GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 1, 2022

Valerie Asberry
Calyx Human Services Inc
49217 Morning Glory Dr.
Macomb, MI 48044

RE: License #: AS820305441
Investigation #: 2022A0121034
Ross Home

Dear Ms. Asberry:

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 (313) 456-0380.

Sincerely,

K. Robinson, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820305441
Investigation #:	2022A0121034
Complaint Receipt Date:	08/08/2022
Investigation Initiation Date:	08/11/2022
Report Due Date:	10/07/2022
Licensee Name:	Calyx Human Services Inc
Licensee Address:	49217 Morning Glory Dr. Macomb, MI 48044
Licensee Telephone #:	(313) 986-3478
Administrator:	Valerie Asberry, Designee
Name of Facility:	Ross Home
Facility Address:	26051 Ross Inkster, MI 48141
Facility Telephone #:	(313) 633-0899
Original Issuance Date:	01/27/2011
License **Status:**	REGULAR
Effective Date:	07/27/2021
Expiration Date:	07/26/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff bring children to work. Residents are not being changed regularly causing skin breakdowns. The licensee asks one resident to do heavy lifting.	Yes
There are lots of medication errors.	Yes
Additional Findings	Yes

***Note**: Some allegations listed in the complaint were not investigated as they are not rule related.*

III. METHODOLOGY

08/08/2022	Special Investigation Intake 2022A0121034
08/11/2022	Special Investigation Initiated - Telephone Call to Valerie Asberry, Licensee designee
08/12/2022	Inspection Completed On-site Interviewed Home Manager, Linda Collins. Reviewed resident records.
08/15/2022	Contact - Telephone call made Follow up call to Valerie Asberry, licensee designee
08/15/2022	Referral - Recipient Rights Online form submitted.
08/17/2022	Contact - Telephone call made Former direct care staff (DCW), Tiara Johnson
08/22/2022	Contact - Telephone call received Jeri Sterrett with the Office of Recipient Rights (ORR)
08/30/2022	Inspection Completed-BCAL Sub. Compliance Interviewed Resident B and Linda Collins
10/12/2022	Contact - Telephone call made Follow up call to ORR, Jeri Sterrett

10/12/2022	Contact – Document received ORR Status report received from Jeri Sterrett
10/24/2022	APS Referral
10/27/2022	Contact - Telephone call made Interview with Relative 1
10/28/2022	Exit Conference Valerie Asberry

ALLEGATION: Staff bring children to work. Residents are not being changed regularly causing skin breakdowns. The licensee asks one resident to do heavy lifting.

INVESTIGATION: On 8/11/22, I initiated the complaint with a phone call to licensee designee, Valerie Asberry. According to Ms. Asberry, the complaint originated from her niece, Tiara Johnson. Ms. Asberry reported Tiara worked for her on/off for years and now Tiara is upset that Ms. Asberry won't give her a raise. Ms. Asberry stated there are 6 residents in care; 5 residents are verbal, and 2 residents use wheelchairs.

On 8/12/22, I completed an onsite inspection at the facility. I interviewed Home Manager, Linda Collins. Ms. Collins is the mother of Tiara Johnson. Ms. Collins confirmed Tiara is upset with her former employer, Ms. Asberry. According to Ms. Collins, Tiara is referring to her as the employee who bring children to work. Ms. Collins denied the allegation. Ms. Collins explained residents and Staff are familiar with her foster children (ages 2, 5, and 10) because she brings them to company outings, like picnics at the park. Ms. Collins also indicated the children would be onsite playing in the backyard, but she said they "never" come inside of the facility. Ms. Collins further explained the children would come to the home with Ms. Asberry or Tiara at shift change; she said Tiara and Ms. Asberry would hand the children off to her when they were done babysitting them while Ms. Collins worked. However, Tiara disputes these claims. Tiara insisted Ms. Collins allows the children to be in the home while she works. Tiara said she has personally observed the children in the home while Ms. Collins covered shifts. On 8/12/22, Resident D reported he has seen Ms. Collins' children at the home. The interview ended abruptly once I noticed Resident D getting agitated with answering questions. I later interviewed Relative 1 to ask about children being at the home. Relative 1 reported she has observed Ms. Collins' "grandchildren or foster children" at the home as recent as "a few months ago." Relative 1 is unsure of the children's ages, but she described them as "they were little kids."

Ms. Collins identified 2 residents as requiring assistance with toileting; however, Resident D prefers to toilet without direct assistance. Per Ms. Collins, Resident D will notify Staff when he has to toilet (typically every 30-45 or more often as needed); he can remove his own diaper. Additionally, Ms. Collins explained Resident A wears "briefs for protection." It is well documented that Resident A uses a colonoscopy bag and catheter. Per Ms. Collins, Resident A has had the colonoscopy bag for 10 years and the catheter 2 years. Ms. Collins acknowledged Resident A suffered from a recent skin breakdown after being hospitalized at Garden City Hospital. Ms. Collins reported she completed a body check on Resident A upon his return home from the hospital and that's when she discovered "bed sores on the heal of his foot, butt, and earlobe." Ms. Collins said she called the hospital immediately to discuss the wounds, but the hospital regarded them as "scratches." As a result, Ms. Collins stated she took Resident A to Beaumont Taylor Hospital the following day for evaluation and treatment. To date, Ms. Collins reported 2 of 3 wounds have completely healed; the wound on his buttocks remains. Ms. Collins reported Resident A attends Dearborn Wound Care for follow up treatment once a month. Resident A's most recent treatment (at the time of my visit) occurred on 8/9/22; he is scheduled for another session on 9/13/22. I reviewed Resident A's, After Visit

Summary from Garden City Hospital to verify his admission; there is no mention of him having bed sores on 10/10/21-10/13/21 or 11/24/21-12/5/21. Based on Resident A's medical records, I determined he requires extensive care. Resident A has cerebral palsy. Resident A's most recent AFC assessment plan documents his need for total care; he cannot talk, walk, or perform any activities for daily living. According to Tiara, Staff often ask Resident B, C, and E to lift Resident A in and out of his wheelchair or bed. Tiara did not identify the Staff by name.

On 9/1/22, I conducted a second onsite inspection at the facility. I interviewed Ms. Collins, Resident B, and reviewed additional records. Resident B acknowledged "sometimes I do lift {Resident A}." When asked the frequency, Resident B replied, "like once a week." Additionally, Resident B identified Ms. Asberry and Ms. Collins as the direct care workers who ask him to lift Resident A. Resident B reported he does not like lifting Resident A because it hurts his back. Per Resident B, he has arthritis in his back. It should be noted that Resident B was not available on my first visit because he had gone to the hospital 20 minutes prior to my arrival for complaints of back pain.

On 10/28/22, I completed an exit conference with Ms. Asberry. Ms. Asberry stated she had no idea Ms. Collins brought children to work. Ms. Asberry indicated she has strict rules and regulations about having children on the premises. According to Ms. Asberry, children are only allowed to attend company events. Ms. Asberry suggested outsiders may be confused if they witnessed the children at a company sponsored event. Ms. Asberry denied residents get bed sores under her care. Ms. Asberry confirmed Resident A got bed sores during his stay at Garden City Hospital. She said they took Resident A to a different hospital the very next day to have the skin tears documented. To date, Ms. Asberry stated Resident A is still in the healing process ("almost healed"). In addition, Ms. Asberry vehemently denied residents are asked or allowed to lift other residents. Ms. Asberry said she does not provide direct care to residents, so she has no reason to ask Resident B to lift anyone. Ms. Asberry kept repeating, "I know that's not true." Ms. Asberry is not in agreement with the department's findings.

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:	• I received 3 separate statements from former direct care worker, Tiara Johnson, Resident D, and Relative 1 who all acknowledged seeing Ms. Collins bring her children to work, thereby impeding Ms. Collins ability to adequately supervise and care for residents especially those who are medically fragile. • There is insufficient evidence to suggest residents have skin breakdowns caused by the Staff's failure to provide care. Ms. Collins reported Resident A returned home from Garden City Hospital with bed sores. Ms. Collins was also able to refute Resident D's diapers are not changed often since he typically changes himself. • Both Tiara and Resident B reported Resident B has lifted Resident A to assist Staff. Because Resident B is not a trained staff person and has a bad back, I determined it is unsafe for him to lift other residents. • Residents cannot perform the job duties of direct care workers. • Licensee designee, Valerie Asberry is complicit is defying the rules as she is named a person who asks Resident B to lift another resident.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: There are lots of medication errors.

INVESTIGATION: According to Tiara, the pharmacy does not always fill prescriptions timely causing residents not to receive their medication as prescribed. Ms. Collins reported the home uses United Specialty Pharmacy to fill and deliver resident medications. Medications are delivered weekly in the form of blister packs per Ms. Collins. On 9/1/22, I asked to see how resident medication is stored. I observed some of Resident A's medication from August was still in the blister pack. Ms. Collins explained the medicine was "leftover" from his recent hospital stay and "this shouldn't be in there" with the September medication. I also observed Resident A's, Pantoprazole Tab 40mg prescribed on 8/6/22 had pills remaining inside of the blister packs. The September blister pack for Pantoprazole was not in the home. Ms. Collins denied residents run out of medication; however, she did not provide an explanation why there were pills left inside the blister pack untouched.

I interviewed Resident B and D to find out how often they get their medication. Resident B reported Staff administer his medication twice daily. Resident D was not willing to discuss his medication routine. Per Ms. Collins, Resident D does not like

to acknowledge he takes medication because he associates it with mental illness; however, she did report all residents are medication compliant.

On 10/28/22, I completed an exit conference with Ms. Asberry. Ms. Asberry acknowledged medication errors occurred, but she insists residents are getting their medication as prescribed. Ms. Asberry said she believes Staff simply forgot to initial the medication administration records to document all medication passes.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	• I observed old medication inside the bin used to administer Resident A's daily standing orders. • I observed gastro medication (pantoprazole) left in the pharmacy supplied container that should have been administered daily to Resident A. • Resident A is medically fragile, so it is imperative that he receive the proper medication regimen to ensure his health, safety, and overall well-being.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

While looking over Resident A's medication administration records (MARs), I observed multiple MARs that do not contain the signature of the person(s) who administered resident medication. Specially, Resident B, C, D, E, F's 3/22, 4/22, 5/22, 6/22, and 7/22 MARs all have missing signatures which does include psychotropic medications. Photocopies of these records were taken.

On 10/28/22, I completed an exit conference with Ms. Asberry. Ms. Asberry agrees with the department's finding, but she assures the department that residents are getting their medication as prescribed. Ms. Asberry blamed the medication errors on former Staff. According to Ms. Asberry, Tiara Johnson and Regina Royal failed to initial the MARs after each medication pass. Both workers are no longer employed at the home. Ms. Asberry indicated she has since increased her presence at the facility to monitor the records and make sure Staff are performing their job duties as required.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (b) Complete an individual medication log that contains all of the following information: (i) The medication. (ii) The dosage. (iii) Label instructions for use. (iv) Time to be administered. (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. (vi) A resident's refusal to accept prescribed medication or procedures.
ANALYSIS:	• I observed medication administration records dating back to March 2022 that were not signed by Staff when administering resident medication. • Staff repeatedly failed to sign the Medication logs sometimes daily.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

10/28/22

Kara Robinson — Date
Licensing Consultant

Approved By:

11/01/22

Ardra Hunter — Date
Area Manager