GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 4, 2022

Ryan Boutell
Rose Adult Foster Care, LLC
4904 Onsikamme St
Montague, MI 49437

RE: License #: AM640397153
Investigation #: 2022A0340021
Rose Care LLC

Dear Mr. Boutell:

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 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 (616) 356-0183.

Sincerely,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM6403971534904 Onsikamme St Montague, MI 49437
Investigation #:	2022A0340021
Complaint Receipt Date:	03/16/2022
Investigation Initiation Date:	03/16/2022
Report Due Date:	05/15/2022
Licensee Name:	Rose Adult Foster Care, LLC
Licensee Address:	4904 Onsikamme St., Montague, MI 49437
Licensee Telephone #:	(231) 670-9475
Administrator:	Ryan Boutell
Licensee Designee:	Ryan Boutell
Name of Facility:	Rose Care LLC
Facility Address:	1318 S Oceana Dr., Shelby, MI 49455
Facility Telephone #:	(231) 670-9475
Original Issuance Date:	02/25/2019
License Status:	REGULAR
Effective Date:	08/25/2021
Expiration Date:	08/24/2023
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was sent to the hospital after a fall. There is concern the facility did not seek timely medical attention.	No
Additional Findings	Yes

III. METHODOLOGY

03/16/2022	Special Investigation Intake 2022A0340021
03/16/2022	Special Investigation Initiated - Face to Face Kasandra Counterman
03/16/2022	Inspection Completed On-site
04/27/2022	APS Referral- denied for investigation
04/27/2022	Telephone call made Dr. Daniel Frederickson-Shelby Mercy
05/02/2022	Telephone call made Muskegon Mercy Hospital-message left with social work
05/03/2022	Telephone call received From Dr. Frederickson
05/03/2022	Exit Conference Licensee Ryan Boutell

ALLEGATION: Resident A was sent to the hospital after a fall. There is concern the facility did not seek timely medical attention.

INVESTIGATION: On March 16, 2022, I received a complaint regarding Resident A who had been sent to the hospital from the Rose Care AFC home. It was reported that he had apparently fallen, and while at the hospital it was discovered that he had broken his leg.

On March 16, 2022, I conducted an unannounced on-site inspection. I spoke with staff Kassandra Counterman and Shawna Roberts. Ms. Counterman informed me that this incident occurred approximately one year ago. She stated that when it occurred, Resident A was sitting at the dining room table and fell out of his chair, landing on the floor. Ms. Counterman stated that she was present when this

happened and immediately called for an ambulance, and he was taken to the hospital. He never returned to the home from the hospital. Ms. Counterman stated this happened so long ago that she does not remember when she found out Resident A was not returning to the home and that he had passed away, but it was the social worker from Mercy that had called her with this information.

Resident A moved into the home on 3/18/2020. I asked Ms. Counterman if Resident A required extra assistance or if he had a history of falling. She stated that Resident A did use a walker, but she had never known him to be a fall risk prior to this incident. There was no documented need for increased supervision that she knew of either. Since Ms. Counterman was present when Resident A fell, I asked her if he had exhibited any change in his behavior in the days leading up to being sent to the hospital. She told me that there was nothing different in how he acted.

I asked to see Resident A's file, which Ms. Roberts produced for me. Resident A's Health Care Appraisal was signed by PA Daniel Erickson on 11/13/20 from Mercy Health. His date of birth is 8/25/57. Resident A's diagnosis included; age related osteoporosis, schizophrenia, and HTN (hypertension).

I reviewed Resident A's Medication Administration Record (MAR) which indicated Resident A's medications were passed as prescribed up until he was sent to the hospital on May 24, 2021. Ms. Counterman stated that this must have been the date that Resident A fell and was sent to the hospital.

I reviewed the Assessment Plan for Resident A which was signed by Licensee Ryan Boutell on 11/13/2020. There was nothing documented in the Assessment Plan to indicate Resident A was a fall risk or required increased monitoring or additional care for any reason.

On April 27, 2022, I called the office of Dr. Frederickson from Mercy Health. I left a message for him to return my call.

On May 2, 2022, I called the social work office at Mercy Hospital in Muskegon and left a message.

On May 3, 2022, I received a call back from Dr. Frederickson. He remembered Resident A from past visits. He stated he had no concerns regarding the care Resident A received while living at the Rose Home. Dr. Frederickson stated Resident A did not require assistance or additional supervision. Resident A did use a wheeled walker, but was not considered a fall risk. I asked Dr. Frederickson for information regarding Resident A's stay at the hospital when he eventually passed away. Dr. Frederickson relayed the following timeline to me:

Resident A was admitted to Mercy Muskegon Hospital on 5/24/21 complaining of abdominal pain. He had a high heart rate and was sleepy. His abdomen was tender. X-rays were completed but did not show anything of concern, no broken leg.

A CT scan was ordered and showed a bowel obstruction. Surgery was scheduled on 5/28/21. Post Op, Resident A had a very high heart rate (161). His blood pressure dropped and his O2 also dropped. Resident A ultimately expired on 5/29/21 at 4:00 am.

Dr. Frederickson stated the cause of death was related to the bowel obstruction. I asked if there was anything the home could have done to prevent this and he said no. I explained that I did not know why someone thought Resident A had broken his leg and that there was a connection of that to his death. Dr. Frederickson stated it was not true and again stated it was the bowel obstruction that preluded his death.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	An allegation was made that Resident A had fallen in the home and may not have received immediate medical attention. Ms. Counterman stated that she called for an ambulance when Resident A fell off his chair while sitting at the dining room table. He was taken to the hospital and did not return to the home. Dr. Frederickson stated Resident A was diagnosed with a bowel obstruction and passed away after surgery four days after arriving at the hospital. He stated Resident A's cause of death was the bowel obstruction and there is no indication of an injury, (no broken leg or bones) found in the X-ray. Hospital records also show Resident A was admitted for abdominal pain caused by a bowel obstruction. Resident A passed away four days later, after surgery for the bowel obstruction. There is no evidence of neglect.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: While conducting this investigation I discovered that there was no Incident Report (IR) created or sent to LARA regarding Resident A's fall and hospitalization. When I asked Ms. Counterman for the IR she stated that she did not know she had to write or send one to me and acknowledged that an IR was not completed.

APPLICABLE RULE	
R 400.14311	**Investigating and reporting of incidents, accidents, illnesses, absences, and death.**
	A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **The death of a resident.** **Any accident or illness that requires hospitalization.** **Incidents that involve any of the following:** **Displays of serious hostility.** **Hospitalization.** **Attempts at self-inflicted harm or harm to others.** **Instances of destruction to property.** **Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.**
ANALYSIS:	An Incident Report was not completed or sent to LARA after Resident A fell and was sent to the hospital where he was admitted.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: While conducting this investigation I discovered that medication prescribed for Resident B was not being administered as prescribed. Lorazepan was to be given at 8:00 am, 12:00 noon, and 6:30 pm. When I reviewed the Medication Administration Record (MAR), I noticed that the noon medication had not been passed. Ms. Counterman stated that there was a change to her medication administration time for the noon pass, however, it is not reflected on the MAR. I advised Ms. Counterman that she should contact the pharmacy to make the change on the MAR because otherwise, it is incorrect, and appears she is not being given the Lorazepan as prescribed.

APPLICABLE RULE	
R 400.14312	**Resident Medication**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed

	physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 e seq. of the Michigan Complied Las, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	The Medication Administration Record for Resident B's Lorazepan indicates it is supposed to be administered at noon, but Ms. Counterman stated that it is now being given at a different time. This change is not reflected on the MAR.
CONCLUSION:	**VIOLATION ESTABLISHED**

On May 3, 2022, an exit conference was conducted with Licensee Ryan Boutell. I informed him of the allegations and findings. He agreed to send a Corrective Action Plan addressing the substantiated rule violations.

IV. RECOMMENDATION

Upon receiving an acceptable Corrective Action Plan, I recommend no change to the current license status.

Rebecca Piccard May 3, 2022

Rebecca Piccard Date
Licensing Consultant

Approved By:

May 4, 2022

Jerry Hendrick Date
Area Manager