GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 15, 2023

Louise Semetko
Everest Inc.
PO Box 2352
Riverview, MI 48193

RE: License #: AS820074518
Investigation #: 2023A0992011
Melbourne Home

Dear Mrs. Semetko:

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 (313) 456-0380.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820074518
Investigation #:	2023A0992011
Complaint Receipt Date:	01/09/2023
Investigation Initiation Date:	01/10/2023
Report Due Date:	03/10/2023
Licensee Name:	Everest Inc.
Licensee Address:	PO Box 2352 Riverview, MI 48193
Licensee Telephone #:	(734) 675-3037
Administrator:	Louise Semetko
Licensee Designee:	Louise Semetko
Name of Facility:	Melbourne Home
Facility Address:	15829 Bellaire Allen Park, MI 48101
Facility Telephone #:	(313) 928-7988
Original Issuance Date:	12/18/1996
License Status:	REGULAR
Effective Date:	10/01/2021
Expiration Date:	09/30/2023
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 01/08/23 the Allen Park Police received a call from a citizen that found Resident A barefoot at the intersection of Goddard Rd and Reeck Rd in Allen Park. The Allen Park Police went to the home, no one answered, and they entered through the front door. The police officer found the home staff in the back room sleeping.	Yes

III. METHODOLOGY

01/09/2023	Special Investigation Intake 2023A0992011
01/10/2023	Special Investigation Initiated - On Site Felicia Wilson, home manager and Resident A
01/20/2023	Contact - Telephone call received Tammy Coleman, Adult Protective Services (APS)
01/23/2023	Contact - Telephone call made Louise Semetko, Licensee Designee was not available. Message left.
01/23/2023	Contact - Telephone call made Michelle Rupert, Administrator
01/23/2023	Contact - Telephone call made Police Report
01/23/2023	Contact - Document Received Ann McGibbon, Resident A's Supports Coordinator with Community Living Services
01/23/2023	Contact - Telephone call made Louise Semetko, Licensee Designee was not available. Message left.
01/31/2023	Contact - Telephone call made Guardian A
01/31/2023	Contact - Telephone call made Ms. McGibbon

02/09/2023	Exit Conference Ms. Semetko
02/10/2023	Referral - Recipient Rights

ALLEGATION: On 01/08/23 the Allen Park Police received a call from a citizen that found Resident A barefoot at the intersection of Goddard Rd and Reeck Rd in Allen Park. The Allen Park Police went to the home, no one answered, and they entered through the front door. The police officer found the home staff in the back room sleeping.

INVESTIGATION: On 01/10/2023, I completed an unannounced onsite inspection and interviewed Felicia Wilson, home manager and observed Resident A. Resident A is non-verbal and unable to be interviewed. Ms. Wilson confirmed the allegations and stated she was not on shift when the incident occurred. She said Jazmin Plummer and Caticae Taylor, direct care staff were scheduled for the day shift. Ms. Wilson said unbeknownst to her Ms. Taylor was running thirty minutes late, and Ms. Plummer was the only staff on shift. She said if staff would have notified her, she would have asked the previous staff to stay over until Ms. Taylor arrived. However, Ms. Wilson said she believe Resident A left the home through the front door and was later found wandering down Goddard Rd. She said someone called the police and she was transported back home. When the police arrived at the home Ms. Plummer was observed sleeping. Ms. Wilson said Ms. Plummer is no longer with the company. I asked if Resident A has a history of elopement and she said yes. She said Resident A eloped once before and as a result door alarms were placed on the front and rear exits. It should be noted, I observed the door alarms at both means of egress, which were loud and functional. Ms. Wilson said the day-to-day staffing ratio is 2:4 and sometimes 3:4 (split shift) depending on the daily activities of the home.

I observed Resident A while onsite. She appears to be very active, constantly walking through the home. She was clean and adequately dressed.

While onsite I obtained a copy of Resident A's individual plan of service (IPOS) and a copy of the incident reports pertaining to her eloping, both past and present. Resident A's IPOS indicates that she needs full assistance in all areas and must be monitored at all times. She needs monitoring with door chimes on at all times due to history of elopement. As it pertains to "awake hours" DCS must be aware of Resident A's whereabouts at all times including a visual check every 15 minutes. In the "community" DCS must be arm-in-arm or hold her hand unless she is holding the shopping cart. As it pertains to the incident reports reviewed, Resident A eloped 06/05/2022 and was found by the police and returned to the home.

On 01/20/2023, I received a call from Tammy Coleman, Adult Protective Services (APS) regarding the reported allegations. Ms. Coleman made me aware that she is investigating the allegations. She said there is a meeting scheduled 01/27/2023 to determine the next course of action for Resident A and to prevent elopement in the future. She said there has been some discussion about relocating Resident A, but it will be further discussed at the meeting.

On 01/23/2023, I contacted Michelle Rupert, Administrator. I interviewed her regarding the allegations in which she confirmed. Ms. Rupert said Ms. Plummer was asked to vacate the premises because she failed to provide an explanation about what happened, she was terminated. Ms. Rupert said there is a meeting scheduled for 01/27/2023 to further discuss Resident A's needs. She said there has been some discussion about Resident A relocating because the alternative is 1:1 staffing, and the home/staffing cannot accommodate 1:1 staffing requirements at this time.
On 01/23/2023, I contacted Ann McGibbon, Resident A's Supports Coordinator with Community Living Services. Ms. McGibbon said she is aware of the allegations and is working with Ms. Rupert and staff to implement changes to better address Resident A's needs. She said since the incident, they have increased the volume on the door alarms and overlapped shifts to assure there is always two staff on shift. Ms. McGibbon said they have explored the possibility of 1:1 staffing but unfortunately that home is unable to accommodate that request at this time. She said there was also mention of buying an alarming mat, that activates with a noise when stepped on. She said at this point they are exploring options and the staff has been very accommodating. Ms. McGibbon said there is a meeting scheduled for 01/27/2023 to further discuss Resident A's needs and the possible changes that can be made to ensure her safety. She said Resident A's guardian, Guardian A is interested in moving her but until she is moved, we must make sure she is safe.

On 01/23/2023, I received a copy of the police report from Ms. Rupert. According to the Allen Park police report, #2023-00000336 police were dispatched to Goddard Rd and Reeck for a Resident A walking in the middle of the street with no shoes on. Upon arrival Resident A was in the car with an unidentified citizen. Resident A was transported home. The police entered the home and staff was observed Ms. Plummer sleeping on the couch.

On 01/31/2023, I contacted Guardian A and interviewed her regarding the allegations. Guardian A confirmed the allegations and said this is the second time Resident A eloped from that home. She said the first time was in 2021 and Resident A was found in a retention pond. She said as a result the home installed door alarms, but obviously Resident A was still able to leave the home without staff knowledge. Guardian A said she is interested in having Resident A moved to a different home, but it has been a very difficult process. Guardian A went on to say that Resident A has a history of elopement, and she is very active and requires 24hr supervision at all times. Guardian A said she intends to follow-up with Ms. McGibbon regarding the next course of action.

On 01/31/2023, I contacted Ms. McGibbon to inquire about the outcome of the meeting regarding Resident A. Ms. McGibbon said Resident A's IPOS was updated, and she is actively looking to relocate her. However, in the interim loud and continuous alarms have been installed on the doors to better notify the staff if Resident A attempts to elope; staggered shifts have been implemented to assure there is at minimum two staff on shift. She said they are also looking to order an alarming mat but have not done so at this time.

On 02/09/2023, I contacted Louise Semetko, licensee designee. I made her aware of my efforts to contact her early-on in the investigation regarding the allegations and I did speak with Ms. Rupert; Ms. Semetko said she is fully aware. I proceeded to conduct and exit conference regarding the findings. I made her aware that based on the investigative findings, there was insufficient staffing at the time Resident A eloped from the home and Ms. Plummer was observed sleeping on shift. I further stated due to the violation, a written corrective action plan is required. Ms. Semetko said Ms. Plummer was fired and she completely understand the violation. Ms. Semetko said she will comply by submitting a corrective action plan.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	During this investigation, I interviewed Louise Semetko, licensee designee; Michelle Rupert, administrator; Felicia Wilson, home manager; Guardian A, Resident A's guardian; Anna McGibbon, Supports Coordinator with CLS and Tammy Coleman, APS regarding the allegations. All confirmed the allegations. I reviewed Police Report #2023-00000336 Allen Park Police Department, which confirmed the allegations. Based on the investigative findings, there is sufficient evidence to support the allegation. The licensee failed to provide sufficient direct care staff for the supervision, personal care, and protection of Resident A as specified in her IPOS. This allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

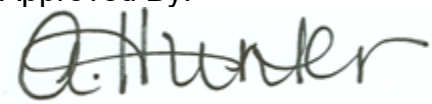
IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend that the status of the license remains the same.

02/10/2023

Denasha Walker Date
Licensing Consultant

Approved By:



02/15/2023

Ardra Hunter Date
Area Manager