GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 13, 2022

Renae-Marie Kiehler
Innovative Housing Dev Corp
Suite 5
3051 Commerce Drive
Fort Gratiot, MI 48059

RE: License #: AS740253775
Investigation #: 2022A0580033
Ravenswood Home

Dear Ms. Kiehler:

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.
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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.

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) 284-9700.

Sincerely,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS740253775
Investigation #:	2022A0580033
Complaint Receipt Date:	04/18/2022
Investigation Initiation Date:	04/20/2022
Report Due Date:	06/17/2022
Licensee Name:	Innovative Housing Dev Corp
Licensee Address:	Suite 5 3051 Commerce Drive Fort Gratiot, MI 48059
Licensee Telephone #:	(810) 385-4463
Administrator:	Mindy Wiegand
Licensee Designee:	Renae-Marie Kiehler
Name of Facility:	Ravenswood Home
Facility Address:	4166 Ravenswood Port Huron, MI 48060
Facility Telephone #:	(810) 364-8831
Original Issuance Date:	03/18/2003
License Status:	REGULAR
Effective Date:	04/12/2021
Expiration Date:	04/11/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 3/24/22, Resident A went to the hospital and the facility is refusing to take her back even though she is at baseline and requires the same care that she needed prior to admission.	Yes

III. METHODOLOGY

04/18/2022	Special Investigation Intake 2022A0580033
04/20/2022	Special Investigation Initiated - On Site An onsite inspection was conducted at Ravenswood Home.
04/20/2022	Contact - Face to Face In-person contact with the home manager, Ms. Dawn Nedron.
04/21/2022	APS Referral This complaint was denied by APS for investigation.
05/04/2022	Contact - Telephone call made A call was made to Ms. Shyann Johnson, CMH Case Manager for Resident A.
06/02/2022	Contact - Telephone call made A call was made to Ms. Wiegand, license administrator.
06/02/2022	Contact - Document Received An email of documents requested was received.
06/06/2022	Contact - Telephone call made A call was made to Ms. Amanda Seales of St. Clair Public Guardian's Office, assigned public guardian for Resident A.
06/08/2022	Contact - Telephone call made Ms. Amanda Seales of St. Clair Public Guardian's Office, assigned public guardian for Resident A.
06/10/2022	Exit Conference AN exit conference was held with the license administrator, Ms. Mindy Wiegand.

ALLEGATION:

On 3/24/22, Resident A went to the hospital and the facility is refusing to take her back even though she is at baseline and requires the same care that she needed prior to admission.

INVESTIGATION:

On 04/18/2022, I received a complaint via BCAL Online complaints.

On 04/20/2022, I conducted an onsite inspection at Ravenswood Home. License administrator, Ms. Mindy Wiegand indicated that Resident A was one of the higher functioning residents in the home. Resident A was rude and disrespectful to the other residents and staff in the home. She indicated that she has spoken with her CMH assigned case manager, Ms. Shyann Johnson at length about having Resident A moved. Resident A went to the hospital on 03/24/2022. She adds that Resident A's ability to walk or toilet herself has diminished, therefore the home is unable to meet her needs. Resident A was not retrieved from the hospital upon being ready for discharge on 04/04/2022. She admitted that Resident A nor her guardian were provided with a written 30-day discharge notice. While onsite I reviewed Resident A's file. There was no discharge notice observed in Resident A's file

The incident report, dated 03/24/2022 at 5:45pm, indicates that Resident A had been lying around most of the day in her room. Resident A chose not to eat dinner. Resident A stated to staff that her back hurt, she has chills, and had not urinated since prior to lunchtime. Resident A denied feeling sick. Resident A was told to inform staff if she continues to have pain. Resident A then went into the bathroom. After 20 minutes in the bathroom, Resident A came out and informed staff that she had called 911. The EMS arrived and took her temperature. Resident A still wanted to be transported to the ER due to still having chills. Resident A was transported to Lake Huron Medical Center to be evaluated. Tubulo Interspatial Nephris was detected at the hospital. Resident A was admitted.

On 04/20/2022, I conducted an in-person interview with the home manager, Ms. Dawn Nedron. She indicated that Resident was mean and disrespectful to the other residents in the home, calling them names, etc. Resident B had been out of the home in rehab, however, he returned while Resident A was in the hospital. It is believed that it is not in Resident B's best interest to be around Resident A. Upon observing the room that belonged to Resident A, I observed that Resident B has since moved in Resident A's room. Resident A's items were removed and stored until they can be retrieved by her case manager or guardian.

On 04/21/2022, I received an email indicating that this complaint was denied by APS for investigation.

On 05/04/2022, I spoke with Ms. Shyann Johnson, assigned case manager for Resident A. She indicated that Resident A remains at the hospital due to a lack of placement. Ms. Johnson indicated that while she has spoken with Ms. Winegard regarding Resident A not being a good fit in the home, she did not provide her with a written 30-day discharge notice.

On 06/02/2022, I spoke with Ms. Mindy Wiegand regarding documents needed to complete the investigation.

On 06/02/2022, I received a copy of the AFC Care Agreement, AFC Assessment Plan for Resident A, Resident Funds II sheet for Resident A. A copy of Ravenswood Home discharge and refund policy was also received.

The AFC Care Agreement is signed and dated by Resident A's guardian on 04/21/2021. It indicates that Resident A's monthly room and board charge is $954.50.

The AFC Assessment Plan for Resident A, signed and by Resident A's guardian on 04/19/2021, indicates that Resident A uses a walker for walking, and may need assistance getting up from the chair and van. The plan also indicates that Resident A does not require assistance with toileting.

The discharge policy for Ravenswood Home indicates that the discharge or transfer of a resident to another group home shall be made only after the determination has been made that the move is in the resident's best interest. The home will provide the resident and/or legal guardian with a 30-day written notice before discharge from the home. The refund agreement indicates the amount of the monthly charge to be returned to the resident will be prorated based on the number of days that the resident lived in the home during that month.

The Resident Funds II sheet for Resident A's monthly payment indicates that Resident A owed $1,158.88 for rent payment at the time of her departure, during the month of April 2022. The AFC received full payment of the overdue balance on 04/28/2022, bringing Resident A's account balance to zero. The Resident II sheet for personal funds indicate that the balance of $64.00 was returned to Resident A's guardian on 04/28/2022.

On 06/06/2022, I made a call to Ms. Amanda Seales of St. Clair Public Guardian's Office, assigned public guardian for Resident A. A voice mail message was left requesting a return call.

On 06/08/2022, I made a follow-up call to Ms. Amada Seales, guardian. A message was left with the secretary requesting a return call.

On 06/10/2022, I conducted an exit conference with the license administrator, Ms. Mindy Wiegand. Ms. Wiegand was informed that the licensing rule violation was found. A corrective action plan is due within 15 days.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	It was alleged that Resident A was improperly discharged from the home. License administrator, Ms. Mindy Wiegand indicated that Resident A was not a good fit for the residents in the home. She indicated that Resident A nor her guardian were provided with a written 30-day discharge notice. . Resident A went to the hospital on 03/24/2022. Resident A was not retrieved from the hospital upon being ready for discharge on 04/04/2022. The discharge policy for Ravenswood Home indicates that the home will provide the resident and/or legal guardian with a 30-day written notice before discharge from the home. Based on the information gathered in the course of this investigation, there is sufficient evidence to support the rule violation, due to the home not providing a 30-day notice.
CONCLUSION:	**VIOLATION ESTABLISHED**

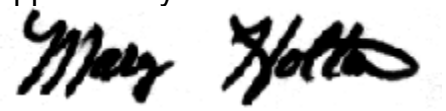
IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no changes to the status of the license is recommended.

June 13, 2022

Sabrina McGowan — Date
Licensing Consultant

Approved By:



June 13, 2022

Mary E. Holton — Date
Area Manager