GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 18, 2024

James Kubicek
Rose Hill Center Inc
5130 Rose Hill Blvd
Holly, MI 48442

RE: License #: AM630009319
Investigation #: 2024A0611022
Malta House

Dear Mr. Kubicek:

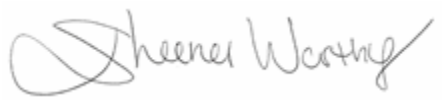
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Sheena Worthy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM630009319
Investigation #:	2024A0611022
Complaint Receipt Date:	08/22/2024
Investigation Initiation Date:	08/23/2024
Report Due Date:	10/21/2024
License Name:	Rose Hill Center Inc
Licensee Address:	5130 Rose Hill Blvd Holly, MI 48442
Licensee Telephone #:	(248) 634-5530
Administrator:	James Kubicek
Licensee Designee:	James Kubicek
Name of Facility:	Malta House
Facility Address:	5161 Rose Hill Boulevard Holly, MI 48442
Facility Telephone #:	(248) 634-5530
Original Issuance Date:	05/11/1992
License Status:	REGULAR
Effective Date:	06/13/2023
Expiration Date:	06/12/2025
Capacity:	12
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was found unresponsive on 8/17/2024. Resident A passed on 8/18/2024.	Yes

III. METHODOLOGY

08/22/2024	Special Investigation Intake 2024A0611022
08/23/2024	Special Investigation Initiated - Telephone I left a voice message for the reporting source requesting a call back.
08/23/2024	Contact - Telephone call received I received a return phone call from the Clinical Director Kelly Waite. The allegations were discussed.
08/23/2024	Contact - Document Received I received the requested documents for Resident S from the Clinical Director Kelly Waite.
08/27/2024	Contact - Telephone call made I left a voice message for the reporting source requesting a call back.
08/27/2024	Contact - Telephone call made I left a voice message for staff member Jill Ingles requesting a call back.
08/27/2024	Contact - Telephone call made I left a voice message for staff member Rilea Kraft requesting a call back.
08/27/2024	Contact - Telephone call made I attempted to contact staff member Jessica Cuz however; there was no answer. There was not an option to leave a message.
08/27/2024	Contact - Telephone call made I made a telephone call to staff member Rilea Kraft. The allegations were discussed.

08/27/2024	Contact - Telephone call received I received a telephone call from recipient rights specialist Avery Barnett from Detroit Wayne Integrated Health Network. The allegations were discussed.
08/27/2024	Contact - Telephone call received I received a return phone call from staff member, Jill Ingles. The allegations were discussed.
08/27/2024	Contact - Telephone call made I left a voice message for staff member Ashlee Wellman requesting a call back.
08/27/2024	Contact - Telephone call made I made a telephone call to Resident S guardian. The allegations were discussed.
08/27/2024	Contact - Telephone call received I received a return phone call from staff member Ashlee Wellman. The allegations were discussed.
08/30/2024	APS Referral An Adult Protective Services (APS) referral was made.
09/05/2024	Exit Conference I attempted to complete an exit conference via telephone with the licensee designee Jim Kubicek however; there was no answer. Therefore, I completed an exit conference via email with Mr. Kubicek.
09/10/2024	Inspection Completed On-site I completed an unannounced onsite. I spoke with Kelly Waite and Jim Kubicek. I attempted to interview Resident K however; she is currently in the hospital. I interviewed Resident D and Resident P. I observed the dining area, the menu, and the area where the incident took place.

ALLEGATION:

Resident A was found unresponsive on 8/17/2024. Resident A passed on 8/18/2024.

INVESTIGATION:

On 08/22/24, an intake was received and assigned for investigation alleging that Resident S was found unresponsive on 8/17/24 in the bathroom by staff and was given CPR. Resident S was transported to the hospital with a pulse and later placed on a ventilator. Staff was contacted at 9:42am on 8/18/24 by the hospital to let them know that Resident S passed away. Resident S did not have any restrictions in place. According to the medical examiner, Resident S passed away due to choking.

On 08/23/24, I received a returned phone call from the Clinical Director, Kelly Waite. Regarding the allegations, Ms. Waite stated she was not present at the AFC group home during the incident on 08/17/24. Ms. Waite confirmed that Resident S passed away at the hospital on 08/18/24. Ms. Waite stated on Monday (08/19/24) she notified the assigned licensing consultant about the incident and; she provided the death notification to Detroit Wayne Integrated Health Network (DWIHN). The house coordinator Rilea Kraft, completed the incident report and Ms. Waite signed the incident report.

Ms. Waite stated on 08/17/24, Resident S was eating dinner when he stood up and told staff member Jill Ingles he needed to use the bathroom. Ms. Ingles told Resident S to make sure he didn't have any food in his mouth before he went to the bathroom. Resident S responded by saying "he knows". Ms. Ingles was not aware that Resident S had any food in his mouth when he went to the bathroom. While Resident S was in the bathroom, Ms. Ingles noticed that Resident S was on the floor in the bathroom. Ms. Ingles contacted Ms. Kraft and staff member Jessica Cuz for assistance. Prior to going to the bathroom, Resident S was eating a sandwich with salmi and cheese in it. Resident S was eating a sandwich as a substitution option because he did not want to eat what was being served on the menu. Ms. Waite stated Resident S did not have any swallow protocol or food restrictions. Resident S was admitted into the AFC group home in November 2002. Ms. Waite is unaware if Resident S has ever had any choking issues before.

Ms. Waite agreed to provide copies of Resident S assessment plan/IPOS, incident report, menu, and the medical examiner's report. Ms. Waite stated the medical examiner's report stated Resident S passed away from choking.

On 08/23/24, I received a copy an incident report signed on 08/19/24, a medical examiner's report, assessment plan, IPOS, and menu. According to the incident report, soon after 6:00pm, Ms. Kraft and Ms. Cuz responded to a call from Ms. Ingles for additional help at the AFC group home. After arriving, Resident S was observed on the bathroom floor with his legs blocking the door. Resident S was cyanotic and unresponsive. Resident S had a large piece of cheese in his mouth. Resident S was moved into the hallway so CPR could be started. At approximately 6:05pm, EMS was called, and they arrived around 6:20pm and performed CPR. Resident S was transported to Genesys hospital at 7:10pm.

According to the medical examiner's report, the medical examiner was John Bechinski. The medical exam indicates that Resident S choked on food and subsequently became unresponsive. A food bolus was dislodged by staff at Genesys ED via suction. Law enforcement was not involved. The means of death is indicated as other. Resident S was pronounced dead on 08/18/24.

The assessment plan dated 05/21/24, does not indicate any food restrictions for Resident S. The IPOS dated 03/17/24, indicates that Resident S wants to cut back on eating cheese, and he will continue to watch what he is eating "especially cheese". The IPOS also states Resident S should be encouraged to eat slowly, chewing each bite completely and to not overfill his mouth which has led to choking in the past. Resident S has a history of drinking soap and cleaning products. Resident S also has a history of swallowing coins so he can go to the hospital for a rest.

According to the menu, on 08/17/24, the residents were served chicken enchilada refried beans, mixed vegetables, dinner salad, fruit and a beverage for dinner. There was no substitution listed on the menu. On 08/23/24, Ms. Waite clarified that the menu's do not indicate the substation options but, there is a sign that hangs up in the dining area providing the alternative food options. Ms. Waite provided a copy of this sign. According to the sign, the alternative menu options are: peanut butter and jelly sandwich or deli cut sandwich (turkey, ham, and salami). The sign indicates that these options are always available upon request as an alternative to the menu.

On 08/27/24, I made a telephone call to the house coordinator Rilea Kraft. Regarding the allegations, Ms. Kraft stated on the day in question, she was contacted by Ms. Ingles when she discovered Resident S on the bathroom floor. Ms. Kraft was next door at the Kelly Center when Ms. Ingles requested assistance. Ms. Cuz was also present at the Kelly Center and she and Ms. Kraft went over to the AFC group home together to assist Ms. Ingles. Staff member Ashlee Wellman was also at the Kelly Center and; Ms. Kraft asked her to assist as well. Ms. Kraft stated Resident S was on the bathroom floor and his feet were against the door. Ms. Kraft and Ms. Wellman had to bend Resident S knees in order to open the bathroom door. Ms. Kraft gave Ms. Cuz her cell phone to call 911. Resident S was moved into the hallway and Ms. Kraft and Ms. Cuz started chest compressions on Resident S. Ms. Wellman was standing near the side entrance next to Resident S bedroom, waiting for EMS to arrive. Ms. Ingles was instructed to keep the other residents in the home from coming down the hallway where Resident S was located.

Ms. Kraft stated before they started chest compressions, she saw a tiny bit of cheese in Resident S teeth and it was taken out. Ms. Kraft stated while performing chest compressions, another small amount of cheese came out. Ms. Kraft stated while performing chest compressions, it took about 15 minutes for EMS to arrive. While EMS was performing chest compressions on Resident S, they were able to get a pulse. Ms. Kraft thinks EMS was able to remove more cheese from Resident S mouth. Ms. Kraft

stated EMS was at the AFC group home for about 45 minutes before they transported Resident S to the hospital.

Ms. Kraft stated prior to Resident S being found on the bathroom floor, Ms. Ingles brought him a sandwich from the kitchen at the Kelly Center because Resident S did not want to eat what was on the menu. Ms. Ingles and Resident S were sitting at the desk in the medication room while he was eating. Resident S told Ms. Ingles he had to go to the bathroom. Ms. Ingles told Resident S to slow down, chew and swallow his food. Resident S responded by saying he did and; then he ran to the bathroom. Ms. Ingles did not check Resident S mouth before he went to the bathroom. Ms. Ingles heard Resident S when he fell in the bathroom which was about a minute later when he entered the bathroom.

Ms. Kraft stated Ms. Ingles was the only staff in the AFC group home before Resident S went to the bathroom. Ms. Cuz was also assigned to work in the AFC group home but, she went to the Kelly Center to grab something before the incident happened. Ms. Kraft stated she thinks a total of 13 residents live in the AFC group home and maybe 10 residents were present during the incident in the TV room and/or in their bedroom.

Ms. Kraft has worked at the AFC group home for two years. During this timeframe, Ms. Kraft is aware of three other instances where Resident S has choked on food due to putting too much food in his mouth, and not chewing enough.

On 08/27/24, I received a telephone call from recipient rights specialist Avery Barnett from Detroit Wayne Integrated Health Network. Mr. Barnett stated he has not finished his investigation and he is unsure on whether or not to substantiate. Mr. Barnett stated since Resident S was able to verbalize that he needed to go to the bathroom, it makes sense for a staff member to assume he did not have any or too much food in his mouth.

On 08/27/24, I received a return phone call from staff member Jill Ingles. Regarding the allegations, Ms. Ingles stated she and Resident S were eating in the medication room when Resident S jumped up and said he had to go pee. While Resident S was walking out of the room, Ms. Ingles told him to make sure he didn't have anything in his mouth. Resident S response was ok. Ms. Ingles did not check Resident S mouth before he left the room. Ms. Ingles stated she took two bites of her food and less than five minutes later, Resident K told her Resident S had collapsed on the bathroom floor. Ms. Ingles stated she could not open the bathroom door because Resident S feet were wedged against the bathroom door. Ms. Ingles called Ms. Kraft and Ms. Cuz for assistance. Ms. Kraft and Ms. Cuz arrived to the AFC group home immediately. Ms. Cuz contacted 911. Ms. Ingles was told to keep the rest of the residents out of the area near Resident S. Ms. Ingles stated there were eleven other residents either in the TV room, or bedrooms and; one resident was smoking on the back porch.

Ms. Ingles stated she did not see anything else that happened because she was in the TV room. Ms. Ingles thinks Ms. Kraft and Ms. Cuz removed Resident S from the bathroom and started CPR. Ms. Ingles confirmed that EMS arrived to the home. Ms.

Ingles stated Resident S did not have a daily issue with eating food. Ms. Ingles stated about 2-3 years ago Resident S had to be told to slow down while he was eating because he started coughing.

On 08/27/24, I made a telephone call to Resident S guardian. Regarding the allegations, the guardian stated he was contacted by a staff member who informed him that CPR was performed on Resident S and he had a weak pulse. The guardian does not remember which staff member contacted him. The guardian stated he does intend to speak with Ms. Ingles to see what Resident S last moments were like. The guardian confirmed that Resident S has resided at the AFC group home for over 20 years. The guardian stated he has never had any concerns with the staff members pertaining to abuse or neglect.

On 08/27/24, I received a return phone call from Ashlee Wellman. Ms. Wellman stated she is an activity coordinator. Regarding the allegations, Ms. Wellman stated Ms. Kraft and Ms. Cuz were paged to go to the AFC group home. Ms. Wellman was also paged to go to the AFC group home for assistance. Ms. Cuz called 911. Ms. Wellman helped Ms. Kraft open the bathroom door. Resident S head was in the shower and his neck was resting on the small step leading inside the shower. Resident S legs were pointing towards the door. Ms. Cuz entered the bathroom and tried to remove a piece of cheese she saw in Resident S mouth. Ms. Cuz was only able to get some of the cheese out of Resident S mouth. Ms. Kraft and Ms. Wellman rolled Resident S on his side and patted his back to try to get the rest of the cheese out of his mouth but, they were unsuccessful. Ms. Kraft started chest compressions. Ms. Wellman contacted a supervisor, and she waited in the doorway for EMS to arrive. Ms. Wellman stated Resident S was known for eating quickly. Resident S was not a choking risk but, staff would have to tell him to slow down while eating.

On 09/05/24, I received a return phone call from the licensee designee Jim Kubicek. An exit conference was completed. The allegations were discussed. Mr. Kubicek was informed that it is a rule violation to not note a substitution on the original menu. Mr. Kubicek was informed that a corrective action plan will be required.

On 09/10/24, I completed an unannounced onsite. I spoke with Kelly Waite and Jim Kubicek. The status of the investigation was confirmed with Mr. Kubicek. Mr. Kubicek stated he did not need to have a second exit conference. Ms. Waite informed me that Resident K was in the hospital as she broke her shoulder from falling in the shower last week. I attempted to contact Resident K in the hospital to interview her however; there was no answer.

On 09/10/24, I interviewed Resident D. Resident D has lived in the AFC group home since May 2024. Resident D likes living in the AFC group home but, he said it’s kind of sad as this is not his home. Resident D is aware that Resident S passed away. Resident D thinks Resident S fell. Resident D stated he gave Resident S poison. Resident D then stated he didn’t give Resident S poison but, “they” poisoned him. Resident D said a drug dealer poisoned him because he was supposed to give him

money. Resident D denied ever seeing Resident S eating nor did he ever see him choke on food. Resident D stated he was present when Resident S went to the hospital. Resident D stated the staff are professionals and they make sure he has what he needs.

On 09/10/24, I interviewed Resident P. Resident P has lived at the AFC group home since March 2024. Resident P likes the staff and they treat him tremendously well. Resident P stated there is mutual respect between him and the staff. Regarding the allegations, Resident P heard Resident S fell and injured himself somehow. Resident P stated he was in the building next door when he saw Resident S being taken away by the EMS. Resident P saw Resident S eat all the time. Resident P never saw Resident S choke on his food. Resident P stated as far as he knows, Resident S did not have any issues with eating. Resident P stated Resident S ate peanut butter by itself, salami, and cheese. Resident P stated Resident S ate these foods because it helped him with his incontinence. Resident P stated the staff was aware when Resident S ate but, Resident S would hide food in his room.

On 09/10/24, I observed the dining area in the AFC group home however; the residents eat in a café in another building. I observed the menu that was displayed on a T.V. The substitution options were added to the bottom of the menu. The rule requirement pertaining to substitutions was discussed with Ms. Waite. I observed the hallway where the incident took place. The bathrooms and Resident S bedroom is located in the same hallway.

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:	Based on my investigation and the information gathered, there is not sufficient information to confirm the allegations. Resident S assessment plan dated 05/21/24, does not indicate any food restrictions. The IPOS dated 03/17/24, indicates that Resident S wants to cut back on eating cheese, and he will continue to watch what he is eating “especially cheese”. The IPOS did not indicate any food restrictions or instructions.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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:	There is no evidence to support that the staff did not ensure Resident S protection or safety. Prior to Resident S going to the bathroom, he was able to verbalize to Ms. Ingles that he had to use the bathroom. Ms. Ingles did speak with Resident S before he went to the bathroom and told him to make sure he didn't have anything in his mouth. Resident S responded back to Ms. Ingles. Therefore, it is reasonable to assume that Resident S did not have a mouth full of food when he went to the bathroom that would cause him to choke.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14313	**Resident Nutrition**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	On 08/23/24, I observed a copy of the original menu. On 08/17/24, the residents were served chicken enchilada, refried beans, mixed vegetables, dinner salad, fruit and a beverage for dinner. There was no substitution listed on the original menu indicating that Resident S ate a salami sandwich.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

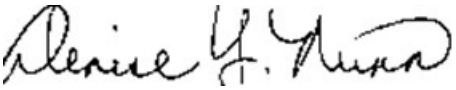
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.

09/10/24

Sheena Worthy
Licensing Consultant

Date

Approved By:



09/18/2024

Denise Y. Nunn
Area Manager

Date