RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

October 4, 2018

Barry Bruns
Homelife Inc
PMB #360
5420A Beckley Rd.
Battle Creek, MI 49015

RE: License #: AM030387355
Investigation #: **2018A0465053**
318 E. Hammond Street AFC

Dear Mr. Bruns:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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) 284-9727.

Sincerely,

Stephanie Gonzalez

Stephanie Gonzalez, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 243-6063

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030387355
Investigation #:	2018A0465053
Complaint Receipt Date:	07/26/2018
Investigation Initiation Date:	07/26/2018
Report Due Date:	09/24/2018
Licensee Name:	Homelife Inc
Licensee Address:	3 Heritage Oak Lane Battle Creek, MI 49015
Licensee Telephone #:	(269) 660-0854
Administrator:	Barry Bruns
Licensee Designee:	Barry Bruns
Name of Facility:	318 E. Hammond Street AFC
Facility Address:	318 E. Hammond Street Otsego, MI 49078
Facility Telephone #:	(269) 694-1601
Original Issuance Date:	10/30/2017
License Status:	REGULAR
Effective Date:	04/30/2018
Expiration Date:	04/29/2020
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 7/14/2018, Resident A was found wandering the streets and the facility was unaware that she had left the facility.	Yes
Resident A is not being provided clothing by the facility.	Yes
Resident A has not taken a shower in approximately nine months.	Yes
Resident A is not allowed access to her personal funds.	No
Resident A's bedroom and the common areas of the home are not maintained to provide adequately for the health and safety of occupants.	Yes
Resident A does not have clean bedding that is in good condition.	Yes
Additional findings	Yes

III. METHODOLOGY

07/26/2018	Special Investigation Intake 2018A0465053
07/26/2018	Special Investigation Initiated - Telephone Spoke to Karen Woodworth
07/26/2018	APS Referral
08/24/2018	Inspection Completed On-site
08/24/2018	Contact - Telephone call made Left voice mail for Guardian A1
08/24/2018	Contact - Telephone call made Left voice mail for Jill Mullins – Interact of Michigan
08/24/2018	APS Referral Follow-up APS Complaint
08/27/2018	Contact - Telephone call received Spoke to Jill Mullins

08/27/2018	Contact - Telephone call received Spoke to Guardian A1
08/27/2018	Contact – Telephone call made Spoke to Lisa Smith from CMH
08/27/2018	Contact - Telephone call made Submitted an ORR Complaint
08/28/2018	Contact - Telephone call received Spoke to Jill Mullins. Informed that Resident A is currently at ER, awaiting inpatient psych admission
08/28/2018	Exit Conference Conducted Exit Conference
08/28/2018	Inspection Completed-BCAL Sub. Non-Compliance

ALLEGATION:

On 7/14/2018, Resident A was found wandering the streets and the facility was unaware that she had left the facility.

INVESTIGATION:

On 7/25/2018, a complaint was received, alleging that on 7/14/2018 Resident A was found wandering the streets wearing only a bedsheet. The complaint stated the following information:

- "[Resident A] is cognitively impaired but high functioning and is slow speaking but is able to clearly and appropriately answer questions asked of her. [Resident A] resides at Hammond Street AFC and the facility is currently pursuing efforts to have a guardian appointed for [Resident A.] [Resident A] no longer wants to reside at the facility due to the pending guardianship and is currently making efforts to get kicked out of the facility. On 7/14/2018, [Resident A] left the facility wearing only a bed sheet because she was attempting to go to the homeless mission in Kalamazoo, Michigan. [Resident A] was found dirty and covered in scabs and bruises by concerned citizens, who subsequently contacted law enforcement. Law enforcement subsequently returned [Resident A] to the facility.

On 7/25/2018, I received a copy of the *Otsego Police Department Summary* written by Officer Akers, dated 7/14/2018. The reported stated, in part, the following:

- On 7/14/2018, I was dispatched to the Otsego Library in reference to a welfare check of a female subject. After further investigation, it was determined that [Resident A] belongs to an adult foster care home located at 318 East Hammond St. in Otsego. I returned [Resident A] to the home where I investigated further and it was determined that this might be a neglect or wrongful placement.
- I arrived at the Otsego Library, at 401 Dix St. in reference to a call placed about a female standing in the rain looking at the library sign. I immediately asked her if she needed medical attention. She told me she just wanted to get to the mission on Kalamazoo and was looking for a ride. While driving back she stated that she was going to be in big trouble now and "it was going to be worse." I asked her that she meant and she did not answer but asked instead to wait in the cruiser while I talked to the caretakers.
- I arrived at the 318 Hammond St. where I was able to make contact with (staff member) Tiffany Rich. I told her that I had one of the ladies that resides with them in the back of my patrol car and I needed to ask her some questions. I explained that we received a call about [Resident A]. Tiffany informed me that she [Resident A] can leave the facility but must come back once her walk is over.
- On 7/16/2018, I made contact with the AFC Home. Ms. {Sjana} Markusic advised me that they are in the process with the court for petitioning for a guardianship of [Resident A] and that when [Resident A] found out about this she no longer wished to live there.

On 7/26/2018, I spoke to APS Worker, Kathleen Woodworth. Ms. Woodworth reported that she conducted an onsite investigation at the facility on 7/26/2018. Ms. Woodworth reported that she spoke to staff member Sjana Markusic, who reported that Resident A's Interact of Michigan case manager, Jill Mullins, has petitioned Allegan County Probate Court to appoint a public guardian for Resident A and the hearing is scheduled for 7/27/2018 at 1:30pm. Ms. Woodworth reported "it did appear to me that the AFC home is trying to work with [Resident A] and do everything in their power to assist her and provide proper care to her. She [Resident A] has just been a very difficult resident and refuses everything."

On 8/24/2018, I conducted an onsite investigation at the facility. I reviewed Resident A's *AFC-Resident Information and Identification Record* which stated that she was admitted to the facility on 11/29/2017. The *Letters of Guardianship* stated that a legal guardian, Guardian A1, was appointed on 7/27/2018, and that the "Guardian shall have the authority to order mental health evaluations and treatment for ward." The *Health Care Appraisal* stated that Resident A is diagnosed with Major Depression Recurrent Episode, Anxiety Disorder, Traumatic Brain Injury and refuses showers, is incontinent, refuses to have RN inspect her skin and has a history of Anorexia with protein malnutrition. The *Assessment Plan for AFC Residents* stated that Resident A does not move independently in the community via vehicle, struggles with understanding and clearly communicating her needs, will disassociate and not talk to

people in her surroundings, is unable to read, requires staff prompting for toileting, bathing, personal hygiene and grooming, refuses to take medication, often refuses ADL care, refuses to wash her hair and will wear soiled clothing and blankets.

I interviewed Resident A, who reported that on 7/14/2018 she left the facility in an attempt to move to the local homeless Mission in Kalamazoo, Michigan. Resident A reported “I knew they were trying to get me a guardian and I don’t want one.” Resident A stated that she spends most of her time alone outside and that staff “only come out to see me when they bring me food.” Resident A reported “I don’t want to be in foster care.”

I interviewed direct care staff member Tiffany Rich, who reported that she has worked at the facility since January 2018. Ms. Rich reported that she was working on 7/14/2018, the day that Resident A wandered away from the facility. Ms. Rich reported that she arrived at work at approximately 7:00am and observed Resident A at the facility. Ms. Rich reported that it is common for Resident A to sit outside “all day,” and therefore her interaction with Resident A is limited. Ms. Rich reported that she last saw Resident A at approximately 11:30am when she made Resident A’s lunch and “set it outside.” Ms. Rich reported that the police arrived at the facility at approximately 12:20pm and that is when she was informed that Resident A had wandered away from the facility. Ms. Rich acknowledged that Resident A needs assistance with personal care, has limited insight into healthy decision making and limited reading and communication skills, but Ms. Rich reported that Resident A “is able to go outside and go for walks by herself as long as she comes home when her walk is done.”

I interviewed direct care staff member Sjana Markusic, who reported that she has worked at the facility since November 2017. Ms. Markusic reported that on 7/14/2018, Resident A was her own guardian and had the right to move independently in the community at that time. Ms. Markusic reported that on 7/14/2018, Resident A was upset about the pending guardianship proceedings and wandered away from the facility in an attempt to move to the local Mission. Ms. Markusic reported that it is common for Resident A to spend the majority of her time outside on the side porch. Ms. Markusic reported that there is no current supervision plan in place that requires staff to check on Resident A on a continuous basis and that Resident A does not require 1:1 supervision.

I interviewed direct care staff member Larreisha Holman, who reported that she has worked at the facility since February 2018. Ms. Holman reported that Resident A spends the majority of her time outside alone. Ms. Holman reported that Resident A is left unsupervised outside and is allowed to move independently in the community. Ms. Holman reported that it is a routine practice for staff to only check on Resident A when they place food outside for her to eat.

I interviewed licensee designee and administrator Barry Bruns via telephone. Mr. Bruns acknowledged that on 7/14/2018, Resident A wandered away from the facility

and staff did not know she was missing. Mr. Bruns reported that Resident A is not required to have 1:1 supervision and therefore she is “difficult to supervise.”

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:	Resident A’s Assessment Plan for AFC Residents states that Resident A does not move independently in the community via vehicle, struggles with understanding and clearly communicating her needs, will disassociate and not talk to people in her surroundings, is unable to read, requires staff prompting for toileting, bathing, personal hygiene and grooming, often refuses ADL care, refuses to wash her hair and will wear soiled clothing and blankets. Ms. Rich and Ms. Markusic both reported that Resident A spends the majority of her time outside and that there is no facility protocol in place to ensure staff check on Resident A on a continuous basis throughout the day. Ms. Rich acknowledged that on 7/14/2018 she was unaware that Resident A had wandered away from the facility until the police officer arrived at the facility and informed her of such. Ms. Rich reported that it is typical that she only has contact with Resident A during meal times, when she has to go outside to give Resident A her food. Based on the information above and interviews with Resident A, Ms. Rich, Ms. Markusic, Ms. Holman and Mr. Bruns, and a review of Resident A’s *Assessment Plan for AFC Residents*, the facility is not providing adequate supervision to Resident A by allowing her to remain outside for extended periods of time in a bedsheet and by allowing her to move independently in the community in a bedsheet and without staff supervision, which allowed for Resident A to wander away from the facility on 7/14/2018 for approximately 50 minutes.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A is not being provided clothing by the facility.

INVESTIGATION:

On 7/25/2018, a complaint was received, alleging that on 7/14/2018 Resident A was found wandering the streets wearing only a bedsheet. The complaint stated that the facility has refused to give Resident A clothing or money to purchase clothing.

On 7/25/2018, I received a copy of the *Otsego Police Department Summary* written by Officer Akers, dated 7/14/2018. The reported stated, in part, the following:

- I arrived at the Otsego Library, at 401 Dix St. in reference to a call placed about a female standing in the rain looking at the library sign. The called had stated she was wearing nothing but a bed sheet and appeared to be dirty, as well as covered in scabs and bruises. I immediately asked her if she needed medical attention. She told me she just wanted to get to the mission on Kalamazoo and was looking for a ride. I asked her why she was only wearing a bed sheet and she explained to me that she didn't want to answer because things would just be worse for her. I asked her what she meant by that and she told me that she was living in an adult foster care home on East Hammond Street but was allowed to leave whenever she wanted to but they "often expose her to things she is allergic to" and don't let her clean her room. I asked her again why she left in just a bed sheet and she informed me that that caretakers at the home refused to give her clothes to wear. I asked her if she had any clothes of her own and she told me that she did not have money on her to buy any. I then asked her if she had money back at the home and she informed me that she had close to $500.00 and had been asking for $60.00 to buy clothes for almost three weeks now but that the head caretaker refused to give it to her. It should be noted that the subject was extremely skinny, covered in scabs and bruises, and the smell of urine and feces coming from her person was overpowering. I informed Dispatch that I would be transporting the subject back to the address on Hammond Street for further investigation. While driving back she stated that she was going to be in big trouble now and "it was going to be worse." I asked her that she meant and she did not answer but asked instead to wait in the cruiser while I talked to the caretakers.
- I arrived at the 318 Hammond St. where I was able to make contact with
- (staff member} Tiffany Rich. I asked her if she had clothes for {Resident A) at the house. She told me "no" but she had a bedsheet she could have and "that is all she ever uses." I asked her if that was common practice there and she was hesitant to answer but eventually told me no. I asked her if we could find [Resident A] clothes somehow and she again told me that she would give her a bed sheet.

- Inside the closet was a dresser I was told was empty. Tiffany Rich reported that [Resident A] only had one article of clothing, a black dress, which she could not locate. I took this opportunity to run to the local Goodwill just up the street and was able to secure a few articles of clothing for [Resident A] to wear until her money could be given to her, and she was able to go shopping herself. Upon my return, [Resident A] began to cry and thank me for helping her and stated again "no one would give me money or help me get clothes. I don't remember the last time I had clothes to wear."
- On 7/16/2018, I made contact with the AFC home. I was able to speak with Ms. Markusic who is the home manager. When I asked staff what happened to the clothes, I was told that [Resident A] often gets them so dirty (with feces and urine) and refuses to take them off for so long that that when the staff is finally able to get a hold of them for cleaning they are beyond salvageable and with [Resident A's] permission, must be thrown out.

On 8/24/2018, I conducted an onsite investigation at the facility. I observed Resident A's bedroom to have one closet and one dresser, both of which did not contain any clothing items.

I reviewed Resident A's *Behavior Assessment and Support Plan* dated 6/19/2018, which stated in part, the following:

- [Resident A] continues to be very resistant to changing her clothes and refuses to bathe or shower for weeks to months at a time. Resident A continues to be incontinent on a daily basis.
- [Resident A] will try to hide feces in clothing and then throw the clothing with the feces out. [Resident A] has stated that she throws her clothing out because it is ruined. [Resident A] also wraps a blanket around her waist and wears it for days/weeks at a time when it is soiled. She is resistant to giving staff the soiled blanket and using a new one. At times the clothing and blankets retain a malodorous smell even after being washed and do have to be thrown out. [Resident A's] plan includes updated procedures for addressing room cleanliness, clothing/blankets, and bathing prompting as well as added target behaviors to address.
- Target Behavior to address clothing: When [Resident A's] clothes are soiled and staff request that she give to staff (and replace with new) to be washed and she refuses. This is tracked daily on first and second shift.
- Staff will conduct four-hour interval prompts to offer Resident A new clothing items and document this information on a tracking sheet.

I reviewed the *[Resident A] Soiled Clothing/Linen Tracking Sheet* for the months of July 2018 and August 2018, which stated that Resident A was offered clothing twice per day, once during first shift and once during second shift, and not every four hours as outlined in Resident A's *Behavior Assessment and Support Plan*. The *[Resident A] Soiled Clothing/Linen Tracking Sheet* does not specify what type of clothing was offered to Resident A.

I interviewed Resident A, who I found sitting outside on the side porch of the facility. I observed Resident A wearing a tank top with a bedsheet wrapped around her body. Resident A's bedsheet had visible feces stains and there was an overwhelmingly strong odor of feces and urine coming from her person. I observed Resident A holding a piece of clothing in her hand that was covered in moist wet feces. I asked Resident A what she was holding and she replied, "I had an accident and I am holding onto it until I can get it cleaned." There were numerous flies swarming around Resident A's person as well as her blanket. Resident A reported "I want clothes but I have accidents. I get diarrhea and then throw my clothes away." Resident A reported "I have clothes but they are locked in the office and I can't get them until I shower." Resident A reported that she has been asking Ms. Markusic for clothing but has been told that she cannot receive new clothing until she has money available to pay for new clothing. Resident A reported that she has also been told by staff that she is not allowed to receive new clothing until she takes a shower. Resident A stated, "they should buy me clothes but they won't." Resident A did acknowledge that she has used scissors to cut her clothing to "make dresses." Resident A reported that she does want clean clothes to wear and has been asking for clean clothing for "a long time."

I interviewed Ms. Rich, who reported that Resident A "doesn't wear clothes, she wears sheets." Ms. Rich reported that it is common for Resident A to wear bedsheets that have dried feces and urine because "she won't let us change her." Ms. Rich reported that as of now, Resident A does not have any clothes "except what she is wearing right now." Ms. Rich reported that it is common for Resident A to not have any clothing and that this has been a normal occurrence since she began working at the facility in January 2018. Ms. Rich acknowledged that on 7/14/2018, when Officer Akers came to the facility, Resident A had no clothing available at that time. Ms. Rich reported that the only clothing that was available for Resident A on 7/14/2018 was a bedsheet, which she did offer to Resident A during the time that Officer Akers was at the facility. Ms. Rich admitted that Officer Akers went to the local Goodwill and purchased a few articles of clothing for Resident A due to the facility not having clothing available for Resident A. Ms. Rich reported that the facility does have an incentive program that they utilize to encourage Resident A to "change her clothing but no incentive points work for her." Ms. Rich reported that on 8/22/2018, Resident A came to her and "asked me to call Salvation Army to get her some clothes donations." Ms. Rich reported that she informed Ms. Markusic of Resident A's request on that same day but that no clothing has been purchased for Resident A as of yet.

I interviewed Ms. Holman, who reported that Resident A "always wears sheets." Ms. Holman reported that Resident A does not currently have any clothing to wear. Ms. Holman reported that Resident A did have two dresses but she is unsure where they are and stated that Resident A "cuts up her clothes." Ms. Holman reported that it is "normal for [Resident A] to wear bedsheets with dried feces and urine."

I interviewed Ms. Markusic, reported that Resident A does wear a bedsheet as clothing. Ms. Markusic reported that the facility has used Resident A's personal funds to purchase her clothing but that Resident A has recently "refused to allow us to use her money to buy her clothes." Ms. Markusic reported that Resident A only has $9.84 in her fund account and does not have enough money to buy clothing at this time. Ms. Markusic reported that the facility has purchased clothing for Resident A in the past, but that they stopped doing this because Resident A "tears clothes to shreds and throws them away." Ms. Markusic reported that the facility has attempted to address Resident A's clothing and hygiene issues through utilization of an Incentive Program. Ms. Markusic reported that Resident A can earn points for bathing/showering, completing personal hygiene, cleaning her bedroom, changing clothes that are soiled in feces or urine, etc. Ms. Markusic reported that, despite the implementation of the incentive program, Resident A has continued to be non-compliant with the upkeep of her personal hygiene. Ms. Markusic reported that as of today, Resident A does not have any clothing in her bedroom that is available for her to wear. Ms. Markusic showed me a large box, with a label marked "Mission," sitting in the main office, which is locked and not accessible to Resident A. Ms. Markusic reported that the box contains Resident A's clothing items, which Resident A requested be mailed to the local Mission as a donation. I observed several clothing items wrapped in plastic inside the box. Ms. Markusic stated that the facility does not plan to mail the items to the Mission and instead plans to hold onto the items and eventually return them to Resident A for use. I requested that Resident A be given clothing to wear and Ms. Markusic reported that the only clothing item available today for Resident A was a dress, which was given to Resident A at my request. Ms. Markusic acknowledged that, regardless of Resident A's daily incontinence of bowel and urine, the facility must always have clothing available for Resident A to wear.

I interviewed licensee designee and administrator Mr. Bruns via telephone. Mr. Bruns stated that he is aware that Resident A is wearing bedsheets in lieu of clothing. Mr. Bruns reported that Resident A has been refusing all care, including wearing clothing. Mr. Bruns reported "we cannot violate her rights. We can't make her put clothes on."

On 8/27/2018, I interviewed CMH Case Manager, Lisa Smith, who reported that she is the case manager for Resident A. Ms. Smith reported that, per Resident A's *Behavior Assessment and Support Plan,* the facility is supposed to be providing clean clothing to Resident A on a daily basis and prompting her every four hours to change her clothing during both first shift and second shift.

On 8/27/2018, I spoke to Guardian A1 who reported that she was appointed legal guardian of Resident A on 7/27/2018. Guardian A1 reported that she did meet with Resident A on one occasion at the facility and is aware that she is wearing bedsheets as clothing. Guardian A1 reported "I can't force her to put clothes on." Guardian A1 reported that she was unaware that the facility did not have clean clothing available at all times for Resident A.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(5) A licensee shall afford a resident with opportunities, and instructions when necessary, to routinely launder clothing. Clean clothing shall be available at all times.
ANALYSIS:	On 7/14/2018, Resident A was found wandering the streets, wearing only a bedsheet. Resident A was returned to the facility by Office Akers, who observed no articles of clothing in Resident A's bedroom. Office Akers went to the local Goodwill and purchased several articles of clothing for Resident A after being informed by Ms. Rich that the facility had no clothing available for Resident A. On 8/24/2018, I conducted an onsite investigation at the facility and observed there to be no clothing items in Resident A's bedroom. I observed Resident A wearing a tank top and bedsheet, with visible signs of feces stains on her bedsheet and an overwhelming odor of urine and feces. Resident A was also holding an article of clothing with moist fecal material on it. I was informed by direct care staff members Ms. Rich and Ms. Markusic that Resident A does not have clothing because she has no money available to purchase clothing at this time. Ms. Markusic reported that the facility has purchased clothing for Resident A in the past, but that they stopped doing this because Resident A "tears clothes to shreds and throws them away." Resident A, Ms. Rich, Ms. Holman, Ms. Markusic and Mr. Bruns all acknowledged that the facility has not had clean clothing available at all times for Resident A. Based on the information above and interviews with Resident A, Ms. Rich, Ms. Holman, Ms. Markusic, Mr. Bruns, Ms. Smith and Guardian A1, the facility is not ensuring that clean clothing is available at all times for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A has not taken a shower in approximately nine months.

INVESTIGATION:

On 7/25/2018, a complaint was received, alleging that Resident A has not bathed or showered in approximately nine months. The complaint stated that on 7/14/2018, Resident A came into contact with law enforcement and smelled overwhelmingly of urine and feces.

On 7/25/2018, I received a copy of the *Otsego Police Department Summary* written by Officer Akers, dated 7/14/2018. The reported stated, in part, the following:

- I arrived at the Otsego Library, at 401 Dix St. in reference to a call placed about a female standing in the rain looking at the library sign. The called had stated she was wearing nothing but a bed sheet and appeared to be dirty, as well as covered in scabs and bruises. It should be noted that the subject was extremely skinny, covered in scabs and bruises, and the smell of urine and feces coming from her person was overpowering.
- On 7/16/2018, I made contact with the AFC home. I was able to speak with Ms. Markusic who is the home manager. Ms. Markusic reported that they are in the process with the court for petitioning for guardianship and that [Resident A] no longer wishes to live there. According to staff, [Resident A] has verbally stated that she refuses to shower for multiple reasons. One reason being that that she thinks if she refuses long enough they will kick her out of the home and let her go wherever she wishes, even though staff has advised her that this is not what will occur. The staff explained that it has been almost nine months since [Resident A] showered last.

On 8/24/2018 I conducted an onsite investigation at the facility. I reviewed Resident A's *Behavior Assessment and Support Plan*, which stated the following:

- [Resident A] requires significant prompting and assistance in completing her daily hygiene tasks. [Resident A] reports that she often has flashbacks of a traumatic incident while in the shower, and therefore, prefers taking a sponge bath. [Resident A] is often incontinent of the bladder and bowel and refuses to shower afterwards, causing sores in her groin and back areas. Female staff will attempt to check these areas regularly to ensure proper hygiene.
- [Resident A] refuses to bathe or shower for weeks to months at a time.
- Intervention: [Resident A] will have a scheduled "shower/bathing day" once a week. This day should be scheduled when a preferred staff are scheduled. [Resident A] is more likely to respond positively to staff if staff engage in her conversation not related to cleanup first. Further staff that have a good relationship with are more likely to get a positive response from her. On shower day, staff may have to be more "assertive and persistent" in order to

> get her washed. To increase the likelihood that [Resident A] will wash up and change, bring her a clean dress, a bar of soap, and washcloth and a towel. If [Resident A] won't shower, bring a bucket to rinse the washcloth in the bedroom and prompt her to wash in either the bedroom or preferably the bathroom. It is important that the previously soiled area dries to prevent a rash or skin breakdown. If [Resident A] is resistant to bathing after the first prompt, staff will prompt every hour until she complies with the request to cleanup and change that day.

I reviewed the *Homelife Incentive Program Tracking* form for the months of July 2018 and August 2018, which documented that Resident A is being prompted for bathing/showering once per day by direct care staff. The Homelife Incentive Program Tracking form did not have any records/notations documenting that Resident A had been prompted "every hour" to bathe, cleanup or change as directed in Resident A's *Behavior Assessment and Support Plan.*

I interviewed Resident A, who I found sitting outside on the side porch of the facility. I observed Resident A wearing a tank top with a bedsheet wrapped around her body. Resident A's bedsheet had visible feces stains and there was an overwhelmingly strong odor of feces and urine coming from her person. I observed Resident A holding a piece of clothing in her hand that was covered in moist wet feces. I asked Resident A what she was holding and she replied, "I had an accident and I am holding onto it until I can get it cleaned." Resident A stated that she spends most of her time outside and stated that she enjoys sitting in the grass on her blanket. Resident A showed me her blanket, which I observed to have visible feces stains on it and an overwhelming strong smell of feces and urine. There were numerous flies swarming around Resident A's blanket and her person. Resident A reported that she does not like taking showers and prefers sponge bathes. Resident A reported that she cannot remember the last time she took a shower but stated "it's been a long time."

I interviewed Ms. Markusic, who reported that Resident A was admitted to the facility on 11/29/2017 and has only taken one shower on 8/10/2018 during the time that she has resided at the facility. Ms. Markusic reported that Resident A refuses all personal care services, including showering and bathing. Ms. Markusic reported that the facility has implemented an incentive/reward program as a way to encourage Resident A to take a shower but "nothing we've tried has worked." Ms. Markusic reported that staff "can't force her to take a shower and since she didn't have a legal guardian, we didn't have a leg to stand on." Ms. Markusic reported that Interact of Michigan began making efforts to petition the court for a guardian for Resident A in February 2018 but that the guardianship was not granted until 7/27/2018. Ms. Markusic reported that the plan was to request inpatient psychiatric hospitalization for Resident A once the guardianship was granted but that Resident A took a shower on 8/10/2018 and the facility felt Resident A was making progress and that inpatient care was no longer needed. Ms. Markusic acknowledged that Resident A has been non-compliant with bathing and showering since 8/10/2018 but stated that efforts to

seek inpatient psychiatric care has not resumed. Ms. Markusic reported that Guardian A1 has vocalized an unwillingness to seek inpatient psychiatric care for Resident A.

I interviewed Ms. Rich, who reported that Resident A has been unwilling to bathe or shower and has made the comment that "showers make me sick." Ms. Rich reported that Resident A has only taken one shower during the ten months that she has resided at the facility. Ms. Rich reported that Resident A took one shower on 8/10/2018. Ms. Rich reported that she is the staff that assisted Resident A with the shower on 8/10/2018. Ms. Rich reported "I am the first and only staff that she has allowed to give her a shower." Ms. Rich stated that she used encouragement and verbal prompting to convince Resident A to shower. Ms. Rich reported that when she assisted Resident A with the shower, she observed "dried feces all over her skin." Ms. Rich reported that Resident A has reported that she cleans herself up via a sponge bath when she is alone in the bathroom, but this has not been observed by staff, and that the odor of feces and urine on Resident A's person is constant. Ms. Rich reported that Resident A spends the majority of the day outside, isolated from residents and staff. Ms. Rich reported that her interactions with Resident A are minimal and primarily consist of face-to-face interaction when she brings Resident A's meals outside. Ms. Rich reported that she prompts Resident A at least once per shift to encourage her to take a bath or shower.

I interviewed Ms. Holman, who reported that Resident A has only showered once since residing at the facility. Ms. Holman reported that Resident A is offered both sponge bathes and showers but refuses both on a consistent basis. Ms. Holman did not report that she documents each time Resident A's refuses to take a bath or shower. Ms. Holman reported that Resident A spends the majority of the day outside, isolated from residents and staff. Ms. Holman reported that her interactions with Resident A are minimal and primarily consist of face-to-face interaction when she brings Resident A's meals outside. Ms. Holman reported that it is a normal daily occurrence for Resident A to walk around wearing bedsheets covered in feces with a strong odor of urine, and that she will wear the same bedsheet for days or weeks before changing. Ms. Holman reported that Resident A is prompted "once per shift" to take a bath or shower.

I interviewed direct care staff member Mariah Barnes, who reported that she has worked at the facility since October 2017. Ms. Barnes acknowledged that Resident A has only take on shower during the ten months that she has resided at the facility. Ms. Barnes reported that Resident A "gets irritated easily" and refuses to bathe or shower. Ms. Barnes reported that Resident A is prompted to bathe and/or shower once "per shift, 1st and 2nd shift."

On 8/27/2018, I interviewed Ms. Mullins from Interact of Michigan. Ms. Mullins reported that she is aware that Resident A has refused to shower or bath for approximately ten months and stated "that's her baseline. It's not acceptable but it's her baseline. It's been difficult to care for her due to her not signing the treatment

plan. She refuses to follow the behavior treatment plan." Ms. Mullins reported "the facility was going to petition the court for an inpatient psychiatric hold but once [Resident A] took a shower, the facility recanted." Ms. Mullins reported that she did accompany Guardian A1 to the facility in July 2018 and stated that Guardian A1 told Resident A "you need to shower and change your clothes." Ms. Mullins reported that Resident A did shower on 8/10/2018 but has not showered or bathed since that time.

On 8/27/2018, I interviewed Ms. Smith from Kalamazoo Community Mental Health, who reported that she is aware of Resident A's personal hygiene issues and her refusal to take a bath or shower. Ms. Smith reported that Resident A has consistently been non-compliant with hygiene requests. Ms. Smith reported that Community Mental Health has been holding monthly meetings to discuss Resident A's care needs but Resident A continues to refuse all hygiene services. Ms. Smith acknowledged that Resident A's physical state is concerning but stated that Resident A cannot be forced to take a shower if she refuses.

I interviewed licensee designee and administrator Mr. Bruns, who reported that he is aware that Resident A has only showered one time during the ten months that she has resided at the facility. Mr. Bruns reported that Resident A "refuses all treatment." Mr. Bruns acknowledged that the physical hygiene of Resident A is concerning but stated "We can't violate her rights. We can't make her put on clothes and shower." Mr. Bruns reported that the facility has made numerous efforts to address Resident A's needs, including requesting Interact of Michigan to start the process of appointment of a legal guardian, maintain consistent contact with CMH, an incentive/reward program and adhering to the *Behavior Assessment and Support Plan*. Mr. Bruns acknowledged that the facility has been unable to meet Resident A's hygiene needs during the ten months that she has resided at the facility but stated he did not issue a 30-Day discharge notice because "I didn't want to dump this on another facility."

I interviewed Guardian A1, who reported that she is aware that Resident A has only bathed/showered once in the last ten months. Guardian A1 reported that she "cannot force [Resident A] to shower or bathe." Guardian A1 did admit that she did not want to pursue petitioning the court for an inpatient psychiatric hold for Resident A because "I wanted to see what she would do voluntarily before petitioning the court." Guardian A1 also reported that she believes Resident A does not meet the necessary criteria for an inpatient psychiatric hold.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.

ANALYSIS:	On 7/14/2018, Resident A was found wandering the streets, wearing only a bedsheet. Officer Akers reported that Resident A's person had an overpowering smell of feces and urine coming from her person. On 8/24/2018, I conducted an onsite investigation at the facility and observed Resident A wearing a tank top and bedsheet, with visible signs of feces stains on her bedsheet and an overwhelming odor of urine and feces coming from her person. Resident A was also holding a garment with moist fecal matter on it. Resident A, direct care staff members Ms. Rich, Ms. Holman, Ms. Barnes, Ms. Markusic, Ms. Mullins, Ms. Smith, licensee designee and administrator Mr. Bruns and Guardian A1 all acknowledged that from 11/29/2017 to 8/24/2018, Resident A took one shower on 8/10/2018. Mr. Bruns acknowledged that all efforts made by the facility were unsuccessful and that the facility has been unable to meet Resident A's hygiene needs yet a discharge notice was not and has not been issued. Resident A's *Behavior Assessment and Support Plan* stated that staff must prompt Resident A to shower and/or bathe every hour on a continuous basis. Based on interviews with Resident A, Ms. Rich, Ms. Holman, Ms. Barnes and a review of the *Homelife Incentive Program Tracking* document, staff are prompting Resident A once per shift, an average of twice per day, which is not every hour, as outlined in Resident A's *Behavior Assessment and Support Plan.* Based on the information above and interviews with Resident A, direct care staff members Ms. Rich, Ms. Holman, Ms. Markusic, Ms. Mullins, Ms. Smith, licensee designee and administrator Mr. Bruns and Guardian A1, the facility is not ensuring that Resident A bathes at least weekly and more often if necessary.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A is not allowed access to her personal funds.

INVESTIGATION:

On 7/25/2018, a complaint was received, alleging that on 7/14/2018 Resident A was found wandering the streets wearing only a bedsheet. The complaint stated that

Resident A believes she has close to $500.00 at the facility. The complaint stated that Resident A has requested access to her personal funds in the amount of $60.00 for approximately three weeks so that she can buy clothing and that the facility has been unwilling to comply with her request.

On 7/25/2018, I received a copy of the *Otsego Police Department Summary* written by Officer Akers, dated 7/14/2018. The reported stated, in part, the following:

- I arrived at the Otsego Library, at 401 Dix St. in reference to a call placed about a female standing in the rain looking at the library sign. I asked her if she had any clothes of her own and she told me that she did not have money on her to buy any. I then asked her if she had money back at the home and she informed me that she had close to $500.00 and had been asking for $60.00 to buy clothes for almost three weeks now but that the head caretaker refused to give it to her.
- I arrived at the 318 Hammond St. where I was able to make contact with (staff member) Tiffany Rich. I told her that I had one of the ladies that resides with them in the back of my patrol car and I needed to ask her some questions. I asked Tiffany if [Resident A] had any money and she stated that there should always be $20 in her file. It should be noted that when [Resident A's] file was opened to find her caseworkers information I did not see any money.
- On 7/16/2018, I made contact with the AFC home. I was able to speak with Ms. Markusic who is the home manager. I was informed that [Resident A] at one point had close to $200 but records at the home show that over the past few months she had given them permission to spend it on clothes for her.

On 8/24/2018, I conducted an onsite investigation at the facility. I reviewed Resident A's *Resident Funds Part II* which stated the following:

- At the beginning of August 2018, Resident A's beginning balance was $78.00. Resident A spent approximately $68.46 from 7/17/2018 through 8/8/2018 on items at Dollar General and Walmart. The Resident Funds Part II states that Resident A was given access to her personal funds on 7/17/2018, 7/24/2018, 8/2/2018, 8/7/2018, and 8/8/2018. Resident A's current balance in her fund account as of 8/24/2018 is approximately $9.84.

I interviewed Resident A, who reported that she believed that she had close to $500.00 at the facility but acknowledged that she wasn't sure how much money she has spent over the past several months. Resident A acknowledged that she may have less money that she thought and that "sometimes I forget things." Resident A stated that she has been given access to her personal funds on many occasions over the last two months. Resident A reported that she asked Ms. Rich and Ms. Markusic, over the last three weeks, to have access to her funds "but they never gave me my money." Resident A reported that she wanted the money so that she could buy clothing. Resident A reported that as of today, she has not received the money from her fund account as she has requested.

I interviewed Ms. Rich, who reported that on 8/22/2018, Resident A did approach her and ask for assistance with calling the Salvation Army to obtain clothing items. However, Ms. Rich denied that Resident A asked her for access to her personal funds. Ms. Rich reported that Resident A's only request was for assistance in obtaining donation clothing from the Salvation Army due to not having sufficient funds in her account to purchase new clothing.

I interviewed Ms. Markusic, who reported that she has always provided Resident A with access to her person funds when requested. Ms. Markusic reported that she is unaware that Resident A made a request for access to her personal funds. Ms. Markusic acknowledged that Resident A has only $9.84 in her personal funds account, which would not be sufficient to purchase an adequate supply of clothing. Ms. Markusic stated that she is unaware of a time when Resident A's request for access to her personal funds was denied.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(7) A resident shall have access to and use of personal funds that belong to him or her in reasonable amounts, including immediate access to not less than $20.00 of his or her personal funds. A resident shall receive up to his or her full amount of personal funds at a time designated by the resident, but not more than 5 days after the request for the funds. Exceptions to this requirement shall be subject to the provisions of the resident's assessment plan and the plan of services.
ANALYSIS:	Resident A's *Resident Funds Part II* states that Resident A was given access to her personal funds on 7/17/2018, 7/24/2018, 8/2/2018, 8/7/2018, and 8/8/2018. Resident A's current balance in her fund account as of 8/24/2018 is approximately $9.84. Resident A acknowledged that she has been given access to her personal funds on a consistent basis and admitted that she is unsure how much money she has left in her account. Both Ms. Rich and Ms. Markusic denied that they refused to allow Resident A to have access to her personal funds. Based on a review of Resident A's *Resident Funds Part II* form and interviews with Resident A, Ms. Rich and Ms. Markusic, there is not information to confirm that the facility has denied Resident A access to her personal funds.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's bedroom and the common areas of the home are not maintained to provide adequately for the health and safety of occupants.

INVESTIGATION:

On 7/25/2018, a complaint was received, alleging that the facility does not clean Resident A's bedroom. The complaint stated that Resident A's bedroom was observed by law enforcement on 7/14/2018, and that there were puddles of urine as well as spots where urine and feces had dried on the floor, spread throughout the bedroom.

On 7/25/2018, I received a copy of the *Otsego Police Department Summary* written by Officer Akers, dated 7/14/2018. The reported stated, in part, the following:

- I arrived at 318 Hammond St. where I was able to make contact with {staff member} Tiffany Rich. I told her that I had one of the ladies that resides with them in the back of my patrol car and I needed to ask her some questions.
- I walked [Resident A] inside to help her cover up with another blanket and she whispered to me to look at her room. I asked the staff if I could do so and they agreed to let me look. Inside her room, spread throughout the room were puddles of urine, as well as spots where urine and feces had dried on the floor.

On 7/26/2018, I spoke to APS Worker, Kathleen Woodworth. Ms. Woodworth reported that she conducted an onsite investigation at the facility on 7/26/2018. Ms. Woodworth reported "it did appear to me that the AFC home is trying to work with [Resident A] and do everything in their power to assist her and provide proper care to her. She has just been a very difficult resident and refuses everything."

On 8/24/2018, I conducted an onsite investigation at the facility. I reviewed Resident A's *Behavior Assessment and Support Plan* dated 6/19/2018, which stated in part, the following:

- When [Resident A] is incontinent of bowel, she appears to attempt to clean it up herself, however, this results in smearing feces on her floor and walls. [Resident A] then becomes resistant to allow staff to clean her room. On several occasions, she has barricaded the door with her dresser or herself in an attempt to keep staff from cleaning her room. She has stated that she does not like the cleaning agents used in her room as the reason she doesn't want her room cleaned.
- [Resident A's] roommate had made a complaint regarding the poor smell of the room due to her incontinence and lack of hygiene. (Resident A has since been given a private bedroom).

- Target Behavior to address clothing: At least once on 1st shift and once on 2nd shift, (staff will) check [Resident A's] room for soiled items such as a blanket with feces in it, smeared feces on the floor or wall, or urine on the floor. If the floor or wall is soiled, clean the floor or wall with the appropriate cleaning solution. [Resident A] has been resistant to allowing staff in the room, therefore it may be beneficial for staff to check her room and clean it as necessary when she is not in the room. Staff must document once per shift that they checked her room and must document whether her room was clean or soiled, and whether staff cleaned her room or not.
- If staff suspect that [Resident A] is hiding fecal matter or soiled items as evidenced by a malodorous smell whose origin cannot be found, staff may conduct a room search per KCMHSAS administrative policy 24.15.

I reviewed the *[Resident A] Soiled Clothing/Linen Tracking* document for the month of July 2018, which did not contain any documentation to confirm that staff checked Resident A's bedroom at least once per shift during the month of July 2018 or prior to July 2018.

I reviewed the *[Resident A] Soiled Room/Clothing/Linen Tracking* document for the month of August 2018, which stated that staff did check Resident A's bedroom once during 1st shift and once during 2nd shift from the dates of 8/7/2018 – 8/20/2018. The document stated that staff did not observe Resident A's bedroom to be soiled, and therefore, did not clean her bedroom from 8/7/2018 – 8/20/2018. The document gives the option to write an "R" on days that Resident A refused to allow staff to clean her bedroom, and during the dates of 8/7/2018 – 8/20/2018, staff documented that Resident A did not refuse to allow them to clean her bedroom. I was unable to find documentation to confirm that the facility conducted visual checks of Resident A's bedroom from 8/21/2018 – 8/23/2018.

I observed Resident A's bedroom to have an overwhelmingly strong odor of feces and urine. I observed approximately 25 flies in Resident A's bedroom, resting on her flooring, walls, dresser and bed. I observed the bedroom window to be open, with no screen in place. I observed dried areas of brown spotting on the floor, which I believed to be dried feces. I did not observe puddles of urine on the floor but I did smell the overpowering odor of urine in the bedroom that appeared to be coming from both the bed and the floor.

I interviewed Resident A, who I found sitting outside on the side porch of the facility. I observed Resident A wearing a tank top with a bedsheet wrapped around her body. Resident A's bedsheet had visible feces stains and there was an overwhelmingly strong odor of feces and urine coming from her person. I observed Resident A holding a piece of clothing in her hand that was covered in moist wet feces. I asked Resident A what she was holding and she replied, "I had an accident and I am holding onto it until I can get it cleaned." There were numerous flies swarming around Resident A's person. Resident A reported that she has asked staff to clean her bedroom but "they don't like going in there." Resident A reported that

she is in agreement with having her bedroom cleaned. Resident A and I went to walk into the facility, and I allowed her to enter the facility first. Directly after Resident A entered the facility, I used a blank piece of white paper to turn the door handle and observed wet feces on the paper.

I interviewed Resident B, who reported that he has had concerns related to Resident A's hygiene. Resident B reported that Resident A "has been in the same room as me and other residents, in the kitchen and dining room, and she (Resident A) smells really bad." Resident B reported that Resident A "smells like poop and she stinks a lot." Resident B reported that he vocalized his concerns to direct care staff and they told him "You have to put up with it."

I interviewed Ms. Rich, who reported that Resident A's current bedroom condition is how the bedroom normally looks on a daily basis. Ms. Rich reported that Resident A does not like for staff to clean her bedroom and "does not give us permission to clean it." Ms. Rich stated that Resident A "used to smear feces on walls, doors, and herself." Ms. Rich reported that, in the past, Resident A has barricaded herself in her bedroom by placing a dresser behind the bedroom door or her person against the door to keep staff out of the bedroom. Ms. Rich acknowledged that on 7/14/2018, when Officer Akers came to the facility, at approximately 12:20pm, Resident A's bedroom was observed to have feces and urine on the floor. Ms. Rich reported "we can't violate her rights. We can't clean her room without her permission" Ms. Rich reported that "cleaning her room makes her upset. If we clean her room, she will take off and leave the facility." Ms. Rich reported that on at least one occasion, Resident A smeared feces on the walls of the common areas of the facility as a way to show her anger after staff cleaned her bedroom. Ms. Rich reported that the facility does have an incentive program that they utilize to encourage Resident A to "allow staff to clean her bedroom but it doesn't work." Ms. Rich reported that Resident A's bedroom has not been cleaned by staff since 8/3/2018, approximately three weeks.

I interviewed Ms. Holman, who reported that Resident A's bedroom "always smells like feces and urine." Ms. Holman reported that in addition to Resident A being incontinent of urine and feces and refusing to bathe/shower or change her clothing, she also will urinate or have bowel movements in her bedroom and outside in the yard. Ms. Holman reported that it is common for Resident A to smear feces on her bedroom walls or place feces in the vents of her bedroom. Ms. Holman reported "we try to clean her bedroom but she won't let us."

I interviewed Ms. Markusic, who reported that Resident A refuses to allow direct care staff clean her bedroom. Ms. Markusic acknowledged that the condition of Resident A's bedroom was not maintained in an acceptable and sanitary manner. Ms. Markusic reported that staff are "supposed to check her [Resident A's] room twice per shift to check to see if the room needs to be cleaned but she [Resident A] doesn't wake up until noon most days so (staff) don't check her room until the second half of second shift." Ms. Markusic reported that staff prompt Resident A on a daily basis and "ask for her permission to clean her room but she refuses." Ms.

Markusic reported that Resident A has barricaded herself in her bedroom in the past when she has not wanted staff to clean her room. Ms. Markusic reported “we (staff) have to decide if cleaning her room will send her into crisis and the risk of elopement is more serious than making sure her room is clean.” I advised Ms. Markusic of the importance of cleaning Resident A’s bedroom immediately, as the current condition of the bedroom was unacceptable. I informed Ms. Markusic that I spoke to Resident A, who stated that she wants staff to clean her bedroom and is in agreement with it being done immediately. Ms. Markusic informed direct care staff that they could clean Resident A’s bedroom and three staff cleaned Resident A’s bedroom prior to my departure from the facility.

On 8/27/2018, I interviewed Ms. Mullins from Interact of Michigan. Ms. Mullins reported that, per the *Behavior Assessment and Support Plan* dated 6/19/2018, that it was her understanding that direct care staff were “cleaning [Resident A’s] bedroom on a daily basis or whenever urine or feces were observed or evidenced by odor, during each shift.” Ms. Mullins reported that she was unaware that Resident A’s bedroom had not been cleaned in approximately three weeks.

On 8/27/2018, I spoke to Guardian A1. Guardian A1 reported that she did meet with Resident A on one occasion at the facility and is aware of Resident A’s personal hygiene issues and the bedroom condition. Guardian A1 reported that she was not aware that the facility was not consistently cleaning Resident A’s bedroom as outlined in the *Behavior Assessment and Support Plan*.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	On 7/25/2018, Officer Akers observed Resident A's bedroom to have puddles of urine, as well as spots where urine and feces had dried on the floor, spread throughout the room. On 8/24/2018, I conducted an onsite investigation at the facility and I observed Resident A's bedroom to have an overwhelmingly strong odor of feces and urine. I observed approximately 25 flies in Resident A's bedroom, resting on her flooring, walls, dresser and bed. I observed the bedroom window to be open, with no screen in place. I observed dried areas of brown spotting on the floor, which I believed to be dried feces. Resident A's bedroom had the overpowering odor of urine that appeared to be coming from both the bed and the floor. Ms. Rich, Ms. Holman and Ms. Markusic all reported that they are unable to clean Resident A's bedroom on a daily basis or as needed, because Resident A refuses to allow them to clean her bedroom. Ms. Rich reported that as of 8/24/2018, Resident A's bedroom had not been cleaned by staff in approximately three weeks. Ms. Markusic acknowledged that staff will not clean Resident A's room if they determine that the risk of elopement is more serious than making sure Resident A's room is cleaned. Based on the information above, the facility has not been properly maintaining and cleaning Resident A's bedroom, thereby allowing Resident A to continuously be exposed to, and sleep in an area, that contains fecal matter and urine on an ongoing basis. Additionally, the facility has allowed all residents to be at risk of coming into contact with feces throughout the common areas of the facility, such as seating, door handles, etc.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A does not have clean bedding that is in good condition.

INVESTIGATION:

On 7/25/2018, a complaint was received, alleging that the facility is not providing Resident A with clean bedding in good condition. The complaint stated that Resident A's bedroom was observed by law enforcement on 7/14/2018, and that Resident A's bed did not have bed linens.

On 7/25/2018, I received a copy of the *Otsego Police Department Summary* written by Officer Akers, dated 7/14/2018. The reported stated, in part, the following:

- I arrived at 318 Hammond St. where I was able to make contact with (staff member) Tiffany Rich. I told her that I had one of the ladies that resides with them in the back of my patrol car and I needed to ask her some questions.
- I walked [Resident A] inside to help her cover up with another blanket and she whispered to me to look at her room. I asked the staff if I could do so and they agreed to let me look. Inside her [Resident A's] room was one mattress with no sheets.

On 8/24/2018, I conducted an onsite investigation at the facility. I reviewed Resident A's *Behavior Assessment and Support Plan* dated 6/19/2018, which stated in part, the following:

- [Resident A] also wraps a blanket around her waist and wears it for days/weeks at a time while it is soiled. She is resistant to giving staff the soiled blanket and using a new one. At times, the blanket retains a malodorous smell even after being washed and does have to be thrown out.
- Target Behavior to address clothing: When [Resident A's] blanket is soiled and staff request that she give it to staff (and replace it with a new one) to be washed and she refuses. This is tracked daily on first and second shift. If staff observe that [Resident A] has a soiled blanket wrapped around her, bring her a clean blanket and let her know that she has to "change blankets." For instance, staff may say "[Resident A], I really need to wash that blanket, here is a new one." Offer to help remove the soiled blanket while motioning to take it. If [Resident A] adamantly refuses, document accordingly.

I reviewed the *[Resident A] Soiled Clothing/Linen Tracking* document for the month of July 2018, which did not contain any documentation to confirm that staff checked Resident A's bedroom at least once per shift during the month of July 2018 or prior to July 2018. The sheet did not list any information related to cleaning and replacing bed linens for Resident A's bed. The *[Resident A] Soiled Clothing/Linen Tracking* document only referenced bed linens as it related to offering Resident A new bed linens to wear on her person as a clothing item.

I reviewed the *[Resident A] Soiled Room/Clothing/Linen Tracking* document for the month of August 2018, which stated that staff did check Resident A's bedroom once during 1st shift and once during 2nd shift from the dates of 8/7/2018 – 8/20/2018. The *[Resident A] Soiled Room/Clothing/Linen Tracking* document only referenced bed linens as it related to offering Resident A new bed linens to wear on her person as a clothing item. I was unable to locate any documentation related to the changing and replacing of bed linens to Resident A's bed.

I observed Resident A's bedroom to have an overwhelmingly strong odor of feces and urine. I observed one twin size bed in the room, covered with a mattress pad. I

observed the mattress pad to have dried areas of brown spotting, which I believed to be dried feces. There was an overwhelming odor of feces and urine coming from the bed. I observed approximately five flies resting on Resident A's bed. I did not observe a bed linen, blanket or pillow in Resident A's bedroom.

I interviewed Resident A, who I found sitting outside on the side porch of the facility. I observed Resident A wearing a tank top with a bedsheet wrapped around her body. Resident A's bedsheet had visible feces stains and there was an overwhelmingly strong odor of feces and urine coming from her person. Resident A showed me her blanket, laying on the ground next to her, which I observed to have visible feces stains on in it and an overwhelming strong smell of feces and urine coming from the blanket. There were numerous flies swarming around Resident A's person as well as her blanket. Resident A reported that she would like to have clean sheets placed in her bed but "staff won't give me any." Resident A reported that she does get feces and urine on her bedding and blankets and "that's why they {staff} won't give me new sheets for my bed or a clean blanket." Resident A stated that it is normal for her to only have a mattress pad on her bed. Resident A reported that the blanket she is currently using to lay on outside is one that she has had for "a long time." Resident A reported that she does not like pillows and does not want any in her bedroom.

I interviewed Ms. Rich, who reported that Resident A's current bedroom condition is how the bedroom normally looks on a daily basis. Ms. Rich acknowledged that on 7/14/2018, when Officer Akers came to the facility, at approximately 12:20pm, Resident A's bed did not have a bed linen. Ms. Rich reported "[Resident A] won't like sheets or pillows on her bed." Ms. Rich acknowledged that Resident A is not provided a bed linen for her mattress and that the only item on the mattress is the mattress protector. Ms. Rich reported that the blanket that Resident A is currently using is one that she has been using for several days. Ms. Rich reported that Resident A "refuses to give us the blanket." Ms. Rich reported that as of 8/24/2018, Resident A's bedroom had not been cleaned by staff in approximately three weeks.

I interviewed Ms. Holman, who reported that Resident A's bed only has a mattress protector on it. Ms. Holman reported that Resident A is not provided a bed linen, except as a clothing item. Ms. Holman reported that Resident A is incontinent of urine and feces, refuses to bathe/shower, and will will urinate or have bowel movements in her bedroom. Ms. Holman reported that it is common for Resident A to use a blanket that has feces and urine on it. Ms. Holman reported "we try to clean her bedroom but she won't let us."

I interviewed Ms. Markusic, who reported that Resident A refuses to allow direct care staff clean her bedroom. Ms. Markusic acknowledged that the condition of Resident A's mattress protector and blanket were not maintained in an acceptable and sanitary manner. Ms. Markusic reported that Resident A does not want bed linens or pillows in her bedroom. I advised Ms. Markusic of the importance of replacing Resident A's mattress protector and blanket with clean ones, in addition to placing

bed linens on Resident A's bed. I informed Ms. Markusic that I spoke to Resident A, who stated that she did want staff to provide her with a clean bed linen, blanket and mattress protector, which Ms. Markusic provided prior to my departure from the facility.

On 8/27/2018, I interviewed Ms. Mullins from Interact of Michigan. Ms. Mullins reported that, per the *Behavior Assessment and Support Plan* dated 6/19/2018, that it was her understanding that direct care staff were "cleaning [Resident A's] bedroom on a daily basis and replacing soiled linens on an ongoing basis." Ms. Mullins reported that she was unaware that Resident A's mattress protector contained visible feces stains and an overwhelming urine odor, and that the facility was not providing a clean bed linen and blanket daily and as needed.

On 8/27/2018, I spoke to Guardian A1. Guardian A1 reported that she did meet with Resident A on one occasion at the facility and is aware of Resident A's personal hygiene issues and the bedroom condition. Guardian A1 reported that she was not aware that the facility was not consistently cleaning Resident A's bedroom and providing clean linens and blankets as outlined in the *Behavior Assessment and Support Plan*.

APPLICABLE RULE	
R 400.14411	**Linens.**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillow case, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.

ANALYSIS:	On 7/25/2018, Officer Akers observed Resident A's bedroom to have one bed mattress with no sheets. On 8/24/2018, I conducted an onsite investigation at the facility and I observed Resident A's bedroom to have one twin size bed, with a mattress protector and no bed linens, pillows, or blanket. Resident A's bed had the overpowering odor of urine and feces and I observed brown spots throughout the mattress protector, which I believed to be dried feces stains. I observed Resident A, outside, resting on her blanket, which had an overwhelming odor of feces and urine as well as numerous brown spots, which I believed to be dried feces stains. Ms. Rich, Ms. Holman and Ms. Markusic all reported that Resident A does not want bed linens or pillows on her bed and refuses to give staff her soiled blanket. However, Resident A reported that she does want clean bed linens/bedding and a clean blanket but these requests have been denied by staff. Ms. Rich reported that as of 8/24/2018, Resident A's bedroom had not been cleaned by staff in approximately three weeks. Ms. Markusic acknowledged that Resident A should be provided a clean mattress protector and clean bed linens for her bed. Ms. Markusic agreed to place a clean mattress protector and clean bed linen on Resident A's bed and also agreed to provide Resident A with a clean blanket, all of which we done prior to my departure from the facility. Based on the information above, the facility has not been provided Resident A with clean bedding that is in good condition, including clean bed linens, a clean mattress protector, and a clean blanket.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 8/24/2018, during on onsite investigation, I observed approximately 25 flies in Resident A's bedroom, resting on her flooring, walls, dresser and bed. I observed the bedroom window to be open, with no screen in place.

I interviewed Ms. Holman, who reported that Resident A's bedroom has a large number of flies due to the bedroom window not having a window screen in place.

Ms. Holman reported that she is uncertain of exactly how long the window screen has been missing but stated “it’s been a while.”

I interviewed Ms. Markusic, who reported that Resident A “popped the screen out and hid it somewhere.” Ms. Markusic reported that the facility has made no efforts to replace the screen because “[Resident A] will just take it out again.” Ms. Markusic acknowledged that the lack of a window screen is allowing for a large number of flies, as well as other insects, to enter into the facility. Ms. Markusic agreed to replace the window screen, which she did prior to my departure from the facility.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(7) Each habitable room shall have direct outside ventilation by means of windows, louvers, air-conditioning, or mechanical ventilation. During fly season, from April to November, each door, openable window, or other opening to the outside that is used for ventilation purposes shall be supplied with a standard screen of not less than 16 mesh.
ANALYSIS:	On 8/24/2018, I conducted an onsite investigation and observed Resident A’s bedroom window did not have a screen in place. Ms. Holman and Ms. Markusic acknowledged that the facility was aware that Resident A’s bedroom window was missing a screen. Ms. Markusic agreed to place a screen in Resident A’s bedroom window prior to my departure from the facility on 8/24/2018.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/28/2018, I conducted an Exit Conference with Mr. Bruns. Mr. Bruns is not in agreement with the recommendation of revocation of the license.

IV. RECOMMENDATION

Due to the severity of the violations, revocation of the license is recommended.

9/26/2018

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Stephanie Gonzalez Date
Licensing Consultant

Approved By:

09/26/2018

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Dawn N. Timm Date
Area Manager