RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

July 25, 2017

Scott Schrum
Residential Opportunities, Inc.
1100 South Rose Street
Kalamazoo, MI 49001

RE: License #: AS390314010
Investigation #: **2017A0462041**
Hill an Brook AFC

Dear Mr. Schrum:

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 (269) 337-5066.

Sincerely,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 251-9037

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390314010
Investigation #:	2017A0462041
Complaint Receipt Date:	05/26/2017
Investigation Initiation Date:	05/26/2017
Report Due Date:	07/25/2017
Licensee Name:	Residential Opportunities, Inc.
Licensee Address:	1100 South Rose Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-3731
Administrator:	David Stedman
Licensee Designee:	Scott Schrum
Name of Facility:	Hill an Brook AFC
Facility Address:	2702 Hill an Brook Dr. Portage, MI 49024
Facility Telephone #:	(269) 488-0977
Original Issuance Date:	10/17/2011
License **Status:**	REGULAR
Effective Date:	04/28/2016
Expiration Date:	04/27/2018
Capacity:	6
Program Type:	MENTALLY ILL DEVELOPMENTALLY DISABLED PHYSICALLY HANDICAPPED

II. ALLEGATION(S)

	Violation Established?
Resident A dug large holes in her feet, hands and knees. These self-injurious wounds eventually became infected as a result of direct care workers failing to obtain medical treatment for Resident A.	No
Additional findings	Yes

III. METHODOLOGY

05/26/2017	Special Investigation Intake 2017A0462041
05/26/2017	Special Investigation Initiated – Email correspondence with Kalamazoo County adult protective services and office of recipient rights.
05/31/2017	Contact - Document Received from APS specialist Mike Hartman.
06/05/2017	Contact - Document Received from recipient rights officer Cori Perkins.
06/08/2017	Contact- Telephone conversation with program manager Bev Reed.
06/12/2017	Contact - Face to face interview with APS specialist Mike Hartman.
06/21/2017	Contact – Requested documentation from program manager Bev Reed.
06/26/2017	Contact - Left telephone for message for DCW Merissa Greenfield. Received no return phone call.
07/03/2017	Contact – Email correspondence with program manager Bev Reed and licensee designee Scott Schrum. Requested additional documentation.
07/03/2017	Contact - Email correspondence with recipient rights officers Cori Perkins. Requested contact information.
07/17/2017	Contact- Telephone interview with KCMHSAS Supports Coordinator Katie Miller and DCW Nichole Maxam. Left a message for DCWs Merissa Greenfield and Dave Stedman.

07/18/2017	Contact- Telephone conversation with DCW Nichole Maxam. Documentation received.
07/25/2017	Exit conference with program manager Bev Reed and licensee designee Scott Schrum.

ALLEGATION:

Resident A dug large holes in her feet, hands and knees. These self-injurious wounds eventually became infected as a result of direct care workers failing to obtain medical treatment for Resident A.

INVESTIGATION:

On 05/26/2017, I received this complaint via the BCHS on-line complaint system. The written complaint indicated that on 05/23/2017, Kalamazoo County Community Mental Health and Substance Abuse Services (KCMHSAS) staff were notified by an AFC staff member that on 05/20/2017 and 05/21/2017, Resident A dug large holes in her feet, hands and knees. KCMHSAS staff requested that direct care workers (DCW) take Resident A to Urgent Care, where it was established that Resident A's injuries were infected. Resident A was prescribed medication to treat her infection.

Through email correspondence, recipient rights officer Cori Perkins informed me that she was conducting an investigation regarding this allegation, and that a referral had been made to Kalamazoo County adult protective services (APS). I left a voicemail for APS specialist Mike Hartman informing him that I would be opening a special investigation regarding this allegation as well.

On 05/31/2017, APS specialist Mike Hartman provided me with a copy of his report. Mr. Hartman's report indicated that he substantiated neglect against facility staff members because they failed to seek appropriate medical care for Resident A immediately after discovering that she injured herself. Mr. Hartman's report indicated that on 05/31/2017, he spoke with one of Resident A's legal guardians Kevin Kroplien, who informed Mr. Hartman that Resident A had a long history of self-harming behaviors, and that he did not believe her injuries would have been caused by anyone other than herself.

It is important to note that on 05/12/2017, the home's administrator Adrian Strebs was terminated. On 06/05/2017, during email correspondence with Ms. Perkins, I was informed that DCW Merissa Greenfield was filling in, while the licensee designee was in the process of appointing a new administrator. On 06/28/2017, I received the necessary documentation to verify the competency of DCW David Stedman, so that he could be appointed administrator of the home.

I reviewed a copy of Resident A's *health care appraisal* and KCMHSAS *Behavior Assessment and Support Plan*, which indicated that Resident A has a diagnoses of

Moderate Mental Retardation, Impulse-Control Disorder NOS, Anxiety Disorder NOS, Obsessive-Compulsive Personality Disorder, Autistic Disorder and Hearing Impairment.

I reviewed an *AFC LICENSING DIVISION-INCIDENT/ACCIDENT REPORT* (IR) written and signed by DCW Crystal Lindsey on 05/20/2017, which indicated that DCWs noticed scratches on the top of both Resident A's hands. There were two scratches on Resident A's right hand, and four long scratches on her left hand. The IR indicated that DCWs wrote Resident A a letter asking her if she was ok and what happened. Resident A nodded her head "yes". The IR gave no indication as to what happened and how Resident A obtained her injuries. The IR indicated that DCWs cleaned both of Resident A's hands, applied ointment and a band aid. The IR indicated that DCWs would continue to monitor Resident A closely, and keep her busy throughout the day to ensure no further injuries occurred. This IR did not indicate whether Resident A was offered to go to the doctor, and/or if Resident A refused.

I reviewed an IR written and signed by DCW Nicole Maxam on 05/21/2017 and faxed to the department on 05/24/2017. This IR indicated that on 05/21/2017, DCWs observed a circle shaped wound on the inside of Resident A's left and right foot, approximately two inches in diameter. The IR indicated that layers of Resident A's skin was torn off. DCWs applied first aid, monitored for signs of infection and notified oncoming staff members. The IR indicated that Resident A tends to pick at her scabs, and DCWs would follow Resident A's behavior guidelines. This IR did not indicate whether Resident A was offered to go to the doctor, and/or if Resident A refused.

I reviewed an IR written and signed by DCWs Alicia Rooker and Merissa Greenfield on 05/22/2017. This IR indicated that on 05/22/2017, DCWs noticed more SIB [sic] injuries on both Resident A's left and right feet, both left and right hands, left upper thigh, both knees and left wrist. DCWs applied first aid and Resident A refused bandages. The IR indicated that DCWs continued to monitor Resident A and follow her behavior guidelines. The IR read, in part: "she keeps picking at the scabs". This IR did not indicate whether Resident A was offered to go to the doctor, and/or if Resident A refused.

I reviewed an IR written, signed by DCW Crystal Lindsey, and faxed to our department on 05/23/2017. This IR indicated that while Resident A was at her day program at the agency MRC Industries, Inc. MRC staff called the home to report that the scratches on Resident A's hands and feet appeared infected. The IR indicated that a DCW picked Resident A up from MRC and took her to Urgent Care for medical treatment. Resident A was prescribed the medication Bactrim for 10 days and was instructed to follow up with her physician. The IR indicated that DCWs were to keep the infected areas clean and dry until healed.

On 06/08/2017, I had a prescheduled face-to-face interview at the home with DCW Merissa Greenfield. Before the interview, I called the home to notify staff that I was running a few minutes behind. Program manager Bev Reed answered the telephone and informed me that she was not aware of this scheduled interview, and also informed me that Ms. Greenfield was not working, and on personal leave for the next several days.

On 06/23/2017, I called DCW Merissa Greenfield and left a voicemail message. Ms. Greenfield did not return my telephone call.

On 07/09/2017, I received an email from Ms. Reed notifying me that at one or more points during the weekend of 05/20/2017-05/21/2017, Resident A was asked if she would go to the doctor and she "vehemently refused".

I reviewed a *Request for Approval of Substitute Forms* letter, dated 09/11/2003, located in the home's file. Although it is not required to use a department form, this letter granted the home permission to use their *written assessment plan* instead of the one provided by the department. I reviewed Resident A's *written assessment plan,* which indicated that Resident A "currently and historically has engaged in SIB, and aggression to objects and others, and there are behavior guidelines in place." Resident A's *written assessment plan* also indicated that Resident A "does not like to go to the Dr.'s office to get checked out. [Resident A] is doing better now, but in the past she has refused to leave her home, refused to enter the building in which her Dr.'s office was located, and has also refused to enter the Dr.'s office and/or the patient rooms."

Resident A's KCMHSAS *Behavior Assessment and Support Plan* indicated that Resident A had a history of engaging in a number of challenging behaviors, which included self-injurious behavior, physically acting out towards objects and physically acting out against others. Resident A's self-injurious behavior (SIB) included picking at her skin, face slapping, or dropping to the floor from a seated position. Resident A had a history of picking at her hands and feet, typically out of DCW's line of sight. Resident A also had a history of picking a hole in the bottom of her feet and ripping off toenails, but this rarely occurred. Resident A's KCMHSAS *Behavior Assessment and Support Plan* indicated that DCWs were to not directly attend to the SIB or make direct comments about any tissue damage. DCWs were to apply first-aid as appropriate for the situation. When doing so, DCWs were to limit communication to essential language only.

On 07/13/2017, Ms. Perkins provided me with a copy of her report, which indicated that she substantiated Neglect III on staff members in the home for failing to seek medical treatment for Resident A after Resident A injured herself, resulting in Resident A being diagnosed with cellulitis. Both Mr. Hartman's and Ms. Perkins' reports indicated that through writing and sign language, Resident A communicated to them that she had caused the injuries herself.

On 07/17/2017, I conducted a telephone interview with KCMHSAS supports coordinator Katie Miller, who confirmed that on the evening of 05/22/2017, DCW Merissa Greenfield sent her an email notifying her that Resident A had injured herself, and that DCWs were concerned regarding Resident A's behavior. Ms. Miller confirmed that she received this email the morning on 05/23/2017. Via email, Ms. Greenfield informed Ms. Miller that DCWs asked Resident A if she wanted to go to the doctor, and Resident A refused. Ms. Miller confirmed that she later reported to Resident A's day program, along with KCMHSAS registered nurse Sara Hill, to assess Resident A's injuries. Ms. Miller stated that it was apparent that Resident A's injuries were infected, and she requested that DCWs take Resident A to Urgent Care as soon as possible. Ms. Miller stated that Resident A was informed that she was going to the doctor to seek treatment for her injuries, and she observed as DCW Crystal Lindsey came to Resident A's day program to transport Resident A to Urgent Care. Resident A left with Ms. Lindsey to go to Urgent Care without any issues.

I conducted a telephone interview with DCW Nicole Maxam, who confirmed writing the IR dated and signed by her on 05/21/2017. Ms. Maxam stated that when she observed the circle shaped wound on the inside of Resident A's left and right foot on 05/21/2017, the wound looked similar to a rug burn or sun blister. Ms. Maxam stated that DCWs did not feel that Resident A's injuries looked infected or needed medical attention.

I asked Ms. Maxam to relay to DCW Merissa Greenfield that I would like for her to return my telephone call, so that I could conduct an interview. Ms. Maxam stated that Ms. Greenfield was currently working at another facility, and that she would call Ms. Greenfield to relay this message once off the telephone with me.

Later that day, I also emailed Ms. Greenfield requesting that she please return my telephone call. Ms. Greenfield did not return my telephone call or email.

On 07/18/2017, I called the home and spoke with Ms. Maxam who stated that when she called Ms. Greenfield yesterday to relay my message, Ms. Greenfield was in the emergency room.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	On 05/20/2017, it was first noted that Resident A had self-inflicted injuries. In the days following, DCWs continued to notice additional self-inflicted injuries, which were documented in IRs. Once DCWs discovered that Resident A injured herself, they did

	provide medical treatment to Resident A by applying ointment, bandages to her injuries, continuing to monitor Resident A injuries, and asking Resident A is she wanted medical treatment. According to IRs written by DCWs on 05/20/2017, 5/21/2017 and 05/22/2017, and information provided to me by DCW Nicole Maxam during our interview, DCWs did not observe any indication that these injuries required further medical treatment. On 05/22/2017, DCW Merissa Green notified KCMHSAS supports coordinator Katie Miller, via email, of Resident A's increased SIB and injuries. Ms. Miller did not provide any additional direction to DCWs regarding the self-injurious behavior or the injuries. Ms. Miller, as well as a registered nurse from KCMHSAS, reported to Resident A's day program on 05/23/2017, and noticed that Resident A's injuries appeared to be infected. Ms. Miller requested that DCWs take Resident A to Urgent Care for medical treatment, which DCWs did immediately on 05/23/2017, where Resident A was diagnosed with cellulitis of multiple sites. It has been established that DCWs followed Resident A's KCMHSAS Behavior Support Plan by applying first aid treatment but not directing much attention to Resident A's SIB. There is no evidence to support the allegation that Resident A's injuries became infected as a result of DCWs failing to obtain medical treatment for her.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

Resident A's *written assessment plan* was completed by an unknown staff member on 03/12/2017. Resident A's *written assessment plan* was not signed and dated by Resident A's legal guardians and the home's licensee designee, indicating that the *written assessment plan* was not completed along with Resident A and/or her legal guardians.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, **and the licensee**. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.

ANALYSIS:	It has been established that Resident A's written assessment plan was not signed and dated by Resident A's legal guardians and the home's licensee designee, indicating that the *written assessment plan* was not completed along with Resident A and/or her legal guardians.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

During the course of this investigation, I received an IR written and signed by DCW Emilie Murphy on 05/28/2017. This IR indicated that on 05/28/2017, Resident A's Lamictal was not administered to Resident A as prescribed. Documented on the IR indicated that the reason for the medication error was because two "relief staff" were working at the home due to ongoing staff shortages.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	It has been established that due to an ongoing DCW shortage, on 05/28/2017, Resident A was not administered her Lamictal pursuant to label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

Michele Streeter 07/24/2017

Michele Streeter Date
Licensing Consultant

Approved By:

Dawn Timm 07/24/2017

Dawn N. Timm Date
Area Manager