GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 5, 2022

Roseline Rowan
Medhealth Suppliers & Providers, Inc.
706 Britten Ave
Lansing, MI 48910

RE: License #: AS230294121
Investigation #: 2022A0783058
Evergreen Place II

Dear Ms. Rowan:

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 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 (517) 284-9730.

Sincerely,

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS230294121
Investigation #:	2022A0783058
Complaint Receipt Date:	08/08/2022
Investigation Initiation Date:	08/09/2022
Report Due Date:	10/07/2022
Licensee Name:	Medhealth Suppliers & Providers, Inc.
Licensee Address:	706 Britten Ave Lansing, MI 48910
Licensee Telephone #:	(517) 712-8585
Administrator:	Roseline Rowan
Licensee Designee:	Roseline Rowan
Name of Facility:	Evergreen Place II
Facility Address:	4048 Windward Dr. Lansing, MI 48911
Facility Telephone #:	(517) 580-4990
Original Issuance Date:	04/28/2008
License Status:	REGULAR
Effective Date:	10/13/2021
Expiration Date:	10/12/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A had a bruise/cut above her left eye and scratches on her back that were unexplained.	No
Additional Findings	Yes

III. METHODOLOGY

08/08/2022	Special Investigation Intake - 2022A0783058
08/09/2022	Special Investigation Initiated - Telephone call with Complainant
08/09/2022	Contact - Telephone call made to Guardian A1
08/25/2022	Inspection Completed On-site
08/25/2022	Contact - Face to Face interviews with direct care staff member Kelley Warner and Resident A
08/25/2022	Contact - Telephone call made to licensee designee Roseline Rowan
08/25/2022	Contact - Document Received - Resident A's written resident record
09/28/2022	Contact - Telephone call made to Roseline Rowan
10/02/2022	Contact - Telephone call made to community mental health (CMH) case manager Dawn Eccles
10/03/2022	Contact - Telephone call made to direct care staff member Camille Owens
10/03/2022	Contact - Telephone call made to direct care staff member Madonna Pinder
10/03/2022	Contact - Document Received - Resident A's written *Treatment Plan*
10/04/2022	Contact - Document Received - Employee records for Kelley Warner and Camille Owens

10/04/2022	Contact - Telephone call made to Roseline Rowan
10/04/2022	Contact - Document Received - Employee schedule for previous 90 days
10/05/2022	Exit Conference - Left message for Roseline Rowan

ALLEGATION:

Resident A had a bruise/cut above her left eye and scratches on her back that were unexplained.

INVESTIGATION:

On August 8, 2022, I received a complaint via centralized intake that stated on August 4, 2022, Resident A had multiple seizures, fell off the dining room chair where she was sitting, and hit her face on the floor or a stand that was near the table. The written complaint stated Resident A went to the hospital after the seizure(s) due to having blood around her nose and mouth area. The written complaint stated that upon meeting Resident A at the hospital Complainant noted “a spot” by Resident A’s left eye, that looked like it happened since the last time Complainant saw Resident A, which was July 24, 2022. The written complaint stated later on August 4, 2022, Complainant was notified Resident A had two scratches on her back. The written complaint stated Complainant was not informed of the scratches nor the injury near Resident A’s left eye.

On August 9, 2022, I spoke to Complainant who verified the allegations in the written complaint. Complainant said no staff member at the facility ever reported the bruise/cut above Resident A’s left eye nor the scratches on her back.

On August 9, 2022, I spoke to Guardian A1 who said on August 4, 2022, she received a phone call letting her know that Resident A had a seizure, fell at the facility and “hit her face” on either the floor or a small table near where Resident A seized and fell. Guardian A1 said Resident A went to the hospital due to having blood around her mouth and nose after the seizure. Guardian A1 said when she saw Resident A at the hospital, she noted a bruise/cut near Resident A’s left eye that appeared “scabbed over” and yellow in color, which Guardian A1 said indicated the bruise/cut did not occur because of the seizure and fall that Resident A had earlier that day. Guardian A1 said when Resident A was discharged from the hospital, she took her home for a visit and then noticed two scratches on Resident A’s back that appeared “scabbed over.” Guardian A1 said she last saw Resident A on July 24, 2022, and Resident A did not have any bruises or scratches on her, so the bruises and scratches were sustained between July 24, 2022 and August 4, 2022. Guardian

A1 said no staff member nor anyone from the facility notified her Resident A was injured or had bruises or scratches on her face nor back. Guardian A1 said Resident A cannot verbally communicate about how the injuries occurred due to her disability. Guardian A1 said Resident A has fallen multiple times at the facility.

On August 25, 2022, I conducted an unannounced onsite investigation and requested an employee schedule from July 24, 2022 – August 4, 2022. Direct care staff member Kelley Warner directed me to a binder containing an employee schedule from March 2022 and there was no written schedule available from July 24, 2022 – August 4, 2022. During the onsite investigation I interacted with Resident A and determined that she was unable or unwilling to answer questions related to the allegations in the complaint. I noted that Resident A did not appear to have any visible marks anywhere on her body and she appeared comfortable and relaxed. I noted that Resident A specifically sought out interactions with Ms. Warner and did not appear to be afraid of Ms. Warner in any way.

On August 25, 2022, I spoke to licensee designee Roseline Rowan who said typically the live–in staff member Kelley Warner works each shift each day but she was out of town from August 1, 2022 – August 3, 2022 and the staff members who worked those days were Camille Owens, Madonna Pinder, and Kenya (last name unknown). Ms. Rowan said an individual named Kenya whose last name she did not know worked the overnight shift on August 1, 2022 and August 2, 2022. Ms. Rowan denied that she had contact information for a staff member known as Kenya. Ms. Rowan said Ms. Pinder worked August 1, 2022 and August 2, 2022, from 9:00 am to 3:00 pm. Ms. Rowan said Ms. Owens worked one shift between August 1, 2022 and August 3, 2022. Ms. Rowan said Resident A has a seizure disorder and that she had a seizure on August 4, 2022, which caused her to fall and hit her head. Ms. Rowan said she was not present but direct care staff member Kelley Warner told her Resident A had a seizure and fell in the dining room on August 4, 2022. Ms. Rowan said she was told that after seizing and falling Resident A was bleeding near her nose and mouth, so Ms. Warner dialed 911 and an ambulance came to the facility and took Resident A to the hospital. Ms. Rowan said Ms. Warner told her that Resident A had a bruise/cut near her left eye that happened before the seizure when Resident A fell because she was wearing another resident's clothing that was too big and Resident A tripped and fell. Ms. Rowan said she saw the bruise/cut and that it looked "new" to her, as if it happened when Resident A fell after she seized. Ms. Rowan said Guardian A1 made her aware of scratches on Resident A's back and that Ms. Rowan looked at the scratches and thought they appeared "fresh," as if it could have happened when Resident A seized and fell. Ms. Rowan said Resident A falls regularly and that she self – harms by smacking herself in the face. Ms. Rowan denied that Resident A ever showed any fear of nor reluctance to be around any staff member at the facility.

On August 25, 2022, I spoke to direct care staff member Kelley Warner who stated she began working at the facility as a live–in staff member on July 27, 2022. Ms. Warner said she did not work from the morning of August 1, 2022 – the evening on

August 3, 2022. Ms. Warner said when she returned to the facility on August 3, 2022, Resident A did not have a bruise/cut above her left eye nor any scratches on her back. Ms. Warner said on August 4, 2022, Resident A had a seizure and fell and that "there was blood everywhere." Ms. Warner said Resident A was bleeding from her face, but she could not tell exactly what was bleeding. Ms. Warner said she telephoned 911 and an ambulance came and took Resident A to the hospital. Ms. Warner said after Resident A seized and fell, she noted "redness" by Resident A's left eye for the first time. Ms. Warner said she also noticed that Resident A's lip was bleeding after she seized and fell. Ms. Warner said she noted scratches on Resident A's back when she returned to the facility on August 3, 2022, after not being there since the morning of August 1, 2022. Ms. Warner said there were two scratches on Resident A's middle back that appeared "fresh." Ms. Warner stated there was no written incident report completed nor verbal report made to her by Ms. Owens nor Ms. Pinder who worked at the facility while she was off from August 1, 2022 – August 3, 2022. Ms. Warner said she notified Guardian A1 of the scratches on August 3, 2022. Ms. Warner said Resident A falls "a lot" and that she self-harms by hitting herself in the temple area. Ms. Warner said she did not do anything to cause a bruise/cut near Resident A's eye nor scratches on her back. Ms. Warner denied that Resident A appeared afraid of nor reluctant to interact with any staff member at the facility.

On October 3, 2022, I spoke to direct care staff member Camille Owens who stated she worked at the facility on August 3, 2022 and observed Resident A. Ms. Owens said Resident A did not have scratches on her back nor a bruise/cut above her eye when she saw her on August 3, 2022. Ms. Owens said when she was working at the facility on August 3, 2022, she observed direct care staff members Madonna Pinder and Kelley Warner both interacting with Resident A. Ms. Owens denied that she had any concerns regarding Ms. Warner nor Ms. Pinder. Ms. Owens denied that Resident A appeared afraid of nor reluctant to interact with Ms. Warner and Ms. Pinder. Ms. Owens said Resident A has a seizure disorder that at times causes her to seize and fall. Ms. Owens said Resident A has an unsteady gait and that she falls regularly. Ms. Owens said Resident A self – harms by hitting herself in the face. Ms. Owens denied that she did nor observed anything that could have caused a bruise/cut above Resident A's eye nor scratches on her back when she worked on August 3, 2022.

On October 3, 2022, I spoke to direct care staff member Madonna Pinder who stated she worked at the facility from 9:00 am to 3:00 pm on August 1, 2022, August 2, 2022, and August 3, 2022. Ms. Pinder said she did not see a bruise/cut above Resident A's eye nor scratches on Resident A's back when she worked at the facility daily from August 1, 2022 – August 3, 2022. Ms. Pinder said she observed Ms. Owens and Ms. Warner at the facility and interacting with Resident A and did not note any concerns. Ms. Pinder said Resident A has a seizure disorder that causes her to seize and fall on occasion and that Resident A also has an unsteady gait and falls frequently. Ms. Pinder said Resident A self – harms by hitting herself in the

face. Ms. Pinder denied that she did nor observed anything that could have caused a bruise/cut above Resident A's eye nor scratches on Resident A's back.

On October 2, 2022, I spoke to community mental health (CMH) case manager Dawn Eccles who said Resident A has a seizure disorder which causes her to seize and fall several times a year which is what happened on August 4, 2022. Ms. Eccles said she was told and received a written incident report that indicated Resident A hit her head when she seized and fell on August 4, 2022, which is what caused the bruise/cut noted above Resident A's left eye on August 4, 2022. Ms. Eccles said Guardian A1 notified her that Resident A had scratches on her back that were first noted on August 4, 2022, after Resident A had a seizure and fell. Ms. Eccles stated Resident A is unable to verbalize how she sustained the bruise/cut above her eye nor the scratches on her back due to her disability. Ms. Eccles stated she visits with Resident A regularly at the facility and has no concerns about the staff members who worked July 24, 2022, through August 4, 2022. Ms. Eccles denied that Resident A ever expressed any verbal nor nonverbal cues that she was afraid of nor reluctant to interact with any staff member at the facility. Ms. Eccles stated she had no reason to suspect that Resident A was abused by any staff member at the facility.

On August 25, 2022, I requested and reviewed Resident A's current written *Health Care Appraisal* which indicated Resident A was diagnosed with seizure disorder as well as psychosis.

On August 25, 2022, I requested and reviewed Resident A's current written *Assessment Plan for AFC Residents* which indicated that Resident A has a history of biting herself and slapping herself in the face. The written assessment plan indicated that Resident A struggles with walking/mobility and that her legs "get weak." The written assessment plan indicated Resident A had a seizure disorder.

On October 3, 2022, I received and reviewed Resident A's current written *Treatment Plan* developed with CMH and noted the *Treatment Plan* documented that Resident A does not express herself verbally, that she has been diagnosed with a seizure disorder and that she has a tendency to self-harm by hitting herself in the face.

APPLICABLE RULE	
R 400.14305	**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:	Based on statements from Guardian A1, Ms. Rowan, Ms. Warner, Ms. Owens, Ms. Pinder, and Ms. Eccles along with written documentation at the facility and my observations at the unannounced onsite investigation I determined that Resident A has been diagnosed with a seizure disorder and that she had a seizure and fell on August 4, 2022 which is the same day she was noted to have a bruise/cut above her left eye and scratches on her back. All staff members who worked with Resident A denied that they did anything to cause the bruise/cut on Resident A's eye nor the scratches on her back. Everyone interviewed denied having any concerns about Resident A's interactions with any staff members who work at the facility. Resident A has a documented history of self-harm and has an unsteady gait which have caused her to fall in the past. The investigation did not reveal any evidence to indicate that Resident A was abused at the facility nor that any staff member did anything to cause the bruise/cut above Resident A's eye and the scratches on her back.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On August 25, 2022, I conducted an unannounced onsite investigation at the facility and asked direct care staff member Kelley Warner for a current staff schedule and was provided a schedule from March 2022. The same day I spoke with licensee designee Roseline Rowan and requested that she send a staff schedule immediately via email for the previous 90 days so I could determine who worked from July 24, 2022 – August 4, 2022. Ms. Rowan stated Ms. Warner is the live–in staff and works all shifts except for August 1, 2022 – August 3, 2022, when staff members Camille Owens, Madonna Pinder, and "Kenya" (last name unknown) worked at the facility while Ms. Warner was out of town. On October 4, 2022, Ms. Rowan provided a written employee schedule that indicated staff members "Kelly" and "Falita" worked from July 24, 2022 – August 4, 2022. There was no additional information available on the schedule.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information:

	(a) Names of all staff on duty and those volunteers who are under the direction of the licensee. **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	Based on interviews with Ms. Warner and Ms. Rowan along with my observations at the onsite investigation and written documentation later provided by Ms. Rowan, I determined that there was no daily employee schedule of advance work assignments including all the required information.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On August 25, 2022, I interviewed direct care staff member Kelley Warner who said she was not trained in any resident care related topics between when she started as a live–in staff member on July 27, 2022, up until the interview which was approximately one month later. Ms. Warner stated the direct care staff member who worked at the facility before her quit abruptly and did not train her and that licensee designee Roseline Rowan was at the facility approximately once weekly to drop off supplies since she started her employment.

On August 25, 2022, September 28, 2022 and October 4, 2022, I spoke to licensee designee Roseline Rowan and she reported direct care staff member Kelley Warner completed training in the topics of medication administration, CPR/first aid, and resident rights. Ms. Rowan denied that Ms. Warner completed training in the topics of reporting requirements, safety and fire prevention, prevention and containment of communicable diseases and the personal care, supervision, and protection needs of the residents in the home. Ms. Rowan acknowledged that while Ms. Warner was out of town for two days, she arranged for one staff member known as Kenya (last name unknown) to work the overnight shift and two additional staff members known as Camille Owens and Madonna Pinder to work at the facility during the day. Ms. Rowan stated a staff member known as “Falita” only worked as “back up” at the facility where she cleaned and did laundry. Ms. Rowan agreed to provide all employee records for facility staff members on October 4, 2022.

On October 3, 2022, I spoke to direct care staff members Camille Owens and Madonna Pinder who stated they worked at the facility between August 1, 2022 and August 3, 2022. Both employees indicated they regularly work at the licensee’s other separately licensed facilities.

On October 4, 2022, licensee designee Roseline Rowan provided employee records for Kelley Warner and Camille Owens. I noted that Ms. Warner's employee record did not contain documentation that she was trained and deemed competent in the required topics. I noted that there were no reference checks completed for Ms. Warner. I noted that Ms. Owens employee record did not contain documentation that at least two references were contacted. Ms. Rowan did not provide employee records for Kenya (last name unknown), Falita (last name unknown), nor Madonna Pinder who she stated worked at the facility between August 1, 2022 and August 3, 2022.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Based on statements from Ms. Warner and Ms. Rowan along with reviewing the written documentation provided by Ms. Rowan I determined that Ms. Warner who is the full – time live – in staff person as well as employees known as "Kenya" (last name unknown), "Falita" (last name unknown) and Madonna Pinder did not complete training in, nor were they assessed and deemed competent in all the required topics listed above.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information:

	(a) Name, address, telephone number, and social security number. **(b) The professional or vocational license, certification, or registration number, if applicable.** **(c)A copy of the employee's driver license if a direct care staff member or employee provides transportation to residents.** **(d) Verification of the age requirement.** **(e) Verification of experience, education, and training.** **(f) Verification of reference checks.** **(g) Beginning and ending dates of employment.** **(h) Medical information, as required.** **(i) Required verification of the receipt of personnel policies and job descriptions.**
ANALYSIS:	Based on statements from Ms. Warner, Ms. Rowan, Ms. Owens, and Ms. Pinder along with written documentation requested from Ms. Rowan I determined that there were five employees in total who worked at the facility from July 24, 2022 and August 4, 2022, who were Ms. Warner, Ms. Owens. Ms. Pinder, a person known as “Kenya” (last name unknown), and a person known as “Falita” (last name unknown). I further determined that Ms. Rowan did not provide complete employee records for each employee at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under

	contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	Based on statements from those interviewed and written documentation in the employee records provided by Ms. Rowan I determined that there was no documentation that a criminal history background clearance was completed for an employee known as “Kenya” (last name unknown), an employee known as “Falita” (last name unknown), and employee Madonna Pinder who all worked at the facility between August 1, 2022 and August 3, 2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On August 25, 2022, I completed an unannounced onsite investigation at the facility and requested and reviewed Resident A’s written resident record which did not contain any written *AFC Licensing Division Incident/Accident Reports* for Resident A.

On August 25, 2022, I interviewed direct care staff member Kelley Warner who said Resident A had a seizure and was hospitalized on August 4, 2022. Ms. Warner said she did not complete a written *AFC Licensing Division Incident/Accident Report* to document Resident A’s admission to the hospital because she “found out about” completing written incident reports after Resident A returned from the hospital. Ms.

Warner stated she never completed a written incident report concerning Resident A's hospitalization on August 4, 2022.

On August 25, 2022, September 28, 2022 and October 4, 2022, I spoke to licensee designee Roseline Rowan who confirmed that no written *AFC Licensing Division Incident/Accident Report* was completed to document Resident A's hospitalization on August 4, 2022.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.**
ANALYSIS:	Based on statements from Ms. Warner and Ms. Rowan along with my observations at the unannounced onsite inspection I determined that Resident A was hospitalized on August 4, 2022 and Ms. Warner who was working at the time, nor Ms. Rowan ever completed a written *AFC Licensing Division Incident/Accident Report* concerning that hospitalization.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in the status of the license.

10/5/2022

Leslie Herrguth Date
Licensing Consultant

Approved By:

10/05/2022

Dawn N. Timm Date
Area Manager