GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 20, 2022

Katherine Cowgill
807 Witters Ct.
Portage, MI 49024

RE: License #: AF390390776
Investigation #: 2022A1024027
Living Water AFC

Dear Ms. Cowgill:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the quality of care violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF390390776
Investigation #:	2022A1024027
Complaint Receipt Date:	03/29/2022
Investigation Initiation Date:	03/29/2022
Report Due Date:	05/28/2022
Licensee Name:	Katherine Cowgill
Licensee Address:	807 Witters Ct PORTAGE, MI 49024
Licensee Telephone #:	(269) 808-5655
Administrator:	N/A
Licensee:	Katherine Cowgill
Name of Facility:	Living Water AFC
Facility Address:	807 Witters Ct Portage, MI 49024
Facility Telephone #:	(269) 808-5655
Original Issuance Date:	03/05/2018
License Status:	REGULAR
Effective Date:	09/03/2020
Expiration Date:	09/02/2022
Capacity:	5
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was provided with a mouthguard by the home which was not stated in her assessment plan.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/29/2022	Special Investigation Intake 2022A1024027
03/29/2022	Special Investigation Initiated - Face to Face with household member Kalena Adams and Frank Adams
03/29/2022	Contact - Telephone call made with licensee Kathy Cowgill
03/29/2022	Contact-Document Received-Review of Bureau Information Tracking System (BITS)
03/29/2022	APS Referral
03/30/2022	Inspection Completed On-site with APS Specialist Gene Coulter, Kalena Adams, and Frank Adams
03/30/2022	Contact - Telephone call made with Relative B1
03/30/2022	Contact - Telephone call made with Relative A1
03/30/2022	Contact-Telephone call made with social worker Elizabeth Powers with Centrica Care Navigators
03/30/2022	Contact - Telephone call made Relative C1
03/30/2022	Contact - Document Received Resident A's death certificate
03/30/2022	Contact-Document Received-Resident A's *AFC Licensing Division-Accident/Incident Report*
03/31/2022	Exit Conference with licensee Kathy Cowgill
04/13/2022	Contact - Telephone call made-Referral to Portage Police Department Sergeant Begemam
04/13/2022	Inspection Completed-BCAL Sub. Non-Compliance

04/15/2022	Contact - Document Received-Email correspondence between Licensing Consultant Michele Streeter and Licensee Kathy Cowgill

ALLEGATION:
Resident A was provided with a mouthguard by the home which was not documented in her assessment plan.

INVESTIGATION:

On 3/29/2022, information was provided to the department that Resident A was provided with a mouthguard by the home which was not documented in her assessment plan. The use of this mouthguard led to Resident A swallowing the mouthguard and choking to death. According to the information received, Resident A moved into the facility on 1/18/2022 and died on 2/19/2022. The facility's responsible person Kalena Adams ordered a mouthguard from Amazon for Resident A which was found lodged in Resident A's throat on the day of her death.

On 3/29/2022, I conducted an onsite investigation at the facility with household members and responsible persons Kalena Adams and Frank Adams. Ms. Adams stated that on 1/18/2022 Resident A moved into the home after being referred by hospice agency Centrica Care Navigators. Ms. Adams stated Resident A passed away on 2/19/2022. Ms. Adams stated during the first of week of Resident A's stay at the home, Ms. Adams observed Resident A to bite down and grind on her teeth to the point where her gums were bleeding. Subsequently, Ms. Adams stated she decided to purchase mouthguards for Resident A to wear on the bottom row of her teeth to prevent Resident A from potentially injuring her gums. Ms. Adams stated she informed Resident A's Centrica Care Navigators hospice social worker Elizabeth Powers and also notified Relative A1 that she would be using the mouthguards for that purpose with Resident A. Ms. Adams stated both Ms. Powers and Relative A1 stated they thought purchasing the mouthguards were a good idea and did not express any concerns. Ms. Adams stated she did not receive a prescription from any medical provider through Centrica Care Navigators or any other physician or therapist for Resident A to use the mouthguard nor was she aware that she needed to update Resident A's *Assessment Plan for AFC Residents* to reflect the use of the mouthguards. Ms. Adams stated she purchased a total of six mouthguards with her own money to ensure Resident A had the mouthguards inserted in her mouth every day. Ms. Adams stated Resident A used the mouthguard while awake during the day and at night while she was sleeping. Ms. Adams further stated additional mouthguards had to be purchased since Resident A would occasionally chew the mouthguard into small pieces while it was in her mouth.

Ms. Adams stated on the day Resident A passed away, Ms. Adams took Resident A's mouthguard out of her mouth, in order for Resident A to eat dinner. Ms. Adams stated after Resident A finished eating and while still at the dining room table, Ms.

Adams inserted the mouthguard back in Resident A's mouth at which time Resident A bit Ms. Adams's hand. Ms. Adams stated she walked away briefly to grab more gloves and upon her return noticed that the mouthguard was no longer in Resident A's mouth. Ms. Adams stated she didn't see the mouthguard anywhere in sight, such as on the floor or table, and therefore she assumed Resident A swallowed the mouthguard. Ms. Adams stated she became concerned so she called Centrica Care Navigators Hospice and informed them Resident A had swallowed her mouthguard. Ms. Adams stated at that point however Resident A was not in distress. Ms. Adams stated the hospice nurse on-call reported she was not able to come to the home to evaluate Resident A because she was not in close proximity to the home. Ms. Adams stated after speaking to the hospice on-call nurse minutes later Resident A started showing signs of distress by making noises like she was having trouble breathing. Ms. Adams stated she didn't know what she was supposed to do since Resident A was in a hospice program and therefore was not supposed to use emergency medical services (EMS) to her understanding. Ms. Adams stated she called Relative A1 and hospice back to inform them of Resident A appearing to be in distress from swallowing the mouthguard at which time both Relative A1 and Centrica Care Navigators hospice on-call representative gave Ms. Adams permission to call 911. Ms. Adams stated she did not perform any emergency rescue procedures like CPR, sweeping her mouth, Heimlich maneuvers, or any type of first aide while waiting for EMS to arrive, even though Resident A did not have a Do Not Resuscitate (DNR) order on file according to Ms. Adams. Ms. Adams stated when the fire department arrived Resident A had stopped breathing and was observed to have no pulse by the fire department. Ms. Adams stated she immediately notified Centrica Care Navigators hospice agency and Relative A1 of Resident A's passing and completed an incident report.

Mr. Adams stated he was aware that Resident A used a mouthguard on the bottom row of her teeth because she routinely grinded her teeth. Mr. Adams stated Ms. Adams purchased mouthguards for Resident A to help prevent Resident A from grinding down on her and inserted the mouthguards in Resident A's mouth daily. Mr. Adams stated he never inserted the mouthguards for Resident A. Mr. Adams stated he was present but working with another resident when Resident A swallowed her mouthguard and eventually passed away on 2/19/2022. Mr. Adams stated he was feeding another resident in the home at the dining room table while Ms. Adams was feeding Resident A however he didn't actually see Resident A swallow her mouthguard because he was busy with the other resident. Mr. Adams stated he heard Ms. Adams state that Resident A swallowed her mouthguard and saw Resident A start to experience distress. Mr. Adams stated Ms. Adams then called hospice services and Relative A1 to get further guidance. Mr. Adams stated Resident A was pronounced dead at the home when the paramedics arrived. Mr. Adams stated he did not take any action to assist Resident A as he was providing care to other residents.

While at the facility, I reviewed Resident A's *Assessment Plan for AFC Residents* which was not dated or signed by the licensee, Resident A, and/or Resident A's

designated representative. According to this plan, there is no mention of Resident A requiring the use of mouthguards or any interventions to assist with grinding her teeth.

On 3/29/2022, I conducted an interview with licensee Katherine Cowgill. Ms. Cowgill stated she was notified by Ms. Adams that Resident A passed away from choking on a mouthguard on 2/19/2022. Ms. Cowgill stated Ms. Adams is a great employee and works well with residents. Ms. Cowgill stated she was not aware that Resident A was using mouthguards as Ms. Adams did not communicate to her on any issues, including personal care, that she had with any of the residents.

On 3/29/2022, I made an APS referral for investigation of suspected neglect by Mrs. Kalena Adams and Frank Adams.

On 3/30/2022, I conducted an onsite investigation at the facility with APS Specialist Gene Coulter and responsible person Kalena Adams. Mr. Coulter stated he spoke with Relative B1 and it was agreed that Resident B would be more suited living in an alternate placement. Mr. Coulter also stated he spoke with Relative C1 who felt no concerns for Resident C to stay in the home with Ms. Adams.

On 3/30/2022, I conducted an interview with social worker Elizabeth Powers from Centrica Care Navigators hospice agency. Ms. Powers stated Resident A was provided hospice services and she regularly visited with Resident A at Living Water AFC home. Ms. Powers stated she was made aware by Ms. Adams that Ms. Adams purchased mouthguards for Resident A to prevent her from grinding down on her teeth causing her gums to bleed. Ms. Powers stated the use of the mouthguards was not documented anywhere nor were the mouthguards prescribed by any hospice medical provider or any other physician. Ms. Powers further stated she did not see any issues with Resident A using the mouthguards.

On 3/30/2022, I conducted an interview with Relative A1. Relative A1 stated on 2/19/2022 she received a phone call from Ms. Adams stating that she could not find Resident A's mouthguard, implying she had swallowed it, and Resident A was making noises of distress. Relative A1 stated Ms. Adams asked if she could call 911 due to the noises Resident A repeatedly made as if she was choking on her mouthguard. Relative A1 affirmed she gave permission for 911 to be called to assess Resident A's condition. Relative A1 stated she believes Ms. Adams should have called 911 first before calling her for permission to call 911 since Resident A was showing signs of choking. Relative A1 further stated she was aware that Ms. Adams suggested that Resident A use a mouthguard to prevent her from biting down on her teeth however this intervention was never updated in Resident A's *Assessment Plan for AFC Residents.*

On 3/30/2022, I reviewed Resident A's *Death Certificate.* According to this death certificate Resident A was pronounced dead on 2/19/2022 and the cause/manner of death is pending.

On 3/30/2022, I reviewed the facility's *AFC Licensing Division-Incident/Accident Report* dated 2/19/2022 written by Kalena Adams. According to this report, Resident A swallowed her mouthguard and started to make sounds of distress. Ms. Adams then called Hospice and was told to call EMS. The report stated when EMS arrived Resident A stopped breathing.

On 4/13/2022, I made a referral to the Portage Police Department regarding Resident A's death.

APPLICABLE RULE	
R 400.1411	**Resident behavior management; general requirements.**
	(2) Methods of behavior management shall encourage cooperation, self-esteem, self-direction, and independence, and shall be administered in accordance with a resident's written assessment plan.

ANALYSIS:	Based on my investigation which included interviews with household members and responsible persons Kalena Adams and Frank Adams, licensee Kathy Cowgill, Relative A1, social worker Elizabeth Powers, review of incident report, review of *Assessment Plan for AFC Residents,* and review of *Death Certificate,* there is evidence that the use of mouthguards to stop Resident A from grinding her teeth was not documented in Resident A's written *Assessment Plan for AFC Residents.* Upon review of Resident A's *Assessment Plan for AFC Residents* there was no documentation stating the mouthguards were being used nor was the duration of or reason for use described in the assessment plan. According to my interview with responsible person Kalena Adams, she stated she voluntarily purchased Resident A non-prescribed mouthguards to prevent Resident A from grinding down on her teeth causing bleeding. Centrica Care Navigators Hospice Social Worker Elizabeth Powers and Relative A1 both stated they were aware that Resident A was provided with mouthguards by Ms. Adams however Ms. Adams did this without a prescription from Resident A's physician and/or hospice medical care provider and without a behavior treatment plan to guide the use of this intervention. Ms. Adams also stated she was not aware that she needed to update Resident A's *Assessment Plan for AFC Residents* to reflect the use of the mouthguards. Further licensee Katherine Cowgill stated she was not aware Resident A was using mouthguards as Ms. Adams did not communicate to her on any issues that she had with any of the residents. It should be noted, Ms. Cowgill, Ms. Adams and Relative A1 all stated Resident A passed away on 2/19/2022 from choking on a mouthguard and the mouthguard was found lodged in Resident A's throat at the time of her death. Consequently, the use of non-prescribed mouthguards that were not approved by Resident A's medical providers to address a behavioral issue led to Resident A swallowing the mouthguard. Even after observing Resident A biting the mouthguard into pieces, responsible person Kalena Adams continued to use the mouthguard. This unapproved, non-prescribed behavioral intervention did not encourage Resident A's cooperation, self-esteem, self-direction, and independence, and was not administered in accordance with a resident's written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

While at the facility, responsible person and household member Kalena Adams stated she submitted a family home license enrollment application for the family home property located at 807 Witters Court in Portage, currently known as Living Water AFC. Ms. Adams stated she did not complete the Michigan Workforce Background Check fingerprint process prior to becoming a responsible person for Living Water AFC nor when she applied for the family home license. Ms. Adams further stated she also did not complete a medical clearance request.

Responsible person and household member Frank Adams also stated that he did not complete the Michigan Workforce Background Check fingerprint process or medical clearance prior to working with the vulnerable adult residents in the home.

On 3/29/2022, I interviewed licensee Katherine Cowgill who stated after selling her business to Kalena Adams, Ms. Cowgill moved out of the home to allow for Kalena and Frank Adams to live and work with the residents. Ms. Cowgill stated she assumed Ms. Adams took care of the necessary paperwork of getting Michigan Workforce Background Check fingerprint process completed therefore Ms. Cowgill did not assure the criminal background check completed for either Kalena or Frank Adams.

On 3/29/2022, I reviewed the Bureau of Information Tracking System (BITS) and did not see any record of Kalena Adams or Frank Adams listed under the Living Waters AFC licensing file as household members nor were they listed as responsible persons. It should be noted Ms. Cowgill did not have employee files for either Ms. Adams or Mr. Adams

APPLICABLE RULE	
R 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(6) If an adult foster care facility determines it necessary to employ or independently contract with an individual before receiving of the individual's criminal history check or criminal history record information required under this

	section, the adult foster facility may conditionally employ the individual if all of the following apply: **(a) The adult foster care facility requests the criminal history check record information required under this section, upon conditionally employing the individual.** **(b) The individual signs a written statement indicating all of the following:** **(*i)* That he or she has not been convicted of 1 or more of the crimes that are described in subsection (1)(a) to (g) within the applicable time period prescribed by subsection (1)(a) to (g).** **(*ii*) That he or she has not been the subject of an order or disposition described in subsection (1)(h).** **(iii*)* That he or she has not been the subject of a substantiated finding as described in subsection (1)(i).** **(*iv*) The individual agrees, that if information in the criminal history conducted under this section does not confirm the individual's statement under subparagraphs (*i*) to (*iii*), his or her employment will be terminated by the adult foster care facility as required under subsection (1) unless and until the individual can prove that the information is incorrect.** **(*v*) That he or she understands the conditions described in subparagraphs (*i*) to (*iv*) that result in the termination of his or her employment and that those conditions are good cause for termination.** **(c)Except as otherwise provided in this subdivision, the adult foster care facility does not permit the individual to have regular direct access to or provide direct services to residents in the adult foster care facility without supervision until the criminal history check or criminal history record information is obtained and the individual is eligible for that employment. If required under this subdivision, the adult foster care facility shall provide on-site supervision of an individual in the facility on a conditional basis under this subsection by an individual who has undergone a criminal history check conducted in compliance with this section. An adult foster care facility may permit an individual in the facility on a conditional basis under this subsection to have regular direct access to or provide direct service to residents in the adult foster facility without supervision if all of the following conditions are met:**

	(*i*) The adult foster care facility, at its own expense and before the individual has direct access to or provides direct services to residents of the facility, conducts a search of public records on that individual through the internet criminal history access tool maintained by the department of state police and the results of that search do not uncover any information that would indicate that the individual is not eligible to have regular direct access to or provide direct services to residents under this section. **(*ii*) Before the individual has direct access to or provides direct services to residents of the adult foster care facility, the individual signs a statement in writing that he or she has resided in this state without interruption for at least the immediately preceding 12-month period.** **(*iii)* If applicable, the individual provides to the department of state police a set of fingerprints on or before the expiration of 10 business days following the date the individual was conditionally employed under this subsection.**
ANALYSIS:	Both Kalena Adams and Frank Adams had regular, direct access to residents but never completed the required Michigan Workforce Background fingerprint check process. Licensee Katherine Cowgill did not assure that either responsible person completed these criminal history clearances before allowing both Kalena Adams and Frank Adams to work independently with residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1405	**Health of a licensee, responsible person, and member of the household.**
	(1) A licensee, responsible person, and a member of the household shall be in such physical and mental health so as not to negatively affect either the health of the resident or the quality of his or her care. **(3) A licensee shall provide the department with written evidence that he or she and each responsible person in the home is free from communicable tuberculosis. Verification shall be within the 3-year period before employment and verification shall occur every 3 years thereafter.**

ANALYSIS:	Neither responsible persons/household members Kalena Adams or Frank Adams had documentation of a completed physician's statement documenting their good physical and mental health nor did they have documentation of a negative TB test result.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my interview with licensee Katherine Cowgill on 03/29/2022, Ms. Cowgill stated she had been working with AFC licensing consultant Michele Streeter and informed Ms. Streeter that she was getting married in 2021. However, Ms. Cowgill stated she did not inform Ms. Streeter when she moved out of her family home Living Water AFC located at 807 Witters Court, Portage MI 49024 in December of 2021 even though this license type requires the licensee to remain living in the facility. Ms. Cowgill stated she currently resides at 1111 Highley Circle E., Schoolcraft MI 49087 and has allowed one of her employees, responsible person Kalena Adams, to live in the family home and care for the residents. Ms. Cowgill stated she formed a limited liability company that she sold to Kalena Adams in December 2021 which is the reason why she allowed Ms. Adams to move into Living Water AFC family home. Ms. Cowgill stated she has not been on the premises of Living Water AFC family home since December 2021.

While at the facility on 03/29/2022, Kalena Adams stated she purchased licensee Kathy Cowgill's business in December 2021 and thereafter moved into Living Water AFC family home property. Ms. Adams stated she does not have a lease to show residence at this property 807 Witters Court Portage, MI 49024 because Ms. Cowgill currently has an active lease with the homeowner of the property which does not expire until September 2022. Ms. Adams stated she plans at that time to enter into a new lease agreement with the homeowner Johan Ipenburg. Ms. Adams stated she currently resides in the home with her husband/household member/responsible person Frank Adams and minor son. Ms. Adams stated at the time she moved into Living Water AFC there were three residents residing in the home with Ms. Cowgill.

I interviewed Frank Adams who also stated he moved into the property located at 807 Witters Court Portage, MI 49024 in November 2021 when Ms. Cowgill moved out of the family home.

On 3/30/2022, I conducted interviews with Relative B1 and Relative C1 who both stated that they were made aware by licensee Katherine Cowgill that she moved out of the home in December of 2021 and Kalena Adams was now living in the AFC family home providing care to their loved ones.

On 4/15/2022, I received and reviewed email correspondence between licensing consultant Michele Streeter and licensee Kathy Cowgill dated 5/27/2021. According to this correspondence, Ms. Cowgill informed Ms. Streeter that she plans on moving out of her family home facility and getting married on July 25, 2021. Ms. Streeter responded and informed Ms. Cowgill that she had to reside in her family home property located at 807 Witters Court Portage, MI 49024 to have a family home license.

APPLICABLE RULE	
MCL 400.722	**Denying, suspending, revoking, refusing to renew, or modifying license; grounds; written notice; hearing; decision; protest; receiving or maintaining adults requiring foster care as felony; penalty; relocation services.**
	Sec. 22. (1) The department may deny, suspend, revoke, or refuse to renew a license, or modify a regular license to a provisional license, if the licensee falsifies information on the application for license or willfully and substantially violates this act, the rules promulgated under this act, or the terms of the license.
ANALYSIS:	Despite being informed in writing on 05/27/2021 by AFC Consultant Michele Streeter that in order to maintain the AFC family home license type Katherine Cowgill must continue to live in the family home located at 807 Witters Court in Portage, Michigan, Katherine Cowgill moved out of this address in December 2021. Per her own admission Katherine Cowgill did not inform the Bureau of Community and Health Systems Licensing and Regulatory Affairs AFC Division that she no longer resided at 807 Witters Court and needed to close her family home license. Living in the family home is a requirement of the term of this license. Consequently, licensee Katherine Cowgill is no longer in compliance with the terms of this license type.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 3/29/2022, while at the facility Ms. Adams was only able to show Resident A's *Assessment Plan for AFC Residents* and was unable to provide the department with Resident A's resident records. Ms. Adams stated she was unaware that she needed to complete any paperwork for Resident A as she was not trained by Ms. Cowgill on this responsibility.

APPLICABLE RULE	
R 400.1422	**Resident records.**
	(1) A licensee shall complete and maintain a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number.** **(iii) Home address.** **(iv) Name, address, and telephone number of the next of kin or designated representative.** **(v) Name, address, and telephone number of person or agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(b) Date of admission.** **(c) Date of discharge and place to which resident was discharged.** **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication.** **(iv) Instructions for emergency care.** **(e) Resident care agreement.** **(g) Weight record.** **(h) Incident and accident reports.** **(i) Resident funds and valuables record.** **(j) Resident grievances and complaint record.**
ANALYSIS:	On 3/29/2022, while at the facility Ms. Adams was only able to show Resident A's *Assessment Plan for AFC Residents* and was unable to provide the department with any other documents for Resident A's resident records. Ms. Adams stated she was unaware that she needed to complete any paperwork for Resident A as she was not trained by Ms. Cowgill on this responsibility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Due to the severity of the quality of care violations, I recommend revocation of the family home license.

5/16/2022

Ondrea Johnson
Licensing Consultant

Date

Approved By:

05/20/2022

Dawn N. Timm
Area Manager

Date