



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

July 28, 2022

Rochelle Reneker-Rothwell  
Rose Hill Center Inc  
5130 Rose Hill Blvd  
Holly, MI 48442

RE: License #: AS630256367  
Investigation #: 2022A0611033  
Horton Home

Dear Ms. Reneker-Rothwell:

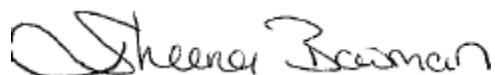
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,

A handwritten signature in black ink that reads "Sheena Bowman". The signature is written in a cursive style with a large initial "S".

Sheena Bowman, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Place  
3026 W. Grand Blvd, Suite 9-100  
Detroit, MI 48202

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS630256367
<b>Investigation #:</b>	2022A0611033
<b>Complaint Receipt Date:</b>	07/07/2022
<b>Investigation Initiation Date:</b>	07/12/2022
<b>Report Due Date:</b>	09/05/2022
<b>Licensee Name:</b>	Rose Hill Center Inc
<b>Licensee Address:</b>	5130 Rose Hill Blvd Holly, MI 48442
<b>Licensee Telephone #:</b>	(248) 634-5530
<b>Administrator:</b>	Rochelle Reneker-Rothwell
<b>Licensee Designee:</b>	Rochelle Reneker-Rothwell
<b>Name of Facility:</b>	Horton Home
<b>Facility Address:</b>	5130 Rose Hill Boulevard Holly, MI 48442
<b>Facility Telephone #:</b>	(248) 634-5530
<b>Original Issuance Date:</b>	01/09/2004
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/11/2020
<b>Expiration Date:</b>	09/10/2022
<b>Capacity:</b>	5
<b>Program Type:</b>	MENTALLY ILL

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Resident A was inappropriately discharged from the AFC group home.	No
Horton Home did not provide transportation to Resident A for his volunteering in January and February 2022.	Yes
Resident A's mother requested a copy of Resident A's contract with Rose Hill Center multiple times in June 2022 and did not receive it.	No

## III. METHODOLOGY

07/07/2022	Special Investigation Intake 2022A0611033
07/12/2022	Special Investigation Initiated - On Site I completed an unannounced onsite. I interviewed the licensee designee Rochelle Rothwell, and the Clinical director, Shawn Bryson. I received copies of the emails that were sent to Resident A's guardian regarding her request for records, I received a copy of the discharge letter that was emailed to Resident A's guardian, and I also received a copy of the AFC group home handbook that indicates drugs and alcohol are prohibited.
07/13/2022	Contact - Document Sent I sent an email to the recipient rights specialist, Dawn Krull regarding the outcome of her investigation.
07/13/2022	Contact - Document Received I received an email from the recipient rights specialist, Dawn Krull. Ms. Krull has not completed her investigation.
07/13/2022	Contact - Telephone call received I received a copy of Resident A's resident care agreement and the addendum regarding transportation.
07/14/2022	Contact - Telephone call made I left a voice message for Easter Seals case manager, Sherry VanHulle requesting a call back.

07/14/2022	Contact - Telephone call made I made a telephone call to the reporting source. The reporting source was not available. I provided my contact information for the reporting source to call me back.
07/14/2022	Exit Conference I completed an exit conference with the licensee designee, Rochelle Rothwell by way of voice message.
07/14/2022	Exit Conference I received a return phone call from the licensee designee, Rochelle Rothwell. Mrs. Rothwell was informed that the allegations will not be substantiated.
07/14/2022	Contact – Telephone call received I received a return phone call from Easter Seals case manager, Sherry VanHulle. The allegations were discussed.
07/26/2022	Contact- Telephone call made I left a voice message for Resident A’s guardian requesting a call back.
07/26/2022	Contact- Telephone call made I made a telephone call to Resident A’s guardian. The allegations were discussed.
07/26/2022	Exit Conference I completed a second exit conference with the licensee designee, Rochelle Rothwell. Mrs. Rothwell was informed that one of the allegations will be substantiated.

**ALLEGATION:**

**Resident A was inappropriately discharged from the AFC group home.**

**INVESTIGATION:**

On 07/07/22, I received the following allegations: Resident A and his family were told that Resident A had to leave by 5/1/22 or pay for care at Horton Home which was not true. Resident A was forced out of Horton Home without housing options in place. Rose Hill Center inappropriately discharged Resident A from Horton Home by basing their decision on financial gains instead of mental health. Resident A received an inaccurate evaluation of functioning. Horton Home did not provide transportation to Resident A for his volunteering in January and February 2022. Resident A's mother requested a copy of Resident A's contract with Rose Hill Center multiple times in June 2022 and did not

receive it. A Rose Hill manager threatened to call APS if Resident A stepped foot on their grounds.

On 07/12/22, I completed an unannounced onsite. I interviewed the licensee designee Rochelle Rothwell and the Clinical Director, Shawn Bryson. I received copies of the emails that were sent to Resident A's guardian regarding her request for records, I received a copy of the discharge letter that was emailed to Resident A's guardian, and I also received a copy of the AFC group home handbook that indicates drugs and alcohol are prohibited.

On 07/12/22, I interviewed the licensee designee, Rochelle Rothwell. Regarding the allegations, Mrs. Rothwell stated Resident A was discharged due to having marijuana in his bedroom. As a result, an emergency discharge was completed. Resident A was referred to the AFC group home by Community Mental Health which means payment for AFC services was received directly from Community Mental Health. Mrs. Rothwell stated whenever a resident is referred by Community Mental Health, there is no contract between the AFC group home and the resident and/or guardian because the resident and/or guardian does not provide payment for AFC services.

Mrs. Rothwell stated the AFC group home handbook indicates drugs and alcohol are prohibited. Mrs. Rothwell explained the AFC group home is also a treatment facility that treats residents with co-occurring disorders. Therefore, the residents are very much aware that drugs and alcohol are not allowed. Mrs. Rothwell stated while Resident A was on a leave of absence with his guardian, his guardian called the AFC group home and asked staff to gather some items for her to come by and pick up. While the staff were gathering the requested items, the staff discovered marijuana in his bedroom.

On 07/12/22, I interviewed the Clinical Director, Shawn Bryson. Regarding the allegations, Mrs. Bryson stated she provide a 24-hour discharge notice to Resident A's guardian via email and mail. Mrs. Bryson also left Resident A's guardian a voice message regarding the emergency discharge. Mrs. Bryson stated marijuana and drug paraphernalia was found in Resident A's nightstand. The emergency discharge notice was provided to Resident A's guardian via email on 06/10/22. Resident A was currently on a leave of absence with his guardian on 06/10/22. Mrs. Bryson explained in her voice message to Resident A's guardian that he could not return to the AFC group home. Mrs. Bryson stated Resident A's guardian did not call her back. Resident A's guardian retrieved Resident A's belongings on or about 06/12/22. Mrs. Bryson stated Resident A was never told to leave the AFC group home on 05/01/22. Resident A's discharge had nothing to do with finances or payment.

Mrs. Bryson stated after Resident A's guardian was notified about the emergency discharge, she made a statement saying she was going to bring Resident A back to the AFC group home anyway. Mrs. Bryson notified Resident A's guardian via voice message that Resident A cannot return to the AFC group home and if he does, they will have to call Adult Protective Services. Mrs. Bryson stated Easter Seals did not disagree with Resident A being discharged from the AFC group home. Mrs. Bryson stated

Resident A has a history of verbal altercations with his father, therefore he was not allowed at his parent's house.

On 07/12/22, I received a copy of the emergency discharge notice dated 06/10/22 that was emailed to Resident A's guardian. The email was sent to Resident A's guardian on 06/10/22 by the Residential Program Case Manager, Robin Link. The emergency discharge letter explains that Resident A is being discharged for possession and use of substance on campus. The emergency discharge notice further explained that Resident A signed and agreed with the program handbook upon admission that indicates residents will not possess or use illicit drugs or alcohol.

On 07/12/22, I received a copy of the statement in the program handbook that indicates any preparation containing alcohol, any type of drug paraphernalia, and K2 or synthetic marijuana is prohibited.

On 07/12/22, I received a copy of the email from the Residential Program Case Manager, Robin Link to Mrs. Bryson and Mrs. Rothwell indicating that she emailed a copy of the discharge letter to Resident A's guardian and Easter Seals and Easter Seals verbally confirmed receipt.

Mrs. Bryson stated she does not know anything about Resident A receiving an inaccurate evaluation of functioning. Mrs. Bryson stated Resident A received a pre-assessment before he was admitted into the AFC group home, a psychiatric evaluation, and a psychosocial social assessment.

On 07/14/22, I made a telephone call to the reporting source. The reporting source was not available. I spoke to Resident A's relative. Resident A's relative stated Resident A is currently residing with his parents.

On 07/14/22, I received a return phone call from Easter Seals case manager, Sherry VanHulle. Regarding the allegations, Ms. VanHulle stated Resident A received a 90-day discharge notice in January 2022 for not meeting the expectations of the program. Resident A's guardian did not want Resident A to leave the AFC group home. Resident A was expected to leave the AFC group home in April 2022 however, an appropriate placement was not found. Ms. VanHulle stated Resident A was immediately discharged from the AFC group home in June 2022 for having drug paraphernalia in his bedroom, which is against the AFC group home policy. Ms. VanHulle was in agreement with the emergency discharge.

Ms. VanHulle stated she has been working with Resident A's guardian with finding placement as she has provided the guardian with resources regarding other AFC group homes. Resident A's guardian does not want to place Resident A in a group home as she feels he is independent. Resident A is currently living in a hotel. Ms. VanHulle stated it is possible that Resident A is at his parent's house during the day, but he is sleeping at a hotel. Ms. VanHulle stated she is going to have a meeting to discuss a

possible change in guardianship for Resident A as his current guardian is not making the best decisions for him.

On 07/26/22, I made a telephone call to Resident A’s guardian. Regarding the allegations, the guardian denied receiving a discharge letter from the AFC group via email or in the mail. The guardian confirmed her email address, which is the exact same email address where Ms. Link sent the discharge letter. I forwarded a copy of the email from Ms. Link to the guardian. The guardian stated that she did receive a phone call from Mrs. Bryson on 06/10/22, regarding Resident A being discharged from the home. The guardian was informed that she can pick up Resident A’s medications and some of his belongings and; the rest of his belongings will be available for pick up at a later date. The guardian stated she has not picked up the rest of Resident A’s belongings because he does not have a place to live. The guardian is working with Easter Seals regarding placement for Resident A.

The guardian denied that drugs and drug paraphernalia belonged to Resident A. The guardian stated she was not aware that the AFC group home has a policy that prohibits drugs and alcohol on the premises. The guardian does not know if Resident A signed the program handbook upon admission that indicates residents will not possess or use illicit drugs or alcohol.

<b>APPLICABLE RULE</b>	
<b>R 400.14302</b>	<b>Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.</b>
	<b>(4) A licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists: (a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home.</b>
<b>ANALYSIS:</b>	Based on my findings and the information gathered, Resident A was not improperly discharged from the AFC group home. Resident A received an emergency discharge due to having marijuana and drug paraphernalia in his bedroom. An emergency discharge was necessary in order for the AFC group home to assure the safety and well-being of the other residents in the home.



	<p>I reviewed the discharge letter and it explained that Resident A is being discharged for possession and use of substance on campus. The emergency discharge notice further explained that Resident A signed and agreed with the program handbook upon admission that indicates residents will not possess or use illicit drugs or alcohol. Resident A's guardian was provided a written discharge letter via email on 06/10/22. Mrs. Bryson also left a voice message for Resident A's guardian notifying her about the emergency discharge on 06/10/22.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

**Horton Home did not provide transportation to Resident A for his volunteering in January and February 2022.**

**INVESTIGATION:**

On 07/12/22, Mrs. Bryson stated Resident A's guardian decided she wanted Resident A to work at his father's job, but he needed transportation. Mrs. Bryson stated before the AFC group home could provide transportation, they needed to verify the job and details about the job. Resident A's guardian wanted Resident A to start the job right away and she did not want to wait for the AFC group home to gather the information they needed. It took the AFC group home five days to ascertain the information they needed about the job and then they started to provide transportation. Resident A's guardian chose to transport Resident A to his job during those five days. Resident A worked at his job for about two months.

On 07/13/22, I received a copy of Resident A's resident care agreement and the addendum regarding transportation. According to the resident care agreement, the basic fees include the following transportation services: work, doctors' appointments, secretary of state, social security offices, churches, off site recreational activities, other special events, and as needed in the event of an emergency.

On 07/26/22, I made a telephone call to Resident A's guardian. Regarding the allegations, the guardian stated the AFC group home did not provide Resident A with transportation to his job until six to eight weeks after he started working.

<b>APPLICABLE RULE</b>	
<b>R 400.14301</b>	<b>Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.</b>
	<b>(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: (a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.</b>
<b>ANALYSIS:</b>	According to Resident A's resident care agreement, the basic fee does include transportation to work. Mrs. Bryson stated that before the AFC group home could provide Resident A transportation to work, they needed to verify the job and details about the job. Resident A's guardian wanted Resident A to start the job right away and she did not want to wait for the AFC group home to gather the information they needed. According to Ms. Bryson, it took the AFC group home five days to ascertain the information they needed about the job and then they started to provide transportation.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**Resident A's mother requested a copy of Resident A's contract with Rose Hill Center multiple times in June 2022 and did not receive it.**

**INVESTIGATION:**

Mrs. Rothwell stated on 06/27/22, Resident A's guardian contacted her via email to ask who to contact to get a copy of all of Resident A's psychiatric records. Mrs. Rothwell directed Resident A's guardian request to the Administrator Assistant, Karen Dixon. Mrs. Rothwell asked Ms. Dixon to reach out to Resident A's guardian and give her the request for records form to fill out in order to receive records. On 06/30/22, Ms. Dixon sent Resident A's guardian an email explaining that a release of information form is attached to the email. Ms. Dixon advised once the form has been signed, email it back to her, and approved by supervision, she will be able to send the requested information

sent directly to her by mail, email, or fax. Mrs. Rothwell stated she does not know if the release of information form was received from Resident A's guardian.

Mrs. Bryson stated Ms. Dixon never received the release of information form from Resident A's guardian. Mrs. Bryson stated the requested records are prepared to be sent to Resident A's guardian once she provides the release of information form.

On 07/12/22, I received a copy of the email from Resident A's guardian requesting Resident A's psychiatric records on 06/27/22. I also received a copy of the email from Ms. Dixon to Resident A's guardian which contained a copy of the release of information form on 06/30/22.

On 07/14/22, I completed an exit conference with the licensee designee, Rochelle Rothwell via telephone. Mrs. Rothwell was informed that the allegations will not be substantiated.

On 07/26/22, I made a telephone call to Resident A's guardian. Regarding the allegations, the guardian denied receiving any email and/or release of information form from the AFC group home. The guardian confirmed her email address with me which is the exact same email address where Ms. Dixon sent the release of information form. I forwarded a copy of the email from Ms. Dixon to the guardian and the guardian confirmed that she received my email.

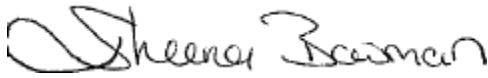
On 07/26/22, I completed a second exit conference with the licensee designee, Rochelle Rothwell via voice mail. Mrs. Rothwell was informed that one of the allegations will be substantiated and a corrective action plan will be required.

<b>APPLICABLE RULE</b>	
<b>R 400.14302</b>	<b>Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.</b>
	<b>(8) At the time of discharge, a licensee shall provide copies of resident records to the resident and his or her designated representative when requested, and as determined appropriate, by the resident or his or her designated representative. A fee that is charged for copies of resident records shall not be more than the cost to the licensee of making the copies available.</b>

<b>ANALYSIS:</b>	On 06/27/22, Resident A's guardian contacted Mrs. Rothwell via email requesting copies of Resident A's psychiatric records. On 06/30/22, the Administrator Assistant, Karen Dixon contacted Resident A's guardian via email. Ms. Dixon provided a release of information form and advised once the form had been signed, emailed back to her and approved by supervision, she will be able to send the requested information by mail, email, or fax. To date, Resident A's guardian has not provided a signed copy of the release of information form. The guardian denied receiving an email from the AFC group home regarding her request for records and the release of information form. The guardian confirmed her email address which was the exact same email address where Ms. Dixon sent the release of information form.
<b>CONCLUSION:</b>	VIOLATION NOT ESTABLISHED

**IV. RECOMMENDATION**

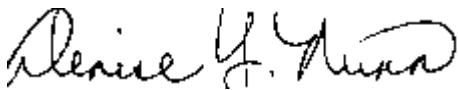
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



Sheena Bowman  
Licensing Consultant

07/26/22  
Date

Approved By:



Denise Y. Nunn  
Area Manager

07/28/2022

Date