STATE OF MICHIGAN
RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS

MIKE ZIMMER
DIRECTOR

December 9, 2015

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

RE: License #: AS630282446
Investigation #: 2015A0603036
Glasgow

Dear Ms. Devereaux:

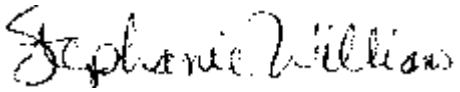
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Stephanie A. Williams, Licensing Consultant
Bureau of Community and Health Systems
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(586) 256-2097

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630282446
Investigation #:	2015A0603036
Complaint Receipt Date:	04/28/2015
Investigation Initiation Date:	04/28/2015
Report Due Date:	06/27/2015
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 was thrown to the ground by staff Laquisha. Resident A and Resident C and are verbally abused by both Laquisha and supervisor Ms. Dunbar.	No
Resident B is a one to one but doesn't receive one to one staffing.	Yes
Resident B does not have her appropriate medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/28/2015	Special Investigation Intake 2015A0603036
04/28/2015	Special Investigation Initiated - On Site Interviewed Staff and Residents.
04/29/2015	Contact - Document Received Email received from Ms. Lori Chandler, administrative assistant.
04/30/2015	Contact – Document Sent Email sent to Mrs. Shadeck, Oakland County ORR Advisor.
05/29/2015	Contact – Telephone call received. Voice message received from Ms. Cynthia Dunbar, home manager.
05/29/2015	Contact – Telephone call made. Spoke with Ms. Dunbar.
08/13/2015	Contact – Telephone call received Spoke with Mrs. Shadeck.
12/08/2015	Exit Conference Spoke with Mrs. Kelly Devereaux, licensee designee/administrator by telephone.

ALLEGATION:

- **Resident A was thrown to the ground by staff Laqueisha.**
- **Resident A and Resident C and are verbally abused by both Laqueisha and supervisor Ms. Dunbar**.

INVESTIGATION:

On 04/28/2015 Oakland County Office of Recipient Rights Advisor, Heather Gooden, Oakland County Adult Protective Services Worker and I completed an onsite investigation at the facility. Laqueisha Williams, staff Ms. Michelle Raby, home manager, Ms. Lori Chandler, Resident A, Resident B, Resident C and Resident D were interviewed individually.

Ms. Williams was interviewed and she stated that she has been working at the home for the last six years. Ms. Williams stated she has never pushed Resident A and this is the first time she is hearing something like this. Ms. Williams stated she has never yelled at any of the residents. Ms. Williams stated that Resident A will get upset when she doesn't get her cigarettes or doesn't get her way. Ms. Williams stated that Resident A will start to curse and call her a "bitch". Ms. Williams stated she has never thrown anybody to the ground or hit any of the residents. Ms. Williams stated that Resident A loves her one minute and the next minute hates everybody.

Ms. Williams stated there has never been an issue with attending to Resident C's hygiene. Ms. Williams stated if there is a problem with Resident C and she wets herself during the night, staff will change her sheets and get her cleaned. Ms. Williams stated she has not been upset with Resident C if she wets herself, has not yelled, cursed or verbally abused Resident C. Ms. Williams stated she has never heard any of the other staff yell or be verbally abusive towards Resident C.

Ms. Michelle Raby was interviewed and stated she was unaware of any incident where staff was verbally and physically abusive towards the residents in the home. Ms. Raby stated she has never harmed a resident that lives in the facility.

Resident A was interviewed and stated that "one of the staff" pushed her down. Resident A then stated that "Laqueisha pushed her and that it happened about a month ago. Resident A stated she poured water on staff "Janae" and that "Janae" then poured water back on her and then pushed her on against the wall. Resident A stated that two other residents witnessed this happening. Resident A then stated that none of the staff have ever talked mean to her and that she likes "Cynthia" and she is alright with her. Resident A stated that she and the staff made up and they are fine.

Resident B was interviewed and she stated that none of the staff have ever cursed at her or been mean to her. Resident B stated she did not observe Resident A being pushed by any staff.

Resident C was interviewed and she stated that she has been living in the home for approximately two years. Resident C stated that she could not remember the staff name that worked at night but stated that she was mean to her. Resident C did not clarify as to how staff is mean. Resident C stated she had not heard staff swear in the home.

I interviewed Resident D and she stated that she has never heard staff cursing or being disrespectful towards the residents in the home. Resident D stated that there was an incident that occurred between Resident A and Janae. Resident D stated that her door was opened and she could see everything that was going on. Resident A got up during the night and poured water on staff Janae. In return Janae pushed Resident A to the door and held her there and then pushed Resident A towards her bedroom. Resident D stated that both Resident A and Janae were wet. Resident D stated that this incident occurred around 1:00 a.m. in the morning. Resident D stated she never observed Ms. Williams push Resident A.

On 05/29/2015, I spoke with Ms. Cynthia Dunbar by telephone. Ms. Dunbar stated she has never cursed at any of the residents at the home or heard any of the staff curse or be disrespectful towards the residents.

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: (a) Use any form of punishment. (b) Use any form of physical force other than physical restraint as defined in these rules. (f) Subject a resident to any of the following: (i) Mental or emotional cruelty. (ii) Verbal abuse.
ANALYSIS:	Resident A stated that Ms. Williams pushed her and was verbally abusive. Resident D stated that it was another staff that pushed Resident A. None of the other residents interviewed stated seeing or hearing that Resident A was physically pushed by Ms. Williams or that any of the staff cursed or was disrespectful towards any of the residents in the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident B is a one to one but doesn't receive one to one staffing.

INVESTIGATION:

On 04/28/2015 Oakland County Office of Recipient Rights Advisor, Heather Gooden, Oakland County Adult Protective Services Worker and I completed an onsite investigation at the facility. Laqueisha Williams, staff Ms. Michelle Raby, home manager, Ms. Lori Chandler, Resident A, Resident B, Resident C and Resident D were interviewed individually.

Ms. Williams was interviewed and she stated that Resident B has a one to one staff and that she has always observed staff to be with Resident B. She has not observed Resident B being alone.

Resident B stated that she is to receive one to one staffing as she has pica and staff has to watch her closely. Resident B stated there has been times when staff will walk off sometimes from her but will come back within five seconds or a couple of minutes. Resident B stated that Michelle has gone to smoke outside and told her to stay inside while she smoked and that staff has fallen asleep a couple of times and she has had to call their name to wake them up. Resident b also stated that she visited her boyfriend at their sister facility (Emma Villa) and was able to be alone with him in his bedroom. Resident B stated that Michelle was her one to one on that day.

Resident B stated on another occasion while at Glasgow she was able to swallow a screw. Resident B stated that staff Sierra was on shift when this happened but was preoccupied plugging her cell phone into the charger. Resident B stated she waited for approximately 10 minutes before alerting Sierra that she had swallowed the screw.

Resident B also stated that when she takes a shower she will swallow soap or tissue even if she is menstruating. Resident B stated that staff is not always in the bathroom with her. Resident B stated that staff is to be with at all times but they are not.

On 04/28/2015, I reviewed Resident B's Individual Plan of Service (IPOS), dated 02/16/2015 at the home. Resident B's IPOS stated: Home Staff will: 1) Ensure the Consumer has 1:1 Staff ratio at all times unless otherwise documented. Staff are not to leave the Consumers side unless relieved by another staff this includes remaining with the Consumer while in the bathroom." "4) Home Staff are to ensure there are no objects left out in which the Consumer may ingest (decorative rocks, soap, shampoo, batteries, sanitary napkins) Consumer has been diagnosed with PICA."

Ms. Raby was interviewed and she stated that she has been assigned as Resident B's one to one at times. Ms. Raby stated that staff is expected to stay with Resident B at all times to ensure that she is safe and that they are following her IPOS. Ms. Raby stated that staff is to engage Resident B to keep her occupied. Ms. Raby stated that she was informed by Resident B that staff was sleeping on shift. Ms. Raby stated that although there was no confirmation that staff Mechelle Wilder did fall asleep she is no longer

working with Resident B. Ms. Raby stated that she has never observed staff not being with Resident B.

Resident D was interviewed and she stated that she has observed staff not always being with Resident B as her one to one. Resident D stated she has observed staff sleeping during the midnight shift when they are supposed to be awake with Resident B. Resident D did not state which staff was observed sleeping on shift or not being with Resident B at all times. Resident D stated that Ms. Raby did a “pretty good job” of being with Resident B during the morning times but that staff don’t always pay attention to Resident B. Resident D stated that she was present when Resident B swallowed the screw and Resident B had to tell staff on shift what she did.

On 05/29/2015, I spoke with Ms. Dunbar by telephone. Ms. Dunbar stated that staff is to be with Resident B at all times. She is unaware of a time when staff was not present with Resident B.

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:	Resident B’s IPOS stated that staff are to be with Resident B at all times. Resident B has been without her one to one staffing at various times. Staff have been observed asleep, stepping away or not close by Resident B. Staff did not provide the supervision and protection required by Resident B’s individual plan of service.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident B does not have her appropriate medications.

INVESTIGATION:

On 04/28/2015 Oakland County Office of Recipient Rights Advisor, Heather Gooden, Oakland County Adult Protective Services Worker and I completed an onsite investigation at the facility. Laqueisha Williams, staff Ms. Michelle Raby, home manager, Ms. Lori Chandler, Resident A, Resident B, Resident C and Resident D were interviewed individually.

Ms. Williams was interviewed and she stated that midnight shift is responsible for administering the morning medications to the residents. Ms. Williams stated that

another staff stated more diabetic test strips were needed and reportedly the pharmacy was contacted the previous day to address getting test strips. Ms. Williams stated that because there was not an updated prescription on file, the doctor has to be contacted.

Ms. Williams stated that the residents' medications usually come in at the end of the month. The corporate office is responsible for getting the medications to the facilities. Ms. Williams stated she was unaware of any other issues with the residents' medications.

Resident A was interviewed and stated that every morning her blood sugar is tested and that staff will write down the number. Resident A stated she has not missed a day.

Resident B was interviewed and stated that staff sometimes appeared to be confused with how to give her medications (Clozaril). Resident B stated that some of her medications were not available for her to take as they were not with the rest of her medications.

I interviewed Resident C and she stated that she takes her medications and that staff will give it to her.

Resident D was interviewed and stated that approximately two months ago her Ativan medication ran out and it took about two days for her to get her medications. Resident D stated she is to receive the Ativan when she hears voices but when she asked for it there was none.

04/28/15, I reviewed Resident A's 04/2015 medication administration records at Glasgow. Resident A's medication records stated "Clozapine 100 mg 2 tabs 1x daily at bedtime for schizophrenia & Clozapine 25 mg1 tab 1x daily in the morning for schizophrenia.

I interviewed Ms. Raby. Ms. Raby stated that Resident B's Clozaril medication was changed during her last inpatient psychiatric hospitalization (1-25mg tablet every morning, 2-100mg tablets at bedtime. Ms. Raby stated that all staff is trained on how to administer medications. Ms. Raby stated that all of Resident B's old medications should have been pulled and sent back to the corporate office to avoid any confusion. Ms. Raby also stated that she was aware that Resident A had not been tested for her blood sugar since last week as there were no more strips available for her to test with. Ms. Raby stated that she had been attempting to contact Resident A's physician to obtain another script for the test script. Ms. Raby stated that there should be documentation in Resident A's file in regards to this matter.

On 04/28/2015, I reviewed Resident A's resident record. There was no documentation of any attempts to contact Resident A's physician to obtain a prescription for testing strips. Upon further search of the medications staff located three testing strips for Resident A. I reviewed Resident A's medication record which stated that Resident A's blood sugar was tested daily.

I also reviewed Resident B's medications and observed that the following medications were not found but were part of Resident A's medication regime: Pro Air Inhaler, Fluticasone Nasal, and Asmanex Twist Inhaler (was out of inhalations).

The following was also observed: Resident B had an old prescription of Clozaril medications that were to be given at 8:00 a.m. and 8:00 p.m. that were filled on 02/04/2015, that still had medication pills however medications were administered from this pack on 04/10/ 2015 at 8:00 p.m. and 04/28/2015 at 8:00 a.m. The 8:00 a.m. Clozapine (Clozaril) 100 mg take two (was crossed out) every one handwritten in and crossed out morning and four at bedtime crossed out 2 tabs handwritten in and the February medication pack for 8 PM Clozapine 100 mg. Take two tablets every morning and four crossed out; then two handwritten in then crossed out 4 1/2 tabs was handwritten in next to it at bedtime. On 04/10 8:00 pm; the dose was dispensed and initialed from the old pack by Sierra Devereaux, staff. On 04/28 8:00 am Resident B was given the old dose by Nakaiya Hennessee, staff (as was initialed on the old medication pack) No one initialed for it on the medication record and Katessa Washington, staff initialed for her other medications but would not have been the one administering them as Nakaiya Hennessee was her one to one and only her one to one is responsible for passing Resident's medications (per Ms. Raby).

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident B's Clozaril medication was recently changed when she was given her old dosage instead of the new dosage prescribed on 04/10 and 04/28. Resident B was also prescribed medication that was not found at the time of the investigation. There is discrepancy in regards to Resident A's test strips. Ms. Raby initially stated that Resident A had not been tested due to not having test strips however three test strips were located and medication record documented daily testing. There is enough information obtained in this investigation to support that Resident B was not given her Clozaril medication as prescribed and that staff are not following the label instruction.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 04/28/2015, during the onsite investigation, I requested a copy of the staff schedule. The staff schedule could not be located. There was no staff schedule available for review.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: (a) Names of all staff on duty and those volunteers who are under the direction of the licensee. (b) Job titles. (c) Hours or shifts worked. (d) Date of schedule. (e) Any scheduling changes.
ANALYSIS:	On 4/28/2015, there was no staff schedule maintained at the facility.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

On 4/28/2015, I reviewed Resident A, Resident B, Resident C, Resident D, and Resident E's medication records. Resident A, Resident B, Resident C, Resident D, and Resident E's medications were not initialed daily as required. Resident B had an old prescription of Clozaril mixed in with current medications.

On 12/08/2015, I completed the exit conference with Mrs. Kelly Devereaux, licensee designee by telephone. I informed Mrs. Devereaux of the violations being cited in the investigation. Mrs. Devereaux stated that she already had several policies in place to addressing these problems but have some problems with staff following the policies. Mrs. Devereaux stated there is a new home manager in place for the last several months and things appeared to be going smoothly. Mrs. Devereaux stated that she would provide a corrective action plan, once she received a copy of the report.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or

	she shall comply with all of the following provisions: (b) Complete an individual medication log that contains all of the following information: (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	Residents' medication records were not initialed at the times medications were administered as required.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	Resident B's Clozaril medication was not disposed after Resident B's Clozaril prescription was changed.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable correction plan, I recommend no change in the status of the license.

Stephanie Williams 12/08/2015

Stephanie A. Williams Date
Licensing Consultant

Approved By:

Denise Y. Nunn 12/08/2015

Denise Y. Nunn Date
Area Manager