GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 19, 2021

Kelly Devereaux
Mentors Of Michigan, Inc.
3812 Finch
Troy, MI 48084

RE: License #: AS630277642
Investigation #: 2021A0991025
Mansfield

Dear Ms. Devereaux:

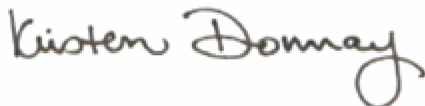
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630277642
Investigation #:	2021A0991025
Complaint Receipt Date:	06/22/2021
Investigation Initiation Date:	06/23/2021
Report Due Date:	08/21/2021
Licensee Name:	Mentors Of Michigan, Inc.
Licensee Address:	3812 Finch Troy, MI 48084
Licensee Telephone #:	(248) 632-3534
Licensee Designee:	Kelly Devereaux
Name of Facility:	Mansfield
Facility Address:	6180 Wynford West Bloomfield, MI 48322
Facility Telephone #:	(248) 632-3534
Original Issuance Date:	09/12/2005
License Status:	REGULAR
Effective Date:	04/22/2020
Expiration Date:	04/21/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A is being neglected and abused by staff.	No
Additional Findings	Yes

III. METHODOLOGY

06/22/2021	Special Investigation Intake 2021A0991025
06/23/2021	Special Investigation Initiated - Telephone Call to Office of Recipient Rights (ORR)- Dawn Krull
06/23/2021	APS Referral Received from Adult Protective Services (APS) - denied for investigation
06/23/2021	Referral - Recipient Rights Call to Dawn Krull
06/24/2021	Contact - Face to Face Interviewed licensee designee, Kelly Devereaux at Lily Lane
06/30/2021	Contact - Telephone call made Interviewed hospital social worker via telephone
06/30/2021	Contact - Telephone call made0 Interviewed Aaliyah Tucker via telephone
07/14/2021	Inspection Completed On-site Interviewed home manager
07/22/2021	Contact - Face to Face Interviewed Resident A at new placement
08/12/2021	Contact - Telephone call made To licensee designee, Kelly Devereaux
08/16/2021	Contact - Telephone call made Left message for staff Aaliyah Tucker

08/17/2021	Contact - Telephone call received From staff Aaliyah Tucker
08/18/2021	Exit Conference I completed the exit conference via telephone with licensee designee, Kelly Devereaux

ALLEGATION:

Resident A is being neglected and abused by staff.

INVESTIGATION:

On 06/22/21, I received a complaint from Adult Protective Services (APS) alleging that Resident A is being abused and neglected by the staff at Mansfield. APS denied the complaint for investigation. The complaint indicated that Resident A reported that staff have not been providing her with her medications, but she also reported that she has been refusing her medications. Resident A stated that staff allowed her to lay in bed for two days, but she could get up on her own if she wanted to get up. Resident A reported that her belongings have gone missing, but she could not provide details about what was missing. Resident A has had an ongoing delusion for 20 years that she was poisoned, and she now believes the group home is poisoning her. The complainant noted that the validity of Resident A's complaints is questionable, as Resident A is experiencing psychosis and is currently hospitalized for mental health treatment. I initiated my investigation on 06/23/21 by contacting the Office of Recipient Rights (ORR) worker, Dawn Krull. Ms. Krull indicated that she was not opening an investigation, as the home was documenting Resident A's mental health and recent decompensation including the hospitalization.

On 06/24/21, I interviewed the licensee designee, Kelly Devereaux. Ms. Devereaux indicated that Resident A has a history of drug use and has drug seeking behaviors. She previously lived in a supervised independent living setting before transitioning to a specialized adult foster care home. Resident A was not happy with the increase in supervision and does not want to return to the home. Resident A has lived at Mansfield for less than a month. She has been refusing her medications and was refusing to get out of bed or eat meals. Staff tried to prompt Resident A, but she continued to refuse. Resident A's daughter picked her up and took her to the hospital. Ms. Devereaux indicated that she was not aware of staff being verbally or physically abusive towards Resident A. She stated that a lot of Resident A's belongings had not yet been unpacked and were still being stored in the garage. She was not aware of staff taking any of Resident A's belongings.

On 06/30/21, I interviewed Natalie Griffin, a social worker at Havenwyck Hospital, via telephone. Ms. Griffin indicated that Resident A was discharged to another home that day. She stated that she did not believe the allegations made by Resident A regarding the Mansfield home were valid. Resident A wanted to get her way and Ms. Griffin felt that Resident A was grasping at things so that she would not have to return to the facility. Resident A reported to her that staff let her stay in bed all day. Ms. Griffin discussed this with Resident A and Resident A agreed that she has free will and could have gotten out of bed if she chose to do so. Ms. Griffin stated that it would have been a violation of Resident A’s rights if staff had forced Resident A to get out of bed. Resident A told Ms. Griffin that staff did not administer her medications, but Resident A also stated that she was refusing to take her medications. Ms. Griffin indicated that Resident A has a history of drug abuse and of making complaints in an attempt to access drugs. Ms. Griffin stated that Resident A did not have any marks or bruises on her body and there was no evidence that she was being neglected by staff at the facility. Resident A stated that staff were poisoning her, but this is an ongoing delusion that Resident A has had for years. Ms. Griffin indicated that she did not have any concrete concerns regarding the facility, and she was pretty confident that Resident A was manipulating the system in an attempt to get her way.

On 06/30/21, I interviewed the regional manager, Aaliyah Tucker, via telephone. Ms. Tucker indicated that she has worked for Mentors of Michigan for four years and has been covering shifts at Mansfield recently due to a staffing shortage. Ms. Tucker indicated that Resident A lived in the home for about a month. Resident A’s mental health had been declining and she was hospitalized on two occasions recently. On the first occasion, Resident A was attempting to harm herself. She threw herself off a chair and stated that she was trying to get closer to God. Resident A’s daughter transported her to the hospital, and she was discharged the same day. On the second occasion, Resident A was refusing to get out of bed. She was refusing to eat and would not take her medications. She had these behaviors for a few days and staff continued to try to prompt Resident A. Ms. Tucker indicated that staff wrote incident reports and documented the behavior in the staff log. Ms. Tucker spoke with the nurse from Easter Seals and Resident A was scheduled to have an emergency evaluation with the psychiatrist, but she was hospitalized before she could go to the appointment. Ms. Tucker indicated that staff never told Resident A that she had to stay in bed. They tried to engage her and frequently prompted and encouraged her to get out of bed. Resident A refused or would pretend to be asleep. Ms. Tucker stated that they rotated staff to try to prompt Resident A in case she was more responsive to someone else. Ms. Tucker stated that she did not have any concerns about staff being abusive or neglectful towards Resident A. She was not aware of any of Resident A’s personal belongings being missing. Resident A never mentioned that she thought she was being poisoned.

On 07/14/21, I conducted an unannounced onsite inspection at Mansfield. Resident A was not present in the home, as she moved to another placement after being discharged from the hospital. I interviewed the home manager, Cassandra Kellar. Ms. Kellar indicated that Resident A lived in the home for about a month. She did not have

any issues with Resident A at first, but then Resident A began refusing to take her medications and would not get out of bed. Staff and Resident A's sister tried to encourage Resident A to get up, but she continued to refuse. Resident A was offered three meals a day, but she refused to eat. Staff documented Resident A's behavior on incident reports. Ms. Kellar indicated that she did not have any concerns with how staff were treating Resident A. She never heard Resident A say that the group home was poisoning Resident A. Resident A did report to Ms. Kellar that Aaliyah Tucker took $32 and her hair dryer. Ms. Kellar indicated that staff did not handle Resident A's money. She was not aware of Ms. Tucker taking Resident A's hair dryer or money.

On 07/22/21, I interviewed Resident A at her new placement. Resident A indicated that she is her own guardian and she lived at Mansfield for about a month. She stated that while she was at Mansfield, she sat in her room and did not want to eat or drink. She stated that staff did not try to get her to take her medications or get her to eat. They never brought food into her room. Resident A stated that she was "not right in the head" and was "vegetating" but staff never helped her. They did not remind her about meals and did not offer her medications. They just left her in bed. Resident A's daughter and sister came over on separate occasions and brought her protein drinks. They tried to get her to drink it, but she would not. Her daughter also brought her pizza to eat. Resident A continued to refuse, so her daughter took her to the hospital. Resident A stated that she returned to the home and two days later she was in the same condition. She stated that did not want to stay at the hospital, so they sent her to Havenwyck. Resident A stated that staff, Aaliyah, stole things from her. She took $32 and her hair dryer. Resident A stated that staff put an old hair dryer into the new box and gave it to her. She also stated that the home has a bookcase, a frying pan, and a small safe that were not returned to her when she changed placements. Resident A stated that she did not recall saying that staff at Mansfield were poisoning her. She stated that they never poisoned her and they were not physically abusive towards her.

On 08/17/21, I conducted a follow up interview with staff, Aaliyah Tucker. Ms. Tucker indicated that she did not take $32 or a hair dryer from Resident A. Ms. Tucker indicated that Resident A received $32 from her sister. Resident A asked staff to keep the money locked up in the desk so that her roommate would not steal her money. Staff gave Resident A money whenever she asked for it and Resident A spent the $32 on snacks and cigarettes. Ms. Tucker indicated that staff did not track Resident A's spending on a Funds Part II form, as they gave the cash to Resident A and she did not get receipts for her purchases. Resident A did not sign anything to indicate that she received the money. Ms. Tucker indicated that she was not aware of Resident A's hair dryer being missing. When staff was helping Resident A pack her belongings, they packed a hair dryer. Resident A told staff that it was not the right hair dryer, and she had another one. Ms. Tucker was not aware of Resident A having two hair dryers.

I reviewed a copy of Resident A's June 2021 medication administration record (MAR). The MAR notes that Resident A refused medications on 06/01/21 at 8:00pm, 06/05/21 at 8:00am, 06/10/21 and 06/11/21 at 8:00am, and 06/12/21 and 06/14/21 at 8:00pm. I reviewed copies of incident reports dated 06/01/21, 06/05/21, 06/10/21, 06/11/21, 06/12/21, and 06/15/21 which note Resident A's decline in mental health. The incident report from 06/01/21 notes that Resident A's daughter transported her to the hospital after she was talking about religious things and throwing herself on the ground. The other incident reports indicate that Resident A was refusing medications, refusing to get out of bed, and refusing to eat meals. They indicate that staff prompted Resident A several times, offered protein shakes, and tried to encourage Resident A to get out of bed. Resident A's daughter took her back to the hospital on 06/15/21 due to Resident A's behaviors.

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:	Based on the information gathered through my investigation, there is insufficient information to conclude that Resident A's personal needs, protection, and safety were not attended to at all times. There is no evidence to support that Resident A was abused or neglected by staff. The incident reports show that Resident A was refusing medications, as well as refusing to eat and get out of bed. Staff prompted Resident A to take her medications, eat meals, and get out of bed. Resident A's family members were notified and Resident A was hospitalized due to her declining mental health status.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During my investigation, I reviewed a copy of Resident A's June 2021 medication administration record (MAR). The MAR notes that Resident A refused medications on 06/01/21 at 8:00pm, 06/05/21 at 8:00am, 06/10/21 and 06/11/21 at 8:00am, and 06/12/21 and 06/14/21 at 8:00pm. I reviewed copies of incident reports dated 06/01/21, 06/05/21, 06/10/21, 06/11/21, 06/12/21, and 06/15/21. The incident reports indicate that

Resident A was refusing medications and that staff prompted her to take her medications and would continue to follow her plan of service.

On 06/30/21, I interviewed the regional manager, Aaliyah Tucker. Ms. Tucker indicated that she spoke with the nurse from Easter Seals regarding Resident A's medication refusals and mental health status. Resident A was scheduled to have an emergency evaluation with the psychiatrist, but she was hospitalized before she could go to the appointment. There was no written documentation regarding this conversation.

On 08/12/21, I interviewed the licensee designee, Kelly Devereaux, via telephone. Ms. Devereaux indicated that staff complete an incident report whenever a resident refuses medication. She stated that the incident report should indicate that the staff contacted the nurse or case manager either via telephone or by sending the incident report. I reviewed the incident reports and noted that they do not specifically state that a health care professional was contacted. The incident reports regarding Resident A's medication refusals did not list any specific instructions that were provided regarding her medication. Ms. Devereaux indicated that this information is not documented in the health care chronological, as staff typically only use that form for appointments. She stated that she would create a new form where staff can document additional information regarding any issues with medications including refusals and errors. The form will include an area for staff to write who was notified and what instructions were provided.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.
ANALYSIS:	Based on the information gathered during my investigation, there is sufficient information to conclude that staff did not contact a health care professional and record the instructions given when Resident A refused to take her medications. Staff completed an incident report form, but they did not include information showing that a health care professional was contacted or what instructions were provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my investigation, Resident A alleged that staff, Aaliyah Tucker, took $32 and a hair dryer from her.

On 08/17/21, I interviewed the regional manager, Aaliyah Tucker, via telephone. Ms. Tucker indicated that she did not take a hair dryer or $32 from Resident A. Ms. Tucker indicated that Resident A received $32 from her sister. Resident A asked staff to keep the money locked up in the desk so that her roommate would not steal her money. Staff gave Resident A money whenever she asked for it and Resident A spent the $32 on snacks and cigarettes. Ms. Tucker indicated that staff did not track Resident A's spending on a Funds Part II form, as they gave the cash to Resident A and she did not get receipts for her purchases. Ms. Tucker indicated that Resident A had a hair dryer when she moved out, but she stated it was not the new one that she had. Ms. Tucker was not aware of Resident A having more than one hair dryer.

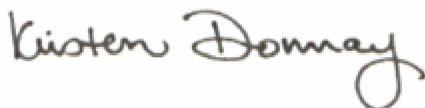
I reviewed a copy of Resident A's Funds Part II forms. They show Resident A's payments for cost of care, but they do not track any of Resident A's cash.

On 08/18/21, I conducted an exit conference via telephone with the licensee designee, Kelly Devereaux. Ms. Devereaux indicated that she was not aware that staff were handling any of Resident A's cash and it should not have been handled in that manner. Ms. Devereaux indicated that she would address the issues with staff and submit a corrective action plan.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that a Funds Part II form was not completed to show Resident A's cash on hand. Resident A's cash was locked in the desk and given to Resident A to spend when requested. Resident A did not sign anything showing how much money was being held for her or when she received spending money from staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



08/18/2021

Kristen Donnay   Date
Licensing Consultant

Approved By:

08/19/2021

Denise Y. Nunn   Date
Area Manager