GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 2, 2023

Roseline Rowan
Medhealth Suppliers & Providers, Inc.
706 Britten Ave
Lansing, MI 48910

RE: License #: AS230294121
Investigation #: 2023A0466011
Evergreen Place II

Dear Ms. Rowan:

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.

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 #:	AS230294121
Investigation #:	2023A0466011
Complaint Receipt Date:	12/05/2022
Investigation Initiation Date:	12/06/2022
Report Due Date:	02/03/2023
Licensee Name:	Medhealth Suppliers & Providers, Inc.
Licensee Address:	706 Britten Ave Lansing, MI 48910
Licensee Telephone #:	(517) 712-8585
Administrator:	Roseline Rowan
Licensee Designee:	Roseline Rowan
Name of Facility:	Evergreen Place II
Facility Address:	4048 Windward Dr. Lansing, MI 48911
Facility Telephone #:	(517) 580-4990
Original Issuance Date:	04/28/2008
License Status:	REGULAR
Effective Date:	10/13/2021
Expiration Date:	10/12/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED ALZHEIMERS

II. ALLEGATIONS:

	Violation Established?
Resident's personal allowance funds are not accounted for.	Yes
Resident A, Resident B, Resident C, Resident D and Resident E were left alone at the facility without the care and supervision that they require.	Yes
Resident A missed appointments at Program of All-Inclusive Care for the Elderly (PACE) on 11/22/2022, 11/23/2022, 11/29/2022 and 11/30/2022.	No
Direct care worker (DCW) Camille Owens yelled at the residents on 12/02/2022.	No
There are locks on resident closets and the closets are kept locked.	No
There is black mold in the back bathroom	No
Additional Findings	Yes

III. METHODOLOGY

12/05/2022	Special Investigation Intake- 2023A0466011.
12/06/2022	Special Investigation Initiated – Telephone call, Complainant interviewed.
12/12/2022	Contact - Document Received- Additional allegation made.
12/12/2022	Contact - Document Sent to APS Robert Joyner.
12/12/2022	APS Referral- APS Robert Joyner already assigned.
12/15/2022	Contact - Telephone call received from case manager Dawn Echoles, interviewed.
12/15/2022	Referral - Recipient Rights- Greg Fox assigned.
12/15/2022	Contact – Telephone call received- Additional allegation made.
12/15/2022	Inspection Completed On-site.

12/28/2022	Contact - Document Received - APS Robert Joyner.
01/27/2023	Contact – Telephone call made DCW Camille Owens, interviewed.
01/30/2023	Contact – Telephone call made to PACE, message left.
01/30/2023	Contact – Telephone call made to MMG, message left.
01/30/2023	Contact- Document sent to APS Robert Joyner.
01/30/2023	Contact- Document sent to Greg Fox.
01/31/2023	Exit Conference with licensee designee Rowan.

ALLEGATION: Resident's personal allowance funds are not accounted for.

INVESTIGATION:
On 12/05/2022, Complainant reported there is a discrepancy in how much allowance is being provided by Guardian A1 for Resident A and how much money Resident A actually receives from licensee designee Rowan. Complainant reported she was told by licensee designee Rowan that Resident A receives $40 a month for a personal spending allowance. Complainant reported when she spoke with Guardian A1, Guardian A1 reported Resident A should be receiving $64 a month in personal spending allowance as that is the amount she provides to licensee designee Rowan every month for Resident A. Complainant reported Resident A is only receiving $40 a month for personal spending allowance and she does not know what is being done with the additional $24 a month Resident A has not been receiving. Complainant reported licensee designee Rowan has not maintained *Resident Funds Part I* and *Resident Funds Part II* for any residents.

On 12/15/2022, I interviewed case manager Echoles who reported she does not audit the residents' personal funds when she is in the home. Case manager Echoles was unaware of any concerns involving any residents' personal funds.

On 12/15/2022, DCW Sedekia reported she has no involvement with any of the residents' personal allowance funds. DCW Sedekia is unaware of how much personal allowance they receive and how those funds are given to them.

On 12/15/2022, I conducted an unannounced investigation and I reviewed resident records for Resident A, Resident B, Resident C, Resident D and Resident E. The findings are listed below:

- Resident A's record did not contain a completed *Resident Funds Part I. The Resident Funds Part II* form was dated 12-1-2021and was last updated on

03/22 with no year documented. The withdrawal and balance portion of the document was left blank. Resident A's record contained $20 cash accessible for use. Resident A's record contained a *Resident Care Agreement* "entrusting the licensee with personal allowance funds."

- Resident B's record did not contain the *Resident Funds Part I, Resident Funds Part II or* a *Resident Care Agreement.*
- Resident C's record did not contain the *Resident Funds Part I, Resident Funds Part II* and the *Resident Care Agreement* was completely blank and signed by Guardian A1 only.
- Resident D's record did not contain the *Resident Funds Part I,* the *Resident Funds Part II* was in the record but blank and there was no *Resident Care Agreement.*
- Resident E's record did not contain the *Resident Funds Part I.* The *Resident Funds Part II form was* dated 08/22/2022-09/01/2022 and showed that Resident E withdrew $44 and had a balance of $0. The form had not been updated since. Resident E's record contained a *Resident Care Agreement* that documented that they agreed to "entrust the following" to the licensee for safe keeping but both the funds and valuables box was left blank and this document was only signed by Guardian E1.

On 12/15/2022, licensee designee Rowan showed me an *Account Summary* where she reported she deposits each residents' allowance into a bank account for safe keeping. The *Account Summary* documented each licensed facility owned by Roseline Rowan has their own checking and savings account. Licensee designee Rowan provided me with a copy of the *Transaction History* which documented the monthly amount being deposited. There was no record of which resident funds are being deposited nor did licensee designee Rowan have any system or documentation to track each residents' funds separately as required. Licensee designee Rowan showed me that Resident A had $20 in cash accessible to her at the facility however there was no cash available for any of the other residents. Licensee designee Rowan reported none of the other residents spend their personal allowance funds because they do not go on outings, trips or shopping. Licensee designee Rowan reported she utilizes the resident funds as needed when a resident needs an item like a new bed, new sheets, new chair etc. Licensee designee Rowan did not have a ledger or any documentation on a *Resident Funds Part II* form to verify how Resident A, Resident B, Resident C, Resident D and Resident E's money was being tracked, spent or how much each of them had available as of 12/15/2022. Licensee designee Rowan did have receipts, but they were not labeled with a resident name so there was no documentation of which purchase was made on behalf of which resident. Additionally, there was no documentation to show how much money Resident A, Resident B, Resident C, Resident D and Resident E had nor any record of how much Resident A, Resident B, Resident C, Resident D and Resident E had spent over the course of a period of time.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(2) The care of any resident funds and valuables that have been accepted by a licensee for safekeeping shall be treated by the licensee as a trust obligation. **(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.**
ANALYSIS:	Although licensee designee Rowan reported she accepts resident personal spending funds and keeps them in a bank account for safe keeping, there were no specific accounting records kept tracking how much personal spending funds have been spent by each resident. There were no labeled receipts separated by resident or any funds at the facility for all but one resident despite residents not going places. Also, a review of the resident records for Residents A-E, revealed licensee designee Rowan has not completed and maintained *Resident Funds Part I* for Resident A, Resident B's Resident C's Resident D and *Resident Funds Part II* for Resident A, Resident B's Resident C's Resident D's and Resident E's. *Funds Part I* and *Resident Funds Part II* are required department forms therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A, Resident B, Resident C, Resident D and Resident E were left alone at the facility and without the care and supervision that they require.

INVESTIGATION:
On 12/15/2022, Complainant reported that on 12/13/2022, she went to the facility and Resident C answered the door and reported the residents were left alone as no direct care staff member was present. Complainant reported Resident C allowed her entrance into the home. Complainant reported she searched the entire home both the main floor and basement and she could not located anyone in the home except Resident A, Resident B, Resident C, Resident D and Resident E. Complainant reported she contacted license designee Rowan who came to the home about 45 minutes later.

On 12/15/2022, I interviewed case manager Echoles who reported that she went to the facility on 12/13/2022 and Resident C told her that there were no direct care staff at the facility. Case manager Echoles reported Resident C allowed her entrance into the home. Case manager Echoles stated she searched the entire home but did not locate anyone else in the facility besides the five residents. Case manager Echoles reported she contacted license designee Rowan who came to the home about 45 minutes later. Case manager Echoles reported that license designee Rowan reported DCW Sedekia was on shift on 12/13/2022 and left without having someone relieve her.

On 12/15/2022, I conducted an unannounced investigation and I interviewed Resident A and Resident B who reported that although they could not report the day they did remember being left without a DCW being in the facility earlier that week. Resident A and Resident B reported that they were left without a care giver for "a little while."

I interviewed DCW Sedekia who reported she was on shift on 12/13/2022 and had texted licensee designee Rowan three to four times throughout her shift asking who was relieving her when her shift ended. DCW Sedekia reported licensee designee Rowan never responded so at 2pm and again at 2:30, DCW Sedekia called and texted license designee Rowan without a response. DCW Sedekia reported she could not stay any longer so she texted licensee designee Rowan she left at 2:30pm. DCW Sedekia admitted she left Resident A, Resident B, Resident C, Resident D and Resident E without any care and supervision even though they require care and supervision to ensure their safety and well-being.

I interviewed licensee designee Rowan who reported that on 12/13/2022, DCW Sedekia left Resident A, Resident B, Resident C, Resident D and Resident E without any care and supervision even though they require care and supervision to ensure their safety and well-being. Licensee designee Rowan reported she talked with DCW Sedekia and told her if she left the faiclity again before a relief staff arrived, she would be terminated. Licensee designee Rowan reported receiving a phone call from case manager Echoles who reported she was at the facility and that there was no DCW on duty. Licensee designee reported she went to the facility as soon as she could. Licensee designee Rowan reported the residents were left alone without care and supervision for about 45 minutes on 12/13/2022.

On 12/15/2022, I conducted an unannounced investigation and I reviewed Resident A, Resident B's, Resident C's, Resident D's and Resident E's written *AFC Assessment Plans* which all documented the following:

- Resident A- requires the assistance of a walker for ambulation and staff assistance with activities of daily living.
- Resident B- a written assessment plan was not available for review at the time of the unannounced investigation.
- Resident C-Is able to use Spec Tran independently, requires some assistance with activities of daily living.

- Resident D- needs constant supervision, limited verbal communication and requires assistance with all activities of daily living
- Resident E- needs constant supervision, tends to wander, sometimes has outbursts and requires redirection. Requires staff assistance with all activities of daily living.

I reviewed DCW Sedekiaia's employee record which contained a Michigan Workforce Background Check that was dated 10/24/2022 and documented DCW Sedekiaia is eligible for employment with an adult foster care facility.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Case manager Echoles, Resident A, Resident B, DCW Sedekia and licensee designee Rowan all reported that on 12/13/2022, Residents A- E were left unsupervised without any care and supervision when DCW Sedekia left the facility before another DCW arrived. On 12/13/2022, the ratio of direct care staff to residents was inadequate as there was less than 1 direct care staff on duty for at least 45 minutes.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care worker (DCW) Camille Owens yelled at the residents on 12/02/2022.

INVESTIGATION:
On 12/05/2022, Complainant reported direct care worker (DCW) Camille Owens yelled at the residents on 12/02/2022. Complainant reported she was in her bedroom and she heard DCW Owens screaming at the residents to "knock it off and sit down."

On 12/13/2022, I interviewed case manager Dawn Echoles who reported she has not observed DCW Owens at the facility when she has been there. Case manager Echoles reported DCW Owens typically works at another licensed facility owned by the licensee.

On 12/15/2022, I conducted an unannounced onsite investigation and interviewed DCW Niyinkunda Sedekia who reported she was not in the facility with DCW Owens

on 12/02/2022. DCW Sedekia reported she worked with her before at another licensed facility and has never observed DCW Owens screaming at the residents. DCW Sedekia reported that none of the residents or other DCWs have reported to her that DCW Owens was screaming at the residents on 12/02/2022 or any other time.

I interviewed Resident A and Resident B who reported they did not recall DCW Owens screaming on 12/02/2022. Resident C declined to be interviewed. Resident D has limited verbal skills and Resident E is non-verbal and therefore unable to be interviewed.

I interviewed licensee designee Roseline Rowan who reported DCW Owens usually works at another licensed facility. Licensee designee Rowan reported she was at the facility on 12/02/2022 with DCW Owens and DCW Warner and she did not observe DCW Owens screaming at the residents or telling the residents to "knock it off and sit down." Licensee designee Rowan reported no DCW or resident has ever reported to her that DCW Owens has screamed at residents.

I reviewed DCW Owens employee record which contained a Michigan Workforce Background Check that was dated 03/15/2015 and documented that she is eligible to work in an adult foster care (AFC) facility.

On 01/27/2022, I interviewed DCW Owens who reported that she does not work at this licensed facility. DCW Owens reported that on 12/02/2022 she and licensee designee Rowan did go to the facility to give DCW Kelley Warner (who was on duty) some paperwork around 9am. DCW Owens reported DCW Warner and the residents were not up because they were all still in their bedrooms while she and licensee designee Rowan were at the facility. DCW Owens reported DCW Warner never came out of her bedroom while she was at the facility. DCW Owens reported being in the facility about a half hour and denied screaming at any residents or telling the residents to "knock it off and sit down."

APPLICABLE RULE	
R 400.14204	**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:	Complainant reported that DCW Owens screamed at the residents on 12/02/2022 telling them to “knock it off and sit down.” Resident A, Resident B and licensee designee Rowan were all at the facility on 12/02/2022 and all denied DCW Owens screamed on 12/02/2022 telling the residents to “knock it off and sit down.” DCW Owens denied screamed at the residents on 12/02/2022 telling them to “knock it off and sit down.” DCW Sedekia and licensee designee Rowan reported that they have never observed DCW Owens screaming at the residents nor have any of the residents or other DCWs reported that DCW Owens screams at residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: There are locks on resident closets and the closets are kept locked.

INVESTIGATION:
On 12/05/2022, Complainant reported there are locks on resident closets that are kept locked. On 12/06/2022, Complainant reported the locks are in plain sight on top of each resident’s closet and that Resident D and Resident E’s closets stay locked.

On 12/15/2022, I interviewed case manager Echoles who reported she has not observed any of the residents’ closets to have locks on them. Case manager Echoles believes the residents have access to their personal clothing and belongings.

On 12/15/2022, I conducted an unannounced investigation and went into Resident A, Resident B, Resident C, Resident D and Resident E’s bedrooms and I did not observe any locks on any closet including Resident D and Resident E’s closets.

I interviewed Resident A, Resident B, DCW Sedekia and licensee designee Rowan and they all denied that there are locks on residents’ closets that are kept locked. Resident A, Resident B, DCW Sedekia and licensee designee Rowan all reported residents have access to their personal clothing and belongings at all times.

APPLICABLE RULE	
R 400.14304	**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: **(j) The right of reasonable access to and use of his or her personal clothing and belongings.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	During my unannounced onsite investigation on 12/15/2022, I went into Resident A, Resident B, Resident C, Resident D and Resident E's bedrooms and I did not observe any closet to have a lock on it. Resident A, Resident B, DCW Sedekia and licensee designee Rowan all denied that there are locks on resident closets that are kept locked.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: There is black mold in the back bathroom.

INVESTIGATION:
On 12/02/2022, Complainant reported that there is black mold in the back bathroom. Complainant reported telling license designee Rowan and reported that she was told to spray bleach on it instead of having it professionally cleaned/removed.

On 12/15/2022, I conducted an unannounced investigation and I did not observe any mold in the bathroom. During the same onsite investigation, I interviewed DCW Sedekia and licensee designee Rowan who both reported they have not seen any mold in the bathroom. Licensee designee Rowan reported DCW Warner stated she saw mold and licensee designee Rowan reported she instructed her to spray it with bleach water to clean it.

I interviewed case manager Echoles who reported that she has not observed black mold in the bathroom.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	During the unannounced onsite investigation on 12/15/2022, I did not observe any black mold in the resident bathroom.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A missed appointments at Program of All-Inclusive Care for the Elderly (PACE) on 11/22/2022, 11/23/2022, 11/29/2022 and 11/30/2022.

INVESTIGATION:
On 12/12/2022, Complainant reported Resident A is 81 years and diagnosed with cognitive impairments, congestive heart failure, chronic obstructive palmary disease (COPD), type II diabetes, schizophrenia, depression/anxiety, dementia and difficulty walking. Complainant reported Resident A is supposed to see her medical provider, PACE, twice weekly to receive physical, occupation and recreational therapy. Complainant reported PACE provides transportation for Resident A and on multiple occasions, the transportation department has arrived to pick Resident A up but she is either not out of bed yet because direct care staff has not woken her up or direct care staff did not get her up in time to get on the bus. Complainant reported on 11/30/2022, PACE transportation department arrived at the facility around 8am to pick Resident A up and after knocking on the door several times, a DCW (name unknown) answered the door and indicated she (the caregiver) did not have enough energy to get the residents out of bed because she was up all night arguing with her boyfriend the night before. Complainant reported this is an ongoing issue and occurred on 11/22/2022, 11/23/2022, 11/29/2022 and 11/30/2022. Complainant reported due to Resident A missing her appointments with PACE, her physical health is declining. Complainant reported it is unknown if DCWs are even getting Resident A out of bed at all.

On 12/13/2022, adult protective service worker (APS) Robert Joyner reported he saw Resident A on 12/07/2022. APS Joyner reported there has been a lot of “finger pointing” with PACE saying direct care staff members don’t get Resident A ready and licensee designee Rowan blaming DCW Warner who has been terminated. APS Joyner reported Guardian A1 is blaming PACE.

On 12/14/2022, I interviewed DCW Warner who reported Resident A has missed the bus for PACE because Resident A did not want to go to PACE and she cannot force her to get up and get ready to go. DCW Warner could not recall the dates Resident A refused to go to PACE. DCW Warner denied telling PACE transportation on 11/30/2022 she did not have enough energy to get the residents out of bed because she was up all night arguing with her boyfriend the night before. DCW Warner reported she has not worked at the facility since 12/02/2022 as licensee designee Rowan terminated her employment.

On 12/15/2022, I conducted an unannounced investigation and I interviewed Resident A who reported that she does go to PACE. Resident A reported she has missed the bus for PACE because she did not wake up. Resident A could not articulate if this was because she was not woken up by DCWs at the facility or if she chose not to wake up/get up to go to PACE. Resident A reported she went to PACE this week.

I interviewed DCW Sedekia who reported Resident A goes to PACE and has never missed the bus when she has been working. DCW Sedekia reported there is only one DCW on shift so she is not sure if Resident A missed the bus when someone else was working. DCW Sedekia reported she did not work on 11/22/2022, 11/23/2022, 11/29/2022 and 11/30/2022.

I interviewed licensee designee Rowan who reported DCW Warner who was the previous live-in direct care staff told licensee designee Rowan Resident A was at PACE when she was not. Licensee designee Rowan admitted Resident A requires some incentive/encouragement to be motivated to go to PACE as Resident A will try to refuse to stay home. Licensee designee Rowan reported DCW Warner did not provide Resident A with encouragement to attend PACE and therefore she did miss PACE to stay home. Licensee designee Rowan reported Resident A is supposed to go to PACE twice a week. Licensee designee Rowan reported she terminated DCW Warner on 12/02/2022 and she moved into the facility to ensure the residents' needs were being met including encouraging Resident A to go to PACE. Licensee designee Rowan reported Resident A has not missed any PACE appointments since.

I reviewed Resident A's written *Assessment Plan for AFC Residents* which documented that Resident A is 81 years and in the "adult activity program and senior center" section of the report is documented, "no, COVID closure." In the "name of primary physician/clinic" section of the report it documented, "PACE/Senior community doctor."

On 12/28/2022, APS Joyner reported he spoke with Guardian A1 who does not plan to move Resident A to another licensed facility as Resident A's needs are being met in this facility. APS Joyner reported licensee designee Rowan stated the issues with Resident A attending PACE consistently have resolved. APS Joyner reported that PACE has provided a hospital bed for Resident A which is also helping.

On 01/30/2022, I called PACE and left a message for a return phone call.

On 01/30/2022, I called Mid-Michigan Guardianship (MMG) and left a message for Guardian A1 for a return phone call.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions:

	(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home. **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**
ANALYSIS:	Complainant reported that Resident A missed appointments at Program of All-Inclusive Care for the Elderly (PACE) on 11/22/2022, 11/23/2022, 11/29/2022 and 11/30/2022. Although DCW Warner admitted that Resident A has missed the bus for PACE because Resident A refused to go. Resident A reported that she has missed the bus for PACE because she did not wake up. Resident A's written assessment plan did not document that Resident A attends PACE therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 12/15/2022, I conducted an unannounced investigation and I reviewed Resident A's written *Assessment Plan for AFC Residents* (assessment plan) which documented that was dated 04/02/2021 and signed by licensee designee Rowan and Guardian A1. Resident A's record did not contain a written assessment plan that had been completed annually.

On 12/15/2022, Licensee designee reported that Resident B had been recently admitted to the facility and not all her paperwork had been completed. Resident B's record did not contain a written assessment plan that was completed at the time of admission. Resident B's record contained a Health Care Appraisal that was dated 11/29/2022 attached to a hospital discharge summary with a date of service dated 11/07/2022 for psychiatric condition. The discharge summary was missing pages and the file did not contain the entire document.

On 01/13/2023, licensee designee reported that Resident B was admitted to the facility on 12/06/2022.

APPLICABLE RULE	
R 400.14301	**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:	Resident A's record contained a written *Assessment Plan for AFC Residents* that was dated 04/02/2021 and signed by licensee designee Rowan and Guardian A1. Resident A's record did not contain a written assessment plan that had been completed annually. Additionally, Resident B was admitted to the facility on 12/06/2022 and her record did not contain a completed written assessment plan as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 12/15/2022, I conducted an unannounced investigation and I reviewed *Resident Care Agreements* for Residents A-Resident E. Below are the findings:

- Resident A's record contained a *Resident Care Agreement* signed by Guardian A1 only.
- Resident B's record did not contain a *Resident Care Agreement.*
- Resident C's record contained a Re*sident Care Agreement that* was completely blank and signed by Guardian A1 only.
- Resident D's record contained a *Resident Care Agreement* that was dated 4/05/21201 and signed by Guardian D1 and licensee designee Rowan.
- Resident E's record contained a *Resident Care Agreement* that was not completely filled out and only signed by Guardian E1.

On 01/13/2023, licensee designee reported that Resident B was admitted to the facility on 12/06/2022.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(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) A description of services to be provided and the fee for the service.** **(c) A description of additional costs in addition to the basic fee that is charged.** **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.** **(e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission.** **(f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule.** **(g) An agreement by the resident to follow the house rules that are provided to him or her.** **(h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident.** **(i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures.** **(j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.14315.** **(k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met.** **(l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.** **(8) A copy of the signed resident care agreement shall be provided to the resident or the resident's designated representative. A copy of the resident care agreement shall be maintained in the resident's record.** **(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.**

ANALYSIS:	Resident B's record did not contain documentation that a *Resident Care Agreement* was completed at the time of admission and maintained in the resident record. At the time of the unannounced investigation there was no documentation to support that licensee designee Rowan reviewed the written *Resident Care Agreements* with Resident A, Resident C and/or Resident E or the resident's designated representative. Resident D's record contained a *Resident Care Agreement* that was dated 4/05/20201 and therefore was not updated annually therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 12/15/2022, I conducted an unannounced investigation and Resident B's bedroom door contained a deadbolt lock. The deadbolt lock required a key to lock/unlock it from the outside. Resident B did not have access to the deadbolt on the inside of the door, so she could be locked into her bedroom without her knowledge from the keyed deadbolt lock.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(4) Interior doorways of bedrooms that are occupied by residents shall be equipped with a side-hinged, permanently mounted door that is equipped with positive-latching, nonlocking-against-egress hardware.
ANALYSIS:	Resident A's bedroom contained a deadbolt lock which is locking against egress and 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 license status.

01/31/2023

Julie Elkins — Date
Licensing Consultant

Approved By:

02/02/2023

Dawn N. Timm — Date
Area Manager