GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 24, 2022

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

RE: License #: AS260010999
Investigation #: 2022A0466033
White Pines CLF

Dear Ms. Ann 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.
- 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) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS260010999
Investigation #:	2022A0466033
Complaint Receipt Date:	03/31/2022
Investigation Initiation Date:	04/01/2022
Report Due Date:	05/30/2022
Licensee Name:	Samaritas
Licensee Address:	8131 East Jefferson Avenue Detroit, MI 48214-2691
Licensee Telephone #:	(231) 730-1195
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

	Violation Established?
Direct care worker (DCW) Mark Perry "shoved" Resident A into the wall.	No
Additional Findings	Yes

III. METHODOLOGY

03/31/2022	Special Investigation Intake- 2022A0466033
04/01/2022	Special Investigation Initiated – Telephone call to ORR Phyllis Kchodl.
04/15/2022	Inspection Completed On-site.
04/15/2022	Contact - Telephone call made to DCW Diane Brown interviewed.
04/15/2022	Contact - Telephone call made to DCW Derrick Lorenz.
04/15/2022	Contact - Telephone call made to DCW Mark Perry.
05/19/2022	Contact - Telephone call made to Lahoma Franz, message left.
05/19/2020	Contact - Telephone call received from Lahoma Franz, interviewed.
05/23/2022	Contact - Telephone call made to Lahoma Franz, message left.
05/23/2022	Exit Conference with licensee designee Ann Meldrum.

ALLEGATION: Direct care worker (DCW) Mark Perry "shoved" Resident A into the wall.

INVESTIGATION:
On 03/31/2022, Complainant reported home manager Lahoma Franz notified the rights office of an issue that occurred in the facility on Friday, 3/25/2022. Complainant reported direct care worker (DCW) Diane Brown reported that DCW Mark Perry "shoved" Resident A into the wall. Complainant reported DCW Brown looked over Resident A and found no marks from the incident. Complainant reported DCW Brown wrote an incident report (IR) about the event.

On 04/01/2022, I interviewed office of recipient rights (ORR) officer Phyllis Kchodl who reported that DCW Perry was initially suspended-

pending investigation. ORR Kchodl reported she interviewed DCW Brown who reported that on 03/25/2022, she was folding clothes on the kitchen table when she heard a noise and looked up. ORR Kchodl reported that DCW Brown witnessed DCW Perry pushing Resident A into the wall. However, ORR Kchodl stated this would not be possible because Resident A would have hit the wall while DCW Brown was looking down folding laundry. ORR Kchodl stated DCW Brown could not have seen Resident A being pushed into the wall. ORR Kchodl reported she interviewed DCW Derrick Lorenz who was also on shift but reported that he did not see or hear anything related to this incident. ORR Kchodl reported she interviewed DCW Perry who reported he was in Resident A's bedroom when Resident A began to walk backwards and DCW Perry reported he reached out to grab Resident A to keep him from falling backwards. ORR Kchodl reported DCW Perry reported that as Resident A moved to go into the living room and DCW Perry saw he was walking forward and steady so he released his hand from him. ORR Kchodl reported Resident A is non-verbal and therefore was not able to be interviewed. ORR Kchodl reported an IR was written. ORR Kchodl reported no other residents witnessed this incident. ORR Kchodl reported she did not have enough evidence to support the allegation and therefore DCW Perry was going to be allowed to resume his position as the facility.

On 04/15/2022, I conducted an unannounced investigation and DCW Ashley Staley and DCW Jennifer Zunich were on duty. DCW Staley and DCW Zunich both reported neither of them worked on 03/25/2022. DCW Staley and DCW Zunich both confirmed Resident A is non-verbal and not able to be interviewed. DCW Staley and DCW Zunich reported Resident A was sleeping while I was at the facility.

On 04/15/2022, I reviewed Resident A's record which contained an *Assessment Plan for Adult Foster Care (AFC) Resident's* which was signed by Guardian A1 and dated 04/12/2021. In the "walking/mobility" section of the report it documented "In familiar settings [Resident A] can ambulate on own. Although at times becomes unsteady on feet my need staff assist up to assistance with wheelchair at times." [sic] In the "use of assistive devices" section of the report it documented "wheelchair at times and during extended outings."

On 04/15/2022, I reviewed Resident A's record which contained a *Health Care Appraisal* dated 02/09/2021 which documented that Resident A has impaired cognitive ability and uses a wheelchair.

On 04/15/2022, I interviewed DCW Brown who reported she worked on 03/25/2022 with DCW Lorenz and DCW Perry. DCW Brown reported she was folding laundry in the kitchen and she saw DCW Perry take Resident A's forearm and pushed Resident A into the wall in the hallway by the bedrooms. DCW Brown reported she saw Resident A off balance and DCW Perry's arm against Resident A's chest. DCW Brown reported she looked up from folding laundry when she heard a noise and that is when she saw Resident A's back hit the wall. DCW Brown reported there was a shower chair in the hallway which Resident A used to stop himself from falling.

DCW Brown reported Resident A is non-verbal and would not be able to be interviewed regarding this incident. DCW Brown reported she did not discuss the incident with DCW Lorenz or DCW Perry. DCW Brown reported she looked over Resident A and did not see any marks or bruises. DCW Brown reported no other residents witnessed this incident. DCW Brown reported she completed an IR and reported the incident to her supervisor DCW Franz. DCW Brown reported Resident A did not appear afraid of DCW Perry and they were getting along the rest of the shift. DCW Brown reported DCW Perry does not typically get upset with the residents. DCW Brown reported DCW Perry does not have a history of being combative with residents and he interacts well with them.

On 04/15/2022, I interviewed DCW Lorenz who reported he worked with DCW Brown and DCW Perry on 03/25/2022. DCW Lorenz reported he was sitting at the table with his back to the hallway so he did not see/hear the incident. DCW Lorenz reported he did not hear any noise, or anything would have directed his attention to look down the hallway. DCW Lorenz reported Resident A is non-verbal and would not be able to be interviewed regarding this incident. DCW Lorenz reported DCW Brown did not tell him what she observed. DCW Lorenz reported DCW Perry is a good DCW and does not get upset with the residents. DCW Lorenz reported DCW Perry does not have a history of being combative with residents and that he interacts well with them.

On 04/15/2022, I interviewed DCW Perry who reported that on 03/25/2022, he worked with DCW Brown and DCW Lorenz. DCW Perry reported he had taken Resident A to the bathroom and put his pajamas on, but Resident A did not want to go to bed. DCW Perry reported Resident A started walking backwards out of his room into the hallway and he was holding his hand so that he did not fall. DCW Perry reported because Resident A was up against the wall in the hallway one of the other DCWs on shift thought that he had pushed him up against the wall. DCW Perry reported Resident A then went and sat in his chair in the family room and watched tv. DCW Perry reported Resident A typically goes to bed between 8pm and 9pm but on this day he did not want to go to bed. DCW Perry reported he did not shove Resident A against the wall. DCW Perry reported Resident A was not having any behavior nor was he acting out. DCW Perry reported Resident A did not want to go to bed and he held his hand so that he would not fall since his gait is unsteady. DCW Perry reported all of the other residents were in their rooms and therefore none of this observed this incident. DCW Perry reported Resident A is non-verbal and therefore not able to be interviewed regarding this incident.

On 05/19/2022, I interviewed house manager Lahoma Franz who reported DCW Brown told her that staff Mark Perry "shoved" recipient Resident A into the wall on 03/25/2022. DCW Franz reported she was not on shift when this alleged incident occurred. DCW Franz reported DCW Brown stated she checked Resident A and found no marks or bruises from the incident. DCW Franz reported she notified the rights office on 03/25/22 about the incident. DCW Franz reported DCW Perry has not had any incident similar to this in the past. DCW Franz reported DCW Perry is a

very good employee and interacts appropriately with the residents. DCW Franz reported Resident A has an unsteady gait and a habit of falling backwards. DCW Franz reported DCW Perry is very gentle with the residents. DCW Franz said DCW Brown wrote an IR about the event. DCW Franz could not report why the IR was not in Resident A's record. DCW Franz reported that she would fax me the IR. DCW Franz reproted that she had previously submitted the IR to assigned licensing consultant Rodney Gill.

On 05/19/2022, I interviewed licensing consultant Gill who reported that he did not receive an IR from the facility nor from DCW Franz.

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:	Although Complainant and DCW Brown reported that DCW Perry "shoved" Resident A into the wall, DCW Lorenz reported that he was sitting at the table with his back to the hallway and did not see/hear any noise or anything would have directed his attention to look down the hallway. Resident A is non-verbal and therefore was not able to be interviewed. DCW Brown and DCW Perry reported that there were not any other residents that witnessed this incident and therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:
On 04/15/2022, I reviewed Resident A's record which contained an *Assessment Plan for AFC Resident's* which was signed by Guardian A1 and dated 04/12/2021. At the time of the unannounced investigation Resident A's record did not contain any updated assessment plans.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with licensee.

	A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	At the time of the unannounced investigation, Resident A's record did not contain a written assessment plan had been updated annually therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 04/15/2022, I reviewed Resident A's record which contained a *Health Care Appraisal* dated 02/09/2021. At the time of the unannounced investigation Resident A's record did not contain an updated *Health Care Appraisal.*

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	At the time of the unannounced investigation Resident A's record did not contain a *Health Care Appraisal* that had been updated annually therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 04/15/2022, I conducted an unannounced investigation and DCW Staley and DCW Zunich reported an IR was completed regarding Resident A on 03/25/2022, however manager DCW Franz had it and was not available. DCW Staley and DCW Zunich reported they did not have access to where the IRs were stored and therefore it could not be provided for review while I was on site.

I reviewed Resident A's record which did not contain an IR dated 03/25/2022.

On 04/15/2022, I interviewed DCW Brown who reported she completed an IR and provided the IR to her supervisor Lahoma Franz.

On 05/19/2022, I interviewed DCW Franz who reported DCW Brown wrote an IR about the event. DCW Franz reported she had the IR and that she would fax me the IR today (05/119/2022). DCW Franz reported she had previously submitted the IR to assigned licensing consultant Rodney Gill. DCW Franz could not explain why the IR was not in Resident A's record.

On 05/19/2022, I interviewed licensing consultant Gill who reported that he did not receive an IR from the facility nor from DCW Franz. As of 05/23/2022, I have not recevied the IR from DCW Franz.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(h) Incident reports and accident records.**
ANALYSIS:	On 04/15/2022, DCW Staley and DCW Zunich could not produce the IR that had been completed on 03/25/2022 involving Resident A written by DCW Brown. Additionally, Resident A's record did not contain the IR as required therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in the status of the license.

05/23/2022

Julie Elkins — Date
Licensing Consultant

Approved By:

05/24/2022

Dawn N. Timm — Date
Area Manager