GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 10, 2024

Kelly Willman-Hill
O & B Community Homes Inc
2819 Birchwood
Trenton, MI 48183

RE: License #: AS820311284
Investigation #: 2024A0116040
Woodruff Home

Dear Ms. Willman-Hill:

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,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820311284
Investigation #:	2024A0116040
Complaint Receipt Date:	08/16/2024
Investigation Initiation Date:	08/19/2024
Report Due Date:	10/15/2024
Licensee Name:	O & B Community Homes Inc
Licensee Address:	2819 Birchwood Trenton, MI 48183
Licensee Telephone #:	(734) 692-1410
Administrator:	Kelly Willman-Hill
Licensee Designee:	Kelly Willman-Hill
Name of Facility:	Woodruff Home
Facility Address:	21886 Woodruff Rockwood, MI 48134
Facility Telephone #:	(734) 236-4791
Original Issuance Date:	01/25/2011
License Status:	REGULAR
Effective Date:	08/02/2023
Expiration Date:	08/01/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
Staff, Michelle Rhodes, was observed sleeping on shift during an unannounced visit by the home manager.	Yes

III. METHODOLOGY

08/16/2024	Special Investigation Intake 2024A0116040
08/16/2024	Referral - Recipient Rights Received.
08/19/2024	Special Investigation Initiated - On Site Interviewed home manager, Lindsey Cronenwett, staff Aimee Miller, and Lynette West, Residents A-C, visually accessed Resident's D-F, and reviewed the individual plans of service (IPOS) for Residents A, D, and F.
08/19/2024	Contact - Document Received Received and reviewed staff, Michelle Rhodes, direct care training.
08/19/2024	Contact - Document Received Received and reviewed staff, Kaiden White's, written statement.
08/19/2024	Inspection Completed-BCAL Sub. Compliance
08/22/2024	APS Referral Made.
08/22/2024	Contact - Telephone call made Left a message for staff, Michelle Rhodes, requesting a return call.
08/28/2024	Contact - Telephone call made Interviewed assigned APS investigator, Laticia Sharp.
09/03/2024	Exit Conference With licensee designee, Kelly Willman-Hill.

ALLEGATION:

Staff, Michelle Rhodes, was observed sleeping on shift during an unannounced visit by the home manager.

INVESTIGATION:

On 08/19/24, I conducted an unannounced on-site inspection and interviewed home manager, Lindsey Cronenwett, staff Aimee Miller, and Lynette West, Residents A-C, visually accessed Residents D-F, and reviewed the IPOSs for Residents A, D, and F.

Ms. Cronenwett reported that she decided to do a routine pop in after receiving complaints that the new staff, Michelle Rhodes, was sleeping during the midnight shift. Ms. Cronenwett reported that there are always at least two staff per shift, and that each staff member is assigned to three residents that they are responsible for during each shift. Ms. Cronenwett reported this is done to ensure that the family or guardian requests are adhered to, as some have requested that only female staff toilet and groom the female residents.

Ms. Cronenwett reported that at 3:10 a.m. on 08/10/24, she entered the home and observed staff, Kaiden White, in the living room sitting up on the couch with the lights and television on, awake and alert. Ms. Cronenwett reported that she did not see staff, Michelle Rhodes, so she asked Mr. White where she was. Ms. Cronenwett reported that Mr. White pointed to the front siting area. Ms. Cronenwett reported that she walked to that area and observed the room to be pitch dark and saw Ms. Rhodes stretched out asleep on the couch snoring. Ms. Cronenwett reported that at 3:30 a.m. Resident F's tube feeding was complete, and his machine started to alarm. Ms. Cronenwett reported that the machine alarmed for about three minutes and Ms. Rhodes finally woke up and went to Resident F's bedroom to turn it off. Ms. Cronenwett reported that when Ms. Rhodes exited Resident F's bedroom, she saw her and went to the front sitting room area and turned the television on. Ms. Cronenwett confirmed with Mr. White what residents he was assigned to and preceded to do bed and brief checks on all of the residents who are incontinent. Ms. Cronenwett reported that Resident B and C are not incontinent, but staff is required to check on them every two hours to see if they need assistance going to the restroom throughout the night. Ms. Cronenwett reported that they both reported they were fine, and that Mr. White had already checked on them. Ms. Cronenwett reported she checked on Resident E and his brief was dry. She reported that these were the three residents assigned to Mr. White. Ms. Cronenwett reported that she then checked on the three residents that were assigned to Ms. Rhodes and reported that all of their briefs were wet/soiled and had not been changed since 11:30 p.m. when the afternoon staff changed them prior to completion of their shift. Ms. Cronenwett reported that once Ms. Rhodes saw that she was completing bed checks, she went and changed Residents A and D, Ms. Cronenwett reported she realized later that she never changed Resident F, so she requested that Mr. White

do so. Ms. Cronenwett reported that she sat down with Ms. Rhodes and spoke with her regarding her observations and the company policy which prohibits sleeping. Ms. Cronenwett reported that she also reminded Ms. Rhodes that Resident F is an aspiration risk and that his IPOS clearly states that staff are to monitor him during all of feedings, which she failed to do. Ms. Cronenwett reported that she sent Ms. Rhodes home and informed her that she needed to contact the main office for next steps. Ms. Cronenwett reported she called another staff in to complete the remainder of Ms. Rhodes shift. Ms. Cronenwett reported that Ms. Rhodes was terminated and has not returned to the home since 08/10/24.

I interviewed staff, Aimee Miller and Lynette West and they both reported that they were not working when the incident occurred and had only heard about it.

I interviewed Resident A and she reported that the staff usually check on her at night and get her to the restroom or change her brief. Resident A did not recall if staff, Michelle Rhodes, checked on her during the early morning hours on 08/10/24.

I interviewed Resident B and he reported that he does not wear briefs and uses a urinal sometimes at night. Resident B is confined to a wheelchair and requires staff assistance when being toileted in the restroom. Resident B reported that he hasn't observed any staff sleeping during the midnight shift because at that time he is in his bedroom asleep.

I interviewed Resident C and he reported that he does not wear briefs and gets up to use the restroom when he needs too. Resident C was unable to report if he had ever observed any of the staff asleep during their shift.

I visually observed Residents D, E and F as they are unable to be interviewed due to their cognitive and developmental delays. They were all neatly dressed and groomed and appeared well.

I reviewed the IPOSs for Residents A, D and F. Resident A's IPOS dated 06/10/24, documents that staff are to check/toilet her every two hours during sleeping hours to prevent skin breakdown. Resident D's IPOS dated 01/01/24, documents that staff should check/toilet her every four hours or more often as needed during sleeping hours. Resident F's IPOS dated 06/20/24, documents that staff should complete visual checks/brief changes on him every two hours or more often if needed. I also reviewed Resident F's aspiration guidelines, which document that during his tube feedings, which are at 8:00 a.m., 4:00 p.m., and 12:00 a.m. and normally last about three to four hours each, staff are to monitor and reposition him every hour to make sure he is in an upright position and has not slid down during the feedings.

On 08/19/24, I received and reviewed the direct care training and in-service training sign off sheets acknowledging that Ms. Rhodes was trained on all of the residents IPOSs and eating/aspiration guidelines. Ms. Rhodes was fully trained in all required areas and has been working in direct care for over 20 years.

On 08/19/24, I received and reviewed staff, Kaiden White's, written statement as he was the other staff on shift with Ms. Rhodes on 08/10/24. In summation, Mr. White documented that he and Ms. White both were scheduled to work the 12:00 a.m. to 8:00 a.m. midnight shit on 08/10/24. Mr. White documented that Ms. Rhodes completed some paperwork, mopped the floors and at around 2:15 a.m. she went in the front sitting room area and laid down on the couch. He documented that he heard her snoring, when he walked down the hall to check on the three residents he was responsible for. Mr. White documented that he checked in on Resident F (who was assigned to Ms. White) as he was still feeding and is an aspiration risk. He documented that was around 3:00 a.m. and Resident F was fine. Mr. White documented that at around 3:10 a.m. he heard the side door open and saw that it was the home manager, Ms. Cronenwett. Mr. White documented she was able to observe Ms. Rhodes asleep in the front room snoring. Mr. White documented that Ms. Cronenwett spoke to Ms. Rhodes after she woke up and eventually sent her home. Mr. White also documented that this is not the first time that he has worked with Ms. Rhodes and observed her sleeping during her shift.

On 08/28/24, I interviewed assigned APS investigator, Laticia Sharp, and she reported that she will be substantiating neglect/lack of physical care. Ms. Sharp reported that staff, Michelle Rhodes was asleep during her shift and not providing the required care to the three residents she was assigned too. Ms. Sharp reported that she had spoken with four of the six guardians and reported they were aware of the incident. Ms. Sharp reported that all of the guardians reported their belief that this was an isolated incident and that the long-term staff who work in the home has always provided good care to the residents. Ms. Sharp reported that all of the guardians reported their desire for the residents to remain in the home and were all satisfied with the action the company took by terminating Ms. Rhodes.

On 09/03/24, I conducted the exit conference with licensee designee, Kelly Willman-Hill, and informed her of the findings of the investigation and the rule cited. Ms. Willman-Hill reported an understanding and reported that Ms. Rhodes was terminated effective 08/14/24 and had only worked in the home since the end of July of 2024. Ms. Willman-Hill reported that she would submit an acceptable corrective action plan upon receipt of the report.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based on the findings of the investigation, which included interviews of home manager, Lindsey Cronenwatt, Residents A-C, review of staff, Kaiden White's written statement, interview of APS investigator, Laticia Sharp, and my review of Residents A, D and F's IPOSs and eating/aspiration guidelines, I am able to corroborate the allegation that staff, Michelle Rhodes, was asleep during her midnight shift and not available for the supervision, personal care and protection of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

09/04/24

Pandrea Robinson
Licensing Consultant

Date

Approved By:

09/10/24

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Ardra Hunter
Area Manager

Date