



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

SHELLY EDGERTON  
DIRECTOR

August 29, 2017

Kelly Devereaux  
Mentors of Michigan, Inc.  
Suite 100  
215 E. Big Beaver  
Troy, MI 48083

RE: License #: AS630282446  
Investigation #: **2017A0989040**  
**Glasgow**

Dear Ms. Devereaux:

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 (248) 975-5053.

Sincerely,



Theresa Cipponeri, Licensing Consultant  
Bureau of Community and Health Systems  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 285-8590

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS630282446
<b>Investigation #:</b>	2017A0989040
<b>Complaint Receipt Date:</b>	03/08/2017
<b>Investigation Initiation Date:</b>	03/09/2017
<b>Report Due Date:</b>	05/07/2017
<b>Licensee Name:</b>	Mentors of Michigan, Inc.
<b>Licensee Address:</b>	19460 Glenn Roseville, MI 48066
<b>Licensee Telephone #:</b>	(248) 740-0964
<b>Administrator:</b>	Kelly Devereaux
<b>Licensee Designee:</b>	Kelly Devereaux
<b>Name of Facility:</b>	Glasgow
<b>Facility Address:</b>	5710 Glasgow Troy, MI 48085
<b>Facility Telephone #:</b>	(248) 828-2947
<b>Original Issuance Date:</b>	05/05/2006
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	11/09/2014
<b>Expiration Date:</b>	11/08/2016
<b>Capacity:</b>	6
<b>Program Type:</b>	MENTALLY ILL DEVELOPMENTALLY DISABLED PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
On 3/1/17 staff left the hospital prematurely before Resident A was admitted.	Yes
Additional Findings	Yes

**III. METHODOLOGY**

03/08/2017	Special Investigation Intake 2017A0989040
03/09/2017	Special Investigation Initiated - Telephone Left voicemail message for the Reporting Source (RS).
03/10/2017	Contact-Face to face Conducted onsite inspection. Interviewed staff, Aleshia Devereaux.
03/13/2017	Contact-Telephone call from Voicemail message from RS.
06/19/2017	Contact - Telephone call made Attempted to contact Licensee, Kelly Devereaux. No answer and no opportunity to leave a voicemail message.
06/19/2017	Contact-Telephone call made Attempted to call facility. No answer and no opportunity to leave a voicemail message.
08/18/2017	Exit conference I left a detailed voicemail message for the licensee, Kelly Devereaux.

**ALLEGATION:**

**On 3/1/17 staff left the hospital prematurely before Resident A was admitted.**

**INVESTIGATION:**

On 3/9/2017, I left a message for the Reporting Source (RS). I requested clarifying information regarding what happened.

On 3/10/2017, I conducted an onsite inspection and interviewed staff, Aleshia Devereaux. Ms. Devereaux stated that on 3/1/2017, Resident A's guardian picked him up and took him to Troy Beaumont Hospital. Resident A's psychiatric behaviors were escalating at a fast pace, which included walking outside naked, taking his clothes off, rectal digging, and smearing feces on the walls and carpet. Ms. Devereaux stated that it was her day off, but she was called in to meet the guardian up at the Emergency Room (ER). The guardian then left Resident A with Ms. Devereaux. Ms. Devereaux stated that the ER staff felt that Resident A needed to be on psychotropic medications, so hospital staff called Resident A's guardian and he consented to the medications. Ms. Devereaux stated that she thought that everything was all set because hospital staff told her that Resident A was going to be taken to the Behavioral Center of Michigan (BCM). Ms. Devereaux stated that she stayed at the ER until 7:00 p.m., and then a sitter from the hospital stay with Resident A the rest of the time until he was transported to BCM. Ms. Devereaux stated that she notified the Licensee, Kelly Devereaux, Human Resources staff, Laurie Chandler to inform them. Ms. Chandler contacted Resident A's case manager at Easter Seals, Sharon Meltzer, and Ms. Meltzer stated that it was acceptable for Ms. Devereaux to leave Resident A at the ER as long as the hospital sitter was going to stay with him. At the time of my onsite inspection, Resident A was still hospitalized.

On 3/13/2017, I received a voicemail message from the RS. According to the RS, Resident A was brought to Troy Beaumont Hospital for increasing psychiatric concerns. Staff stayed at the hospital for a while, but eventually left Resident A in the hospital before Resident A was admitted to their hospital or a psychiatric hospital. RS voiced concerns regarding proper supervision by the facility's staff.

<b>APPLICABLE RULE</b>	
<b>R 400.14305</b>	<b>Resident protection.</b>
	<b>(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.</b>
<b>ANALYSIS:</b>	According to interviews with the RS and Ms. Devereaux, Resident A was brought to the Troy Beaumont Hospital ER after his psychiatric behaviors significantly increased at the facility. Resident A's guardian left the ER after bringing him there. Ms. Devereaux stayed at the hospital for a time with Resident A, however, she left at 7:00 p.m. before Resident A was admitted. Ms. Devereaux stated that there was a hospital babysitter with Resident A, so she thought she could leave Resident A in the care of the ER as long as his case manager approved.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On 3/10/2017, I conducted an onsite inspection and interviewed staff, Aleshia Devereaux. Ms. Devereaux stated that on 3/1/2017, Resident A's guardian picked him up and took him to Troy Beaumont Hospital for escalating psychiatric symptoms. Resident A was eventually taken to BCM by Troy Beaumont Hospital staff. I requested the incident report, and Ms. Devereaux stated that she did not fill one out but maybe another staff did. Ms. Devereaux stated that the incident reports are completed but not kept onsite. Laurie Chandler from the Human Resources Department picks them up, reviews them, and then sends them to the necessary agencies/responsible parties. Ms. Devereaux briefly looked for an incident report regarding this incident, but it was not onsite. I requested a copy of the incident report.

On 8/18/2017, I attempted to conduct an exit conference with the licensee, Kelly Devereaux, however I was unsuccessful. I left a detailed voicemail message for Ms. Devereaux explaining the cited rule violations.

<b>APPLICABLE RULE</b>	
<b>R 400.14311</b>	<b>Investigation and reporting of incidents, accidents, illnesses, absences, and death.</b>
	<b>(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (c) Incidents that involve any of the following: (ii) Hospitalization.</b>
<b>ANALYSIS:</b>	Ms. Devereaux did not fill out an incident report regarding this issue, but surmised that maybe another staff person did. The incident report was not onsite at the time of the onsite inspection. I requested a copy of the incident report from Ms. Devereaux, but I did not receive it.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Upon the receipt of an acceptable corrective action plan, I recommend no change to the status of this license.

*Theresa Cipponeri*

8/29/2017

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Theresa Cipponeri  
Licensing Consultant

Date

Approved By:

*Denise Y. Nunn*

08/29/2017

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Denise Y. Nunn  
Area Manager

Date