GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 1, 2023

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

RE: License #: AS820273992
Investigation #: 2023A0101023
Henry's Inc. Paradise 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,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820273992
Investigation #:	2023A0101023
Complaint Receipt Date:	04/19/2023
Investigation Initiation Date:	04/19/2023
Report Due Date:	06/18/2023
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:	Henry's Inc. Paradise Home
Facility Address:	30935 Pennsylvania Romulus, MI 48174
Facility Telephone #:	(313) 363-7018
Original Issuance Date:	06/07/2005
License **Status:**	REGULAR
Effective Date:	11/20/2021
Expiration Date:	11/19/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was an 86-year-old male. Resident A had lost a lot of weight and he had multiple bedsores.	No
Additional Findings	Yes

III. METHODOLOGY

04/19/2023	Special Investigation Intake 2023A0101023
04/19/2023	Special Investigation Initiated - Telephone Shelia Hawkins, Administrator/Designated Person
04/19/2023	Referral received from APS.
04/28/2023	Inspection Completed-BCAL Sub. Compliance
05/10/2023	Comment - ORR referral made.
05/10/2023	Contact - Telephone call made. Resident A's guardian
05/10/2023	Contact - Telephone call made. APS worker Kya Lockett left message.
05/10/2023	Contact - Telephone call made. Resident A's guardian
05/10/2023	Contact - Telephone call made. APS Worker Kya Lockett
05/11/2023	Contact - Telephone call received. Ms. Lockett
05/12/2023	Contact - Telephone call received. Ms. Hawkins
05/18/2023	Contact – Telephone call made. Latrice Edwards, Area Manager
05/18/2024	Contact – Telephone call made. Resident A’s Primary Care Physician

05/18/2024	Contact – Telephone call made. Stephine Jackson, Direct Care Staff
05/18/2023	Contact – Telephone call made. Samantha Grace, Direct Care Staff
05/19/2023	Contact – Telephone call made. Beaumont Home Care
05/19/2023	Contact – Telephone call received. Debbie Kirschman, Beaumont Home Care Legal Department
05/19/2023	Contact – Document received.
05/19/2023	Contact – Telephone call made. Lynn Rogers, Direct Care Staff
05/19/2023	Contact – Document received.
05/19/2023	Exit Conference with Administrator/Designated Person Licensee Designee on medical leave

ALLEGATION: Resident A was an 86-year-old male. Resident A had lost a lot of weight and he had multiple bedsores.

INVESTIGATION: On 04/19/2023, I spoke with the Administrator/Designated Person Shelia Hawkins. Ms. Hawkins stated Resident A only had one bedsore. Ms. Hawkins further stated the home was addressing Resident A's weight loss. Ms. Hawkins stated in February staff noticed Resident A was "not eating well". He also was "very weak and lethargic." Resident A was taken to his primary care physician.

I requested Resident A's weight record. Ms. Hawkins stated she did not have a weight record for him because the home did not have a wheelchair weight scale. I requested Resident A's treatment plan. Ms. Hawkins stated Resident A's treatment plan did not indicate he was supposed to be re-positioned every two hours. However, after Resident A's hospitalization for the bed sore and other symptoms his case manager amended his treatment plan to include re-positioning every two hours. I received and reviewed Resident A's amended treatment plan on 05/04/2023.

On 04/28/2023, I interviewed the area manager Latrice Edwards. Ms. Edwards stated Resident A had one bedsore on his left hip. Ms. Edwards further stated on 02/06/2023, Resident A was taken to his primary care physician because he was not eating and was lethargic. Ms. Edwards stated Resident A was prescribed Ensure

Plus and a CAT Scan of his abdomen and pelvis was ordered. However, the CAT Scan was not completed because the insurance company would not pay for it.

Ms. Edwards gave me a copy of the consultation from Resident A's 02/06/2023, doctor appointment. Resident A's weight was not taken because he was unable to sit on the scale. According to Resident A's Medical Needs Assessment, Resident A required hands on assistance with all activities of daily living.

On 05/11/2023, I spoke with the Adult Protective Services Worker (APS), Kya Lockett. Ms. Lockett stated when APS received the referral the Strike Team went to the hospital. Ms. Lockett stated according to the Strike Team's notes Resident A had a covered pressure sore on his left hip and the pressure sores on his legs were healing.

I spoke with Resident A's guardian on 05/11/2023. Resident A's guardian stated Resident A had multiple bed sores on his legs and ankles. Resident A's guardian stated she does not believe the group home neglected or abused Resident A. Then she informed me that Resident A passed away on 05/02/2023. Resident A's guardian stated the group home sent Resident A to the hospital on 05/01/2023, because he did not seem like himself. He was also not responding to questions. That evening she got a phone call from hospital personnel stating Resident A's hemoglobin was low and he needed a blood transfusion. Resident A's guardian gave permission for the transfusion. Resident A's guardian stated when she arrived at the hospital the next day, she was informed Resident A passed away.

Resident A's guardian stated she did not know the cause of death. However, the doctor informed her that the foods Resident A ate did not go into his stomach it was going into his lungs. Resident A had a pureed diet.

On 05/16/2023, I spoke with Ms. Edwards. I asked Ms. Edwards how is it that staff did not notice the pressure sore on Resident A's left hip? Ms. Edwards stated we did, and a doctor appointment was scheduled. Ms. Edwards stated sometime during the week of 03/26/2023, DCS Lynn Rogers told her she noticed a mark on Resident A's left hip. A doctor appointment was scheduled for 04/03/2023. However, on 04/02/2023, Resident A mouth appeared "slightly twisted". Resident A was transported to Wayne Beaumont Hospital. Resident A was in the hospital for four days. Ms. Edwards further stated the mark on Resident A's left hip resembled a "carpet burn".

On 05/17/2023, I received and reviewed Resident A's hospital discharge summary. Resident A's admitting diagnoses were "general weaking, Decubitus ulcer of hip, stage 2, and chest pain unspecified." Resident A discharge diagnosis was "Decubitus of hip stage 2." The discharge summary did not indicate there were other bed sores.

I spoke with DCS Samantha Grace and Stephine Jackson on 05/18/2023. They

both stated Resident A had one bedsore on his left hip. Ms. Jackson stated it resembled a “rug burn” and Ms. Grace stated it resembled “a small cut”.

On 04/10/2023, Resident A had a hospital follow-up visit with his primary care physician. The physician’s notes on the consultation form indicates there was a pressure sore on Resident A’s left hip and wound care was needed. It did not mention there were other bedsores.

On 05/19/2023, Ms. Hawkins submitted written documentation from Resident A’s primary care physician. The documentation indicates Resident A missed his doctor appointment on 04/3/2023 because he was hospitalized on 04/02/2023.

I spoke with DCS Lynn Rogers on 05/19/2023. Ms. Rogers stated Resident A had one pressure sore on his hip. Ms. Rogers stated the healing sores on his ankles were not bedsores. Ms. Rogers stated his wheelchair caused those sores.

Noteworthy, on 04/28/2023, I observed Resident A’s wheelchair. It is an outdated wheelchair. The legs and footrest are positioned in front of the wheelchair. So, whenever Resident A propelled his wheelchair his legs and ankles would hit the metal legs and footrest. Ms. Edwards informed me that this was the wheelchair his guardian brought and wanted him to use.

On 05/24/2023, I conducted an exit conference with Ms. Hawkins. Ms. Hawkins agrees with my findings.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(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:	Prior to the onset of Resident A’s bedsore repositioning him every two hours was not in his treatment plan. On 04/14/2023, Resident A’s treatment plan was amended to include repositioning Resident A every two hours.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**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:	Henry's Inc. Paradise Home's staff obtain needed care whenever there was a sudden adverse change in Resident A's condition. When staff noticed what we now know was an early-stage bedsore a doctor appointment was scheduled. Resident A saw his primary care physician for weight loss on 02/06/2023.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

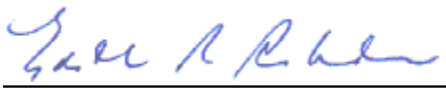
ADDITIONAL FINDINGS:

INVESTIGATION: On 04/19/2023, I spoke with the Administrator/Designated Person Shelia Hawkins. I requested Resident A's weight record. Ms. Hawkins stated she did not have a weight record for him because the home did not have a wheelchair weight scale.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	On 04/19/2023, I requested Resident A's weight record. Ms. Hawkins stated she did not have a weight record for him because the home did not have a wheelchair weight scale.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



05/31/2023

Edith Richardson
Licensing Consultant

Date

Approved By:

06/01/2023

Ardra Hunter
Area Manager

Date