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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 10, 2024

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

RE: License #: AS390243308
Investigation #: 2024A0581037
Schuring

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 #:	AS390243308
Investigation #:	2024A0581037
Complaint Receipt Date:	08/20/2024
Investigation Initiation Date:	08/21/2024
Report Due Date:	10/19/2024
Licensee Name:	Residential Opportunities, Inc.
Licensee Address:	1100 South Rose Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-3731
Administrator:	Elisha Harvey
Licensee Designee:	Jeana Koerber
Name of Facility:	Schuring
Facility Address:	1013 Schuring Portage, MI 49024
Facility Telephone #:	(269) 327-9315
Original Issuance Date:	03/20/2002
License Status:	REGULAR
Effective Date:	04/12/2023
Expiration Date:	04/11/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION

	Violation Established?
On 08/12/2024, Resident A and Resident B were left unattended in the shower despite needing supervision by direct care staff.	Yes

III. METHODOLOGY

08/20/2024	Special Investigation Intake 2024A0581037
08/20/2024	Referral - Recipient Rights - ISK received allegations and is investigating.
08/20/2024	APS Referral - APS received the allegations, but denied investigating
08/21/2024	Contact - Document Sent - Email to ISK ORR, Kate Koyak.
08/21/2024	Special Investigation Initiated – Letter - Received ISK plans for residents from ISK ORR, Ms. Koyak.
08/21/2024	Contact - Document Sent - Email to facility's program director requesting staff contact information.
08/21/2024	Contact - Document Received - Email from Ms. Clayborn, program director.
08/22/2024	Contact - Telephone call made - Interview with facility nurse, Rebecca Barlow
08/22/2024	Contact - Telephone call made -Interview with direct care staff, Kaliajah Taylor
09/13/2024	Inspection Completed On-site - Observed residents and interviewed staff.
10/03/2024	Inspection Completed-BCAL Sub. Compliance
10/08/2024	Exit conference with the licensee designee, Jeana Koerber, via telephone.

ALLEGATION: On 08/12/2024, Resident A and Resident B were left unattended in the shower despite needing supervision by direct care staff.

INVESTIGATION: On 08/20/2024, I received this complaint through the Bureau of Community Health System (BCHS) online complaint system. The complaint alleged on or around 08/12/2024, direct care staff, Kaliajah Taylor, left both Resident A and Resident B unattended in the shower on separate occasions.

The complaint alleged Resident A is nonverbal, has an intellectual disability, cerebral palsy, and should not be left alone while showering. The complaint alleged the facility's nurse, Rebecca Barlow, discovered Resident A naked, wet, and curled up in a towel shivering in the shower room after being left unattended for approximately 10 minutes. The complaint alleged Resident A had a large amount of mucus in her mouth from lying flat, but Ms. Barlow was able to clear the mucus from her mouth. The complaint alleged Resident A did not sustain any injuries while being left unattended. The complaint also alleged the reason Ms. Taylor left Resident A unattended was because Resident A had a bowel movement; however, the complaint alleged there was no evidence Resident A had a bowel movement while in the shower. The complaint alleged Ms. Taylor was observed in the facility's living room playing on her phone while Resident A was in the shower room unattended.

The complaint also alleged Resident B is limited verbally, has a moderate intellectual disability, is non ambulatory and should not be left alone while showering. The complaint alleged Ms. Barlow heard water running from the facility's shower room and upon going into the shower room she discovered Resident B sleeping in a shower chair and holding a shower wand that was spraying her in the chest. The complaint alleged Resident B's skin was observed "pink". The complaint alleged Ms. Barlow woke Resident B up and shouted for Ms. Taylor to assist Resident B. The complaint alleged Resident B's skin color returned to normal, and Resident B sustained no injuries. The complaint alleged Resident B was left alone for approximately 10 minutes; however, the complaint alleged the time frame could not be confirmed. The complaint alleged Ms. Taylor reported Resident B was left unattended because Resident B was having a bowel movement. The complaint alleged Ms. Taylor was observed in the facility's living room on her phone while Resident B was left unattended in the shower room.

The complaint alleged Ms. Taylor was no longer employed with the licensee or working in the facility due to quitting.

On 08/20/2024, Integrated Services of Kalamazoo Recipient Rights Officer, Kate Koya, emailed me the *AFC Licensing Division – Incident / Accident Report* (IR), dated 08/14/2024, which was completed by Ms. Barlow. According to the IR, on 08/12/2024 at approximately 6 pm, Ms. Barlow documented after showering Resident A, Ms. Taylor reported to her she was giving Resident A "sometime in the shower room". Ms. Barlow documented Ms. Taylor then sat on the facility's couch and looked at her phone. Ms. Barlow documented in the IR she immediately went to

the shower room because Resident A "…is ill, on hospice and current on supplemental O2". Ms. Barlow stated she discovered Resident A "shivering, head not elevated with a large amount of mucus in her mouth". Ms. Barlow documented in the IR she "informed staff to immediately reposition [Resident A]" and to put her back on O2. No additional information was documented on the IR other than Ms. Barlow notifying her supervisor on 08/13/2024 at 12 pm.

Ms. Koya also emailed Resident A's and Resident B's "Supervision Protocols", dated 01/24/2024, which were completed by the licensee. Resident A's supervision protocol documented the following:

> "[Resident A] requires closer supervision when showering/bathing. [Resident A] will use the therapeutic whirlpool tub with mechanical lift and/or the shower trolley in the roll in shower and will have staff assist her. Staff will monitor water temperature to prevent scalding. [Resident A] will not be left alone in the bathroom."

Resident B's supervision protocols documented the following:

> "[Resident B] requires closer supervision when showering/bathing. [Resident B] will use a shower chair, toilet chair, shower trolley, and mechanical lift and will have staff assist her to prevent falls. Staff will monitor water temperature to prevent scalding. [Resident B] will not be left alone in the bathroom."

On 08/21/2024, the facility's Executive Director, Susan Clayborn, emailed confirming Ms. Taylor quit working for the licensee without notice on 08/20/2024. Ms. Calyborn confirmed both residents' supervision protocols "clearly indicate they are not to be left alone in the bathroom and [Ms. Taylor] clearly did so".

On 08/22/2024, I interviewed the facility's nurse, Rebecca Barlow, via telephone. Ms. Barlow's statement was consistent with the information provided in the complaint and in the IR. Ms. Barlow stated Ms. Taylor started Resident A's shower around 6 pm. She stated while Ms. Taylor assisted Resident A in the shower, Ms. Barlow assisted other residents. Ms. Barlow stated she observed Ms. Taylor come out of the shower and reported she was giving Resident A "a minute." Ms. Barlow stated Ms. Taylor went into the living room and proceeded to look at her phone. Ms. Barlow stated she walked down the hall, went into the shower room and discovered Resident A curled up on the shower cart. She stated Resident A was not propped up on the shower cart pillow. She stated the water was off, the cart's sides were up, and Resident A was covered in a thin towel. Ms. Barlow stated she did not observe any urine or bowel movements on or near Resident A.

Ms. Barlow stated she removed mucus from Resident A's mouth, propped her up, turned on the heat light. She stated she poked her head out of the shower room door to instruct Ms. Taylor to get back in the shower room and assist Resident A. Ms. Barlow stated Ms. Taylor got up and immediately came into the shower room. She stated Ms. Taylor dressed Resident A, placed her in her wheelchair and took her to the living room. Ms. Barlow stated she estimated Resident A was by herself in the shower room for approximately 10 minutes.

Ms. Barlow stated at approximately 8 pm while she was preparing to pass medications, Ms. Taylor got Resident B ready for a shower. Ms. Barlow stated she observed Ms. Taylor get Resident B into the shower room using the shower cart. Ms. Barlow stated she assisted another resident with care in their bedroom for approximately 10-15 minutes. She stated when she completed the resident's care, she heard water running in the facility's shower room. She stated when she looked in the shower room, she observed Resident B sleeping in the shower cart with her right hand holding onto the shower head. Ms. Barlow stated she yelled for Resident B to wake up and turned off the water. Ms. Barlow stated the water was not scalding or too hot. Ms. Barlow stated Resident B did not have towel on her, so she put one over her and immediately went into the living room where she observed Ms. Taylor sitting on the couch looking at her phone. She stated Ms. Taylor immediately went into the shower room, dried Resident B off, and took Resident B into her bedroom. Ms. Barlow stated Ms. Taylor did not provide an explanation for why she left Resident B in the bathroom unattended. Ms. Barlow stated she did not observe any urine or feces near Resident B to indicate she had experienced incontinence while in the shower.

On 08/22/2024, I interviewed Kaliajah Taylor, via telephone. Ms. Taylor's statement to me was consistent with the allegations, the IR and with Ms. Barlow's statement; however, she stated she "did everything right" when she assisted Resident A and Resident B with their showers on the evening of 08/12/2024. Ms. Taylor stated while in the middle of Resident A's shower, Resident A had a bowel movement. She stated when she observed Resident A's bowel movement, she stopped showering her, cleaned her up, and wrapped her in a towel. She stated Resident A was sick that day but wasn't throwing up. Ms. Taylor stated Resident A "coughed up snot", but stated she wiped the snot off her mouth. She stated while Resident A was wrapped up in the shower cart, she turned on the shower's heat lamp and then went to check on the other residents. She stated she was gone approximately five minutes. She stated while she was checking on the residents, Ms. Barlow found her in the living room and told her to check on Resident A because she observed mucus on Resident A's mouth. Ms. Taylor stated when she went back in the shower room, she finished showering Resident A, wiped the mucus off her face again, dressed her and wheeled her into the living room. Ms. Taylor denied Resident A being distressed, cold, or shivering. She stated Resident A's entire shower lasted approximately 30 minutes.

Ms. Taylor stated she showered Resident B a couple hours later. She stated Resident B is able to rinse herself in the shower so while Resident B was rinsing herself, Ms. Taylor she went to check on other residents again. Ms. Taylor also stated Resident B often falls asleep in the shower. She stated Resident B can be in the shower by herself. Ms. Taylor stated while she was in the living room, Ms. Barlow came in and told her to check on Resident B because Resident B fell asleep. Ms. Taylor stated when she went back into the shower room, she observed Resident B holding the shower head on her chest. She stated she finished showering Resident B and then assisted her getting into her nightgown and put her in bed. Ms. Taylor denied Resident B being in any distress or having any injuries.

On 09/13/2024, I conducted an unannounced inspection at the facility. Resident A was sleeping during the inspection; therefore, I was unable to interview her. Upon observing Resident A, I identified no concerns as she appeared well taken care of. I also attempted to interview Resident B; however, she was difficult to understand or engage in conversation; however, Resident B also appeared well cared for.

During the inspection, I interviewed facility nurse, David Sturgis. Mr. Sturgis stated it was the expectation staff to set up the bathrooms prior to to assisting residents in shower so staff have everything they need. Mr. Sturgis stated neither Resident A nor Resident B should be left unattended in the shower. He stated if staff needed something while showering a resident then it would be expected they poke their head out of the shower room door and request the second staff working obtain what is needed rather than leaving a resident unattended in the shower room.

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 a review of Resident A's and Resident B's assessment plans and their Supervision Protocols, dated 01/24/2024, AFC Licensing Division – Incident / Accident Report (IR), dated 08/14/2024, and interviews with the facility's nurse, Rebecca Barlow, and direct care staff, Kaliajah Taylor, there is supporting evidence both Resident A and Resident B require supervision from direct care staff while each is bathed/showered; however, on 08/12/2024, by her own admission, Ms. Taylor left both Resident A and Resident B unattended in the shower for at least five minutes. Consequently, Ms. Taylor did not adequately provide supervision to either Resident A or Resident B when she assisted them with bathing, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/08/2024, I conducted my exit conference with the licensee designee, Jeana Koerber, via telephone. Ms. Koerber acknowledged the findings and stated she would submit an acceptable plan of correction upon receipt of the report.

IV. RECOMMENDATION

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

10/08/2024

Cathy Cushman Date
Licensing Consultant

Approved By:

10/10/2024

Dawn N. Timm Date
Area Manager