

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

March 14, 2022

Ann Meldrum Samaritas 8131 East Jefferson Avenue Detroit, MI 48214-2691

RE: License #: AS260010999
Investigation #: 2022A0123019
White Pines CLF

Dear Ms. Meldrum:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. 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 (906) 226-4171.

Sincerely,

Shamidah Wyden, Licensing Consultant Bureau of Community and Health Systems

411 Genesee P.O. Box 5070 Saginaw, MI 48607 989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS260010999
Investigation #:	2022A0123019
Complaint Receipt Date:	01/25/2022
Investigation Initiation Date:	01/26/2022
Donort Duo Doto:	03/26/2022
Report Due Date:	03/20/2022
Licensee Name:	Samaritas
Licensee Address:	8131 East Jefferson Avenue Detroit, MI 48214-2691
Licensee Telephone #:	(231) 936-1012
Administrator:	Ann Meldrum
Licensee Designee:	Ann Meldrum
Name of Facility:	White Pines CLF
Facility Address:	1411 Spring St Gladwin, MI 48624
Facility Telephone #:	(989) 426-0424
Original Issuance Date:	04/14/1992
License Status:	REGULAR
Effective Date:	10/13/2020
Expiration Date:	10/12/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

Violation Established?

On 01/23/2022, staff Carol Ross forcibly opened Resident A's mouth to make Resident A take his medication. Staff Ross also yelled at Resident A to take his medication.	Yes
yourd at Nosident /\ to take his medication.	

III. METHODOLOGY

01/25/2022	Special Investigation Intake 2022A0123019
01/26/2022	Special Investigation Initiated - Telephone I spoke with recipient rights investigator Phyllis Kchodl via phone.
02/03/2022	APS Referral An APS referral was completed.
02/09/2022	Inspection Completed On-site I conducted an unannounced on-site visit at the facility.
02/11/2022	Contact - Telephone call made I spoke with staff Carol Ross via phone.
02/11/2022	Contact - Telephone call received I made an attempted call to staff Dereck Lorenz.
02/11/2022	Contact - Telephone call made I left a voicemail requesting a return call from staff Christina Prudhomme.
02/11/2022	Contact - Telephone call received I interviewed Staff Prudhomme via phone.
02/24/2022	Contact- Telephone call made I interviewed Staff Lorenz via phone.
03/02/2022	Contact- Telephone call made I spoke with home manager Lahoma Frantz via phone.
03/09/2022	Contact- Telephone call made I left a voicemail requesting a call back from licensee designee Ann Meldrum.

03/09/2022	Exit Conference-	
	I spoke with licensee designee Ann Meldrum via phone.	

ALLEGATION: On 01/23/2022, staff Carol Ross forcibly opened Resident A's mouth to make Resident A take his medication. Staff Ross also yelled at Resident A to take his medication.

INVESTIGATION: On 01/26/2022, I spoke with recipient rights investigator Phyllis Kchodl via phone. She stated that staff Carol Ross is currently suspended. She stated that Staff Ross is a long-time employee. Staff Christina Prudhomme reported that she saw the alleged incident happen. Staff Derrick Lorenz is a witness as well. Staff Brenda Cole denied witnessing or hearing anything, and Staff Ross denied the allegations, and reported that there was no way she squeezed Resident A's face. She stated that Staff Ross reported that she held Resident A's face gently and told Resident A to open his mouth. Staff Lorenz was the "med buddy" to Staff Ross and was standing right next to Staff Ross during the alleged incident. Resident A is nonverbal. She stated that she must substantiate the allegations in her investigation due to there being two eyewitnesses.

On 02/09/2022, I conducted an unannounced on-site visit at the facility. I observed Resident A sitting on the couch under a blanket. Resident A was not interviewed due to being non-verbal. I reviewed a copy of Resident A's assessment plan. It notes that Resident A needs staff assistance with all medication passes. The *Assessment Plan for AFC Residents* was signed by his guardian on 10/12/2021.

I obtained a copy of an incident report dated for 01/23/2022. I was notified of this incident on 01/24/2022 via phone. The incident report states, "Carol was passing meds and when #2 resident refused Carol grabbed him by the chin, squeezed in order to get him to open mouth, and repeatedly yelled to "open your mouth." Staff said "Jesus! Stop!" to Carol and reported to PC. Recipient Rights, CMH, Licensing, LeRoy Goldsworks was notified. Staff will not be working until this is resolved. Incident report completed & emailed to parties above."

On 02/09/2022, I spoke with home manager Lahoma Frantz. She stated that she is still currently Resident A's guardian until the end of the month, as they are awaiting a court date to change the guardian. She stated that Staff Prudhomme wrote the incident report and notified management. She stated that she has known Staff Ross for a long time, and that just watching her behavior, she thinks the incident did happen. She stated that Staff Lorenz reported that he heard it happen but did not see it.

On 02/09/2022, I interviewed Staff Brenda Cole. Staff Cole stated that she heard about the incident, and was present in the home that morning, but she was not the "med buddy." She stated that she was helping other residents with breakfast and has no idea what happened.

On 02/11/2022, I made a call to staff Carol Ross. Staff Ross stated that she no longer works at the facility. She stated that she retired. Staff Ross denied the allegations. She stated that she was passing medications to Resident A. Resident A was moving his hands around, and she tried to coax him into cooperating. She stated that she took her hand and placed it on the edge of Resident A's chin and put his medication into his mouth. She stated that she asked another staff person (Staff Lorenz) to get Resident A something to drink. She denied yelling at Resident A and denied forcibly opening his mouth. She stated that she has a loud voice but was not yelling. She stated that she went on to finish passing medication to the other residents, and that other staff only made one comment which was "Wow, we don't have any trouble with him." She stated that no other staff present redirected her. She stated that Staff Lorenz has not liked her since he started working with her, and that Staff Prudhomme is a "troublemaker." She stated that she did not do anything she was not supposed to do, and that she had worked there for 18 to 19 years. She stated that she knows that you don't force residents to take medication.

On 02/11/2022, I interviewed staff Christina Prudhomme via phone. Staff Prudhomme stated that she was about to feed Resident A. Resident A was refusing to take his medication by shaking his head. Staff Ross yelled "open your mouth!" at Resident A, while squeezing hard on his chin. She stated that Staff Ross was getting rough and loud, and there was no reason to get that rough. She stated that the med pass should have been documented as a refusal. She stated that she intervened verbally by saying "Jesus! Stop!" to Staff Ross, and that Staff Ross didn't pay her any attention. She stated that she asked management to address Staff Ross about her behavior. Staff Prudhomme stated that Staff Lorenz was there and witnessed it, and Staff Cole was present as well but was on her phone and apparently didn't see anything, but said she heard her (Staff Prudhomme) yell at Staff Ross to stop. Staff Prudhomme stated that Resident A does flail, but Staff Ross was too rough with him. She stated that it was kind of intense. Staff Prudhomme stated that she thought she was overthinking the situation, because no one else said anything but her, and it made her second guess herself. When asked if she has ever witnessed Staff Ross behave this way before, she stated that Staff Ross barks at people, and that she rarely saw Staff Ross interact with others. She stated that she only worked with Staff Ross during shift changes which were about 30 minutes at a time.

On 02/24/2022, I made a call to the facility. I interviewed staff Dereck Lorenz via phone. Staff Lorenz stated that on the day of the alleged incident, they were passing medications. Staff Ross grabbed the bottom of Resident A's chin, forcefully making Resident A take his medications. He stated that Staff Ross yelled at Resident A and was being loud. He stated that Staff Prudhomme said something about it like "Stop. Jesus. What are you doing?" He stated that Staff Ross has apparently quit working at the facility recently.

On 03/02/2022, I made a call to the facility. I spoke with home manager Lahoma Frantz. She stated that the change of guardianship hearing for Resident A is

scheduled for 03/23/2022, and that she will send documentation regarding the court date via fax when she receives it.

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:	Staff Prudhomme and Staff Lorenz were interviewed and reported witnessing Staff Ross forcefully administer medication to Resident A by grabbing his chin and yelling at him.		
	Staff Ross denied the allegations. Staff Cole denied witnessing anything.		
	Resident A's guardian, Lahoma Frantz reported that based on her observations of Ms. Ross's behaviors, she thinks the incident probably did occur.		
	There is a preponderance of evidence to substantiate a rule violation.		
CONCLUSION:	VIOLATION ESTABLISHED		

On 03/09/2022, I conducted an exit conference with licensee designee Ann Meldrum via phone. I informed her of the findings and conclusion.

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of this AFC small group home license (capacity 6).

Marile Todal	03/10/2022
Shamidah Wyden Licensing Consultant	Date

Approved By:

Mey	Holles 03	3/14/2022
Mary E Holton		Date
Area Manager		