GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 17, 2023

Melissa Sevegney
Wood Care VIII, Inc.
910 S Washington Ave
Royal Oak, MI 48067

RE: License #: AL090281510
Investigation #: 2023A0572019
Leighton House Inn

Dear Mrs. Sevegney:

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) 643-7960.

Sincerely,

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL090281510
Investigation #:	2023A0572019
Complaint Receipt Date:	01/18/2023
Investigation Initiation Date:	01/23/2023
Report Due Date:	03/19/2023
Licensee Name:	Wood Care VIII, Inc.
Licensee Address:	910 S Washington Ave Royal Oak, MI 48067
Licensee Telephone #:	(947) 282-7555
Administrator:	Melissa Sevegney
Licensee Designee:	Melissa Sevegney
Name of Facility:	Leighton House Inn
Facility Address:	6700 Westside Saginaw Rd Bay City, MI 48706
Facility Telephone #:	(989) 667-9800
Original Issuance Date:	12/05/2007
License **Status:**	REGULAR
Effective Date:	06/07/2022
Expiration Date:	06/06/2024
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff, Shanesha Cooper-Harris yelled at Resident A and stated, "We are not going to do this (explicit) today."	No
Resident A is a 2-person assist and staff attempted to assist her on her own when she fell on 12/22/2022.	Yes
Resident A injured her right arm and left leg and it took the facility a week to get x-rays.	No
On 12/03/2022, Resident A fell, and family was not notified.	No

III. METHODOLOGY

01/18/2023	Special Investigation Intake 2023A0572019
01/23/2023	APS Referral APS made referral.
01/23/2023	Special Investigation Initiated - Letter
01/26/2023	Inspection Completed On-site Home Manager, Diane McGoutry; Hospice Nurse 1, and Nurse Practitioner, Jenna McKeever.
02/21/2023	Contact - Face to Face Staff, Julie Brent and Staff, Teonna Williams.
03/13/2023	Contact – telephone call made Ex-staff, Shanesha Cooper Harris.
03/13/2023	Inspection Completed-BCAL Sub. Compliance
03/16/2023	Contact – telephone call made Ex-staff, Amber Wilson.
03/16/2023	Contact – telephone call made Resident A's Family Member #1.

03/16/2023	Exit Conference Licensee Designee, Melissa Sevegney
03/17/2023	Contact – Phone call Holly Martin.
03/17/2023	Contact - Face to face Home Manager, Hathaway Synder.
03/17/2023	Exit Conference License Designee, Melissa Sevegney.

ALLEGATION:
Staff, Shanesha Cooper-Harris yelled at Resident A and stated, “We are not going to do this (explicit) today.”

INVESTIGATION:
On 01/18/2023, the local licensing office received a complaint for investigation. Adult Protective Services (APS) made the referral.

On 01/26/2023, an announced onsite was made at Leighton House Inn, located in Bay County Michigan. Interviewed in person and/or via phone were, Home Manager, Diane McGoutry, Hospice Nurse 1, and Nurse Practitioner, Jenna McKeever.

On 01/26/2023, I interviewed Home Manager, Diane McGoutry regarding the allegation. Ms. McGoutry informed that Resident A’s family member #1 made them aware of the situation. When management interviewed several staff members, they said that they did not see the incident, but Ms. Cooper-Harris’ demeanor suggested that something happened. Ms. Cooper-Harris was informed that the facility has a zero-tolerance policy when it comes to mistreatment of their residents, so they terminated her. Ms. Cooper-Harris denied any wrongdoing. Resident A is unable to speak on what happened to her but could tell that she was negatively impacted by something because she was in tears.

On 01/26/2023, I received a copy of Shane-Nesha Cooper-Harris Termination Letter. She was terminated on 01/03/2023 due to disruptive, discourteous, or disrespectful behavior or conduct towards any guest, visitor, or employee.

On 02/21/2023, I made another unannounced onsite to Leighton House Inn and spoke with staff, Julie Brant regarding the allegation. Ms. Brant heard on more than one occasion that Ms. Cooper-Harris was cursing at Resident A, but she had never witnessed it. She has worked with Ms. Cooper-Harris before and admits that she can have a bit of an attitude but does not know if she would curse at a resident or not.

On 02/21/2023, I interviewed Staff, Teonna Williams regarding the allegation. Ms. Williams has never witnessed Ms. Cooper-Harris cursing at Resident A or any other residents. She said that it wouldn't really come to a complete surprise if it did occur because Ms. Cooper-Harris was restricted from another resident's room due to allegedly being mean to that resident as well.

On 03/13/2023, I interviewed former staff, Shanesha Cooper-Harris regarding the allegation. Ms. Cooper-Harris denied that this occurred and informed that she heard that management was asking staff if she had been disrespectful towards residents, but they did not have any proof that she was. For some reason, the Administrator, Hathaway Snyder was picking on her and she does not know why. She informed that she had the opportunity to keep her job, but she did not fight for it because she did not want to work under current management.

On 03/16/2023, I interviewed Family Member #1 regarding the allegation. She informed that she had a caregiver come out to the facility to check on Resident A and the caregiver, Holly Martin; witnessed staff being mean to her and putting her call button out of reach so that she wouldn't push it. Staff would become upset with her because she would press the button to use the restroom while staff were busy setting up for lunch. She does not know the names of the staff members who were mean to her. Family Member #1 indicated that she knows that sometimes it may be a wait if staff are busy, but they shouldn't be upset when she asks for assistance, especially when she is blind and can't see that it is lunch time. She believes that staff should be trained in the area of compassion, because it is lacking in the facility.

On 03/17/2023, I attempted to contact Ms. Holly Martin regarding the allegation, but did not get an answer.

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: **(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.**

ANALYSIS:	Based on the interviews conducted for this investigation, there is not enough evidence to establish a violation. Staff did not witness any incident of Ms. Cooper-Harris being disrespectful towards any residents. Family Member #1 informed that Resident A's caregiver had witnessed a staff being very disrespectful towards Resident A but did not know the staff member's name.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- Resident A is a 2-person assist and staff attempted to assist her on her own when she fell on 12/03/2022.
- Resident A injured her right arm and left leg and it took the facility a week to get x-rays.
- On 12/03/2022, Resident A fell, and family was not notified.

INVESTIGATION:

On 01/26/2023, I interviewed Home Manager, Diane McGoutry regarding the allegations. Ms. McGoutry was aware of a fall, which was a slip in the bathroom. Resident A is not a 2-person assist, as she is able to transfer on her own. Resident A is able to pivot and sit without any assistance. Resident A is Extensive Assistive 1 for her ADL's, so they are allowed to do a 2-person assist or use a mechanical lift if Resident A is weak. Resident A only needed assistance with transfers. Ms. McGoutry is aware that Resident A's Family #1 was very upset that Resident A had fallen. Ms. McGoutry theory is that Resident A may have only received a scrape and was not presenting with any noticeable pain. The facility would have received instructions from the Nurse Practitioner. Once staff would have noticed any pain from Resident A, the Nurse Practitioner would have ordered x-rays for Resident A.

On 01/26/2023, I interviewed Hospice Nurse 1 regarding the allegations. She informed that they use a sit-to-stand for the bathroom. They did not become involved until after the fall.

On 01/26/2023, I interviewed Nurse Practitioner, Jenna McKeever regarding the allegations. She was aware of the fall. Resident A has chronic knee pain which was not related to the fall. Resident A did not appear to be in much pain. After she started showing signs of pain, an x-ray was ordered. Jennifer discussed with the family about Resident A going into hospice care.

On 01/27/2023, I reviewed the incident report regarding Resident A's fall. It states, "Staff was lifting guest up from toilet and taking her out of bathroom, and guest lost grip slipped out from the sit and stand and her knees hit the platform (bottom where your feet go)". "Staff unhooked the guest from the sit and stand lowered her to the

floor where staff assessed for injuries and pain. Guest stated she was not hurt and was having no pain, staff then put guest in wheelchair and then placed guest in recliner." "Guest was reminded to hold on to the sit and stand when transferring." The incident occurred on 12/03/2022 at 2am and Resident A's family Member #1 was informed on 12/05/2022.

On 02/21/2023, I interviewed Staff, Julie Brent regarding the allegations. She informed that they use a sit-to-stand for the bathroom and indicated that she was a 2-person assist. Ms. Brent recalls Resident A complaining about her legs but does not believe that had anything to do with her fall. She's not sure how Resident A had fallen. She believes that someone would have contacted Family Member #1, but she is not certain that it happened.

On 02/21/2023, I interviewed Staff, Teonna Williams regarding the allegations. Resident A usually has two people assisting her in the bathroom and does not recall her falling because only one staff was assisting her. Ms. Williams informed that Resident A was a 2-person assist. Ms. Williams does not know if Family Member #1 was informed of the fall.

On 03/16/2022, I attempted to contact ex-staff, Amber Wilson. Her phone is disconnected.

On 03/16/2023, I interviewed Resident A's Family Member #1. She informed that she was never notified that Resident A had fallen in the bathroom. Family Member #1 indicated that she still does not know if an incident report was written because she has never seen one and the only reason she knew that she had fallen is because Resident A asked her if she had received a call from the facility, which she hadn't. Resident A proceeded to inform Family Member #1 that the staff member dropped her. According to Family Member #1, the staff forgot to lock her wheelchair and that's how she fell. When she asked management why she had not received a call, she was told that they thought that she had been contacted. Management informed her that the staff was terminated, but she was still not satisfied because she was never notified. When asked was Resident A a 2-person assist, she said, "Yes, we paid an extra $400 per month because she was a 2-person assist." Family Member #1 sent me a bill which indicates that she was paying $400 for the assistance. She also informed that Resident A did not receive any x-rays until a week later. Resident A passed away on 02/21/2022 and does not believe that she was taken care of during her last days as her health changed after the fall and she never recovered from it.

On 03/17/2023, I made an unannounced onsite to Leighton House Inn to speak with Home Manager, Hathaway Snyder. She informed that Resident A was a 2-person assist and showed me Resident A's Plan of Service which indicates that she was a 2-person assist. When asked if staff attempted to transfer on their own, she informed that the staff did attempt to use the sit to stand on her own and that's how Resident A fell. Ms. Hathaway indicated that Resident A indicated that she felt fine, but then

told the nurse on 12/05/2022 that she was experiencing some knew pain. Ms. Hathaway was instructed to order x-rays which were completed on 12/09/2022. If she would have been instructed to order them STAT, then the x-rays would have been completed within 24 hours, but they did not have an order to order them STAT. Ms. Hathaway also gave me documentation, separate from the incident Report detailing the events of the fall and her contact with Family Member #1. On 12/03/2022 at 2:05am, she was contacted by former staff member, Zelma Crawford that Resident A had fallen, but no injuries were noted. On 12/03/2022, at 2:15am, she called Family Member #1, but got no answer and would call again in the morning. On 12/04/2022, she called Family Member #1 to inform her that Resident A had fallen in the bathroom, but there was no injuries or complaints of pain. On 12/05/2022, she spoke with Family Member #1, who informed her that she had found the staff who was working with Resident A when she fell, badge under Resident A's chair and they scheduled a time to discuss Hospice Care. On 12/06/2022, Family Member #1 agreed to Hospice Care and services began on that day.

APPLICABLE RULE	
R 400.15303	**Resident health care.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Ms. McGoutry stated that Resident A is not a 2-person assist, as she is able to transfer on her own. Ms. Hathaway indicated that Resident A was a 2-person assist and it was confirmed in the Assessment Plan for Resident A. Based on the interviews and the documentation received, there is enough evidence to establish a violation. Staff, Julie Brent, and Teonna Williams indicated that Resident A was a 2-person assist and Family Member #1 was paying an extra $400 per month to ensure that she had two staff members assist her.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Based on interviews and documentation, there is not enough evidence to establish a violation. Staff and the nurse conducted range of motion and search for marks and bruises. Resident A also indicated that she was not hurt. The nurse practitioner determined that an x-ray was not needed at the time of the incident.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information: **a) The name of the person who was involved in the accident or incident.** **b) The date, hour, place, and cause of the accident or incident.** **c) The effect of the accident or incident on the person who was involved and the care given.** **d) The name of the individuals who were notified and the time of the notification.** **e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.** **f) The corrective measures that were taken to prevent the accident or incident from happening again.**
ANALYSIS:	Based on the interviews and documentation, there is not enough evidence to establish a violation. The incident report indicates that Family Member #1 was informed of the fall on 12/05/2022.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 03/16/2023, an Exit Conference was held with Licensee Designee, Melissa Sevegney regarding the results of the special investigation. She was informed that a corrective action plan will need to be received within 15 days of receipt of this report.

On 03/17/2023, another Exit Conference was held with Licensee Designee, Melissa Sevegney, updating her on the results of the investigation.

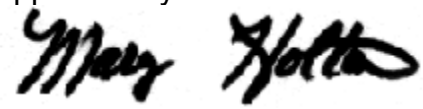
IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this large adult foster care group home, pending the receipt of an appropriate corrective action plan (1-20).

03/17/2023

Anthony Humphrey Date
Licensing Consultant

Approved By:



03/17/2023

Mary E. Holton Date
Area Manager