GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 18, 2024

Bridget Malek
RGRPS.
Ste. 4-B
33930 W. 8 Mile Rd.
Farmington Hills, MI 48335

RE: License #: AS820397466
Investigation #: 2024A0992019
Fenton II

Dear Mrs. Malek:

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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820397466
Investigation #:	2024A0992019
Complaint Receipt Date:	02/01/2024
Investigation Initiation Date:	02/01/2024
Report Due Date:	04/01/2024
Licensee Name:	RGRPS.
Licensee Address:	Ste. 4-B 33930 W. 8 Mile Rd. Farmington Hills, MI 48335
Licensee Telephone #:	(248) 477-5209
Administrator:	Bridget Malek
Licensee Designee:	Bridget Malek
Name of Facility:	Fenton II
Facility Address:	8273 Fenton St Dearborn Heights, MI 48127
Facility Telephone #:	(248) 477-5209
Original Issuance Date:	06/12/2019
License Status:	REGULAR
Effective Date:	12/12/2023
Expiration Date:	12/11/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff 2 sleeps during shifts and neglect her duties. While Staff 2 were sleeping Resident A was soaked in urine and feces.	Yes

III. METHODOLOGY

02/01/2024	Special Investigation Intake 2024A0992019
02/01/2024	Special Investigation Initiated - Telephone LaTicia Sharp, Adult Protective Services
02/01/2024	Comment – Pictures received.
02/06/2024	Inspection Completed On-site Staff 1, 2, 3, 4, 5 and Residents A, and B
02/12/2024	Contact - Telephone call made Bridget Malek, licensee designee
03/13/2024	Contact - Telephone call made Lexis Davis, office of recipient rights (ORR)
03/13/2024	Contact - Telephone call made Ms. Sharp
03/13/2024	Contact - Telephone call made Relative A, Resident A's guardian, was not available. Message left.
03/13/2024	Exit Conference Ms. Malek

ALLEGATION: Staff 2 sleeps during shifts and neglect her duties. While Staff 2 were sleeping Resident A was soaked in urine and feces.

INVESTIGATION: On 02/01/2024, I contacted LaTicia Sharp, Adult Protective Services (APS) regarding the reported allegations. Ms. Sharp explained that the complaint is relatively new, and she is still investigating. Ms. Sharp said she is aware that Lexis Daivs, Office of Recipient Rights (ORR) investigated the allegation and

substantiated the complaint. Ms. Sharp said Resident A is non-verbal and unable to be interviewed. She said she did receive pictures of Staff 2 sleeping, a bed with soiled linen and individual in a soiled incontinence brief. Ms. Sharp agreed to provide me with a copy of the pictures and keep me abreast of her findings.

On 02/01/2024, I received 3 pictures via email. One was a bed with soiled linen, one of a female staff sleeping in a chair and the other of an individual in a soiled incontinence brief with feces on the linen and the individual's behind and leg area.

On 02/06/2024, I completed an unannounced onsite inspection and interviewed Staff 1, 2, 3, 4, 5 and Residents A, and B regarding the allegations. Staff 1 said she did not witness Staff 2 sleeping on shift or Resident A being left soiled. Staff 1 said she was made aware of the allegations by Office of Recipient Rights (ORR). She said she is not sure exactly when the incident occurred. However, Staff 1 said she is aware there was a heated argument between Staff 2 and 5. Staff 1 stated Staff 2 and 5 were going back and forth because Staff 2 said Staff 5 was sleeping on shift, at some point ORR was contacted and a complaint was filed. Staff 1 stated she believe the allegations were reported by Staff 5 as a form of retaliation against Staff 2. Staff 1 said based on the information presented by ORR, Staff 2 and 5 were verbally reprimanded for their unprofessionalism and Bridget Malek, licensee designee was made aware of what was going on. She stated Staff 2 also received a writeup for sleeping on shift and it is uncertain if further action will be taken by upper management. As it pertains to Resident A, I asked if Resident A was left soiled due to Staff 2 sleeping on shift, and Staff 1 said she is not sure. I explained that I observed pictures of a soiled bed, a staff sleeping and an individual in a soiled incontinence brief. Staff 1 said she is not sure when the pictures were taken and under what conditions. She said sometimes the residents do have accidents, so it is not clear when or what was going on. I asked about the staff's daily routine and responsibilities as it pertains to the resident's needs. Staff 1 said the staffing scheduled is color coded with each staff's shift, their responsibilities and which resident they are assigned to for the day. Staff 1 said assigning the residents to a particular staff usually makes the facility run smoothly. She said there are typically 3 staff on shift during the day/evening and 2 on midnights. Staff 1 said Staff 2 takes really good care of the residents. Staff 1 provided me with a copy of the staff schedule and Staff 2's writeup. According to the writeup, the incident occurred on 01/17/2024.

I interviewed Staff 2. Prior to addressing the allegations, Staff 2 explained that Staff 5 is a new hire, and they worked the same shift. She said Staff 1 asked her how Staff 5 was doing, and she said she told her that she slept most of the shift. Staff 2 said Staff 1 addressed Staff 5. Staff 2 said Staff 5 accused her of telling on her which led to an argument. Staff 2 said Staff 5 said some very nasty things to her and was very unprofessional. Staff 2 said she is there to do her job and take care of the residents, not to make friends. I asked Staff 2 if she was sleeping during shift, she said it is possible she dozed off. Staff 2 said it is possible that once all her duties are fulfilled and the resident, she is assigned to is taken care of, she will sit down, and

dozes off. She denied ever being in a deep sleep. She said it is normal for the staff to doze off once the residents are taken care of; she said it is considered down time. Staff 2 showed me a picture of a staff sleep, that she identified as Staff 5. Staff 2 said she has been with the company for over 5 years and would not do anything to deliberately jeopardize her job.

I interviewed Staff 3. Staff 3 said she only works the day shift, and she normally works with Staff 2. Staff 3 said to be honest she has observed several staff doze off once they have made sure the resident, they are assigned to is taken care of and all their tasks are complete. She said most of the staff work excessive overtime, 12 and 13 days straight; she said they doze off here and there. Staff 3 said she has been with the company for over 24 years, and this is not unheard of or abnormal behavior for the staff to doze off on shift. She denied the staff be in a deep sleep, but they might close their eyes for a couple of minutes or so. She stated she has observed Staff 2 doze off on shift. She denied witnessing Staff 5 doze off on shift, but she stated she does not normally work with Staff 5.

I interviewed Staff 4. Staff 4 said he is relatively new to the company, and he often works along with Staff 2. Staff 2 denied he was witnessed Staff 2 particularly sleeping on shift. However, he said it is not unusual for the staff to doze off when the residents are napping or once the staff has showered the residents and they are in their bedrooms. He said everybody naps. Staff 4 said a lot of the staff work excessive hours to help cover shifts and make sure there is sufficient staffing. Staff 4 denied the residents are at risk.

I interviewed Staff 5. Staff 5 stated she is relatively new to the home. She stated her normal shift is 3:00 p.m. – 11:00 p.m. When asked if she has observed staff sleeping, she said yes. Staff 5 said she has observed Staff 2 sleeping on shift on multiple occasions. Staff 5 said on one day in particular Staff 2 had worked a double and she was observed sleeping while Resident A was soiled. She said Staff 2 neglected her duties. I asked Staff 5 if she has ever dozed off on shift and she said no. I referenced the picture I observed, and Staff 5 denied she has ever dozed off on shift.

I observed Resident A. Resident A is nonverbal and unable to be interviewed.

I interviewed Resident B regarding the allegations. Resident B denied that he has ever witnessed the staff sleeping. As it pertains to his needs, he said the staff is very attentive. Resident B is in a wheelchair and stated he has a colostomy bag. He said he can toilet and when he needs staff always assist him. Resident B said staff takes good care of him and he denied having any concerns.

I attempted to interview Resident C regarding the allegation. Resident C appeared to be focused on watching television. Resident C did not provide narrative regarding the allegations. She said the staff treat her well.

On 02/12/2024, I contact Bridget Malek, licensee designee and discussed the allegations. Ms. Malek said she was previously made aware by ORR and their investigation was substantiated against Staff 2. I explained once the investigation is complete an exit conference will be conducted, and she will be made aware of the investigative findings.

On 03/13/2024, I contacted Lexis Davis, ORR and discussed the allegations. Ms. Davis confirmed she investigated the same allegations, and the complaint was substantiated. She further stated that based on the pictures, interviewed and witness testimony the complaint was substantiated due to potential risk of harm of the residents while Staff 2 was asleep.

On 03/13/2024, I made follow-up contact with Ms. Sharp. Ms. Sharp said although it is uncertain what day the pictures were taken, who was the individual in the pictures and whose bed was observed soiled; there is evidence that Staff 2 was sleeping on shift. Ms. Sharp said as a result the complaint will be substantiated.

On 03/13/2024, I made follow-up contact with Ms. Malek regarding the allegations. I acknowledged the fact that there is some turmoil amongst the staff. However, it appears that all the staff doze off periodically during their shift. I asked if there is a policy regarding staff sleeping on shift, and Ms. Malek said yes. She said per their internal policy, there is no sleeping and/or staff cannot be found in a sleeping position on shift. Ms. Malek said because management did not witness Staff 2 sleeping, she was given a formal reprimand and 3-day suspension. Ms. Malek said based on her internal investigation, it was discovered that Resident A was given a PRN for constipation, so it is possible the soiled brief was a result of the medication. She said typically there are a minimum of 3 staff on shift and sometimes 4 depending on the daily activities of the home. She said the facility is also staffed as such due to fire safety because of the mobility issues in the home. I conducted an exit conference and explained that based on the investigative findings, there is evidence to support the allegation. I explained that Staff 2 admitted to dozing off on shift based on the interviews other staff have witnessed Staff 2 sleep. I made Ms. Malek aware that it was reported that it is customary for the staff to doze off during shift. Also, according to Staff 2's writeup it was reported that Staff 2 has left residents in soiled briefs and failed to attend to their personal care. Due to the violations, I made Ms. Malek aware that a written corrective action plan is required, which she agreed to provide.

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:	During this investigation, I interviewed Bridget Malek, licensee designee; Lexis Davis, ORR; Laticia Sharp, APS; Staff 1, Staff 2, Staff 3, Staff 4, Staff 5; Residents B and C. Staff 3 and Staff 5 admitted to observing Staff 2 sleep on shift. Staff 5 stated while Staff 2 was asleep, Resident A was soiled. I observed pictures of a bed with soiled linen, one of a female staff sleeping in a chair and the other of an individual in a soiled incontinence brief with feces on the linen and the individual's behind and leg area. It was also outlined in Staff 2's writeup that she has failed to attend to the resident's personal care, which was signed by Staff 2 on 2/16/2024. Based on the investigative findings, there is sufficient evidence that Staff 2 failed to attend to the resident's personal care at all times. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend that the status of the license remains the same.

03/15/2024

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Denasha Walker Date
Licensing Consultant

Approved By:

03/18/2024

_____

Ardra Hunter Date
Area Manager