GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 3, 2021

Louise Semetko
Everest Inc.
PO Box 2352
Riverview, MI 48193

RE: License #: AS820016002
Investigation #: 2021A0116030
Truman CLF Home

Dear Mrs. Semetko:
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 #:	AS820016002
Investigation #:	2021A0116030
Complaint Receipt Date:	08/09/2021
Investigation Initiation Date:	08/11/2021
Report Due Date:	10/08/2021
Licensee Name:	Everest Inc.
Licensee Address:	PO Box 2352 Riverview, MI 48193
Licensee Telephone #:	(734) 675-3037
Administrator:	Louise Semetko
Licensee Designee:	Louise Semetko
Name of Facility:	Truman CLF Home
Facility Address:	32346 Truman Rockwood, MI 48173
Facility Telephone #:	(734) 379-0515
Original Issuance Date:	03/08/1995
License Status:	REGULAR
Effective Date:	03/15/2020
Expiration Date:	03/14/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A is not being receiving adequate care. Staff put Resident A to bed at 6:30 p.m. on 08/06/21 and did not get him out of bed until 12:00 noon the following day. Staff did not change him, and he is still wearing his clothes from yesterday. Resident A asked to get out of bed and the staff told him it was not time yet.	Yes
Resident A was not offered breakfast and spent 18 hours lying in bed.	Yes

III. METHODOLOGY

08/09/2021	Special Investigation Intake 2021A0116030
08/09/2021	APS Referral Referral made
08/11/2021	Special Investigation Initiated - On Site Interviewed Residents A-C, home manager Angie Broman, visually observed Resident's D-F, and reviewed Residents A-C's assessment plans.
08/12/2021	Contact - Telephone call made Interviewed staff Sam Hicks.
08/12/2021	Contact - Telephone call made Interviewed licensee designee Louise Semetko.
08/12/2021	Inspection Completed-BCAL Sub. Compliance
08/25/2021	Contact - Telephone call received Interviewed assigned APS investigator Sharon Sabbath.
08/27/2021	Contact - Telephone call made Interviewed staff Kristina Colon.
09/03/2021	Exit Conference With licensee designee Louise Semetko.

ALLEGATION:

Resident A is not being properly cared for. Staff put Resident A to bed at 6:30 p.m. on 08/06/21 and didn't get him out of bed until 12:00 noon the following day. Staff did not change him, and he is still wearing his clothes from yesterday. Resident A asked to get out of bed and the staff told him it wasn't time yet.

INVESTIGATION:

On 08/10/21, I conducted an unscheduled onsite inspection and interviewed Residents A-C and home manager Angie Broman. Resident A reported that the weekend staff is making him, and the other residents go to bed as early as 6:30 p.m. and leaving them in bed until 12:00 noon or longer on Saturdays and Sundays. Resident A reported that this only happens on the weekends because during the week they get up around 6:30 a.m.-7:00 a.m. Resident A reported that he along with Residents B and C are all confined to wheelchairs and because they are dependent on staff for assistance, they are stuck lying in bed all that time and he is sick of it. Resident A further reported that the staff will come into his room on the weekend and administer his morning medications, but won't get him up out of bed, until they feel like it. Resident A reported that when he asks staff to get him out of bed, they tell him that it's not time and leave out of the room. Resident A reported that when staff finally get him up, they will provide a.m. care and put clean clothes on.

Resident A reported that most of the weekend staff are guilty of this but reported that staff Sam Hicks and Kristina Colon consistently put them to bed by 6:30 p.m. when they are working and leave them in bed until the following afternoon. Resident A added that he will be glad when his family moves him out of the home.

On 08/10/21, I interviewed Resident B and she reported that the weekend staff are putting all the residents in bed between 6:00 p.m. and 6:30 p.m. and then leaving them in bed until 11:00 a.m. or 12:00 p.m. the following day. Resident B reported that the staff will administer their morning medications while they are in bed but refuse to get them up for the day. Resident B reported that her body starts to hurt after lying in bed for that length of time and reported that when she asks staff to get her up, they tell her that it's not time yet. Resident B further reported that the staff do not check her brief, knowing it is soiled after being on for such a long time. Resident B reported that Kristina Colon and Sam Hicks are the staff that consistently do this.

On 08/10/21, I interviewed Resident C and she provided the same account previously provided by Residents A and B. Resident C reported that the allegation is true and that although Sam Hicks and Kristina Colon put them to bed early and leave them in bed until the afternoon consistently, she added that all staff who work weekends do the same thing. Resident C reported that on top of the body aches she gets from being in bed that long, remaining in a soiled brief is the worst part for her.

Resident C reported that she is glad I was notified and is hopeful that the investigation will prevent this from continuing to happen.

On 08/10/21, I interviewed home manager Angie Broman. Ms. Broman reported that she works Monday through Friday and is usually gone by 4:00 p.m. daily. Ms. Broman reported that she was not aware that this was going on and denied that it was brought to her attention by any of the residents. Ms. Broman reported that staff knows better and reported that on the weekends the residents like to sleep in a little later, normally until 8:00 a.m. or 9:00 a.m. but anything later than that is not the norm. Ms. Broman reported that she will immediately address this issue with all staff to prevent this from continuing.

On 08/10/21, I visually observed Residents D-F as they are nonverbal and unable to be interviewed. They appeared well and were neatly dressed and groomed.

On 08/10/21, I reviewed the written assessment plans for Residents A-C and each plan documents that the residents require assistance with their activities of daily living and are dependent upon staff for assistance.

On 08/12/21, I interviewed staff Sam Hicks and he reported that on occasion he has put the residents in bed early around 7:00 p.m. I asked Mr. Hicks did the residents request to go to bed early and he reported that they did not. I asked Mr. Hicks what his reason was for putting the residents to bed early and he could not provide an answer. I reminded Mr. Hicks that the residents are adults and should not be made or forced to go to bed. Mr. Hicks reported an understanding.

Mr. Hicks further reported that on 08/06/21 midnight staff Kristina Colon called him at work and asked him to have the residents in bed before she arrived at work. Mr. Hicks reported he did what she asked him and put them all to bed before he left at 7:00 p.m. Mr. Hicks reported that he did not question Ms. Colon and reported that in retrospect he should have. Mr. Hicks reported that the residents are normally in bed between 8:30 p.m. and 8:45 p.m.

On 08/12/21, I interviewed licensee designee Louise Semetko who reported being aware of the allegations. Ms. Semetko reported that she finds the allegations hard to believe as staff are aware that the residents have a choice regarding bedtimes and should not be made or forced to do anything. Ms. Semetko also reported that it is unacceptable for staff to be leaving the residents in bed on the weekends until 11:00 a.m. or 12:00 noon, unless the resident requests it. Ms. Semetko reported that if that is the case the staff should still be changing their briefs and making sure that their personal care needs are being met. Ms. Semetko reported this will be addressed immediately.

On 08/25/21, I interviewed assigned APS investigator Sharon Sabbath. Ms. Sabbath reported that she would be substantiating the allegations for physical neglect

On 08/27/21, I interviewed staff Kristina Colon. Ms. Colon denied the allegations and reported that she gives the residents a choice in the times that they want to go to bed. Ms. Colon denied that she contacted Mr. Hicks on 08/06/21 and requested that he have all the residents in bed prior to her arrival. Ms. Colon reported that the allegations are all lies. Ms. Colon reported that she is no longer with the company.

On 09/03/21, I conducted the exit conference with Ms. Semetko and informed her of the findings of the investigation and the specific rule violation. Ms. Semetko reported an understanding.

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:	Residents A-C all reported that staff Sam Hicks and Kristina Colon consistently put them in bed early, normally around 6:30 p.m. and leave them in bed until 11:00 p.m. or 12:00 p.m. the following day. Residents B and C reported that the staff leave them in soiled briefs and do not get them up until they are ready too. Resident C added that lying in her bed in a soiled brief is the most difficult part for her. Residents B and C reported that their bodies start to ache and hurt from lying in one position so long. Resident C reported being hopeful that this investigation would prevent staff from continuing to do this. This violation is established because the residents are not being treated with dignity and their personal needs, including protection and safety are not being attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was not offered breakfast and spent 18 hours lying in bed.

INVESTIGATION:

On 08/10/21, I conducted an unscheduled onsite inspection and interviewed Residents A-C and home manager Angie Broman. Residents A-C were interviewed separately, and all reported that on the weekends when staff put them to bed at 6:30 p.m. and fail to get them up until 11:00 a.m. or 12:00 p.m. they are forced to go 17 or 18 hours without eating. Residents A-C further reported that because they are put to bed right after dinner, they are unable to have an evening snack, and by the next afternoon they are starving. Resident B reported at times she is so hungry that she gets a headache. Residents A-C reported that the staff do not offer them any snacks or food until they finally get them up and dressed the following afternoon.

On 08/10/21, I interviewed home manger Angie Broman. Ms. Broman reported that she was unaware that on the weekends the residents were being put to bed early and made to lie in bed until the next afternoon. Ms. Broman reported that that is unacceptable, and it prevents the residents from having their evening snack and morning breakfast. Ms. Broman reiterated that this matter would be rectified immediately.

On 08/12/21, I interviewed staff Sam Hicks and he reported that if he is on shift on a Saturday or Sunday morning that he prepares breakfast for the residents when they get up and denied any knowledge of the residents going 17 or 18 hours without eating.

On 08/12/21, I interviewed licensee designee Louise Semetko and she reported that if the staff are putting residents to bed at 6:30 p.m. and not getting them up until the following afternoon, then they are in violation of the licensing rule and the company's internal policy. Ms. Semetko reported that the matter will be addressed and rectified.

On 08/25/21, I interviewed assigned APS investigator Sharon Sabbath. Ms. Sabbath reported that she is substantiating the allegations for neglect.

On 08/27/21, I interviewed staff Kristina Colon and she denied the allegation. Ms. Colon reported that while she was employed at the home, she provided breakfast to the residents in the morning when she got them up. Ms. Colon denied that any of the residents to her knowledge have gone more than 14 hours without eating.

On 09/03/21, I conducted the exit conference with licensee designee Louise Semetko and informed her of the findings of the investigation. Ms. Semetko reported an understanding.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form,

	consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Residents A-C all reported that on the weekends they are going more than 14 hours without eating due to the staff putting them in bed at 6:30 p.m. and not getting them up until the following afternoon around 11:00 a.m. or 12:00 p.m. Residents A-C reported that when they finally eat something they are starving. Resident B added that she has been so hungry that it has caused her to have headaches. This violation is established. Although the residents are provided three meals daily, during the weekends staff are allowing more than 14 hours to elapse between the evening and morning meal.
CONCLUSION:	**VIOLATION ESTABLISHED**

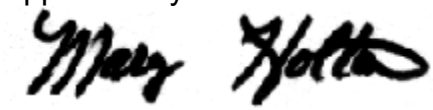
IV. RECOMMENDATION

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

09/03/21

Pandrea Robinson — Date
Licensing Consultant

Approved By:



09/03/21

Mary E. Holton — Date
Area Manager