GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 26, 2022

Ann Meldrum
Samaritas
Suite A
2080 Union Ave. SE
Grand Rapids, MI 49507

RE: License #: AS610015816
Investigation #: 2022A0357027
Samaritas --Mararebecah Lane

Dear Ms. Meldrum:

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) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610015816
Investigation #:	2022A0357027
Complaint Receipt Date:	06/29/2022
Investigation Initiation Date:	06/29/2022
Report Due Date:	08/28/2022
Licensee Name:	Samaritas
Licensee Address:	Suite A 2080 Union Ave. SE Grand Rapids, MI 49507
Licensee Telephone #:	(313) 823-7700
Administrator:	Ann Meldrum
Licensee Designee:	Ann Meldrum
Name of Facility:	Samaritas --Mararebecah Lane
Facility Address:	2760 Mararebacah Lane Muskegon, MI 49442-1577
Facility Telephone #:	(231) 777-5767
Original Issuance Date:	03/14/1994
License Status:	REGULAR
Effective Date:	08/23/2020
Expiration Date:	08/22/2022
Capacity:	3
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 06/29/2022 Resident A was hit in the face by a direct care staff Travis Hoeft which left a bruise on her chin.	Yes

III. METHODOLOGY

06/29/2022	Special Investigation Intake 2022A0357027
06/29/2022	Special Investigation Initiated - Telephone Email from Caren Lynn APS worker, Muskegon County.
06/29/2022	Contact - Telephone call received Received telephone from Darcy Torrey, Home Supervisor
06/29/2022	Contact - Telephone call received On 06/28/2022, I received a phone call from the Licensee Designee/Administrator, Ann Meldrum.
06/29/2022	Contact - Document Received Email received from Caren Lynn, DHHS, APS, Muskegon County
07/01/2022	Inspection Completed On-site Met with Ann Meldrum, Licensee Designee/Administrator, Darcey Torrey, Home Supervisor, Linda K. Wagner, Recipient Rights, HealthWest and Caren Lynn, MS. DHHS, APS Caren Lynn.
07/01/2022	Contact - Face to Face Interviewed Resident A, Resident B, Darcy Torrey, Home Supervisor, and Ann Meldrum. Conducted a telephone interview with staff, Travis Hoeft.
07/01/2022	Contact - Document Received Email from Caren Lynn MS, APS, called Direct Care Staff, Travis Hoeft and left voicemail with no return call.
07/01/2022	Contact - Document Received Email from Linda K. Wagner about the investigation.
07/01/2022	Contact - Document Received Received document about the nurse's evaluation of Resident A at her day program.

07/06/2022	Contact - Document Received Caren Lynn, APS sent an email stating she had telephoned Travis Hoeft, three times and there was no answer and she left three voice mail messages and he did not contact her back.
07/13/2022	Contact - Document Received Linda K. Wagner sent me her completed "Report of Investigative Findings," signed on the same date. Recipient Rights HealthWest.
08/26/2022	On 08/26/2022 I conducted a telephone exit conference with the Licensee Designee/Administrator, Ann Meldrum.

ALLEGATION: On 06/29/2022 Resident A was hit in the face by direct care staff Travis Hoeft which left a bruise on her chin.

INVESTIGATION: On 06/28/2022 I received telephone from Darcy Torrey, Home Supervisor on 06/28/2022, stating that Resident A reported she was bruised on her chin and had scratches on her neck and she identified staff as "male." There is only one male staff working in the home. Ms. Torrey reported that she had notified Muskegon County Adult Protective Services (APS) and Recipient Rights at HealthWest. I also received a phone call from the Licensee Designee/Administrator, Ann Meldrum and she stated that Resident A has made other allegations against a male staff and she also reported the home only has one male staff, Travis Hoeft. She stated Linda Wagner from Recipient Rights is coming to the home on Friday 07/01/2022 at 9:00 AM. to interview the resident and the staff. Note: A referral to adult protective serves was not made as the allegations had already been reported to APS at the same time they were reported to me.

On 06/29/2022, I received an email from Karen Lynn APS. She included in her email the following: *"Allegations: (Resident A) resides in an AFC home. (Resident A) has cerebral palsy and anxiety. (Resident A) does not have a legal guardian. On Friday, (Resident A) was hit in the face by a staff member names Travis Hoeft. Travis had left a bruise on her chin and a couple of scratches on her neck. Physical abuse alleged."* The complaint was opened on 06/29/2022 from the referral from Adult Protective Services.

On 06/29/2022, I contacted Ms. Lynn and explained that Recipient Rights from HealthWest would be at the AFC home on Friday 07/01/2022 and she was invited to join us to interview the staff and Resident A. She agreed.

On 07/01/2022, I was at the AFC home and the following were present; Ann Meldrum, Licensee Designee/Administrator, Darcy Torey, Home Supervisor, Linda Wagner, Recipient Rights Advisor from HealthWest, Caren Lynn, APS. We met Resident A and I observed a dime sized bruise on the side of her face. Ms. Meldrum explained that Resident A has been a resident for a long time. She stated that

Resident A does not have a guardian and she can speak for herself with her communication board that contains words and letters, and she points to them. Ms. Wagner, Ms. Lynn and I, conducted the face-to-face interview with Resident A. During the interview if we had difficulty in understanding Resident A, Ms. Torrey would help to clarify with her. We asked her how she had received the bruise on the side of her face. She pointed to the word “man and angry” and “towel in my mouth.” When asked where this occurred, Resident A responded with “bedroom.” When asked if he was trying to clean her up? Resident A responded with, “angry.” When asked if he was yelling, Resident A said, “yes.” When asked if this has happened before she responded with the word “yes.” When asked if it was the same staff she pointed to “yes.” When asked if she told anyone about it she responded with “MOKA.” When asked what day this happened, she pointed to “no.” (Resident A was not able to identify day or the date). When asked if it was day or night she pointed to “night.” When asked if she had told any of the staff at the home she pointed to “no.” Then Resident A said, “move.” When asked who should move, she responded “man.” When asked why the male staff became angry, she responded with “no.” Then she communicated with “finger, mouth” and when asked did he put his finger in your mouth she pointed to “yes.” When asked if he had hurt her, she pointed to her chest and responded with “yes.” When asked if he had hurt her chest she responded with “yes.” When asked how she received the bruise she responded with “man.” When asked if he had hit her, she responded with “yes.” When asked how many times, she responded with “nine.” When asked if he did put his hand over her mouth she responded with “yes.” When asked if he put a blanket and a pillow over her face she responded with “yes.” When asked if she were you in bed when this happened, she responded with “yes.” Resident A added “bid blanket.” When asked if anyone else was in the home she responded with (Resident B’s) name. Resident A pointed to “move man.” When asked if she would feel safe if the man was not here and Resident A responded by pointing to “yes.” We also asked Resident A if something happened during dinner and she pointed to “yes.” We asked her if she was loud, and she pointed to “yes.”

On 07/01/2022, we conducted a face-to-face interview with Resident B who Resident A had identified as being in the home when the incident occurred. She reported that she likes living in the home and that the staff are nice to her. She was able to identify some of the staff by name. When asked about direct care staff Travis Hoeft, she said he was “ok.” She reported that he had given them dinner, but she was unable to report the day or date. When asked if she has ever heard Travis Hoeft yell Resident B said he had yelled at the her and she did not know why. She reported that she has heard him yell at Resident A and Resident C. When asked if she had seen anyone hurt at this home, she said she did not know. When asked if she had seen him hit anyone she said “no.”

On 07/01/2022, we conducted an interview with the Home Manager, Darcy Torrey. She explained that the home has only one staff working at a time therefore, Mr. Hoeft would have been working alone. Ms. Torrey stated that he works second shift and he had been back to work in the home for about a month. She continued to say

that he had worked for Samaritas before but had left and then came back. She stated that she had called Mr. Hoeft to let him know that he needed to be in the home on 07/01/2022, at 9:00 AM and he agreed to be here. She was unsure why he had not showed up or called her to say that he could not come. Ms. Torrey called him and asked why he was not at the home, and he said he was not coming because of his daughter. She asked him if we could speak with him via speaker and he said yes. Ms. Torrey told him who was present, and he was asked what he remembered about his shift on 06/28/2022. He said he did not remember anything. When asked if there was an issue with Resident A he started yelling and said, "Did you see anything written about anything? No you did not, that means nothing happened." He then yelled, "I don't need this job", and would not respond to our questions. At this point, Ann Meldrum explained to him that we were trying to figure out what had happened. Mr. Hoeft responded, "This is bull shit, I did not record anything, so nothing happened. These people can say anything about you and I don't want this job anymore." At this point Ms. Meldrum determined that we were not getting anywhere in our discussion with Mr. Hoeft so she ended the telephone call. Ms. Meldrum stated that she has never experienced Ms. Hoeft this way and that normally is much calmer. Ms. Meldrum stated that Resident A is a good source of information especially when she is consistent with her story, which she stated she has been.

On 07/01/2022, Ms. Lynn and I learned from Ms. Wagner that Resident A had been interviewed by nurses at MOKA's day program where Resident A attends. The two nurses, Sarah Cunningham, RN and Joe Clifford, RN, had taken pictures of Resident A's injury on her face. They had also written their statement about what Resident A told them about the incident. Ms. Wagner stated that she would send Ms. Lynn and myself the pictures taken of Resident A's face, and she would send the written statement by the nurses.

On 07/01/2022, Ms. Torrey provided me with copies of Resident A's assessment plan, and PCP, and Health Care Appraisal. The Health Care Appraisal dated 08/25/2021, and the diagnoses included: *"Dysphagia, Pharyngeal Phase, Cerebella Palsy, Insomnia, Chronic Major Depression and Anxiety."* Resident A signed her own AFC-Resident Care Agreement on 11/30/2021. Resident A's, Assessment Plan was signed by Resident A. This document read that Resident A communicates her needs by using a "*dynavox and a bliss board to communicate."* Under the section of Controls Aggressive Behavior, "No" was checked and it read, *"At times, may strike out and try to bite staff when she gets frustrated."* Under the section of the assessment plan of "Self care Skill Assessment with the sections of A through H were checked with "yes," which means she needs help and requires assistance with all of her *"Eating/Feeding, Toileting, Bathing, Grooming (hair care, teeth, nails, etc.) Dressing Personal Hygiene, and Walking/Mobility."* The assessment also indicated that she uses a wheelchair, shower chair, bliss board and coated spoon. I reviewed her HealthWest "Treatment Plan." This document indicated she has a risk of injury related to dependence upon staff for mobility and severe spastic quadriplegia.

On 07/01/2022, I received the information from Ms. Wagner through secured email. There were pictures of the bruise on the side of Resident A's face and the information provided from Sarah Cunningham, RN at MOKA, dated 06/28/2022, which read as follows: "*This RN was contacted by Supervisor Laura Ritchie because there was an incident at the home and the client (Resident A) arrived at MOKA with a bruise on her face. Recipient Rights was notified, and they asked an RN to see Client (Resident A) today to assess the bruise. I brought Joe Clifford-RN out with me to assess her. She has a small dime sized brise on the left side of her chin. It was purple already and the client (Resident A) stated it was from Friday night. We asked her what happened for (Resident A) to get the bruise and Nikki (no last name provided) (MOKA Staff) stated that she had talked with (Resident A) this morning and asked (Resident A) permission to say what happened and (Resident A) said yes. Nikki says that (Resident A) stated that a male staff was feeding her Friday night and she was being loud, he told her to be quiet, she did not, and he put his hand over her mouth. She was still making noise, so he took her to her bedroom put her to bed and put the blanket over her face. (Resident A) started to wheel back while we were talking and went to the changing room at MOKA. We followed her and she pointed to the pillow and her face. She asked to move out of the home. I told her that the male staff is being taken off work and that we will let Laura and SC (Supports Coordinator) Sera (Castaneda) know about her wishes. She did have 2 scratches on her face and her neck, but she said she did it to herself on Saturday. The brise was purple, oval, dime sized on the left side of her chin. It looked like it could be a fingerprint."*

On 07/06/2022, I received an email from Ms. Caren Lynn, APS and she wrote that she had called Mr. Travis Hoeft three times with no answer, and she said she left three messages and he did not return any of her phone calls.

On 07/13/2022, Linda K. Wagner, Recipient Rights, sent me her completed "Report of Investigative Findings," signed on the same date. Her report stated that she substantiated abuse against Travis Hoeft.

On 08/24/2022, I reviewed the Incident/Accident Report dated on 06/28/2022, written by direct care staff, Mary Elders. The report read, "*When staff arrived for shift, staff noticed that (Resident A) had a bruise by her mouth on her chin and that she had scratches on her neck on right side. The brise is dark purple and looks fresh. Staff made Home Manager aware of it and that it was there when staff arrived for shift. Home Manager was made aware and will look into it."* Written on the IR by Darcy Torrey, "Laura Ritchie called at 9:34 & 9:54. Home Manager made appropriate phone calls after speaking with her at 9:59. MOKA staff talked to her (Resident A) and she stated male staff hit her. Staff was put on administrative leave per investigation on 07/01/2022.

On 08/24/2022, I sent an email to Ann Meldrum. She wrote back to me saying that they terminated Travis Hoeft the day of the investigation 07/01/2022.

On 08/25/2022, Caren Lynn, APS substantiated against Travis Hoeft.

On 08/26/2022, I conducted a telephone exit conference with the Licensee Designee/Administrator, Ann Meldrum. She agreed with my findings. She stated they terminated the staff immediately.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	On 06/28/2022 Direct Care Staff, Mary Elders reported seeing a bruise on Resident A by her mouth. Registered Nurse, Sarah Cunningham reported Resident A had a small dime sized brise on the left side of her chin that looked like it could be a fingerprint. She reported that Resident A had informed another staff of the home that a male staff was feeding her on Friday night put his hand over her mouth and a blanket over her face. Resident A communicated to me through the use of her bliss board that staff Travis Hoeft had been angry with her, put his finger in her mouth and put a blanket and a pillow over her face. She reported he had put the bruise on her face. On 07/01/2022, I observed a bruise on the side of Resident A's face near her mouth and her chin. Ms. Meldrum the Licensee Designee confirmed that Resident A is a good source of information especially when she is consistent with her story, which she has been. Travis Hoeft stated nothing happened and refused to answer any questions regarding the allegation. During this investigation evidence was found that direct care staff, Travis Hoeft, had his hand over Resident A's mouth causing a bruise and he had put a blanket and a pillow over

	Resident A's face. His action was intentional to Resident A. Therefore Ms. Hoeft had mistreated Resident A resulting in a violation being established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend that the Licensee provide an acceptable plan of correction and the license remain unchanged.

Arlene B. Smith 08/26/2022

Arlene B. Smith, MSW Date
Licensing Consultant

Approved By:

Jerry Hendrick 08/26/2022

Jerry Hendrick Date
Area Manager