RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

July 18, 2017

Cynthia White
Neighborhood Residential Inc.
Suite 104
48711 Van Dyke
Shelby Township, MI 48317

RE: License #: AS630312997
Investigation #: **2017A0989086**
**Terova Home**

Dear Ms. White:

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

| | |
|---|---|
| **License #:** | AS630312997 |
| | |
| **Investigation #:** | 2017A0989086 |
| | |
| **Complaint Receipt Date:** | 05/05/2017 |
| | |
| **Investigation Initiation Date:** | 05/05/2017 |
| | |
| **Report Due Date:** | 07/04/2017 |
| | |
| **Licensee Name:** | Neighborhood Residential Inc. |
| | |
| **Licensee Address:** | Suite 104<br>48711 Van Dyke<br>Shelby Township, MI 48317 |
| | |
| **Licensee Telephone #:** | (586) 799-4937 |
| | |
| **Administrator:** | Cynthia White |
| | |
| **Licensee Designee:** | Cynthia White |
| | |
| **Name of Facility:** | Terova Home |
| | |
| **Facility Address:** | 2448 Terova<br>Troy, MI 48098 |
| | |
| **Facility Telephone #:** | (248) 689-7572 |
| | |
| **Original Issuance Date:** | 02/29/2012 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 09/27/2014 |
| | |
| **Expiration Date:** | 09/26/2016 |
| | |
| **Capacity:** | 3 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A was observed to be walking down the street unsupervised. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 05/05/2017 | Special Investigation Intake<br>2017A0989086 |
| 05/05/2017 | Special Investigation Initiated - On Site<br>Conducted unannounced onsite inspection. No answer; I left my business card in the door. |
| 05/10/2017 | Contact - Telephone call made<br>Attempted to contact the facility; no answer. |
| 05/10/2017 | Contact - Face to Face<br>Conducted unannounced onsite inspection to the facility. Interviewed staff, Jazmine Weems, and observed Residents A and B. |
| 7/11/2017 | Contact-Telephone call to<br>Resident A's guardian. |
| 7/11/2017 | Exit Conference<br>Left a voicemail message for the Licensee, Cynthia White. |

**ALLEGATION:**

**Resident A was observed to be walking down the street unsupervised.**

**INVESTIGATION:**

On 5/5/2017, the Department of Licensing and Regulatory Affairs (LARA) received a complaint stating that Resident A was seen walking down the street unsupervised.

On 5/10/2017, I conducted an unannounced onsite inspection to the facility. I interviewed staff, Jazmine Weems, and observed Residents A and B. Ms. Weems stated that on 5/2/2017, Resident A wanted to go for a walk so she got Resident A and Resident B ready to go. Resident A ran out of the house and Ms. Weems asked him to

come back until Resident B was ready to go. Resident A did not listen, and began to run faster. Ms. Weems stayed behind to tend to Resident A and shouted for Resident A to come back and wait for them. By the time Ms. Weems finished getting Resident B ready to go in the house, Resident A came walking up the driveway put of breath. Ms. Weems stated that she was the only staff on shift with Residents A and B.

Ms. Weems stated that she is aware that Resident A is not allowed to be unsupervised in the community and it was accidental. However, Ms. Weems added that there is some confusion as to the specifics regarding Resident A's supervision. The Home Manager, Dawn Simer, told staff that Resident A could go down the street 4-5 houses or so as long as he is within staff's line of sight. However, the previous home manager told staff that Resident A cannot be unsupervised at any time, therefore she is uncertain as to how closely Resident A is supposed to be supervised. Ms. Weems then stated that she was aware that Resident A needs to be supervised 1:1, but wasn't quite sure what that meant.

I observed the incident report written by Ms. Weems and saw that it was not clear. The sentences and words all ran into each other, making the document unreadable and confusing. The incident report did indicate that Ms. Weems was the only staff that witnessed this incident because she was the only staff on shift.

I observed the staff note written by Ms. Weems, which stated that Resident A ran off when Ms. Weems tried to take Residents A and B for a walk.

I observed Residents A, who did not wish to be interviewed at that time. I was unable to interview Resident B as she is non-verbal and unable to hold a speaking conversation.

On 7/11/2017, I contacted Resident A's guardian. The guardian stated that staff is supposed to be supervising Resident A 1:1, and she was already made aware of this incident.

On 7/13/2017, I received a copy of Resident A's Individual Plan of Service (IPOS). Resident A's IPOS indicates that Resident A is to be within arm's reach at all times while crossing streets. Under no circumstances is Resident A to be left alone in the community and he always needs to be accompanied by a responsible adult. Yet, while Resident A is in the home staff just needs to be aware of his whereabouts. The IPOS indicated that Resident A does need direct supervision when he is doing household chores, cooking, and during hygiene activities.

| **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 my interview with Ms. Weems, Resident A ran |

| | |
|---|---|
| | away from her while she was getting Residents A and B ready to go for a walk. Ms. Weems stated that she was told conflicting stories from home managers as to how closely Resident A is supposed to be supervised, however, she knows that he cannot be unsupervised in the community.<br><br>I reviewed Resident A's IPOs, which indicates that he needs to be supervised in the community and within arm's reach while crossing the streets. This incident was accidental and unintentional. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On 5/10/2017, I conducted an unannounced onsite investigation to the facility and interviewed staff, Jazmine Weems. I requested to see Resident A's IPOS. The last IPOS for Resident A in the facility expired on 6/30/2015 (effective 7/14/2017-6/30/2015), and there was no current IPOS on file for Resident A.

| | |
|---|---|
| **R 400.14316** | **Resident records.** |
| | (1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information:<br>(f) Assessment plan. |
| **ANALYSIS:** | On 5/10/2017, I conducted an onsite inspection to the facility and observed that the last IPOS in Resident A's file expired on 6/30/2017. There was no new or recent IPOS for him onsite at the facility. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

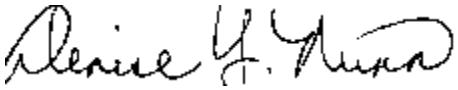
## IV. RECOMMENDATION

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

7/11/2017

Theresa Cipponeri — Date
Licensing Consultant

Approved By:



07/18/2017

Denise Y. Nunn — Date
Area Manager