GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 6, 2024

Jeana Koerber
Residential Opportunities, Inc.
1100 South Rose Street
Kalamazoo, MI 49001

RE: License #: AS390337773
Investigation #: 2024A0581034
Portage AFC

Dear Jeana Koerber:

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 #:	AS390337773
Investigation #:	2024A0581034
Complaint Receipt Date:	08/14/2024
Investigation Initiation Date:	08/14/2024
Report Due Date:	10/13/2024
Licensee Name:	Residential Opportunities, Inc.
Licensee Address:	1100 South Rose Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-3731
Administrator:	Jennifer Goodyke
Licensee Designee:	Jeana Koerber
Name of Facility:	Portage AFC
Facility Address:	10145 Portage Road Portage, MI 49002
Facility Telephone #:	(269) 327-3640
Original Issuance Date:	03/25/2013
License Status:	REGULAR
Effective Date:	09/24/2023
Expiration Date:	09/23/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATIONS

	Violation Established?
A direct care staff gave Resident A a peanut butter cookie when he has a known food allergen to peanuts.	Yes
Resident A's allergy protocol was not followed correctly by direct care staff after he ingested a known food allergen.	No
Resident A's as needed or PRN medication, Benadryl, was not available after Resident A ingested a known food allergen.	No

III. METHODOLOGY

08/14/2024	Special Investigation Intake 2024A0581034
08/14/2024	Referral - Recipient Rights ISK received the complaint and is investigating.
08/14/2024	Special Investigation Initiated - Letter Email correspondence with ORR
08/20/2024	Inspection Completed On-site Interviewed staff and obtained documentation.
08/22/2024	Contact - Telephone call made - Interview with direct care staff, Kevin Lemos'Moore
08/23/2024	Inspection Completed-BCAL Sub. Compliance
08/23/2024	APS referral - No allegations of abuse or neglect. No referral needed.
08/23/2024	Contact – Document Sent – email to Administrator, Jennifer Goodyke.
08/27/2024	Contact – Document Received – fax from Ms. Goodyke.
09/05/2024	Exit conference with licensee designee, Jeana Koerber.

ALLEGATION: A direct care staff gave Resident A a peanut butter cookie when he has a known food allergen to peanuts.

INVESTIGATION: On 08/14/2024, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged on or around 07/10/2024, Resident A, who has a known food allergen to peanuts, consumed a peanut butter and chocolate chip cookie, which was provided by direct care staff, Kevin Lemos'Moore. The complaint alleged direct care staff, Whitney

Hudson, observed Resident A eating the cookie who then alerted direct care staff, Melinda Thompson, who was able to give Resident A something safer to eat. The complaint alleged there are signs both posted in the facility's kitchen documenting Resident A's peanut allergy and information in his chart.

On 08/14/2024, Integrated Services of Kalamazoo (ISK) Recipient Rights Officer (RRO), Kate Koyak, confirmed via email she received the allegations and was investigating. Ms. Koyak emailed me copies of Resident A's Food Allergy and Anaphylaxis Emergency Care Plan, dated 06/26/2024, which documented Resident A is allergic to peanuts, tree nuts, and shellfish. She also provided Resident A's August 2024 Medication Administration Record (MAR), which also identified Resident A's allergies as the following: Abilify, Ativan, Trazodone, Thorazine, Zyprexa, Zydis, Peanut, Tree Nut. Ms. Koyak provided Resident A's ISK Annual Assessment, dated 01/09/2024, which documented the same allergies identified on his August 2024 MAR.

On 08/20/2024, I conducted an unannounced inspection at the facility. I interviewed the facility's Administrator, Jennifer Goodyke. The facility's identified assistant home manager, Dean Luscomb, was also present for the interview. Neither Ms. Goodyke nor Mr. Luscomb were working in the facility when Resident A consumed the peanut butter cookie on or around 07/10/2024. Ms. Goodyke stated in the evening on 07/10/2024, she received a telephone call from Ms. Thompson who reported to her Resident A had taken a bite of a peanut butter cookie after Mr. Lemos'Moore gave it to Resident A as a snack. Ms. Goodyke stated Resident B's guardian brought the peanut butter cookies into the facility after dropping Resident B off from an outing. Ms. Goodyke stated it is "very obvious" Resident A has a known allergy to peanuts as this information is posted in the facility's kitchen and in Resident A's MAR. Ms. Goodyke stated it was her understanding Resident A did not experience any adverse reactions after consuming the cookie.

Ms. Goodyke stated she spoke to Resident B's guardian about not bringing in outside food and discussed with Mr. Lemos'Moore about the importance of being mindful and paying attention when providing snacks and food to residents.

During the inspection, I interviewed direct care staff, Whitney Hudson and Melinda Thompson. Both Ms. Hudson's and Ms. Thompson's statements were consistent with Ms. Goodyke's statement to me. Ms. Thompson stated when Resident B's guardian dropped off Resident B, she informed staff the cookies were made with peanut butter. Ms. Thompson stated when she observed Resident A eating a cookie, she immediately asked Resident A for the cookie and gave him another snack. Both Ms. Hudson and Ms. Thompson stated Resident A ate less than half of the cookie. They both stated Resident A was administered 50 mg of Benadryl and he did not appear to suffer any adverse reactions from ingesting the peanut butter cookie.

I did not interview Resident A during the inspection due to him being non-verbal; however, Resident A appeared well cared for, clean, and content lying on his bed in his bedroom.

During the inspection, I observed Resident A's Food Allergy and Anaphylaxis Emergency Care Plan on the facility's refrigerator.

On 08/22/2024, I interviewed Mr. Lemos'Moore via telephone. Mr. Lemos'Moore's statement was consistent with Ms. Hudson's and Ms. Thompson's statements to me. Mr. Lemos'Moore stated he "wasn't thinking" when he gave Resident A one of the peanut butter cookies. He stated he "just grabbed it and gave it to [Resident A]". Mr. Lemos'Moore stated giving Resident A the cookie was "an error" and "lapse of paying attention".

I reviewed the facility's *AFC Licensing - Incident /Accident Report* (IR), completed 07/10/2024, by Ms. Thompson. According to the IR, on 07/10/2024 at approximately 5:30 pm, Mr. Lemos-Moore gave Resident A a cookie with nuts in it to eat. The IR documented Resident A ate less than half of the cookie. The IR documented Resident A has a food allergy to peanuts and tree nuts; however, Ms. Thompson documented Resident A had no injuries from consuming the food allergy. The IR documented Resident A's food allergy action plan and the as needed medication, Benadryl, 50 mg, was administered. The IR documented Resident A would be monitored for any changes in his condition and staff would be more cautious when passing snacks and food to Resident A.

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 my investigation, which included interviews with the facility's Administrator, Jennifer Goodyke, direct care staff, Whitney Hudson, Melinda Thompson, and Kevin Lemos'Moore, and my review of Resident A's Food Allergy Plan and Anaphylaxis Emergency Care Plan, dated 06/26/2024, his August 2024 Medication Administration Record (MAR), his ISK Annual Assessment, dated 01/09/2024, and the *AFC Licensing - Incident /Accident Report* (IR), completed 07/10/2024, Resident A has an established and known food allergen to peanuts. Despite staff being aware of this allergy, direct care staff, Mr. Lemos'Moore, provided Resident A with cookie containing peanuts on 07/10/2024. Consequently, Resident A was not provided with adequate supervision, protection and personal care as required in his assessment plan when he was given a snack containing peanuts, which is an established food allergen for him.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's allergy protocol was not followed correctly by direct care staff after he ingested a known food allergen.

INVESTIGATION: The complaint alleged Resident A's emergency protocol documents Resident A's EpiPen be administered immediately if it's suspected he's consumed peanuts. The complaint alleged the emergency protocol also documents Benadryl can be administered to Resident A for non-serious allergy exposure.

Ms. Goodyke stated Resident A's EpiPen was in the facility at the time he consumed a peanut butter cookie; however, it was not administered because he wasn't having symptoms of an allergic reaction. She stated if Resident A is not exhibiting symptoms of an allergic reaction, he can be administered an antihistamine, like Benadryl. Ms. Goodyke stated Benadryl was not in the facility at the time Resident A consumed the peanut butter cookie, but staff immediately went to the store to purchase the as needed medication. Ms. Goodyke stated the medication had expired and not been replenished prior to Resident A ingesting the allergen.

I reviewed both Resident A's Food Allergy Action Plan and Food Allergy and Anaphylaxis Emergency Care Plan, both dated 06/26/2024, which identified when Epinephrine and/or Antihistamine should be administered to Resident A in the event a food allergen is ingested. The plan documented if Resident A ingests a food allergen, but he is not experiencing any symptoms then he could be administered an antihistamine, which the plan identified as "Benadryl 50 mg tablet/capsule by mouth". The plan also identified the various symptoms Resident A could experience if the allergen was affecting any of the symptom areas such as his mouth, skin, gut, throat, lungs or heart.

Though Resident A's emergency care plan documented Resident A should be given epinephrine immediately if the allergen was "likely" eaten, for "any" symptoms; the plan differentiated between mild and severe symptoms. The plan identified mild symptoms of the nose, mouth, skin and gut as itchy or runny nose, sneezing, itchy mouth, a few hives, mild itch, and mild nausea or discomfort. The plan documented if more than one mild symptom was experienced in more than one system area then epinephrine should be administered, but if Resident A experienced mild symptoms from just a single system area, then an antihistamine may be given; however, it documented someone should stay with Resident A and epinephrine should be given if symptoms worsen.

The emergency plan identified severe symptoms of the lung, heart, throat, mouth, skin, and gut as shortness of breath, wheezing, repetitive cough, pale or blue skin, faintness, weak pulse, dizziness, tight or hoarse throat, trouble breathing or swallowing, significant swell of the tongue or lips, many hives over body, widespread redness, repetitive vomiting, severe diarrhea, or the feeling of something bad is about to happen, anxiety, or confusion. The emergency care plan identified if any severe symptoms were present then epinephrine should be administered immediately and 911 should be contacted. It also provided further instructions for how to assist Resident A in the event his symptoms were severe.

Ms. Hudson, Ms. Thompson, and Mr. Lemos'Moore all denied Resident A exhibited any mild or severe symptoms from any of his system areas after he consumed the peanut butter cookie on 07/10/2024. They stated he was monitored for symptoms after he was administered the Benadryl, but he remained asymptomatic. Their statements were consistent with Ms. Goodyke's statement regarding Ms. Thompson going to the local store to purchase Benadryl, which was ultimately administered to Resident A.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**

ANALYSIS:	Based on my investigation, which included interviews with the facility's Administrator, Jennifer Goodyke, direct care staff, Whitney Hudson, Melinda Thompson, and Kevin Lemos'Moore, and my review of Resident A's Food Allergy Plan and Anaphylaxis Emergency Care Plan, both dated 06/26/2024, the facility's staff followed Resident A's food allergy plan and emergency care plan as directed by Resident A's physician who signed both the plans. Though Resident A ingested a known food allergen, peanuts, none of his systems exhibited any symptoms. Subsequently, direct care staff followed Resident A's allergy plans by only administering the antihistamine, Benadryl, as instructed by Resident A's physician.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A's as needed or PRN medication, Benadryl, was not available after Resident A ingested a known food allergen.

INVESTIGATION: The complaint alleged after Resident A consumed a known food allergen, peanuts, direct care staff were unable to administer Resident A's as needed medication, Benadryl, because it was not in the facility. The complaint alleged Benadryl is identified as an needed medication on Resident A's Food Allergy Plan and Anaphylaxis Emergency Care Plan. The complaint alleged direct care staff, Melinda Thompson, was sent to the pharmacy to obtain the Benadryl.

Ms. Goodyke's, Ms. Thompson's, Ms. Hudson's, and Mr. Lemos'Moore's statements were all consistent with one another. They all stated Benadryl is identified on Resident A's emergency care plan in the event he ingests peanuts. They also all stated the Benadryl was not in the facility at the time he ingested the peanut cookie on 07/10/2024. Ms. Goodyke stated there had been Benadryl at some point, but it was disposed of because it had expired and not replenished. Neither Ms. Hudson nor Ms. Thompson stated it took long for Ms. Thompson to go to the store, purchase the Benadryl and administer it to Resident A, as required. Though they could not recall the specific amount of time; they both stated it could have approximately been around 20 minutes and stated the response to obtaining the medication was "immediate".

Resident A's Food Allergy Plan and Anaphylaxis Emergency Care Plan, both dated 06/26/2024, documented antihistamine, Benadryl 50 mg, should be administered to Resident A as part of his treatment when he ingested a known food allergen and is asymptomatic or if Resident A experienced mild symptoms from just a single system area (e.g. nose, mouth, skin and gut), then just an antihistamine could be administered.

I reviewed Resident A's July 2024 MAR, which documented Ms. Thompson administered Benadryl to Resident A on 07/10/2024 at approximately 5:30 pm. Ms. Thompson documented on the MAR it was administered because of a "food allergy". She documented she followed up with Resident A on 07/10/2024 at approximately 7 pm. She documented he was not exhibiting any symptoms and was happy.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my investigation, Resident A's physician provided a written order for the antihistamine, Benadryl, 50 mg, with the instruction it should be administered to Resident A in the event he ingests a known allergy and is asymptomatic or he has mild symptoms from only one system (e.g. nose, mouth, skin and gut). Despite ingesting peanuts, an established food allergen, Resident A remained asymptomatic at the time the allergen was ingested and throughout the evening, even after he was administered the Benadryl. Though the licensee did not have Benadryl at the facility at the time Resident A ingested the food allergen, the facility's staff obtained the Benadryl within a reasonable time frame and were able to still administer it to him within approximately 20 minutes.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 09/05/2024, I conducted the exit conference with the licensee designee, Jeana Koerber, via telephone. I explained my findings and provided an opportunity for questions or comments.

IV. RECOMMENDATION

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

08/27/2024

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Cathy Cushman Date
Licensing Consultant

Approved By:

09/05/2024

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Dawn N. Timm Date
Area Manager