GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 18, 2023

Michelle Rupert
Everest Inc.
PO Box 2352
Riverview, MI 48193

RE: License #: AS820014113
Investigation #: 2023A0116046
Larkspur Home

Dear Ms. Rupert:

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
REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS820014113
Investigation #:	2023A0116046
Complaint Receipt Date:	08/30/2023
Investigation Initiation Date:	08/31/2023
Report Due Date:	10/29/2023
Licensee Name:	Everest Inc.
Licensee Address:	PO Box 2352 Riverview, MI 48193
Licensee Telephone #:	(734) 675-3037
Administrator:	Michelle Rupert
Licensee Designee:	Michelle Rupert
Name of Facility:	Larkspur Home
Facility Address:	10426 Larkspur Grosse Ile, MI 48138
Facility Telephone #:	(734) 692-1491
Original Issuance Date:	12/27/1988
License **Status:**	REGULAR
Effective Date:	06/27/2022
Expiration Date:	06/26/2024
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
• Staff, Diane Kline, screams at Resident A and B and calls Resident B names. • Staff, Diane Kline, threatens to sit on Resident A while getting her dressed, if she refuses to remain still. • Resident A was observed with a bruise on her right leg after being hit by staff, Diane Kline.	Yes

III. METHODOLOGY

08/30/2023	Special Investigation Intake 2023A0116046
08/30/2023	Referral - Recipient Rights Received.
08/30/2023	APS Referral Made by Recipient Rights.
08/30/2023	Contact - Telephone call received Voicemail message left from licensee designee, Michell Rupert, informing me of a rights investigation pertaining to the allegations.
08/31/2023	Special Investigation Initiated - Telephone Interviewed Guardian B.
08/31/2023	Contact - Telephone call made Interviewed licensee designee, Michelle Rupert.
08/31/2023	Contact - Telephone call made Interviewed staff, Diane Kline.
09/05/2023	Inspection Completed On-site Interviewed home manager, Felicia Wilson, and Resident's A and B.
09/05/2023	Contact - Telephone call made

	Interviewed Jeri Sterrett, assigned rights investigator.
09/08/2023	Contact - Telephone call made Interviewed assigned APS investigator, Ladonna Johns.
09/13/2023	Contact - Telephone call made Interviewed former staff, India Beasley.
09/13/2023	Inspection Completed-BCAL Sub. Compliance
09/13/2023	Exit Conference With licensee designee, Michelle Rupert.

ALLEGATION:

- **Staff, Diane Kline, screams at Resident A and B and calls Resident B names.**
- **Staff, Diane Kline, threatens to sit on Resident A while getting her dressed, if she refuses to remain still.**
- **Resident A was observed with a bruise on her right leg after being hit by staff, Diane Kline.**

INVESTIGATION:

On 08/30/23, I interviewed Guardian B and she reported that she talks to Resident B regularly and reported that she has not shared any concerns with her about the staff. Guardian B also reported that most times when she speaks to Resident B she is on speaker phone and staff is normally close by which may have prevented Resident B from expressing any concerns. Guardian B reported that she will follow up with Resident B and see if she shares anything regarding staff, Diane Kline. Guardian B added that Resident B has lived in this home for over 30 years and things have been really good.

On 08/31/23, I interviewed licensee designee, Michelle Rupert, and she reported that as soon as she was made aware of the allegations on 08/29/23, staff, Dianne Kline was removed from the schedule, and she began her internal investigation along with fully cooperating with adult protective services (APS) and the office of recipient rights (ORR). Ms. Rupert reported that the rights investigator, Jerri Sterrett, was at the home yesterday and after speaking with staff and Resident A and B she recommended termination of staff, Diane Kline, and demotion of home manager, Felicia Wilson. Ms. Rupert reported that Ms. Sterrett came to that recommendation after both Resident A and B confirmed the allegations. Ms. Rupert reported that Resident A was able to point to her upper thigh area where the bruise was and say Diane did it. Resident B also told Ms. Sterrett that Ms. Kline yelled and screamed at

her and Resident A and reported that she would get close to her ear and scream directly in it. Ms. Rupert reported Ms. Sterrett had concerns with home manager, Felicia Wilson's, failure to report as former staff, India Beasley, had informed her of what she had observed, what Resident B had told her and sent her a picture of the bruise on Resident A's leg. Ms. Rupert reported that Ms. Sterrett stated that Ms. Wilson, especially as a manager should know her obligation to report.

Ms. Rupert reported that she interviewed Ms. Kline regarding the allegations and reported that she denied them. Ms. Rupert reported that Ms. Kline had worked in the home for about 14 years and prior to this incident she had not had any concerns or complaints regarding the care she provided to the residents.

On 08/31/23, I interviewed staff, Dianne Kline, and she denied the allegations. Ms. Kline reported that she does talk loudly but denied ever yelling at any of the residents. Ms. Kline also denied that she hit or punched Resident A as alleged. Ms. Kline reported that Resident A is always combative and gives staff a difficult time when changing her briefs and when taking off and putting on her clothes. Ms. Kline reported that Resident A may have sustained the bruise while kicking and throwing a tantrum. Ms. Kline reported that she is suspended and hopes that she does not lose her job.

On 09/05/23, I conducted an unscheduled onsite inspection and interviewed home manager, Felicia Wilson, and Residents A and B. Ms. Wilson reported that she was informed of the allegations two days after they were alleged to have happened. Ms. Wilson reported the incident with Resident A allegedly being hit by Ms. Kline happened on 08/18/23 and reported that she was informed about it on 08/20/23. Ms. Wilson reported she spoke to Ms. Kline about it, and she denied the allegations. Ms. Wilson also reported that she attempted to interview Resident A and she did not disclose anything to her. Ms. Wilson further reported that she observed the bruise but reported that it was plausible that Resident A could have sustained the bruise accidently as she is combative at times and kicks and flails. Ms. Wilson reported that she failed to immediately report it, because she was dealing with an incident at one of the other homes that she manages and had a lot going on. Ms. Wilson reported that she informed her management team on 08/29/23 when the rights investigation was initiated.

I interviewed Resident A and she pulled up her pant leg, pointed to the area on her upper right thigh and said, "Diane did it." Resident A did not provide any other information and went back to watching television. The bruise was no longer visible on Resident A's thigh area, however Ms. Wilson confirmed it was previously visible on the upper right thigh.

I interviewed Resident B and she reported that Ms. Kline, screams at her and when she was helping get her dressed she screamed directly in her ear. Resident B reported that Ms. Kline would call her stupid and dumb and was mean at times. Resident B reported that Ms. Kline would also yell at Resident A, and she reported

observing her hit Resident A in her knee area. Resident B denied ever being hit by Ms. Kline.

On 09/05/23, I interviewed Jeri Sterrett, rights investigator. Ms. Sterrett reported that she has completed her investigation and will be substantiating abuse II, abuse III, failure to report and safe environment. Ms. Sterrett reported Resident B's admission that she heard Ms. Kline threaten to sit on Resident A if she kept kicking and moving creates an unsafe environment. Ms. Sterrett reported that Ms. Kline has been terminated and she has recommended that the home manager, Felicia Wilson, be demoted back to a staff.

On 09/08/23, I interviewed Ladonna Johns, assigned APS investigator. Ms. Johns reported that she will be substantiating the allegations based on the information that Resident A and B shared with rights and licensing. Ms. Johns reported that when she went to the home neither of the residents disclosed anything to her, but due to their disclosure to rights and licensing she will use that information to support substantiating physical and verbal abuse.

On 09/13/23, I interviewed staff, India Beasley and she reported that she quit on 08/24/23 and is no longer employed with the company. Ms. Beasley reported that during the six weeks she worked in the home, she reported observing Ms. Kline cursing and yelling at Resident A and B, reported Ms. Kline was easily agitated and short tempered. Ms. Beasley reported that she and Ms. Kline worked midnights together and, in the mornings, when it was time to get the residents up she always wanted to provide am care for Residents A and B. Ms. Beasley reported that on or about 08/18/23, while she was provided am care to another resident she overhead Ms. Kline telling Resident A, "Put your fucking legs down, if you kick me we are going to have a fucking problem, I'm going to sit on you." Ms. Beasley reported she then hears a loud smack, which she assumed is when Ms. Kline hit Resident A. Ms. Beasley reported that she looked Resident A over before leaving on 08/18/23 and did not observe any marks or bruises. Ms. Beasley reported the next day when she was preparing medication for Resident A's feeding tube, she observed a bruise on her right thigh. Ms. Beasley reported that she contacted her manager, Felicia Wilson, and informed her of what had taken place and shared how Ms. Kline was always yelling and cursing at Resident A and B the day prior. Ms. Beasley reported she also took a picture of the bruise and sent it to Ms. Wilson's phone. Ms. Beasley reported that Ms. Wilson told her that she was not going to report it, but that she would talk to Ms. Kline. Ms. Beasley reported that Ms. Wilson's response was unacceptable and that she made a decision that this was not a company that she wanted to continue to be employed with.

On 09/13/23, I conducted the exit conference with licensee designee, Michelle Rupert and informed her of the findings of the investigation. Ms. Rupert reported an understanding of the rule violation and reported that Ms. Kline was terminated, and Ms. Wilson has been demoted and moved to another home to work under the direction of another home manager. Ms. Rupert reported a manager from one of the

company's other licensed homes will take over management responsibilities at this home.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.

ANALYSIS:	Based on the findings of the investigation, which included interviews of Residents A and B, Ms. Wilson, Ms. Sterrett and Ms. Beasley, I am able to corroborate the allegations. Resident A was able to pull up her pant leg, point to her thigh area and say, “Diane did it”, when interviewed about the allegations. Resident B reported that Ms. Kline yelled at her and Resident B, screamed directly in her ear and reported observing Ms. Kline hit Resident A in her knee. Resident B also reported that Ms. Kline called her stupid and dumb. Ms. Wilson admitted she was informed of the allegations by staff, India Beasley, and was sent a picture of the bruise on Resident A’s thigh. Ms. Wilson failed to report it and did not take any actions to prevent additional mistreatment. Ms. Sterrett reported that both Resident A and B disclosed the physical and verbal abuse by Ms. Kline. Ms. Sterrett reported that Resident B heard Ms. Kline threaten to sit on Resident A if she continued to be combative. Ms. Sterrett confirmed that she substantiated all of the allegations. Ms. Beasley reported that she observed and overheard Ms. Kline verbally abuse and threaten Resident A. She reported that she also heard Ms. Kline yell and curse at Resident B. Ms. Beasley reported that she did her part by reporting it to her manager, Ms. Wilson. Ms. Beasley reported nothing was done until an official complaint was filed with ORR.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

09/18/23

Pandrea Robinson
Licensing Consultant

Date

Approved By:

09/18/23

Ardra Hunter
Area Manager

Date