GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 13, 2024

Toccaria Smith
Michigan Share Corporation
P.O. Box 404
St. Clair Shores, MI 48080

RE: License #: AS500011889
Investigation #: 2024A0990024
Clearview

Dear Ms. Smith:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500011889
Investigation #:	2024A0990024
Complaint Receipt Date:	06/27/2024
Investigation Initiation Date:	06/28/2024
Report Due Date:	08/26/2024
Licensee Name:	Michigan Share Corporation
Licensee Address:	P.O. Box 404 St. Clair Shores, MI 48080
Licensee Telephone #:	(586) 350-0675
Administrator:	Toccaria Smith
Licensee Designee:	Toccaria Smith
Name of Facility:	Clearview
Facility Address:	39269 Clearview Harrison Township, MI 48045
Facility Telephone #:	(586) 463-3446
Original Issuance Date:	05/21/1980
License Status:	REGULAR
Effective Date:	05/08/2023
Expiration Date:	05/07/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 06/16/2024, Resident A was admitted to Detroit Receiving Hospital due to 1st-2nd degree burns to his back. Resident A was lying on a heating pad with no on or off switch.	Yes

III. METHODOLOGY

06/27/2024	Special Investigation Intake 2024A0990024
06/27/2024	APS Referral Adult Protective Services (APS) complaint was completed at intake.
06/28/2024	Special Investigation Initiated - On Site I conducted an onsite investigation. I interviewed the home manager Ashley Dusenberry. I reviewed some records. I observed Resident A.
08/06/2024	Contact - Telephone call made I left a message with Resident A's home care provider.
08/06/2024	Contact - Telephone call made I left a message with Relative A.
08/06/2024	Contact - Document Received I reviewed Resident A's resident record.
08/06/2024	Contact - Document Sent I emailed Toccaria Smith, licensee designee (LD) regarding Resident A's hospital discharge summary. I received via fax.
08/08/2024	Contact - Telephone call made I conducted a phone interview Chirstina Hill. Supports Coordinator.
08/12/2024	Contact- Telephone call made I conducted a phone interview with Relative A.
08/12/2024	Contact- Document Sent I emailed Jasmine Martin-Morris, APS investigator requesting the status of the investigation.

08/12/2024	Exit conference I conducted an exit conference with Toccaria Smith.

ALLEGATION:

On 06/16/2024, Resident A was admitted to Detroit Receiving Hospital due to 1st-2nd degree burns to his back. Resident A was lying on a heating pad with no on or off switch.

INVESTIGATION:

On 06/27/2024, I received the complaint via email. In addition to the allegations, the complaint indicated that Resident A was admitted to the hospital on 06/16/2024. Resident A was discharged on 06/25/2024 and returned to his group home. It is unknown how long Resident A was lying on the heating pad.

On 06/28/2024, I conducted an onsite investigation. I interviewed the home manager, Ashley Dusenberry. I observed Resident A, who is nonverbal. Ms. Dusenberry is the new home manager and was aware of the allegations. Ms. Dusenberry said that an APS worker came to the home yesterday. Ms. Dusenberry described various events that led to Resident A using the heating pad. The first incident is when he stubbed his toe on an outing with Relative A. When he returned from the outing, he was trying to show staff his stubbed toe, and when he raised his leg, he fell onto the floor. After the fall, the staff decided that he needed hospital care, which occurred on 06/11/2024.

Resident A was diagnosed with a fall and compression fracture of the L4 vertebrae (according to the health care notes). Resident A was scheduled for a follow-up after the fall because he was still showing signs of discomfort. Ms. Dusenberry said the former home manager, Sharita Neely, placed a heating pad on his back for pain relief. Resident A was on bed rest and was using the heating pad. Resident A was lying in bed propped up because lying flat was uncomfortable. The heating pad was on his back as he lay propped up. Ms. Dusenberry said she was present and discovered the burn on 06/16/2024. Ms. Dusenberry was getting him up for a shower and saw blisters on his back; the heating pad was still in his bed. Ms. Dusenberry was unsure how long the heating pad was on his back. However, the heating pad did not automatically shut off. Ms. Dusenberry said that Ms. Neely ordered the heating pad from a medical supply company, Ameri Health, and filed a grievance with the company because the heating pad should automatically shut down. Resident A has a home health nurse who is coming to the home to treat the burn. Ms. Dusenberry said that a medical professional did not prescribe the heating pad. I observed Resident A sleeping in his recliner chair. I observed a large bandage covering most of his back.

On 08/06/2024, I reviewed Resident A's resident record. Resident A's *Assessment Plan* documented that he is "alert" but needs guidance with ADLs and prompts. I reviewed Resident A's Individual Plan of Services (IPOS) and it is documented that Resident A

has poor safety and decision-making skills. Resident A is diagnosed with a seizure disorder, and seizure precautions will be observed at all times. Resident A is diagnosed with cerebral palsy, intellectual disabilities-moderate, generalized anxiety disorder, and unspecified dementia without behavioral disturbance. Resident A is prescribed psychotropic medications. Staff must be present with Resident A in the community. Resident A needs assistance with food prep, fastening, buckling, buttoning, and zipping clothing. Staff are to complete bed checks every two hours, observing the rise and fall of Resident A's chest to ensure optimal health and safety. Resident A needs specialized residential caregiver support while living in his community-based home. Staff support Resident A by directing many of his daily tasks and administering medications. They also offer guidance, direction, and training for meal preparation, laundry, housekeeping, and social/recreational activities. Resident A needs verbal assistance for bathing, advice, and direction in personal hygiene and dressing. Staff will assist Resident A with hand-over-hand aid, pulling the blankets over his bed. Staff will assist Resident A with hand-over-hand assistance to fluff his blankets and pillows daily if needed.

I reviewed Resident A's *Medication Administration Record* and standing medication orders. I did not observe an order for the heating pad's application.

I reviewed the discharge summary from Detroit Receiving Hospital. Resident A was admitted to the hospital on 06/16/2024, and discharged on 06/24/2024, and was diagnosed with a burn to the back.

On 08/08/2024, I conducted a phone interview with Christina Hill, supports coordinator. Ms. Hill was informed of Resident A's injuries via an incident report. Ms. Hill said that after receiving the incident report, she followed up with the former home manager, Ms. Neely, who was terminated shortly after that. Ms. Hill said that Ms. Neely informed her that she placed the heating pad on Resident A's back to help alleviate pain. Ms. Neely said she was unsure why the heating pad was left on his back overnight and why the staff did not check him the entire night. Ms. Hill said that she spoke with Relative A, who also told her that Resident A has some nerve blockage in his back and probably could not feel the heating pad burning him. Ms. Hill said that she informed the new home manager, Ms. Dusenberry, that a heating pad should not be used unless prescribed.

On 08/12/2024, I conducted a phone interview with Relative A. Relative A was aware of the allegations. Relative A said that initially, Resident A had a fall at the home and hurt his back. Relative A said that Ms. Neely purchased a heating pad for Resident A because he was uncomfortable. Relative A was informed that the heating pad had no automatic shut-off capability. Relative A said staff told him that the heating pad was on his back for two days, but apparently, it was left on his back continuously. Relative A said that Resident A does not have a lot of feeling on his back because of some paralysis. Relative A said the staff observed the blisters when they were about to shower him and took him to the emergency room. Resident A had to be transferred to Detroit Receiving Hospital because they have a burn unit. Relative A does not believe that Resident A was burned intentionally but that it was a careless mistake. Resident A is healed and doing well in the home.

On 08/12/2024, I conducted an exit conference with Toccaria Smith. Ms. Smith is the new licensee designee and administrator as of July 2024. Ms. Smith became aware of Resident A's burn by the former home manager of the home, Ms. Neely. Ms. Neely was terminated for various reasons in July 2024. Ms. Smith confirmed that Resident A was not prescribed a heating pad. Ms. Smith was informed that using the heating pad requires a prescription from a medical practitioner. Ms. Smith agreed, was informed of the tentative violations, and decided to submit a corrective action plan when necessary.

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 the investigation, sufficient evidence supports that Resident A was not always protected and attended to at all times. On 06/11/2024, Resident A had a fall that resulted in a back injury. Due to the back injury, the former home manager (Sharita Neely) purchased a heating pad to apply to Resident A's back for pain relief. On the morning of 06/16/2024, Resident A was found by the current home manager, Ashley Dusenberry, with burns and blisters, on his back. Resident A was admitted to Detroit Receiving Hospital Burn Center for one week. Based on interviews with Ms. Dusenberry, support coordinator, and Relative A, the heating pad was left on Resident A's back for an extended period, which caused the burns.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14303	**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 on the investigation, sufficient evidence supports that Resident A's written IPOS, was not followed. As a result, he had burns on his back from a heating pad. Per Resident A's IPOS, he must receive bed checks every two hours at night. Resident A slept with a heating pad on his back throughout the night on

	06/16/2024. Resident A is nonverbal and requires assistance from staff for prompts with ADLs and direction in many of his daily living tasks. Staff are to assist Resident A with hand-over-hand aid to pull the blankets over his bed. Staff will also assist Resident A with hand-over-hand assistance to fluff his blankets and pillows daily if needed. Resident A needs more cognitive skills to remove a heating pad from his back with staff assistance.
CONCLUSION:	**VIOLATION ESTABLISHED**

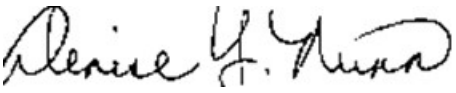
IV. RECOMMENDATION

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

08/13/2024

LaShonda Reed — Date
Licensing Consultant

Approved By:



08/14/2024

Denise Y. Nunn — Date
Area Manager