RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

March 23, 2018

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

RE: License #: AS630312997
Investigation #: **2017A0989087**
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.
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A previous recommendation for a provisional license was made in Special Investigation #2017A0991033, dated 8/29/2017, which remains in effect

Upon receipt of an acceptable corrective action plan, a six-month provisional license will be issued. If you accept the provisional license, this must be indicated in your corrective action plan. If you do not agree to a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. You must still submit an acceptable corrective action plan.

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.

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 #:	2017A0989087
Complaint Receipt Date:	07/12/2017
Investigation Initiation Date:	07/12/2017
Report Due Date:	09/10/2017
Licensee Name:	Neighborhood Residential Inc.
Licensee Address:	Suite 104 48711 Van Dyke 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 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?
On 7/1/2017, staff left Resident alone in the facility with no supervision.	Yes
On 7/2/2017, staff did not give Resident A his morning medications.	No
Additional Findings	Yes

III. METHODOLOGY

07/12/2017	Special Investigation Intake 2017A0989087
07/12/2017	APS Referral Received complaint from Adult Protective Services (APS).
07/12/2017	Special Investigation Initiated - Face to Face Interviewed Resident A at New Horizons Day Program.
07/12/2017	Contact - Telephone call made Spoke to Ms. Goodin.
07/18/2017	Contact-Telephone call to Spoke to Resident A's mother, Kelly Clark.
07/19/2017	Contact - Face to Face Conducted unannounced onsite inspection to the facility, accompanied by Ms. Goodin. Observed Resident A and interviewed home manager, Dawn Simer.
08/02/2017	Contact - Telephone call made Spoke to Ms. Goodin.
08/10/2017	Contact - Telephone call made Left a voicemail message for staff, Kevin Alston, requesting a return call.
08/18/2017	Contact - Telephone call made Attempted to contact staff, Alston, however his phone was disconnected.
08/18/2017	Contact - Telephone call made

	Left a voicemail message for staff, Florence, Hammond, requesting a return call.
08/18/2017	Contact - Telephone call made Interviewed staff, Janea Marcilis, via telephone.
08/18/2017	Contact - Telephone call made Left a voicemail message for Resident A's supports coordinator, Melanie Wrobel, requesting a return call.
09/01/2017	Contact - Telephone call made Left a voicemail message for Ms. Wrobel, requesting a return call.

ALLEGATION:

On 7/1/2017, staff left Resident alone in the facility with no supervision.

INVESTIGATION:

On 7/12/2017, I interviewed Resident A at the New Horizons Day Program. I was accompanied by the assigned Adult Protective Services (APS) investigator, Heather Goodin. Resident A stated that staff member, Kevin, left him alone because he had to get to his other job. Resident A stated that Kevin told him “You’ll be OK alone.”, and he left. Resident A stated that another staff member, Janea came in to the facility and saw him alone and she was upset about it. Resident A stated that staff is usually always with him because it’s their job. Resident A stated that there is only one staff member on shift rigjt now since he is the only resident who lives in the facility right now.

On 7/19/2017, I conducted an unannounced onsite inspection to the facility accompanied by Ms. Goodin. When I arrive onsite, Resident A was outside by himself walking around the next door neighbor’s driveway, looking at their flowers. There were no staff outside with him, however, within a few minutes the home manager, Dawn Simer, came outside when she saw me talking to Resident A outside. Ms. Simer stated that Resident A does not require 1:1 supervision and just has to be within sight of staff. She invited me inside and Resident A went inside with us. I interviewed Ms. Simer, and she stated that on 7/1/2017, a staff member, Florence Hammond, stopped by the facility to drop off a gas card. She was not scheduled to work that day and this was purely coincidental. When Ms. Hammond saw that Resident A was alone, she called Ms. Simer and told her that staff member, Kevin Alston, was supposed to be working that shift but he had left the facility and Resident A was alone. Ms. Simer stated that Mr. Alston was scheduled to work the 2:00-11:00 p.m. shift, and when Ms. Hammond called her it was approximately 10:05 p.m. The next staff member, Janea Marcilis, was not scheduled to come on shift until 11:00 p.m. Ms. Simer stated that she does not know what time Mr. Alston left or how long Resident A had been left alone. Ms. Marcilis was called to come in early, and Ms. Hammond stayed with Resident A until Ms. Marcilis

arrived. Ms. Simer stated that she tried to reach Mr. Alston, however, he did not respond to any of her calls or text messages. Ms. Simer informed the licensee, Cynthia White, and Ms. White said she'd take care of it. I briefly reviewed Resident A's Individual Plan of Services (IPOS) and the incident report (IR) regarding this incident onsite written by Ms. Hammond. The IR indicated that Ms. Hammond stopped by the facility on 7/1/2017 and there were no staff present with Resident A.

Ms. Simer provided me with Mr. Alston's, Ms. Marcilis, and Ms. Hammond's phone numbers. In addition, I obtained the phone number for Melanie Wrobel, Resident A's supports coordinator.

On 8/2/2017, I spoke to Ms. Goodin. She is substantiating neglect for staff leaving Resident A alone and unsupervised at the facility.

On 8/10/2017 and 8/18/2017, I left voicemail messages for Mr. Alston, requesting a return call. Mr. Alston never called me back.

On 8/18/2017, I reviewed Resident A's IPOS. The IPOS stated that Resident A needs to be within visual contact at all times by staff when he is in the community, due to his long history of behavioral challenges and limited safety skills. The IPOS further indicated in bold, capital letters, "UNDER NO CIRCUMSTANCES IS (Resident A) TO BE EVER LEFT ALONE. HE ALWAYS NEEDS TO BE ACCOMPANIED BY A RESPONSIBLE ADULT WHEN IN HIS COMMUNITY."

On 8/18/2017, I interviewed Ms. Marcilis via telephone. Ms. Marcilis stated that Mr. Alston called her three times around 10:15 p.m. or so but did not leave a voicemail. Ms. Marcilis stated that she was sleeping when he did this, as her shift did not begin until 11:00 p.m., and when she tried to call him back he did not answer. Ms. Marcilis stated that when she arrived at the facility, Ms. Hammond was there waiting for a staff member to come in. Ms. Hammond was not working a shift and had just happened to stop in at the facility to drop something off. This is when she found Resident A alone, so she waited for Ms. Marcilis to come in and then she left.

On 8/18/2017 and 9/1/2017, I left a voicemail message for Resident A's supports coordinator, Melanie Wrobel, requesting a return call in regards to clarifying how Resident A's level of supervision. I stated in the voicemail that when I arrived at the facility on 7/19/2017, Resident A was outside by himself.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(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.

ANALYSIS:	On 7/1/2017, Resident A was left alone and unsupervised in the facility after staff member, Kevin Alston, left his shift. Another staff member, Florence Hammond stopped by the facility to drop something off and she was not scheduled to work. When Ms. Hammond arrived at the facility, she found Resident A by himself with no staff present. Another staff member, Janea Janea Marcilis, came to her shift early and Ms. Hammond waited at the facility with Resident A until Ms. Marcilis arrived.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	On 7/19/2017, I arrived at the facility and witnessed Resident A outside by himself with no staff present. Resident A was standing in the next door neighbor's driveway and smelling their flowers. I stood outside with Resident A for several minutes until the home manager, Dawn Simer, came out of the facility. Ms. Simer stated that Resident A does not have 1:1 supervision, and he just needs to be within staff's line of sight. I observed Resident A's Individual Plan of Service (IPOS), which specifically indicates that Resident A is never to be left alone under any circumstances and always needs to be accompanied by a responsible adult.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 7/2/2017, staff did not give Resident A his morning medications.

INVESTIGATION:

On 7/12/2017, I interviewed Resident A at the New Horizons Day Program. I was accompanied by the assigned Adult Protective Services (APS) investigator, Heather Goodin. Resident A stated that staff gives him his medications at all hours of the day, in the mornings, days, and evenings. He did not remember the times, and stated that staff gives him mediations every day. He did not remember any days or times that staff did not give him his medications.

On 7/12/2017, I spoke to Ms. Goodin, who stated that she spoke to Resident A's mother. According to Resident A's mother, it was Resident A who told her that he did not received his morning medications but she does not have any evidence as to whether this happened or not.

On 7/19/2017, I conducted an unannounced onsite inspection to the facility, accompanied by Ms. Goodin. I interviewed the home manager, Dawn Simer, who stated that staff member, Kevin Alston, did not pass Resident A's evening medication to him on 7/1/2017 because he left his shift early. However, Ms. Marcilis passed Resident A's medications to him when she came on shift. I reviewed Resident A's medication logs, specifically dates 7/1 and 7/2, and all medications were initialed by staff and accounted for. Ms. Simer stated that Resident A's parents picked him up on 7/2/2017 around 10:00 a.m., and he arrived back to the facility around 4:00 p.m.

On 7/18/2017, I spoke to Kelly Clark, Resident A's mother. Ms. Clark stated that when she picked up Resident A from the facility on 7/2/2017, he told her that he didn't receive his morning medications. Ms. Clark stated that she does not know if this is true or not.

On 8/2/2017, I spoke to Ms. Goodin. She is not substantiating staff for medical neglect.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**
ANALYSIS:	Resident A stated that staff gives him his medications all day, and he could not remember a time when he did not receive his medications. Resident A's mother, Kelly Clark, stated that Resident A told her that he did not receives his morning medications on 7/2/2017, but she does not know if that is true or not. I reviewed Resident A's medication logs and all medications had been signed for.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

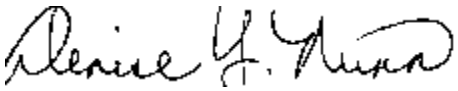
IV. RECOMMENDATION

A previous recommendation for a provisional license was made in Special Investigation #2017A0991033, dated 8/29/2017, which remains in effect.

9/1/2017

Theresa Cipponeri — Date
Licensing Consultant

Approved By:



03/23/2018

Denise Y. Nunn — Date
Area Manager