GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 20, 2022

Angela Snyder
ADAPT, Inc.
202 Morse Street
Coldwater, MI 49036

RE: License #: AS120359237
Investigation #: 2022A0007014
Quimby Home

Dear Ms. Snyder:

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 (313) 456-0380.

Sincerely,

Mahtina Rubritius

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604

Enclosures

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

I. IDENTIFYING INFORMATION

License #:	AS120359237
Investigation #:	2022A0007014
Complaint Receipt Date:	02/16/2022
Investigation Initiation Date:	02/16/2022
Report Due Date:	04/17/2022
Licensee Name:	ADAPT, Inc.
Licensee Address:	202 Morse Street Coldwater, MI 49036
Licensee Telephone #:	(517) 279-7531
Administrator:	Angela Snyder
Licensee Designee:	Angela Snyder
Name of Facility:	Quimby Home
Facility Address:	804 Cornell Coldwater, MI 49036
Facility Telephone #:	(517) 639-3562
Original Issuance Date:	03/01/2015
License Status:	REGULAR
Effective Date:	09/01/2021
Expiration Date:	08/31/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On February 12, 2022, a direct care staff member observed Resident A standing outside of the back door of the home, in her nightshirt and crocks. When asked why the resident was outside, Employee #1, Direct Care Staff stated, “Because the door was locked, and I was going to leave her outside for a few minutes.”	Yes

III. METHODOLOGY

02/16/2022	Special Investigation Intake - 2022A0007014
02/16/2022	Special Investigation Initiated – Letter to APS.
02/16/2022	APS Referral made.
03/17/2022	Inspection Completed On-site - Unannounced - Face to face contact with Employee #2, Resident A, and other staff and residents.
04/07/2022	Contact - Telephone call made to Employee #1. I left a message and requested that she return my call.
04/11/2022	Contact - Telephone call made to Employee #1. I left another message and requested that she return my call.
04/12/2022	Contact - Telephone call made to Facility. I spoke to Employee #2. Additional information gathered.
04/12/2022	Contact - Telephone call made - Interview with Employee #4.
04/12/2022	Contact - Telephone call made - Interview with Home Manager #1.
04/12/2022	Contact – Document Sent – Email to Ms. Snyder, Licensee Designee. I requested that she give me a phone call regarding the exit conference.
04/12/2022	Contact – Document Received – Email from Ms. Snyder.
04/13/2022	Contact – Telephone call made – Interview Employee #1.
04/13/2022	Exit Conference conducted with Ms. Snyder, Licensee Designee.

ALLEGATIONS:

On February 12, 2022, a direct care staff member observed Resident A standing outside of the back door of the home, in her nightshirt and crocks. When asked why the resident was outside, Employee #1, Direct Care Staff stated, "Because the door was locked, and I was going to leave her outside for a few minutes."

INVESTIGATION:

I received and reviewed an incident report regarding Resident A, and the following was noted:

> When Employee #2, Direct Care Staff, arrived to work for her shift on February 12, 2022, Employee #1, Direct Care Staff, started telling Employee #2 about Resident A, grabbing a drink from her and the drink spilling on Resident A's nightgown. Resident A refused to get changed.
>
> While in the kitchen, Employee #2 heard Resident A yell out. When Employee #2 looked up, she observed Resident A standing outside the back door. Resident A was only wearing her nightgown and crocks. Employee #2 asked Employee #1 why Resident A was outside. Employee #1 stated, "Because the door was locked, and I was going to leave her outside for a few minutes."
>
> Employee #2 went over to the door and let Resident A into the home. She also assisted with getting Resident A changed. Employee #2 documented that Resident A's skin was cold to the touch.
>
> It was also noted on the incident report that in an effort to not interfere with the ORR investigation, a note was left for staff regarding the importance of facility doors being unlocked while residents were outside, staff consideration of weather conditions while the residents were outside, and residents being offered weather appropriate clothing. Additional follow-up would be made pending the investigation.

On March 17, 2022, I conducted an unannounced on-site investigation and made face to face contact with Employee #2, Resident A, other staff, and residents.

I interviewed Employee #2. Employee #2 stated that for exercise, Resident A would often go in the backyard and walk over to the fence, touch the fence, then walk to the other side of the yard, touching the other fence.

Regarding the incident, when Employee #2 arrived at work, Employee #1 said Resident A was on a roll. She (Employee #1) recalled that Resident A grabbed the cup and squeezed it, causing the drink to splash on Resident A.

During the interview, as Employee #2 recalled the incident, the information reported was consistent with what was documented in the incident report. After Resident A was observed outside the back door, Employee #2 went and got Resident A, bringing her back inside the home.

According to Employee #2, the temperature outside was 18 degrees Fahrenheit that day, and Resident A's skin was cold to the touch, from being outside.

Employee #2 expressed being sad that Resident A had this experience. Employee #2 stated that this was Resident A's home, and she should not have been left outside in a wet shirt.

I inquired if Resident A could tell me what happened and Employee #2 stated that Resident A says words, but she would just repeat what you say. While at the facility, I made face to face contact with Resident A. Based on this information and her diagnosis, I did not interview Resident A. It was noted that Resident A was also recovering from a recent fall on the ice.

On April 7, 2022, I left a message for Employee #1 and requested that she return my phone call.

On April 11, 2022, I left another message for Employee #1 and requested that she return my phone call.

On April 12, 2022, I called the facility and spoke with Employee #2. She provided me with the contact information for the home manager. In addition, she informed me that Employee #3 was in the laundry room when the incident occurred; however, that Employee #4, knew about the situation, as she was standing in the kitchen.

On April 12, 2022, I interviewed Employee #4. Employee #4 stated that she works night shift, and in the morning, they unlock the doors that are used. On the morning in question, no-one had been outside yet, so the door was still locked. Resident A went out the door and when it shut, it obviously was still locked. Employee #4 stated that Resident A was not outside that long. I inquired about the spilled drink; Employee #4 informed me that it was staff's drink that Resident A grabbed, and when staff tried to get the Styrofoam cup back, the cup broke. Employee #4 was not aware of Resident A's clothing being wet from the spilled drink, and she did not recall if she (Resident A) was wearing a nightgown or regular clothing during that incident.

Employee #4 stated that Resident A will go out and walk in the backyard, she will walk from one side to the other, touching the fences. When Resident A returned

from walking, staff unlocked the door. According to Employee #4, Resident A was outside for less than a minute.

I inquired if anything had changed since this incident occurred and Employee #4 informed that the doors are now unlocked in the morning.

On April 12, 2022, I interviewed Home Manager #1. According to Home Manager #1, Staff (Employee #2) contacted her and informed that when she got to work, she heard Resident A yell. Resident A was outside and could not get back into the home. The other staff sitting in the kitchen said that Resident A had stolen her drink and that she (Employee #1) was going to let her sit out there for a while. Prior to Resident A going outside, when Employee #1 attempted to get her drink back from Resident A, it spilled, and Resident A's shirt was wet.

Home Manager #1 also informed me that ORR investigated, and the allegations were substantiated. Employee #1 received disciplinary actions. In addition, administrative staff talked with the facility employees, and they have been instructed that they are to make sure the doors are unlocked when residents are outside.

On April 13, 2022, I interviewed Employee #1. She stated that she was getting ready for break and did not get a chance to unlock the door. Employee #1 informed the incident happened very fast. That morning, Resident A got out of bed and decided to go for a walk. The wind caught the door and slammed it shut. Employee #1 stated that Resident A was locked outside. Employee #1 informed that Employee #2 and Employee #4 were in the kitchen at the time. Employee #1 denied stating that she was going to leave Resident A outside for a few minutes. Resident A was outside for a short period of time.

I inquired about the temperature that day, and Employee #1 recalled that it was a cold day in February; she reported that the temperature outside was approximately 20 degrees Fahrenheit.

According to Employee #1, Resident A was wearing a nightgown, long pants, and socks. She was not wearing a coat.

I asked about the drink getting spilled and Employee #1 informed that it was her drink, which had been purchased at a gas station. According to Employee #1, Resident A snatched her (Employee #1) cup, squeezing it, causing the drink to explode everywhere.

Employee #1 stated that the drink incident occurred after Resident A had returned from outside, not before. Employee #1 did not confirm that Resident A was outside in a wet shirt.

Employee #1 confirmed that she spoke with ORR; however, she was unclear about the conclusion of the investigation. I inquired if she received any disciplinary action

and she informed that she received a verbal warning. I asked what the verbal warning was regarding, and Employee #1 stated that they “can’t lock consumers outside,” and they need to make sure that the doors are unlocked before they get the residents out of bed for the day.

On April 13, 2022, I conducted the exit conference with Ms. Snyder, Licensee Designee. She stated that ORR also substantiated the allegations, and Employee #1 received a written warning. Staff were informed that they must make sure the doors are unlocked. Ms. Snyder agreed to submit a written corrective action plan to address the established violation.

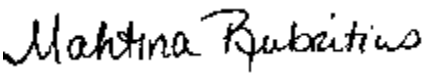
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	When Employee #2 arrived to work for her shift on February 12, 2022, Employee #1, started telling Employee #2 about Resident A, grabbing a drink from her and the drink spilling on Resident A's nightgown. Resident A refused to get changed. While in the kitchen, Employee #2 heard Resident A yell out. When Employee #2 looked up, she observed Resident A standing outside the back door. In the incident report, Employee #2 documented that Resident A was only wearing her nightgown and crocks. Employee #2 asked Employee #1 why Resident A was outside. Employee #1 stated, "because the door was locked, and I was going to leave her outside for a few minutes. Employee #2 went over to the door and let Resident A into the home. She (Employee #2) also assisted with getting Resident A changed. According to Employee #2, the temperature outside was 18 degrees Fahrenheit that day, and Resident A's skin was cold to the touch, from being outside. Employee #4 stated that she works night shift, and in the morning, they unlock the doors that are used. On the morning in question, no-one had been outside yet, so the door was still locked. Resident A went out the door and when it shut, it obviously was still locked. Employee #4 stated that Resident A was not outside that long. According to Home Manager #1, Staff (Employee #2) contacted her and informed that when she got to work, she heard Resident A yell. Resident A was outside and could not get back into the home. The other staff sitting in the kitchen said that Resident A had stolen her drink and that she (Employee #1) was going to let her sit out there for a while. When Employee #1 attempted to get her drink back from Resident A, it spilled, and Resident A's shirt was wet. Employee #1 informed the incident happened very fast. That morning, Resident A got out of bed and decided to go for a walk. The wind caught the door and slammed it shut. Employee #1 stated that Resident A was locked outside. According to Employee #1, Resident A was wearing a nightgown, long pants, and socks. She was not wearing a coat.

	Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Resident A was not treated with dignity and her personal needs, including protection and safety, were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

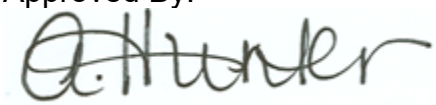
Contingent upon receipt of an acceptable written corrective action plan, I recommend no change to the status of the license.



04/13/2022

Mahtina Rubritius Date
Licensing Consultant

Approved By:



04/20/2022

Ardra Hunter Date
Area Manager