GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 8, 2025

Karen Goreta
Karen's Helping Hands
4425 High Street
Ecorse, MI 48229

RE: License #: AS820294958
Investigation #: 2025A0116006
Church Hill Estate

Dear Ms. Goreta:

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,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820294958
Investigation #:	2025A0116006
Complaint Receipt Date:	11/26/2024
Investigation Initiation Date:	11/26/2024
Report Due Date:	01/25/2025
Licensee Name:	Karen's Helping Hands
Licensee Address:	4425 High Street Ecorse, MI 48229
Licensee Telephone #:	(313) 282-6158
Administrator:	Karen Goreta
Licensee Designee:	Karen Goreta
Name of Facility:	Church Hill Estate
Facility Address:	18870 Church Hill Riverview, MI 48192
Facility Telephone #:	(734) 286-2313
Original Issuance Date:	12/15/2008
License Status:	REGULAR
Effective Date:	06/06/2023
Expiration Date:	06/05/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

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II. ALLEGATION(S)

	Violation Established?
On 11/25/24, I received a phone call from licensee designee, Karen Goreta, informing me that Resident A sustained 1st or 2nd degree burns, from possibly being showered. Resident A is currently in the hospital.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/26/2024	Special Investigation Intake 2025A0116006
11/26/2024	Contact- Telephone call received Telephone call from licensee designee, Karen Goreta providing an update regarding Resident A.
11/26/2024	Referral - Recipient Rights Made by licensee designee, Karen Goreta, on 11/25/24.
11/26/2024	APS Referral Made.
11/27/2024	Contact - Telephone call made Interviewed home manager, Debra Lyons.
11/27/2024	Contact - Telephone call made Interviewed staff, Kayla Hebron.
11/27/2024	Contact - Telephone call made Left a message for staff, Anne Igbinigie, requesting a return call.
11/27/2024	Contact - Telephone call made Interviewed staff, Carol Collins.
12/03/2024	Inspection Completed On-site Spoke with home manager Debra Lyons, interviewed assistant manager, Anthony Lyons, interviewed Residents B and C, reviewed Resident A's records and tested the hot water in the kitchen and bathrooms.
12/03/2024	Contact - Telephone call received

	Spoke with licensee designee, Karen Goreta. Ms. Goreta provided an update regarding Resident A and reported that home manager Debra Lyons had filed a police report regarding the matter.
12/04/2024	Contact - Telephone call made Interviewed staff, Anne Igbinigie
12/04/2024	Contact - Document Received Received verification of staff, Javien McNary's, direct care training, special certification training, and background clearance. Ms. Goreta also forwarded pictures of Resident A’s injuries.
12/09/2024	Contact - Document Received Received staff progress notes dated 11/24/24 and 11/25/24 completed by afternoon staff Javien McNary, and midnight staff Carol Collins and Anne Igbinigie.
12/09/2024	Contact - Telephone call made Interviewed staff, Javien McNary.
12/09/2024	Contact - Telephone call made Left a message for Tyree Harper, Resident A's public guardian with Michigan Guardian Services.
12/11/2024	Contact - Telephone call received Interviewed Tyree Harper, Resident A's public guardian.
12/11/2024	Inspection Completed-BCAL Sub. Compliance
01/07/2025	Contact - Telephone call made Spoke with Nurse Telaviv, at Detroit Receiving Hospital.
01/07/2025	Contact - Telephone call made Spoke with Pam Singleton, social worker at Detroit Receiving Hospital.
01/07/2025	Exit Conference With licensee designee, Karen Goreta.

ALLEGATION:
On 11/25/24, I received a phone call from licensee designee, Karen Goreta, informing me that Resident A sustained 1st or 2nd degree burns, from possibly being showered. Resident A is currently in the hospital.

INVESTIGATION:

On 11/26/24, I received a telephone call from licensee designee, Karen Goreta, informing me that there had been an incident at the home with Resident A allegedly sustaining 2nd degree burns to his genital area, after being showered by staff, Javien McNary, on 11/24/24. Ms. Goreta reported that Resident A is currently in the burn unit at Detroit Receiving and she is unaware of a discharge date. Ms. Goreta reported that Resident A is nonverbal and confined to a wheelchair due to being diagnosed with cerebral palsy. Ms. Goreta reported that she has pictures of the injuries and that she would forward them to me. Ms. Goreta reported her belief, based on the burns/blisters being contained in the genital area only, that Resident A soiled his brief and instead of cleaning him in his bed, staff, Javien McNary, took him in the bathroom, did not check the water and showered his genital area. Ms. Goreta reported that is the only area on Resident A's body that is burned and blistered.

Ms. Goreta reported once she was made aware of the situation she immediately went to the home and turned the water heater temperature down. Ms. Goreta reported that she was so upset that prior to turning the water heater temperature down, she didn't think to test it first. Ms. Goreta reported that she and all of the staff have been testing the water daily to ensure it remains between 105 to 120 degrees Fahrenheit. Ms. Goreta reported that she has also has required staff to test and take a picture of the water temperature prior to showering residents. Ms. Goreta reported the staff has to send her a picture of the thermometer displaying what the water temperature is prior to showering each resident. Ms. Goreta reported that the water has been testing at around 113 degrees Fahrenheit. Ms. Goreta reported that she has a heating and cooling company coming to the home to install a device on the hot water heater that will prevent staff from turning the water temperature up. Ms. Goreta reported that this has been an issue and although she has continually warned staff about doing it, they've continued to do so. Ms. Goreta reported that she has scheduled an emergency staff meeting for 11/27/24 to go over water safety and the importance of staff checking the water temperature with their hands/arms etc. prior to showering residents and informing staff of the new device that will be put on the hot water heater. Ms. Goreta was very emotional during the interview and reported how terrible she feels that this happened to Resident A.

Ms. Goreta reported that she contacted the office of recipient rights and has been in contact with an investigator. Ms., Goreta could not recall the name of the person she spoke with. Ms. Goreta provided names and contact information for staff and Resident A's public guardian.

On 11/27/24, I interviewed home manager, Debra Lyons, and she reported that upon her arrival at work Monday, 11/25/24, at 8:00 a.m., midnight staff, Carol Collins, reported to her that Resident A needed to be taken to the emergency room. Ms. Lyons reported that Ms. Collins stated her belief that Resident A either had a bad rash or an allergic reaction to something in his genital area. Ms. Lyons reported when she observed Resident A's genital area, she knew he needed immediate

treatment, and reported that the assistant manager, Anthony Logan, took Resident A to Henry Ford Hospital Wyandotte, and once there the doctors informed him that Resident A had sustained 1st or 2nd degree burns. Ms. Lyons reported that Resident A was then transferred to Detroit Receiving Hospital's burn unit for evaluation and treatment. Ms. Lyons reported that Resident A remains hospitalized.

On 11/27/24, I interviewed staff Kayla Hebron, and she reported that she worked from 8:00 a.m. to 8:00 p.m. on Saturday 11/23/24 and Sunday 11/24/24, with staff, Javien McNary. Ms. Hebron reported that she is a new staff and is still learning and to date has not showered any of the residents. Ms. Hebron reported that during her shifts she feeds Resident A and administers his medications. She reported that Mr. McNary provided all other care to Resident A. Ms. Hebron reported that to her knowledge Mr. McNary did not shower Resident A on 11/23/24 or 11/24/24 and reported that he told her that he completed his progress notes for 11/24/24 on 11/23/24 documenting that he had showered Resident A because that was what he planned to do on 11/24/24. Ms. Hebron reported that Mr. McNary reported that he does his progress notes in advance all the time so that at the end of his shift he can leave on time instead of having to stay longer to complete the notes. Ms. Hebron reported that Mr. McNary verbalized his plan to shower Resident A on 11/24/24, but for whatever reason never got around to showering him. I asked Ms. Hebron if Mr. McNary would have showered Resident A would she have heard it and she reported that she would have because the house is a ranch, and the location of the bathroom in proximity to the living room area, where she and some of the other residents were, most of the shift, she definitely would have heard the shower, and observed Mr. McNary going in and coming out of the bathroom with Resident A.

On 12/03/24, I conducted an unscheduled on-site inspection and spoke with home manager Debra Lyons, interviewed assistant manager, Anthony Logan, and Residents B and C. Ms. Lyons reported that Resident A remains hospitalized but is doing well. She reported that once discharged Resident A will go to a rehabilitation/nursing center and then hopefully return to the home. Ms. Lyons reported that Resident A's guardian wants him to return to the home, as he has been in the home since 09/28/18 and has done well there.

Ms. Lyons reported that based on the progress notes completed by staff, Javien McNary, he documented that he showered Resident A on 11/24/24.

I interviewed assistant manager, Anthony Logan, and he reported that he arrived to work on Monday, 11/25/24 at around 8:00 a.m. and was immediately told by midnight staff, Anne Ibginigie, that Resident A needed to go to the hospital because he either had an extremely bad allergic reaction to something or a bad rash. Ms. Logan reported when he observed Resident A's groin/penis he knew that he needed immediate care. Mr. Logan reported that he transported Resident A to Henry Ford Hospital Wyandotte and reported as soon as the emergency room doctor saw Resident A's groin area, he told him that it was not a rash or allergic reaction, but a 1st or 2nd degree burn. Mr. Logan reported that Resident A was transported by

ambulance to Detroit Receiving Hospital and reported he followed behind the ambulance. Mr. Logan reported he stayed at the hospital with Resident A until he was admitted and in a room which was about 4:00 p.m. Mr. Logan reported that based on the progress notes completed by staff, Javien McNary, he was the last person to shower Resident A on 11/24/24.

I interviewed Resident B, and she reported that she heard that something happened to Resident A and that he was in the hospital. Resident B reported that the staff treat her and the other residents good. She reported that staff Javien McNary was kindhearted and that she had nothing bad to say about him.

I interviewed Resident C with the assistance of home manager, Debra Lyons. Resident C is visually and hearing impaired, so in order to communicate staff use their fingers to write the letters/words in the palm of his hand and he is able to respond. Resident C reported that staff treat him good and that he never had any issues with staff, Javien McNary, and stated that he treated him fine.

I requested to review staff, Javien McNary's, employee record. Ms. Lyons reported that it was at the office due to the recent termination. I requested Ms. Lyons to email me verification of direct care training and the background clearance for Mr. McNary.

I tested the water temperature in the kitchen and both bathrooms. The water tested at 113 degrees Fahrenheit in all areas.

On 12/04/24, I received and reviewed staff, Javien McNary, verification of required direct care trainings and background clearance. Mr. McNary was fully trained in all required areas prior to assumption of duties and is eligible to work in adult foster care. Ms. Goreta also sent pictures of Resident A's injuries. The burns and blisters are all over Resident A's penis and inner thighs.

On 12/09/24, I received the progress note that staff, Javien McNary completed which documents that he showered Resident A on Sunday 11/24/24.

On 12/09/24, I interviewed staff, Javien McNary and he reported that he worked from 8:00 a.m. to 8:00 p.m. on Saturday 11/23/24 and Sunday 11/24/24. Mr. McNary reported that staff, Kayla Hebron, was the other staff on shift with him. Mr. McNary reported that knows he has messed himself up by completing his progress notes in advance. He reported that he completed his progress notes for 11/24/24 on 11/23/24 and in the notes he documented that he showered Resident A on 11/24/24 and reported that he did not shower him. Mr. McNary reported that during his shift Resident A was fine and he denied observing any burns or blisters to his genital areas. Mr. McNary reported that something may have happened to Resident A during the midnight shift on 11/24/24 and reiterated that he did not shower or use water at all on Resident A during his shift on 11/24/24.

Mr. McNary reported that he completes the progress notes early all the time to avoid having to do them at the end of his shift, forcing him to stay longer. Mr. McNary admitted that he knows this is not right, but reported it saves times. Mr. McNary reported that in the 10 months he has worked in the home it was never a problem completing the notes in advance, because he would do everything he was required to do. Mr. McNary reported he had planned to shower Resident A on 11/24/24 after he was unable to do it on 11/23/24, which is one of Resident A's scheduled shower days. Mr. McNary reported things got busy on 11/24/24 and he didn't get a chance to shower Resident A on 11/24/24 either.

Mr. McNary asked if I had interviewed staff Kayla Hebron and reported if I hadn't to please do so as he had told her what he did regarding completing his progress notes in advance. Further, he reported that Kayla would know if he showered Resident A because she would have heard the shower and assisted him with transferring Resident A from his wheelchair to the shower chair. Mr. McNary reported that he knows he was wrong for completing the shift progress notes in advance and is upset with himself for doing it because now he is being accused of causing the severe burns to Resident A when in fact, he did not. Mr. McNary reported that he has been terminated. Mr. McNary reported that he has spoken with the recipient rights investigator and reported that gave her the same account of events that he has shared with me.

On 12/11/24, I interviewed Tyree Harper, Resident A's public guardian case manager. Mr. Hill reported that licensee designee, Karen Goreta informed him of the incident. Mr. Harper reported that Resident A will be discharged from the hospital in the next couple days as they are waiting for Detroit Wayne Integrated Health Network to complete the required paperwork for him to go into a nursing/rehabilitation center for a few weeks. Mr. Harper reported that once he completes his stay there, he plans to return him back to the home. Mr. Harper reported that Resident A has lived in the home since 2018 and has done exceptionally well under the care and supervision of Ms. Goreta and her staff. Mr. Harper reported that Ms. Goreta is one of the best providers of AFC care that he knows and reported that he will not let the irresponsible acts of one staff, taint his thoughts and feelings about the remainder of the staff that Ms. Goreta employees. Mr. Harper reported that Ms. Goreta has already been in contact with a heating and cooling company who has ordered a device to put on the hot water tank in all of her licensed homes, that will prevent the staff from adjusting the temperature on the water tanks.

On 01/07/25, I spoke with Nurse Telaviv, from Detroit Receiving Hospital, and she reported that she is one of the nurses who has been providing care to Resident A. Nurse Telaviv reported that Resident A is medically stable and is ready for discharge. Ms. Telaviv reported that Resident A is pleasant and although he is nonverbal, he interacts by smiling, gesturing, and making sounds to respond. Nurse Telaviv reported that Resident A's burns are healing well, and he is no longer receiving treatment from the burn unit.

On 01/07/25, I interviewed Detroit Receiving Hospital social worker, Pam Singelton. Ms. Singleton reported that Resident A is and has been medically ready for discharge. She reported that he is stable, happy and is doing very well. Ms. Singleton reported that the delay in discharge is due to Westwood Nursing Center not having any current Medicaid beds available. Ms. Singleton reported that she is hopeful that a bed will be available this week.

On 01/07/25, I conducted the exit conference with licensee designee, Karen Goreta, and informed her of the findings of the investigation and the specific rules cited. Ms.

Goreta reported an understanding and stated she would forward an acceptable corrective action plan and documents of compliance upon receipt of the report. Ms. Goreta also reported that Mr. McNary and Ms. Collins have been terminated and staff Ms. Igbinine was given a day off, unpaid, and a written reprimand.

Ms. Goreta further reported that the security device has been professionally installed on the hot water heater, that will prevent staff from adjusting the temperature once it is set. Ms. Goreta reported a specific tool will have to be used to change the temperature and she and her husband will be the only ones with access to the tool. She reported the tool will not be stored in the home.

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 findings of the investigation, which included interviews with licensee designee, Karen Goreta, home manager, Debra Lyons, assistant manager, Anthony Logan, staff, Javien McNary, I am able to corroborate the allegation that Resident A sustained second degree buns in his genital and thigh areas, after being showered/cared for by staff, Javien McNary. Ms. Goreta reported that based on the injuries Resident A sustained, it is her belief that Resident A soiled his brief and staff, Javien McNary, showered only his genital area attempting to clean him, failed to check the water, which ultimately caused the burns. Ms. Goreta reported that Mr. McNary documented that he was the staff person who showered Resident A on 11/24/24. Ms. Lyons and Mr. Logan both reported that on 11/25/24, upon their arrival to work, they both observed Resident A's genital area and inner thighs, and knew he required immediate care. They both confirmed that based on review of the progress notes that staff, Javien McNary documented that he showered Resident A on 11/24/24. Mr. McNary denied that he showered Resident A on 11/24/24, although he documented on the progress notes that he did. Mr. McNary reported that Resident A was fine during his shift on 11/24/24 and reported that he did not observe any burns or blisters on his genital areas during his shift. Although Mr. McNary denied showering Resident A during my interview with him, the progress notes dated 11/24/24, completed by Mr. McNary document that he showered, applied lotion, and dressed Resident A. The progress note is also signed and dated by Mr. McNary.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(2) Hot and cold running water that is under pressure shall be provided. A licensee shall maintain the hot water

	temperature for a resident's use at a range of 105 degrees Fahrenheit to 120 degrees Fahrenheit at the faucet.
ANALYSIS:	Based on the findings of the investigation, which included an interview of Ms. Goreta, I am able to corroborate the allegation that Resident A sustained second degrees burns after being showered by staff, Javien McNary. Ms. Goreta reported that she has had ongoing issues with the staff turning the temperature up on the water heater. Ms. Goreta reported that she has warned her staff and told them on several occasions that this practice is prohibited, and they have continued to do so. Ms. Goreta reported that as soon as she became aware that Resident A sustained 2nd degree burns after being showered, she went to the home and turned the water temperature down. Ms. Goreta reported that once the water cycled through the home, she retested it, and it was 113 degrees Fahrenheit. On 12/03/24, during my onsite inspection, I tested the water in the kitchen and both bathrooms and it was 113 degrees Fahrenheit. Although, the water temperature was not tested prior to Resident A sustaining 2nd degree burns, or after Ms. Goreta became aware of Resident A sustaining the burns, based on the severity of his burns and the blistering of his skin, I can conclude that the water in the home exceeded 120 degrees, resulting in severe injury to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 11/27/24, I interviewed home manager, Debra Lyons, and she reported that upon her arrival at work Monday 11/25/24, at 8:00 a.m., midnight staff, Carol Collins, reported to her that Resident A needed to be taken to the emergency room. Ms. Lyons reported that Ms. Collins stated that her belief that Resident A either had a bad rash or an allergic reaction to something in his genital area. Ms. Lyons reported when she observed Resident A’s genital area, she knew he needed immediate treatment.

Ms. Lyons reported that she later interviewed the midnight staff, Carol Collins, and Anne Igbinigie, to determine when they observed the injuries to Resident A's penis and groin area, and to inquire as to why they did not seek medical treatment at that time. Ms. Lyons reported that they reported that they thought it was just rash or reaction to something and did not believe it warranted immediate treatment.

On 11/27/24, I interviewed staff, Carol Collins, and she reported that she worked the midnight shift, with staff, Anne Igbinigie on Sunday 11/24/24 and reported that they worked from 8:00 p.m. until 8:00 a.m. Ms. Collins reported that Ms. Igbingie was assigned to Resident A and reported that she only helped transfer Resident A from his wheelchair to bed. Ms. Collins reported that around 10:00 p.m. Ms. Igbingie put on Resident A's pajamas and checked his brief and reported noticing some redness in the creases on both sides in his groin area. Ms. Collins reported that Ms. Igbingie reported that she checked Resident A a few more times throughout the night and he was dry so she did not have to open his brief, as she could feel that it was dry. Ms. Collins reported that at 6:00 a.m. while Ms. Igbingie was checking Resident A's brief, she heard her scream and called for her to come into his bedroom. Ms. Collins reported that Resident A's groin area and penis looked worse, and she advised her to call the manager to inform her and to see how she wanted them to proceed. Ms. Collins reported that Ms. Igbinigie said that Ms. Lyons would be there in a couple of hours, and she would show her once she arrived. Ms. Collins reported that she told Ms. Igbinigie that she thought Resident A needed to see a doctor, however reported that she did not listen to her. I informed Ms. Collins that she too had a responsibility to seek needed care for Resident A, if she felt it was warranted, and did not need Ms. Igbinigie's permission to do so. Ms. Collins reported an understanding and reported that this is a lesson learned, and in the future, she would not depend on someone else to do the right thing. Ms. Collins reported that home manager, Debra Lyons arrived to work at 8:00 a.m. on Monday 11/25/24, and after observing Resident A's groin and penis, directed assistant manager, Anthony Logan, to transport Resident A to local the emergency room.

On 12/04/24, I interviewed staff, Anne Igbinigie, and she reported that she was one of the midnight staff on Sunday 11/24/24 along with Carol Collins. Ms. Igbinigie reported that the residents are usually in bed by 10:00 p.m. and are already in their pajamas when the midnight staff arrive. Ms. Igbinigie reported that she believes that Resident A was in his pajamas that night and his brief was dry. Ms. Igbinigie reported that at around 3:00 a.m. she completed rounds and checked Resident A's brief and reported it was dry, and that she was able to determine that without having to open the brief. Ms. Igbinigie reported that at 6:00 a.m. she checked Resident A and was preparing to provide care and his brief was wet. Ms. Igbinigie reported that when she opened Resident A's brief, she screamed, after observing redness, blistering and the skin off of his penis. She reported that she yelled for Ms. Collins to come in and look at Resident A. She reported that they decided to change the brief but not to wipe or touch the area because they were not sure if it was a rash or an allergic reaction to something. Ms. Igbinigie reported that she knew that the home

manager was arriving within the next two hours and would show her Resident A's groin area and determine next steps at that time. Ms. Igbinigie reported that was the biggest mistake she made and reported that she should have called 911 and then contacted the home manger after. Ms. Igbinigie was emotional during the interview and just repeated that she knows she messed up bad and knows that she will be disciplined, if not terminated for her actions. Ms. Igbinigie reported that licensee designee, Karen Goreta held an emergency staff meeting on 11/27/24, and went over staff responsibilities, water safety when it comes to showering residents, as well as seeking immediate care for residents. Ms. Igbinigie further reported that they were informed that a heating and cooling company would be installing a device on the hot water tank that will prevent staff from turning the water heater up on the tank. I reiterated to Ms. Igbinigie the importance of always erring on the side of caution and adhering to the rule requirement of seeking immediate medical attention once observing a change in a resident's physical condition or adjustment. Ms. Igbinigie reported that this would never happen again, and she has learned from her mistake.

On 12/09/24, I received and reviewed the progress notes completed by midnight staff, Carol Collins and Anne Igbinigie. Ms. Collins documented that she stripped and changed Resident A's bed linen because he had soiled them. The note also documents that Ms. Collins changed Resident A's brief and observed swelling in the right thigh area and redness to his penis and that she monitored the area closely throughout the night. The progress notes authored by Ms. Igbinigie make no mention of her observing the swelling/redness or penis discolorations. After reviewing the progress notes there are inconsistences in what both Ms. Collins and Ms. Igbinigie reported when I interviewed them. The inconsistencies show that they both observed and were aware of the serious injury to Resident A and both failed to seek immediate medical attention.

On 01/07/25, I conducted the exit conference with licensee designee, Karen Goreta, and informed her of the findings of the investigation and the specific rule cited. Ms. Goreta reported an understanding and reported that she has addressed this rule and matter with all staff. Ms. Goreta reported that both staff on shift that night knew better and there is no logical reason why they didn't seek immediate care for Resident A.

APPLICABLE RULE	
R 400.14310	**Resident health care.**

	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on the findings of the investigation, which included interviews of home manager, Debra Lyons, staff, Carol Collins and Anne Igbinigie, and my review of Ms. Collins and Ms. Igbinigie's progress notes, I am able to corroborate that neither staff sought needed care immediately after observing an adverse change in Resident A's physical condition. Ms. Collins reported in her interview with me that staff, Anne Igbinigie, was assigned to Resident A and provided care to him during the shift and she only assisted in transferring him from wheelchair to bed. However, after reviewing Ms. Collins progress notes from the night of 11/24/24 and morning of 11/25/24, she documented that she changed Resident A's bedding and sheets after he soiled/wet them. Further, she documented that she changed Resident A's brief and observed swelling in his right thigh area and redness and discoloration to his penis and that she monitored the area closely throughout the night. Ms. Igbinigie reported in her interview that she had checked Resident A throughout the night and his brief was dry and was able to tell without opening the brief. Ms. Igbinigie reported that at 6:00 a.m. Resident A's brief was wet and when she opened it and saw his penis and groin area she screamed and called out to Ms. Collins. Ms. Igbinigie admitted that after observing the area, she still waited an additional two hours for the manager to arrive and showed her Resident A's genital area. Ms. Igbinigie reported she messed up and should have called 911 or driven Resident A to the hospital. Ms. Igbinigie's progress notes from the night of 11/24/24, and morning of 11/25/24, do not document or make mention of her ever observing the injuries/burns to Resident A's penis or thigh area. The progress notes authored by both Ms. Collins and Ms. Igbinigie and their verbal interviews with me are full of inconsistences. The inconsistencies show that they both observed and were aware of the serious injury to Resident A and both failed to seek immediate medical attention.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

01/07/25

Pandrea Robinson
Licensing Consultant

Date

Approved By:

01/08/2025

Ardra Hunter
Area Manager

Date