GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 23, 2023

Betty Mackie
Henrys Inc.
P.O. Box 81733
Rochester, MI 48308

RE: License #: AS820311703
Investigation #: 2023A0992021
Henrys Inc. LaShae Home

Dear Ms. Mackie:

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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820311703
Investigation #:	2023A0992021
Complaint Receipt Date:	03/23/2023
Investigation Initiation Date:	03/24/2023
Report Due Date:	05/22/2023
Licensee Name:	Henrys Inc.
Licensee Address:	P.O. Box 81733 Rochester, MI 48308
Licensee Telephone #:	(313) 910-2951
Administrator:	Shelia Hawkins
Licensee Designee:	Betty Mackie
Name of Facility:	Henrys Inc. LaShae Home
Facility Address:	19438 Beech Daly Road Redford, MI 48240
Facility Telephone #:	(313) 910-2951
Original Issuance Date:	08/03/2011
License Status:	REGULAR
Effective Date:	02/03/2022
Expiration Date:	02/02/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
• There is concern that the staff have been overmedicating Resident A and neglecting her. The staff may be using Resident A's Ativan prescription to chemically restrain her for long periods of time so they do not have to supervise her. • Resident A has significant weight loss and is so malnourished that she now has symmetrical depressions on the sides of her head and her body weight is dangerously low. Resident A is not being fed or given water due to these long periods of sedation.	No
Additional Findings	Yes

III. METHODOLOGY

03/23/2023	Special Investigation Intake 2023A0992021
03/24/2023	Special Investigation Initiated - Telephone Eryn Sherman, Adult Protective Services (APS)
03/27/2023	Contact - Face to Face Resident A
04/03/2023	Inspection Completed On-site Robert Hawkins, Staff and Facility Supervisor.
04/04/2023	Contact - Document Received Medication/prescription records, weights, health care appraisal, medical consultation forms and menus.
04/07/2023	Contact - Telephone call made. Relative A, Resident A's guardian was not available. Message left.
04/10/2023	Contact - Telephone call received. Relative A
05/01/2023	Contact - Telephone call made

	Michael Dean, Resident A's Supports Coordinator with Wayne Center.
05/05/2023	Contact - Document Received Resident A additional MARs.
05/10/2023	Contact - Telephone call made Latrice Edwards, home manager
05/17/2023	Contact - Telephone call made Jerri Sterrett, office of recipient rights (ORR)
05/17/2023	Contact - Telephone call made Kiera Caldwell, direct care staff
05/17/2023	Contact - Telephone call made Ms. Hawkins
05/17/2023	Exit Conference Betty Mackie, licensee designee

ALLEGATION:

- **There is concern that the staff have been overmedicating Resident A and neglecting her. The staff may be using Resident A's Ativan prescription to chemically restrain her for long periods of time so they do not have to supervise her.**

- **Resident A has significant weight loss and is so malnourished that she now has symmetrical depressions on the sides of her head and her body weight is dangerously low. Resident A is not being fed or given water due to these long periods of sedation.**

INVESTIGATION:

On 03/24/2023, I made telephone contact with Eryn Sherman, Adult Protective Services (APS) regarding the reported allegations. Ms. Sherman stated that she investigated the allegations, which were unfounded. She further stated that based on review of Resident A’s records and collateral contacts with Resident A’s treating physician and social work staff at Beaumont Hospital Wayne, Resident A was not overmedicated or malnourished. She said Resident A is prescribed Ativan and other medications by her treating physician which she verified via prescriptions. Ms. Sherman said Resident A was seen regularly by a physician and no concerns were

reported. She further stated that there was an instance when the staff felt as though Resident A was not her normal self and they contacted her physician and expressed concerns. Ms. Sherman said Resident A was examined by her physician and referred to Beaumont Hospital Wayne because she seemed lethargic, but no concerns of overmedicating were reported. Ms. Sherman made me aware that the allegations were originally reported in 11/2022 and Resident A has since relocated to Novus Living I in Romulus., MI. As it pertains to the allegations, Ms. Sherman said the complaint was unsubstantiated.

On 03/27/2023, I completed an unannounced onsite inspection at Novus Living I and observed Resident A. Resident A has limited communication skills and was unable to be interviewed. Resident A was observed laying on the couch in fetal position, she appears to have a small build.

On 04/03/2023, I completed an unannounced onsite inspection at Henry's Inc LaShae Home and interviewed Robert Hawkins, staff and facility supervisor. I requested to review Resident A's resident file. Mr. Hawkins explained that Resident A's file was not onsite. He contacted Sheila Hawkins, administrator and made her aware of my presence. Ms. Hawkins explained that she was contacted by Jerri Sterrett, office of recipient rights (ORR) and she requested several documents from Resident A's file. Ms. Hawkins stated that she has the file with her to make copies and send to Ms. Sterrett. She stated that Ms. Sterrett requested medication/prescription records, weights, adult foster care assessment plan/individual plan of services (IPOS), health care appraisal, medical consultation forms and menus. I requested Ms. Hawkins provide me with copies of the same documentation, in which she agreed to do so.

On 04/04/2023, I received copies of the requested documentation. I reviewed Resident A's medication and prescription records to determine the label instructions as it pertains to dosage and time to be administered. The medication administration records (MARs) received were from 09/2022 through 11/2022. According to the MARs Resident A was prescribed Ativan 0.5MG PO TAB, take 1 tablet by mouth one daily at 8:00 a.m. and Ativan 1MG PO TAB, take 1 tablet by mouth once daily at 4:00 p.m. Based on the MARs the medications were administered as prescribed; no discrepancies observed as it pertains to overmedicating. I also observed prescriptions for Ativan 0.5MG and 1MG prescribed by Karen Watson as dated 11/03/2022. I reviewed a medical consultation form for Resident A dated 11/09/2022 due to her being lethargic and loss of appetite; Resident A was referred to Beaumont Hospital Wayne by Dr. Normita Vicencio. She was also seen by Dr. Vicencio on 06/14/2022 for an annual physical exam (health care appraisal); lab and chest x-rays were ordered but no other health-related information or concerns were noted. I also reviewed Resident A's 2021 health care appraisal; no health concerns were noted. As it pertains to Resident A's weight for the last two years, she has weighed between 109lbs to 116lbs, no significant weight loss observed based on her weight record. I also reviewed the facility menus, which appeared to meet the nutritional requirements.

On 04/10/2023, I contacted Relative A, Resident A's guardian and interviewed her regarding the allegations. Relative A stated she has some concerns regarding Resident A. She stated that Resident A is non-verbal and unable to advocate for herself. Relative A said she has had an opportunity to review Resident A's medical records and assess her physically and she appears to be malnourished. She stated Resident A has symmetrical depressions on the sides of her head and her body weight is dangerously low. I asked Relative A if her assessment is supported by Resident A's physician, and she said you can physically see it when you look at Resident A. I made Relative A aware that I am not familiar with Resident A historically, to attest to her physical characteristics and that her physician would have to determine that she has symmetrical depressions on the sides of her head as a result of being malnourished/low body weight. As it pertains to Resident A's medications, Relative A stated that the medications are causing her to be heavily sedated. I asked Relative A if she has requested a medication review with Resident A's physician. She said she has expressed her concerns to Resident A's doctors, but a medication review has not been conducted. I explained that the direct care staff is responsible for administering the medication as prescribed by Resident A's physician and they cannot modify the medication without authorization. I further explained that if the direct care staff notice the medication is negatively affecting Resident A, they can bring it to the physician's attention for her to be reassessed. I made Relative A aware that the allegations will be investigated, and I will make follow-up contact with her if necessary.

On 05/01/2023, I contacted Michael Dean, Resident A's Supports Coordinator with Wayne Center and interviewed him regarding the allegations. Mr. Dean stated that he has been Resident A's Supports Coordinator for a couple years and he has never had any concerns regarding the level of care she receives from the Henry's Inc LaShae Home staff. He said as far as the staff overmedicating her, that would be hard to gauge because her demeanor/behavior has been up and down since he has known her. He said there are days when she appears to be tired, then there are days when she is grabbing things and dropping to the ground. He said she has not observed anything out of the ordinary that would suggest she is being overmedicated. As far as being malnourished, Mr. Dean said Resident A has a small build. He said in his opinion she has maintained her weight within the last couple years and has not had any drastic weight loss. I asked Mr. Dean if Relative A has ever expressed any concerns regarding Relative A being over medicated or malnourished and he said no. He said he has only had contact with Relative A once and that he is mainly in contact with Nikeisha Brown, Resident A's representative.

On 05/05/2023, I received additional MARs records for Resident A from 12/2021 through 08/2022. Based on review of the MARs, I did not observe any discrepancies that would allude to Resident A being overmedicated. I did observe several medications were not initialed on the MARs and not explanation was provided.

On 05/10/2023, I contacted Latrice Edwards, home manager, and interviewed her regarding the allegations, which she denied. Ms. Edwards said Resident A's medication was never used a form of restraint. She said the medication was used as prescribed by her doctor. She said Resident A has been prescribed the same medications since she was admitted into the home. She said Resident A is very active and sometimes she is easily agitated which is why she is prescribed Ativan twice during the morning and afternoon, and Benadryl at bedtime for insomnia. She said Resident A sees her doctor regularly and she continues to prescribe the medication and the staff administers it as such. She said as it pertains to her being malnourished, her doctor has never expressed any concerns and Resident A eats regularly. However, Ms. Edwards said during Covid-19, some of the residents did lose weight from being sick but that was isolated. I asked Ms. Edwards if Relative A has ever communicated any concerns about Resident A's physical condition and she said no. She said out of the five years she has worked at the home she has only visited with Resident A 3-4 times.

On 05/17/2023, I contacted Jerri Sterrett, office of recipient rights (ORR) and interviewed her regarding the allegations. Ms. Sterrett confirmed she did investigate the same allegations. Ms. Sterrett said she interviewed the staff and spoke with Karen Watson, Pure Psychiatry, regarding the Ativan. She the staff denied the allegations. As for Ms. Watson, she stated she have appointments with most clients at least once a month, if not twice. She stated Resident A was prescribed the appropriate dosage. She said she would never overmedicate her clients. She said Ms. Watson denied having any concerns regarding the group home administering the medication other than how it was prescribed. Ms. Sterrett said the complaint was unsubstantiated. Ms. Sterrett also provided me with a copy of her investigative report.

On 05/17/2023, I contacted Kiera Caldwell, direct care staff and interviewed her regarding the allegations. Ms. Caldwell denied having any knowledge of the staff overmedicating Resident A. She said all medications were administered as prescribed by the treating physician. As for Resident A she said she would have her good and bad days. She said there were days when she just wanted to lay around all day and there were days when she was extremely active. She said Resident A has an unsteady gait, so she does not just get up and go although sometimes she would try to, but staff would remain in close proximity. Ms. Caldwell said Resident A had good eating habits and she would sometimes ask for seconds. She said Resident A has limited verbal skills but when you have worked with her for some time, you manage to communicate with her. She said Resident A is tall but has a small frame. Ms. Caldwell denied Resident A appeared malnourished and said she has maintained her weight.

On 05/17/2023, I made follow-up contact with Ms. Hawkins regarding my findings. I explained that based on the reported allegations, I am unable to determine that the direct care staff were overmedicating Resident A or that she is malnourished. She denied having any questions.

On 05/13/2023, I completed an exit conference with Betty Mackie, licensee designee. I made her aware that as it pertains to the reported allegations, there is insufficient evidence to support the allegations. She denied having any questions.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	During this investigation, I interviewed Sheila Hawkins, administrator; Latrice Edwards, home managers; Keira Caldwell, direct care staff; Michael Dean, Resident A's Supports Coordinator with Wayne Center; Jerri Sterrett, ORR; Eryn Sherman, APS; Relative A. All denied the allegations except for Relative A. I reviewed Resident A's MARs and prescription records; all of which did not support the reported allegations. Based on the investigative findings, there is insufficient evidence to support the allegation that Resident A's medication was not given her medication as prescribed by a licensed physician. The allegation is substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	I reviewed Resident A's weights, health care appraisal, medical consultation forms and menus; all of which did not support the reported allegations. Resident A's 2021 and 2022 health care appraisals did not have any health concerns noted. As it pertains to her weight for the last two years, she has weighed between 109lbs to 116lbs. I also reviewed the facility menus, which appeared to meet the nutritional requirements. Based on the investigative findings, there is insufficient evidence to support the allegation, the allegation is substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 05/05/2023, I received the MARs records for Resident A from 12/2021 through 08/2022. Based on review of the MARs, the person who administered the medication failed to initial at the time the medication was given.

The MARs dated 03/04/2022 through 04/08/2022 was as follows:

- Vitamin D3 5000-unit PO CAP; take 1 capsule by mouth once daily was not initialed on 03/31/2022 at 8:00 a.m.
- RisperDal 2MG PO TAB; take 1 tablet by mouth every morning & (1) tablet at 4:00 p.m. was not initialed on 03/31/2022 at 8:00 a.m. or 4:00 p.m.
- Depakote sodium ER 250MG ER TAB, take 2 tablets by mouth at bedtime was not initialed on 03/31/2022 at 8:00 a.m.
- Depakote sodium ER 500MG ER TAB, take 2 tablets by mouth at bedtime was not initialed on 03/31/2022 at 8:00 p.m.
- Paxil HCL 30MG PO TAB, take 1 tablet by mouth once daily every morning was not initialed on 03/31/2022 at 8:00 a.m.
- Ativan 0.5MG PO TAB, take 1 tablet by mouth once daily at 8:00 a.m. was not initialed on 03/31/2022.
- Ativan 1MG PO TAB, take 1 tablet by mouth once daily at 4:00 p.m. was not initialed on 03/31/2022.

The MARs dated 04/01/2022 through 05/05/2022 was as follows:

- Vitamin D3 5000-unit PO CAP; take 1 capsule by mouth once daily was not initialed on 04/30/2022 at 8:00 a.m.
- Paxil HCL 30MG PO TAB, take 1 tablet by mouth once daily every morning was not initialed on 04/30/2022 at 8:00 a.m.

- RisperDal 2MG PO TAB; take 1 tablet by mouth every morning & (1) tablet at 4:00 p.m. was not initialed on 04/30/2022 at 8:00 a.m. or 04/05/2023 at 4:00 p.m.
- Depakote sodium ER 250MG ER TAB, take 2 tablets by mouth at bedtime was not initialed on 04/30/2022 at 8:00 a.m.
- Ativan 0.5MG PO TAB, take 1 tablet by mouth once daily at 8:00 a.m. was not initialed on 04/30/2022.

The MARs dated 05/02/2022 through 06/03/2022 was as follows:

- Vitamin D3 5000-unit PO CAP; take 1 capsule by mouth once daily was not initialed on 05/31/2022 at 8:00 a.m.
- Ativan 0.5MG PO TAB, take 1 tablet by mouth once daily at 8:00 a.m. was not initialed on 05/31/2022.
- Ativan 1MG PO TAB, take 1 tablet by mouth once daily at 4:00 p.m. was not initialed on 05/31/2022.
- RisperDal 2MG PO TAB; take 1 tablet by mouth every morning & (1) tablet at 4:00 p.m. was not initialed on 05/31/2022 at 8:00 a.m. or 4:00 p.m.
- Depakote sodium ER 500MG ER TAB, take 2 tablets by mouth at bedtime was not initialed on 05/31/2022 at 8:00 p.m.
- Paxil HCL 30MG PO TAB, take 1 tablet by mouth once daily every morning was not initialed on 05/31/2022 at 8:00 a.m.
- Depakote sodium ER 250MG ER TAB, take 2 tablets by mouth at bedtime was not initialed on 05/31/2022 at 8:00 a.m.

The MARs dated 06/03/2022 through 07/03/2022 was as follows:

- Ativan 0.5MG PO TAB, take 1 tablet by mouth once daily at 8:00 a.m. was not initialed on 06/30/2022.
- Depakote sodium ER 250MG ER TAB, take 2 tablets by mouth at bedtime was not initialed on 06/30/2022 at 8:00 a.m.
- RisperDal 2MG PO TAB; take 1 tablet by mouth every morning & (1) tablet at 4:00 p.m. was not initialed on 06/30/2022 at 8:00 a.m. or 4:00 p.m.
- Paxil HCL 30MG PO TAB, take 1 tablet by mouth once daily every morning was not initialed on 06/30/2022 at 8:00 a.m.

*It should be noted that the RisperDal 2MG PO TAB and Depakote sodium ER 500MG ER TAB were initialed on 06/31/2022 (June only has 30 days).

On 05/17/2023, I contacted Ms. Hawkins and explained that after reviewing the MARs, the staff failed to initial, and the MARs are not dated accurately. Ms. Hawkins stated she will address the issue with her staff and contact the pharmacy and get it straightened out.

On 05/13/2023, I completed an exit conference with Betty Mackie, licensee designee. I made her aware of the additional findings including the MARs not being initialed as required and no other explanation provided. I explained due to the violations identified in the report, a written corrective action plan is required. She denied having any questions.

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:	Based on review of Resident A's medication administration records, the person who administered the medication, failed to initial at the time the medication was given.
CONCLUSION:	**VIOLATION ESTABLISHED**

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

05/19/2023

_____

Denasha Walker Date
Licensing Consultant

Approved By:

05/23/2023

_____

Ardra Hunter Date
Area Manager