/11/22, written by direct care staff, Melita Jurick, in summary indicates, she observed a bruise on Resident A’s chin. Resident A was taken to urgent care.
- IR dated 08/13/22, written by direct care staff, Melita Jurick, in summary indicates, she observed a bruise on Resident A’s thigh.
- IR dated 08/13/22, written by direct care staff, MaChristiana Quick in summary indicates, Resident A’s left arm was swollen and had bruising on the left upper arm, under the armpit. Resident A was taken to the emergency room.

On 08/29/22, I completed a telephone interview with direct care staff, Ebony Jones. Ms. Jones stated she has been employed with the company for one month. She stated she worked on 08/12/22 and 08/13/22. On 08/12/22, Resident A behaved normally, there were no issues or injuries observed. On 08/13/22, Ms. Jones worked from 8:00 am – 4:00 pm with direct care staff Melita Jurick. Resident A refused his breakfast and lunch, he did not want to get out of bed. This behavior was very unusual for Resident A as he is very active. Ms. Jones stated Resident A laid in bed most of her shift. He was laying on his arm. As such, she never observed any swelling or bruising on Resident A’s arm. Ms. Jones stated around noon, Resident A went to the bathroom. When the blankets were pulled back exposing his legs, she observed a bruise on Resident A's left thigh. Area manager, Ms. Lindsey was notified. Ms. Jones stated she works with direct care staff Robert Johnson. Mr. Johnson is helpful and teaches her a lot. Ms. Jones stated she has never observed Mr. Johnson being physically abusive to any of the residents in the home. Ms. Jones denied that she was physically abusive towards Resident A. She stated Resident A tries to transfer himself out of his wheelchair without assistance. He needs assistance and should not transfer himself as he may get hurt. Ms. Jones stated she has not witnessed Resident A have any recent accidents that could have resulted in this injury.

On 08/29/22, I held an exit conference via telephone with licensee, Renee Ostrom. Ms. Ostrom stated they are working with psychiatry to determine if there can be a lock on Resident A's wheelchair seatbelt. Resident A is new to the home, and they are still learning and finding out many things about him that they did not know prior to moving in in. I reviewed my findings with Ms. Ostrom, and she agreed to provide a corrective action plan for the rule violation.

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 upon the information gathered through my investigation, there is sufficient information to conclude Resident A's personal needs, including protection and safety, were not attended to at all times. Resident A sustained a left humerus arm fracture. Area manager, LaShonda Lindsey, home manager, Rosalind Alexander, direct care staff, Melita Jurick, direct care staff, MaCristina Quick, direct care staff, Ebony Jones, and licensee, Renee Ostrom, consistently stated that the cause of this injury is unknown. However, they suspected Resident A may have fell. It was consistently stated by all staff interviewed that Resident A is active. He crawls around the home and transfers himself out of his wheelchair. These are known behaviors of Resident A. As the cause of this injury is unknown, it can be determined that Timber Hill staff failed to attend to Resident A's personal needs, including protection and safety and therefore, he fractured his left arm requiring surgery.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 upon the information gathered through my investigation, there is insufficient information to conclude that direct care staff, Robert Johnson or any Timber Hill staff used physical force against Resident A. Resident A's McLaren Clarkston Emergency Department discharge paperwork indicates a humerus arm fracture could be caused by a fall, a hard direct hit to the arm, or a car accident. According to Resident A's father/guardian, Resident A is not a reliable source of information. Area manager, LaShonda Lindsey, home manager, Rosalind Alexander, direct care staff, Melita Jurick, direct care staff, MaCristina Quick, direct care staff, Ebony Jones, licensee, Renee Ostrom, and Resident B consistently stated that they have never witnessed Mr. Johnson being aggressive or physically abusive to any resident. They further remarked that Mr. Johnson is kind and helpful. There were no concerns reported regarding with the care Mr. Johnson provides to the residents who live in this home. Mr. Johnson denied the allegation. None of the information gathered suggests Mr. Johnson or any Timber Hill staff used physical force against Resident A resulting in a left humerus arm fracture.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

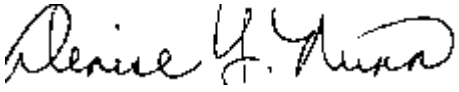
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

08/30/2022

_____

Johnna Cade — Date
Licensing Consultant

Approved By:



09/20/2022

_____

Denise Y. Nunn — Date
Area Manager