GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 5, 2024

Kristen Wright
Hope House I Nonprofit Hsg Corp
P 0 Box 1978
524 North Jackson St.
Jackson, MI 49201

RE: License #: AL380007059
Investigation #: 2024A0007012
Hope House II/Fowler House

Dear Kristen Wright:

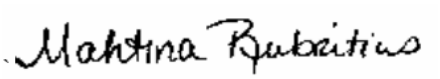
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9720.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL380007059
Investigation #:	2024A0007012
Complaint Receipt Date:	01/09/2024
Investigation Initiation Date:	01/10/2024
Report Due Date:	03/09/2024
Licensee Name:	Hope House I Nonprofit Hsg Corp
Licensee Address:	P 0 Box 1978 524 North Jackson St. Jackson, MI 49201
Licensee Telephone #:	(517) 784-4426
Administrator:	Kristen Wright
Licensee Designee:	Kristen Wright
Name of Facility:	Hope House II/Fowler House
Facility Address:	400 Van Buren Street Jackson, MI 49201
Facility Telephone #:	(517) 784-1522
Original Issuance Date:	10/01/1980
License Status:	REGULAR
Effective Date:	04/09/2022
Expiration Date:	04/08/2024
Capacity:	16
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On December 23, 2023, Employee #1 arrived at the facility on her day off and took Resident A's medication from Employee #2. Employee #1 tried to force Resident A to take her meds by plugging Resident A's nose.	Yes

III. METHODOLOGY

01/09/2024	Special Investigation Intake - 2024A0007012
01/09/2024	APS Referral Received.
01/10/2024	Special Investigation Initiated – Letter - Emailed referral to ORR.
01/10/2024	Contact - Face to Face - contact with Aubrey Lee, Adult Protective Services. Discussion.
01/16/2024	Contact - Document Received from Ashlee Griffes, ORR Officer. Previous investigation information. CAP submitted to ORR.
01/25/2024	Inspection Completed On-site - Unannounced - Face to face contact with Judy Reed, Home Manager, Cory Evans, Assistant Home Manager, Resident A, other residents, and staff.
03/01/2024	Contact - Telephone call made - Interview with Employee #2.
03/01/2024	Contact - Telephone call made - Interview with Employee #1.
03/01/2024	Contact - Telephone call made to Judy Reed. I requested contact information for Employee #3 and Employee #4. Employee #3 no longer works in the home and the last number they have for her is not working.
03/04/2024	Contact - Telephone call made to Judy Reed. Discussion.
03/04/2024	Contact - Face to Face contact with Aubrey Lee, APS. Discussion.
03/04/2024	Contact - Document Sent - Email sent to Kristen Wright, Licensee Designee. I requested a phone call to conduct the exit conference.
03/04/2024	Contact - Telephone call received from Kristen Wright, Licensee Designee. Discussion.

03/04/2024	Contact - Document Received - Copy of ORR Report.
03/04/2024	Contact - Telephone call made to Employee #4. No answer. The voicemail box was full, and I was unable to leave a message.
03/04/2024	Contact - Telephone call made to Aubrey Lee, APS. Discussion.
03/05/2024	Exit Conference conducted with Kristen Wright, Licensee Designee.

ALLEGATION:

On December 23, 2023, Employee #1 arrived at the facility on her day off and took Resident A's medication from Employee #2. Employee #1 tried to force Resident A to take her meds by plugging Resident A's nose.

INVESTIGATION:

On January 10, 2024, I made face to face contact with Aubrey Lee from Adult Protective Services (APS). He stated he made face to face contact with Resident A on January 4, 2024 and that Resident A is non-verbal. He stated he interviewed Judy Reed, Home Manager, Cory Evans, Assistant Home Manager, and other direct care staff. It was reported to him that Resident A has a difficult time taking her medications and if she does not take them, there can be serious physical health related consequences such as Resident A would likely have a grand mal seizure that day if she did not take her medications as prescribed. He interviewed Employee #1, who reported to take her index finger, putting it under Resident A's nose, and lifting her head back, to make sure the medications were not spit out. Aubrey Lee reported that he did not think that Employee #1 plugged Resident A's nose. According to Aubrey Lee, Resident A tends to hold her head down when taking medications leading to everything ending up in her lap. Employee #1 has been suspended pending the investigation. He has also spoken to Guardian A1 about the investigation.

On January 25, 2024, I conducted an unannounced on-site investigation and made face to face contact with Judy Reed, Home Manager, Cory Evans, Assistant Home Manager, Resident A, other residents, and direct care staff.

I spoke with Judy Reed, Home Manager, and she reported that Resident A can be difficult, when it comes to taking her medications. Judy Reed informed me that Resident A does not like the taste of the medications, even if it's mixed with apple sauce or pudding. She stated that on the day in question, Employee #1 was not working but came in to visit and check on the other residents and ended up assisting with administering Resident A's medications. Judy Reed informed me that Resident A regularly holds her head down, and she drools. According to Judy Reed, Resident

A was refusing her medications on December 23, 2023, and Employee #1 placed her hand on Resident A's face, near her nose, to lift and tip her head back. Judy Reed stated some direct care staff working stated Employee #1 was pinching Resident A's nose while other direct care staff stated Employee #1's hand was next to her nose. Judy Reed stated that they take Resident A's situation very seriously, as it is very important that she takes her medications. If she does not receive her medications, she could stop breathing. Judy Reed states that she did not think that Employee #1 would intentionally hurt Resident A. Judy Reed stated direct care staff were stressed about her not getting the medication, and they wanted to ensure she received it to prevent her from having a seizure. Since this incident, Resident A's doctor changed Resident A's medications to liquid form and extended the administration time frames.

I inquired about Employee #2 and Judy Reed informed me that she quit on the day of the incident. According to Judy Reed, Employee #2 was a good worker. She also provided me with some history regarding staff conflicts.

According to Judy Reed and Cory Evans, on January 5, 2024, ORR completed a special training with staff, which included teaching direct care staff not to put their hand on a resident's face to administer medications. Judy Reed provided me with a copy of the training information and staff sign-in sheet. The special training also included information regarding the steps to be followed when administering medications and the steps to be followed when a resident refuses medication. It also documented that residents have a right to refuse medications.

Judy Reed informed me that Employee #1 was suspended for five days without pay. While in the facility, I reviewed Resident A's file and the *AFC Assessment Plan*. Judy Reed also provided me with copies of the *PCP Meeting and Treatment Plan*, and *Medication Logs*, for Resident A.

I also made face to face contact with Resident A. I observed her in the kitchen, sitting in her wheelchair. I spoke to her, and she started to shake her head "No." She then pointed towards the door which ended the interview.

On March 1, 2024, I interviewed Employee #2. Employee #2 informed me that on the day in question, she, Employee #3, and Employee #4 were the workers on duty. Employee #3 and Employee #4 were passing medications and they informed Employee #2 that Resident A would not take her medications as she had spit out the medication mixed in apple sauce. Employee #2 stated they asked her to try and get her to take her medications. Employee #2 stated that she went and spoke to Resident A, telling her it was good for her to take her medications and that she would feel better. Employee #2 was able to get Resident A to take a spoonful of the medication with apple sauce.

According to Employee #2, Employee #3 then realized that Employee #1 was in the home, as she had stopped by to check on another resident, and they called her

over. Employee #2 stated that Resident A was in her wheelchair, and she was sitting next to her. Employee #2 stated she did not recall if Employee #1 grabbed the cup from her or if she gave it to her, but Employee #1 then had the medication. Employee #2 informed Employee #1 that Resident A already had medication in her mouth. According to Employee #2, Employee #1 pulled Resident A's wheelchair towards her, then plugged Resident A's nose. Employee #2 stated that she said to Employee #1, "Nope, we're not doing that." According to Employee #2, Employee #1 then told Employee #2 that if she did not like it to "'Get the hell out of here!'" Employee #2 stated that she repeated that "we're still not going to do that," and Employee #1 told her to "Call Rights." Employee #2 later assisted and put Resident A to bed. Employee #2 stated she has worked in the medical field a long time, and she did not know why someone would ever think it was okay to block an individual's airway.

On March 1, 2024, I interviewed Employee #1 who reported she went to the facility on December 23, 2023, and Employee #3 and Employee #4 were in the dining room trying to give Resident A her medication. Employee #1 stated they were talking to Resident A trying to talk her into taking her medication. Employee #1 stated Resident A had already spit out some her medication and she had less than half of the apple sauce with medications left in the cup. Employee #1 stated that Resident A was prompted to take her medication; she is non-verbal but made the sound of "No." Employee #1 stated Resident A was in her wheelchair, she was facing Resident A, on the left side. She got on her level and then prompted Resident A to tip her head back and swallow the apple sauce and medications that were already in her mouth. According to Employee #1, Resident A finally swallowed the medication, and she was prompted to finish the rest, which was a "small bite." Resident A refused and Employee #1 told the staff to document that she did not get all her medications, but she swallowed the medications that were in her mouth.

Employee #1 denied plugging Resident A's nose. She stated that she touched the brim of Resident A's nose with her index finger, to tip her head back, so that she would not drool the medication that was already in her mouth and the saliva that she was producing.

On this same date, I spoke with Employee #1 again, as I had some follow up questions. She informed me that Employee #2 was in the home, however, she was not the one passing the medications. Employee #1 stated that Employee #2 was sitting at the dining room table. Employee #1 stated that Employee #2 never said to her "Nope, we're not doing that." Employee #1 stated that Employee #2 said she was not supposed to be giving meds. Employee #1 stated this was because she was not on shift. Employee #1 stated that Resident A picks and chooses who she wants to administer her medications. Employee #1 stated that prior to assisting, she asked Employee #3 and Employee #4 if they wanted her to help and they said "yes," if she could get Resident A to take her medications.

I asked Employee #1 if she told Employee #2 to "'Get the hell out of here,'" and she stated she never said that. In addition, Employee #1 stated why she would say that when Employee #2 was scheduled to work. Employee #1 stated that she was at the home for another reason. Employee #1 also stated that she did not tell Employee #2 to call Recipient Rights. Employee #1 stated that she told Employee #2 they could call On-Call, which is upper management staff, that is covered on a rotational basis.

On March 4, 2024, I spoke to Judy Reed and inquired about which staff said that Employee #1 was observed squeezing Resident A's nose, and she stated it was the two staff that quit, Employee #2 and Employee #3.

I inquired why Employee #1 was suspended and Judy Reed informed me that it was while the allegations were being investigated. Additionally, that ORR provided additional medication training. According to Judy Reed, since this issue, Resident A's doctor prescribed most of Resident A's medications to be in liquid forms. The doctor also expanded the timeframes and windows that staff could administer the medication, as staff were really concerned that when Resident A has a seizure, she stops breathing. According to Judy Reed, Resident A is doing much better, and there have been less medication refusals.

On March 4, 2024, I made face to face contact with Aubrey Lee from APS. He stated that staff were concerned that Resident A might not get her medications and the serious consequences of missing her medication. Additionally, that ORR provided staff with additional training. He stated that his investigation was still pending and does not plan to substantiate the allegations; however, he will let me know if anything changes.

On March 4, 2024, I spoke with Kristen Wright to conduct the preliminary exit conference. We discussed the investigation and my recommendations. Kristen Wright stated that because of this incident, Employee #1 was suspended for seven days, she was written up, and she must meet with Judy Reed weekly. Kristen Wright informed me that ORR substantiated the allegations for unreasonable force. Kristen Wright stated that staff are supposed to coach and verbally prompt Resident A to take her medication, or move her to a different location, with less stimuli, and prompt her to take the medication within the allotted time frames. Kristen Wright stated that she recently completed the written corrective action plan that was due to ORR. Kristen Wright provided me with a copy of the related documents. I informed her that I would review the information and follow-up with her.

On March 4, 2024, I attempted to contact Employee #4 without success.

I also reviewed the ORR investigative findings report and the following was noted:

> LaShanda Walker, ORR Specialist reviewed the written statement, dated December 26, 2023, which was authored by Employee #4. It was noted that Employee #3 crushed Resident A's medication and placed it into applesauce.

Employee #4 reported that Resident A had the medication in her mouth but refused to swallow them. Resident A spit the medication out on to the floor, and there was no way to tell how much medication Resident A had received. Employee #4 reported that Employee #3 was trying to get Resident A to take the rest of her medication. Employee #1 walked into the room. Employee #4 reported that Employee #1 took the remainder of the applesauce and medication mixture, and when Resident A refused to take them, Employee #1 pinched Resident A's nose and tried to get her to swallow the rest. Employee #4 reported that Employee #2 asked Employee #1 not to do that, and Employee #1 reported that is how they get Resident A to take medication in the morning. Employee #2 repeatedly asked Employee #1 to stop and Employee #1 told her if she felt that way, she could leave work.

LaShanda Walker, ORR Specialist also reviewed the written statement, dated December 26, 2023, which was authored by Employee #3. It was noted that Employee #1, who was off duty, was in the home while Employee #3 and Employee #4 were attempting to pass Resident A her medications. Employee #3 reported that Resident A spit out some of the medications and she still had some of the medications in her mouth. That is when Employee #1 plugged Resident A's nose to try to get her to swallow the medication. The staff argued and then went their separate ways.

LaShanda Walker, ORR Specialist interviewed Employee #2 and documented the following in her report: Employee #2 reported that Employee #2 and Employee #3 were trying to give Resident A her medications. Resident A was refusing the medication. According to Employee #2, Employee #3 said to her "Come get your girl." Employee #3 was referring to Resident A. Employee #2 reported that Employee #1 came to the home and took the mediation of with Employee #3's hand and plugged her nose, to get her to swallow the medication in her mouth. Employee #2 reported that she told Employee #1 "No, no, no, we're not going to do that." Employee #2 reported that Employee #1 told her, "Don't like it, get out of here and call Rights." Employee #2 informed ORR that Resident A refused the rest of the mediation and Employee #1 stopped, and eventually left the home.

LaShanda Walker, ORR Specialist interviewed Employee #1 and documented the following in her report: Employee #1 stopped by the home while medications were being passed and she was asked to speak with Resident A. Employee #1 reported that she tried to verbally reason with Resident A and Resident A continued to put her head down. Employee #1 reported to LaShanda Walker that she lifted Resident A's head by putting her finger on the bridge of Resident A's nose. This was so she would not choke on the medication that was already in her mouth. Employee #1 reported that Resident A did not take the remainder of the medication, so she told Employee #3 to document that the medication was refused. Employee #1 reported that she is left-handed and thinks the way she

was angled might have appeared as though she plugged Resident A's nose, but she did not.

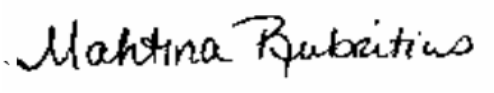
According to the ORR report, the allegations were substantiated for Abuse Class II – Unreasonable Force.

On March 5, 2024, I conducted the exit conference with Kristen Wright, Licensee Designee. We discussed the findings and my recommendations. She agreed to submit a written corrective action plan to address the established violation.

APPLICABLE RULE	
R 400.15305	**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:	During this investigation, it was reported Resident A has a history of refusing her medications, so direct care staff will prompt her to take her medications, as she may have a grand mal seizure and stop breathing if she doesn't receive her prescribed medications. According to Employee #2, Employee #1 pulled Resident A's plugged Resident A's nose while administering medication on December 23, 2023. Employee #1 denied plugging Resident A's nose. She stated that she touched the brim of Resident A's nose with her index finger, to tip her head back, so that she would not drool the medication that was already in her mouth and the saliva that she was producing. Multiple written statements listed in the ORR Report along with Employee #2's statement documented what they observed, which was that Employee #1 plugged Resident A's nose while attempting to administer her medications. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence that Resident A was not treated with dignity and her personal needs, including protection and safety, were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.



03/05/2024

Mahtina Rubritius Date
Licensing Consultant

Approved By:

03/05/2024

Dawn N. Timm Date
Area Manager