

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

November 22, 2022

Molly Mendenhall 318 Richfield Ave Battle Creek, MI 49037

> RE: License #: AF130294056 Investigation #: 2022A1034006

The Morris House

Dear Ms. Mendenhall:

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,

Kevin L. Sellers

Kevin Sellers, Licensing Consultant Bureau of Community and Health Systems 611 W. Ottawa Street P.O. Box 30664 Lansing, MI 48909 (517) 230-3704

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF130294056
Investigation #:	2022A1034006
Communicat Descript Date:	00/00/0000
Complaint Receipt Date:	09/28/2022
Investigation Initiation Date:	09/29/2022
investigation initiation bate.	03/23/2022
Report Due Date:	11/27/2022
Licensee Name:	Molly Mendenhall
Licensee Address:	318 Richfield Ave
	Battle Creek, MI 49037
Licensee Telephone #:	(269) 965-4645
Licensee Telephone #.	(200) 300-4040
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	The Morris House
Facility Address:	318 Richfield Ave
racinty Address.	Battle Creek, MI 49037
	Battle Greek, IIII 16661
Facility Telephone #:	(269) 965-4645
Original Issuance Date:	03/24/2008
License Ctature	DECLUAD
License Status:	REGULAR
Effective Date:	10/01/2020
Liiotivo Buto.	10/01/2020
Expiration Date:	09/30/2022
Capacity:	6
	DEVELOPMENTALLY DISCIPLIES
Program Type:	DEVELOPMENTALLY DISABLED
	MENTALLY ILL AGED
	NOLD

II. ALLEGATION(S)

Violation Established?

There is a video of a female taking Resident A to his financial	No
institution withdrawing large amounts of money. Complainant is	
concerned the person may be a staff member taking advantage of	
the resident since the purpose for the money is unknown.	
There is no phone for residents or staff to use in the house.	No
There is damage to the kitchen floor which is concerning.	No
Additional Findings	Yes

III. METHODOLOGY

09/28/2022	Special Investigation Intake 2022A1034006
09/28/2022	APS Referral- not required as APS is investigating
09/28/2022	Contact - Telephone call made left voice message for Complainant.
09/28/2022	Contact - Telephone call received with voice message from Complainant.
09/28/2022	Contact - Document Received with an email from Complainant.
09/29/2022	Special Investigation Initiated – Telephone contact with Complainant, Complainant interviewed.
09/30/2022	Inspection Completed On-site with APS specialist Rebecca Karrar
09/30/2022	Contact - Face to Face interviews with direct care workers-Brittany Wines and Joshua Morris, Licensee-Molly Mendenhall, Residents A, B, C and D.
09/30/2022	Contact - Document Received through an email from Licensee- Molly Mendenhall, regarding renewal completion and receipt.
10/06/2022	Exit Conference with Licensee-Molly Mendenhall
10/07/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

- There is a video of a female taking Resident A to his financial institution withdrawing large amounts of money. Complainant is concerned the person may be a staff member taking advantage of the resident since the purpose for the money is unknown.
- There is no phone for residents or staff to use in the house.

INVESTIGATION:

On 09/28/2022, I received a complaint through the Bureau of Community Health Systems' (BCHS) online complaint system alleging there is video footage of female taking Resident A to his financial institution and withdrawing large amounts of money. Complainant did not know who this female was but was concerned it might be a staff member or the licensee of the facility taking advantage of Resident A. It was alleged Resident A did not know what this money is for, nor how much he is paying in rent. Complainant also alleged Resident A told staff he needed the money to get "Molly", the licensee, off his back. Complainant indicated there was no working house phone for residents or staff to use.

On 09/30/2022, I spoke briefly with Calhoun County Department of Health and Human Services Adult Protective Services (APS) Specialist Rebecca Karrar prior to my unannounced onsite investigation. Ms. Karrar reported the concerns regarding Resident A's money, a non-working phone and floor damage in the kitchen were brought to her attention several days ago. Ms. Karrar reported already visiting the home and contacting local law enforcement due to the concerns for Resident A.

On 09/30/2022, I conducted an unannounced onsite investigation at the home in conjunction with APS Specialist, Rebecca Karrar. I interviewed licensee Molly Mendenhall who reported being aware money was taken from Resident A. Ms. Mendenhall denied that herself nor any of her current direct care staff have coerced or stolen money from Resident A. Ms. Mendenhall reported she has previously provided Resident A transportation to his bank several times so Resident A could take out money from his bank account. Ms. Mendenhall reported direct care worker (DCW) Joshua Morris has also provided transportation for Resident A to do the same. Ms. Mendenhall reported the only financial means she retrieves from residents are their monthly rent. Ms. Mendenhall denied keeping track of resident's funds unless residents request it. Ms. Mendenhall then shared staff member Demonta Jenkins-Gooden was terminated over a month ago for various work performance related reason. Ms. Mendenhall stated she later learned Demonta Jenkins-Gooden also took money from Resident A after Resident A reported to her Demonta Jenkins-Gooden took his money. Ms. Mendenhall denied know the exact amount of money Demonta Jenkins-Gooden stole from Resident A. Ms. Mendenhall stated Resident A admitted to giving this former staff member Resident A's bank debit card and pin number after asking Demonta Jenkins-Gooden to take out money for Resident A. Ms. Mendenhall reported Resident A could not provide any dates

when he gave Demonta Jenkins-Gooden verbal permission to go to the bank for him. Ms. Mendenhall reported confronting Demonta Jenkins-Gooden about taking Resident A's money without his permission along with other items from the family home. Ms. Mendenhall reported Demonta Jenkins-Gooden denied taking Resident A's money or taking things out of the house. Ms. Mendenhall said she terminated Demonta Jenkins-Gooden due to ongoing issues and days after terminating Demonta Jenkins-Gooden is when she noticed all six resident records were missing. Ms. Mendenhall reported contacting Battle Creek Sheriff Department and filing a police report about Resident A's stolen money and the missing resident records. Ms. Mendenhall reported Calhoun County Sheriff came to the AFC home on 09/29/2022, so she was able to give further information about Resident A's stolen money and the missing resident records. Ms. Mendenhall denied having any issues providing copies of her bank records proving she never stole money from Resident A. Ms. Mendenhall reported each resident is aware of how much they pay in rent each month. Ms. Mendenhall also stated there is a telephone available in the AFC home for staff and resident use.

During the unannounced onsite investigation, I interviewed DCW Joshua Morris and DCW Brittany Wines both of whom denied any knowledge of Ms. Mendenhall ever taking money from Resident A. DCW Wines and DCW Morris reported learning Resident A had given former staff member Demonta Jenkins-Gooden his bank debit card and pin number allowing her easy access to take money out of Resident A's bank account. DCWs Wines and Morris both reported they never knew Resident A had given former direct care worker Demonta Jenkins-Goodman verbal permission to use the debit card. Additionally, DCW Morris reported how resident records came up missing around the same time direct care worker Demonta Jenkins-Gooden was terminated. DCW Morris reported being aware Ms. Mendenhall contacted the police regarding both incidents and filing a police report.

I interviewed Resident A who denied having knowledge of a video footage of a female taking Resident A to his financial institution and withdrawing large amounts of money. Resident A then shared Ms. Mendenhall and DCW Morris have provided Resident A transportation in the past to his banking institution to withdraw money. Resident A denied neither Ms. Mendenhall nor DCW Morris has ever taken any money from him outside of his monthly rent. Resident A denied remembering anyone stealing his money, however, Resident A was hesitant on answering the question more in detail. Resident A reported knowing what his monthly rent is each month and was able to verbalize it. Resident A denied having any issues with staff or other residents while residing in the home. Resident A admitted to giving former direct care staff member Demonta Jenkins-Gooden, his bank debit card and pin number to the debit card. Resident A denied knowing how much money former direct care worker Demonta Jenkins-Gooden took from him without his permission.

I interviewed Residents B, C and D who all denied having any issues with staff or their living accommodations in the home. Residents B, C and D reported knowing what their monthly rent is and was able to verbalize how much each of them paid each month.

During the unannounced onsite investigation, I observed the AFC home telephone was working and available for resident and staff use.

APPLICABLE RU	LE	
R 400.1409	Resident rights; licensee responsibilities.	
	 (1) Upon a resident's admission to the home, the licensee shall inform and explain to the resident or the resident's designated representative all of the following resident rights: (o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy. 	
ANALYSIS:	Based on interviews with Residents A, B, C, D, licensee Molly Mendenhall, and DCWs Morris and Wines I did not obtain any disclosures Resident A's money was stolen from him by a direct care staff member. Based on my investigation, there is no evidence towards allegations of a video of a female taking Resident A to his financial institution withdrawing large amounts of money to use without his permission. Resident A admitted given his bank debit care information to a direct care staff member so money could be withdrawn for him. Resident A, B, C and D were able to verbalize what each of them pay in monthly rent. There were no disclosures from Resident A, B, C and D having any issues residing in the home or the residents not being treated with consideration and respect in any manner including their finances.	
CONCLUSION:	VIOLATION NOT ESTABLISHED	

APPLICABLE I	RULE
R 400.1409	Resident rights; licensee responsibilities.
	(1) Upon a resident's admission to the home, the licensee shall inform and explain to the resident or the resident's designated representative all of the following resident rights:
	(e) The right of reasonable access to a telephone for private communications. A licensee may charge a resident for long distance telephone calls. A pay telephone shall not be considered as meeting this requirement.

CONCLUSION:	VIOLATION NOT ESTABLISHED
ANALYSIS:	During my unannounced onsite investigation, I observed the home to have a working telephone available for resident and staff use.

ALLEGATION: There is damage to the kitchen floor which is concerning.

INVESTIGATION:

The complainant alleged there is damaged flooring in the kitchen that is concerning for the mobility of the residents, as they use adaptive equipment to assist with mobility. On 09/30/2022, during the unannounced onsite investigation, I observed the alleged damaged kitchen floor. After completing a walk through across the kitchen floor. I observed a damaged area on the ceramic tile leading from the dining room area to the living room. However, after I walked across the floor several times, I found no issues which would cause a tripping hazard or obstruct residents or anyone else residing in the home from using this space. I briefly spoke with Ms. Mendenhall who reported showing the flooring to AFC licensing consultant Eli Deleon and she has contacted several general contractors to get the ceramic tile fixed.

APPLICABLE RULE	
R 400.14403	Maintenance of premises.
	(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair.
ANALYSIS:	Complainant reported damaged flooring in the kitchen that is concerning for the mobility of the residents, as they adaptive equipment to be mobile. Ms. Mendenhall admitted there was some floor damage to the ceramic tile at the edge of the dining room floor walking into the living room. Ms. Mendenhall reported contacting several contractors for estimates to get the damage repaired. Ms. Mendenhall also reported showing the floor to AFC licensing consultant, Eli Deleon, in August 2022, during an inspection and Mr. Deleon providing technical assistance on how she can repair the damage herself until she is able to have a contractor come into her home and fix the damage ceramic tile. I observed the damage ceramic tile and found no concerns or issues with the current condition hindering and of the residents in the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 09/30/2022, I interviewed Ms. Mendenhall who reported terminating former direct care worker Demonta Jenkins-Gooden and days after, Ms. Mendenhall noticed all six resident records were missing from the home. Ms. Mendenhall reported contacting Battle Creek Sheriff Department and filed a police report regarding the missing resident records.

On 09/30/2022, I interviewed DCW Morris who reported the same information as Ms. Mendenhall about the missing 6 resident record binders.

During an unannounced onsite investigation, I observed all six resident records were missing. However, I observed new binders for each of the residents which had each of the residents' names on the front of the binders. I also observed required AFC forms inside each of the binders for each of the residents.

APPLICABLE RULE	
R 400.14316	Resident records.
	 (1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: (a) Identifying information, including, at a minimum, all of the following: (i) Name (ii) Social security number, date of birth, case number, and marital status. (iii) Former address. (b) Date of admission. (c) Date of discharge and the place to which the resident was discharged. (d) Health care information, including all of the following: (ii) Medication logs. (g) Weight records.
ANALYSIS:	Based on my investigation, through interviews with licensee, Ms. Mendenhall, DCW Morris and observing resident records, no resident records were available for review in the AFC home at the time of my investigation as required.
CONCLUSION:	VIOLATION ESTABLISHED

On 10/06/2022, I completed a scheduled onsite renewal inspection at the facility,

where I was able to review all residents' records. Each resident record contained all required AFC documentation as listed above.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change in license is recommended.

Kevin L. Sellers		11/21/2022
Kevin Sellers Licensing Consultant		Date
Approved By: Dawn Jimm	11/22/2022	
Dawn N. Timm Area Manager		Date