GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 27, 2023

Charles Kelly
R & B Living Supports, Inc.
130 45th Street
Bloomingdale, MI 49026

RE: License #: AS030390275
Investigation #: 2023A0581016
Blue Sky AFC

Dear Mr. Kelly:

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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS030390275
Investigation #:	2023A0581016
Complaint Receipt Date:	01/14/2023
Investigation Initiation Date:	01/17/2023
Report Due Date:	03/15/2023
Licensee Name:	R & B Living Supports, Inc.
Licensee Address:	130 45th Street Bloomingdale, MI 49026
Licensee Telephone #:	(269) 521-4500
Administrator:	Charles Kelly
Licensee Designee:	Charles Kelly
Name of Facility:	Blue Sky AFC
Facility Address:	331 49th Street Grand Junction, MI 49056
Facility Telephone #:	(269) 521-6789
Original Issuance Date:	06/27/2018
License Status:	REGULAR
Effective Date:	12/27/2022
Expiration Date:	12/26/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Transportation is not assured to Resident D after visits to the Emergency Room.	No
Guardian D1 is not informed when Resident D has Emergency Room visits.	Yes
The facility van is inoperable.	No
Additional findings.	Yes

***To maintain the coding consistency of residents from a recent renewal licensing study report, the resident in this special investigation is not identified in sequential order.

III. METHODOLOGY

01/14/2023	Special Investigation Intake 2023A0581016
01/16/2023	APS Referral APS received the allegations but denied investigating the complaint.
01/17/2023	Special Investigation Initiated - On Site Interview with staff, resident, and obtained documentation
01/17/2023	Contact - Telephone call made Voicemail left with hospital
01/17/2023	Contact – Telephone call made Left voicemail with Guardian A1.
01/18/2023	Contact - Telephone call made Left voicemail with Licensee Designee, Ben Kelly.
01/23/2023	Contact - Telephone call received Interview with Mr. Kelly.
01/25/2023	Contact – Telephone call made Interview with Guardian A1
01/25/2023	Contact – Telephone call made Interview with Heather Bullock, West Michigan Community Mental Health case manager.
01/25/2023	Contact – Telephone call made

	Interview with direct care staff, Shauna Kent.
02/27/2023	Exit conference with licensee designee, Charles Kelly.

ALLEGATION:

Transportation is not assured to Resident D after visits to the Emergency Room.

INVESTIGATION:

On 01/14/2023, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged Resident D has a Traumatic Brain Injury (TBI) and visits the Emergency Room (ER), usually at night, after arguments with other residents. The complaint alleged that once Resident D is at the ER the facility's direct care staff are unable to provide transportation back to the facility. The complaint alleged there had been a recent incident where Resident D had to sleep in the ER until police transported him back to the facility. The complaint also alleged on 01/13/2023, Resident D was at the ER and when he called the facility requesting staff pick him up, he was told they could not come get him due to the facility van not having gas.

On 01/18/2023, I completed an unannounced onsite inspection at the facility. I interviewed direct care staff, Sara Cooley, who stated Resident D was admitted to the facility on 06/08/2022. Ms. Cooley stated she was not working during the shifts when Resident D had gone to the ER; therefore, she had no direct knowledge of any of the concerns he was not being transported back to the facility. She stated he typically goes during second shift while she primarily works first shift. Ms. Cooley stated she had no concerns with Resident D not being taken to his scheduled appointments and outings. She also indicated he has no restrictions with community access.

Ms. Cooley stated the facility only has one direct care working per shift unless residents have scheduled appointments or outings and then other direct care staff comes in to provide transportation. She stated when there are situations, like Resident D needing a ride back from the ER, then direct care staff coordinate transportation for him by either contacting incoming direct care staff at shift changes to determine if either the outgoing or incoming direct care staff can pick him up and they'll also contact direct care staff at the licensee's other facilities to determine if any staff are available for transportation. She stated, in addition, direct care staff contact the facility's administrators or human resource office to let those personnel know Resident D requires transportation back to the facility.

I also interviewed Resident D who confirmed he is often calling 911 and taking an ambulance to the ER. He stated he calls 911 when he feels like self-harming himself. Resident D confirmed he had not been admitted to the ER but is evaluated and then discharged. He stated that due to the facility being "short staffed", he sometimes is unable to get a ride from direct care staff back to the facility once he has been discharged from the ER. He indicated there had been a couple incidences where he was brought back by hospital staff/security guard and/or police otherwise he waited at the ER until facility staff can coordinate a ride for him.

I reviewed Resident D's *Assessment Plan for AFC Residents* (assessment plan), which was not signed or dated by either the licensee, Guardian D1 or Resident D's responsible agency; however, his assessment indicated he could move independently within the community.

I also reviewed Resident D's *Resident Care Agreement* (RCA), which also was not signed or dated by either the licensee, Guardian D1 or Resident D's responsible agency. The only information inputted on the RCA was the basic fee amount being charged by the facility and that the basic fee includes the services of "medical, dental, and routine eye care". Any information regarding transportation was not completed.

In Resident D's resident file was a copy of the licensee's "Rural Transportation Policy", signed and dated by Guardian D1 on 07/28/2022. This document stated the following:

> Most RBLS [licensee] homes are in rural settings. Rural setting transportation may be limited to RBLS staff, as some CMH transportation services are not offered in certain rural areas. Transportation to all necessary appointment[*sic*] will be provided by RBLS staff. RBLS staff will also provide transportation on as many outings in the community as staffing and weather conditions permit.

I reviewed the facility's *AFC Licensing Division Incident / Accident Reports* (IR) from October 2022 through January 2023 relating to Resident D, which included five IRs where Resident D was taken from the facility by ambulance to the ER or hospital, which included 10/02, 10/04, 10/15, 11/07, 12/25, and 01/13. None of the IRs indicated if direct care staff provided Resident D with transportation home from the ER.

On 01/23/2023, I interviewed the facility's licensee designee, Charles Kelly. Mr. Kelly's statement to me was consistent with Ms. Cooley's statement to me. He stated due to the facility's rural location and staffing shortages, facility staff may not be immediately available to pick up residents upon their request, which includes Resident D after he has been discharged from the ER. He indicated if Resident D

was transported home from the ER by a security guard or police it was because transportation had not been figured out yet among facility staff, himself or human resource personnel.

Additionally, Mr. Kelly stated he picked up Resident D from the ER on 01/13/2023 within 15 minutes after he received a phone call from Allegan County dispatch indicating Resident D needed transportation back to the facility.

On 01/25/2023, I interviewed Resident D's guardian, Guardian D1. Guardian D1's statement to me about Resident D going to the ER and being discharged was consistent with Resident D's statement to me. Guardian D1 stated Resident D usually goes to the ER in the evening and after these two previous incidences he had to wait at the ER for several hours because there were no direct care staff members available to transport him back to the facility. Guardian D1 stated since Resident D has been at the facility, transportation seems to be difficult to obtain for emergency type situations but indicated facility staff take him to his scheduled medical appointments.

On 01/25/2023, I interviewed direct care staff, Shauna Kent, via telephone. Ms. Kent stated she has worked at the facility for approximately four months and primarily works second shift, which is from 3 pm until 11 pm. Ms. Kent stated Resident D has unrestricted community access. She stated Resident D often contacts 911 to pick him up when he's out in the community or even at the facility and gets transported to the ER. She stated there is one direct care staff working at a time, unless residents have scheduled outings or appointments then an additional staff will come and provide transportation. She stated direct care staff cannot leave the facility to pick Resident D up because then staff would be leaving the remaining residents unattended. Ms. Kent indicated no concerns with any of the residents, including Resident D, not attending any scheduled appointments.

Ms. Kent stated when Resident D goes to the ER when one staff is working, either Resident D or the hospital personnel will contact facility staff to let them know Resident D has been discharged. Ms. Kent's statement to me regarding the coordination of transportation to pick up Resident D was consistent with Ms. Cooley's and Mr. Kelly's statement to me. She stated if she must call the Human Resource Department of the licensee designee, she always speaks to someone on the phone and is not leaving messages waiting for call backs. Ms. Kent acknowledged there were a couple incidences where Resident D had been brought home by police due to direct care staff not being able to pick him up in a timely manner.

Ms. Kent stated on the evening of 01/13/2023, Resident D scratched his arm and then called 911 to be transported to the ER. She stated she received a phone call from either Resident D or the hospital personnel close to 11 pm stating he was discharged. She stated due to the call being around shift change she was going to pick him up while the third shift staff stayed with the residents. Ms. Kent stated when

she went to the facility van, she discovered there wasn't enough gas in it to get to the hospital and back. She stated that due to the time of night, she wasn't sure if she even had enough gas to get to an opened gas station. Subsequently, she informed the hospital she was unable to get him. She stated she also contacted the facility's Human Resource personnel, Cheryl Zelmer, who then made phone calls to either the licensee designee or other staff to coordinate someone to pick up Resident D. She stated Resident D had not returned prior to her leaving her shift and therefore, had no knowledge of what time he returned to the facility. She stated when she spoke to Resident D prior to leaving he indicated to her he had been in contact with Mr. Kelly who indicated he would be picking him up.

On 01/25/2023, I interviewed West Michigan Community Mental Health (CMH) agency case worker, Heather Bullock. Ms. Bullock stated the facility's Human Resource personnel, Laura Swedburg, had been contacting her over the last several months reporting Resident D's frequent contact with 911 and ER visits. Ms. Bullock was not aware of facility staff not being able to provide transportation for Resident D in the event of an emergency. She indicated there have been instances where Resident D, while out in the community, has contacted 911 rather than contacting staff to get transportation to the ER. Ms. Bullock stated she had no concerns with facility direct care staff not transporting Resident D to scheduled medical appointments or outings within the community when planned. Ms. Bullock stated she was in the process of connecting with OnPoint CMH to connect Resident D with more local services since the West Michigan CMH agency is two hours away.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.**

ANALYSIS:	Based on my investigation, which included a review of Resident D's *Resident Care Agreement*, *Assessment Plan for AFC Residents*, the facility's policy on Rural Transportation, and interviews with direct care staff as well as Resident D, there is no evidence indicating the facility was required to provide transportation to Resident D when discharged from the ER. Despite the facility not always being able to provide transportation, transportation was nevertheless assured by either the hospital staff/guard or police providing transportation to Resident D back to the facility on at least two occasions.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Guardian D1 is not informed when Resident D had Emergency Room visits.

INVESTIGATION:

The complaint alleged Resident D's guardian, Guardian D1, has not been contacted about Resident D's recent or past ER visits.

Ms. Cooley stated she had not notified Guardian D1 when Resident D went to the ER. She stated she completed an IR and sent the IR to the licensee's main office. Ms. Cooley indicated Resident D contacted Guardian D1 and informed her when he was at the ER.

Resident D indicated he contacted 911 on or around 01/13/2023 after he tried self-harming by cutting and burning himself with a lighter.

The IR dated, 01/13/2023, which was completed by direct care staff, Ms. Kent, was consistent with Resident D's statement to me. The IR indicated the facility's "admin" was notified and an IR was written. Relative D1 was indicated on the IR, but there was no indication she was notified of the incident.

Guardian D1 stated facility direct care staff had not contacted her when Resident D went to the ER; however, she indicated both Resident D and the hospital staff contacted her to let her know what was going on. She stated Resident D is always seen by ER staff and then discharged, rather than admitted to the ER or to another unit within the hospital.

Ms. Kent's statement to me regarding not notifying Guardian D1 was consistent to Ms. Cooley's statement to me.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.** **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.** **(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.**
ANALYSIS:	Based on my investigation, Resident D's visits to the ER have not resulted in hospitalization; therefore, the rule doesn't require the facility's staff to notify Guardian D1; however, based on my review of the IR, dated 01/13/2023, and my interviews with Resident D, Guardian D1 and direct care staff indicate direct care staff at the facility did not make a reasonable attempt to contact her when Resident D engaged in self harm and was taken to the hospital. Additionally, they did not follow up with Guardian D1 with a written report within 48 hours, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility van is inoperable.

INVESTIGATION:

The complaint alleged on 01/13/2023, while Resident D was being discharged from the ER, he contacted facility direct care staff members to pick him up; however, he was informed no one could pick him up because the facility's van had no gas.

Direct care staff, Ms. Cooley and Ms. Kent, both confirmed the facility has a van, which provides transportation for residents to scheduled appointments. Both Ms.

Cooley and Ms. Kent also stated staff can utilize their own vehicles as well for transportation, if needed. Ms. Cooley indicated staff will be reimbursed for mileage if they use their own vehicle or need to use their own funds to put gas in the facility van. Ms. Kent indicated she had no knowledge about putting gas in the facility van due to working 2nd shift when residents are not participating in scheduled outings. Ms. Cooley stated it was not normal or a regular occurrence for the facility van to not have gas.

Mr. Kelly also stated it was not a routine occurrence for the facility van to be out of gas and indicated gas was put in the vehicle the following day. He stated emergency transportation for residents, specifically Resident D, will be coordinated at shift change due to staffing shortages. He stated, as the Licensee Designee, he may be a last resort, but he has been contacted to provide transportation for Resident D.

APPLICABLE RULE	
R 400.14319	**Resident transportation.**
	When a home provides transportation for a resident, the licensee shall assure all of the following: **(a) That a vehicle is in good operating condition.**
ANALYSIS:	Based on my investigation, though the facility's van did not have sufficient gas in it on 01/13/2023, the licensee still assured transportation to Resident D by the licensee designee, Charles Kelly, picking him up from ER and transporting him back to the facility in his own vehicle. Subsequently, the vehicle in which Mr. Kelly transported Resident D in was in good operating condition, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

Upon review of Resident D's *Assessment Plan for AFC Residents* (assessment plan) and *Resident Care Agreement (*RCA*)*, I established his assessment plan was neither signed nor dated by the licensee, Resident D and/or Resident D's representative and responsible agency, which would demonstrate all required persons participated in the development of his written assessment plan.

Additionally, upon my review of the RCA, it was not thoroughly completed nor signed and dated by the licensee, Resident D and/or Resident D's designated representative and responsible agency.

The licensee designee, Mr. Kelly, stated Adult Foster Care Consultant, Eli Deleon, had cited the licensee for not reviewing the assessment plans and RCAs on an annual basis for Resident A, B, and C. Mr. Kelly stated he was in the process of completing the Corrective Action Plan (CAP).

On 01/24/2023, Mr. Deleon, forwarded me the licensee's CAP, dated 01/23/2023, which stated all resident assessment plans and RCAs had been resent for signatures and copies would be forwarded to licensing upon the return of the documentation. The CAP indicated the facility's administrative personnel would be in contact with case managers and guardians to ensure all documents are received and returned by appropriate persons and forwarded to licensing by 02/28/2023.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on my review of Resident D's *Assessment Plan for AFC Residents*, it had not been reviewed and signed by Guardian D1, the responsible agency, West Michigan Community Mental Health agency, or the licensee upon admission, as required. Signatures of the licensee, resident and/or resident's representative and responsible agency, demonstrate all required persons have participated in the development of the written assessment plan. Though a violation has been established in this special investigation, the Renewal Licensing Study Report (LSR), dated 01/03/2023, also established the same violation. As a result of this violation, the licensee submitted an acceptable CAP, dated 01/23/2023, which was approved by the Department on 01/24/2023. Subsequently, the violation has already been addressed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.
ANALYSIS:	Based on my review of Resident D's *Resident Care Agreement*, it had not been reviewed and signed by Guardian D1, the responsible agency, West Michigan Community Mental Health agency, or the licensee upon admission, as required. Though a violation has been established in this special investigation, the Renewal Licensing Study Report (LSR), dated 01/03/2023, also established the same violation. As a result of this violation, the licensee submitted an acceptable CAP, dated 01/23/2023, which was approved by the Department on 01/24/2023. Subsequently, the violation has already been addressed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 02/27/2023, I attempted to contact the licensee designee, Charles Kelly, via telephone; however, I was unable to reach him, but I left a voicemail. Additionally, I followed my voicemail up with an email to Mr. Kelly explaining my findings.

IV. RECOMMENDATION

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

02/23/2023

Cathy Cushman Date
Licensing Consultant

Approved By:

02/24/2023

Dawn N. Timm Date
Area Manager