RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

September 20, 2017

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

RE: License #: AS630282446
Investigation #: **2017A0989079**
Glasgow

Dear Ms. Devereaux:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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

License #:	AS630282446
Investigation #:	2017A0989079
Complaint Receipt Date:	06/06/2017
Investigation Initiation Date:	06/07/2017
Report Due Date:	08/05/2017
Licensee Name:	Mentors of Michigan, Inc.
Licensee Address:	19460 Glenn Roseville, MI 48066
Licensee Telephone #:	(248) 740-0964
Administrator:	Kelly Devereaux
Licensee Designee:	Kelly Devereaux
Name of Facility:	Glasgow
Facility Address:	5710 Glasgow Troy, MI 48085
Facility Telephone #:	(248) 828-2947
Original Issuance Date:	05/05/2006
License Status:	REGULAR
Effective Date:	11/09/2014
Expiration Date:	11/08/2016
Capacity:	6
Program Type:	MENTALLY ILL DEVELOPMENTALLY DISABLED PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A is supposed to be supervised 1:1. On 6/5/2017 he walked away from the facility and was found at the park in a lake.	No

III. METHODOLOGY

06/06/2017	Special Investigation Intake 2017A0989079
06/06/2017	APS Referral Received complaint from Adult Protective Services (APS).
06/07/2017	Special Investigation Initiated - Face to Face Conducted unannounced onsite inspection. Interviewed home manager, Angela Owens, staff, Alicia Devereaux, Director of Human Resources, Lori Chandler, licensee designee, Kelly Devereaux, Residents A-C, and observed Residents D and E.
06/07/2017	Contact-Telephone call made Interviewed Resident A's guardian.
06/08/2017	Contact-Documents received Received incident reports, 30 day discharge notice to Resident A, and staff schedule via email from Ms. Chandler.
08/04/2017	Contact-Telephone call made Attempted to contact the facility. No answer or opportunity to leave a voicemail message.
08/07/2017	Contact-Telephone call made Left voicemail message for the licensee, Kelly Devereaux.
08/07/2017	Contact-Telephone call from Ms. Chandler.
08/08/2017	Contact-Telephone call made Left voicemail message for staff, Doreal Rogers.
08/08/2017	Contact-Telephone call from Ms. Rogers.

08/08/2017	Exit conference Held with licensee designee.

ALLEGATION:

Resident A is supposed to be supervised 1:1. On 6/5/2017 he walked away from the facility and was found at the park in a lake.

INVESTIGATION:

On 6/7/2017, I conducted an unannounced onsite inspection to the facility. I interviewed the home manager, Angela Owens, staff, Alicia Devereaux, Director of Human Resources, Lori Chandler, licensee designee, Kelly Devereaux, Residents A-C, and observed Residents D and E. I interviewed Ms. Owens and Alicia Devereaux, and Ms. Owens stated that this incident occurred on 6/5/2017, and she was here along with another staff member, Doreal Rogers. Ms. Owens stated that it is specifically stated in his Individual Plan of Service (IPOS) that he is to have 1:1 supervision during the day, so Ms. Rogers was Resident A's 1:1 supervisor that day. Resident A was agitated that day and he sometimes gets this was when he has too much energy. On this particular day, Resident A was refusing to follow the house rules and became angry. He tipped the refrigerator over and then went outside. Ms. Owens stated that Ms. Rogers attempted to re-direct him and try to talk him back into the facility, however he wasn't listening. Ms. Owens stated that she also tried to re-direct him, however, none of their attempts worked. Ms. Owens stated that staff are not allowed to put their hands on the residents or touch them, so they have to use verbal prompts and this does not always work. Ms. Owens stated that she stayed in the facility with the other residents, and Ms. Rogers followed Resident A outside for as long as she could. When these attempts failed, Ms. Rogers returned to the facility and called 911 immediately. Ms. Owens stated that this is common for Resident A to elope, and his favorite place to go is the lake in a nearby park. This information was conveyed to the police, and the police quickly discovered Resident A in the lake where he was trying to hide from them.

Alicia Devereaux added that even though she was not working on the day of this incident, Resident A has a tendency to elope when he becomes restless and staff has to follow procedures. She is aware that Resident A needs 1:1 supervision, and stated that there is always staff there to provide 1:1 supervision.

I interviewed Ms. Chandler, who stated that Resident A has lived in several of their facilities in attempts to best serve his needs. Resident A first went to one of their facilities in White Lake, MI in November 2016, however he was only there for a month or so because he was having these same types of difficulties. Resident A then came to this facility at the end of November 2016 and stayed until April 2017, but he was having difficulties still so they moved him to their Abbey Villa facility. Resident A ran from that facility, so they soon brought him back here in April 2017 and he has been here since that time.

I interviewed Kelly Devereaux, who stated that Resident A was issued a 30 discharge notice on 6/11/2017 and he is supposed to be out by 6/11/2017, however a new placement has not been found for him as of this time. Resident A has caused many problems for this facility, and despite their best efforts they are just unable to contain him, which is why the 30 discharge notice was issued. No other resident is 1:1, however, Resident A's frequent elopements is not a good fit for this facility.

I reviewed Resident A's crisis plan as written in his IPOS (dated 12/2/2016), which stated "(Resident A) is currently on 1:1 staffing during awake hours, and at night the 1:1 will be reduced effective 12/3/2016 from 12:00 a.m.-8:00 a.m. Ms. Owens stated that Resident A never runs during the night, so that is why his case manager reduced the 1:1 supervision.

I reviewed the staff schedule and confirmed that there are two staff members on shift during the day, and one staff member on shift during the night hours for a facility of six residents.

I interviewed Resident A, who stated that he runs from the facility because he has an anger problem and at times he has trouble coping. Resident A stated that he was frustrated because it was hot that day, so he knocked over a refrigerator and just wanted to leave. He is always supervised 1:1 because his case manager mandated that, so Ms. Rogers was his 1:1 staff that day. After he knocked over the refrigerator, he started screaming and yelling, then he went out the front door. He stated that he wanted to go swimming because it was hot, so there is a lake in a park nearby that he usually goes to when he runs away. Ms. Rogers kept following him and trying to get him to return to the facility, but he would not listen and kept running away from her. He got to the lake and stepped in a sinkhole, then he saw the police and tried to hide underwater, but they found him. Resident A added that staff is always with him, and further added that had staff not followed him and called 911 then may have drowned. Resident A stated that when he runs, staff always call 911 and they always find him.

I interviewed Resident B, who stated that there are plenty of staff here to supervise the residents. Resident A has to have a staff with him at all times, and there always is. Resident B stated that Resident A runs away a lot, and staff always knows about it because they are always supervising him. Staff calls 911 and the police bring him back. Resident A's 1:1 staff person was with him on the day of this incident, and Resident A ran away from her. She could not get him to come back, so she called 911 and the police found him.

I briefly interviewed Resident C, however, he stated that he has only been at the facility for a few days and was not here when this incident occurred.

I was unable to interview Resident D and Resident E, due to cognitive delays, and Resident F was not at the facility at the time of my onsite inspection.

On 6/7/2017, I interviewed Resident A's guardian via telephone. The guardian stated that she knows that Resident A has extensive mental health issues and when he feels cooped up, he doesn't know how to cope so he just runs. The guardian stated that his case manager has placed him on 1:1 staff supervision at the facility, and staff always supervises him closely. She is aware that staff cannot physically place their hands on him, so when he runs they just have to follow proper procedures. The guardian stated that staff always calls her to inform her when Resident A elopes, and staff had made her aware of this latest incident. The guardian stated that she has no concerns that staff is not supervising him as they are supposed to.

On 6/8/2017, I received copies of the incident reports, 30 day discharge notice to Resident A, and staff schedule via email from Ms. Chandler as I had requested.
On 8/7/2017, I spoke to Ms. Chandler. Ms. Chandler stated that Resident A did leave the facility sometime in June 2017, and his guardian took him back home to live with her. Ms. Chandler provided me with Ms. Rogers' phone number as well.

On 8/8/2017, I interviewed Ms. Rogers via telephone. Ms. Rogers stated that she and Ms. Owens were on shift together on the day of this incident, and she was assigned to Resident A as his 1:1 staff. Ms. Rogers stated that Resident A was agitated that day and was screaming and yelling in his bedroom, which he does when he gets angry and becomes restless. Resident A stormed out of the facility, and she followed him outside while continually attempting to verbally re-direct him. Ms. Rogers stated that staff are not allowed to touch the residents, so they have to use verbal prompts and this is what she did. Ms. Rogers stated that Resident A just kept walking and was showing no signs of stopping. She followed him for a while, but when it became apparent that he was not going to return to the facility with her, she went back to the facility and immediately called 911. The police arrived, and she and Ms. Owens told them that Resident A's favorite place to go when he absconds is to a nearby park with a lake that he likes to hide in. Ms. Rogers stated that the police found him quickly.

On 8/8/2017, I held an exit conference with the licensee designee, Kelly Devereaux. I explained that I had not found any violations and she will be receiving a copy of my special investigation report in the mail. Ms. Devereaux stated that she and her staff do care very much for the residents and try to accommodate them in every way they can. Ms. Devereaux stated that Resident A is intelligent and has much potential. She added that she wants to see him succeed in life and wishes him the best, even though he is no longer living in this facility.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	According to interviews with Ms. Owens, Alicia Devereaux, Ms. Chandler, Kelly Devereaux, and Ms. Rogers, it is a common and frequent occurrence for Resident A to run away from the facility. Staff were aware that Resident A is to be supervised, as written in his IPOS. Resident A did have a 1:1 staff that day, and she contacted 911 when it became clear that Resident A was not going to heed her verbal prompts and return to the facility. Police responded and brought resident back to the facility after finding him in a nearby park. According to interviews with Resident A, he was being supervised 1:1 that day, however he ran away and did not listen to staff's requests for him to return to the facility. Staff is properly supervising Resident A as written in his IPOS.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

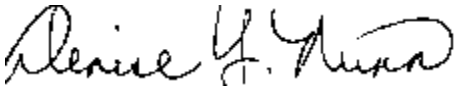
IV. RECOMMENDATION

I recommend no change to the status of this license.

8/8/2017

Theresa Cipponeri — Date
Licensing Consultant

Approved By:



09/20/2017

Denise Y. Nunn — Date
Area Manager