GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 13, 2024

Clifford Brown
Care Assistant Living Home Inc.
430 Franklin Lake Circle
Oxford, MI 48371

RE: License #: AS630325547
Investigation #: 2024A0605024
Care Assisted Living 3

Dear Clifford Brown:

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,

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630325547
Investigation #:	2024A0605024
Complaint Receipt Date:	04/10/2024
Investigation Initiation Date:	04/10/2024
Report Due Date:	06/09/2024
Licensee Name:	Care Assistant Living Home Inc.
Licensee Address:	430 Franklin Lake Circle Oxford, MI 48371
Licensee Telephone #:	(248) 722-7171
Administrator:	Ebony Goree
Licensee Designee:	Clifford Brown
Name of Facility:	Care Assisted Living 3
Facility Address:	28948 Herndonwood Drive Farmington Hills, MI 48334
Facility Telephone #:	(248) 536-2044
Original Issuance Date:	09/07/2012
License **Status:**	REGULAR
Effective Date:	04/24/2024
Expiration Date:	04/23/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has significant injuries. Direct care staff (DCS) deny that she had any falls.	Yes

III. METHODOLOGY

04/10/2024	Special Investigation Intake 2024A0605024
04/10/2024	Special Investigation Initiated - Telephone Discussed allegations with reporting person (RP)
04/10/2024	APS Referral Adult Protective Services (APS) made referral
04/10/2024	Contact - Telephone call made Left message for APS worker Johnathan Johnson
04/10/2024	Contact - Face to Face Contact made with Resident A and attending physician Dr. Kamelia Albujoq at Henry Ford West Bloomfield Hospital
04/10/2024	Contact - Telephone call made Discussed allegations with the physician's assistant (PA) Rebecca Kahn at Henry Ford West Bloomfield Hospital
04/11/2024	Inspection Completed On-site Conducted an unannounced on-site investigation in collaboration with APS worker Jonathan Johnson
04/11/2024	Contact - Telephone call made Interviewed direct care staff (DCS) Michelle John and DCS Denise Johnson in collaboration with APS worker Jonathan Johnson
04/11/2024	Contact - Telephone call made Interviewed hospice nurse Dawnitta with Millennium Home Health Care (HHC)
04/11/2024	Contact - Telephone call made Discussed allegations with Dr. Bryant, Resident A's doctor
04/17/2024	Contact - Telephone call received Follow up with APS worker Jonathan Johnson

04/22/2024	Contact - Telephone call received Discussed allegations with licensee designee Clifford Brown
04/22/2024	Contact - Telephone call made Left message for Detective Bragole with Farmington Hills Police Department (FHPD)
04/22/2024	Contact - Telephone call received Discussed allegations with Detective Bragole
04/29/2024	Contact - Telephone call received Follow up call received from licensee designee Clifford Brown
05/01/2024	Contact - Telephone call received Discussed allegations with Director of Operations Chandra Grant and Detective Bragole
05/01/2024	Contact - Telephone call made Left message for Resident A's guardian
05/20/2024	Contact - Document Sent Email to APS
05/20/2024	Contact - Document Received Email from APS
05/22/2024	Contact - Telephone call made With physical therapist (PT) Yomi and the Director of Nursing Lex with Millenium Home Health Care (HHC)
05/23/2024	Contact - Document Received Email from Chandra Grant
05/28/2024	Contact - Telephone call made Followed up with Director of Nursing Lex with Millenium HHC and Detective Bragole with FHPD
05/28/2024	Contact - Telephone call received From PT Yomi with Millenium HHC
06/13/2024	Exit Conference Conducted exit conference with licensee designee Clifford Brown with my findings.

ALLEGATION:

Resident A has significant injuries. Direct care staff (DCS) deny that she had any falls.

INVESTIGATION:

On 04/10/2024, intake #200404 was referred by Adult Protective Services (APS) regarding Resident A went to Henry Ford West Bloomfield Hospital complaining of right sided leg pain. Resident A has significant injuries, which include compound fracture in her right arm, right and left rib fractures and has new and old compression spine fractures. Resident A also has chronic wounds which are consistent for someone who has not moved out of bed.

On 04/10/2024, I interviewed the reporting person (RP) regarding the allegations. Resident A presented to the hospital via ambulance. The RP spoke with Chandra Grant who reported that the right leg was swelling, and Resident A complained of pain after she was struck in the right knee with her wheelchair. Ms. Grant denied any recent falls or any trauma. The injuries are inconsistent with Ms. Grant's explanation. Resident A has a compound fracture of her right arm, below her elbow. There are some old fractures to her right and left ribs and new fractures found on right and left ribs. Resident A has "bruising everywhere," and skin breakdown to her bone which lead to an infection. The RP stated, "at a minimum, Resident A was neglected as she had not been moved and at most she was abused, given her injuries." Pictures were taken of her pressure wounds. Per the physical therapist (PT) and occupational therapist (OT) Resident A was total assist which means she was a two-person assist.

On 04/11/2024, I followed up with APS worker Jonathan Johnson who was investigating these allegations. Mr. Johnson went to the hospital to see Resident A yesterday and agreed to conduct a joint investigation. He will meet me at this group home today.

On 04/11/2024, I attempted to make a face-to-face visit with Resident A at Henry Ford West Bloomfield Hospital but was informed that I was unable to go into her room as she was being cared for by her nurse. I discussed the allegations with the attending physician, Dr. Kamelia Albujoq. The following injuries were found; right hip posterior fracture, bi-lateral rib fractures, right forearm compound fracture, lumbar compression fracture, and some old ribs and spine fractures. The right tibia fibula contracture- twisted leg. She also had a pressure wound on her right hip that Dr. Albujoq stated, "this does not happen overnight. She was not turned for long periods of time." Dr. Albujoq believes that the compound fracture of the arm may have occurred if someone pulled Resident A's arm. Regarding the injuries to the right side of the body, Dr. Albujoq believes that Resident A was "possibly," dropped as that would explain how she sustained the fractures to her right side. Resident A is a full assist, and it is unclear what her baseline is, but she requires two people to provide her with care while she has been here at the hospital. Resident A is also malnourished and extremely frail. She is too frail to undergo

debridement for the right hip wound, so she will be transitioning to comfort care and then hospice.

Dr. Albujoq provided me with the notes pertaining to Resident A while in the emergency room and in the intensive care unit. Resident A had imaging that revealed: minimally displaced fracture of the mid-distal ulnar diaphysis in right wrist with soft tissue swelling; intramedullary rod in right femur-fracture of right proximal tibia and fibula: CT imaging revealed: multiple chronic rib fractures on bilaterally acute rib fractures bilateral 10th and 11th ribs; severe compression deformity chronic at L1, L2, L5, T12- acute LS compression deformity, moderate compression L4, T7, T9. I also was provided with pictures of the wounds found on Resident A. Wound on her right heal, open wound on her coccyx, and left hip. Bruising on back and legs. Prognosis poor.

On 04/11/2024, I along with APS worker Jonathan Johnson conducted an unannounced on-site investigation at Care Assisted Living 3. Present was the home manager (HM)/administrator Ebony Goree, Resident B, Resident C, and Resident D. Resident B and Resident C were sitting in the living room and Resident D was lying in her bed. Resident D shared a room with Resident A. I interviewed Resident B and Resident C in the living room. Both reported they do not know who Resident A is. They do not know how many residents live here and both stated, “people come and go.” They reported no concerns regarding staff or observing anyone falling.

I interviewed the HM/administrator Ebony Goree regarding the allegations. Resident A had a diagnosis of dementia and osteoarthritis. Her guardian is Advocates for Independence and Self-Reliance, Jamesa McCarty with Jennifer Carney’s office. Resident A received home health care (HHC) with Millennium HHC. She had a registered nurse (RN) Dawnitta and physical therapist (PT) Yomi coming to the home weekly. On 03/30/2024, Resident A began complaining about right leg pain to direct care staff (DCS) Denise Johnson. Ms. Johnson reported this complaint to Ms. Goree who then contacted Dr. Everett Bryant, Resident A’s primary care visiting physician (PCP) informing him of her leg pain complaint. Due to Resident A’s surgery on her right hip and knee prior to her admission, Dr. Bryant ordered an X-ray. The X-ray technician came to the home on 04/01/2024 and the results were no fractures. Resident A was still complaining about pain. Dr. Bryant recommended pain medication and if no improvement in pain, then refer to orthopedic evaluation. He did not give a timeframe on when to call him, but she knew that the RN would be coming in a couple of days. On 04/05/2024, RN Dawnitta arrived at the home to see Resident A for her scheduled appointment and wound care. The RN observed Resident A’s leg discolored and then called Dr. Bryant who advised the RN he will come to the home to see Resident A. On 04/06/2024, Dr. Bryant arrived at the home and examined Resident A. Dr. Bryant ordered a doppler test. The doppler test was completed on 04/06/2024 and the results were sent to Ms. Goree on 04/08/2024 stating that everything was normal. Dr. Bryant then advised Ms. Goree to send Resident A to the hospital, which an ambulance was called, and she was transported to the hospital on 04/08/2024. Ms. Goree was surprised to hear all the fractures, old and new that were found on Resident A. She denied ever dropping Resident A and stated that DCS Michelle John and DCS Denise Johnson have

never reported any recent falls. The only fall Resident A had was on 12/12/2023 when she rolled out of bed. Dr. Bryant ordered bedrails and bumper pads. Since that fall, Ms. Goree denied any other falls. Ms. Goree denied any abuse of Resident A by her or any other staff at this home. Resident A is wheelchair bound; therefore, she requires full assist. She is a one-person assist with the Hoyer lift for all transfers. Ms. Goree cannot provide an explanation as to the injuries because when the ambulance came to the home on 04/08/2024 to get Resident A, she was using her right hand/arm eating her food and the X-ray showed no fracture. Resident A cannot roll herself; she cannot fall out of bed and no staff reported any fall or trauma to Ms. Goree on 03/30/2024 or any other day leading up to her recent hospitalization.

Ms. Goree stated when Dr. Bryant was at the home on 04/06/2024, Heart to Heart Hospice and Resident A's guardian, Jamesa McCarty were also present. Hospice was discussed for Resident A, but Ms. McCarty was against it and refused hospice services, even though Dr. Bryant recommended it since Resident A was declining. Resident A had a stroke in 01/2024 and since then, she was declining. She was eating but not gaining weight. Dr. Bryant reported, "Resident A's body is not absorbing the nutrition from the food, making it difficult for her wounds to heal and for her to gain weight." He informed Ms. McCarty this information, but again she refused hospice services. Ms. Goree stated that two DCS were weighing Resident A by holding her under her armpits and getting her on the scale; therefore, the weights are not 100% accurate. Resident A was being rotated every two-hours as per RN. Per RN, staff were trained to clean the wound using wound cleanser provided by the RN and then pack the wound. The wound was not healing due to Resident A's body not absorbing the nutrition with food due to her decline. Dr. Bryant had discussed a wound care doctor if the guardian continued to refuse hospice, but then Resident A was hospitalized. Despite repositioning and completing wound care on Resident A, her wounds were not healing.

I reviewed the RN notes which indicated the following:

- On 09/21/2023, HHC began services on 07/15/2023 and at that time patient had multiple necrotic wounds. Patient had staples to the right hip, thigh, and knee from a previous surgery. Wounds were to the left and right heel covered with black eschar at that time. Multiple changes were made in patient's daily care; heel protectives, allowing patient to be up in chair for no more than two-hours twice daily, elevating lower extremities, and ensuring that patient is eating a variety of foods to aid in wound healing. Patient developed two new wounds on 08/03/2023 to the right ischium which has now healed and the right lower back, stage three. An order has been placed for an air mattress. Currently wounds to the heels are healing without complications. No necrotic tissue present. Woulds continue to show signs of healing as of this time. No necrosis, no odor, no purulent drained noted.
- On 03/06/2024, visit was made today to assess patient after recent hospitalization for stroke. Patient was discharged from HHC nursing services on 02/22/2024. At that time, patient had no open wounds. Patients skin is very thin, and she usually has bruising to her arms and legs. Upon examination, patient has developed two new skin tears. A large one to the left calf and a small one to the left forearm. Neither of

these wounds were present upon discharge of nursing services. Nursing will resume care for wound care and education on stroke prevention, to ensure patients' needs are met.

- On 04/04/2024, patient has declined significantly in the past two months. Guardian notified of patients declining status and possible need for hospice care. Patient is in pain, which she rarely complains of pain. Her pain is generalized, and she is unable to indicate source. Patient has developed two new wounds in the past week despite regular turning and repositioning. Patient appears weak and pale in color. Vitals remain stable at this time. Patient falls asleep frequently during this visit and is intermittently confused. PCP notified of patients decline and possible need for hospice care.

I reviewed Resident A's body mapping that the group home documented each time a skin tear, bruising, or mark is found on Resident A's body. Body mapping was completed on 06/23/2023, 08/27/2023, 10/14/2023, 12/28/2023, 01/15/2024, 02/07/2024, 03/04/2024, 04/01/2024, and on 04/04/2024. DCS were documenting charting their observations at the beginning of each shift as to the skin tears, bruises, marks, and pressure wounds observed. DCS were also charting each time Resident A returned from the hospital.

On 04/11/2024, I along with APS worker Jonathan Johnson interviewed DCS Michelle John via telephone regarding the allegations. Ms. John has been working for this corporation since 01/2020. She works day shift from 8AM-5PM, but sometimes she also works the midnight shift. There is usually one DCS per shift, but sometimes Ebony Goree will work with staff if there is a need. Resident A was admitted into this group home on 06/23/2023. She had undergone hip fracture surgery and was admitted with staples on her hip and leg. She was in a wheelchair. Resident A required one DCS for transfers with the Hoyer lift from her bed to her wheelchair. Resident A has never fallen on Ms. John's shift. Ms. John stated, "our policy is if a resident gets a scratch, we are required to put it on the body chart and notify management." In addition to charting residents' marks/bruises/skin tears, the staff have care meetings and discuss residents' needs and any concerns. After Resident A's first hospitalization in 01/2024, she had a decline in processing communication and her cognitive awareness. She slept more and at times, staff had to assist with feeding. Then in 03/2024, Resident A had a stroke and was hospitalized again. After this return, she rapidly declined. She was hallucinating and her communication declined. She was extremely fragile and only complained of right leg pain on 03/30/2024. An X-ray was completed on 04/01/2024 and the results were "no fracture." Resident A was still complaining about her right leg, so her doctor ordered a doppler to check her blood circulation. Those results showed that everything was "ok." Ms. John cannot explain how Resident A had new fractures on her bilateral ribs, compound fracture on her lower right arm, tibia fibula fracture on her right leg and old and new spine fractures. She said, "Resident A is bedbound so I'm not sure how she sustained these fractures. I've never witnessed her fall while being cared for by another staff nor have, I heard from anyone that a staff had dropped her." Ms. John denied causing any of these injuries to Resident A. When Ms. John repositioned Resident A in her bed, she was gentle with her because Resident A was "so fragile."

She used the bed liner to help her guide Resident A and then would put her hand on Resident A's hip and the other hand on Resident A's shoulder to turn her and then used the bed liner to adjust her after completing the turn. She never pulled or yanked her right arm to turn her. It was always putting her hand on her hip and shoulder.

When Resident A returned from the hospital in 03/2024, staff documented a wound on her left hip. Resident A was receiving wound care with an RN, Dawnitta with Millenium HHC. Per RN, DCS were advised to reposition Resident A every two-hours and change the wound dressing every two-days or as needed. When changing the wound dressing, Ms. John would clean the wound with would cleanser supplied by the RN, apply cream supplied by the RN, then place gauze on top of it and then tape. Even though staff were following RN's recommendations, repositioning and wound care, the wounds were not healing. Resident A was eating, about 99% of her food during each meal but she was not gaining weight. According to the RN and Dr. Bryant, Resident A was not processing the nutrition from her food because she was declining which was leading to weight loss and her wounds not healing even though she was eating.

On 04/11/2024, I along with APS worker Jonathan Johnson interviewed DCS Denise Johnson via telephone regarding the allegations. Ms. Johnson has worked for this corporation for about two years. She works the afternoon shift from 5PM-8AM. There is only one DCS per shift. Resident A was wheelchair bound at admission. She was complaining of leg pain, so an X-ray was completed, and it came back with "no fracture." Resident A has never fallen during Ms. Johnson's shift and Ms. Johnson denied causing any of Resident A's fractures. She denied yanking Resident A's right arm or dropping her on her right side. She uses the Hoyer lift during transfers and denied dropping her out of the Hoyer lift. Resident A only complained of the right leg pain and never complained of arm or rib pain. When Ms. Johnson was repositioning Resident A, she would slide under her and turn her from left to right. She put her hand at her side and turned her without putting any weight on Resident A.

Resident A was receiving wound care from RN Dawnitta who advised staff in 03/2024 to leave Resident A in bed and reposition her every two hours. The RN showed staff how to care for the wound on her right hip. When caring for the wound, Ms. Johnson would spray the wound with wound cleanser, then cream around the outside and then put a patch on it. She cared for the wound twice during her shift and as needed depending on how soiled it was. Ms. Johnson described the wound as "not being deep," and "did not see bone." She stated, "We did what we could." Resident A was eating but Ms. Johnson did not know why she was not gaining weight and stated, "she probably wasn't processing nutrition."

On 04/11/2024, In collaboration with APS worker Jonathan Johnson, Dr. Everette Bryant was interviewed regarding these allegations via telephone. Dr. Bryant became Resident A's PCP sometime in 10/2023. She was fully alert, conversated a lot and was friendly. She was admitted into this group home after having right hip and knee surgery and had wounds on both heels. Around 02/2024, there was an abrupt change in Resident A. She was observed with drooping of the mouth and not talkative. Dr. Bryant

sent Resident A to Henry Ford West Bloomfield Hospital where it was confirmed that, “Resident A suffered a stroke.” The stroke did some damage as Resident A was “not the same,” and “she was not improving.” Resident A was discharged back from the hospital to the group home beginning of 03/2024. Dr. Bryant was not informed by the hospital that there were any pressure wounds observed and stated, “if there were any deep pressure wounds, then the hospital should have mentioned it because Resident A was getting wound care, but they did not mention anything to be during that conversation.” After Resident A was discharged back to this group home, the group home observed wounds on Resident A’s body and contacted the RN Dawnitta to reinstate wound care services. Dr. Bryant was contacted by this group home regarding Resident A complaining of right leg pain. He ordered an X-ray that showed old fractures but no new fractures. He advised the home if Resident A continued to complain of leg pain, to call him back. He received a telephone call from Ebony Goree about a day or two later stating that there is bruising and discoloration of lower leg. Dr. Bryant ordered a doppler thinking it may be due to “poor circulation.” The doppler results were negative. He then had her sent to Henry Ford West Bloomfield Hospital as her leg was not getting better and he was concerned about the discoloration. Whenever Dr. Bryant visited Resident A at the group home, she was always in her Geri chair. He never observed staff transferring her and never observed her falling or being dropped by any staff. Dr. Bryant stated that on 04/08/2024 when he was at the home visiting with Resident A, he only observed the bruising on Resident A’s right lower leg. He stated, “I don’t know if something happened outside of the home or at the hospital, because the staff here are good about calling me if anything happened to Resident A.” Resident A never complained of any pain to him during his contacts with her.

Dr. Bryant stated he did not notice a drastic weight loss with Resident A. She was eating but not as much as before her stroke. He noticed a change with Resident A after her hospital discharge in 03/2024. He mentioned hospice services to the attending physician at Henry Ford West Bloomfield Hospital when she was there and was surprised Resident A was not discharged with hospice services. On 04/08/2024, again he felt that Resident A needed hospice services and wrote an evaluation for hospice, but he decided to send her to the hospital because of the bruising to her right leg.

On 04/11/2024, I interviewed via telephone RN Dawnitta Frazier with Millenium HHC regarding the allegations. The RN was providing nursing and wound care services to Resident A beginning 06/2023. At admission, Resident A was discharged to the group home with staples on her right hip and leg due to having surgery. The RN removed the staples. Resident A had wounds on both heels and was at the home initially twice weekly and then once a week. On 03/06/2024, Resident A’s wounds on her heels were closed as the home was providing wound care per the RN’s recommendations. On 03/28/2024, there was blanched redness on Resident A’s right hip. The RN advised the staff to not keep Resident A in her wheelchair for more than an hour per day and to reposition Resident A every two hours while in bed. On 04/04/2024, The right hip wound was not healing properly and was unstageable. There was yellow sloth with small area of black sloth about 9cm x 6 cm x 0.1 depth. There was quite of bit of drainage. There was also a wound on the left hip that was non blanchable redness. Also, the right leg

was swollen. The RN contacted Resident A's PCP, Dr. Bryant advising him of the wounds and the swelling of the right leg. Dr. Bryant ordered an X-ray of the leg which was negative for a fracture. Per the RN, her experience in working with elderly people is that their body declines and unable to heal like it normally does especially when they are not absorbing nutrition when eating. This is why, the RN recommended hospice. The RN has observed multiple bruising and skin tears on Resident A, but that is because Resident A is frail and has thin skin which the slightest bump, the skin will bruise or tear. The RN then stated, "I have no concerns of staff abuse or neglect at this home. With this facility, they have been diligent about repositioning and following my recommendations. The staff are always receptive to care and eager to follow instructions. I've made recommendations to other families for their loved ones to come and live at this home."

On 04/11/2024, the RN Dawnitta emailed me pictures of Resident A's wounds she had taken a picture of on 04/04/2024. One picture was of a wound on her buttocks that was about four and a half inches long with some black and yellow hard tissue, but the wound was not open. Another picture was of the left hip about four centimeters long purplish black in color. No open wound. The last picture was of Resident A's right lower leg that had purplish blue bruising from the knee down to her ankle. There were some skin tears on the lower right leg.

On 04/17/2024, I received a telephone call from APS worker Jonathan Johnson. He reported that Resident A passed away and he is waiting for the cause of death. He will update me once available.

On 04/22/2024, I received a telephone call from licensee designee Clifford Brown regarding the allegations. Mr. Brown is aware of the old fractures as Resident A was living independently and had fallen which resulted in her broken him and surgery. She was admitted to this group home from the hospital after her surgery with staples on her right hip and knee. He is puzzled about all the new fractures because an X-Ray was taken on 04/01/2024 of her right leg after Resident A complained of pain. The results were negative. His staff have treated Resident A with care, and he has care meetings with staff during the weekends discussing all the residents' needs. When there is a fall, the first thing staff must do is take vitals, then call management, complete an incident report (IR) and if there is a hint of injury, then 911 is called to transport the resident to the hospital. He nor anyone from management had received any IR's or calls regarding Resident A falling or had been dropped or that any injury had occurred. Resident A was extremely fragile so he believes it is possible that the new fractures may have been caused outside the home while Resident A was transported to the hospital or even at the hospital. He has questioned staff about the injuries and staff denied dropping her and denied Resident A falling and denied that they caused these injuries. Resident A only complained of leg pain and no other pain. He stated, "if these injuries happened at our home, it may be possible how staff were handling her, but I do not believe staff would cause these injuries out of malice." Resident A was bruising easily due to her frail state and very thin skin. Mr. Brown is determined to find out what happened to Resident A because his staff is trained to follow protocol and if someone dropped her

accidentally, he would want the staff to admit to this, but he again believes these injuries occurred outside the home. When Resident A was sent to the hospital on 04/08/2024, Chandra Grant received a voice mail message from the hospital saying that they will keep her to evaluate overnight and then will send her back to the group home. He does not know why the hospital would report this and then call hours later saying they found all these fractures.

Mr. Brown reported that Resident A was admitted to the group home in 06/2023 after her surgery with wounds on both heels. Resident A received wound care with the RN Dawnitta and the heels were healed because his staff was caring for the wounds. Each time Resident A was sent to the hospital and discharged back from the hospital, the staff are required to complete a skin assessment. Each time Resident A returned from the hospital, she had new pressure wounds. Also, Resident A was eating while at the group home as they have pictures of her eating. He believes due to her decline after her stroke, she was not processing her food, so the wounds were not healing and causing her to lose weight. Mr. Brown stated he will cooperate with the detective and licensing regarding this investigation as he too wants to learn what happened to Resident A.

On 04/22/2024, I received a telephone call from Detective Bragole with Farmington Hills Police Department (FHPD). She is investigating regarding Resident A's injuries. She does not want me to inform the group home of Resident A's death as she would like to interview all staff including licensee designee regarding the allegations.

On 04/29/2024, I received a telephone call from licensee designee Clifford Brown. Mr. Brown stated that his staff have been interviewed by the police and the only person left was DCS Denise Johnson. He too has asked several times if they had dropped Resident A and staff continue to say, "No."

On 05/01/2024, I received a follow-up telephone call from APS worker Jonathan Johnson. He has left a message for the guardian but received no return call. The detective observed Resident A's injuries and believed that the injuries "must be trauma caused by someone." I advised him that I will attempt to call the guardian.

On 05/01/2024, I left a voice mail message for Jamesa McCarty with Jennifer Carney's office but never received a return call.

On 05/01/2024, I received a telephone call from Detective Bragole stating that DCS Denise Johnson ended her employment with this group home and is refusing to speak with police. Ms. Johnson advised the group home she is now working for another group home. I advised Detective Bragole that I do not have any information as to staff's employment.

On 05/01/2024, I received a telephone call from Director of Operations Chandra Grant regarding the allegations. Ms. Grant was interviewed by Detective Bragole and afterwards requested to speak with DCS Denise Johnson. Mr. Grant told the police she will transport Ms. Johnson to the police station for the interview. Ms. Grant contacted

Ms. Johnson to set up the interview and Ms. Johnson initially agreed, but then on 04/30/2024, Ms. Johnson contacted licensee designee Clifford Brown advising him that she was quitting and then quit and is now refusing to speak with police. Ms. Grant was unaware of all the new fractures that were found by the hospital. She is surprised because when Resident A was sent to the hospital on 04/08/2024, she contacted the hospital at 7PM to check on Resident A. She left a message and then received a voice mail message around 7:30PM from the emergency room saying they were keeping Resident A overnight and then discharging her back to the group home the next day. Then about 10:30PM, Ms. Grant received a call informing her of all the new fractures they found. Ms. Grant asked the hospital, “what did you do to her?” An X-ray was taken on 04/01/2024 of Resident A’s right leg at the home after Resident A complained of leg pain on 03/28/2024 or on 03/31/2024. The results were negative. Resident A continued to complain of leg pain, so Dr. Bryant was called again. He ordered a doppler which was also negative. Also, Resident A was eating but not gaining weight which was another concern. PT had been working with Resident A on 03/28/2024 and told the group home that Resident A was “doing fine.” Dr. Bryant sent Resident A to the hospital on 04/08/2024 due to the bruising on the right leg that was expanding even though the X-Ray and the doppler were negative. Hospice was also discussed with the guardian on this day, but the guardian refused hospice services.

On 05/06/2024, I received an email from Chandra Grant with the voice mail left for her by the attending physician at Henry Ford West Bloomfield Hospital. The voice mail stated that Resident A was seen and will be kept overnight so she can be evaluated by PT in the morning and then discharged back to the group home.

On 05/20/2024, I received an email from APS Jonathan Johnson stating that he substantiated his case for unexplained injuries, but the perpetrator is “unknown.”

On 05/22/2024, I contacted PT Yomi with Millenium HHC. Yomi stated he is with a patient and to call Millenium HHC for his contacts as he does not recall Resident A.

On 05/22/2024, I contacted the Director of Nursing, Lex with Millenium HHC who stated she will review the notes and call me back. Never received a return call.

On 05/23/2024, I received an email from Chandra Grant with a picture of Resident A’s condition after she was discharged from Henry Ford West Bloomfield Hospital on 03/04/2024. The picture is of Resident A’s right leg with a large bandage on a wound with what appeared to be blood dripping from underneath the bandage. Next to the right leg is a leg protector that was put on the right leg from the hospital after her discharge. There are blood stains on the leg protector. Ms. Grant also included the skin assessment body mapping for Resident A completed by Ms. Goree after hospital

discharge on 03/04/2024. There is a skin tear on right upper forearm, right hand, and right knee. A skin tear on the left lower forearm, left side skin teat was dried up blood on tear, wound care completed by staff. There is a right hip skin tear and right him swelling increase. There is a left hip skin tear and a left calf skin tear.

On 05/28/2024, I followed up with Chandra Grant regarding the picture taken on 03/04/2024. Ms. Grant stated that this was the condition Resident A was sent to the group home after her discharge from Henry Ford West Bloomfield Hospital. Ebony Goree was home when the ambulance brought Resident A back on 03/04/2024. Ms. Goree immediately called Ms. Grant who advised Ms. Goree to take pictures and send them to the guardian, which Ms. Goree did. In addition, Ms. Grant advised Ms. Goree to contact the RN with Millenium HHC to begin wound care services again since Resident A was discharged with multiple wounds. Ms. Grant also sent a picture dated 04/08/2024 of Resident A using her right arm while eating dinner.

On 05/28/2024, I contacted Lex, the Director of Nursing with Millenium HHC. She reviewed Yomi, the PT's notes and reported the following.

- On 03/29/2024, Yomi visited with Resident A and completed range of motion exercises on Resident A's shoulders, elbows, forearms, fingers, wrists, trunk, knees, hips, ankles, and neck. Yomi reported stiffness in both left and right knees with Resident A reported a pain of three out of 10. Resident A also complained of lower back pain of three out of 10.
- On 04/05/2024, Yomi visited Resident A and completed range of motion exercises again on Resident A's shoulders, elbows, forearms, fingers, wrists, trunk, knees, hips, ankles, and neck. Yomi reported stiffness in both left and right knees with Resident A reported a pain of three out of 10. Resident A also complained of lower back pain of three out of 10. He reported joint stiffness and poor endurance overall.

Lex stated she also discussed with Yomi his observations while he was with Resident A and Yomi stated, "I didn't observe anything out of the ordinary."

On 05/28/2024, I received a return call from Yomi, PT with Millenium HHC. Yomi stated during his visits on 03/29/2024 and on 04/05/2024, Resident A did not express significant pain that would alarm him. She only reported pain of her knees and lower back. If Resident A would have yelled or expressed pain that was alarming, he would have noted that, but she did not.

On 05/28/2024, I followed up with Detective Bragole with FHPD. She is meeting with the medical examiner today regarding Resident A's autopsy. The group home is aware that Resident A passed away since Resident A's guardian removed their other wards from the home. The group home informed the detective that due to no residents at this home, they will not be renewing their lease and closing the license of this home.

On 06/13/2024, I conducted the exit conference with licensee designee Clifford Brown via telephone with my findings. Mr. Brown stated that all the residents were removed from this group home; therefore, he has requested the license to be closed.

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:	Based on my investigation and information gathered, Resident A experienced some type of trauma that resulted in serious injuries. On 04/08/2024, Resident A was sent to Henry Ford West Bloomfield Hospital for right leg pain and discoloration of the leg. While at the hospital, it was discovered that Resident A sustained fractures of her right forearm, right tibia and fibula, bilateral ribs, and lower spine. Resident A is wheelchair/ bedbound and requires full assist with all her personal needs, protection, and safety. I interviewed DCS Ebony Goree, Michelle John, and Denise Johnson who all denied Resident A falling, being dropped by anyone or any DCS caused these injuries. Although it is unclear how Resident A sustained these injuries, according to both the hospital and Detective Bragole with FHPD, these injuries were a result of trauma by someone. Therefore, Resident A's personal needs, including protection and safety were not attended to at all times due to her serious unexplainable injuries.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR# 2019A0989061 dated 04/18/2019; CAP dated 07/09/2019**

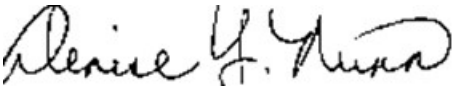
IV. RECOMMENDATION

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

06/13/2024

Frodet Dawisha — Date
Licensing Consultant

Approved By:



06/13/2024

Denise Y. Nunn — Date
Area Manager