RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

October 12, 2017

Roseline Rowan
Medhealth Suppliers & Providers, Inc.
706 Britten Ave
Lansing, MI 48910

RE: License #: AS230294121
Investigation #: **2017A0466037**
Evergreen Place II

Dear Mrs. Rowan:

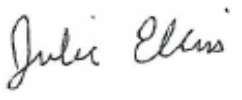
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9727.

Sincerely,



Julie Elkins, 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 #:	AS230294121
Investigation #:	2017A0466037
Complaint Receipt Date:	08/16/2017
Investigation Initiation Date:	08/17/2017
Report Due Date:	10/15/2017
Licensee Name:	Medhealth Suppliers & Providers, Inc.
Licensee Address:	706 Britten Ave Lansing, MI 48910
Licensee Telephone #:	(517) 585-6685
Administrator:	Roseline Rowan
Licensee Designee:	Roseline Rowan
Name of Facility:	Evergreen Place II
Facility Address:	4048 Windward Dr. Lansing, MI 48911
Facility Telephone #:	(517) 712-8585
Original Issuance Date:	04/28/2008
License Status:	REGULAR
Effective Date:	02/23/2017
Expiration Date:	02/22/2019
Capacity:	6
Program Type:	MENTALLY ILL DEVELOPMENTALLY DISABLED AGED/ALZHEIMERS PHYSICALLY HANDICAPPED

II. ALLEGATION(S)

	Violation Established?
On 08/11/2017, Resident A had a black eye that was covered up by concealer make-up. Staff are unaware of how the black eye happened or who may have hit Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

08/16/2017	Special Investigation Intake 2017A0466037
08/17/2017	Special Investigation Initiated – Telephone call to Complainant
08/17/2017	Contact - Document Sent email sent to APS worker.
08/25/2017	Inspection Completed On-site
08/25/2017	Inspection Completed-BCAL Sub. Compliance
09/14/2017	Contact - Telephone call made to Dawn Eccles, CMH Case Manager.
09/14/2017	Contact- telephone call to Stacey Bakken, Guardian, left message.
09/14/2017	Contact - Telephone call made Transition South DDC, Shane Simon
09/14/2017	Contact - Telephone call made to Camille Owens DCW at Evergreen II. DCW Owens interviewed.
09/19/2017	Contact - Telephone call received Dawn Eccles case manager and she was interviewed.
09/29/2017	Contact - Telephone call made interviewed Shane Simon DDS at Transition South.
09/29/2017	Contact - Document Received 05/01/2017 medical document received.
09/29/2017	Contact - Telephone call made Telephone call to Roseline Rowan.
10/02/2017	Contact- Telephone call received from APS worker Shelly Stratz.
10/06/2017	Contact- telephone call to Stacey Bakken, Guardian, left message.

10/06/2017	Contact- telephone call to Roseline Rowan to request personnel policies and procedures to review about mistreatment, neglect or abuse of residents.
10/092017	Contact- telephone call to Roseline Rowan to request personnel policies and procedures.
10/10/2017	Contact- email received from Roseline Rowan with personnel policies.
10/10/2017	Exit conference with Roseline Rowan

ALLEGATION:

On 08/11/2017, Resident A had a black eye that was covered up by concealer make-up. Staff are unaware of how the black eye happened or who may have hit Resident A.

INVESTIGATION:

On 08/16/2017, Complainant reported that on 8/10/2017, Transition South day programming staff noticed that Resident A had a faint dark ring under his right eye, making it appear as though he didn't get enough sleep. When Resident A was in the shower later that day, AFC staff noticed a pink substance running off his face, suggesting that someone attempted to conceal the fact that Resident A had a black eye**.**

On 08/25/2017, I conducted an unannounced on-site investigation with Eaton County Department of Health and Human Services (DHHS) Adult Protect Services Worker (APS) Shelly Stratz. Direct care worker (DCW) Latricia Bell was on shift when we arrived at the facility. DCW Bell reported that she is a live-in staff and that she saw Resident A before he attended day program at Transition South on 08/10/2017. DCW Bell reported that when she put Resident A on the bus to go to Transition South on 08/10/2017 Resident A did not have a black eye nor did Resident A have any make-up/cover-up or calamine lotion on his face. DCW Bell reported that Resident A returned from program at 4:30 pm on 08/10/2017 as the bus was running late. DCW Bell reported that Resident A's Community Mental Health (CMH) of Clinton, Eaton and Ingham Counties case manager Dawn Eccles and Resident A's guardian Stacey Bakken were present when Resident A got off the bus on 08/10/2017. DCW Bell reported she promptly showered Resident A as he had had a toileting accident while on the bus. DCW Bell stated that as she washed Resident A's face, a pink substance ran from his face onto the wash rag. DCW Bell stated it appeared as though Resident A had cover up or calamine lotion on his face and as this substance was washed off Resident A's face, a black eye appeared. DCW Bell reported calling for her co-worker DCW Camille Owens to see Resident A's eye. DCW Bell reported taking pictures of Resident A's eye and called licensee

designee Roseline Rowan. DCW Bell had the pictures that she took of the black eye on 08/10/2017 that she texted to me for review.

On 08/25/2017, I reviewed Resident A's resident record. The *Assessment Plan for AFC Residents* documented that:

> "*Resident A is non-verbal and deficient in safety skills and awareness of dangers, especially while rocking. Resident A lacks safety skills and awareness of environmental dangers. Staff will constantly and closely supervise, monitor and direct Resident A."*

On 08/25/2017, I observed Resident A sitting in his rocking chair in the family room smiling. When I talked to Resident A, I did not receive a response. Resident A is non-verbal and was not able to participate in the interview process.

During the unannounced on-site investigation at Evergreen Place II, I observed the facility to be organized and free of environmental hazards that could be harmful or a threat to the physical safety of the residents. I did not observe any tripping hazards or any specific areas, such as sharp corners or edges, where Resident A may have fallen and hit his face/head.

On 09/14/2017, I interviewed DCW Owens who reported that she was at the facility when Resident A came home on the bus on 08/10/2017 from Transition South along with Ms. Eccles and DCW Bell. DCW Owens reported that DCW Bell yelled for her while giving Resident A a shower and at that time DCW Owens noticed "some substance that looked like foundation or calamine lotion on [Resident A's] face." DCW Owens reported as DCW Bell continued to clean Resident A's face that was the first time she noticed that Resident A had a black eye. DCW Owens reported that DCW Bell finished Resident A's shower and then took a picture of the eye and contacted Roseline Rowan.

On 09/19/2017, I interviewed Ms. Eccles who reported being at the facility when Resident A got off the bus on 08/10/2017 and that she did not see any bruising on Resident A's face nor did she see a black eye. Ms. Eccles reported not staying long after Resident A arrived due to him having an accident on the bus and needing a shower. Ms. Eccles reported Ms. Rowan notifying her of the black eye and that the staff reported some sort of concealer over the bruising. Ms. Eccles has no idea what the substance was that was on Resident A's face or how it got on Resident A's face. Ms. Eccles stated she does not have any concerns the care provided to Resident A by staff members at the facility.

On 09/29/2017, I interviewed Shane Simon, Developmental Disability Clinician (DDS) at Transition South who has been working with Resident A for 3 ½ years. Mr. Simon reported that on 08/10/2017, at lunch time a staff member sat with Resident A due to dysphagia diet and chocking risk. Mr. Simon reported that staff noticed a faint blank ring under Resident A's eye which they assumed was from Resident A not sleeping well or being tired and disregarded the marks. Mr. Simon reported later

receiving a telephone call from Ms. Rowan to report that after Resident A returned home it appeared as though Resident A had some sort of make up or calamine lotion on his face to cover up the bruising as it appeared after the substance was washed off in the shower. Mr. Simon reported having a good working relationship with the facility and not having any concerns with the staff. Mr. Simon reported that the facility has been responsive when residents have needed things and they have willingly brought forgotten items over. Mr. Simon reported that there were no progress notes or incident reports to review as nothing was documented about this incident at transition south. Mr. Simon has no knowledge of what substance was on Resident A's face nor how it go there.

On 09/29/2017, I interviewed Ms. Rowan who reported that she was contacted by DCW Bell on 08/10/2017 when the black eye was discovered and pictures of the eye were texted to her. Ms. Rowan reported that both DCW Bell and DCW Owens wrote statements about the sequence of events that occurred on 08/10/2017 and she emailed me those documents for review. Ms. Rowan reported calling Mr. Simon and the bus driver as soon as she learned of the bruise. Ms. Rowan reported talking to Mr. Simon who told her that at lunch Resident A was observed to have a faint mark by his eye but that no note was sent home about it nor was a progress note completed. Ms. Rowan has no idea how the black eye occurred. Ms. Rowan did state that Resident A does rock a lot and hard and that he is not aware of his surroundings when he is rocking. Ms. Rowan reported that they recently moved his bedroom so that Resident A would have a bed where the mattress was more securely attached to the frame to assure his safety while he is rocking and that when she is transporting him in the car, he tries to rock and she is afraid that his head is going to his the dash board of the car. Ms. Rowan reported that the bus driver did not notice bruising on Resident A's eye on 08/10/2017. Ms. Rowan does not know what substance was on Resident A's or how it got there.

On 10/02/2017, I received a call from APS worker Ms. Stratz who reported that her investigation could not determine how Resident A got a black eye nor how it was concealed or who concealed the black eye.

On 09/14/2017 and on 10/06/2017 I contacted Stacy Bakken, guardian to Resident A. I left a message and have not heard back from Ms. Bakken.

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:	On 08/10/2017, Resident A had a black eye that was observed by DCW Bell and DCW Owens; however neither staff member reported having any knowledge of how Resident A's eye was injured. Also, both DCWs Bell and Owens observed a pinkish colored, concealer type of substance streaming from Resident A's eye after washing his face upon his return from day program on 08/10/2017. This was the same eye that was bruised. Resident A is non-verbal and was not able to provide any information about what happened to his eye. I also observed the facility to be organized and free of any tripping or safety hazards that could have been harmful to Resident A. Lastly, APS did not have sufficient evidence that the facility staff members purposefully caused Resident A's black eye and then tried to conceal the injury with make-up. Consequently, there is not enough evidence that Resident A's protection and safety needs were not attended to at all times by facility staff members.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 08/25/2017, while walking through the facility I noticed the door to Resident A's bedroom door had a large hole in it that had been covered up by a sheet of paper that had Resident A's name on it. The damage to the door consisted of four round smaller holes and then several layers of the door missing which led to larger hole through the door. I also noticed Resident A's bedroom door had a metal device attached to the molding of the door that had a hole in it that would typically be used for a pad lock. DCW Bell removed that metal device. Further, while trying to close Resident A's bedroom door, I observed that the door did not latch in the closed position and therefore did not stay closed for privacy.

On 10/03/2017, I received a fax from Ms. Rowan verifying that Resident A's bedroom door had been repaired and a new non-locking against egress door knob was installed.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	Resident A's bedroom door has not been properly maintained as it has layers of the door missing and holes in it that were attempted to be covered up by a sign that had the resident's name on it.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(4) Interior doorways of bedrooms that are occupied by residents shall be equipped with a side-hinged, permanently mounted door that is equipped with positive-latching, non-locking-against-egress hardware.
ANALYSIS:	Resident A's bedroom door was damaged and therefore did not positively latch to allow Resident A privacy as desired.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/12/2017

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Julie Elkins Date
Licensing Consultant

Approved By:

10/12/2017

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Dawn N. Timm Date
Area Manager