GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 26, 2024

Kathleen Hockey
Moore Apt Non-Profit Housing Corp.
5900 Executive Drive
Lansing, MI 48911

RE: License #: AS620413384
Investigation #: 2024A0340015
Countryside

Dear Ms. Hockey:

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 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 (616) 356-0183.

Sincerely,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS620413384
Investigation #:	2024A0340015
Complaint Receipt Date:	01/09/2024
Investigation Initiation Date:	01/09/2024
Report Due Date:	03/09/2024
Licensee Name:	Moore Apt Non-Profit Housing Corp.
Licensee Address:	5900 Executive Drive Lansing, MI 48911
Licensee Telephone #:	(517) 393-2103
Administrator:	Kathleen Hockey
Licensee Designee:	Kathleen Hockey
Name of Facility:	Countryside
Facility Address:	6116 W. Pat St. Fremont, MI 49412
Facility Telephone #:	(517) 393-2103
Original Issuance Date:	10/04/2022
License Status:	REGULAR
Effective Date:	04/04/2023
Expiration Date:	04/03/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had marks on her neck due to possible abuse by staff.	Yes

III. METHODOLOGY

01/09/2024	Special Investigation Intake 2024A0340015
01/09/2024	Special Investigation Initiated – Telephone Nikki Plotts, Administrator
01/10/2024	Contact - Document Received from Kathy Hockey
01/10/2024	Contact – Document Sent ORR Jill McKay
01/10/2024	Contact – Document Received ORR Jill McKay
01/10/2024	Contact – Telephone call made Home manager Irene Keigley
01/10/2024	Contact - Telephone call made staff Zoe Francis-no answer/no voicemail
01/30/2024	Inspection Completed On-site
02/12/2024	Contact - Telephone call made staff Zoe Francis-no VM
02/12/2024	Contact - Telephone call made staff Desaree Gabriel-left message
02/12/2024	Contact - Telephone call made staff Becky Freese-LM
02/12/2024	Contact - Telephone call made Designee Kathy Hockey
02/12/2024	Contact - Telephone call received staff Desaree Gabriel
02/12/2024	Contact - Telephone call made Administrator Nikki Plotts

02/12/2024	Contact - Document Received ORR report
02/26/2024	Exit Conference Designee Kathy Hockey

ALLEGATION: Resident A had marks on her neck due to possible abuse by staff.

INVESTIGATION: On January 9, 2024, a complaint was filed with BCAL Online Complaints. It stated that Resident A was asked if someone grabbed her neck after scratches and dried blood were observed by staff Zoe Francis. Resident A is non-verbal but indicated "yes" when she was asked.

On January 9, 2024, I contacted Administrator Nikki Plotts. I asked Ms. Plotts if she knew about the incident. She said she did. She was not present so all she knew was that staff were working and found marks on Resident A's neck. Pictures were taken to document.

Ms. Plotts sent me photos that she stated were taken of Resident A's neck which I reviewed. There was a mark observed in the photos which resembles a vertical scratch on the left side of her neck from approximately her earlobe to halfway down her neck. Another possible scratch is seen further down her neck going horizontal and perpendicular to the above scratch. Then there is what appears to be a vertical bruise running perpendicular to the horizontal scratch. It was not clear in observing these marks that they were necessarily a result of being grabbed, slapped, or being caused by a person's hand or fingers.

On January 10, 2024, I contacted ORR Jill McKay. She informed me she sent me the Recipient Rights complaint that had been filed by staff Zoe Francis. It stated: *'I arrived to 2nd shift at 4 pm and was notified by Irene Keigley that (Resident A's) neck had been very dry and had cracked in certain spots because of how she pushes her head back into her wheelchair. (Resident A's) neck had a little dried blood on it but it looked like that may have happened. (Resident A) was toileting before her shower and I cleaned up her neck before starting. There are 3-2 inch red marks on the left side of her neck and a single small scabbed wound on the right side of her neck. Finished shower and other staff on shift looked at her neck as well. The shape and placement of the scratched look a lot like a hand mark. I asked (Resident A) with other staff present if anyone had grabbed her neck. (Resident A) signed "yes" 3x after being asked 3x. We attempted to ask if she knew who did it but her answers were inconsistent. First time she was asked was at around 6 pm, asked her again if anyone had grabbed her neck and she signed "yes" again at 8 pm. I don't know what happened to her neck or when it happened, I'm concerned about the look of it.'*

On January 10, 2024, I contacted Home Manager Irene Keigley. She stated that Resident A is non-verbal. Her parents had both recently passed away and she has been "having behaviors" while staff try to transfer her. She had also been tipping her head back while in her wheelchair to the point she rubbed a spot on her head bald. When this was noticed her doctor instructed staff to remove the headrest off Resident A's wheelchair. Ms. Keigley also noticed dry skin on Resident A's neck at this time and began putting lotion on her skin, but it wasn't fixing the problem. Resident A's skin on her neck did appear to have eczema and had cracked. Ms. Keigley and I discussed treatment for eczema and dry skin. Ms. Keigley expressed her belief that the marks on Resident A's neck were from the cracks and eczema. She did not believe the marks were caused from being grabbed around the neck.

The details she had been informed of were that on January 4th staff Zoe Francis and staff Desare Gabriel were helping Resident A in the shower and noticed marks on her neck. They asked Resident A about them and if it hurt which Resident A signaled yes (she squeezes your hand to indicate "yes"). Staff continued to put lotion on it but it was not looking better. Ms. Keigley informed all staff to keep Resident A's neck moisturized and put her headrest back on her wheelchair to keep her head from tipping back and irritating the dry skin. Some days passed and her neck started looking better. It was almost gone and then Ms. Francis informed Ms. Keigley that she had filed the ORR complaint. There was no further discussion that Ms. Keigley had with Ms. Francis. Ms. Keigley did not know who the allegations were against.

Ms. Keigley stated she was "shocked" when she heard the allegation and never would have guessed one of her staff would maliciously hurt any of the residents. She did not have any history of such problems and no current concerns with the staff.

On January 30, 2024, I conducted an unannounced home inspection. Resident A was home at the time of my visit. Ms. Keigley was also home and assisted with Resident A due to her non-verbal cognition. I met with Resident A and Ms. Keigley in Resident A's room. It was obvious that Resident A does not have the cognitive ability to be interviewed. I observed her neck and it appeared to be healed with no sign of dry skin, scratches, or other marks. I observed that the questions I asked Resident A were then repeated by Ms. Keigley who was holding Resident A's hand and she was able to indicate "yes" by squeezing Ms. Keigley's hand. Due to staff previously interviewing Resident A, I determined questions and Resident A's responses to have already been "tainted" by staff Zoe Francis.

On February 12, 2024, I received a call back from staff Desaree Gabriel. She reiterated the statements in the complaint without any new information. She saw the marks on Resident A's neck and thought they were scratches from something. When Ms. Keigley spoke to staff to tell them about Resident A's dry skin, Ms. Gabriel assumed it was related. Then Ms. Gabriel heard Ms. Francis questioning

Resident A if someone hurt her. Ms. Gabriel believed it was then that Ms. Francis filed the ORR complaint.

On February 12, 2024, I called Ms. Hockey to obtain the ORR report. She informed me that ORR had substantiated against staff Becky Freese whom they have since terminated due to the ORR findings.

After unsuccessful attempts to contact Ms. Francis, I utilized the ORR report which contained her interview. It stated: *'When I arrived on shift Irene told me about the dry skin on (Resident A's) neck and that it was because she was pushing her head back in to her wheelchair. A little later while toileting her I cleaned up her neck before starting a shower and noticed that there were marks and scratches on either side of her neck. When I gave her the shower is when I noticed the bruising. Ms. Francis went on to say that, "I asked the 3rd shift staff, Desiree and Becky, if they knew what happened and Becky told me that, "maybe I scrubbed her neck to hard." I took another staff with me and asked (Resident A) if someone had grabbed her neck and she signed 'yes'. I asked her 3 separate times, but her answers were inconsistent.*

I was also unable to obtain a call back from staff Becky Frees who has been terminated from employment. In the ORR report it stated that Ms. Frees did state; *'I could have washed her face and neck to (sic) hard.'*

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:	The allegation was made that Resident A had marks on her neck due to abuse by staff. Resident A is non-verbal. Staff Zoe Francis had "interviewed" Resident A numerous times about the marks on her neck which Ms. Francis states she received confirmation someone had hurt her. The marks on Resident A's neck do not clearly indicate that she was physically grabbed or struck. Staff Becky Frees admitted it was possible, that while washing Resident A's neck, she rubbed too hard, according to ORR reports.

	ORR did substantiate Ms. Frees and she has since been terminated. There is a preponderance of evidence that Resident A was not protected from harm in this incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

On February 26, 2024, I conducted an exit conference with Designee Kathy Hockey. We discussed the allegations and my findings. She agreed to send a corrective action plan and had no further questions.

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change to the current license status.

February 26, 2024

Rebecca Piccard Date
Licensing Consultant

Approved By:

February 26, 2024

Jerry Hendrick Date
Area Manager