GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 6, 2024

DamBriell McClendon
Howells Adult Foster Care Inc
P.O. Box 14622
Saginaw, MI 48601

RE: License #: AM730014896
Investigation #: 2024A0572020
Howell's Group Home

Dear DamBriell McClendon:

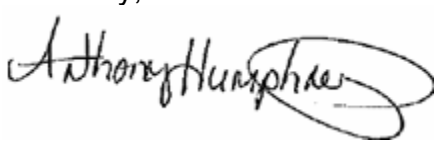
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 643-7960.

Sincerely,



Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM730014896
Investigation #:	2024A0572020
Complaint Receipt Date:	01/24/2024
Investigation Initiation Date:	01/25/2024
Report Due Date:	03/24/2024
Licensee Name:	Howells Adult Foster Care Inc
Licensee Address:	506 S 29th Street Saginaw, MI 48601
Licensee Telephone #:	(989) 270-1852
Administrator:	Valerie Woods
Licensee Designee:	DamBriell McClendon
Name of Facility:	Howell's Group Home
Facility Address:	3106 Walters Dr. Saginaw, MI 48601
Facility Telephone #:	(989) 270-1852
Original Issuance Date:	04/01/1993
License Status:	REGULAR
Effective Date:	12/18/2022
Expiration Date:	12/17/2024
Capacity:	11
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has been pushed and knocked down to the floor by staff. Incident has happened more than once.	No
Additional Findings	Yes

III. METHODOLOGY

01/24/2024	Special Investigation Intake 2024A0572020
01/25/2024	Special Investigation Initiated - On Site
01/25/2024	Contact - Face to Face Resident A, Resident B, Resident C, Resident D, Resident E, Staff Lonza Simpson, and Staff Ineka Nelson.
01/31/2024	Contact - Telephone call made Resident A's Guardian.
03/01/2024	Contact - Face to Face Licensee, DamBriell McClendon.
03/01/2024	Contact - Telephone call received Administrator, Valerie Woods.
03/01/2024	Exit Conference Licensee Designee, DamBriell McClendon.
03/06/2024	APS Referral APS referral was made.
03/06/2024	Exit Conference Licensee Designee, DamBriell McClendon.

ALLEGATION:
Resident A has been pushed and knocked down to the floor by staff. Incident has happened more than once.

INVESTIGATION:
On 01/24/2024, the local licensing office received a complaint for investigation. Adult Protective Services (APS) received a referral for further investigation.

On 01/25/2024, I made an unannounced onsite at Howell's Group Home, located in Saginaw County, Michigan. Interviewed were Resident A, Resident B, Resident C, Resident D, Resident E, Staff Lonza Simpson, and Staff Ineka Nelson.

On 01/25/2024, I interviewed Resident A regarding the allegation. Resident A informed that the allegation was true and that staff, Ineka Nelson pushed Resident A to the ground because Resident A was mad. Resident A does not know if anyone else witnessed the incident. Resident A was mad because Resident A did not have a cord to charge Resident A's phone. The owner of the AFC home gave Resident A a cord. Resident A is moving soon and does not feel safe in the home.

On 01/25/2024, I interviewed Resident B regarding the allegation. Resident B informed that Resident A hit Resident B and called Resident B a derogatory name. Staff never hit Resident A. All of the staff are nice. Resident A is mean.

On 01/25/2024, I interviewed Resident C regarding the allegation. Resident C has never witnessed Resident A be hit or pushed down by staff. Resident A is the one who attacks people. Resident A recently attacked Resident B for no reason and staff had to break it up.

On 01/25/2024, I interviewed Resident D regarding the allegation. Resident D has never witnessed Resident A get hit or pushed down by staff. Staff do their job and treat everyone well. Resident A recently became mad and threw a handful of change at Resident D because Resident A was mad.

On 01/25/2024, I interviewed Staff, Lonza Simpson regarding the allegation. Lonza Simpson indicated that he had not heard about any staff hitting or pushing Resident A down. Resident A has been in the home for about two months and never mentioned to him any mistreatment from staff. Lonza Simpson informed that had he been aware, he would have reported it. Lonza Simpson informed that Resident A recently hit Resident B on top of the head for no reason. They were all quiet and watching tv and then Resident A hit Resident B on the head.

On 01/25/2024, I interviewed Staff, Ineka Nelson regarding the allegation. Ineka Simpson denied the allegation and informed that she grabbed Resident A after Resident A hit Resident B on the head. Resident A came out of the bedroom and sat on the daybed, then out of nowhere, just hit Resident B for no reason. Ineka Nelson grabbed Resident A to keep Resident A from hitting Resident B again and they both

fell onto the daybed. 911 was called and Resident A went to the hospital for evaluation. The hospital was ready to release Resident A but Resident A refused unless someone bought Resident A a meal at McDonald's. Security Guards at the hospital had Resident A surrounded and Resident A was causing a scene. The entire incident began earlier in the day when Resident A wanted a charger for cellphone.

On 01/25/2024, I interviewed Resident E regarding the allegation. Resident E never seen any staff hit or push Resident A down. Resident A gets mad very easily and when Resident A gets mad, Resident A goes all out. The last incident started all because Resident A needed a charger for cellphone.

On 01/31/2024, I interviewed Resident A's Public Guardian regarding the allegation. Public Guardian was aware of the incident and informed that Resident A was sent to the hospital for an evaluation. The hospital saw no need to admit Resident A, so they sent Resident A back home. Public Guardian does not have any reason to believe that Resident A is being targeted by staff or any other persons in the home.

On 02/20/2024, I interviewed Resident A's case manager, Jody Fetters regarding the allegation. Jody Fetters informed that Resident A has said that staff are being mean. Jody Fetters had suspected something was going on in the home due to increased behaviors by Resident A. Resident A does not have a history of hallucinations or making things up, however, Resident A does have a history of being physically aggressive. When asked if there is a Plan of Service in place, Jody Fetters informed that currently they do not have a plan in place that is documented.

On 03/01/2024, I reviewed the Incident Report. It indicates that on 01/22/2024, Resident A came out of bedroom and into the TV Room, sat down and then out of nowhere, hit Resident B. Staff caught Resident A's hand before Resident A could hit Resident B again. 911 was called and the ambulance transported Resident A to Covenant Hospital to be evaluated. When staff went to pick Resident A up from the hospital, staff was met with security because Resident A would not leave unless she say, "I will buy you some McDonald's". Staff told security that she could not say that, but security insisted that Resident A leave the premises. 5 security guards escorted Resident A to the car.

On 03/01/2024, I asked Administrator Valerie Woods if she had the Assessment Plan for Resident A and she informed that she had only been there for a couple months and they had not received one as of yet and they had not made one yet. They also did not receive a Plan of Service from the case manager as of yet.

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: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based on the interviews and documentation that I reviewed during my investigation, there is not enough evidence to issue a licensing rule violation. Staff and Residents were interviewed and they all informed that Resident A was the aggressor and attacked Resident A for no reason. Resident A informed that the allegation is true and that Resident A is afraid to be in the home. Resident A's Public Guardian does not believe that staff are targeting Resident A, however; Resident A's Case Manager informed that she believes that something is going on because Resident A's behaviors has increased.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:
During my onsite, I asked for Resident A's Assessment Plan and the home did not have one for Resident A.

INVESTIGATION:
On 03/01/2024, while I was reviewing Resident A's file, I did not see the Assessment Plan. Licensee Designee, DamBriell McClendon called Administrator Valerie Woods while I was still at Howell's Group Home and informed that there was no Assessment Plan for Resident A.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**

ANALYSIS:	At the time of my onsite, there was no Assessment Plan for Resident A. I looked in the file and did not see it. I then asked Licensee Designee, DamBriell McClendon if there was one. DamBriell McClendon called the Administrator, Valerie Woods and she informed that she did not have one.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/01/2024, I held an Exit Conference with Licensee Designee, DamBriell McClendon regarding the results of the special investigation. On 03/06/2024, I updated DamBriell McClendon on the findings due to accepting Resident A without an Assessment Plan.

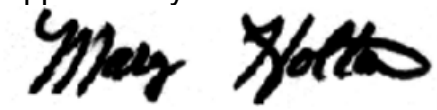
IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this medium-size Adult Foster Care group home (Capacity 1-11).

03/06/2024

Anthony Humphrey Date
Licensing Consultant

Approved By:



03/06/2024

Mary E. Holton Date
Area Manager