GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 5, 2022

Karrie Beilfuss
LifeSpan...A Community Service
PO Box 1978
524 North Jackson Street
Jackson, MI 49201-1978

RE: License #: AS380379307
Investigation #: 2023A0007003
Seymour Road Home

Dear Ms. Beilfuss:

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.

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,

Mahtina Rubritius

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604
(517) 763-0211

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380379307
Investigation #:	2023A0007003
Complaint Receipt Date:	11/14/2022
Investigation Initiation Date:	11/15/2022
Report Due Date:	01/13/2023
Licensee Name:	LifeSpan...A Community Service
Licensee Address:	PO Box 1978 524 North Jackson Street Jackson, MI 49201-1978
Licensee Telephone #:	(517) 784-4426
Administrator:	Robert Dangler
Licensee Designee:	Karrie Beilfuss
Name of Facility:	Seymour Road Home
Facility Address:	4361 Seymour Road Jackson, MI 49201
Facility Telephone #:	(517) 395-4309
Original Issuance Date:	12/29/2015
License Status:	REGULAR
Effective Date:	06/29/2022
Expiration Date:	06/28/2024
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On November 11, 2022, Resident A had an altercation with Tyrone Sanders, Direct Care Staff. Resident A sustained an injury to his head that required staples. Mr. Sanders has been suspended and is pending termination.	Yes

III. METHODOLOGY

11/14/2022	Special Investigation Intake- 2023A0007003
11/14/2022	APS Referral Received.
11/14/2022	Contact - Telephone call received message from Ms. Beilfuss.
11/14/2022	Contact - Telephone call made - Case discussion with Ms. Beilfuss.
11/15/2022	Special Investigation Initiated – Telephone call made to Guardian A. Interview.
11/15/2022	Inspection Completed On-site - Unannounced - Face to face contact with Home Manager #2, two direct care staff, Resident A, and another resident.
11/17/2022	Contact - Document Received - Aftercare Summary for Resident A.
12/27/2022	Contact - Document Sent - Email to ORR to confirm they received the referral.
12/27/2022	Contact - Telephone call made to Mr. Sanders, Message left. I requested a returned phone call.
12/27/2022	Contact - Telephone call made to Home Manager #1. Message left. I requested a returned phone call.
12/27/2022	Contact - Telephone call received from Home Manager #1. Interview.

12/27/2022	Contact - Document Received - Email from ORR Officer #1.
12/28/2022	Contact - Telephone call made to Mr. Sanders, No answer.
12/29/2022	Contact - Document Received - Training Records and background check information for Mr. Sanders.
12/29/2022	Contact - Telephone call made to Mr. Sanders, No answer.
12/29/2022	Contact - Telephone call received from Mr. Sanders, Interview.
12/29/2022	Exit Conference conducted with Ms. Beilfuss, Licensee Designee.

ALLEGATIONS:

On November 11, 2022, Resident A had an altercation with Tyrone Sanders, Direct Care Staff. Resident A sustained an injury to his head that required staples. Mr. Sanders has been suspended and is pending termination.

INVESTIGATION:

On November 14, 2022, I spoke with Ms. Beilfuss, Licensee Designee. We discussed the situation. It was reported that Resident A had a bad day, and he was upset over pop. The situation escalated and it was stated that Resident A charged at Mr. Sanders, Direct Care Staff. Mr. Sanders reacted and hit Resident A in the head with the T.V. remote. This caused Resident A to require staples. According to Ms. Beilfuss, given Mr. Sanders' years of experience and training, this situation could have been avoided. Mr. Sanders is going to be terminated tomorrow. Adult Protective Services and Office of Recipient Rights have been contacted. Home Manager #1 was contacted about the incident, and Home Manager #2 came in and covered the remainder of Mr. Sanders' shift.

On November 14, 2022, I interviewed Resident A's guardian, Guardian A. She informed me that facility staff contacted her on-call system right away to inform them of the situation. Guardian A was concerned about the incident and reported that the staff member was immediately removed from the home. Guardian A first received information that Resident A had been accidently hit in the head with a remote and that he was bleeding from the head. They also needed permission to take Resident A to the emergency room. Resident A was taken in for treatment. Guardian A contacted Home Manager #1 and asked how the alleged accident occurred. Home Manager #1 then informed her that it wasn't an accident, and the staff member would be terminated. I inquired if I would be able to interview Resident A and Guardian A informed me that given his diagnosis, he would just repeat what is said

to him. During the interview, Guardian A also wondered how the staples would heal and if Resident A would pick at them. Guardian A informed me that Resident A was scheduled to see his primary physician for a follow-up appointment later that day. In addition, that she would send me the aftercare summary for Resident A.

On November 15, 2022, I conducted an unannounced on-site investigation and made face to face contact with Home Manager #2, and Resident A. There were also two direct care staff and another resident observed in the home.

Home Manager #2 informed me that on Friday, November 11, 2022, around 7:55 p.m., he received a call from Mr. Sanders, who reported that he had a bit of a situation. Home Manager #2 stated that Mr. Sanders did not know how to describe the incident and struggled with coming up with words to describe what happened. Mr. Sanders reported to Home Manager #2 that Resident A was asking for coffee and pop. Resident A had just had coffee. Resident A asked for more coffee. Mr. Sanders says to Resident A “not right now.” This agitated Resident A, and he spit at Mr. Sanders. Home Manager #2 stated, “then the story was weird.” Mr. Sanders said that he forgot he had the remote in his hand. Mr. Sanders was redirecting Resident A to his room. While in the hallway, Resident A charged at Mr. Sanders. Mr. Sanders then said he didn’t know what happened. Mr. Sanders reported to Home Manager #2 that Resident A got “really mad” and somehow the remote hit Resident A in the back of his head. Mr. Sanders told Home Manager #2 that Resident A was bleeding right now. Home Manager #2 asked if Mr. Sanders checked the bleeding and Mr. Sanders said, “No.” Home Manager #2 then called Home Manager #1. Home Manager #1 called Mr. Sanders and he got a different story. Mr. Sanders admitted to Home Manager #1 that he hit Resident A in the back of the head with the remote. Home Manager #1 told Home Manager #2 to get to the house as fast as he could. When Home Manager #2 arrived at the home, Resident A was bleeding down the side of his neck. Mr. Sanders had put two band-aids, cross shaped, over the injury. Home Manager #2 assisted Resident A, cleaned the wound, and placed a bandage around his head. Mr. Sanders was sent home and Home Manager #2 completed the remainder of the shift. The appropriate officials were contacted, including upper management, the guardian, and ORR. Resident A was then taken to the emergency room for treatment.

No other staff witnessed the situation; only Mr. Sanders, Resident A, Resident B, and Resident C were in the home at the time of the incident. According to Home Manager #2, the residents in the home would not be able to provide information about the incident.

According to Home Manager #2, Resident A would reach up and say “ouch, ouch” when touching the staples. While observing Resident A, Home Manager #2 stated that there were questions about Resident A having some additional marks on the back of his head. Resident A also has eczema. I observed two staples on the back of Resident A’s head.

On December 27, 2022, I conducted an interview with Home Manager #1. He recalled that it was a Friday night when he received a text message from Home Manager #2 regarding there being an incident between Mr. Sanders and Resident A; the incident resulted in Resident A having an injury. Home Manager #1 called and spoke to Mr. Sanders, and he confessed that he struck Resident A because he (Mr. Sanders) felt like he was getting attacked. Home Manager #1 stated that he stayed on the phone with Mr. Sanders and was on the other line with Home Manager #2, immediately sending him to the home. It was discovered that earlier that day, Resident A had a bad day. Once home, he was denied access to coffee and water, which caused him to get "heightened." Then the altercation occurred.

I inquired if there had been any issues with Mr. Sanders being aggressive in the past and he stated, there were none with the residents. Home Manager #1 recalled that Mr. Sanders would sometimes have a temper with other staff but was never aggressive towards the residents. Mr. Sanders was fully trained and had been employed for over three years. Mr. Sanders has been terminated.

I inquired how Resident A was doing and Home Manager #1 stated that he seemed to be doing okay. The staples have been removed. In addition, they don't talk about Mr. Sanders in the home.

On December 27, 2022, ORR Officer #1 followed-up and informed me that they received and investigated the complaint. The allegations were substantiated and per the written corrective action plan, Mr. Sanders was terminated on November 15, 2022. Their investigation closed on December 14, 2022.

On December 29, 2022, I conducted the interview with Mr. Sanders. Mr. Sanders reported that in March he would have been employed for five years, and that he had been trained to provide direct care. He stated that his co-worker and some of the residents went to the movies. There were no problems in the home and things were calm. When he arrived, his co-worker (Employee #1) told him that Resident A had been "going crazy," as he was getting into staff's cars and getting drinks. Mr. Sanders recalled that Resident A had gotten into his car the week before and took a drink.

Mr. Sanders stated that after he gave the residents their snacks and medications, he went to watch the game. He was standing by the fireplace looking for the channel that the game was playing on. Resident A was in the kitchen by the sink, getting a drink. Once he was done, Resident A started running through the living room. Mr. Sanders told Resident A to "slowdown before you fall." Mr. Sanders stepped to the side of Resident A, telling him to slowdown. Resident A hit himself, and spit at Mr. Sanders. Resident A then went to his room. Mr. Sanders stated that he was the only staff in the home, so he had to be aware of all the noises and what was going on in the home. He was holding the remote, while watching T.V., when he heard a door close. He went to check the rooms and Resident A asked for coffee and pop. Mr. Sanders told Resident A that he "can't have any because we don't have none."

Resident A started hitting the wall and when Mr. Sanders turned around, Resident A was coming at him. Mr. Sanders stated he tried to hold Resident A's arms up and Resident A spit at him. Mr. Sanders stated that surprised him. Mr. Sanders then stated, "I accidentally hit him in the side of the head with the remote." I inquired if Resident A appeared to be in pain and Mr. Sanders stated that Resident A was fine. Mr. Sanders went on to say that he did not know that Resident A was injured but discovered that he was bleeding when he checked on him again. Once he observed the cut, he provided first aid. When Mr. Sanders called to inform his boss of the situation, he did not know Resident A was hurt. He confirmed that he had been terminated. Mr. Sanders stated that this was an accident and that he tries to do the right thing. He stated that he did not mean to hit Resident A. He concurred that he could have handled the situation differently.

On December 29, 2022, I conducted the exit conference with Ms. Beilfuss, Licensee Designee. I informed her of my findings and recommendations. She stated that Mr. Sanders was pulled off the shift once they learned of the incident, and he has not returned to the home. Mr. Sanders has been terminated. A written corrective action plan will be submitted to address the established violation.

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: **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.** **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.** **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.** **(e) Withhold food, water, clothing, rest, or toilet use.** **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.** **(g) Refuse the resident entrance to the home.** **(h) Isolation of a resident as defined in R400.14102(1)(m).**

	(i) Any electrical shock device.
ANALYSIS:	Guardian A first received information that Resident A had been accidently hit in the head with a remote and that he was bleeding from the head. Home Manager #1 later informed her that it wasn't an accident, and the staff member would be terminated. Mr. Sanders reported to Home Manager #2 that Resident A got "really mad" and somehow the remote hit Resident A in the back of his head. Home Manager #1 called and spoke to Mr. Sanders, and he confessed that he struck Resident A because he (Mr. Sanders) felt like he was getting attacked. During the interview, Mr. Sanders stated, "I accidentally hit him in the side of the head with the remote." As a result, Resident A sustained an injury to his head that required staples. Mr. Sanders has been terminated. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Mr. Sanders mistreated and physically harmed Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, I recommend that the status of the license remains unchanged.

Mahtina Rubritius 12/29/2022

_____

Mahtina Rubritius Date
Licensing Consultant

Approved By:

01/05/2023

_____

Ardra Hunter Date
Area Manager