GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 6, 2021

Kenneth Jordan
Samaritan Homes, Inc.
22610 Rosewood
Oak Park, MI 48237

RE: License #: AS820068075
Investigation #: 2021A0116026
Vreeland Home

Dear Mr. Jordan:

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 #:** | AS820068075 |
| | |
| **Investigation #:** | 2021A0116026 |
| | |
| **Complaint Receipt Date:** | 07/13/2021 |
| | |
| **Investigation Initiation Date:** | 07/13/2021 |
| | |
| **Report Due Date:** | 09/11/2021 |
| | |
| **Licensee Name:** | Samaritan Homes, Inc. |
| | |
| **Licensee Address:** | 22610 Rosewood<br>Oak Park, MI 48237 |
| | |
| **Licensee Telephone #:** | (248) 399-8115 |
| | |
| **Administrator:** | Kenneth Jordan |
| | |
| **Licensee Designee:** | Kenneth Jordan |
| | |
| **Name of Facility:** | Vreeland Home |
| | |
| **Facility Address:** | 17090 Ray<br>Riverview, MI 48194 |
| | |
| **Facility Telephone #:** | (734) 282-0230 |
| | |
| **Original Issuance Date:** | 10/01/1995 |
| | |
| License **Status:** | REGULAR |
| | |
| **Effective Date:** | 05/15/2020 |
| | |
| **Expiration Date:** | 05/14/2022 |
| | |
| **Capacity:** | 5 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| On 7/4/2021, Resident A was taken to the hospital due to seizure activity, while in the hospital the facility issued an improper emergency discharge. | Yes |
| On 06/28/21, Resident A was observed with a bruise to her left wrist and redness on the right side of her face. | No |

## III. METHODOLOGY

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|---|---|
| 07/13/2021 | Special Investigation Intake<br>2021A0116026 |
| 07/13/2021 | Special Investigation Initiated - Telephone<br>Interviewed program manager Stacey Washington. |
| 07/13/2021 | Contact - Telephone call made<br>Interviewed Complainant. |
| 07/13/2021 | Contact - Telephone call made<br>Interviewed Guardian (1). |
| 07/13/2021 | Contact - Telephone call made<br>Interviewed Supports Coordinator Jessica VanHamme. |
| 07/14/2021 | Contact-Document Received<br>Resident A's Behavior Assessment, body charts, behavior plan, Urgent Care discharge instructions, and ABC behavior charts. |
| 07/26/2021 | Contact - Document Sent<br>Email sent to assigned adult protective services (APS) investigator Ms. Mayfield Murphy requesting a call to discuss investigation. |
| 07/27/2021 | Contact - Telephone call made<br>Spoke to Ms. VanHamme. |
| 07/28/2021 | Inspection Completed On-site<br>Interviewed home manager Michelle Foster, staff Kristina Mills, Deloris Reeves, and Resident B. |
| 08/02/2021 | Contact - Document Sent |

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| | Email sent to Ms. Murphy-Mayfield requesting a telephone call to discuss the investigation. |
| 08/03/2021 | Contact - Telephone call made<br>Spoke with Guardian (1). |
| 08/04/2021 | Contact - Telephone call made<br>Interviewed Kimberly Biondi, Henry Ford Wyandotte Hospital social worker. |
| 08/04/2021 | Inspection Completed-BCAL Sub. Compliance |
| 08/04/2021 | Exit Conference<br>With licensee designee Kenneth Jordan. |

**ALLEGATION:**

**On 7/4/2021, Resident A was taken to the hospital due to seizure activity, while in the hospital the facility issued an improper emergency discharge.**

**INVESTIGATION:**

On 07/13/21, I received a telephone call from Ms. Washington, program manager for the home. Ms. Washington reported that Resident A was hospitalized due to her seizure activity and that tests were being ran in efforts to determine the possible cause.

On 07/13/21, Ms. Washington further reported that licensee designee Kenneth Jordan had initially completed an emergency discharge notice on 07/09/21 but needed to include additional information so he re-issued the notice to all required parties on 07/13/21 (copies of both discharge notices in file). Ms. Washington reported the emergency discharge was due to the homes inability to meet Resident A's increasing needs, the Guardian's refusal to allow the home to seek needed psychiatric services for Resident A, Resident A's increase in self-harming behaviors, her recent seizure activity, and failure of the Guidance Center to re-assign Resident A to a new behavior specialist, after her previous one quit over three months ago. Ms. Washington also reported that Resident A's guardian was demanding 1 on 1 staffing for Resident A, which had not been approved by the Detroit Wayne Integrated Health Network (DWIHN) who serve as the contract agency.

Ms. Washington reported that the home tried their best to work with Resident A's guardian to maintain her safely in the home. Ms. Washington reported that with the

increase in behaviors, the lack of a behavior specialist for the home to contact for guidance and/or updates to the behavior plan to address the behaviors, placed Resident A at risk. Ms. Washington added that the direct care staff at the home are not trained/certified behavior specialist and were not equipped to take on that role.

On 07/13/21, I interviewed Guardian (1). Guardian (1) reported that she does not believe that an emergency discharge is warranted and believes the home is being retaliatory due to some other concerns that she had and addressed with the home, law enforcement and adult protective services (APS). Guardian (1) reported that she was not aware of any increase in Resident A's behaviors that was cause for concern and reported she could have paid or tried to get Resident A another behavior specialist in place if that was an issue. Guardian (1) reported that Resident A does not have an history of seizures and that 07/04/21 was the first time she had had one. Guardian (1) reported that Resident A has not had any other seizures since she has been hospitalized. Guardian (1) reported her belief that a 30-day discharge would have been more appropriate, and she is not happy about how this was done.

On 07/13/21, I interviewed supports coordinator Jessica Van Hamme and she confirmed that the home has been in "limbo" after the previous behavior therapist quit the job some months ago. Ms. Van Hamme reported that a new behavior therapist has been hired but had not had the opportunity to contact the home and begin services for Resident A. Ms. Van Hamme reported that she tried to help by going over the behavior plan with program manager Stacey Washington, although admitting she was not the author of the plan. Ms. Van Hamme reported that Resident A does exhibit self-harming behaviors. Ms. Van Hamme reported that it is plausible that those behaviors could have escalated after Resident A's move to the home on 06/14/21, after the home she previously lived in closed due to lack of staffing. Ms. Van Hamme reported that home was with the same corporation that owns the home that Resident A currently resides in.

Ms. Van Hamme reported that she received a copy of the emergency discharge and has put in a request for a new placement.

On 07/13/21, I received and reviewed the written emergency discharge notice that documented that due to the increase in Resident A's behaviors, specifically self-harming, the absence of an assigned behavior therapist, and the lack of cooperation from the guardian to assist the home in meeting the needs of the resident the home could no longer safely maintain the resident. The discharge notice did not document where the resident would be placed following her discharge from the hospital.

On 07/14/21, I received and reviewed copies of Resident A's behavior assessment, behavior plan and ABC charts. The behavior assessment dated 08/17/20 documents that Resident A has a history of hitting herself in the face, hitting staff, turning on water faucets, and property damage. The treatment plan documents that these behaviors can occur multiple times per week to a couple times per month. The treatment plan also outlines the steps the staff should take when Resident A is

exhibiting behaviors and requires staff to document behaviors on ABC behavior charts. The staff document on the charts the date, time, what Resident A was doing before the behavior (A), what the behavior was, and any injuries observed (B) and how the behavior stopped (C). I reviewed the ABC charts dating back to 06/14/21 through 06/28/21, and they show that Resident A was having multiple behaviors per day and the steps taken by staff to redirect.

On 07/26/21, I emailed the assigned APS worker Ms. Ms. Murphy-Mayfield and 08/02/21 requesting contact to discuss the investigation. To date Ms. Murphy-Mayfield has not contacted me.

On 07/27/21, I spoke with Ms. Van Hamme and she reported that Resident A remains hospitalized awaiting placement. Ms. Van Hamme reported that Resident A has been medically ready for discharge for over a week, but the home is not willing to take her back while they continue to search for placement.

On 07/28/21, I conducted a scheduled onsite at the home and interviewed staff Kristina Mills. Ms. Mills reported that prior to working in this home she was employed with several agencies that provided staffing for residents in their homes. Ms. Mills reported that she worked in Resident A's parental home as one of her staff for five years. Ms. Mills reported that she has witnessed firsthand the increase in Resident A's behaviors, specifically self-harming. Ms. Mills reported that the home and staff are unable to meet Resident A's needs, especially with key components of her service needs not in place. Ms. Mills reported that she is referring to the lack of a behavior therapist in place, and her recent seizure activity.

I received and reviewed the incident report that documented on 07/04/21 while sitting at the kitchen table playing with a toy Resident A had a seizure that lasted for a minute. The home manager Michelle Foster called 911 and Resident A was transported to Henry Ford Wyandotte Hospital.

On 08/03/21, I spoke with Guardian (1) and she reported that DWIHN is still searching for placement for Resident A. Guardian (1) reported that the current plan is for a temporary placement to be secured so that they can get Resident A out of the hospital and continue the search for a permanent placement. Guardian (1) reported that the relationship with the previous home has deteriorated and placing her back in that home is not an option.

On 08/04/21, I interviewed Kimberly Biondi, Social Worker at Henry Ford Hospital Wyandotte. Ms. Biondi reported that she spoke with Ms. Washington and during that conversation she asked her if the home would be able/willing to take Resident A back once she was medically ready for discharge. Ms. Biondi reported that Ms. Washington reported to her that the home would not be taking Resident A back citing staffing issues, Resident A's increase in behaviors, and the homes inability to meet her needs. Ms. Biondi reported that Ms. Washington was aware at the time of

their conversation that no other placement arrangement had been secured for Resident A. Ms. Biondi reported that Resident A has been medically ready for discharge since 07/15/21. Ms. Biondi added that a prospective home provider completed an assessment on Resident A on 08/03/21 and has accepted her for placement. Ms. Biondi reported that Guardian (1) plans to go look at the home and make a decision regarding the placement.

On 08/04/21, I conducted the exit conference with Mr. Jordan and informed him of the findings of the investigation. Mr. Jordan reported an understanding but added that he did not agree. Mr. Jordan reported that bringing Resident A back in the home fully aware that the home cannot meet her needs puts him and his staff in an unfair and unsafe situation and places Resident A at risk. Mr. Jordan also reported that Guardian (1) was a hinderance to Resident A's treatment and success in the home. Mr. Jordan reported that he would submit an acceptable corrective action plan to address the violation.

| **APPLICABLE RULE** | |
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| **R 400.14302** | **Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.** |
| | **(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident:**<br>**(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:**<br>**(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** |

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| **ANALYSIS:** | Samaritan Homes issued an emergency discharge notice for Resident A on 07/09/21 and re-issued it on 07/13/21 with additional information. Resident A was hospitalized and being treated for seizure activity.<br><br>Resident A was medically ready for discharge on 07/15/21. Ms. Biondi reported that when she contacted the home and spoke with Ms. Washington, she refused to allow Resident A to return to the home.<br><br>Ms. Van Hamme reported that upon receipt of the discharge notice, she put in the request for a new placement, however a new placement that meets Resident A's needs has not been secured.<br><br>The violation is established because the home refused to allow the resident to return to the home at the time she was medically stable, knowing that another appropriate placement that meets the needs of the resident had not been secured. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**On 06/28/21, Resident A was observed with a bruise to her left wrist and redness on the right side of her face.**

**INVESTIGATION:**

On 07/13/21, I received a telephone call from Ms. Washington reporting that she was made aware that APS and the police would be conducting investigations regarding the bruise that was observed on Resident A's left wrist on 06/28/21. Consultant was aware of the bruise as the home had submitted an incident report documenting the bruise and supporting documentation of Resident A's self-harming behaviors.

Ms. Washington reported that Guardian (1) contacted her questioning her about the bruise and how it occurred. Ms. Washington reported that she informed Guardian (1) that she was not at the home on 06/28/21 and was made aware of the bruise once the home manager Michelle Foster and staff Kristina Mills were getting Resident A up and dressed for the day and they noticed it. Ms. Washington reported that Guardian (1) decided to take Resident A to urgent care to have the bruise looked at.

Ms. Washington reported when Resident A returned to the home, they obtained copies of the discharge paperwork that documented a contusion to the left wrist, no follow up required. Ms. Washington reported that Resident A was with Guardian (1) on 06/27/21 and returned back to the home between 9:30 p.m. and 10:00 p.m.. Ms. Washington reported that staff Deloris Reeves was on shift and reported that while Guardian (2) was trying to get Resident A in the house she turned to run away, and Guardian (2) grabbed her wrist/arm area and escorted her in the house. Ms. Washington reported that it cannot be ruled out that that could have caused the bruise. Ms. Washington added that Resident A was out of the home on 06/27/21 and they do not know what could have happened during the time they were not responsible for her care. Ms. Washington reported regarding the red mark to Resident A's face, she reported that she did not see it, but reported Guardian (1) sent her a picture.

Ms. Washington further reported that the redness on Resident A's face comes from her repetitive motion of tapping, sometimes hitting her toys on her face and chest area. Ms. Washington reported that this is a behavior that is documented in Resident A's behavior assessment and behavior plan.

On 07/13/21, I interviewed the complainant, complainant confirmed allegations as reported.

On 07/13/21, I interviewed Guardian (1). Guardian (1) reported that she does not believe that Resident A caused the bruise by self-harming. Guardian (1) reported that Resident A does have a history of tapping her face and chest repetitively and it has caused redness and slight bruising in the past. Guardian (1) reported that she has never known Resident A to self-harm to this extent. Guardian (1) reported that when Resident A was picked up by a family member on 06/27/21 she did not have any marks or bruises on her, and reported she was returned that night to the home without any marks or bruises on her by Guardian (2). Guardian (1) reported on 06/28/21 Resident A was picked up for lunch by her brother and he observed the bruise and sent a picture to Guardian (1). Guardian (1) reported that she contacted the home manager Ms. Foster and Ms. Washington to determine what happened. Guardian (1) reported that she decided to take Resident A to urgent care for evaluation. The bruise was examined and documented as a contusion. Guardian (1) reported that the doctor did not want to speculate or assume anything and did not file an APS complaint. Guardian (1) reported that she is not saying that the home did anything to intentionally harm Resident A but believes something happened.

Guardian (1) further reported that on 07/04/21 Resident A had a seizure and is still hospitalized. Guardian (1) reported that the treating physician informed her that it was plausible that Resident A could have had an unwitnessed seizure at the home and hit something or fell, causing the bruise. Guardian (1) reported that Resident A does have a history of seizures and reported to her knowledge this was her first one. Guardian (1) reported that prior to this incident she did not have any concerns

regarding Resident A's safety in the home but feels that these types of homes should have multiple staff in the home as a common/best practice.

I received and reviewed Resident A's behavior assessment dated 08/17/20. In the assessment it documents that Resident A has had severe behaviors including harm to self and others through physical and verbal aggression as well as property destruction and food aggression since she was a child. The assessment also documents that Resident A's behaviors include hitting herself in the face with toys and her hands, hitting staff members, turning on water faucets, and inappropriate toileting. The plan documents that Resident A has bruised herself but has not broken the skin.

On 07/28/21, I conducted a scheduled onsite inspection and interviewed staff persons, Ms. Reeves, Ms. Mills, Ms. Foster, and Resident B. I visually observed Residents C-E as they could not be interviewed due to their developmental disabilities. Residents C-E were sitting in the living room and all appeared well. They were neatly dressed and groomed.

On 07/28/21, Ms. Reeves reported that she was the staff on shift on the night of 06/27/21. Ms. Reeves reported that Resident A was returned to the home around 10:00 p.m. Ms. Reeves reported that when she went to open the door for Resident A, she observed her turn away and start to run away from the home. She reported that Guardian (2) grabbed her arm and was able to get her in the house. Ms. Reeves reported that it's a possibility that that may have unintentionally caused the bruise, in addition to Resident A's history of self-harm.

On 07/28/21, Ms. Mills reported that on 06/28/21 she woke Resident A up and that's when she observed he bruise to her left wrist area. Ms. Mills reported there was no redness on either side of her face. Ms. Mills reported she notified her manager Ms. Foster, completed the incident report and body check chart. Ms. Mills reported that she didn't think anything of it because of Resident A's history of self-harm. Ms. Mills also reports that depending on how Resident A sleeps she will sometimes wake up with red pressure marks on her arms and face. Ms. Mills denied that she caused the bruise to Resident A.

On 07/28/21, Ms. Foster reported that on 06/28/21 Ms. Mills informed her that she had observed a bruise on Resident A's left wrist area. Ms. Foster reported that both completed incident reports and body check charts. Ms. Foster reported that due to Resident A's history of self-harm she attributed the bruise to that. Ms. Foster reported that Resident A has different toys that she uses at times and hits herself with. Ms. Foster reported that she and the staff will remove the hard objects from the toys to prevent Resident A from hurting herself or causing marks or bruises. Ms. Foster denied that she caused the bruise to Resident A and does not believe any other staff did.

On 07/28/21, I interviewed Resident B and she reported that she loves her home and that the staff treat her and her roommates good. Resident B was focused on her nails that she recently had painted and was not interested in answering any additional questions. Resident B was neatly dressed and groomed.

I conducted the exit conference with Mr. Jordan on 08/04/21 and informed him of the findings of the investigation. Mr. Jordan agreed with the findings.

| **APPLICABLE RULE** | |
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| **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:** | Resident A sustained a bruise to her left wrist and redness to the side of her face. |

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| | I completed interviews with Ms. Washington, Guardian (1), Ms. Reeves, Ms. Mills, Ms. Foster and reviewed Resident A's behavior assessment.<br><br>Ms. Washington, Ms. Mills, and Ms. Foster all reported that the bruise on Resident A's wrist and the redness on her face was not caused by any abuse or neglect by staff. They all reported their belief that it was caused by Resident A's self-harm.<br><br>Ms. Reeves reported that the bruise could have been caused unintentionally by Guardian (2) when he grabbed Resident A by the arm on the night of 06/27/21, while trying to prevent her from running toward the street.<br><br>Resident A was examined at Urgent Care on 06/28/21 and seen by several doctors while in the hospital from 07/04/21 and neither have filed a complaint with APS citing a suspicion of abuse or neglect.<br><br>Resident A's behavior assessment documents her history of self-harming behaviors. |
| | Guardian (1) reported her concern over the bruise but reported that she was not accusing the staff at the home of abuse. Guardian (1) also reported that one of the doctors at the hospital told her it was plausible that Resident A could have had an unwitnessed seizure and hurt herself.<br><br>Based on the aforementioned, there is in insufficient evidence to establish this violation. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

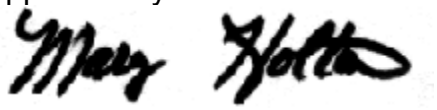
## IV. RECOMMENDATION

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

08/05/21

Pandrea Robinson Date
Licensing Consultant

Approved By:



08/06/21

Mary Holton Date
Area Manager