GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 11, 2020

Randy and Bonnie Reeves
20544 McAllister Rd
Battle Creek, MI 49016

RE: License #: AM130281778
Investigation #: 2020A0581015
Reeves Adult Foster Care

Dear Mr. and Mrs. Reeves:

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 (616) 356-0183.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM130281778
Investigation #:	2020A0581015
Complaint Receipt Date:	01/21/2020
Investigation Initiation Date:	01/23/2020
Report Due Date:	02/20/2020
Licensee Name:	Randy and Bonnie Reeves
Licensee Address:	20544 McAllister Rd Battle Creek, MI 49016
Licensee Telephone #:	(269) 962-3628
Administrator:	Bonnie Reeves
Licensee Designee:	N/A
Name of Facility:	Reeves Adult Foster Care
Facility Address:	20544 McAllister Rd. Battle Creek, MI 49016
Facility Telephone #:	(269) 962-3628
Original Issuance Date:	08/23/2006
License Status:	REGULAR
Effective Date:	08/12/2019
Expiration Date:	08/11/2021
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
The facility's direct care staff failed to obtain emergency medical attention for Resident A after he was observed unresponsive.	Yes
• Resident A's overall hygiene isn't being addressed. • His teeth are rotting. • His beard isn't being shaved. • Resident B isn't being bathed. • Resident B's hygiene isn't being addressed.	No
The facility's direct care staff is leaving Resident B in soiled incontinence briefs.	No
Additional findings.	Yes

III. METHODOLOGY

01/21/2020	Special Investigation Intake 2020A0581015
01/21/2020	APS Referral APS received the allegations; however, they're not investigating.
01/21/2020	Referral - Other Referral to the Veteran's Administration's case manager, Renee Lewis. She advised she's had no contact with Resident A as he was not placed in a medical VA foster home.
01/21/2020	Contact - Document Received Received additional information relating to the complaint through the BCHS on-line complaint system.
01/22/2020	Contact - Document Received Received additional allegations from intake #170488, which were added to this special investigation.
01/22/2020	APS Referral APS received allegations and investigated, referral not necessary.
01/23/2020	Special Investigation Initiated - Telephone Interview with medical social worker, Larissa Weld.
01/23/2020	Inspection Completed On-site Interview with residents and licensees. Obtained documentation.

01/23/2020	Exit conference with licensees, Randy and Bonnie Reeves.
02/04/2020	Inspection Completed-BCAL Sub. Compliance
02/04/2020	Contact – Document Sent Email to Calhoun Adult Protective Services Specialist, Joy Riley.
02/05/2020	Contact – Document Received Email from Ms. Riley.
02/11/2020	Contact – Telephone call made Interview explaining findings with licensee, Randy Reeves.

ALLEGATION:

The facility's direct care staff failed to obtain emergency medical attention for Resident A after he was observed unresponsive.

INVESTIGATION:

On 01/21/2020, I received this complaint through the Bureau of Community Health Systems (BCHS') on-line complaint system. The complaint alleged Resident A was taken to the ER by ambulance after the facility contacted 911 the morning of 01/15/2020 after finding Resident A unresponsive. It was alleged Resident A had been unresponsive the night before; however, it was believed Resident A was "in a deep sleep"; therefore, emergency services were not contacted.

On 01/23/2020, I interviewed medical social worker, Larissa Weld, via telephone. Ms. Weld stated Resident A was admitted to the ER because he had been found "unresponsive" by direct care staff at the facility and direct care staff believed he was going in and out of sleep. Ms. Weld emailed me later in the day stating she had observed Resident A noting he had a "fairly large" bruise over his left eye. She stated she had attempted to speak with him, but his speech was "incomprehensible". Ms. Weld stated Resident A would be transferred to a rehab facility because he was having trouble walking.

On 01/23/2020, I conducted an unannounced on-site investigation at the facility. I interviewed licensees, Bonnie and Randy Reeves and direct care staff, Matt Griffin. I did not interview Resident A as he was still at the ER. I interviewed several other residents in the facility, as well.

Mr. and Mrs. Reeves stated Resident A had been at the facility since January 24, 2014. They stated on 01/14/2020, Resident A had "appeared fine" in the evening prior to them leaving the facility and Mr. Griffin taking over as the primary care staff.

They both stated there was no indication anything was wrong with Resident A when they left. Mrs. Reeves stated when she came back to the facility around 8 am the next morning she and Mr. Griffin tried waking up Resident A. She stated when she tried waking him up, his eyes were observed just “rolling around” and he was unable to talk. She stated she immediately called 911 and he was taken away by ambulance to the ER. Both Mr. and Mrs. Reeves agreed Resident A would sometimes fall asleep on the facility’s couch and would appear to be in a “deep sleep.” They stated that deep sleep meant Resident A was difficult to rouse meaning he’d be lethargic and wouldn’t respond to their attempts to awaken him. They both reported that despite Resident A having difficulty being roused, he would still verbally respond to them with statements like “leave me alone” or “let me sleep.” Both Mr. and Mrs. Reeves stated there had never been a time when Resident A was so far into a deep sleep that he failed to respond to them in some way. They both agreed his complete unresponsiveness was abnormal or unusual for him.

Mr. and Mrs. Reeves stated they had been told by Mr. Griffin Resident A appeared to have been unresponsive throughout the evening, but Mr. Griffin believed Resident A was in a “deep sleep.” They stated Mr. Griffin told them while he was attempting to put Resident A in his wheelchair so he could put him in his bed, Resident A slipped and may have hit his face or head on the arm of the chair. Mr. and Mrs. Reeves stated when the EMT’s took Resident A out of the facility on 01/15/2020 they observed some slight bruising around his eye area.

Mr. and Mrs. Reeves stated they have an emergency protocol, which they provided for my review. According to this protocol, direct care staff are to call 911 in the event of an emergency. Direct care staff should then contact the licensees as soon as they are able to and to provide the licensees with information on what happened to the resident that caused direct care staff to contact 911 in the first place.

Direct care staff, Matt Griffin, confirmed he was working at the facility on the evening of 01/14/2020. Mr. Griffin stated around 8:45 pm he observed Resident A sitting in a chair in the living room and he was “awake and alert”. Mr. Griffin stated he went upstairs and came back down around 9:25 pm and again observed Resident A still in his chair, but he appeared to be sleeping. He stated he put his hand on Resident A’s chest and could tell he was breathing. He stated it was normal for Resident A to fall asleep in the living room, but normally if he attempted to rouse him, he would wake up. Mr. Griffin stated that night; however, Resident A didn’t move at all and didn’t say anything when Mr. Griffin tried to transfer him into his wheelchair. Mr. Griffin stated it was during the transfer when Resident A slipped from Mr. Griffin’s arms possibly hitting his head or face against the armchair, but Mr. Griffin stated he didn’t actually see Resident A hit anything.

Mr. Griffin stated he attempted to call and text the licensees, Randy and Bonnie Reeves, on the evening of 01/14/2020 to request their assistance with Resident A; however, neither the calls nor the texts went through. He stated he never contacted 911 because he believed Resident A was in a “deep sleep.” He stated he checked

on Resident A every two hours throughout the night and each time Resident A was "snoring." He stated around 8 am the next morning he texted the licensees again, but still didn't hear from them. He stated he only discovered the licensee's phones hadn't been working when Mr. and Mrs. Reeves came to the facility between 8 am and 8:30 am and informed Mr. Griffin that neither her nor Mr. Reeves had received their messages or phone calls. Mr. Griffin stated it was determined by Mrs. Reeves to contact 911 as Resident A was still unresponsive, and she believed something was wrong with him.

I interviewed Resident C, Resident D, Resident E, and Resident F who all stated it was normal for Resident A to fall asleep in the living room, but staff would be able to wake him up and Resident A would then take himself to his bedroom and go to bed. The residents agreed it wasn't normal for Resident A to be so asleep he wasn't responsive to anyone or attempts to wake him up.

I reviewed Resident A's *Health Care Appraisal*, dated 11/12/2019, and his *Assessment Plan for AFC Residents*, dated 01/01/2019; however, there was no indication in either document Resident A was a "deep sleeper" or any documentation or diagnosis indicating it was normal for Resident A to sleep so soundly he would be become unresponsive.

I also reviewed the facility's *Incident Report* (IR), dated 01/17/2020. The IR was consistent with what was reported to me by the licensees and Mr. Griffin. It stated in the IR that Mr. Griffin had attempted to contact the licensees for assistance in putting Resident A to bed because Resident A was in a deep sleep; however, Mr. Reeves stated in the IR that his phone was charging and Mrs. Reeves never received Mr. Griffin's calls or texts.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Based on my interviews with the licensees, Bonnie and Randy Reeves, the hospital social worker, Larissa Weld, direct care staff, Matt Griffin, and Resident C, Resident D, Resident E, and Resident F, and my review of Resident A's *Health Care Appraisal*, dated 11/12/2019, his *Assessment Plan for AFC Residents*, dated 01/01/2019, and the *Incident Report*, dated 01/17/2020, there is evidence indicating that despite Resident A being a "deep sleeper" he was always able to be roused awake by direct care staff and the licensees. While it was normal for Resident A to fall asleep in the facility's living room, he would typically make statements that he wanted to continue sleeping or be left alone. On 01/14/2020, while in the care of direct care staff, Matt Griffin, Resident A appeared to Mr. Griffin as "unresponsive." Mr. Griffin was unable to roust Resident A awake despite attempts to do so. Additionally, Mr. Griffin was concerned about Resident A not being able to be roused so much so that he attempted to contact the licensees on their cell phones; however, when he received no responses from either licensee he put Resident A into bed while he continued be unresponsive. Based on my investigation, Resident A's sudden unresponsiveness was an adverse change, which required immediate medical attention, which the facility's direct care staff, Matt Griffin, failed to do.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **Resident A and Resident B's overall hygiene isn't being addressed.**
- **Resident A's teeth are rotting.**
- **Resident A's beard isn't being shaved.**
- **Resident B isn't being bathed.**

INVESTIGATION:

The complaint received also alleged Resident A's hygiene wasn't being addressed. The complaint alleged Resident A wasn't groomed, his beard needed to be shaved and his teeth were rotting and causing foul breath.

I received an additional complaint on 01/21/2020 alleging Resident B's hygiene wasn't being addressed either. It was alleged Resident B wasn't being bathed because his body was observed to be dirty and dried feces was observed on his feet and toes.

During my on-site investigation, Mr. and Mrs. Reeves denied Resident A's hygiene not being addressed. Both Mr. and Mrs. Reeves stated Resident A was assisted with showering at the facility at least once to twice a week. They provided me with a copy of the facility's "shower schedule", which I reviewed. According to this schedule, Resident A's days to shower were Mondays and Thursday. Mr. and Mrs. Reeves stated if any of the residents, including Resident A, want to shower more frequently, then they're able. Mr. and Mrs. Reeves and Mr. Griffin all stated Resident A requires assistance showering, which consists of helping him sit in the shower chair, shampooing his hair and washing his body. Mr. Griffin also stated he would also provide Resident A with "sponge baths" if he didn't want to take a shower.

Mr. and Mrs. Reeves stated Resident A is taken at least every few months to have his beard and hair trimmed at a local barber, but it could be as much as once a month if time allows. Mr. Reeves stated he had planned on recently taking Resident A to have his beard trim, but then the 01/14/2020 incident occurred.

Mr. and Mrs. Reeves denied Resident A's teeth were rotting. They stated Resident A did not require assistance with brushing his teeth and they would have noticed if he had foul breath or observed his teeth rotting. They both stated Resident A did not complain of tooth or gum pain. Mr. Reeves stated Resident A had his annual health care appraisal on 11/12/2019, which the doctor looked in Resident A's mouth and no oral issues were noted. I reviewed Resident A's Health Care Appraisal, dated 11/12/2019, which confirmed Mr. Reeves statement.

Mrs. Reeves stated she makes dental appointments for all of the residents; however, Resident A's insurance through the VA doesn't cover dental appointments.

I was unable to interview Resident B during the on-site investigation as he was still in the hospital.

Resident C, Resident D, Resident E and Resident F all agreed they have a shower schedule; however, they all agreed they're able to shower more if they want. All the residents stated Resident A and Resident B received assistance with showering in the facility. None of the residents believed Resident A or Resident B had any hygiene issues.

I reviewed Resident A's *Assessment Plan for AFC Residents*, dated 01/01/2019 which stated Resident A "needs promptings to take a shower." It also stated Resident A "needs promptings: to change depends" under the section of Personal Hygiene. According to the assessment, Resident A requires no help with grooming (i.e. hair care, teeth, nails, etc.).

Regarding Resident B's hygiene, Mr. and Mrs. Reeves denied it wasn't being addressed. They stated Resident B was taken to the Veteran's Administration (VA) Urgent Care on 01/21/2020 after he was found in another resident's bedroom with a

“blank” look on his face. Mr. Reeves stated Resident B was observed to have no pants on and there was “poop everywhere.” Mr. Reeves stated he and Mr. Griffin cleaned Resident B up, using wet wipes, before taking him to Urgent Care. Mr. Reeves stated he did not shower Resident A after discovering him because he wanted to get him to urgent care as quickly as possible.

Mr. Reeves stated Resident B is assisted with showering at least once a week, as well, but Resident B is able to shower more if he’d like. According to the facility’s shower schedule, Resident B’s shower days are Mondays and Thursdays.

Mr. Griffin’s statement was consistent with Mr. Reeves’ statement to me.

I reviewed Resident B’s *Assessment Plan for AFC Residents*, dated 01/01/2019 which stated Resident B “needs promptings” with bathing. Under the section of personal hygiene, it stated Resident B “sometimes” needs assistance; however, the type of assistance was not indicated. According to the assessment, Resident B required no assistance or help with grooming.

On 02/05/2020, I emailed Calhoun County Adult Protective Services (APS) Specialist, Joy Riley. Ms. Riley stated “The AFC did what was appropriate for the resident and did provide care prior to going to the hospital. I am not substantiating.”

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Based on my interviews with the licensees, Bonnie and Randy Reeves, direct care staff, Matt Griffin, interviews with Resident C, Resident D, Resident E and Resident F, my review of the facility’s shower schedule and my review of Resident A and Resident B’s *Assessment Plans for AFC Residents*, both dated 01/01/2019, there is no evidence indicating the facility wasn’t providing Resident A and Resident B with the opportunities and instruction for daily bathing and oral and personal hygiene. Additionally, the licensees were providing Resident A and Resident with opportunities to bathe at least once a week, if not more, if needed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility's direct care staff is leaving Resident B in soiled incontinence briefs.

INVESTIGATION:

The additional complaint alleged on 01/21/2020 Resident B and his clothes were urine soaked. It was alleged his incontinence brief was also urine soaked and he smelled of urine and feces.

Mr. Reeves stated on 01/21/2020, Resident B was found in another resident's bedroom with a "blank" look on his face and after being cleaned up, he was taken to the VA Urgent Care. Mr. Reeves stated prior to leaving for Urgent Care, Resident B was cleaned up with "wet wipes", a new incontinence brief was put on him, and his clothes were changed. Mr. Reeves stated on the way to Urgent Care Resident B threw up on himself and had to be cleaned up again. Mr. Reeves stated he did not believe Resident B experienced incontinence on the way to Urgent Care, but acknowledged it was possible. Mr. Reeves stated it was approximately an hour and a half from when Resident B was discovered in the facility to when he was finally admitted into the ER. He stated it was possible Resident B experienced incontinence during that time; however, they were focusing more on getting Resident B medical attention rather than checking his incontinence briefs during that hour and a half. Mr. Reeves stated Resident B utilizes incontinence briefs on a regular basis and Resident B's briefs are changed, at a minimum, at breakfast, lunch and dinner time, or more often, if needed.

Mr. Griffin statement was consistent with Mr. Reeves' statement. Mr. Griffin stated he has a "weak stomach" so he would have noticed if Resident B had soiled himself on the way to Urgent Care. Mr. Griffin did not believe Resident B experienced incontinence after they left the facility to when he was admitted into the ER.

I reviewed Resident B's *Assessment Plan for AFC Residents*, dated 01/01/2019, which did not indicate Resident B's need for incontinence briefs or the type of care required by direct care staff in regard to Resident B's use of incontinence briefs.

Resident C, Resident D, and Resident F stated they remembered the day Resident B had to go to Urgent Care. They all agreed Resident B was cleaned up and changed prior to being taken to Urgent Care.

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 this act.
ANALYSIS:	Based on my investigation, there is no evidence indicating the facility or the facility's direct care staff knowingly left Resident B in soiled incontinence briefs on 01/21/2020. Licensee Randy Reeves and direct care staff Matt Griffin both stated Resident B was changed into a clean incontinence brief prior to being transported to Urgent Care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

Mr. Reeves stated Resident B required the use of incontinence briefs on a regular and consistent basis. He stated Resident B was prompted around breakfast, lunch and dinner to change his brief, but this could be more often, if needed.

I reviewed Resident B's *Assessment Plan for AFC Residents*, dated 01/01/2019, which did not indicate Resident B required the use of incontinence briefs or indicated what type of assistance he required of direct care staff members regarding toileting.

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.
DEFINITIONS:	**(d) "Assessment plan" means a written statement which is prepared in cooperation with a responsible agency or person and which identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical and behavioral needs and well being and the methods of providing the care and services, taking into account the preferences and competency of the individual.**

ANALYSIS:	During this investigation, it was established an assessment plan had been completed for Resident B on 01/01/2019; however, Resident B's assessment plan did not document Resident B's care in terms of him using incontinence briefs. Resident B's assessment neither addressed Resident B's need for the regular use of incontinence briefs nor did it document what the responsibilities were for the licensees and direct care staff in terms of Resident B's use of incontinence briefs. For example, such as prompting him to change them or assisting him in changing them. The facility did not document Resident B's self-care needs in the written assessment plan and did not specify the licensee's responsibilities, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/11/2020, I conducted a follow-up exit conference with the licensee, Randy Reeves. Mr. Reeves acknowledged my findings. He stated he understood assessments needed to be updated to reflect a resident's current care.

IV. RECOMMENDATION

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

Cathy Cushman

02/06/2020

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Cathy Cushman Date
Licensing Consultant

Approved By:

Dawn Timm

02/11/2020

_____

Dawn N. Timm Date
Area Manager