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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

Michael Houck
Adapt St. Joe, Inc.
907 N. Clay
Sturgis, MI 49091

February 16, 2024

RE: License #: AS750402074
Investigation #: 2024A1030016
Polaris Home

Dear Mr. Houck:
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 (616) 356-0183.

Sincerely,
Nile Khabeiry, LMSW

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS750402074
Investigation #:	2024A1030016
Complaint Receipt Date:	01/22/2024
Investigation Initiation Date:	01/23/2024
Report Due Date:	03/22/2024
Licensee Name:	Adapt St. Joe, Inc.
Licensee Address:	907 N. Clay Sturgis, MI 49091
Licensee Telephone #:	(269) 651-7900
Administrator:	Michael Houck
Licensee Designee:	Michael Houck
Name of Facility:	Polaris Home
Facility Address:	1610 W. Chicago Road Sturgis, MI 49091
Facility Telephone #:	(269) 651-1838
Original Issuance Date:	12/10/2019
License **Status:**	REGULAR
Effective Date:	06/10/2022
Expiration Date:	06/09/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff did not properly supervise Resident A.	Yes
Resident bathroom door does not close properly, and the ventilation fan is broken.	Yes
Additional Findings	No

III. METHODOLOGY

01/22/2024	Special Investigation Intake 2024A1030016
01/23/2024	Special Investigation Initiated - Letter Email to LD by Cassandra Duursma
01/23/2024	APS Referral Denied for investigation.
02/01/2024	Contact - Face to Face Interview with Resident A
02/01/2024	Contact - Face to Face Interview with Angela Boyd
02/01/2024	Contact - Face to Face Interview with Mellisa Rice
02/01/2024	Contact - Face to Face Interview with Alexis Kime
02/01/2024	Contact - Telephone call made Interview with Tambra Miller
02/01/2024	Contact - Telephone call made Interview with Nick Houck
02/02/2024	Contact – Documents received Received and reviewed documents
02/06/2024	Exit Conference Exit conference by phone

ALLEGATION:

Staff did not properly supervise Resident A.

INVESTIGATION:

On 1/24/24, I received and reviewed the staff schedule for the home on 1/18/24.

On 2/1/24, I interviewed Resident A at the home. Resident A reported she is upset because her staff did not know where she was on 1/18/24. Resident A reported she attends a program at the St. Joe County Co-Op and gets transported there twice per week by her CLS worker, Tambra Miller. Resident A reported she was picked up and informed the overnight staff member that she was leaving. Resident A reported one of the day staff members texted and called Ms. Miller asking where she was and should have known. Resident A expressed some concerns about the resident bathroom as the door does not close properly, there is no shower curtain and the fan in the shower does not have a cover. I inspected the bathroom and found the bathroom does not fit properly and does not close. I also noted there is not a shower curtain in the shower however there is a shower curtain installed in the doorway as you enter the bathroom itself. Inside the shower there is a fan/light however the cover was not present.

On 2/1/24, I interviewed supervisor, Angela Boyd at the home. Ms. Boyd reported she was not the staff member who contacted Ms. Miller about the situation and provided the Direct Care Staff Members (DCSM) name. Ms. Boyd reported she believes there was "miscommunication" between the over night staff and the day staff. Ms. Boyd reported she is unsure why Resident A and Ms. Miller were so upset about the situation but they have a resolution now and will have the DCSM who is working at the time go outside and have Ms. Miller sign Resident A out of the building.

On 2/1/24, I interviewed Program Excellent director Mellisa Rice at the home. Ms. Rice reported she has worked at the home for six years. Ms. Rice reported she was working on 1/18/24 when Resident A returned home and was upset because she said she "does not feel safe" at the home and that her "rights were violated." Ms. Rice reported DCSM Alexis Kime tried comfort Resident A. Ms. Rice reported Ms. Miller then came into the home and said, "how dare you call me, she does not deserve this." Ms. Rice reported the staff were unaware that Resident A was with Ms. Miller and called and texted her to ask about Resident A.

On 2/1/24, I interviewed Alexis Kime at the home. Ms. Kime reported she has worked at the home for three years. Ms. Kime reported she was working day shift on 1/18/24 and came to work at 8:00am. Ms. Kime reported and assumed Resident A was in her bedroom sleeping. Ms. Kime reported the overnight staff knew that she was picked up

by her CLS case worker but did not communicate with the day staff. Ms. Kime reported after they discovered that Resident A was not in her bedroom, she called the Co-Op in St. Joe County at 11:00am and was told that Resident A was in the building. Ms. Kime reported her supervisor asked her to text Ms. Miller and come into the home and sign Resident A out when she takes her to the day program.

On 2/1/24, I interviewed case manager Tambra Miller by phone. Ms. Miller reported she is Resident A's CLS case manager and picks her up for the program two or three times per week. Ms. Miller reported Resident A was scheduled on 1/18/24 from 8:00am to 12:00pm and was picked up about 7:45am. Ms. Miller reported she spoke with the DCSM who was working on 1/18/24 when she picked Resident A up. Ms. Miller reported she received a text message from a DCSM at 11:30am asking about Resident A and asking that I come into the building and sign her out in the future.

On 2/1/24, I interviewed DCSM Nick Houck by phone. Mr. Houck confirmed that he was working the overnight shift on 1/18/24. Mr. Houck reported he was aware that Resident A was picked up by Ms. Miller and taken to her program but forgot to inform the day shift. Mr. Houck reported he is frustrated because they did not check on her until 11:30am and should have checked on her as soon as they began the shift.

On 2/2/24, I received and reviewed Resident A's Assessment Plan for AFC Residents (AP) and Pivotal Community Mental Health treatment plan (TP.)

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:	It was alleged the staff did not properly supervise Resident A. Based on interviews and review of Resident A's AP this violation will be established. On 1/18/24 Resident A left the home at 8:00am to attend a scheduled program with a Community Mental Health staff member. The overnight staff were aware that Resident A left the home but did not communicate that to the daytime staff. The daytime staff did not check on Resident A until 11:00am when they discovered she was not in the home. Although Resident A's was located and was safe, the daytime staff did not check on Resident A for at least three hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident bathroom door does not close properly, and the ventilation fan is broken.

INVESTIGATION:

Resident A expressed some concerns about the resident bathroom as the door does not close properly, there is no shower curtain and the fan in the shower does not have a cover. I inspected the bathroom and found the bathroom door does not fit properly and does not close. I also noted there is not a shower curtain in the shower however there is a shower curtain installed in the doorway as you enter the bathroom itself. Inside the shower there is a fan/light however the cover was broken.

Ms. Boyd confirmed there are some problems with the bathroom and explained they have a resident who is autistic and very destructive. Ms. Boyd reported that resident will be moving out within a couple of weeks, and they will repair all the damage caused by her.

APPLICABLE RULES	
R 400. 14407	**Bathrooms.**
	1) Bathrooms and toilet facilities that do not have windows shall have forced ventilation to the outside. Bathroom windows that are used for ventilation shall open easily.
	2) Bathrooms shall have doors. Only positive-latching, non-locking-against-egress hardware may be used. Hooks and eyes, bolts, bars, and other similar devices shall not be used on bathroom doors.

ANALYSIS:	It was alleged the resident bathroom door does not close properly and the ventilation fan is broken. Based on an on-site investigation, this violation will be established. The bathroom door and ventilation fan were broken by an autistic resident who has a history of property destruction. The home issued a 30-day discharge notice and that resident will be moved by the end of February 2024. The home will then begin repairing the damage in the resident bathroom.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/3/24, I shared the findings of my investigation with licensee, Micael Houck. Mr. Houck acknowledged and agreed to submit a corrective action plan.

IV. RECOMMENDATION

Nile Khabeiry, LMSW 2/16/24

Nile Khabeiry Date
Licensing Consultant

Approved By:

Russell Misiak 2/21/24

Russell B. Misiak Date
Area Manager