



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 3, 2025

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

RE: License #: AS820014113
Investigation #: 2026A0116006
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) 456-0439.

Sincerely,

A handwritten signature in blue ink that reads "Pandrea Robinson". The signature is written in a cursive, flowing style.

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**

I. IDENTIFYING INFORMATION

License #:	AS820014113
Investigation #:	2026A0116006
Complaint Receipt Date:	11/13/2025
Investigation Initiation Date:	11/13/2025
Report Due Date:	01/12/2026
LicenseeName:	Everest Inc.
Licensee Address:	PO Box 2352 Riverview, MI 48193
Licensee Telephone #:	(734) 675-3037
Administrator:	Michelle Rupert
Licensee Designee:	Michelle Rupert, Designee
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:	06/27/2024
Expiration Date:	06/26/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 11/16/25, staff, Kristy Russell, left Resident A unattended in the bathroom. Resident A fell, had a lump on the left side of her head and swelling to the bridge of her nose. Resident A was taken to the hospital and diagnosed with a concussion. Resident A's Individual Plan of Service (IPOS) documents Resident A is not to be left alone as she requires full staff assistance when toileting.	Yes

III. METHODOLOGY

11/13/2025	Special Investigation Intake 2026A0116006
11/13/2025	Contact - Telephone call received Licensee designee, Michelle Rupert.
11/13/2025	Referral - Recipient Rights Made by home manager, Felicia Wilson.
11/13/2025	Special Investigation Initiated - Telephone Assigned rights investigator, Dominique Moore.
11/13/2025	APS Referral Made by ORR, Ms. Moore.
11/13/2025	Contact - Document Received Received and reviewed written statements from home manager, Felcia Wilson, staff Kristy Ruseell and Christina McFall and Resident A's hospital discharge summary and current IPOS.
11/18/2025	Inspection Completed-BCAL Sub. Compliance Interviewed home manager, Felicia Wilson, visually observed Residents A, C-F, Interviewed Resident B.
11/24/2025	Contact - Telephone call made Ashley Wise, Resident A's support coordinator. Left a message requesting a return call.
11/24/2025	Contact - Telephone call made Staff, Kristy Russell, left a message requesting a return call.

11/24/2025	Contact - Telephone call made Amy Torony, Public Guardian.
12/01/2025	Contact - Telephone call made Ashley Wise, Resident A's supports coordinator.
12/01/2025	Exit Conference, licensee designee, Michelle Rupert.

ALLEGATION:

On 11/16/25, staff, Kristy Russell, left Resident A unattended in the bathroom. Resident A fell, had a lump on the left side of her head and swelling to the bridge of her nose. Resident A was taken to the hospital and diagnosed with a concussion. Resident A's Individual Plan of Service (IPOS) documents Resident A is not to be left alone as she requires full staff assistance when toileting

INVESTIGATION:

On 11/13/25, I received a telephone call from license designee, Michelle Rupert. Ms. Rupert reported that staff, Kristy Russell, left Resident A alone in the bathroom while she went to get some supplies. Resident A who is visually impaired, got off the toilet, fell and hit her head/face area. Resident A was taken to the hospital and diagnosed with a concussion. Resident A was also observed to have some bruising on the bridge of her nose. Ms. Rupert reported that staff, Ms. Russell, has been employed in the home a few years and knows that Resident A's IPOS documents that she is never to be left alone. Additionally, Resident A is totally dependent on staff and requires full assistance with all activities of daily living. Ms. Rupert added that all staff are aware that none of the residents in the home are to be left alone in the bathroom. She reported that home manager, Felicia Wilson, re-in-serviced all staff on 11/07/25, on the IPOSs of all six residents, focusing on their monitoring guidelines in and out of the home. Ms. Rupert reported she would forward the written statements from all of the staff who were in the home at the time of the incident.

Ms. Rupert reported that she suspended Ms. Russell immediately on 11/06/25, without pay, pending the outcome of the APS and recipient rights investigations.

On 11/13/25, I interviewed recipient rights investigator, Dominique Moore, and she reported that she plans to go to the home next week, however, she has reviewed Resident A's IPOS and reported that it's clear that she is never to be left alone. Ms.

Moore reported that Resident A is also visually impaired and is totally dependent on staff for all of her personal care needs.

On 11/13/25, I reviewed the written statements of home manager, Felicia Wilson, staff, Kristy Russell, and Christina McFall. They were all in the home at the time of the incident. I also received and reviewed Resident A's hospital discharge summary and her current IPOS effective 09/30/25.

Felicia Wilson's written statement documents that on 11/06/25 at around 6:30 p.m. she was completing a walkthrough of the home, checking on the residents, when she heard noises coming from the back of the house. She walked around to the back bathroom and observed Resident A on the floor, in the bathroom with no staff present. Ms. Wilson documented that she yelled for staff, Kristy Russell, and Christina McFall to assist with getting Resident A off the floor and back on the toilet. Ms. Wilson documented that she observed a lump on the right side of Resident A's forehead and swelling on the bridge of her nose. Ms. Wilson instructed Ms. Russell to transport Resident A to the hospital for evaluation and treatment.

Kristy Russell's written statement documents that on 11/06/25, at 6:30 p.m. she took Resident A to the back bathroom and placed her on the toilet. While on the toilet, Ms. Russell left out of the bathroom to get supplies and Resident A fell off the toilet. Ms. Russell documented that staff, Christina McFall, assisted her with getting Resident A off the floor. Ms. Russell observed a lump on the right side of Resident A's forehead and some swelling to the bride of her nose. Ms. Russell documented that she transported Resident A to Corewell Trenton emergency room.

Christina McFall's written statement documented that on 11/06/25 at 6:30 p.m. she was in the kitchen/dining room area when she heard home manager, Felicia Wilson, yell that Resident A was on the floor in the bathroom. Ms. McFall went to the bathroom and assisted Ms. Russell with getting Resident A up and back on the toilet. Ms. McFall documented that she immediately observed a lump on the right side of Resident A's head and swelling to the bride of her nose. Ms. Russell was instructed to transport Resident A to the hospital for evaluation and treatment.

I reviewed the discharge summary from Corewell Trenton Hospital dated 11/06/25. Resident A was diagnosed with a head contusion, and concussion. Resident A had x-rays of her head, neck and spine and no fractures were found.

I also reviewed Resident A's current IPOS effective 09/30/25. The plan documents that Resident A is visually impaired and requires a high level of support for personal care, ADLs, and transfers on/off toilet. Resident A requires 24/7 care due to her inability to provide for herself. Resident A's IPOS also states that she is never left alone as she is totally dependent on staff for all of her personal care needs.

On 11/18/25, I conducted an unscheduled onsite inspection and interviewed home manager, Felicia Wilson, Resident B and visually observed Resident A, C-F. Ms.

Wilson reported that Resident A is doing well and has had two additional x-rays at the request of her guardian. Ms. Wilson reported that both were negative for fractures and the bruises on her nose are gone. Ms. Wilson reported that APS has been to the home, however she was unable to provide the name of the investigator. Ms. Wilson reported that on 11/07/25, she re-in-serviced all staff on the monitoring/supervision requirements documented in the IPOSs of all six residents.

I visually observed Resident A sitting in her wheelchair in the living room. She was neatly dressed and groomed. Resident A could not be interviewed as she is non-verbal.

I interviewed Resident B, and she reported that staff help her with showering and getting dressed. She reported that she is allowed to be in the bathroom for a little while without staff supervision. Resident B reported that she likes living in the home and the staff treat her well.

I visually observed Residents C-F they were neatly dressed and well groomed. They were unable to be interviewed as they are non-verbal.

On 11/24/25, I interviewed Amy Torony, Resident A's public guardian, and she reported that home manager, Felicia Wilson, informed her of the incident and she went to the home to see Resident A after the incident. Ms. Torony reported that Resident A has been in the home for years and has done well. She reported that she has not had any major concerns regarding the care the staff provides, but reported this incident was preventable. Ms. Torony reported that Resident A's IPOS is clear in that Resident A should not be left alone in the bathroom, as she is totally dependent on staff for all her care needs. Ms. Torony reported there is no excuse for what happened.

On 12/01/25, I interviewed Ashley Wise, Resident A's supports coordinator. Ms. Wise reported that there is no excuse or acceptable explanation for what happened as the IPOS is clear that Resident A is not to be left alone. She reported it could not be any clearer. Ms. Wise reported that Ms. Russell was neglectful in her actions, resulting in Resident A sustaining a concussion. Ms. Wise reported she is glad that Resident A did not sustain any broken or fractured bones.

On 12/01/25, I conducted the exit conference with licensee designee, Michelle Rupert, and informed her of the findings of the investigation. Ms. Rupert reported an understanding. Ms. Rupert reported that Ms. Russell remains suspended without pay and she is uncertain at this time whether she will remain employed with the company.

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	<p>Based on the findings of the investigation, there is a preponderance of evidence to substantiate the allegation. Resident A was left unattended in the bathroom, got off the toilet, fell and sustained a concussion.</p> <p>This violation is established as Resident A's IPOS documents that she is not to be left alone as she is dependent on staff for all her care needs. Staff, Kristy Russell, did not provide supervision, protection and personal care as specified in her plan.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



Pandrea Robinson
Licensing Consultant

12/02/25
Date

Approved By:



12/3/25

Ardra Hunter
Area Manager

Date