RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

December 1, 2017

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

RE: License #: AS390314010
Investigation #: **2017A0578035**
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

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(517) 281-9913

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

I. IDENTIFYING INFORMATION

License #:	AS390314010
Investigation #:	2017A0578035
Complaint Receipt Date:	09/26/2017
Investigation Initiation Date:	09/26/2017
Report Due Date:	11/25/2017
Licensee Name:	Residential Opportunities, Inc.
Licensee Address:	1100 South Rose Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-3731
Administrator:	Scott Schrum
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?
Overnight staff were observed and allowed to sleep during a shift with a medically fragile resident.	Yes

III. METHODOLOGY

09/26/2017	Special Investigation Intake 2017A0578035
09/26/2017	APS Referral
09/26/2017	Special Investigation Initiated - Telephone ORR Kalamazoo
10/02/2017	Inspection completed On-site -Interviewed staff member David Steadman
10/27/2017	Contact Phone interview completed with staff member Evelese Dean.
12/1/2017	Exit Conference -Left message with facility

ALLEGATION:
Overnight staff were observed and allowed to sleep during a shift with a medically fragile resident.

INVESTIGATION:

On 09/26/2017, I received this complaint through the BCAL on-line complaint system. It was alleged on 09/16/2017, staff member Evelese Dean slept during an overnight shift at the facility. Resident A is medically fragile and requires the use of a Vagus Nerve Stimulation Device (VNS) for seizures. Resident A is provided a baby monitor at night for staff to be aware of seizure activity. Ms. Dean was unable to assess if Resident A needed his VNS device while she sleeping.

On 10/02/2017, I completed an unannounced on-site investigation at the facility and interviewed staff member David Steadman regarding the allegations. Mr. Steadman reported that he had arrived at 3AM on 09/16/2017 like he sometimes does in order to complete random inspections. Mr. Steadman clarified that he will sometimes do this more often if he suspects staff may not be completing their job duties, but on this particular day, his inspection was random.

Mr. Steadman reported that when he arrived at the home, he could observe staff member Evelese Dean on the couch with her eyes closed and apparently asleep. Mr. Steadman reported that he took several pictures to document Ms. Dean's behavior. Mr. Steadman provided two pictures on a cell phone of an individual he identified as Ms. Evelese Dean. Ms. Dean could be observed in a seated position on a couch with her eyes closed and mouth open. Mr. Steadman accessed the details portion of each picture and demonstrated that both pictures were created on 09/16/2017 at 03:11AM and 03:01AM.

Mr. Steadman reported Resident A has a Vagus Nerve Stimulation Device. Mr. Steadman stated the device is used by staff whenever Resident A has a seizure that lasts more than one minute. Mr. Steadman reported there was no way to determine if Resident A had a seizure during the time staff member Evelese Dean was asleep because she could not monitor Resident A in a sleeping state. Mr. Steadman reported staff complete two hour room checks at night otherwise they use a baby monitor to listen for any calls for assistance from Resident A.

Mr. Steadman reported that he confronted Ms. Dean and sent her home and worked the remainder of the shift himself. Mr. Steadman reported it is a personnel policy of the organization that all overnight shifts are alert and awake and no sleeping is allowed. Mr. Steadman clarified the staffing patterns for the facility consisted of three staff during the day and one staff at night.

Mr. Steadman stated that Resident A does have significant medical needs but was unaware if he was awake or asleep at that time. Mr. Steadman explained this was because Resident A was monitored by staff with the use of a baby monitor while he is in room with the door closed. Mr. Steadman stated that based on the time of night he would assume that Resident A was sleeping. Mr. Steadman stated that staff member Ms. Dean was no longer employed by the facility.

Resident A was unable to be interviewed based on cognitive impairment and limited verbal skills. I observed Resident A to be smiling, groomed neatly, and dressed appropriately for the environment.

On 09/27/2017, I reviewed the Residential Options Inc., Assessment completed for Resident A. The level of supervision required for Resident A states, "Staff will check on Resident A every 15min. while in the home. Staff will be close by and available at all times in the community due to limited pedestrian skills. While sleeping, staff will check on him every 2 hours as well as use a baby monitor to listen for seizure activity."

On 09/27/2017, I reviewed the Kalamazoo Community Mental Health and Substance Abuse Services Assessment completed for Resident A. Resident A is described as diagnosed with Moderate Intellectual Disability, Generalized Convulsive Epilepsy, Sleep Apnea, and Nocturnal Enuresis.

The assessment identified that Resident A utilizes a Vagus Nerve Stimulation device to curtail seizures. Resident A's seizures are described as "very debilitating."

On 10/27/2017, I interviewed staff member Evelese Dean over the phone. Ms. Dean agreed that she was working the night of 09/16/2017 when staff member David Steadman arrived at the home and relieved her. Ms. Steadman acknowledged that she was sleeping during her shift but was unsure how long she was asleep. Ms. Dean stated she neglected to take her usual nap during the day and was extra tired. Ms. Dean reported that sleeping during her shift is not allowed, and she was the only staff on duty at the facility. Ms. Dean denied ever sleeping during her shift any other time. Ms. Dean stated she no longer worked for the facility and voluntarily quit.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident care agreement and assessment plan.
ANALYSIS:	Based on the interviews with staff members David Steadman and Evelese Dean, both staff members acknowledged that there is only one staff member during the overnight night shift and that staff member is required to be alert and awake per company policy. Ms. Dean acknowledged sleeping during her shift but could not recall for how long. Photographs provided by Mr. Steadman also documented Ms. Dean sleeping, but did not identify how long she had been sleeping prior to his arrival. Mr. Steadman identified the staffing patterns of the home to be three staff during the day and one staff on overnights, with no sleeping allowed. Although there is no evidence that Resident A experienced a seizure or other medical emergency while Ms. Dean was sleeping, sufficient direct care staff were not available for the supervision and protection of Resident A and to meet his specific medical care needs during the shift on 09/16/2017 that Ms. Dean was found sleeping.
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.

11/20/2017

Eli DeLeon Date
Licensing Consultant

Approved By:

11/20/2017

Dawn N. Timm Date
Area Manager