GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 11, 2023

Roland Higgs
Family Living Center Inc.
Suite 101
132 Franklin Blvd
Pontiac, MI 48341

RE: License #: AS630012322
Investigation #: 2023A0993015
Dawn Lane House

Dear Mr. Higgs:

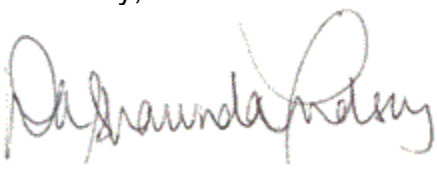
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012322
Investigation #:	2023A0993015
Complaint Receipt Date:	01/20/2023
Investigation Initiation Date:	01/25/2023
Report Due Date:	03/21/2023
Licensee Name:	Family Living Center Inc.
Licensee Address:	Suite 101 132 Franklin Blvd Pontiac, MI 48341
Licensee Telephone #:	(248) 334-5330
Administrator:	Roland Higgs
Licensee Designee:	Roland Higgs
Name of Facility:	Dawn Lane House
Facility Address:	4112 Dawn Lane West Bloomfield, MI 48323
Facility Telephone #:	(248) 626-0276
Original Issuance Date:	01/22/1981
License Status:	REGULAR
Effective Date:	07/11/2021
Expiration Date:	07/10/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was taken to an unknown urgent care. Resident A was found to have five fractured ribs and a bruised chest. Staff reported it was from a fall which occurred a week ago. The urgent care doctor (name unknown) reported the injuries are not consistent with a fall and concerns for the group home waiting so long to seek medical treatment for Resident A. The doctor was also concerned with treating Resident A so often due to alleged falls and her injuries are becoming more severe with each visit.	No

III. METHODOLOGY

01/20/2023	Special Investigation Intake 2023A0993015
01/20/2023	APS Referral Received allegations from adult protective services (APS). Assigned APS specialist is Jonathan Johnson.
01/23/2023	Referral - Recipient Rights Investigation assigned to recipient rights advocate Katie Garcia
01/25/2023	Special Investigation Initiated - Letter Emailed recipient rights advocate Katie Garcia
02/08/2023	Inspection Completed On-site Conducted an unannounced onsite investigation
02/16/2023	Contact - Telephone call made Telephone call made to APS specialist Jonathon Johnson. Left a message.
02/16/2023	Contact - Telephone call made Telephone call made to Easter Seals case manager Alexis Smith
02/16/2023	Contact - Telephone call received Telephone call received from APS specialist Jonathon Johnson
02/16/2023	Contact - Telephone call made Telephone call made to regional manager Kikelomo Waugh. Left a message.
02/16/2023	Contact - Document Sent Requested medical records from Henry Ford urgent care

02/16/2023	Contact - Document Sent Requested police records from West Bloomfield police department
02/17/2023	Contact - Document Received Received police records from West Bloomfield police department
02/23/2023	Contact - Telephone call made Telephone call made to regional manager Kikelomo Waugh
02/23/2023	Contact - Telephone call made Telephone call made to staff Rosalind Avery Thomas
02/28/2023	Contact - Telephone call made Telephone call made to APS specialist Jonathon Johnson
02/28/2023	Contact - Telephone call made Telephone call made to staff Ramia Temple
03/16/2023	Contact - Document Received Received medical records
03/16/2023	Contact - Telephone call made Telephone call made to recipient rights advocate Katie Garcia
03/16/2023	Contact - Telephone call made Telephone call made to APS specialist Jonathon Johnson
03/28/2023	Exit Conference Held with licensee designee Roland Higgs

ALLEGATION:

Resident A was taken to an unknown urgent care. Resident A was found to have five fractured ribs and a bruised chest. Staff reported it was from a fall which occurred a week ago. The urgent care doctor (name unknown) reported the injuries are not consistent with a fall and concerns for the group home waiting so long to seek medical treatment for Resident A. The doctor was also concerned with treating Resident A so often due to alleged falls and her injuries are becoming more severe with each visit.

INVESTIGATION:

On 01/20/2023, I received the allegations from adult protective services (APS). The assigned APS specialist was Jonathon Johnson.

On 01/23/2023, I learned the assigned recipient rights advocate was Katie Garcia.

On 02/08/2023, I conducted an unannounced onsite investigation. I interviewed home manager Bertina Seaton. Ms. Seaton denied being present in the facility when Resident A sustained the fractured ribs. Per Ms. Seaton, staff Rosalind Avery Thomas stated Resident A attacked her on 01/12/2023 and then they both fell. Resident A was not taken to urgent care after the incident. On 01/19/2023, staff Ramia Temple took Resident A to urgent care after hearing Resident A say “ouch” and complaining about her side. While at urgent care, an xray was completed and Ms. Temple was informed Resident A had sustained two fractured ribs. There were no bruises on her chest. Ms. Seaton stated Resident A only had a bruise on her knee and the front part of her leg near her waist. These sustained these bruises from a fall (an incident different from the incident that occurred between Ms. Avery Thomas and Resident A). Ms. Seaton did not know which day Resident A fell in the facility. Ms. Seaton denied that Resident A is taken to urgent care often. Resident A’s last fall in the facility, prior to these incidents, occurred in September 2022.

While in the facility, I attempted to interview Resident A with no success. Resident A has limited cognitive abilities. I observed a bruise in the area above Resident A’s right eye. Ms. Seaton stated Resident A sustained the bruise from a fall last Monday. Ms. Avery Thomas was on shift during the incident.

I also reviewed an incident report (IR). Per the incident report, on 01/12/2023, Resident A got off the couch and was saying bathroom. She went by Ms. Avery Thomas and slapped her. Ms. Avery Thomas attempted to redirect her. Resident A grabbed her shirt and hit her again. Ms. Avery Thomas attempted to free herself from Resident A’s grip, tripped, and they both fell to the floor. As Ms. Avery Thomas was trying to get up, Resident A tried to hit Ms. Avery Thomas again. Ms. Avery Thomas ran, and Resident A tripped on the stair from the living room to the kitchen area. Resident A got up and sat down.

On 02/16/2023, I interviewed Easter Seals case manager Alexis Smith. Ms. Smith stated the urgent care physician contacted Easter Seals medical director Dr. Bail to express concerns about Resident A. Resident A was taken to urgent care. It was determined that she sustained broken ribs and bruises. It was reported that Resident A had fallen in the facility one week prior to seeking medical treatment. Ms. Smith reached out to regional manager Kikelomo Waugh and was informed that a fist fight had occurred between staff and Resident A. Ms. Smith did not know the name of the staff who Resident A alleged fought.

On 02/16/2023, I conducted a telephone interview with APS specialist Jonathon Johnson. Mr. Johnson stated his investigation was still pending. He talked to the police detective investigating the allegations. The police detective informed Mr. Johnson that police had been to the facility multiple ties due to Resident A’s behaviors.

On 02/17/2023, I reviewed police reports from West Bloomfield police department. From 01/03/2020 until present, the police department was dispatched to the facility due to Resident A four times. The reasons for dispatch were as followed:

- On 07/28/2022, police were dispatched due Resident A being combative and disrupting the facility. Resident A was transported to the hospital for an evaluation. A petition was also completed.
- On 02/17/2020, police were dispatched due Resident A throwing things and breaking items. Resident A also hit another resident.
- On 02/10/2020, police were dispatched due to Resident A punching another resident.
- On 01/03/2020, police were dispatched due to Resident A pushing staff.

On 02/23/2023, I interviewed regional manager Kikelomo Waugh. Ms. Waugh stated she is a home manager in another licensed adult foster care facility. She helped out at Dawn Lane until a home manager was hired. Per Ms. Waugh, she was not present in the facility when the incident between Ms. Avery Thomas and Resident A occurred. Ms. Waugh stated she heard there was a fight between Ms. Avery Thomas and Resident A, but she was not certain. She did not know what occurred that day.

On 02/23/2023, I conducted a telephone interview with staff Rosalind Avery Thomas. Ms. Thomas stated on 01/12/2023, she was staining by the doorway near the family room and kitchen. Resident A was sitting on the sofa. Resident A jumped up and lounged towards Ms. Avery Thomas. They both fell, landing on the step between the kitchen and family room. While on the floor, they struggled a little bit. Ms. Avery Thomas tried to get away. Resident A had a hold of Ms. Avery Thomas' clothes. Ms. Avery Thomas managed to get up and called the home manager. Ms. Avery Thomas stated she kept her distance from Resident A for the rest of her shift. In addition, she wrote an IR. Ms. Avery Thomas stated she did not occur any marks or bruises on Resident A. Resident A also did not complain of pain and/or appear to be in pain. Ms. Avery Thomas stated another staff took Resident A to urgent care one week later due to her being in pain.

On 02/28/2023, I conducted a telephone interview with staff Ramia Temple. Ms. Temple stated she was on shift with Ms. Avery Thomas on the day in question, but she was not present in the facility. She had left to take one of the other residents to get a haircut. Ms. Temple stated when she returned to the facility, Ms. Avery Thomas stated Resident A attacked her. While she was trying to get her off her, they both fell. Resident A hit the stair between the kitchen and family room. One or two days later, Ms. Temple stated she saw a bruise on Resident A's right and left hip/thigh. She did not observe any bruises on her chest. Ms. Temple took Resident A to urgent care because something did not seem right with her. In addition, Resident A kept saying "ouch". They did an x-ray and learned Resident A had fractured ribs. Ms. Temple stated she took Resident A back to urgent care about one week later because Resident A said her shoes were too small. While at urgent care, they x-rayed her hip and knee as well as performed a range of motion. They did not observe any concerns. Per Ms. Temple stated Resident A has attacked everyone in the facility. Resident A targets new staff. At the time of the

incident, Ms. Avery Thomas was a new staff member. Ms. Temple stated it is likely Resident A waited until she left the facility before attacking Ms. Avery Thomas. Ms. Temple stated Resident A was adamant about staying in the facility with Ms. Avery Thomas that day. She refused to go with her. Ms. Temple denied ever observing staff abuse, neglect, or do anything to mistreat the residents.

On 03/16/2023, I reviewed Resident A's medical records. Per the records, Resident A was taken to Henry Ford GoHealth Urgent Care on 01/19/2023 due to a rib injury. Staff Ramia (last name not documented) stated one week prior while in the facility Resident A tried to attack one of the staff. They both fell during the episode. Medical staff at the urgent care documented that Resident A had a couple of bruises, one to the left outer thigh, one to the right knee. Resident A complained of pain to right lower rib area multiple times. During the visit, it was determined that Resident A had mildly displaced fractures of the lateral right sixth through 10th ribs. Moderate right pleural effuse. It was noted in the record that Resident A had been seen in the ER three times since November 2021 and urgent care in August 2022 for various injuries including facial injury (with an old nasal bone fracture noted on CT), hyponatremia, finger laceration, and a displaced phalanx fracture. This concern was discussed with medical director Dr. Bali, and he escalated it. On 01/26/2023, Resident A was taken back to urgent care due to right ankle pain. Per the record, Resident A was seen for a follow up after an injury that occurred two weeks prior (when Resident A and a staff fell from a single step to landing below. The record noted she was seen on 01/19/2023 for multiple rib fractures, and she continued to complain of pain. Staff noted Resident A was hesitant to walk normally on right leg and foot. Staff was unable to identify exactly where the pain was coming from, and Resident A was administered ibuprofen every six hours. After examination, no evidence of acute fracture was found in Resident A's right knee and right hip.

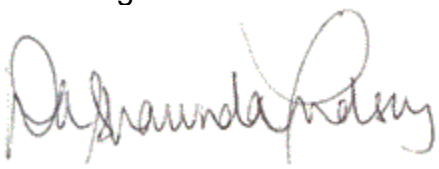
On 03/28/2023, I conducted an exit conference with licensee designee Roland Higgs. I informed him of the findings. He agreed to submit a corrective action plan.

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:	On 01/12/2023, Resident A attacked Ms. Avery Thomas. Resident A and Ms. Avery Thomas fell on the floor. Resident A was taken to urgent care, and it was determined that Resident A sustained fractured ribs and bruises from the fall.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In care of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	On 01/12/2023, Resident A attacked Ms. Avery Thomas. Resident A and Ms. Avery Thomas fell on the floor. Resident A was taken to urgent care, and it was determined that Resident A sustained fractured ribs and bruises from the fall. Resident A was not taken to urgent care until one week after the fall.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

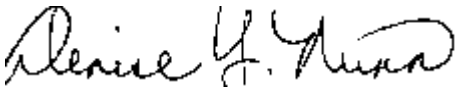
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



03/28/2023

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



04/11/2023

Denise Y. Nunn — Date
Area Manager