GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 7, 2023

James Palmer
Covenant to Care, Inc.
44997 Coachman Ct.
Canton, MI 48187

RE: License #: AS820316698
Investigation #: 2023A0121042
Jacquelyn Street

Dear Mr. Palmer:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 11/02/23, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

K. Robinson

K. Robinson, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820316698
Investigation #:	2023A0121042
Complaint Receipt Date:	09/13/2023
Investigation Initiation Date:	09/13/2023
Report Due Date:	11/12/2023
Licensee Name:	Covenant to Care, Inc.
Licensee Address:	181 Dogwood Ct Canton, MI 48187
Licensee Telephone #:	(734) 228-6933
Administrator:	James Palmer, Designee
Name of Facility:	Jacquelyn Street
Facility Address:	28646 Jacquelyn Livonia, MI 48154
Facility Telephone #:	(734) 524-0159
Original Issuance Date:	03/13/2012
License **Status:**	REGULAR
Effective Date:	10/03/2022
Expiration Date:	10/02/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident eloped from the facility and was found 2.8 miles away from the group home. Staff required to conduct bed checks every 30 minutes per policy.	Yes

III. METHODOLOGY

09/13/2023	Special Investigation Intake 2023A0121042
09/13/2023	Special Investigation Initiated - Telephone Call to APS, Brian Sims
09/14/2023	Contact - Telephone call made DCW Miranda Sims
09/14/2023	Contact - Telephone call made Licensee, James Palmer
09/18/2023	Contact - Telephone call made Follow up call to M. Smith, Manager
09/18/2023	Contact - Document Received Email from Mr. Palmer
09/22/2023	Contact - Telephone call received Mr. Palmer
09/25/2023	Contact - Telephone call made Charmaine Wright, new provider
09/25/2023	Contact - Telephone call made Yolanda Tab, current home manager
09/25/2023	Contact - Telephone call made Left message for Mrs. Williams-Kennedy with MORC
09/26/2023	Contact - Telephone call received Return call from Mrs. Williams-Kennedy
09/26/2023	Inspection Completed On-site

	unannounced Interviewed Home Manager, Miranda Smith
10/05/2023	Contact - Telephone call made Left message for Mrs. Williams-Kennedy with MORC
10/06/2023	Contact - Telephone call received Return call from Mrs. Williams-Kennedy
10/06/2023	Contact - Telephone call made Follow up call to M. Smith
10/09/2023	Contact - Telephone call made Follow up call to Mrs. Williams-Kennedy
10/09/2023	Contact - Document Sent Email to MORC
10/12/2023	Contact - Document Received Resident A's IPOS and Behavior Plan
10/30/2023	Contact - Telephone call made M. Smith
10/30/2023	Exit Conference Mr. Palmer
11/02/2023	CAP received and approved.

ALLEGATION: Resident eloped from the facility and was found 2.8 miles away from the group home. Staff required to conduct bed checks every 30 minutes per policy.

INVESTIGATION: On 9/13/23, I initiated the complaint with a phone call to Adult Protective Services worker, Brian Sims. Mr. Sims confirmed law enforcement found Resident A eloping miles away from the group home. On 9/14/23, I interviewed Home Manager, Miranda Smith by phone. Ms. Smith reported Resident A had a history of eloping from the home. Ms. Smith explained Staff were required to conduct routine bed checks of the residents every 15 minutes. According to Ms. Smith, direct care worker, Krystal Graves was on duty the night Resident A went missing. On 9/14/23, I phoned licensee designee, James Palmer. Mr. Palmer reported the incident happened months ago. Mr. Palmer stated he conducted an internal investigation and determined DCW Krystal did not follow the home's bed check policy the night Resident A went missing. In addition, Mr. Palmer reported

Recipient Rights Investigator, Tonia McMurray also found Krystal Graves neglected her job duties by not performing a visual check of Resident A as required. As a result, Mr. Palmer stated, Krystal was fired. Resident A was later discharged from the home on 8/24/23.

On 9/25/23, I attempted to locate Resident A at her new placement address. Ms. Charmaine Wright reported Resident A was placed in her unlicensed home "a couple of weeks ago", but Resident A had since eloped. Home Manager, Yolanda Tab confirmed Resident A was placed in the home on 9/8/23. According to Ms. Tab, Resident A eloped at least 3 times since being placed there. Resident A was admitted to inpatient care at the Behavioral Center of Michigan on 9/22/23. Therefore, Resident A was not available for interview.

On 9/26/23, I conducted an unannounced onsite inspection at the facility. Ms. Smith was present and available for interview. Ms. Smith explained easterseals | MORC failed to provide them with a copy of Resident A's Crisis Plan to confirm the 1:1 staffing assignment.

On 9/26/23, I interviewed Resident A's case manager, DeRhonda Williams-Kennedy. Mrs. Williams-Kennedy reported Resident A is assigned 1:1 Staffing due to her history of elopement. I requested a copy of Resident A's treatment plan. On 10/6/23, I made a follow up call to Mrs. Williams-Kennedy. Mrs. Williams-Kennedy stated, "the moment she walked in that house, she had 1:1 staffing", referring to Resident A. On 10/9/23, I received a phone call from Mrs. Williams-Kennedy to report the agency's Management Team will not provide me a copy of Resident A's Crisis Plan without a court order or consent to release from the guardian. On 10/9/23, I sent an email to Mrs. Williams-Kennedy explaining the department's role as a Regulatory Agent to ensure the safety and protection of vulnerable adults. On 10/12/23, Mrs. Williams-Kennedy forwarded a copy of Resident A's treatment plan and behavior plan. Resident A's Crisis Prevention & Safeguard Plan dated 7/1/23 states, "{Resident A} has a 1:1 and therefore staff is with her at all times during the day and night while in the home. If {Resident A} is sleeping staff will leave the room and perform visual check in 15-minute intervals."

On 10/30/23, I completed an exit conference with Mr. Palmer. Mr. Palmer is adamant easterseals | MORC did not provide him with a copy of Resident A's Crisis Plan or updated IPOS upon request. To date, Mr. Palmer says he's never received payment for 1:1 staffing because he never possessed anything in writing to support the authorization. Mr. Palmer seemed surprised the department received the complaint so late, considering the AWOL incident happened on 5/17/23. Mr. Palmer does not dispute the department's findings and recommendation. Mr. Palmer acknowledged DCW Krystal did not follow protocol. Per policy, staff are to conduct routine bed checks on all residents every 15 minutes. Both Mr. Palmer and Ms. Smith indicated this policy was in place prior to Resident A's placement. The policy was implemented to safeguard all residents during sleeping hours. On 11/2/23, Mr. Palmer submitted an approved plan of correction.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	• Resident A demonstrated chronic truancy behavior that placed her at risk of harm in the community. • Staff Krystal Graves neglected her job duties by not conducting visual checks of the resident every 15 minutes per policy. • Resident A's Crisis Plan authorized 1:1 Staffing. • Therefore, Resident A was not provided adequate supervision as specified in her plan, in addition to, the home's bed check policy.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received, therefore, I recommend the status of this license remain unchanged.

11/2/23

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Kara Robinson Date
Licensing Consultant

Approved By:

11/7/23

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Ardra Hunter Date
Area Manager