GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 17, 2021

Barbara Freysinger
Hope House I Nonprofit Hsg Corp
P 0 Box 1978
524 North Jackson St.
Jackson, MI 49201

RE: License #: AL380007059
Investigation #: 2021A0122024
Hope House II/Fowler House

Dear Ms. Freysinger:

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
THIS REPORT CONTAINS PROFANITY

I. IDENTIFYING INFORMATION

License #:	AL380007059
Investigation #:	2021A0122024
Complaint Receipt Date:	07/29/2021
Investigation Initiation Date:	08/06/2021
Report Due Date:	09/27/2021
Licensee Name:	Hope House I Nonprofit Hsg Corp
Licensee Address:	P 0 Box 1978 524 North Jackson St. Jackson, MI 49201
Licensee Telephone #:	(517) 784-4426
Administrator:	Barbara Freysinger
Licensee Designee:	Barbara Freysinger
Name of Facility:	Hope House II/Fowler House
Facility Address:	400 Van Buren Street Jackson, MI 49201
Facility Telephone #:	(517) 784-1522
Original Issuance Date:	10/01/1980
License **Status:**	REGULAR
Effective Date:	04/09/2020
Expiration Date:	04/08/2022
Capacity:	16
Program Type:	PHYSICALLY HANDICAPPED

	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff A is mentally unstable to meet the physical, emotional, intellectual, and social needs of the residents.	No
Resident A was forced to use the Easy Stand Lift, an assistive device two months ago.	No
Staff member, Laney Wells, screams, and uses profanity in front of the residents. Staff member, Kristen Wells, uses profanity, and made a racist statement in front of residents.	Yes
Residents A, B, and C were injured, and medical care was not obtained to address the injuries.	No
Residents A, B, and C were involved in accidents and incident/accident reports were not completed.	No
Additional Findings	Yes

III. METHODOLOGY

07/29/2021	Special Investigation Intake 2021A0122024 APS Referral
08/02/2021	Special Investigation Initiated – On Site Completed interviews with Residents D and E. Received requested information – Staff schedule, Staff names and phone numbers. Reviewed resident files.
08/02/2021	Contact - Document Received Intake # 181092 received. Allegations added to this special investigation.
08/05/2021	Contact - Document Received Intake #181169 received. Allegations added to this special investigation.
08/06/2021	Contact - Telephone call made Barb Freysinger, Licensee Designee.
08/06/2021	Contact - Document Received Intake #181197 received. Allegations added to this special investigation.
08/06/2021	Contact - Telephone call made

	Completed interviews with the following staff members: Michelle King, Ieashea James, Courtney Wilson, Laney Wells, Cori-Ann Evans, and Shy Johnson. Completed interview with Complainant 1. Completed interview with Barbara Freysinger, Licensee Designee.
08/09/2021	Contact - Document Received Email BCAL Complaint Department. Additional information that was received was discussed with Complainant 1 during the interview on 08/06/2021.
08/09/2021	Contact - Telephone call made Complainant 1. No answer. No return phone call.
08/09/2021	Inspection Completed On-site Completed interviews with staff members, Judy Reid, Vernisha Hutchins, Christy Dimery, Winifred Robinson, and Kayla Kilgore, Observed Residents A, B, and C. Received information from Resident files.
08/09/2021	Contact - Document Received Email received from Recipient Rights Personnel.
08/10/2021	Contact – Telephone Calls made Mallory Kettlehut, RN, assigned to work with Resident A. Heather Caldwell, Case Manager, assigned to work with Resident A. Staff members, Kristen Wells and Morgan Wells. Kristen Wells was unavailable. Voice message was left requesting return phone call. Relative A, Relative B, and Relative C.
08/10/2021	Contact – Telephone Call received Completed interview with Mallory Kettlehut, RN, and Heather Caldwell, Case Manager, assigned to work with Resident A. Completed interview with Relative B and Staff member, Morgan Wells.
08/13/2021	Contact – Telephone Call made Staff member, Kristen Wells. Ms. Wells was unavailable. Voice Message was left requesting that she return my phone call.
08/16/2021	Exit Conference Discussed findings with Barbara Freysinger, Licensee Designee

ALLEGATION: Staff A is mentally unstable to meet the physical, emotional, intellectual, and social needs of the residents.

INVESTIGATION: On 08/02/2021, Complainant 1 reported that Staff A is mentally unstable, and it is known that she is prescribed medication to address her mental health issues. Complainant 1 has observed "fresh cuts" on Staff A that she assumed are self-inflicted. Complainant 1 gave no specific examples of how Staff A's alleged mental illness negatively affects her ability to perform her job duties or provide care to the residents.

On 08/02/2021, I completed an on-site inspection. I observed residents and staff in several areas of the facility. There were residents in the family room watching television, sitting on the porch, and some were sitting in the dining room. Staff members were observed in all areas as well monitoring and assisting the residents as needed. None of the residents were observed to be in distress or uncomfortable. I observed lunch being prepared and served. Staff members were observed assisting residents as needed with no signs of discomfort or distress noted from residents.

On 08/02/2021, I interviewed Residents D and E, whom are the only verbal residents with the ability to participate in an interview. Resident D reported that she did not know Staff A but that she had no issues with any of the staff members working at Hope House II adult foster care facility. Per Resident D she receives assistance from staff members as needed and has no issues or concerns regarding staff members.

On 08/02/2021, Resident E reported that she knew Staff A. Resident E stated that Staff A "always gives her assistance as needed" and she has specifically helped her comb/braid her hair and paint her fingernails. She has observed Staff A interact appropriately with other residents. She reported no issues and/or concerns with the care and assistance received by Staff A.

On 08/06/2021, I interviewed the following staff members: Michelle King, Ieashea James, Courtney Wilson, Cori-Ann Evans, and Shy Johnson. On 08/09/2021, I interviewed the following staff members: Judy Reid, Vernisha Hutchins, Christy Dimery, Winifred Robinson, and Kayla Kilgore. All 10 staff members reported they had observed appropriate interaction between Staff A and residents. None had received reports from residents who are able to communicate verbally that they had concerns regarding the care they have received from Staff A.

On 08/02/2021, I reviewed Staff A's employee file. She was hired on 06/10/2021 and began working on 06/24/2021. Prior to her employment she was taken through a screening process which includes a medical clearance, reference checks, and criminal history check. Staff A had her physician complete a Medical Clearance

Request Form established by the Bureau of Children and Adult Licensing – Division of Adult Foster Care & Home for the Aged Licensing to screen physical and mental condition suitability for those working in adult foster care facilities. The form is dated 06/11/2021 and describes that Staff A has "no physical/mental condition or health problem exists that would limit the ability to work with or around children/dependent adults."

All other pre-employment screening tasks for Staff A were completed and disclosed no issues of concerns. Staff A was offered employment through Hope House I Nonprofit Housing Corporation and began working on 06/24/2021 once she completed training.

On 08/16/2021, I completed an exit conference with Barbara Freysinger, Licensee Designee, where my findings were discussed with her. Ms. Freysinger was in agreement with my findings.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Staff A is mentally unstable to meet the physical, emotional, intellectual, and social needs of the residents. On 08/02/2021, Complainant 1 alleged that Staff A is mentally unstable, and that Staff A takes prescribed medications to address her mental health issues. On 08/02/2021, I completed an on-site inspection. All residents were observed in different areas of the adult foster care facility. Staff members were observed in areas where residents were present assisting them as needed. Residents displayed no signs of discomfort or distress. All residents appeared to be receiving adequate care and supervision from staff members. On 08/02/2021, both Residents D and E reported they receive appropriate care from all staff members assigned to work at the Hope House II adult foster care facility. Resident E specifically sated that Staff A "always gives her assistance as needed."

	On 08/06/2021 I interviewed the following staff members: Michelle King, Ieashea James, Courtney Wilson, Cori-Ann Evans, and Shy Johnson. On 08/09/2021, I interviewed the following staff members: Judy Reid, Vernisha Hutchins, Christy Dimery, Winifred Robinson, and Kayla Kilgore. All 10 staff members reported they had observed appropriate interaction between Staff A and residents. On 08/11/2021, I reviewed Staff A's employee file. Staff A completed an employment screening process that included a medical clearance, reference checks, criminal history check, and training. On 06/11/2021, Staff A's physician completed a Medical Clearance Request Form and described that she has "no physical/mental condition or health problem exists that would limit the ability to work with or around children/dependent adults." Based upon my investigation I find that Staff A possesses the qualifications of being suitable to meet the physical, emotional, intellectual, and social needs of each resident.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A was forced to use the Easy Stand Lift, an assistive device, two months ago.

INVESTIGATION: On 08/06/2021, Complainant 1 reported that Resident A was "resisting" the Easy Stand Lift while "it was lifting her, and staff still made her do (use) it" anyway two months ago.

On 08/09/2021, I attempted to complete an interview with Resident A, however due to cognitive limitations she was unable to participate in an interview. I observed Resident A sitting at the dining room table with other residents waiting for lunch to be served. She appeared comfortable showing no signs of distress. It appeared as if she was receiving proper care and supervision from staff.

On 08/09/2021, I reviewed Resident A's file. According to her Treatment Plan which includes an assessment of her needs dated 06/07/2021 she is dependent on staff members for ambulation. The plan states she was initially assigned the assistive device of the Easy Stand Lift that staff members were to use when transferring her, however after a reassessment of her needs by an occupational therapist she is currently assigned a Hoyer Lift for transferring assistance. All documentation for Resident A's assistive device is current and placed in her file.

On 08/06/2021, I interviewed the following staff members: Michelle King, Ieashea James, Courtney Wilson, Laney Wells, Cori-Ann Evans, and Shy Johnson. On 08/09/2021, I interviewed the following staff members: Judy Reid, Vernisha Hutchins, Christy Dimery, Winifred Robinson, and Kayla Kilgore. Ten staff members stated they did not observe nor receive reports that Resident A was forced to use the Easy Stand Lift.

On 08/06/2021, Staff member, Ieashea James reported she remembered Resident A screamed approximately 2 months ago but could give no additional information i.e., she does not remember the staff member providing care to Resident A, she does not remember the date, nor the time that Resident A screamed. Ms. James stated she was assisting another resident and when she saw Resident A later, she appeared to be fine. Ms. James did not report what she heard as there were no other incidents during her shift.

On 08/06/2021, I completed an interview with Barbara Freysinger, Licensee Designee. Ms. Freysinger stated she had received no reports stating that Resident A was forced to use the Easy Stand Lift by staff members.

On 08/10/2021, I completed an interview with Mallory Kettlehut, RN, assigned to work with Resident A. Ms. Kettlehut reported that she has been working with Resident A since April 2021 and completes medical visits in the facility every 4-6 weeks. Ms. Kettlehut confirmed that Resident A is non-verbal and therefore unable to participate in an interview. Ms. Kettlehut stated she never observed Resident A refusing to use the Easy Stand Lift. Ms. Kettlehut never received reports from staff members that Resident A was refusing to use the Easy Stand Lift.

On 08/10/2021, Staff member, Morgan Wells denied that she had observed Resident A being forced to use the Easy Stand Lift. She reported that she was hired in June 2021 and has always been directed to use the Hoyer Lift when assisting her with a transfer.

On 08/16/2021, I completed an exit conference with Barbara Freysinger, Licensee Designee, where my findings were discussed with her. Ms. Freysinger was in agreement with my findings.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:

	(m) The right to refuse treatment and services, including the taking of medication, and to be made aware of the consequences of that refusal.
ANALYSIS:	Resident A was forced to use the Easy Stand Lift, an assistive device, two months ago. On 08/06/2021, Complainant 1 reported that Resident A was "resisting" the Easy Stand Lift as "it was lifting her, and staff still made her do (use) it" anyway two months ago. On 08/09/2021, I determined that Resident A was unable to participate in an interview due to cognitive limitations. I observed Resident A within the facility appearing to be comfortable with no signs of distress. Resident A appeared to be receiving appropriate care and supervision by staff. On 08/09/2021, I reviewed Resident A's file. Her Treatment Plan which includes an assessment of her needs dated 06/07/2021 she is dependent on staff members for ambulation. The plan states she was initially assigned the assistive device of the Easy Stand Lift that staff members were to use when transferring her, however after a reassessment of her needs by an occupational therapist she is currently assigned a Hoyer Lift for transferring assistance. All documentation for Resident A's assistive device is current and placed in her file. On 08/06/2021, I interviewed the following staff members: Michelle King, Ieashea James, Courtney Wilson, Laney Wells, Cori-Ann Evans, and Shy Johnson. On 08/09/2021, I interviewed the following staff members: Judy Reid, Vernisha Hutchins, Christy Dimery, Winifred Robinson, and Kayla Kilgore. Ten staff members stated they did not observe nor receive reports that Resident A was forced to use the Easy Stand Lift. On 08/06/2021, Ieashea James reported that she heard Resident A scream approximately 2 months ago but could give no additional information i.e., she does not remember the date, nor the time that Resident A screamed, nor who was assisting her. On 08/10/2021, Mallory Kettlehut, RN, assigned to work with Resident A reported that she had never observed nor receive reports that Resident A refused or made to use the Easy Stand Lift

	On 08/10/2021, Staff member, Morgan Wells, reported that she was hired in June 2021 and has always been directed to use the Hoyer Lift when assisting Resident A with a transfer. Based upon my investigation I find that Resident A's right to refuse treatment and services, including the taking of medication, and to be made aware of the consequences of that refusal has been upheld. There is no evidence to support the allegation that Resident A was forced to use the assistive device, the Easy Stand Lift. The Easy Stand Lift was assigned to Resident A by her Occupational Therapist and was later replaced with another assistive device based upon her physical needs.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Staff member, Laney Wells, screams, and uses profanity in front of the residents.**
- **Staff member, Kristen Wells, uses profanity, and made a racist statement in front of residents.**

INVESTIGATION: On 07/29/2021 and 08/02/2021, Complainant 1 submitted allegations to the Bureau of Children and Adult Licensing's complaint department that staff members, Laney Wells and Kristen Wells used profanity and scream in front of the residents. She also reported that Kristen Wells made a racist statement in front of the residents.

During my interview with Complainant 1 on 08/06/2021 she reported that both staff members, Laney and Kristen Wells, have screamed the following, "Fuck this place" and call a resident a "Bitch." Complainant 1 stated both staff members would make these statements in the facility office/medication room with the door closed. Complainant 1 is unsure if residents or other staff members heard the alleged comments made by Laney and Kristen Wells.

On 08/06/2021, Laney Wells denied using profanity and screaming while working. She reported that she has overheard Kristen Wells use profanity but could give no additional information. Ms. Wells could not remember what alleged words Kristen Wells stated nor could she give any context or condition of why the words were used. Laney Wells stated she did not remember if anyone else was present when Kristen Wells allegedly used profanity.

On 08/06/2021, I interviewed the following staff members: Michelle King, Ieashea James, Courtney Wilson, Laney Wells, Cori-Ann Evans, and Shy Johnson. On 08/09/2021, I interviewed the following staff members: Judy Reid, Vernisha

Hutchins, Christy Dimery, Winifred Robinson, and Kayla Kilgore. Eight staff members reported that they had not witnessed Laney Wells nor Kristen Wells scream or use profanity in front of the residents.

On 08/06/2021, Ieashea James reported that she had witnessed Laney Wells use profanity on 06/24/2021. Per Ms. James, she had asked Laney Wells to move to another location in the facility and Ms. Wells responded by stating the following, "I don't have to do that, Fuck this, it doesn't make any sense. This is bullshit." Ms. James stated that eventually Ms. Wells stopped using profanity and she finished her shift without further incident. Ms. James stated that none of the residents heard Laney Wells' outburst as it was approximately 11:15 p.m. and they were in bed. She did report the incident to Julie Reid the following day on 06/25/2021.

On 08/09/2021, Julie Reid confirmed that Ieashea James reported the incident of Laney Wells using profanity while at work 06/24/2021. Ms. Reid stated she addressed the incident by discussing guidelines of staff during third shift, 11:00 p.m. – 7:00 a.m. with both Ieashea James and Laney Wells in June and received no further reports of Laney Wells using profanity while at work. Julie Reid received no reports that Kristen Wells used profanity while working.

On 08/10/2021, I interviewed Morgan Wells, staff member. Ms. Wells confirmed that she had witnessed both Laney Wells and Kristen Wells use profanity in front of residents. She witnessed Laney Wells use profanity responding to a co-worker asking her to relocate to another part of the facility. Morgan Wells stated a resident was present during that interaction, but she doesn't remember the name of the resident.

On 08/10/2021, Morgan Wells stated that Kristen Wells uses profanity as part of her normal communication style. Morgan Wells stated she has witnessed Kristen Wells use profanity while speaking in front of residents but not while speaking directly to residents. Morgan Wells doesn't remember any specific word, date, or circumstance but again she has heard Kristen Wells use profanity in front of the residents.

On 08/10/2021, Morgan Wells denied witnessing Laney or Kristen Wells yell or scream in front of residents.

During my interviews with Relative B and Case Manager, Heather Caldwell, I asked if they had observed staff members screaming or using profanity around residents. Both replied with the following statements: On 08/10/2021, Relative B reported that she has never witnessed staff members yell, scream, or use profanity while performing their job duties or interacting with other residents. On 08/10/2021, I interviewed Heather Caldwell, Case Manager assigned to work with Resident C. Ms. Caldwell stated she has never witnessed staff members yell, scream, or use profanity while interaction or providing care to the residents.

On 08/10/2021 and 08/13/2021, I attempted to complete a phone interview with Kristen Wells. Kristen Wells was unavailable on both dates, and I left voice messages requesting that she return my phone call. To date I have received no contact from Kristen Wells, therefore I was unable to complete an interview with her.

On 08/02/2021, Complainant 1 reported that staff member, Kristen Wells, made a racist statement in front of the residents on 07/30/2021.

On 08/06/2021, I interviewed the following staff members: Michelle King, Ieashea James, Courtney Wilson, Laney Wells, Cori-Ann Evans, and Shy Johnson. On 08/09/2021, I interviewed the following staff members: Judy Reid, Vernisha Hutchins, Christy Dimery, Winifred Robinson, and Kayla Kilgore. Eight staff members reported that they had not witnessed Kristen Wells make a racist statement in the facility. All eight staff members reported they had heard about the incident that involved Shy Johnson and Kristen Wells.

On 08/06/2021, staff member, Shy Johnson, reported that Kristen Wells made a racist statement towards her in the kitchen while she was preparing dinner for the residents on 07/30/2021. Per Ms. Johnson, Kristen Wells entered the kitchen and made the following comment, “Yeah make that good nigga spaghetti.” Ms. Johnson reported the incident to Julie Reid on the same day. Ms. Johnson stated Ms. Reid asked me if I was “ok” to which I replied, “I’m fine” and I continued to work with no further incident. Ms. Johnson stated she believes an internal investigation was completed and Kristen Wells received disciplinary action. She reported her co-workers, Kayla Kilgore and Morgan Wells overheard Kristen Wells make the comment as well.

On 08/09/2021, Kayla Kilgore, confirmed that on 07/30/2021 she overheard Kristen Wells make the above statement to Shy Johnson. Ms. Kilgore discussed the statement with Ms. Johnson, and it was reported to Julie Reid on the same day.

During their interviews on 08/06/2021 and 08/09/2021 respectively, neither Shy Johnson or Kayla Kilgore knew if residents overheard Kristen Wells make the above statement as most are non-verbal and they had received no reports from Residents D and E, who are verbal, but confirmed that the statement was made in the kitchen where the dining and family rooms are adjacent to the kitchen and residents were present.

On 08/02/2021, during my interviews with Residents D and E, neither of them stated they overheard Kristen Wells make a racist statement. However, on 08/10/2021, Morgan Wells confirmed that Kristen Wells made the racist statement to co-worker, Shy Johnson on 07/30/2021. Morgan Wells stated that both Kristen and Shy were in the kitchen, and she was in dining room with residents. She heard the statement and confirmed that there were residents present in the dining room and they heard the statement as well. Per Morgan Wells, an internal investigation was completed when the incident was reported.

On 08/06/2021, Barbara Freysinger stated she had received no reports that staff members, Laney Wells and Kristen Wells were yelling, screaming, or using profanity in front of residents. Ms. Freysinger stated she was aware of the alleged racist statement made by Kristen Wells. She stated an internal investigation had been completed and Ms. Wells received disciplinary action based upon the findings of the investigation.

On 08/10/2021 and 08/13/2021, I attempted to complete a phone interview with Kristen Wells. Kristen Wells was unavailable on both dates, and I left voice messages requesting that she return my phone call. To date I have received no contact from Kristen Wells, therefore I was unable to complete an interview with her.

On 08/16/2021, I completed an exit conference with Barbara Freysinger, Licensee Designee, where my findings were discussed with her. Ms. Freysinger was in agreement with my findings and stated she had begun working on a corrective action plan to address rule violations.

APPLICABLE RULE	
R 400.15305	**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:	Staff members, Laney and Kristen Wells scream and use profanity in front of residents. Staff member, Kristen Wells, made a racist statement in front of residents. On 07/29/2021, 08/02/2021, and 08/06/2021 Complainant 1 reported that both staff members, Laney and Kristen Wells, scream and use profanity in front of residents. Complainant 1 alleged that both Laney and Kristen Wells stated the following, “Fuck this place” and called a resident a “Bitch.” On 08/06/2021, Complainant 1 disclosed that Laney and Kristen Wells made the above statements while they were in the facility office/medication room with the door closed. Complainant 1 stated she was unsure if the residents heard Laney or Kristen Wells make the above comments. On 08/02/2021, both Residents D and E reported they had not witnessed any staff member yell or use profanity while working at the Hope House II adult foster care facility.

	On 08/06/2021, Laney Wells denied using profanity while working at the Hope House II adult foster care facility. Laney Wells reported that she had overheard Kristen Wells used profanity but could give no specific information i.e., she could remember no words or condition/context of the alleged profanity she heard Kristen Wells use. On 08/06/2021, I interviewed the following staff members: Michelle King, Ieashea James, Courtney Wilson, Laney Wells, Cori-Ann Evans, and Shy Johnson. On 08/09/2021, I interviewed the following staff members: Judy Reid, Vernisha Hutchins, Christy Dimery, Winifred Robinson, and Kayla Kilgore. Eight staff members reported that they had not witnessed Laney Wells nor Kristen Wells scream or use profanity in front of the residents. On 08/06/2021, Ieashea James reported that she had witnessed Laney Wells use profanity on 06/24/2021. Ms. James stated that Laney Wells said the following: "I don't have to do that, Fuck this, it doesn't make any sense." However, Ms. James reported that none of the residents heard Laney Wells make this statement as they were all in bed. On 08/10/2021, Morgan Wells reported that she has witnessed Kristen Wells uses profanity in front of residents but not while speaking to the residents. On 08/10/2021, Relative B and Case Manager, Heather Caldwell, reported that they had never witnessed any staff members yell, scream, or use profanity while assisting residents or performing other job duties. On 08/10/2021 and 08/13/2021, I attempted to complete a phone interview with Kristen Wells. Kristen Wells was unavailable on both dates, and I left voice messages requesting that she return my phone call. To date I have received no contact from Kristen Wells, therefore I was unable to complete an interview with her. On 08/02/2021, Complainant 1 reported that Kristen Wells made a racist statement in front of residents. On 08/06/2021, Shy Johnson, confirmed that Kristen Wells made a racist statement, "Yeah make that good nigga spaghetti," towards her on 07/30/2021 while she was in the facility kitchen preparing dinner for the residents.

	On 08/09/2021, staff member, Kayla Kilgore confirmed that she overheard Kristen Wells make the above statement to Shy Johnson inf the facility kitchen. Neither Ms. Johnson nor Ms. Kilgore know if the residents overheard Ms. Wells make the statement. On 08/10/2021, staff member, Morgan Wells, confirmed that she overheard Kristen Wells make the above statement to co-worker, Shy Johnson. Morgan Wells reported she heard the statement while she was in the dining room with other residents. Morgan Wells confirmed that the residents that were present in the dining room heard Kristen Wells make the statement as well. On 08/06/2021, Barbara Freysinger reported she had received no reports that staff members, Laney Wells and Kristen Wells, were yelling, screaming, or using profanity in front of the residents. Ms. Freysinger was aware of the alleged racist statement made by Kristen Wells. Per Ms. Freysinger, an internal investigation had been completed and Kristen Wells received disciplinary action based upon the findings of the investigation. On 08/10/2021 and 08/13/2021, I attempted to complete a phone interview with Kristen Wells. Kristen Wells was unavailable on both dates, and I left voice messages requesting that she return my phone call. To date I have received no contact from Kristen Wells, therefore I was unable to complete an interview with her. Based upon my investigation I find that the residents of Hope House II are not always treated with dignity by staff members. My investigation disclosed that staff members, Laney Wells used profanity in front of residents as observed and witnessed by Morgan Wells and Ieashea James. My investigation disclosed that staff member, Kristen James, uses profanity in front of residents and made a racist statement overheard by residents as observed and witnessed by Shy Johnson, Kayla Kilgore, and Morgan Wells. Most of the residents of Hope House II are nonverbal but have their hearing intact. The profanity used, and statements made while in their presence maybe words and statements, they find offensive, but they are unable to communicate due to their limited verbal skills.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents A, B, and C were injured, and medical care was not obtained to address the injuries.

INVESTIGATION: On 07/29/2021, Complainant 1 reported on 07/27/2021, staff member Laney Wells pushed the Easy Stand Lift over Resident B's foot "causing bleeding, swelling, and bruising."

On 08/02/2021, I completed an on-site inspection. I observed Resident B sitting in the family room. She was observed to be appropriately dressed, comfortable, and exhibiting no forms of distress. Staff members were observed providing care and supervision to Resident B along with the other residents. Resident B appeared to be receiving appropriate care and supervision. Resident B is non-verbal and therefore, unable to participate in an interview.

On 08/02/2021, I interviewed Judy Reid. I asked if she had observed if Resident B had an injury to her feet, to which she replied, "no." Ms. Reid confirmed that Resident B uses the assistive device of the Easy Stand Lift but had neither received report nor observed her being injured using the device. Ms. Reid checked Resident B's feet, a scratch was observed on the left foot, and sent Resident B to urgent care to be medically assessed.

On 08/06/2021, Laney Wells confirmed on 07/27/2021, Resident B received a minor injury while she was assisting her using the Easy Stand Lift. Laney Wells reported the following: she was assisting Resident B with a transfer from the bed to the wheelchair using the Easy Stand Lift and somehow Resident B lost her balance. Laney Wells stated that Resident B did not fall but scraped her foot. She described the injury as "pea-sized with a small amount of blood."

On 08/06/2021, I interviewed the following staff members: Michelle King, Ieashea James, Courtney Wilson, Laney Wells, Cori-Ann Evans, and Shy Johnson. On 08/09/2021, I interviewed the following staff members: Vernisha Hutchins, Christy Dimery, Winifred Robinson, and Kayla Kilgore. Eight staff members reported they did not witness nor observe Resident B having injury on her feet.

On 08/06/2021, Courtney Wilson reported that she observed that Resident B had a "small blister/scratch" on her foot, she couldn't remember if it was the left or right, but she treated with an antibiotic ointment with no further incident. Ms. Wilson further reported she does not believe the allegations that Resident B was injured using the Easy Stand Lift and that the injury was very minimal.

On 08/02/2021, Resident B was taken to urgent care to make certain an injury was not missed. I reviewed the After Visit Summary Report dated 08/02/2021. Resident B was assessed for "foot injury, contusion of left foot." The report lists Resident B's future medical appointments, diagnosis, and medication list. There is nothing documented that Resident B had a foot injury or contusion of the left foot." There are no recommendations regarding her feet or prescribed medication for her feet.

On 08/02/2021, I reviewed Resident B's file. According to her Treatment Plan which includes an assessment of her needs dated 09/09/2021 she is dependent on staff members for ambulation and all activities of daily living including grooming. She is prescribed a "standing device at home," to assist with all ambulation and transfers. All documentation for Resident B's assistive devices is current and placed in her file.

On 08/06/2021, Barbara Freysinger reported she had been made aware that Resident B was observed to have a small abrasion on the top of one of her foot (she was uncertain as to which one). Ms. Freysinger stated Resident B had been taken to have her feet assessed to make certain no injury had been missed. Ms. Freysinger had been informed that Resident B's feet had been assessed and she had been discharged back to the facility without further incident.

On 08/10/2021, I completed an interview with Relative B. Relative B reported that she had been made aware that there was a special investigation being conducted to determine if Resident B was injured using an Easy Stand Lift to assist her. She was also informed that although no injury had been found on Resident B, she was being sent out to be medically assessed and it was determined no injury was found on Resident B.

On 08/10/2021, Relative B reported that she last visited with Resident B the week of August 2nd. Relative B stated she makes monthly unannounced visits for Resident B. Relative B reported she does not have any concerns with the care Resident B is being provided by the staff members of the Hope House II adult foster care facility. She reports that Resident B "never looked so good" and she is happy that Resident B resides in the facility.

08/06/2021, Complainant 1 reported that Resident A received injury 2 months ago, June 2021, by staff members using the Easy Stand Lift which caused bruises on her knees." Complainant 1 does not know which staff member caused injury to Resident A but further reported that an x-ray was taken, and she was bed bound for 2-3 weeks due to her injury.

On 08/06/2021 I interviewed the following staff members: Michelle King, Ieashea James, Courtney Wilson, Cori-Ann Evans, and Shy Johnson. On 08/09/2021, I interviewed the following staff members: Judy Reid, Vernisha Hutchins, Christy Dimery, Winifred Robinson, and Kayla Kilgore. All members stated they did not observe Resident A receive an injury in June 2021 by using the Easy Stand Lift.

On 08/06/2021, I reviewed Resident A's file. According to her Treatment Plan which includes an assessment of her needs dated 06/07/2021 she is dependent on staff members for ambulation. Per Resident A's plan initially she was assigned the assistive device of the Easy Stand Lift that staff members were to use when transferring her, however after a reassessment of her needs she is currently assigned a Hoyer Lift for transferring assistance. All documentation for Resident A's assistive devices is current and placed in her file.

On 08/06/2021, Barbara Freysinger stated she is familiar with Resident A but received no report stating she had been injured while being assisted using the Easy Stand Lift in June 2021.

On 08/09/2021, I attempted to complete an interview with Resident A, however due to cognitive limitations she was unable to participate in an interview. I observed Resident A sitting at the dining room table with other residents waiting for lunch to be served. She appeared comfortable showing no signs of distress. It appeared as if she was receiving proper care and supervision from staff.

On 08/09/2021 Judy Reid, stated she did not receive any reports that Resident A received injury by staff members using the Easy Stand Lift in June 2021. She reported that Resident A receives Palliative Care Services and has monthly visits from her nurse, Mallory Kettlehut. Ms. Reid stated that Ms. Kettlehut did not report that Resident A received injury from an Easy Stand Lift in June 2021 but did confirm that she uses a Hoyer Lift to assist with transfers after assistive devices for Resident A had been reassessed.

On 08/10/2021, I completed an interview with Mallory Kettlehut, RN, assigned to work with Resident A. Ms. Kettlehut reported that she been working with Resident A since April 2021 and completes medical visits in the facility every 4-6 weeks. Ms. Kettlehut confirmed that Resident A is non-verbal and therefore unable to participate in an interview. Ms. Kettlehut reported that Resident A initially used the Easy Stand Lift as an assistive device but was later switched to a Hoyer Lift to provide assistance due to her physical needs. Ms. Kettlehut stated that switch was based upon the recommendation of the Occupational Therapist that completed an assessment on Resident A.

Per Ms. Kettlehut on 08/10/2021, an x-ray was performed on Resident B towards the end of May 2021 as she observed some bruising on her left knee. The x-ray didn't show any issues or breaks in the knee. Ms. Kettlehut is unable to state how the bruising may have occurred but does not feel as it was caused by abuse and/or neglect of the staff members of Hope House II adult foster care facility. Ms. Kettlehut does not have any issues or concerns regarding the care that is provided by the staff members of Hope House II adult foster care facility nor has she observed any negative interaction between resident and staff members.

On 08/05/2021, Complainant 1 reported that Resident C was injured while out in the community with staff. Complainant 1 stated that Resident C fell forward out of his wheelchair hitting his head due to his gait belt being used to secure him while using his wheelchair.

According to the staff scheduled dated August 2021, staff members Laney and Morgan Wells were assigned to take Resident C on an outing. Therefore, they were the only staff members interviewed regarding this allegation.

On 08/06/2021, Laney Wells reported that she and co-worker, Morgan, took Resident C to the park on 08/03/2021. Ms. Wells confirmed that Resident C's gait belt was used as a "seatbelt" to secure him in his wheelchair. She stated as he was being pushed in his wheelchair, he rolled over a bump in the sidewalk, and fell forward. She observed that his belt was loose, and he fell on the ground. Ms. Wells stated that Resident C's impact on the ground was not hard, and she helped him. She observed that he had "scrapes" on his forehead, knee, and shoulder but he appeared to be fine. According to Ms. Wells, Resident C stated he wasn't hurt.

On 08/06/2021, Ms. Wells stated pictures were taken of Resident C on 08/03/2021 and sent to the Medical Coordinator, Courtney Wilson, to determine if he should be taken in for a medical assessment. Ms. Wells reported that Ms. Wilson determined that the wound was superficial, and the outing was continued.

On 08/06/2021, I interviewed Courtney Wilson, Medical Coordinator. She confirmed that she was informed that Resident C had fallen out of his wheelchair and had received minor injury from the accident. Ms. Wilson confirmed that she received and assessed pictures taken of Resident C's injuries on 08/03/2021. She also stated

that staff had reported that Resident C appeared to be well and having no adverse reactions from the fall. Per Ms. Wilson, she reviewed the pictures and described them as showing “slight abrasion on forehead that wasn’t bleeding.” Based upon the information she received she did not recommend taking Resident C to the emergency room but rather the outing could continue.

On 08/06/2021 and 08/09/2021 I observed Resident C. On 08/06/2021, I observed Resident C during a video conference. He was able to identify himself but unable to participate in an interview due to limited cognitive ability. He smiled but couldn’t answer any questions that I presented to him other than stating his name. I observed a minor red scrape on the top of his head approximately 1 inch in length. On 08/09/2021, I observed Resident C at the facility. I observed the same injury on the top of his head. He appeared comfortable and showed no signs of distress.

On 08/09/2021, I reviewed Resident C’s file. According to his Treatment Plan which includes an assessment of his needs dated 11/20/2020 he is dependent on staff members for ambulation. He uses a wheelchair and a gait belt for transfers. There is nothing in Resident C’s plan that states he is to use a gait belt to secure him in his wheelchair. All documentation for Resident C’s assistive devices is current and placed in his file.

On 08/06/2021, Ms. Freysinger reported she had been informed of Resident C’s accident. She stated that he had been medically assessed on 08/06/2021 and returned to the facility without further incident.

On 08/09/2021, I received and reviewed Resident C’s Order Sheet dated 07/21/2020 authorizing the use of a Gait Belt and Wheelchair by his physician. It states that Resident C will need this assistive device indefinitely. The authorization form was updated in July 2021 by his physician.

On 08/10/2021, I reviewed an After Visit Summary Report dated 08/06/2021 for Resident C. He was sent to assess his “injury from fall.” Resident C was prescribed a topical antibiotic ointment to be applied twice daily. There is no mention in the report that medical treatment was delayed or should have been sought sooner.

On 08/10/2021, I completed an interview with Jennifer Marsh, Case Manager for Resident C. Ms. Marsh stated that she was informed about the incident involving Resident C while he was on an outing. She was also made aware that he had been assessed medically on 08/06/2021 and no injury other than a minor abrasion to his forehead was found.

On 08/10/2021, Jennifer Marsh stated she visits with Resident C monthly and has observed resident and client interaction. Ms. Marsh has no issues or concerns regarding the care being provided to Resident C by the staff members of the Hope House II adult foster care facility. Nor does she have any concerns regarding the

care being provided to the other residents by the staff members of the Hope House II adult foster care facility.

On 08/10/2021, I interviewed Morgan Wells. Ms. Wells reported that she was working with Laney Wells transporting Resident C on an outing. Morgan Wells confirmed that Resident C fell forward out of his wheelchair as Laney Wells was pushing him. She stated both she and Laney assessed Resident C and his injuries didn't appear severe. According to Morgan Wells they reported the incident to Courtney Wilson, Medical Coordinator, and sent pictures on 08/02/2021. They were directed to resume the outing and continue to monitor Resident C. Morgan Wells stated the outing resumed without further incident and Resident C appeared to be fine.

On 08/16/2021, I completed an exit conference with Barbara Freysinger, Licensee Designee, where my findings were discussed with her.

APPLICABLE RULE	
R 400.15310	**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:	On 07/29/2021, Complainant 1 reported that on 07/27/2021, staff member Laney Wells pushed the East Stand Lift over Resident B's foot causing injury. On 08/06/2021, Laney Wells confirmed on 07/27/2021, that Resident B received minor injury to her foot while she was assisting Resident B using the Easy Stand Lift. On 08/06/2021, staff member Courtney Wilson, reported that Resident B had a "small blister/scratch" on her foot and applied antibiotic ointment with no further incident. On 08/06/2021, I interviewed the following staff members: Michelle King, Ieashea James, Cori-Ann Evans, and Shy Johnson. On 08/09/2021, I interviewed the following staff members: Vernisha Hutchins, Christy Dimery, Winifred Robinson, and Kayla Kilgore. All eight staff members reported they did not witness nor observe Resident B having injury on her feet. On 08/02/2021, Judy Reid reported that she did not witness nor observe Resident B have an injury to her feet. On 08/02/2021, Resident B was taken to urgent care for an assessment of her feet. The medical assessment report did not document any injury to Resident B's feet.

	On 08/06/2021, Complainant 1 reported that Resident A received injury 2 months ago, June 2021, by staff members using the Easy Stand Lift which caused bruising to her knees. On 08/06/2021 I interviewed the following staff members: Michelle King, Ieashea James, Courtney Wilson, Cori-Ann Evans, and Shy Johnson. On 08/09/2021, I interviewed the following staff members: Judy Reid, Vernisha Hutchins, Christy Dimery, Winifred Robinson, and Kayla Kilgore. All members stated they did not observe Resident A receive an injury in June 2021 by using the Easy Stand Lift. On 08/06/2021, Barbara Freysinger, Licensee Designee, stated she received no report stating that Resident A had been injured in June 2021 using the Easy Stand Lift. On 08/10/2021, Mallory Kettlehut, RN, assigned to work with Resident A reported that had not received any reports that Resident A was injured using the Easy Stand Lift but observed bruising on her knees at the end of May 2021. Per Ms. Kettlehut, x-rays were performed showing no injury to Resident A's knees. On 08/05/2021, Complainant 1 reported that Resident C was injured with out in the community with staff. Complainant 1 reported that Resident C fell forward out of his wheelchair hitting his head. On 08/06/2021 and 08/10/2021, Laney Wells and Morgan Wells confirmed that Resident C fell out of his wheelchair and received injury they described as "scrapes to his forehead." Both reported Resident C's injury to the Medical Coordinator, Courtney Wilson. On 08/06/2021, Courtney Wilson, confirmed that she received report from both Laney and Morgan Wells that Resident C received injury from falling out of his wheelchair. Ms. Wilson described the injury to Resident C as a "slight abrasion on forehead without bleeding." On 08/06/2021, Barbara Freysinger, Licensee Designee, reported that she had been informed of Resident C's accident. On 08/10/2021, Resident C was assessed for injury by urgent care medical personnel. Resident C was prescribed a topical

	antibiotic ointment to be applied twice daily. There was no mention in the report that medical treatment was delayed or should have been sought sooner. Based upon my investigation I find that the staff members of Hope House II obtained appropriate care as needed for each accident. There is no evidence to support that Resident B needed additional medical attention based upon the allegation that the Easy Stand Lift was pushed over her foot. There is no evidence to support that Resident A received injury from the Easy Stand Lift in June 2021. Resident C did receive minor injury however there was no documentation from his medical assessment that the staff members inappropriately addressed his needs.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Residents A, B, and C were involved in accidents and incident/accident reports were not completed.

INVESTIGATION: On 07/29/2021, Complainant 1 reported that Resident B was injured by staff members using the Easy Stand Lift to assist her. On 08/05/2021, Complainant 1 stated Resident C was injured while out in the community with staff. On 08/06/2021, Complainant 1 reported that Resident A received injury 2 months ago, June 2021, by staff members using the Easy Stand Lift which caused bruises on her knees. Complainant 1 stated Incident Reports were not written to document the injuries of Residents B, C, and A.

On 08/10/2021, I reviewed incident reports written for Residents B and C both dated 08/05/2021. Residents B's incident happened on 07/27/2021 and there is an incident report written and signed by Complainant 1 on 08/05/2021. It documents that staff member, Laney Wells, pushed the Easy Stand Lift over Resident B's foot and she observed a "small cut and bruising."

Resident C's incident happened on 08/03/2021 and an incident report is written and signed by Morgan Wells on 08/05/2021. It documents what happened to Resident C, that he was assessed, the incident was reported to the supervisor and determined that "a trip to the ER wasn't necessary."

During my investigation I found no evidence that Resident A received injury in June 2021, therefore there is no incident/accident report written.

On 08/16/2021, I completed an exit conference with Barbara Freysinger, Licensee Designee, where my findings were discussed with her.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.** **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.** **(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.**
ANALYSIS:	It was alleged that Residents A, B, and C were involved in accidents and incident/accident reports were not completed. On 07/29/2021, Complainant 1 reported that Resident B was injured by staff members using the Easy Stand Lift to assist her. On 08/05/2021, Complainant 1 stated Resident C was injured while out in the community with staff. On 08/06/2021, Complainant 1 reported that Resident A received injury 2 months ago, June 2021, by staff members using the Easy Stand Lift which caused bruises on her knees. Complainant 1 stated It On 08/10/2021, I reviewed incident reports written for Residents B and C dated 08/05/2021. Resident B's accident happened on 07/27/2021 and the incident report was completed on 08/05/2021. It is written and signed by as required. Resident C's accident happened on 08/03/2021. The incident report was completed on 08/05/2021. It Is written and signed by Morgan Wells. During my investigation I found no evidence that Resident A received injury in June 2021, therefore there is no incident/accident report written.

	Based upon my investigation the staff members of Hope House II did follow the licensing rules pertaining to the requirements of written incident reports. The incidents/accidents that involve Residents A, B, and C do not meet the requirements of completing an incident report.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 08/06/2021 and 08/10/2021, Laney Wells and Morgan Wells confirmed that Resident C fell out of his wheelchair on 08/03/2021 and received injury described as "scrapes to his forehead." Both reported that Resident C's gait belt was used to secure him in his wheelchair. They also reported that the gait belt loosened causing him to fall forward out of his wheelchair and that the wheelchair had no seat belt.

On 08/09/2021, I reviewed Resident C's file. According to his Treatment Plan which includes an assessment of his needs dated 11/20/2020 he is dependent on staff members for ambulation. He uses a wheelchair and a gait belt for transfers. There is nothing in Resident C's plan that states he is to use a gait belt to secure him in his wheelchair. All documentation for Resident C's assistive devices is current and placed in his file.

On 08/06/2021, Ms. Freysinger reported she had been informed of Resident C's accident. She stated that he had been medically assessed on 08/06/2021 and returned to the facility without further incident.

On 08/09/2021, I received and reviewed Resident C's Order Sheet dated 07/21/2020 authorizing the use of a Gait Belt and Wheelchair by his physician. It states that Resident C will need this assistive device indefinitely. The authorization form was updated in July 2021 by his physician.

On 08/16/2021, I completed an exit conference with Barbara Freysinger, Licensee Designee, where my findings were discussed with her. Ms. Freysinger was in agreement with my findings and stated she had begun working on a corrective action plan to address rule violations.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(1) An assistive device shall only be used to promote the enhanced mobility, physical comfort, and well-being of a resident.

ANALYSIS:	On 08/06/2021 and 08/10/2021, staff members Laney Wells and Morgan Wells confirmed that Resident C fell out of his wheelchair on 08/03/2021 and received injury described as "scrapes to his forehead." Both reported that Resident C's gait belt was used to secure him in his wheelchair. Resident C's Treatment Plan which includes an assessment of his needs dated 11/20/2020 states he is dependent on staff members for ambulation. The plan states he uses a wheelchair and a gait belt for transfers. There is nothing in Resident C's plan that states he is to use a gait belt to secure him in his wheelchair. Based upon my investigation I find that the assistive device assigned to Resident C for transfer, his gait belt, was not used correctly by staff members Laney and Morgan Wells. Therefore, Resident C's gait belt was not used to promote his enhanced mobility, his physical comfort, nor his well-being.
CONCLUSION:	**VIOLATION ESTABLISHED**

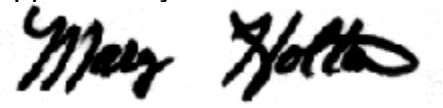
IV. RECOMMENDATION

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

08/17/2021

Vanita C. Bouldin — Date
Licensing Consultant

Approved By:



08/17/2021

Mary Holton — Date
Area Manager