GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 3, 2020

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

RE: License #: AS390011376
Investigation #: 2020A0581018
Engel Court AIS/MR

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 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 #:	AS390011376
Investigation #:	2020A0581018
Complaint Receipt Date:	01/31/2020
Investigation Initiation Date:	02/03/2020
Report Due Date:	03/31/2020
Licensee Name:	Residential Opportunities, Inc.
Licensee Address:	1100 South Rose Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-3731
Administrator:	Nancy Bolen
Licensee Designee:	Scott Schrum
Name of Facility:	Engel Court AIS/MR
Facility Address:	7925 Engel Court Portage, MI 49002
Facility Telephone #:	(269) 329-0313
Original Issuance Date:	09/29/1982
License Status:	REGULAR
Effective Date:	08/23/2019
Expiration Date:	08/22/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Bed rails were being used on Resident A's bed without them being identified in her assessment plan.	Yes
There was no physician's order for Resident A's bed rails.	Yes

III. METHODOLOGY

01/31/2020	Special Investigation Intake 2020A0581018
01/31/2020	Referral - Recipient Rights Kalamazoo recipient rights already investigation; referral not necessary.
01/31/2020	Contact - Document Received Received Incident Report regarding incident via email.
02/03/2020	Special Investigation Initiated - Face to Face Interviews with direct care staff at facility main office with Recipient Rights Officer, Lisa Smith.
02/05/2020	Contact - Face to Face Additional interviews with direct care staff.
03/02/2020	Inspection Completed-BCAL Sub. Compliance
03/02/2020	Exit conference with licensee designee, Scott Schrum.

ALLEGATION:

Bed rails were being used on Resident A's bed without them being identified in her assessment plan.

INVESTIGATION:

On 01/31/2020, I received this complaint as a referral from Kalamazoo Recipient Rights Officer (RRO), Lisa Smith. Ms. Smith stated direct care staff used bed rails on Resident A's bed when they weren't approved to do so. Ms. Smith forwarded me the facility's Incident Report (IR) pertaining to the incident.

I reviewed the IR, which had been completed by direct care staff, Cayla Milner. The IR stated between 4:10 am and 5:15 am Resident A's pillow was observed on the floor and it was believed she had hit her face on her bedrails causing a black eye. It stated on the IR, in the corrective measures section, the bedrails had since been removed from Resident A's bed. It was also noted on the IR Resident A did not have an order for bedrails.

On 02/03/2020, in conjunction with RRO, Ms. Smith, and ROI's program director, Susan Clayborn, we interviewed direct care staff, Cayla Milner, at ROI's main office. Ms. Milner stated she had been at the facility since December 2, 2019. She stated on the 01/30/2020, she went into Resident A's bedroom and saw Resident A's pillow on the floor with Resident A leaning on her bedrail. She stated when she turned on the bedroom light, it appeared Resident A's left eye was bruised while her right eye started to swell. She stated Resident A does engage in self-injurious behavior; however, she did not believe Resident A engaged in self-injurious behavior that night because she would make obvious noises while doing so. Ms. Milner stated she believed Resident A had gotten the injuries from the bedrail. Ms. Milner stated when she arrived to work at 11 pm that night, Resident A was in bed, her bedrails were already up, but no injuries had been observed.

Ms. Milner stated it wasn't consistent when Resident A's bedrails were being used. She stated she primarily worked 3rd shift and whether or not the bedrails were up "depended on other employees." She stated she never had any conversations with any other direct care staff on whether Resident A required the regular use of bedrails. She stated if they were down when she came into work then she would put them up. Ms. Milner could not indicate if the bedrails were identified in Resident A's assessment plan.

Ms. Clayborn provided me with Resident A's Kalamazoo Community Mental Health Treatment Plan, dated 07/01/2019. I reviewed this treatment plan, which did not indicate Resident A required the use of bed rails.

I reviewed Resident A's Kalamazoo Community Mental Health Assessment, dated 06/06/2019. This assessment plan stated Resident A "can get in and out of bed or other resting situations but may require verbal or physical assistance from staff". There was no indication in this assessment plan indicating Resident A required the use of bedrails.

I reviewed ROI's Assessment Plan for Resident A, dated 06/05/2019. According to this assessment, a gait belt and wheelchair where the only two assistive devices utilized by Resident A to assist in her mobility.

Ms. Clayborn also provided me with the physician's order for Resident A's new bed and bedrails. According to this physician's order, dated 12/10/2019, Resident A was ordered a "hospital bed with half rails."

Ms. Clayborn also provided me with two written statements from direct care staff, Jay Bostic and Grace Jackson who both stated they had informed Ms. Milner Resident A's bedrails were not to be used.

On 02/05/2020, I interviewed direct care staff, Saheed Sarumi. Mr. Sarumi stated he primarily works 2nd shift, which is 3 pm until 11 pm. He stated Resident A's bedrails were "always up" when he worked.

On 02/05/2020, I also interviewed direct care staff, Desmond Garland. Mr. Garland stated he works 2nd shift at the facility and had been there three years. He stated he did not put Resident A's bedrails up because it was his understanding bedrails were "restrictive." Mr. Garland didn't believe anyone else put Resident A's bedrails up either.

Ms. Clayborn acknowledged having a physician's order for Resident A's hospital bed with half bedrails; however, she stated the bed rails should have been immediately taken off since they weren't identified in Resident A's assessment plan. Ms. Clayborn stated it appeared newer staff were confused about the use of the bedrails while direct care staff who had worked at the facility for several years seemed to understand when bed rails should be utilized.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	I reviewed both Resident A's ROI Assessment Plan, dated 06/09/2019, and her Kalamazoo Community Mental Health assessment plan, dated 06/06/2019, and the use of bed rails was not identified in either document, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.

ANALYSIS:	I reviewed a physician's order, dated 12/10/2019, for Resident A confirming a licensed physician authorized the use of Resident A's hospital bed and half bed rails, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 03/02/2020, I conducted an exit conference with licensee designee, Scott Schrum, allowing him an opportunity for questions or comments.

IV. RECOMMENDATION

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

03/02/2020

Cathy Cushman Date
Licensing Consultant

Approved By:

03/03/2020

Dawn N. Timm Date
Area Manager