GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 18, 2021

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

RE: License #: AS390011401
Investigation #: 2021A0462032
Osterhout 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 immediately, please contact the local office at (517) 284-9730.

Sincerely,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-9037

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390011401
Investigation #:	2021A0462032
Complaint Receipt Date:	04/28/2021
Investigation Initiation Date:	04/28/2021
Report Due Date:	06/27/2021
Licensee Name:	Residential Opportunities, Inc.
Licensee Address:	1100 South Rose Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-3731
Administrator:	Kaley Cargile
Licensee Designee:	Scott Schrum
Name of Facility:	Osterhout AFC
Facility Address:	1233 W Osterhout Portage, MI 49024
Facility Telephone #:	(269) 327-6432
Original Issuance Date:	N/A
License Status:	REGULAR
Effective Date:	09/27/2019
Expiration Date:	09/26/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On the evening of 04/27/2021 and/or in the early morning hours of 04/28/2021, direct care worker Dontavia Williams left the facility to go to a party, leaving five residents alone unsupervised.	Yes

III. METHODOLOGY

04/28/2021	Special Investigation Initiated – Telephone interview with administrator Kaley Cargile. Special Investigation Intake 2021A0462032 Contact- Requested and received documentation via email. Referral made to APS and Kalamazoo County Office of Recipient Rights.
04/29/2021	Contact – Interviews with administrator Kaley Cargile, and DCWs Careem Gibbs and Jean Toney via Microsoft Teams. Contact- Attempted interview with DCW Dontavia Williams via Google Meet.
05/03/2021	Contact- Attempted interview with DCW Dontavia Williams via Google Meet. Contact- Interview with Program Director Tara Cyrocki via Google Meet.
05/05/2021	Contact - Interview with DCW Dontavia Williams via Google Meet.
05/19/2021	Unannounced investigation on-site.
05/26/2021	Contact- Telephone interview with Program Director Tara Cyrocki.
06/18/2021	Exit Conference with licensee designee Scott Schrum via telephone.

ALLEGATION: On the evening of 04/27/2021 and/or in the early morning hours of 04/28/2021, direct care worker Dontavia Williams left the facility to attend a party, leaving five residents alone unsupervised.

INVESTIGATION: On 04/28/2021, via telephone, facility administrator Kaley Cargile reported the above allegation. According to Ms. Cargile, Ms. Williams was the only direct care worker (DCW) scheduled to work the facility's overnight shift, which started at 10:00PM on 04/27 and ended at 7:30AM on 04/28. Ms. Cargile confirmed five residents lived in the facility.

Via email, I reported the allegation to Adult Protective Services (APS), via the Department of Human Services' Centralized Intake Unit, as well as to the Kalamazoo County Office of Recipient Right.

According to the department's Bureau Internal Tracking System, the facility is licensed to provide 24-hour care, supervision, and protection to the developmentally disabled and physically handicapped populations.

For the purpose of this investigation, it is important to note that according to the website www.lifewire.com, a Snapchat Story is a photo or video, or series of, that is posted to the account of an individual on the social media platform Snapchat. Stories posted to Snapchat accounts remain available for viewing on Snapchat for 24 hours. People can view Snapchat stories as often as they want during that period. Once the 24-hour limit is up, Snapchat automatically deletes the story.

Ms. Cargile emailed me and Kalamazoo County Recipient Right's Officer Suzie Suchyta video recordings of a Snapchat Story (series of four videoclips). According to Ms. Cargile, Ms. Williams posted the Snapchat Story (series of four videoclips) to her Snapchat account on the evening of 04/27 and in the early morning hours of 04/28, while she was supposed to be working in the facility. According to Ms. Cargile, the Snapchat Story (series of four videoclips) were posted in "real time" and were of Ms. Williams at locations that were not the facility. Ms. Cargile explained that if a Snapchat Story (photos or videoclips) posted to Snapchat accounts were older photos and/or prerecorded videos and not posted in real-time, the text "from camera roll" would appear on the Snapchat Story (photos and/or videoclips) when posted. However, instead of the text "from camera roll", the text indicated on the first two videoclips posted to Ms. Williams' Snapchat account read, "12 hours ago." Ms. Cargile reported the text on the third videoclip read, "9 hours ago", and the text on the forth videoclip read, "4 hours ago."

I reviewed the first video Ms. Cargile emailed to me. It was a cellphone video recording of a videoclip posted to what was identified as Ms. Williams' Snapchat account. I confirmed the text on the videoclip was posted 12 hours from the time it was viewed and recorded on another cellphone. The videoclip was of the top half of an individual Ms. Cargile identified as Ms. Williams. In the videoclip, Ms. Williams was wearing what appeared to be a blue sleeveless halter top. You can hear Ms.

Williams say, “I’m drunk. Fitn’ to clock in at work and then go to the block party like what.”

I reviewed the second video Ms. Cargile emailed to me, which was also a cellphone video recording of a videoclip posted to what was identified as Ms. Williams’ Snapchat account. I confirmed the text on the second videoclip indicated the videoclip was posted 12 hours from the time it was viewed and recorded on another cellphone. Ms. Williams was wearing the same blue sleeveless halter top and was eating what appeared to be a sandwich. In this videoclip you can hear Ms. Williams say, “first time in my birth to do this, let me tell ya’ all. [sic]”

I reviewed the third video Ms. Cargile emailed to me, which was also a cellphone video recording of a videoclip posted to what was identified as Ms. Williams’ Snapchat account. The text on the third videoclip posted to Snapchat read,

“9:19 (AM)
lilbaby68
9h ago” (which was 1:19AM on 04/28).

This videoclip was of Ms. Williams at what appeared to be a large outside party, with several people in attendance.

I reviewed the fourth video Ms. Cargile emailed to me, which was also a cellphone video recording of a videoclip posted to what was identified as Ms. Williams’ Snapchat account. The text on the fourth videoclip posted to Snapchat read,

“9:20 (AM)
lilbaby68
4h ago” (which was 6:20AM on 04/28).

This videoclip was of what was assumed to be Ms. Williams inside a moving car, returning to the facility. The videoclip is of either Ms. Williams, or a passenger in the car with Ms. Williams, recording through the front windshield of the car, while the car was in motion. You can hear music playing in the background.

Via email, I requested and received from Ms. Cargile copies of Residents A, B, C, D, and E’s written *health care appraisals* (HCA). According to documentation on the written HCAs, in addition to several other medical conditions, Resident A had a diagnosis of cerebral palsy. Resident B was diagnosed with profound mental retardation and cerebral palsy. Resident C was diagnosed with cerebral palsy, cognitive impairment and was unable to stand, sit and/or lift on her own. Resident D was diagnosed with Autism, was hearing and vision impaired, and was unable to stand, sit, and/or lift on his own. Resident E was diagnosed with the rare genetic condition Phenylketonuria.

On 04/29 Ms. Suchyta and I conducted separate face-to-face interviews with Ms. Cargile, and DCWs Careem Gibbs and Jean Toney, via Microsoft Teams. According to Ms. Cargile, Ms. Williams was hired to work full time at the facility in March 2021, and besides a few minor non-related work performance issues, was considered “one of the best overnight workers.” Ms. Cargile stated Ms. Williams had never been previously accused and/or disciplined for leaving residents unsupervised. Ms. Cargile explained the facility’s overnight shift began at 10:00PM and typically ended at 7:30AM. According to Ms. Cargile, only one DCW to five residents was scheduled to work in the facility during this time. Ms. Cargile stated that at approximately 7:30AM on 04/28 she reported to the facility for work and relieved Ms. Williams, who worked the overnight shift. Ms. Cargile stated that upon relieving Ms. Williams she initially did not notice anything unusual. According to Ms. Cargile the facility was clean, and all five residents were up and eating breakfast. Ms. Cargile stated that after Ms. Williams clocked out and left the facility, she observed Resident A’s urine-soaked pajamas in the washer. According to Ms. Cargile, Resident A required frequent adult brief changes throughout sleeping hours. Ms. Cargile stated she then received a telephone call from facility program director Tara Cyrocki. Ms. Cyrocki informed Ms. Cargile she had just observed a Snapchat Stories (series of videoclips) Ms. Williams posted to her Snapchat account on the evening of 04/27, and into the early morning hours of 04/28, of herself at places other than the facility. According to Ms. Cargile, she then used her cellphone to view the same Snapchat Stories (series of four videoclips) she later recorded and emailed to Ms. Suchyta and I. Ms. Cargile stated when she relieved Ms. Williams at 7:30AM on 04/28, Ms. Williams was wearing the same blue sleeveless halter top she was wearing in the Snapchat Story posted to her Snapchat account. According to Ms. Cargile, based on the time she viewed the Snapchat Story, she believed the second videoclip of Ms. Williams eating a sandwich was posted in real-time to Ms. Williams’ Snapchat account at approximately 12:30AM. Ms. Cargile stated it was evident Ms. Williams was not at the facility when she recorded and posted the Snapchat Story (series of four videoclips) to her Snapchat account in real-time, at approximately 12:30AM, 1:19AM, and 6:20AM on 04/28. According to Ms. Cargile, upon reviewing Ms. Williams “punch record”, she confirmed Ms. Williams clocked into work at the facility late on 04/27, at 10:40PM.

Both Ms. Gibbs and Ms. Toney stated they worked the facility’s second shift on 04/27, which typically ends at 10:00PM. According to Ms. Gibbs and Ms. Toney, shortly before 10:00PM on 04/27, they received a telephone call from Ms. Williams who informed them she would be 10 minutes late. However, Ms. Williams ended up being over 30 minutes late for her shift. Ms. Gibbs stated she found nothing unusual about Ms. Williams when she arrived at work, other than the fact she was late, which was uncommon. According to Ms. Gibbs, she reported to Ms. Williams what had occurred during the facility’s second shift, and then left the facility. Ms. Toney confirmed Ms. Williams was wearing a blue sleeveless halter top when she arrived to work on the evening of 04/27. According to Ms. Toney, she recalled thinking Ms. Williams shirt was not appropriate for work, as it was “open in the back.” Ms. Toney stated Ms. Williams appeared to be in a good mood when she arrived at work. Ms.

Toney described Ms. Williams' behavior on the evening of 04/27 as "perky". According to Ms. Toney, this was unusual as Ms. Williams was typically quiet and "moody". Ms. Toney stated she recalled noticing Ms. Williams smelled like "cigarettes and body spray". According to Ms. Toney, she now believed it was possible Ms. Williams may have been under the influence of marijuana when she arrived at the facility on the evening of 04/27.

Ms. Suchyta and I attempted to conduct a face-face interview with Ms. Williams via Google Meet, as Ms. Williams was unable to utilize the Microsoft Teams application on her cellphone. However, prior to conducting the interview, it was discovered Ms. Williams was in a vehicle with her sister, who was not employed at the facility. According to Ms. Williams, there was no way for her sister to exit the vehicle while we interviewed Ms. Williams. Due to confidentiality concerns, Ms. Williams' interview was rescheduled for 05/03.

Ms. Suchyta and I conducted an interview with Ms. Cyrocki, via Microsoft Teams. Ms. Cyrocki stated that upon being notified of the allegation, Ms. Williams was immediately placed on suspension. According to Ms. Cyrocki, she planned to terminate Ms. Williams' employment after Ms. Suchyta and I collected her statements.

On 05/03 Ms. Suchyta and I attempted to conduct a face-to-face interview with Ms. Williams via Google Meet. However, Ms. Williams did not show up for the prescheduled interview.

Ms. Suchyta and I conducted a second face-to-face interview with Ms. Cyrocki, via Google Meet. Ms. Cyrocki stated she reported the allegation to all five residents' legal guardians, as well as to Kalamazoo County APS

On 05/05 Ms. Suchyta and I conducted a face-to-face interview with Ms. Williams, via Google Meet. Ms. Williams confirmed she posted the Snapchat Story (series of four videoclips) to her Snapchat account on 04/27 and 04/28, and confirmed she was the individual in the videoclips. However, Ms. Williams denied the allegation. According to Ms. Williams, the Snapchat Story (series of four videoclips) she posted to her Snapchat account on 04/27 and 04/28 were old videoclips from "over a year ago", when she worked at a different job. When questioned further, Ms. Williams was unable to provide an explanation as to why the text on the Snapchat Story (at least three out of the four videoclips) would indicate she posted the Snapchat Story of her in locations other than the facility in real-time, at 12:30AM, 1:19AM, and 6:20AM on 04/28. Ms. Williams stated other facility staff members were attempting to get her in trouble.

I researched the Snapchat Application feature using the internet search engine Google. According to social.techjunkie.com, when previously recorded videos are posted to someone's Snapchat account, the text "from camera roll" appears on the video, making it obvious the video was not recorded and posted in real-time. This

was consistent with Ms. Cargile's statements and confirmed the Snapchat Story (at least three out of four videoclips) Ms. Williams posted to her Snapchat account of herself in locations other than the facility, occurred at 12:30AM, 1:19AM, and 6:20AM on 04/28.

On 05/19 I conducted an unannounced investigation at the facility. I attempted to conduct interviews with Residents A, B, C, D, and E. However, due to symptoms associated with their diagnoses, they were unable to participate in an interview. I observed Residents A, B, C, D, and E to be clean and well groomed. Residents A, B, C, D, and E appeared to be content and did not display any signs of pain and/or distress.

On 05/26 I conducted a telephone interview with Ms. Cyrocki, who informed me Ms. Williams' employment was terminated immediately following Ms. Suchyta and I's interview with Ms. Williams on 05/05.

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's resident care agreement and assessment plan.
ANALYSIS:	Based upon my investigation, which consisted of interviews with multiple facility staff members, a review of a Snapchat Story (series of four videoclips), and documentation relevant to this investigation, there is enough evidence to substantiate the allegation that in the early morning hours of 04/28, DCW Dontavia Williams, who was the only DCW working at the facility, left the facility to go to a party, leaving five residents alone in the facility unsupervised. Based upon the text indicated on three of four videoclips Ms. Williams posted as a Snapchat Story on her Snapchat account, Ms. Williams was away from the facility on 04/28 for at least six hours. Subsequently, it has been established that in the early morning hours of 04/28, the facility did not have sufficient DCWs on duty, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/18 I conducted an exit conference with licensee designee Scott Schrum via telephone and shared with him the findings of this investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

06/18/2021

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Michele Streeter Date
Licensing Consultant

Approved By:

06/18/2021

_____

Dawn N. Timm Date
Area Manager