GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 31, 2022

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

RE: License #: AM640397153
Investigation #: 2022A0340026
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 #:	AM640397153
Investigation #:	2022A0340026
Complaint Receipt Date:	05/04/2022
Investigation Initiation Date:	05/04/2022
Report Due Date:	07/03/2022
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 urinates in her bed and is not allowed to wash her sheets more than once per week.	No
Additional Findings	Yes

III. METHODOLOGY

05/04/2022	Special Investigation Intake 2022A0340026
05/04/2022	APS Referral
05/04/2022	Special Investigation Initiated - Telephone staff Kasandra Counterman
05/23/2022	Inspection Completed On-site
05/26/2022	Exit Conference Licensee Ryan Boutell
05/26/2022	Contact – Telephone Call Made Kassandra Counterman
05/31/2022	Corrective Action Plan requested and due on: 6/15/2022

ALLEGATION: Resident A frequently urinates in her bed and is not allowed to wash her sheets more than once per week.

INVESTIGATION: On May 4, 2022, I received a complaint from BCAL Online Complaints which stated Resident A regularly urinates the bed. She wears a brief, but urinates through them. Resident A cannot change or clean her sheets for days because Rose Home staff won't allow it.

On May 4, 2022, I left a message for staff Kassandra Counterman regarding laundry protocols at the home.

On May 23, 2022, I conducted an unannounced home inspection. Resident A and I are familiar with each other, so she welcomed my request to speak with her in her room. As I entered the room, I did not notice any odor that would indicate any cleanliness issues.

I did notice two large laundry baskets sitting by Resident A's bed. When I asked about them, Resident A stated that her laundry day had previously been Tuesday

(tomorrow) but it was switched to Fridays. I asked Resident A if she's able to do any wash on another day if she needs to. Resident A said she is not and proceeded to dig through her basket and show me clothes which she said were stained with menstrual blood. I was able to see Resident A's sheets under her blanket and there was a very large wet spot running off the side of a mattress pad she had on her bed on top of the fitted sheet. I asked Resident A about that. Resident A did not appear surprised but acknowledged the soiled sheet. I asked her if she is able to wash them today even though it's not her day. Resident A said "no". I informed Resident A that she is allowed to wash her sheets when this happens and that I would speak to staff right away.

Staff Mia Counterman was present at this time. I asked Ms. Counterman about the laundry schedule. She showed me the white board posted on the laundry room door. I could see that Resident A was previously down on Tuesday, but her name was crossed off and moved to Friday. I asked Ms. Counterman what happens if a resident needs to wash something due to having an accident, urine, blood, etc. She stated that they absolutely can wash a load of laundry when necessary. I advised her that Resident A is in need of doing a load of laundry. Ms. Counterman stated that Resident A had told her she wanted to do a load of laundry but she did not tell her there was a need due to soiling.

I spoke to both Ms. Counterman and Resident A together. I told Resident A that she has the right to wash her soiled sheets or clothing as needed under these circumstances, but because there are 12 people doing laundry at the home, she needs to let staff know the reason, and not that she just feels like jumping ahead of other residents. Ms. Counterman affirmed my statement and reiterated that Resident A needs to tell her if she has an accident. I also suggested that Ms. Counterman check with Resident A for a while since it is known that Resident A utilizes briefs and/or mattress pads and Resident A seemed embarrassed about the accident.

APPLICABLE RULE	
R 400.14411	**Linens.**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillowcase, a minimum of 1 blanket, and a bedspread for each bed. Bed linins shall be changed and laundered at least once a week or more often if soiled.
ANALYSIS:	An allegation was made that Resident A urinates in her bed and is not allowed to wash her sheets more than once per week. I witnessed soiled bedsheets and stained clothing in Resident A's room.

	Resident A stated she has asked staff to do laundry on days that were not her scheduled day, but she did not share the reason for wanting to do so. Staff Counterman assured Resident A that she is able to wash her soiled sheets or stained clothing whenever needed if she informs staff of the need.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: While I was in Resident A's bedroom, I noticed the window I had previously cited for being broken, looked like it may have broken glass around the perimeter. I attempted to open the window to see if the broken window had been replaced with a piece of plexiglass or if the glass part was simply removed and not replaced. I was not able to open the window as the mechanism was broken.

I asked Resident A about her window. She said all the handles in her room were broken and did not open. I checked the other windows in her room and confirmed that they were all broken and did not open at all. Resident A denied that there were leaks or drafts coming through the windows.

I spoke with Residents B and C and they confirmed that the windows in their room also had broken hardware. Resident B informed me that she needs to take out the screen and then she is able to push the window open. Residents B and C showed me their windows to be non working and not easily openable.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(7) Bedrooms shall have at least 1 easily openable window.
ANALYSIS:	While speaking with Resident A in her room I noticed it looked like broken glass around the perimeter of her window. When I attempted to open the window to inspect the glass, I found the hardware to be broken and I was unable to open the window. Residents B and C stated, and I confirmed, that they have to remove the screen to their bedroom windows and then push the glass in order to open their windows.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: While following up and checking on a previously cited licensing violation (Corrective Action Plan Verification) regarding a medication error, I observed Resident D's medications had been set up in a pill box for the entire week and not in the original pharmacy containers. I asked staff Mia Counterman about the pill box. She stated that it came with him when he moved from another adult foster care home owned by Ryan Boutell (Fessenden). Ms. Counterman stated she did not know that pill boxes were not allowed, and she will not continue using it.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(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 the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	I observed a weeks' supply of Resident D's medications set up in a pill box that was not pharmacy labeled. Ms. Counterman stated she was unaware that pill boxes were not allowed, and she agreed not to use it again.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: While conducting a Corrective Action Plan verification for a previous cited medication error, I observed that Resident D did not have a Medication Administration Record (MAR). Resident D had moved to the home over the weekend. I asked staff Mia Counterman if his MAR was in another location. She stated that he does not have one and explained that he had just moved to the home from an adult foster care home (Fessenden) and his MAR was not sent over. Ms. Counterman stated she was giving Resident D his medications as per the instructions on the label, but not marking it down anywhere. I viewed the prescription bottles for Resident D which were in the medication cabinet in a Ziploc. I discussed with Ms. Counterman the requirement for a MAR to be present and used by staff when administering resident medications. I suggested she create and fill

one out until the other one is sent over or the pharmacy sends a new one to the home. While I was at the home staff Kassandra Counterman arrived at the Rose home and showed Mia Counterman where the blank MAR sheets were located, and Kassandra began to fill it out for Resident D.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (b) Complete an individual medication log that contains all of the following information: (i) The medication. (ii) The dosage. (iii) Label instructions for use. (iv) Time to be administered. (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. (vi) A resident's refusal to accept prescribed medication or procedures.
ANALYSIS:	Staff were administering Resident D's medications but were not documenting their administration on a MAR or in any other manner. Staff Mia and Kassandra Counterman both confirmed there was no MAR for Resident D.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Rebecca Piccard May 31, 2022

Rebecca Piccard, Licensing Consultant Date

Approved By:

May 31, 2022

Jerry Hendrick, Area Manager Date