GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 6, 2024

Theodore DeVantier
Macomb Residential Opportunities Inc.
Suite #102
14 Belleview
Mt Clemens, MI 48043

RE: License #: AS630012622
Investigation #: 2024A0612011
Kern Group Home

Dear Mr. DeVantier:

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,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012622
Investigation #:	2024A0612011
Complaint Receipt Date:	01/09/2024
Investigation Initiation Date:	01/09/2024
Report Due Date:	03/09/2024
Licensee Name:	Macomb Residential Opportunities Inc.
Licensee Address:	Suite #102 14 Belleview Mt Clemens, MI 48043
Licensee Telephone #:	(586) 469-4480
Administrator:	Theodore DeVantier
Licensee Designee:	Theodore DeVantier
Name of Facility:	Kern Group Home
Facility Address:	3535 Kern Road Oakland Township, MI 48363
Facility Telephone #:	(248) 377-1940
Original Issuance Date:	05/18/1990
License Status:	REGULAR
Effective Date:	11/11/2022
Expiration Date:	11/10/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 12/20/23, direct care staff, Shameika Hilgris left four residents in the parking lot in the van while she went into the store.	Yes

III. METHODOLOGY

01/09/2024	Special Investigation Intake 2024A0612011
01/09/2024	Special Investigation Initiated - Letter I emailed Recipient Rights Specialist, Rishon Kimble regarding the allegation.
01/09/2024	APS Referral Adult Protective Services (APS) referral was completed by Recipient Rights Specialist, Rishon Kimble via Centralized Intake. APS is not investigating.
01/18/2024	Contact - Document Received I received a copy of Resident A, Resident B, Resident C, and Resident D's Individual Plan of Service and a copy of the Kern Group home transportation log via email.
01/24/2024	Contact - Telephone call made Telephone interviews completed with home manager Valerie Sass, direct care staff Shameka Hilgris, Resident A, and Resident D.
01/25/2024	Inspection Completed On-site I completed an unannounced onsite investigation. I interviewed assistant home manager Hope Johnson, and Resident C.
01/31/2024	Contact - Telephone call made Telephone call to direct care staff, Shameka Hilgris.
01/31/2024	Contact – Document Sent Text message sent to direct care staff, Shameka Hilgris.
02/05/2024	Exit Conference Telephone call to licensee designee, Ted DeVantier to hold an exit conference and review findings.

ALLEGATION:

On 12/20/23, direct care staff, Shameika Hilgris left four residents in the parking lot in the van while she went into the store.

INVESTIGATION:

On 01/09/24, I received a referral from Recipient Rights Specialist, Rishon Kimble. The referral states home manager, Valerie Sass reported on 12/20/23, direct care staff Shameika Hilgris left Resident A, Resident B, Resident C, and Resident D alone in the van while she went into the store. On 01/09/24, I initiated my investigation with an email to Recipient Rights Specialist, Rishon Kimble. Ms. Kimble stated she made a referral to Adult Protective Services (APS) via centralized intake on 01/03/24, APS is not investigating. Ms. Kimble stated Resident A and Resident D reported to her that Ms. Hilgris left them in the van and went into Dollar Tree. Resident B and Resident C are both nonverbal and were unable to be interviewed. Ms. Kimble interviewed home manager Valerie Sass who said upon her review of the transportation log she wondered how Ms. Hilgris took all four residents into the store since two of the residents use wheelchairs.

On 01/24/24, I interviewed home manager, Valerie Sass. Ms. Sass became the home manager in July 2023. Ms. Sass stated on 12/20/23, she completed morning transport. She took Resident A, Resident B, and Resident D to workshop. Ms. Hilgris stayed at the home and assisted Resident C onto the school bus. After dropping off the residents she went to the main office which is in Macomb County. Then, she went to PNC Bank to meet her boss. She was there to open a bank account for one of the residents. After her meeting at the bank, she stopped at Walmart before returning to the Kern group home and ending her shift around 1:30 pm. Ms. Sass stated Ms. Hilgris was scheduled to complete afternoon transport. During afternoon transport the staff should pick up Resident A and Resident B from Lasher workshop. Then get Resident D from New Horizons workshop. After that they return to the house to get Resident C from the school bus by 3:30 pm. Resident A and Resident B both use wheelchairs and require total care. Resident D and Resident C are both ambulatory.

Ms. Sass stated when she returned to work the next day, she reviewed the vehicle transportation log and noticed that Ms. Hilgris wrote that she went to workshop and the store. The log indicated that Ms. Hilgris took all four residents with her. Ms. Sass texted Ms. Hilgris and asked her how she pushed Resident A and Resident B, who are both in wheelchairs, at the store. Ms. Hilgris told her that she went to the store before she came back, and Ms. Sass left to go to the office. Ms. Sass asked Resident D if she went to the store with Ms. Hilgris and Resident D said they went to Dollar Tree and stayed in the van while Ms. Hilgris went into the store. Ms. Sass stated Ms. Hilgris is suspended pending the outcome of the investigation.

On 01/24/24, I interviewed Resident A via telephone. Resident A stated Ms. Hilgris went inside the store and left her, Resident B, Resident C in the van alone. Resident A stated the van was running. Resident A cannot recall if Resident B was with them. Resident A does not remember the name of the store or how long she and her housemates were alone in the van.

On 01/24/23, I interviewed Resident D via telephone. Resident D stated before Christmas Ms. Hilgris took her, Resident A, Resident B, and Resident C to Dollar Tree. Ms. Hilgris went inside, and they stayed in the van. Resident D said the van was off. She cannot recall how long Ms. Hilgris was inside of the store.

On 01/24/23, I interviewed direct care staff, Shameka Hilgris. Ms. Hilgris began her employment in July 2023. Ms. Hilgris stated on 12/20/23, she worked from 7:04 am – 8:59 pm. During her shift she completed morning transport while Ms. Sass stayed at the home with Resident C to assist him onto the school bus. Ms. Hilgris stated she dropped Resident A and Resident D off at workshop. She cannot recall if Resident B went to workshop that morning or if she stayed home for a doctor's appointment. On her way back to the house she stopped at Dollar Tree. Ms. Hilgris stated she had no residents with her when she stopped at the store. While at Dollar Tree she purchased something to drink and a few Christmas gifts. Then, she went back to Kern group home and Ms. Sass took the van to run errands. When Ms. Sass returned with the van, Ms. Hilgris completed afternoon transport and Ms. Sass ended her shift. Ms. Hilgris stated she picked up the residents from workshop then returned to the home and waited in the van with the residents for Resident C to get home and get off the bus. When Resident C got off the bus, he got into the van so he could stay warm. While all the residents were in the van with her, she completed the vehicle transportation log. Then, she unloaded Resident A and Resident B from the van and Resident C and Resident D got out of the van and they all went into the house.

Ms. Hilgris stated she completed the transportation log incorrectly when she wrote that she had all four residents. Ms. Hilgris explained she wrote all four of the resident's names down because she thought the log was to be completed for the entire day. Ms. Hilgris denied ever going to the store and leaving any resident in the van. Ms. Hilgris stated she paid for her items at Dollar Tree with a credit card and she has requested a statement from her bank that includes a time stamp of the purchase to prove that she went to the store after she dropped the residents off at workshop that morning. On 01/31/24, at 11:10 am, I placed a telephone call to direct care staff, Shameka Hilgris to follow up on the bank statement she requested to provide. While on the telephone with Ms. Hilgris she attempted to text me a copy of the bank statement. I informed her I did not receive the document. Ms. Hilgris stated she would email me a copy of the documentation. I provided her with my email address. At 1:20 pm, I informed Ms. Hilgris via text message that I had not received an email from her. Ms. Hilgris stated she would send it by the end of the day. As of 02/05/24, I have not received a copy of the bank statement.

On 01/26/24, I completed an unannounced onsite investigation. I interviewed assistant home manager Hope Johnson, and Resident C.

On 01/26/24, I interviewed assistant home manager, Hope Johnson. Ms. Johnson stated she has worked at the home for 14 years. Ms. Johnson was not aware of the allegation and had no information to provide regarding the alleged incident. Ms. Johnson stated she has only worked with Ms. Hilgris once and therefore, she does not know her well. Ms. Johnson stated Resident D is a reliable source of information. Her memory is good, and she can recall details of what she experienced. Resident A is usually a good source of information but there are times when she may not be able to recall accurate information.

On 01/26/24, I interviewed Resident C. Resident C was observed sitting in a chair in the living room. Resident C was wearing noise canceling headphones, he was appropriately dressed and well groomed. Resident C is nonverbal and was not able to be interviewed for this investigation.

I reviewed the Kern Group home vehicle transportation log. There were two entries dated 12/20/2023:

- Valerie Sass - Workshop, office, bank (Resident A, Resident D)
- Shameika Hilgris - Workshop, store (Resident A, Resident B, Resident C, and Resident D)

I reviewed Resident A, Resident B, Resident C, and Resident D's MORC Easter Seals Individual Plan of Service (IPOS). The following is relevant information:

- Resident A's IPOS states, "Kern home provides 24-hour supervision as (Resident A) does not independently recognize nor meet her own health and safety needs." Resident A uses a wheelchair to ambulate.
- Resident B's IPOS states, Resident B requires 24/7 supervision and care to meet her health and safety needs. Resident B does not know the importance of safety signs. Staff must assist with safety skills while in the community through verbal prompts and practicing safety hands. Resident B uses a wheelchair to ambulate.
- Resident C's IPOS states, "Kern home provides 24-hour supervision as (Resident C) does not independently recognize nor meet his own health and safety needs." Resident C is nonverbal.
- Resident D's IPOS states, "(Resident D) is dependent on caregivers to participate in activities in her community." Kern Group Home provides 24/7 care and supervision.

On 02/25/24, I placed a telephone call to licensee designee, Ted DeVantier to hold an exit conference and review findings. Mr. DeVantier did not have any additional information to provide regarding this investigation. Mr. DeVantier acknowledged that a corrective action plan would be required.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the information gathered through my investigation there is sufficient information to determine that on 12/20/23, direct care staff, Shameika Hilgris left Residents A, B, C, and D in the van while she went into the store and therefore, failed to provide supervision, protection, and personal care as defied in their written assessment plans. Per Residents A, B, C, and D's IPOS they require 24-hour supervision as they are not able to independently recognize nor meet their own health and safety needs. Ms. Hilgris documented on the Kern Group home vehicle transportation log that she transported all four residents to workshop and the store. Resident A and Resident D consistently reported that Ms. Hilgris went into the store and left all the residents alone in the van. Ms. Hilgris denied the allegation. Ms. Hilgris stated she stopped at the Dollar Tree on her way back to the house after completing morning transport and therefore, she had no residents with her when she stopped at the store. However, per the Kern Group home vehicle transportation log Ms. Hilgris did not complete transportation the morning of 12/20/23.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 sufficient information to determine on 12/20/23, direct care staff, Shameika Hilgris failed to attend to Residents A, B, C, and D's personal needs, including protection and safety. Per Resident A and Resident B's IPOS they both use a wheelchair to ambulate. Resident C is nonverbal and Resident D is

	dependent on caregivers while in the community. Residents A, B, C, and D's IPOS consistently indicate that they require 24-hour supervision as they are not able to independently recognize nor meet their own health and safety needs. Leaving these residents in the van, unsupervised, was not in compliance with their written assessment plans and placed them at risk of harm.
CONCLUSION:	**VIOLATION ESTABLISHED**

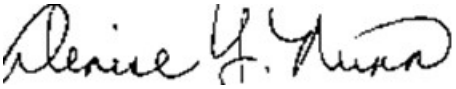
IV. RECOMMENDATION

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

02/05/2024

Johnna Cade — Date
Licensing Consultant

Approved By:



02/06/2024

Denise Y. Nunn — Date
Area Manager