GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 23, 2024

DamBriell McClendon
Howells Adult Foster Care Inc
P.O. Box 14622
Saginaw, MI 48601

RE: License #:	AM730014896
Investigation #:	2024A1039042
	Howell's Group Home

Dear DamBriell McClendon:

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 do so can 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) 643-7960.

Sincerely,

Martin Gonzales, 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 #:	AM730014896
Investigation #:	2024A1039042
Complaint Receipt Date:	07/03/2024
Investigation Initiation Date:	07/03/2024
Report Due Date:	09/01/2024
Licensee Name:	Howells Adult Foster Care Inc
Licensee Address:	506 S 29th Street Saginaw, MI 48601
Licensee Telephone #:	(989) 270-1852
Administrator:	Valerie Woods
Licensee Designee:	Dambriell McClendon
Name of Facility:	Howell's Group Home
Facility Address:	3106 Walters Dr. Saginaw, MI 48601
Facility Telephone #:	(989) 270-1852
Original Issuance Date:	04/01/1993
License Status:	REGULAR
Effective Date:	12/18/2022
Expiration Date:	12/17/2024
Capacity:	11
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was observed with a red and swollen arm. It was discovered that Resident A had a fractured bone.	Yes

III. METHODOLOGY

07/03/2024	Special Investigation Intake 2024A1039042
07/03/2024	Special Investigation Initiated - Telephone contacted referral source.
07/03/2024	Contact - Telephone call made Phone interview with Guardian A1.
07/09/2024	APS Referral completed and sent via email.
07/11/2024	Contact - Document Sent Email to APS worker Erica Partlow regarding the complaint.
07/26/2024	Inspection Completed On-site Completed onsite investigation with Beacon Harbor DCW. Resident A was at PACE in Saginaw.
07/26/2024	Contact - Face to Face Completed interviews at PACE with Quality Improvement Officer Ashley Hurley and Resident A.
07/26/2024	Contact - Telephone call made Attempted phone call with Dambriell McClendon. No Answer.
07/29/2024	Contact - Face to Face Completed interview with Administrator Valerie Woods.
08/07/2024	Contact - Document Received Email from APS worker Erica Partlow regarding the complaint.
08/12/2024	Contact - Telephone call made Attempted phone call with Dambrell McClendon. No answer.

08/14/2024	Contact - Telephone call made Completed phone interview with Dambrell McClendon.
08/16/2024	Exit Conference Completed with LD and Administrator.
08/16/2024	Inspection Completed-BCAL Sub. Compliance
08/16/2024	Corrective Action Plan Requested and Due on 08/31/2024

ALLEGATION:

Resident A was observed with a red and swollen arm. It was discovered that the Resident A had a fractured bone.

INVESTIGATION:

On 07/03/2024, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that Resident A was observed with a red and swollen arm. It was discovered that Resident A's arm was broken.

On 07/03/2024, I completed a phone interview with Resident A's guardian, Guardian A1, concerning the allegations regarding Resident A. Guardian A1 stated that on 06/07/2024, she received a call from PACE (Program of All-inclusive Care for the Elderly) informing her that Resident A was complaining of arm pain. Guardian A1 stated that PACE informed her that they contacted Howell's Group Home to see if they had any more information as to why Resident A's arm was hurting. Guardian A1 stated that Howell's Group Home stated that they thought that something happened to Resident A while he was at PACE. Guardian A1 stated that PACE took Resident A to Covenant Hospital and it was determined that Resident A had a left wrist fracture.

Guardian A1 stated that Resident A was staying at Howell's Group Home for a respite as she was out of town. Guardian A1 stated that Resident A did not go back to the Howell's Group Home and was moved to Beacon Harbor Assisted Living in Pinconning, MI. Guardian A1 stated that Resident A was only at the home for approximately a week from 05/31/2024 to 06/07/2024.

On 07/26/2024, I completed an unannounced onsite investigation at Beacon Harbor Assisted Living concerning the allegations regarding Resident A. I interviewed Direct Care Worker Lorraine Strobel. I attempted to interview Resident A at Beacon Harbor Assisted Living, but he was present at the time of my interview. I was informed that Resident A was at PACE in Saginaw for the day for his normal day programming.

On 07/26/2024, I completed an interview with Direct Care Worker (DCW) Lorraine Strobel concerning the allegations regarding Resident A. DCW Strobel was not familiar with the allegations concerning Resident A but was aware that he had a fractured wrist and that he had some issues at his previous home. DCW Strobel stated that Resident A was not currently at the home because he was at his day program at PACE in Saginaw, MI. DCW Strobel stated that Resident A is blind and has reported issues falling if he stands up alone without staff assistance. DCW Strobel stated that Resident A has not had any issues falling at their home since he has been there. DCW Strobel stated that Resident A does have issues with verbal aggression if he does not receive immediate help when he calls out for assistance. DCW Strobel stated that Resident A has not had any issues at night getting out of bed or falling out of bed and that if he needs help, he can ask for staff assistance.

On 07/26/2024, I completed an unannounced onsite investigation at PACE (Program of All-inclusive Care for the Elderly) concerning the allegations regarding Resident A. I interviewed the following people: Quality Improvement Officer Ashley Hurley and Resident A.

On 07/26/2024, I interviewed Quality Improvement Officer (QIO) Ashley Hurley concerning the allegations regarding Resident A. QIO Hurley stated that she was aware of the allegations and believed that Resident A had fallen at Howell's Group Home the previous day and it was not properly addressed by the staff. QIO Hurley stated that Howell's Group Home was contracted with PACE and that they arranged the respite for Resident A at Howell's Group Home. QIO Hurley stated that on the morning of 06/07/2024, Resident A was having some issues with his arm and was having problems feeding himself and that he had pain using his arm. QIO Hurley stated that Guardian A1 was notified of Resident A's issues and that he was going to be evaluated at Covenant Hospital in Saginaw. QIO Hurley stated that Resident A had stated that he called for help, but no one came so he got up and fell in front of the bathroom. Resident A stated that a staff member helped him on the toilet and back into bed. QIO Hurley stated that Howell's Group Home was contacted, and they sent over and Incident Report, but that the information in the Incident Report is not accurate as it notes that Guardian A1 was notified and she came to the home and checked out Resident A. QIO Hurley stated that Guardian A1 was in the upper peninsula at the time of the incident and that she did not go to the home as she had spoken to her previously about Resident A's injury and taking him to Covenant Hospital. QIO Hurley stated that Resident A did not go back to Howell's Group Home and was moved into another home after the incident occurred. She stated that she also contacted Howell's Group Administrator after the incident occurred and informed them that the Incident Report had incorrect information on it and that the incident was not handled properly and that neither PACE or the guardian were notified when it occurred. QIO Hurley stated that the Howell's Group Administrator stated that she would was very upset with her staffing team's handling of the incident and that she would be doing staff education on resident falls and also what must be reported in a timely manner.

QIO Hurley provided discharge paperwork from Covenant Hospital dated 06/07/2024. The discharge paperwork showed that Resident A had triquetral avulsion fragments in the left wrist. Resident A required a splint for his left wrist.

QIO Hurley provided an Incident Report dated 06/03/2024. The report was completed by Licensee Designee (LD) Dambriell McClendon. The Incident Report states that Resident A fell at PACE earlier in the day and that Guardian A1 was contacted and she came to see Resident A at Howell's Group Home. The Incident Report states that Resident A never fell at Howell's Group Home.

QIO Hurley provided a care plan that was developed on 01/31/2024. The care plan notes that Resident A is independent with no assistive devices but requires supervision and contact. The care plan notes that Resident A requires moderate assistance to use the toilet.

On 07/26/2024, I completed an interview with Resident A at PACE in Saginaw, MI, concerning the allegations. Resident A was neat and clean and was able to communicate. Resident A was in a wheelchair when I interviewed him, we were located in a conference room. Resident A is diagnosed with the following: Type II diabetes with diabetic cataract, Parkinson's disease with behavior and hallucinations and Undiagnosed developmental disability. Resident A is legally blind due to the Type II diabetes with diabetic cataracts. Resident A stated that he was familiar with the allegations and that he remembers the incident. Resident A stated that he was new to Howell's Group Home and was not familiar with his surroundings and got up at night to use the bathroom and fell. Resident A stated that he yelled for staff, and they didn't come right away so he got up and tried to make it to the bathroom on his own. Resident A stated that a staff member came and helped him use the bathroom and assisted him back into bed. Resident A stated that the staff did not call a doctor or anything, they just helped him back into bed and he went back to sleep. Resident A stated that when he went to PACE the next day, they took him to Covenant Hospital to get checked out and he didn't go back to Howell's Group Home after he fell. Resident A stated that he likes his new home and has not had any issues with staff or falling since he has been there.

On 07/29/2024, I completed an unannounced onsite investigation at Howell's Group Home concerning the allegations regarding Resident A. I interviewed Administrator Valerie Woods regarding the allegations. Administrator Woods stated that she was not here when it happened and has not been at the home since 06/07/2024. Administrator Woods stated that she knows that Resident A went to Covenant Hospital and moved into a new AFC home. Administrator Woods stated that she believes that Resident A tried to get up and walk to the bathroom himself and fell. Administrator Woods stated that she never witnessed Resident A fall while he was at the home, but they had to pay close attention to him because he was very impatient and did not wait for staff to help him. Administrator Woods stated that her staff have not had any issues sleeping at night and if Resident A asked for help, then they would have come and helped him use the bathroom. Administrator Woods stated that LD Dambriell McClendon completed the Incident Report but that he is no longer working at the home. Administrator Woods

stated that LD McClendon is her son and left to take a job at General Motors in Houston, Texas.

Administrator Woods provided a Health Appraisal, Face Sheet and Incident Report dated 06/03/2024. Administrator Woods stated that an assessment plan was not completed for Resident A as he had only been in the home approximately a week and they have 30 days to complete one.

On 08/14/2024, I completed a phone interview with LD Dambriell McClendon concerning the allegations regarding Resident A. LD McClendon stated that he doesn't remember too much from that time except that he thinks that Resident A got up on the middle of the night and fell and got back up into bed. LD McClendon stated that no one knew he got up from his bed. LD McClendon stated that Resident A left shortly after that and did not come back to Howell's Group Home.

I asked LD McClendon about the Incident Report that was dated 06/03/2024 that he completed. I informed him that there were some inconsistencies in the Incident Report and what he told me, and he said he doesn't remember or know why it's different than what he told me. LD McClendon stated that he doesn't remember any further details.

On 08/16/2024, I completed an exit interview with the Licensee Designee Dambriell McClendon and Administrator Valerie Woods. I informed them of the findings of my investigation. The LD and administrator did not have any additional questions regarding the rule violation. Administrator Woods stated that she understood why there was a rule violation.

APPLICABLE RULE	
R 400.14305	**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:	It is alleged Resident A was observed with red and swollen arm. It was discovered that the resident's wrist was broken. I completed interviews with the licensee designee, administrator, PACE quality improvement officer, Adult Protective Services Worker, Guardian A1, Beacon Harbor Direct Care Worker and Resident A. Upon completion of my investigation, it was determined that there was enough evidence to conclude that there was a preponderance of evidence that R 400.14305 (3) was violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

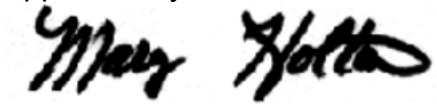
IV. RECOMMENDATION

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

08/22/2024

Martin Gonzales Licensing Consultant	Date

Approved By:



08/23/2024

Mary E. Holton Area Manager	Date