GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 26, 2022

Rochelle Reneker-Rothwell
Rose Hill Center Inc
5130 Rose Hill Blvd
Holly, MI 48442

RE: License #: AL630007341
Investigation #: 2022A0465033
Kelly Community Center

Dear Ms. Reneker-Rothwell:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (248) 975-5053.

Sincerely,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-514-9391
Fax: 517-763-0204

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630007341
Investigation #:	2022A0465033
Complaint Receipt Date:	06/13/2022
Investigation Initiation Date:	06/16/2022
Report Due Date:	08/12/2022
Licensee Name:	Rose Hill Center Inc
Licensee Address:	5130 Rose Hill Blvd Holly, MI 48442
Licensee Telephone #:	(248) 634-5530
Administrator:	Rochelle Reneker-Rothwell
Licensee Designee:	Rochelle Reneker-Rothwell
Name of Facility:	Kelly Community Center
Facility Address:	5130 Rose Hill Boulevard Holly, MI 48442
Facility Telephone #:	(248) 634-5530
Original Issuance Date:	05/11/1992
License Status:	REGULAR
Effective Date:	10/11/2021
Expiration Date:	10/10/2023
Capacity:	20
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 6/8/2022, Resident A stole the facility's vehicle, eloped from the facility, purchased drugs and returned to the facility unbeknownst to staff.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/13/2022	Special Investigation Intake 2022A0465033
06/16/2022	Special Investigation Initiated - Letter Spoke to Complainant via email exchange
06/20/2022	Contact - Document Received Documents received from LD via email
06/23/2022	Inspection Completed On-site I conducted walkthrough of facility, reviewed Resident A's file and interviewed clinical director, Shawn Bryson
06/24/2022	Contact - Document Received Additional facility documents received via email
07/07/2022	Contact - Telephone call made Spoke to Guardian A1, who stated she is unavailable to talk at this time. Requested I call her back another time
07/18/2022	Contact - Telephone call made Left a voice mail for Guardian A1
07/20/2022	Contact - Document Received Additional facility documents received from facility
07/21/2022	Contact - Document Received Additional documents received from facility
07/21/2022	Contact – Telephone call made I spoke to Ms. Bryson via telephone

07/22/2022	Contact - Telephone call made I interviewed direct care staff, Karen Dixon, via telephone
07/25/2022	Contact - Telephone call made I interviewed direct care staff, Eileen Bower, via telephone
07/26/2022	Contact - Telephone call made I interviewed direct care staff, Christine Perry, via telephone
07/26/2022	Exit Conference I conducted an exit conference with Ms. Bryson in-person at the facility
07/27/2022	Exit Conference I conducted an exit conference with licensee designee/administrator, Ms. Reneker-Rothwell, via telephone

ALLEGATION:

On 6/8/2022, Resident A stole the facility's vehicle, eloped from the facility, purchased drugs and returned to the facility unbeknownst to staff.

INVESTIGATION:

On 6/13/2022, an *Incident/Accident Report* was received, indicating that on 6/8/2022, direct care staff did not provide adequate supervision, safety, and protection to Resident A. The incident report stated that on this date, Resident A was able to access the facility's vehicle keys, leave the property from 8:30pm to 11:30pm (approximately three hours), purchase drugs in a nearby city, and return to the facility unbeknownst to staff. Direct care staff did not discover that Resident A had eloped from the facility until the next day.

On 6/16/2022, I spoke to Complainant via telephone. Complainant acknowledged that the information contained in the complaint is accurate.

On 6/23/2022, I conducted an onsite investigation at the facility. At the time of my onsite investigation, Resident A was no longer residing at the facility. During the onsite investigation, I conducted a walkthrough of the facility, reviewed Resident A's file and interviewed home manager, Shawn Bryson.

The *Face Sheet* indicated that Resident A was admitted to the facility on 12/16/2021 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Major Depressive Disorder, Borderline Personality Disorder and Opioid Use Disorder. I was unable to locate an *Assessment Plan for AFC Residents* document in Resident A's file. I was unable to locate any document in Resident A's file

that specified community access guidelines or restrictions. I reviewed the *Pre-Admit/ Adult Mental Health Initial Written Assessment,* dated 12/16/2021, which indicated that Resident A has emotional regulation difficulties, a history of self-harm behavior and alcohol/drug addiction, independently completes self-care tasks and does not require use of assistive devices for mobility.

The facility's policy requires that visual checks are completed for all residents on an hourly basis. I reviewed the *Kelly Center Afternoon Rounds* for 6/8/2022, which is the document that direct care staff use to document hourly visual checks of all residents. The *Kelly Center Afternoon Rounds* document stated that direct care staff, Karen Dixon and Christine Perry, initialed that they completed visual checks of Resident A on 6/8/2022, at 9:00pm, 10:00pm and 11:00pm.

During the onsite investigation, I interviewed clinical director/direct care staff, Shawn Bryson. Ms. Bryson stated, "On 6/6/2022, direct care staff, Eileen Bower, lost the keys to the vehicle. She initially thought she had misplaced them. However, on the morning of 6/9/2022, Ms. Bower observed the vehicle parked in a location that was unusual. We discovered that a female was observed driving the vehicle off campus the prior evening and the description matched Resident A. Resident A was interviewed and she admitted that she had taken the vehicle keys from Ms. Bower's desk. Resident A stated that she left the facility around 8:30pm, drove to Detroit, met up with her drug dealer and purchased drugs, and then returned to the facility sometime after 11:00pm. Resident A admitted that she had purchased Fentanyl, used the Fentanyl, and then returned to the facility after. We did not find any drugs on Resident A nor in her room. Resident A refused to submit to a drug test, so we immediately called Guardian A1 and she picked up Resident A the next day and she was officially discharged.

I conducted a review of the rounds schedule to determine who was responsible for completing the visual checks of Resident A and discovered that direct care staff, Karen Dixon, initialed that she completed a visual check of Resident A at 9:00pm but admitted she did not complete the visual check. I also interviewed direct care staff, Christine Perry, who initialed that she completed visual checks of Resident A at 10:00pm and 11:00pm. Ms. Perry stated that she believed Resident A was in her room sleeping but acknowledged that she did not visually observe Resident A in the bedroom. All three staff, Ms. Bower, Ms. Dixon and Ms. Perry, were given written reprimands. Resident A was discharged from the facility on 6/9/2022 and returned to Guardian A1's home." Ms. Bryson acknowledged that Resident A does require supervision in the community and that adequate supervision was not provided to Resident A on 6/8/2022. Ms. Bryson stated that she is in the process of making policy and procedures changes to prevent this type of incident from happening in the future.

On 7/22/2022, I interviewed direct care staff, Karen Dixon, via telephone. Ms. Dixon stated that she has worked at the facility for three years. Ms. Dixon stated, "I am familiar with Resident A, and I was working on 6/8/2022. We are required to complete visual checks of all residents every hour. On 6/8/2022, I made a mistake, and I did not complete a visual check of Resident A at 8:00pm and 9:00pm. I did complete the

7:00pm visual check of Resident A and I observed her leave the facility to take trash outside. I did not see her after that. I asked Ms. Perry to complete the visual checks of Resident A but I initialed the log as if I had completed the visual checks. I don't remember who was supposed to complete the visual checks for the remainder of the night because we rotate and I cannot recall whose turn it was for the 9:00pm, 10:00pm and 11:00pm visual checks. Also, when we complete visual checks, sometimes we just crack the door open and will only see a head or an arm/leg and we count that as a visual check. We are not allowed to enter a resident's bedroom without permission so sometimes our visual check is a brief look in the room." Ms. Dixon stated that she did not see Resident A in the facility after 7:00pm and did not know that Resident A had eloped from the facility until the next day, when Resident A admitted to leaving the facility. Ms. Dixon stated that Resident A requires permission to leave the facility and supervision while in the community.

On 7/25/2022, I interviewed direct care staff, Eileen Bower, via telephone. Ms. Bower stated, "I lost the vehicle keys but cannot remember how many days the keys were missing, but it was around three days. The first day that I realized the keys were missing, I thought I had left them at home. That night, I went home and could not find them, so I thought I left them in my car. The next day I looked in my car and could not find the keys. On the third day, 6/9/2022, I arrived at work in the morning, and I saw that the vehicle was parked in a location that staff would not have parked it and my heart sank. I knew at that moment that someone had the keys. I immediately informed management and it was discovered that a woman was observed leaving the facility the night prior in the vehicle, and the description fit Resident A. Resident A was interviewed and did eventually admit to taking the vehicle. I normally lock the keys in my office drawer. However, I must have left the keys on my desk, and my office is in the break room area, accessible to residents. I now make sure I lock the keys in the cabinet at all times. Something like this has never happened before." Ms. Bower acknowledged that she left the vehicle keys unsupervised and accessible to Resident A.

On 7/26/2022, I interviewed direct care staff, Christine Perry, via telephone. Ms. Perry stated, "I was working on 6/8/2022 and I am familiar with Resident A and the incident during which she eloped from the facility. I don't know when Resident A left the facility. While we are working, we conduct hourly visual checks on all residents. I did initial that I completed a visual check of Resident A at 10:00pm and 11:00pm on 6/8/2022, however I did not actually see Resident A. The lights were off in the bedroom, so I just briefly looked in the bedroom and assumed that Resident A was laying in bed sleeping. I never actually saw Resident A in her bedroom. We are not allowed to go into resident bedrooms without their permission." Ms. Perry acknowledged that she initialed the *Kelly Center Afternoon Rounds,* without visually laying eyes on Resident A.

On 7/7/2022 and 7/18/2022, I attempted to interview Guardian A1 and Resident A via telephone. However, Guardian A1 stated that she and Resident A were unavailable to speak at that time. Guardian A1 has not returned my calls as of the date of this report.

APPLICABLE RULE	
R 400.15305	**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 6/13/2022, at approximately 8:30pm, Resident A was able to steal the facility's vehicle, leave the property, purchase drugs in a nearby city, use the drugs, and then drive back to the facility while under the influence of drugs, and return to the facility at 11:30pm, without direct care staff knowing. According to Ms. Dixon, Ms. Bower and Ms. Bryson, the facility's policy requires that visual checks are completed for all residents on an hourly basis. Ms. Dixon and Ms. Bower did not complete visual checks of Resident A on 6/8/2022, between the hours of 8:00pm and 11:00pm. Ms. Dixon and Ms. Bower acknowledged that they falsified the *Kelly Center Afternoon Rounds* document by initialing that they had completed a visual check of Resident A despite not having physically observed her inside the facility. Based on the information above, on 6/8/2022, direct care staff failed to ensure that Resident A's personal needs, including protection and safety, were attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite investigation at the facility, I was unable to locate an *Assessment Plan for AFC Residents* document in Resident A's file. I was also unable to locate any substitute document in Resident A's file that included all of the required content contained within this document.

On 7/21/2022, I interviewed Ms. Bryson, who stated, "We used to have a form that incorporated all of the information listed in the *Assessment Plan for AFC Residents* document. However, we revised our electronic forms process approximately two years ago. By error, someone removed the form, and I did not realize it until now. We will update our system to re-include the required information."

On 7/26/2022, I conducted an exit conference with licensee designee and administrator, Ms. Reneker-Rothwell. Ms. Reneker-Rothwell is in agreement with the findings of this report and in agreement with the issuance of a six-month provisional license.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on the information above, the facility has not completed, and maintained in the home, a written assessment plan for Resident A, as required by the department.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective plan, I recommend that a six-month provisional license be issued.

Stephanie Gonzalez

07/27/2022

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Stephanie Gonzalez Date
Licensing Consultant

Approved By:

Denise Y. Nunn

08/26/2022

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Denise Y. Nunn Date
Area Manager