GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 2, 2023

Onome Akise
Rose's American Homes LLC
25083 Ross Dr.
Redford, MI 48239

RE: License #: AS820344486
Investigation #: 2023A0121010
Ross AFC Home

Dear Mr. Akise:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On January 25, 2023, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (313) 456-0380.

Sincerely,

K. Robinson

K. Robinson, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820344486
Investigation #:	2023A0121010
Complaint Receipt Date:	11/22/2022
Investigation Initiation Date:	11/23/2022
Report Due Date:	01/21/2023
Licensee Name:	Rose's American Homes LLC
Licensee Address:	25083 Ross Dr. Redford, MI 48239
Licensee Telephone #:	(248) 254-2285
Administrator:	Onome Akise
Licensee Designee:	Onome Akise
Name of Facility:	Ross AFC Home
Facility Address:	25083 Ross Dr Redford, MI 48239
Facility Telephone #:	(313) 694-3896
Original Issuance Date:	08/01/2014
License **Status:**	REGULAR
Effective Date:	07/01/2022
Expiration Date:	06/30/2024
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 10/1/22, direct care worker, Rachel Gallow pushed Resident A while trying to get him out of the garage.	Yes

III. METHODOLOGY

11/22/2022	Special Investigation Intake 2023A0121010
11/22/2022	APS Referral To LARA
11/22/2022	Referral – Recipient Rights Onome Akise, Licensee designee, sent referral to Rights
11/23/2022	Special Investigation Initiated - Telephone Call to Mr. Akise
11/30/2022	Contact - Telephone call received Mr. Akise asked to postpone onsite until after 12/5/22; he's going out of town.
12/08/2022	Inspection Completed On-site Interviewed Mr. Akise and Resident A.
01/12/2023	Contact - Telephone call made Left message for Staysha Ellison with Adult Protective Services. No response.
01/13/2023	Contact - Telephone call made Direct care worker, Rachel Gallow
01/13/2023	Contact - Telephone call made

	Left message for Amanda Kevnick with Recipient Rights. No response.
01/20/2023	Contact - Telephone call made Amanda Kevnick, Recipient Rights Invesigator (RRI)
01/20/2023	Contact - Telephone call made Follow up call to Mr. Akise
01/23/2023	Contact - Telephone call made Phone interview with Resident B
01/23/2023	Exit Conference Mr. Akise
01/25/2023	Corrective Action Plan Received
01/25/2023	Corrective Action Plan Approved
02/02/2023	Contact – Telephone call made Phone interview with direct care worker, Gail Williams

ALLEGATION: On 10/1/22, direct care worker, Rachel Gallow pushed Resident A while trying to get him out of the garage.

INVESTIGATION: On 12/8/22, I completed an onsite inspection at the facility. I interviewed Resident A who maintains direct care worker, Rachel Gallow pushed him because he ignored her directive to leave the garage area. Resident A acknowledged he was smoking in the garage which is against the house rules. Resident A explained Ms. Gallow became aggressive as she pushed the couch he was sitting on, then she "tipped the couch over" causing him to tumble. Resident A further explained, after the couch fell Ms. Gallow picked up a 2 X 4 piece of wood stored in the garage and "tried to hit me with it"; however, she did not strike him. Resident A reported Ms. Gallow used swear words at him during the altercation. I asked Resident A how the altercation ended. Resident A indicated he does not remember the details, but Ms. Gallow's work shift ended shortly after. Also, Resident A stated he did not report the attack until 2-3 weeks after it happened. Resident A said, "Rachel is always yelling at me."

On 1/13/23, I interviewed Ms. Gallow. Ms. Gallow reported she's been a direct care worker at the facility for 2 years. She denied ever pushing, attempting to push, yelling, or cursing at residents, including Resident A. Ms. Gallow reasoned, "I am an old woman, how can I push them?"

On 1/20/23, I spoke with Recipient Rights Investigator, Amanda Kevnick who indicated Resident A told her that Ms. Gallow knocked him off the couch. According to Ms. Kevnick, Resident A initially reported the incident to his case manager, Morgan (last name unknown) at Lincoln Behavior Services. Per Ms. Kevnick, Morgan is not available for interview as she is currently on maternity leave.

On 1/20/23, I made a follow-up call to licensee designee, Onome Akise. Mr. Akise confirmed Resident A first disclosed the incident to his case manager during a meeting when Mr. Akise provided his 30-day discharge notice. Mr. Akise reported he's received a previous complaint from a former resident about Ms. Gallow's tone and demeanor. Mr. Akise said he's reprimanded Ms. Gallow in the past about her interaction with residents. Mr. Akise described Ms. Gallow as "frail" and a "busy body." According to Mr. Akise, Ms. Gallow walks with a slight bend and she's probably 5 feet, two inches, whereas Resident A is "bigger than her … he could have easily overpowered her."

On 1/23/23, I interviewed Resident B by phone. Resident B described Ms. Gallow as "nice, but it wasn't her type of job." Specifically, Resident B reported Ms. Gallow would come to work "grumpy" and act "snotty" towards residents for no reason. Resident B also stated Ms. Gallow "didn't know how to talk to people." For example, Resident B stated Ms. Gallow would "curse you out" whenever the residents tried to tell her they didn't like her cooking. Although Resident B said Ms. Gallow never tried to physically manage him, Resident B reported he has gotten into "heated conversations" with her. However, Resident B did report a situation where Ms. Gallow tried to "snatch" food out of his hand because she caught him in the kitchen cooking. I asked Resident B if he believed Ms. Gallow would push or hit residents,

Resident B replied, “knowing her yes because she’s ballsy” (meaning, she has a lot of guts and courage).

On 1/23/23, I completed an exit conference with Mr. Akise. I asked Mr. Akise if there are any 2 X 4 wood pieces available in the garage. Mr. Akise acknowledged he has small wood pieces inside the garage leftover from a storage unit he built; he stated residents are not allowed in the garage for safety reasons. Based on the investigative findings, I asked Mr. Akise to submit a plan of correction to address Ms. Gallow’s mishandling of residents. Mr. Akise does not dispute the department’s findings. In fact, Mr. Akise stated he believes Ms. Gallow does take things “too far” with residents especially considering her complaint history involving a former resident. Mr. Akise removed Ms. Gallow from the home schedule pursuant to the investigation.

On 2/2/23, I contacted direct care worker, Gail Williams for a statement. Ms. Williams acknowledged she relieved Ms. Gallow on the day of the incident involving Resident A. Ms. Williams said she did not witness the alleged abuse, but she does remember Ms. Gallow telling her that Resident A accused her of hitting him. Ms. Williams indicated she’s had problems with Resident A smoking in the garage as well, but she has been able to redirect him with verbal prompts without incident. Ms. Williams expressed concern that Ms. Gallow was “just there for a paycheck.” Ms. Williams reported she’s seen Ms. Gallow “several times” throw things at residents, like a cigarette. Overall, Ms. Williams reported “I didn’t like the way she treated them”, referring to Ms. Gallow. Ms. Williams concluded, Ms. Gallow “wasn’t suited for that kind of work.”

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.** **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.** **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.** **(e) Withhold food, water, clothing, rest, or toilet use.** **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.**

	(ii) Verbal abuse. **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.** **(g) Refuse the resident entrance to the home.** **(h) Isolation of a resident as defined in R400.14102(1)(m).** **(i) Any electrical shock device.**
ANALYSIS:	• Resident A reported Ms. Gallow tried to physically manage him as punishment for smoking in the garage. Resident A's statement has remained consistent for months. • Resident B reported Ms. Gallow does use profanity when talking to residents. Resident B also reported Ms. Gallow acted aggressive toward him for trying to cook when he wasn't supposed to. • Mr. Akise reported he's received complaints in the past from a former resident about Ms. Gallow's aggressive tone and demeanor with residents. • Direct care worker, Gail Williams observed Ms. Gallow treat the residents in an undignified manner. Specifically, Ms. Williams has seen Ms. Gallow repeatedly throw things at the residents. • Therefore, the department determined direct care staff, Rachel Gallow subjected the residents to punishment, physical force, mental and emotional cruelty, and verbal abuse.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend the status of this license remain unchanged.

K. Robinson 2/2/23

Kara Robinson Date
Licensing Consultant

Approved By:

2/2/23

Ardra Hunter Date
Area Manager