GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 28, 2024

Sandra Costello
Hope Network Rehabilitation Serv
1490 E Beltline SE
Grand Rapids, MI 49506

RE: License #: AL330417843
Investigation #: 2024A1033038
HNRS Cedarwood

Dear Ms. Costello:

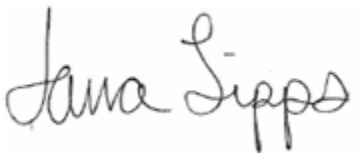
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9730.

Sincerely,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330417843
Investigation #:	2024A1033038
Complaint Receipt Date:	04/24/2024
Investigation Initiation Date:	04/29/2024
Report Due Date:	06/23/2024
Licensee Name:	Hope Network Rehabilitation Serv
Licensee Address:	1490 E Beltline SE Grand Rapids, MI 49506
Licensee Telephone #:	(517) 332-1616
Administrator:	Sandra Costello
Licensee Designee:	Sandra Costello
Name of Facility:	HNRS Cedarwood
Facility Address:	2711 East Lansing Drive East Lansing, MI 48823
Facility Telephone #:	(517) 332-1616
Original Issuance Date:	11/21/2023
License **Status:**	TEMPORARY
Effective Date:	11/21/2023
Expiration Date:	05/20/2024
Capacity:	14
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was dropped while being transferred with her Hoyer lift, resulting in an intracerebral hemorrhage.	Yes
Resident A has been sexually assaulted by direct care staff, Tony Schornak.	No
Additional Findings	Yes

III. METHODOLOGY

04/24/2024	Special Investigation Intake 2024A1033038
04/24/2024	APS Referral- Denied APS referral.
04/24/2024	Contact - Telephone call made- Attempt to interview APS referral source. Voicemail message left, awaiting response.
04/29/2024	Contact - Telephone call made- Attempt to interview APS referral source. Voicemail message left, awaiting response.
04/29/2024	Special Investigation Initiated – Letter- Email correspondence sent to Adult Protective Services, Adult Services Worker, Holly Franck.
04/29/2024	Contact - Document Received- Email correspondence received from APS, Holly Franck.
04/30/2024	Inspection Completed On-site- Interviews conducted with direct care staff, Anthony Schornak, Allison Hansel, licensee designee, Sandra Costello, Resident A. Review of Resident A and Resident B's resident records initiated.
04/30/2024	APS Referral- Investigation assigned to Adult Services Worker, Holly Franck.
04/30/24	Exit Conference- Conducted on-site with licensee designee, Sandra Costello.

ALLEGATION: Resident A was dropped while being transferred with her Hoyer lift, resulting in an intracerebral hemorrhage.

INVESTIGATION:

On 4/24/24 I received an online complaint regarding the HNRS Cedarwood adult foster care facility (the facility). The complaint alleged that Resident A was dropped while being transferred with her Hoyer lift which resulted in an intracerebral hemorrhage. The complaint alleged that this incident was due to direct care staff negligence at the time of the incident. On 4/29/24 I sent and received email correspondence from Adult Protective Services, Adult Services Worker, Holly Franck, regarding the allegations. Ms. Franck reported that she was currently assigned to this investigation and had been to Sparrow Hospital to interview Resident A. She reported that Resident A is difficult to communicate with and noted she would like to conduct a follow up interview with Resident A with this licensing consultant.

On 4/30/24, Ms. Franck and I conducted an unannounced, on-site investigation at the facility. We interviewed direct care staff, Anthony “Tony” Schornak, regarding the allegations. Mr. Schornak reported that he is currently an Assistant Supervisor at the facility. He reported that he has worked on and off for the facility for a period of about nine years. Mr. Schornak reported that Resident A can only have her personal care needs provided by female staff members as stated in her *Resident Care Agreement*. He reported that he was not present on the date, 4/12/24, when the incident with Resident A's Hoyer lift occurred but he did receive report from direct care staff, Sharece Webb, regarding the incident. Mr. Schornak reported Ms. Webb and direct care staff, Allison Hansel, were working together to transfer Resident A with the Hoyer lift when the strap was not properly strapped and Resident A fell to the bathroom floor, causing injury to her knee and her head. Mr. Schornak reported that these are the facts that Ms. Webb reported to him. He reported Resident A was taken to the emergency department and then admitted to the hospital for a couple of days due to the injuries sustained in the incident. He further reported that he drove Resident A for a follow up visit to a medical provider on 4/22/24 for a visit related to these injuries. Mr. Schornak reported that all direct care staff must complete a training on the use of Hoyer lifts prior to assisting with Hoyer lift transfers. Mr. Schornak reported that this class is either led by licensee designee, Sandra Costello, or one of the physical therapists on-site. He reported he believes the training is called, “Mobility & Transfer Training” and he reported that Resident A requires two direct care staff to assist with her Hoyer lift transfers so that the second staff can ensure that all straps have been successfully connected.

On 4/30/24, during the on-site investigation, Ms. Franck and I interviewed Ms. Hansel regarding the allegation. Ms. Hansel reported that on 4/12/24 she and Ms. Webb were transferring Resident A, via her Hoyer lift, to the shower. She reported that all straps had been connected. Ms. Hansel reported that they then heard a loud popping noise and Resident A began to fall to the floor, headfirst. Ms. Hansel reported that one strap had come unlatched and caused the Hoyer lift to drop backwards, but the other straps were still holding Resident A in the air. She reported that Resident A fell backwards, and

her head hit the leg of the Hoyer lift. Ms. Hansel reported that Resident A did not have any loss of consciousness, bleeding, or confusion at the time of the incident. She reported that Ms. Webb made attempts to contact the facility supervisor on duty that day and then they contacted 911 for assistance and assessment of Resident A's injuries. Ms. Hansel reported that initially they had thought the strap on the Hoyer lift broke, but after the incident they did an assessment of the Hoyer lift and none of the straps were broken. She reported that the strap that came loose must not have been tightened properly. Ms. Hansel reported that Resident A was sent to the hospital and stayed a couple of days, due to her injuries. When Ms. Hansel was questioned about the training, she had received to transfer residents via Hoyer lift, Ms. Hansel reported that she received training after the incident occurred, from the occupational therapist at the facility.

On 4/30/24, during on-site investigation, Ms. Franck and I interviewed Ms. Costello regarding the allegation. Ms. Costello reported that she had been working the date of 4/12/24 at the time of the incident with Resident A's Hoyer lift. She reported that she had been off site getting lunch when the incident occurred. Ms. Costello reported that she had received a telephone call from the direct care staff regarding the incident and had gone back to the facility to check on Resident A. She reported she spoke with direct care staff, Tristan Albrecht, regarding the incident. Ms. Costello reported that when she arrived at the facility Resident A was on the bathroom floor laying on her back. She reported that she was informed Resident A had hit the back of her head on the left leg of the Hoyer lift when she fell and that 911 had been called to assess the resident. Ms. Costello reported that initially Ms. Webb and Ms. Hansel assumed that the Hoyer lift strap had broken when they were transferring Resident A, which caused the fall. Ms. Costello reported that this was found to not be accurate information after they assessed the equipment post incident. She reported that they assessed that the strap had slipped out of place, causing the Hoyer lift malfunction. Ms. Costello reported that Resident A sustained a 0.2cm subdural hematoma because of the incident. She reported that on 4/12/24 the CT result was negative for a subdural hematoma but on 4/13/24 the bleed had developed and the CT scan was now positive for a subdural hematoma. Ms. Costello reported that the facility has trainings in place to train direct care staff to Hoyer lift use and transfers. She reported that they have a "Mobility & Transfers Training" and a "Just in Time Training" regarding Hoyer lifts. Ms. Costello reported that after the incident she had verified trainings for Ms. Webb and Ms. Hansel and noted that Ms. Webb had received full training for Hoyer lift transfers, but Ms. Hansel had not completed her Hoyer lift transfer trainings. Ms. Costello reported that on 4/12/24 she had occupational therapist, Shanna Thelen, complete the Hoyer lift transfer training with Ms. Hansel.

During the on-site investigation on 4/30/24, I reviewed the following documents:

- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 4/12/24. Under the section, *Facts of the Incident*, it reads, "While transferring client for a brief change heard a loud pop sound as [Resident A] started to dangle from her Hoyer lift, as staff and I attempted to lower her to the ground, she slid further from out of her sling and hit her head on the metal leg of the lift. 2nd staff

attempted to protect her head as I continued to lower her to the ground. We did a brief assessment of [Resident A], she was alert the entire time, she responded to our questions. [Resident A] stated increased blurred vision more than at baseline. We contacted paramedics and one of our RN's. [Resident A] is in route to Sparrow Hospital. After contacting paramedics, staff examined the sling and no rips or tears were found." Section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, reads, "[Occupational Therapist] completed mobility and transfer training with both involved staff. Review of Compass indicated that one staff had already completed this training, however the other staff had not. The Hoyer lift used for the patient was identified as having an open-loop system for placing the loops of the sling, which led to the loops being able to slide off if not looped through far enough; this is an HNNR-provided Hoyer lift as the patients' Hoyer lift is currently out of commission. All HNNR lifts were assessed, and this is the only lift with the open-loop system. Program management is in the process of upgrading to closed-loop lifts to prevent future occurrences of sling sliding off the bar. Hoyer lift was replaced with another HNNR Hoyer lift that has a closed-loop system. SW/CM is in the process of ordering patient a new patient-owned lift, as she is due for a replacement."

- *HNNR Patient Care Form,* for Resident A, dated 1/11/24. Under section, *Transfers*, it reads, "Hoyer lift with 2 staff."

APPLICABLE RULE	
R 400.15303	**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:	Based upon interviews with Mr. Schornak, Ms. Hansel, and Ms. Costello, as well as review of Resident A's resident record, it can be determined that Resident A's care plan requires the assist of two direct care staff for transfers with her Hoyer lift device. Upon review of the documentation provided and based upon interviews given it can be determined that Ms. Hansel had not been properly trained to use a Hoyer lift prior to being assigned to assist Ms. Webb in transferring Resident A in her Hoyer lift. It was determined after the incident that the Hoyer lift strap was not connected correctly and/or securely causing it to slip out of place, leading to Resident A being dropped from the lift and hitting her head. This fall ultimately resulted in a subdural hematoma injury for Resident A. Since Ms. Hansel was not properly trained, direct care staff did not provide adequately for Resident A's protection and safety during this Hoyer lift transfer. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(d) Personal care, supervision, and protection.**
ANALYSIS:	Based upon the interviews with Ms. Hansel and Ms. Costello, as well as review of Ms. Hansel's training record, it can be determined that Ms. Hansel had not been properly trained to use a Hoyer lift, prior to assuming the responsibility of assisting Ms. Webb in transferring her via her Hoyer lift on 4/12/24. Ms. Hansel did not demonstrate competence prior to completing this task, ultimately resulting in the injury of Resident A, therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A has been sexually assaulted by direct care staff, Tony Schornak.

INVESTIGATION:

On 4/24/24 I received an online complaint regarding the facility. The complaint alleged that Resident A is being sexually assaulted at the facility by direct care staff, Tony Schornak. On 4/30/24 Ms. Franck and I conducted an unannounced on-site investigation and interviewed Mr. Schornak regarding the allegations. Mr. Schornak reported that there is a policy at the facility that Resident A is only to have females provide for her personal care, including toileting procedures. He reported that he has never assisted Resident A in the shower or with any of her incontinence brief changes. Mr. Schornak reported that he has never assisted Resident A with dressing or any form of personal hygiene. Mr. Schornak adamantly denied ever sexually assaulting Resident A in any capacity. Mr. Schornak reported that he does provide transportation for Resident A and does so independently. When inquired what his protocol is if Resident A requires personal care/toileting when she is in the community, alone, with Mr. Schornak, he reported that he would have the staff at the physician's office assist with her personal care, or he would wait until they returned to the facility so that a female direct care staff member could assist. Mr. Schornak reported that to his knowledge there has never been a male staff member provide for Resident A's personal care, including showering and toileting needs. Mr. Schornak reported that to his knowledge, Resident A has never

made a complaint that someone was being inappropriate with her, or sexually assaulting her in any way.

On 4/30/24, during the on-site investigation, Ms. Franck and I interviewed Ms. Hansel regarding the allegation. Ms. Hansel reported that only female staff provide any type of personal care to Resident A, per their policy. Ms. Hansel reported that she has never observed a male direct care staff member assist with Resident A's personal care. She further reported that female staff members are scheduled for every shift. Ms. Hansel reported that Resident A has not made any direct allegations to her regarding concerns of anyone sexually assaulting her at the facility. Ms. Hansel reported that she does complete incontinence brief changes and showers for Resident A and she has never noticed any physical signs of abuse when providing this care. She reported no instances where she has observed, scratches, bleeding, bruising, or any other signs of abuse that would cause alarm or questions. Ms. Hansel reported that Mr. Schornak does take Resident A to her medical appointments. She reported that she is not certain what the protocol for Resident A's personal care needs would be if she required personal care while away from the facility with just a male direct care staff member.

During the on-site investigation on 4/30/24, Ms. Franck and I interviewed Resident A. Resident A is very difficult to understand due to her communication difficulties. She speaks rather softly and has a difficult time annunciating words. She requires the use of a voice amplifier to communicate effectively. Resident A reported that Mr. Schornak does not perform any of her personal care or incontinence brief changes. She reported that sometimes he administers medications and he will transport her to her medical appointments. Resident A reported that when Mr. Schornak transports her to her medical appointments she will need to wait for a brief change until she returns to the facility as a female direct care staff member does not attend with Mr. Schornak and she does not want to receive care from a male direct care staff member. Resident A reported that she feels safe with Mr. Schornak and she has no concerns about the care he is providing to her. She denied that Mr. Schornak has ever sexually assaulted her. Resident A reported that Resident B will come into her resident bedroom from time to time to "play with me." She reported that she does not like Resident B. She reported that Resident B will sneak up on her in the facility. Ms. Franck and I attempted to determine what Resident A was referring to by the statement, "play with me." Resident A became frustrated with this licensing consultant and Ms. Franck and requested that we leave her resident bedroom. She did deny that Resident B is naked when he is in her bedroom. It was this question that made her upset and requested the interview to end. She did not provide any concrete details regarding Resident B's behaviors.

During the on-site investigation on 4/30/24 Ms. Franck and I interviewed Ms. Costello. Ms. Costello reported that she has never received any reports of allegations that anyone at the facility has sexually assaulted Resident A. Ms. Costello reported that Resident A has never stated to her that Resident B is coming into her bedroom to "play with [Resident A]." Ms. Costello reported that Resident A and Resident B have both been residents of the facility for multiple years. She reported that they know one another well and there was a point when Resident A requested that Resident B be moved to

another hallway of the facility because she did not like his lack of cleanliness. Ms. Costello reported that this is the only complaint Resident A has made about Resident B. Ms. Costello reported that she has not received any reports from direct care staff or other residents that Resident B has been wandering into other resident bedrooms. Ms. Costello reported that Resident B does not have a history of sexually inappropriate behaviors. Ms. Costello reported that this is not a behavior Resident B has exhibited thus far. Ms. Costello reported that the facility is staffed with at least two to three direct care staff members during overnight hours and these direct care staff are awake during these overnight shifts.

During the on-site investigation on 4/30/24, Ms. Franck and I conducted a follow-up interview with Mr. Schornak. Mr. Schornak reported that he is familiar with Resident B's behaviors. He reported that Resident B does not have a history of wandering into other resident bedrooms at the facility. He reported that Resident A has not made any complaints to him about Resident B's behaviors. Mr. Schornak reported that Resident B does not have a history of sexually inappropriate behaviors to this point. He further reported that Resident A has not made any complaints, to his knowledge, about Resident B wandering into her room at night.

APPLICABLE RULE	
R 400.15305	**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:	Based upon interviews with Mr. Schornak, Ms. Hansel, Resident A, Ms. Costello, it can be determined that there is no evidence Mr. Schornak has sexually assaulted Resident A in any way. Resident A denied these allegations and Mr. Schornak adamantly denied these allegations. There was no identified source of where the allegations stemmed from and no evidence to suggest that Resident A is being assaulted in any manner. Resident A made statements regarding Resident B coming into her bedroom uninvited, but ended the interview on her own accord and did not elaborate on what these allegations were in reference to. There is a significant lack of evidence and information to suggest that Resident A is being sexually assaulted in any way at the facility. A violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 4/30/24 Ms. Franck and I interviewed Mr. Schornak. Mr. Schornak reported that there is a policy at the facility that Resident A is only to have females provide for her personal care, including toileting procedures. He reported that he has never assisted Resident A in the shower or with any of her incontinence brief changes. Mr. Schornak reported that he has never assisted Resident A with dressing or any form of personal hygiene. Mr. Schornak adamantly denied ever sexually assaulting Resident A in any capacity. Mr. Schornak reported that he does provide transportation for Resident A and does so independently. When inquired what his protocol is if Resident A requires personal care/toileting when she is in the community, alone, with Mr. Schornak, he reported that he would have the staff at the physician's office assist with her personal care, or he would wait until they returned to the facility so that a female direct care staff member could assist. Mr. Schornak reported that to his knowledge there has never been a male staff member provide for Resident A's personal care, including showering and toileting needs.

On 4/30/24, during the on-site investigation, Ms. Franck and I interviewed Ms. Hansel. Ms. Hansel reported that only female staff provide any type of personal care to Resident A, per their policy. Ms. Hansel reported that Mr. Schornak does take Resident A to her medical appointments. She reported that she is not certain what the protocol for Resident A's personal care needs would be if she required personal care while away from the facility with just a male direct care staff member.

During the on-site investigation on 4/30/24, Ms. Franck and I interviewed Resident A. Resident A reported that Mr. Schornak does not perform any of her personal care or incontinence brief changes. She reported that sometimes he administers medications, and he will transport her to the medical appointments. Resident A reported that when Mr. Schornak transports her to her medical appointments she will need to wait for a brief change until she returns to the facility as a female direct care staff member does not attend with Mr. Schornak and she does not want to receive care from a male direct care staff member.

During the on-site investigation on 4/30/24 Ms. Franck and I interviewed Ms. Costello. Ms. Costello reported that there are times when Mr. Schornak provides independent transportation to Resident A to her medical appointments. She reported that they do not have a plan in place for how Resident A would receive incontinence care if she required this care while away from the facility with only a male direct care staff member available to assist her. Ms. Costello reported that Resident A's *Resident Care Agreement* document does include the provision that she is not agreeable to accept personal care/incontinence care from a male direct care staff member.

During the on-site investigation on 4/30/24, I reviewed the following document from Resident A's resident record:

- *AFC Resident Care Agreement*, dated 1/5/24. This document reads, under section, *Resident or Designate Representative Check All Boxes Below That Apply*, “I do not agree to receive assistance in bathing, dressing, or personal hygiene by a staff member of the opposite sex, if a member of the same sex is not available.”

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(6) A licensee shall afford a resident the opportunity to receive assistance in bathing, dressing, or personal hygiene from a member of the same sex, unless otherwise stated in the home's admission policy or written resident care agreement.
ANALYSIS:	Based upon interviews with Mr. Schornak, Ms. Hansel, Ms. Costello, and Resident A, as well as review of Resident A’s *Resident Care Agreement* form, it can be determined that Resident A does not agree to receive care from male direct care staff members in regards to her personal care, hygiene, and incontinence brief changes, yet a male direct care staff member transports Resident A, independently to medical appointments without a plan in place for how Resident A’s incontinence care will be provided for while she is away from the facility in the event of this need arising. Based on this information, there is demonstration that Resident A’s *Resident Care Agreement* is not able to be followed and her care is compromised by the administration allowing a male direct care staff to transport her, alone, to her medical appointments.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

5/16/24

_____

Jana Lipps Date
Licensing Consultant

Approved By:

05/28/2024

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Dawn N. Timm Date
Area Manager