GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 6, 2024

Happiness Nwaopara
Divined Company
6400 Royal Pointe Drive
West Bloomfield, MI 48322

RE: License #: AS820337215
Investigation #: 2024A0122020
Divined Company: Park Place Home

Dear Ms. Nwaopara:

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) 284-9720.

Sincerely,

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820337215
Investigation #:	2024A0122020
Complaint Receipt Date:	05/10/2024
Investigation Initiation Date:	05/15/2024
Report Due Date:	07/09/2024
Licensee Name:	Divined Company
Licensee Address:	6400 Royal Pointe Drive West Bloomfield, MI 48322
Licensee Telephone #:	(248) 346-4397
Administrator:	Happiness Nwaopara
Licensee Designee:	Happiness Nwaopara
Name of Facility:	Divined Company: Park Place Home
Facility Address:	35842 Park Place Romulus, MI 48174
Facility Telephone #:	(248) 346-4397
Original Issuance Date:	08/02/2013
License **Status:**	REGULAR
Effective Date:	04/01/2024
Expiration Date:	03/31/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 04/19/2024, There was insufficient staff to provide supervision, personal care, and protection to the residents.	Yes

III. METHODOLOGY

05/10/2024	Special Investigation Intake 2024A0122020
05/15/2024	Special Investigation Initiated - Telephone Completed interviews with staff member, Cynthia Egop, and Licensee Designee, Happiness Nwaopara.
05/15/2024	APS and Recipient Right Referrals
05/15/2024	Inspection Completed On-site Completed interviews with Home Manager, Kenneth Ekwueme, and Residents B and C. Reviewed Residents A, B, and C files. Observed Resident A.
05/28/2024	Contact – Telephone call made. Completed interview with Johancy Rivera, Case Manager.
05/28/2024	Exit Conference Discussed findings with Happiness Nwaopara, Licensee Designee.

ALLEGATION: On 04/19/2024, There was insufficient staff to provide to provide supervision, personal care, and protection to the residents.

INVESTIGATION: On 05/15/2024, I completed an interview with staff member, Cynthia Egop. Ms. Egop reported that she was assigned to work with home manager, Kenneth Ekwueme, on 04/19/2024. Per Ms. Egop, on the morning of 04/19/2024, Mr. Ekwueme took three residents to the store leaving her with three residents at the facility including Resident A who is assigned to have one-to-one staffing.

Ms. Egop stated that as she was in the kitchen, Resident A came towards her and began attacking/hitting her. Ms. Egop stated that due to Resident A's assault she ran out of the facility and Resident A followed her leaving the other two residents in the facility unattended. Ms. Egop reported Resident A continued to hit her, so she ran, entered the facility from the back door, and locked herself in the bathroom.

Ms. Egop stated that Resident A followed her back into the facility and banged on the bathroom door attempting to enter. Ms. Egop reported that she attempted to reach Mr. Ekwueme by phone, however, he was non-responsive, so she called 911 to receive emergency assistance. Ms. Egop stayed in the bathroom until emergency personnel arrived to assist acknowledging that the three residents were unsupervised until that time. Per Ms. Egop, Mr. Ekwueme was informed of the incident and returned to the facility by the time emergency personnel arrived.

Ms. Egop reported that she completed an incident report. She received medical treatment on 04/20/2024 where she was informed that her wrist had been fractured as a result of the incident with Resident A.

On 05/15/2024, I completed an interview with Licensee Designee, Happiness Nwaopara. Ms. Nwaopara confirmed the incident between Resident A and Ms. Egop on 04/19/2024. She stated the incident had been reported to her and Ms. Egop was not working at this time due to injury. Ms. Nwaopara confirmed that Resident A is assigned one-to-one staffing and that 2 staff members are assigned to all shifts.

On 05/15/2024, I interviewed Home Manager, Kenneth Ekwueme. Mr. Ekwueme confirmed that he worked with staff member, Cynthia Egop on 04/19/2024, however, he was not present during the incident between Ms. Egop and Resident A as he was transporting three other residents in the community. Mr. Ekwueme confirmed that Resident A, B, and C were left in the facility while he was away.

Mr. Ekwueme reported he had limited interaction with Resident A prior to leaving the facility with the other residents. He stated that Resident A came into the den area where he was working, requested that her tablet be charged which he complied with. He asked Resident A if she needed anything else and then he went into the facility garage to obtain something there. According to Mr. Ekwueme, Resident A followed him into the garage, and he directed her to go back into the facility, either go to her room or the den area. Mr. Ekwueme stated Resident A went upstairs to her room and he did not see her again until after the incident with Ms. Egop as he left the facility.

On 05/15/2024, I completed interviews with Resident B and C. Both Residents stated they did not observe the incident but heard the commotion of the assault. They do not know if Ms. Egop ran outside but both stated they were able to observe Ms. Egop run into the bathroom and Resident A follow her. They observed Resident A banging on the door while Ms. Egop was in the bathroom. When asked how long

Ms. Egop was in the bathroom, Resident B replied that she did not know. Resident C initially stated she didn't know; she was unable to determine the amount of time because she has brain damage and then she finally stated that Ms. Egop was in the bathroom for 20 minutes and did not come out until representatives from the police department showed up.

On 05/15/2024, I reviewed Resident B's file. According to her health care appraisal she is diagnosed with schizophrenia and dementia. Resident B's Assessment Plan states that she can ambulate in the community independently and that she is independent with all self-care activities.

On 05/15/2024, I reviewed Resident C's file. According to her health care appraisal she is diagnosed with obesity, chronic obstructive pulmonary disease, muscle weakness, difficulty walking, and anxiety disorder. Resident C's Assessment Plan states that at times she requires assistance in the community with ambulation and she is independent with self-care activities. She uses a wheelchair and walker to assist with ambulation.

On 05/15/2024, I observed Resident A in the facility. Resident A was walking throughout the facility comfortably. She went into the kitchen and asked a staff member for a snack and was singing. Resident A was seated in the den, I observed her to be comfortable and at peace. She is autistic and therefore unable to complete an interview as her verbal communication is limited.

On 05/15/2024, I reviewed Resident A's file. Resident A's Functional Behavior Assessment/Positive Behavior Support Plan dated 02/05/2024 states she is diagnosed with mild intellectual disability, autism, and unspecified psychotic disorder. She displays physical aggression displayed in the form of hitting, kicking, property destruction, yelling, swearing, verbally threatening and intimidating others. Resident A displays the above when she is feeling frustration and/or does not get her requests met when she expects them.

Due to Resident A's behaviors, she is assigned to receive "16 hours of 1:1 arm's length supervision to assist in addressing severe property destruction, physical aggression towards others, and potential self-harm…" The report does not give specific instructions of the assigning Resident A's 1:1 supervision.

Licensee Designee, Happiness Nwaopara, was present at the facility on 05/15/2024. She stated that Resident A is given 1:1 supervision during the hours of 4:00 p.m. through 8:00 a.m., as this is when she feels Resident A requires the most assistance with her behaviors. Both Ms. Nwaopara and Mr. Ekwueme stated the incident that happened between Resident A and Ms. Egop during the morning of 04/19/2024, after 8:00 a.m. when 1:1 supervision was not given.

On 05/15/2024, I reviewed Divined Company Park Place's staff schedule. On Friday's, there are two staff members scheduled for the AM Morning Shift, 8:00 a.m.

– 4:00 p.m. On 04/19/2024, staff members Kenneth Ekwueme and Cynthia Egop were scheduled to work from 8:00 a.m. – 4:00 p.m.

On 05/15/2024, I reviewed Resident A's incident reports dated 05/03/2023, 10/04/2023, and 04/19/2024. Each report documents Resident A displaying behaviors noted in her Functional Behavior Assessment/Positive Behavior Support Plan. In one of the incident reports, Resident A attempted to attack a resident.

On 05/28/2024, I completed an interview with Johancy Riveria, Case Manager for Resident A. Ms. Riveria confirmed that she had been informed about the incident on 04/19/2024 involving Resident A and Cynthia Egop. Ms. Riveria stated she received an incident report as well. Ms. Riveria also confirmed that Resident A receives between 16 – 19 hours of 1:1 supervision daily to be used at the discretion of Happiness Nwaopara. Ms. Riveria reported that she feels like Ms. Nwaopara and staff members will appropriately address the incident that happened on 04/19/2024. She has no concerns regarding the care Resident A is receiving from the staff members of Divined Company: Park Place Home.

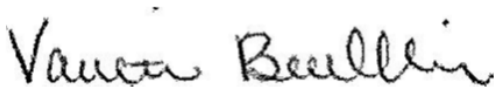
On 05/28/2024, I completed an exit conference and discussed my findings with Happiness Nwaopara, Licensee Designee. Ms. Nwaopara was upset and did not agree with my findings. I informed her that upon receipt of a copy of the completed special investigation report a corrective action plan would be required.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	On 04/19/2024, staff member, Cynthia Egop, locked herself in the bathroom for approximately 20 minutes due to an incident involving Resident A. Ms. Egop was the only staff member present in the facility during the incident with Resident A. On 05/15/2024, both Residents B and C confirmed that Ms. Egop was the only staff member present during the incident with Resident A and Ms. Egop locked herself in the bathroom. Resident B's Health Care Appraisal documents that she is diagnosed with schizophrenia and dementia. Resident C's Resident C's Health care appraisal documents that she is diagnosed with obesity, chronic obstructive pulmonary disease, muscle weakness, difficulty walking, and anxiety disorder. Resident C's Assessment Plan documents that use a wheelchair and walker to assist with ambulation. Resident A's Functional Behavior Assessment/Positive Behavior Support Plan dated 02/05/2024 documents that she displays physically aggressive behavior such as hitting, kicking, property destruction, yelling, swearing, verbally threatening and intimidating others. Per the Support Plan Resident A is also assigned 1:1 staffing for at least 16 hours daily, that staff is to be at arm's length during those hours. On 05/15/2024, I reviewed Resident A's past incident reports which documents that she attempted to attack another resident. Based upon my investigation I find that on 04/19/2024, Residents A, B, and C's supervision and protection was not attended to, as the only staff member present at the facility, Cynthia Egop, locked herself in the bathroom for approximately 20 minutes.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan I recommend no change to the status of the license.



Vanita C. Bouldin
Licensing Consultant

Date: 05/28/2024

Approved By:

Ardra Hunter
Area Manager

Date: 06/06/2024