GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 1, 2024

Sheana Waldburg
Heavenly Comfort LLC
19103 Woodmont
Harper Woods, MI 48225

RE: License #: AS820406532
Investigation #: 2024A0992038
Heavenly Comfort Woodmont 3

Dear Ms. Waldburg:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (313) 456-0380.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820406532
Investigation #:	2024A0992038
Complaint Receipt Date:	06/14/2024
Investigation Initiation Date:	06/14/2024
Report Due Date:	08/13/2024
Licensee Name:	Heavenly Comfort LLC
Licensee Address:	19230 Silvercrest Drive Southfield, MI 48075
Licensee Telephone #:	(313) 307-0002
Administrator:	Sheana Waldburg
Licensee Designee:	Sheana Waldburg
Name of Facility:	Heavenly Comfort Woodmont 3
Facility Address:	19330 Woodmont Harper Woods, MI 48225
Facility Telephone #:	(313) 307-0002
Original Issuance Date:	04/14/2021
License Status:	REGULAR
Effective Date:	04/14/2024
Expiration Date:	04/13/2026
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff, Deshara Robinson snatched a soda can out of Resident A's hand and swatted at her.	Yes

III. METHODOLOGY

06/14/2024	Special Investigation Intake 2024A0992038
06/14/2024	Special Investigation Initiated - Telephone Licensee designee, Sheana Waldburg, was not available. Message left.
06/17/2024	Contact - Telephone call made Ms. Waldburg.
07/01/2024	Contact - Face to Face Direct care staff, Angelique King, and Resident A.
07/01/2024	Contact - Telephone call made Direct care staff, Kasia Agee.
07/17/2024	Contact - Telephone call made Resident A's guardian, Marcella Harris with Faith Connections.
07/17/2024	Contact - Telephone call made Faith Connections, Rebecca Bringman.
07/17/2024	Contact - Telephone call made Direct care staff, Deshara Robinson.
07/17/2024	Contact - Telephone call made Ms. Waldburg.
07/23/2024	Contact - Document Sent Email sent to Ms. Waldburg
07/25/2024	Contact - Telephone call made Ms. Waldburg was not available. Unable to leave a message, no voicemail system set-up.

ALLEGATION: Direct care staff, Deshara Robinson snatched a soda can out of Resident A's hand and swatted at her.

INVESTIGATION: On 06/17/2024, I contacted licensee designee, Sheana Waldburg and interviewed her regarding the allegation. Before addressing the allegation, Ms. Waldburg explained that Resident A has fluid intake restrictions. She stated she was previously allowed 60 ounces (oz) of fluid daily, but it was recently changed to 70 ounces per day. She stated while reviewing the cameras installed in the common areas, she observed direct care staff, Deshara Robinson inappropriately interacting with Resident A on 05/21/2024. She stated Ms. Robinson swatted Resident A's hand and snatched her pop out of her hand. Ms. Waldburg stated Ms. Robinson was yelling and threatening Resident A including threatening to call law enforcement on her. Ms. Waldburg stated Ms. Robinson was immediately removed from the schedule and terminated. Ms. Waldburg stated Resident A is verbal but has a low comprehension level and stated interviewing her will be difficult. Ms. Waldburg identified Resident A's guardian as Marcella Harris with Faith Connection.

On 07/01/2024, I completed an unannounced onsite inspection and interviewed direct care staff, Angelique King, and Resident A regarding the allegation. Ms. King said she was not on shift when the incident occurred. She said Ms. Robinson was on shift with direct care staff, Kasia Agee; she provided Ms. Agee's contact number.

I attempted to interview Resident A. Resident A stated she got into a fight with "Ray," and she waved her hand in a swatting motion. I observed Resident A's hands, no marks or bruises were observed. Resident A said, "Ray," took her pop. Resident A was very talkative, but every time I attempted to address the allegations, she would change the subject. I asked Resident A if she feels safe in the home, and she said yes.

While onsite I reviewed Resident A's individual plan of service, which stated the following "(Resident A) is restricted to 2.7 liters of fluids per day. (Resident A) will seek out water at times and needs staff to redirect her…" "It should be known that once (Resident A) finds something she likes that she will become fixated on it for a long time…" "(Resident A) might also become verbally and physically aggressive when she becomes upset."

On 07/01/2024, I contacted direct care staff, Kasia Agee and interviewed her regarding the allegation. Ms. Agee confirmed she worked alongside Ms. Robinson on the day the incident occurred. She stated it was between 8:00 a.m. and 9:00 a.m. and Ms. Robinson had just finished assisting Resident A with her hygiene. Ms. Agee stated Resident A is not typically allowed in the kitchen but on this day, she had a soiled brief in her hand and wanted to throw it away in the trash can in the kitchen. Ms. Agee stated while in the kitchen, Resident A grabbed her pop out of the refrigerator and ran towards her bedroom. Ms. Agee stated Ms. Robinson took the

pop and tried to redirect her Resident A. She stated Ms. Robinson told her it was too early, and she could have the pop later. Ms. Agee stated Resident A took the pop out of Ms. Robinson's hand and insisted on drinking the pop. Ms. Agee stated she did not witness Ms. Robinson hit or swat Resident A's hand, but they did go back-and-forth about the pop. Ms. Agee stated she did not hear Ms. Robinson use any obscenities while trying to redirect Resident A. Ms. Agee stated she tried to intervene and redirect Resident A, but she was agitated and fixated on her pop.

On 07/17/2024, I contacted Ms. Harris and interviewed her regarding the allegation. Ms. Harris denied having any knowledge of the allegation. She stated she visited with Resident A on 06/08/2024 and 07/05/2024 and was not made aware of any incident involving Resident A. Ms. Harris was uncertain if an incident report was received in her office. She stated all incident reports are faxed to Faith Connections, and director, Rebecca Bringman will contact her if necessary. Ms. Harris suggested I contact Ms. Bringman to verify if the incident report was received. As far as Resident A, Ms. Harris said Resident A has a fixation with pop and she will become agitated when she cannot have it.

On 07/17/2024, I contacted Ms. Robinson and interviewed her regarding the allegation. Ms. Robinson explained that Resident A has a fluid intake restriction. She stated historically Resident A receives fluids during lunch and dinner except for taking her medication and at the time her fluid intake is minimal. She stated on the day the incident occurred; she was assigned as Resident A's 1:1 staff. She stated she had just finished assisting Resident A with hygiene and getting dressed in her bedroom. She stated as she was putting Resident A's belongings away in her bedroom, Resident A ran out the bedroom to the kitchen and got her pop out the refrigerator. Ms. Robinson said she immediately yelled out for Ms. Agee while running to the kitchen. Ms. Robinson said as she ran towards the kitchen, Resident A was running back towards her bedroom with her pop in her hand. Ms. Robinson stated as they were running towards each other, she took the pop out of Resident A's hand and proceeded to the kitchen. Ms. Robinson stated Resident A started to chase her. She stated she tried to redirect Resident A, but Resident A was screaming. Ms. Robinson stated Resident A rushed at her in attempt to take the pop and even tried to push her down the stairs. Ms. Robinson stated she felt threatened, and she did threaten to call law enforcement on Resident A due to her behavior. Ms. Robinson stated she contacted Ms. Waldburg and Ms. Waldburg was unable to redirect Resident A's behavior and advised her to give Resident A her pop. She stated Ms. Waldburg can review the cameras and see Resident A was out of control. Ms. Robinson stated Resident A has hit her before and she was not about to let her hit her again. Ms. Robinson admitted she was yelling at Resident A to redirect her, but she did not threaten to harm her. She stated she would not do anything to hurt or harm Resident A.

On 07/17/2024, I contacted Ms. Waldburg. I explained to Ms. Waldburg that based on the investigative findings, I am unable to determine that Ms. Robinson hit and/or swatted at Resident A. Ms. Waldburg stated Ms. Robinson did not intentionally hit

Resident A. She stated it appeared to be more of a physical maneuver to take the pop away from her. However, she stated Ms. Robinson was intimidating Resident A. She stated the pop belonged to Resident A and she had the right to drink it. She stated although Resident A has a fluid restriction, at the time the incident occurred, it was between 8:00 a.m. and 9:00 a.m., and Resident A had not reached her limit. She stated Ms. Robinson overreacted and did not handle the situation appropriately. I asked Ms. Waldburg to provide me with a copy of the video, which she agreed.

During this investigation, additional attempts were made to contact Ms. Waldburg to obtain a copy of the video, Ms. Waldburg did not respond.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.** **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.** **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.** **(e) Withhold food, water, clothing, rest, or toilet use.** **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.** **(g) Refuse the resident entrance to the home.** **(h) Isolation of a resident as defined in R 400.14102(1)(m).** **(i) Any electrical shock device.**

ANALYSIS:	During this investigation, I conducted interviews with the licensee designee, direct care staff, Resident A's guardian and Resident A. Initially the licensee designee stated the direct care staff "swatted" Resident A's but later stated the direct care staff did not hit Resident A, it was more of a "physical maneuver" to take the pop away. I requested a copy of the video from Ms. Waldburg, but she did not produce it. Based on the inconsistency of the interviews with the licensee designee, there was no eyewitness, and I was not afforded the opportunity to view the video footage, there is insufficient evidence to substantiate the allegation that on 05/21/2024, direct care staff Deshara Robinson used physical force or threaten to harm Resident A. The allegation is unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with the licensee designee, direct care staff, Resident A's guardian and Resident A, there is sufficient evidence to substantiate the allegation that direct care staff Deshara Robinson did not handle the situation appropriately. She engaged in a verbal confrontation with Resident A and threatened to call law enforcement on her. The allegations are substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/31/2024

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Denasha Walker Date
Licensing Consultant

Approved By:

08/01/2024

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Ardra Hunter Date
Area Manager