RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

November 14, 2018

Scott Schrum
Residential Opportunities, Inc.
1100 South Rose Street
Kalamazoo, MI 49001

RE: License #: AS390314010
Investigation #: **2018A0462058**
Hill an Brook AFC

Dear Mr. Schrum:

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.

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 (616) 356-0183.

Sincerely,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 251-9037

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390314010
Investigation #:	2018A0462058
Complaint Receipt Date:	09/18/2018
Investigation Initiation Date:	09/19/2018
Report Due Date:	11/17/2018
Licensee Name:	Residential Opportunities, Inc.
Licensee Address:	1100 South Rose Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-3731
Administrator:	David Steadman
Licensee Designee:	Scott Schrum
Name of Facility:	Hill an Brook AFC
Facility Address:	2702 Hill an Brook Dr. Portage, MI 49024
Facility Telephone #:	(269) 488-0977
Original Issuance Date:	10/17/2011
License **Status:**	REGULAR
Effective Date:	04/28/2018
Expiration Date:	04/27/2020
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care workers leave Resident A in urine-soaked clothing and bedding.	No
A prescription pill was found on Resident B's stuffed animal without any explanation of why or how it got there.	Yes
"Undercooked" meat was served to residents in the facility.	No
A direct care worker "forcibly" pulled Resident C into Resident A's bedroom and tried to start a fight between Residents A and C.	No
A direct care worker verbally and physically mistreated Resident A resulting in Resident A punching a window and injuring his hand.	Yes

III. METHODOLOGY

09/18/2018	Special Investigation Intake 2018A0462058
09/19/2018	Special Investigation Initiated – Telephone Interview with Kalamazoo County Recipient Rights Officer Michele Schiebel.
09/25/2018	Contact - Telephone interview with Kalamazoo County Recipient Rights Officer Michele Schiebel.
09/25/2018	Contact - Face to Face interviews with program manager Bev Reed, DCW Katelynn Salisbury, Kiyondra Edmonds, Ajani Rodgers and Arrion Hill.
09/27/2018	Requested documentation from program director Bev Reed.
09/28/2018	Received requested documentation via fax.
10/05/2018	Received a referral from Kalamazoo County APS.
10/09/2018	Contact - Face to Face interviews with assistant manager Carla Beltron, administrator David Steadman and DCW Andre Wilson.
10/09/2018	Investigation completed On-site. Interviews with Residents A and C.
10/12/2018	Received an email from program director Bev Reed.
11/14/2018	Exit conference with licensee designee Scott Schrum.

ALLEGATION:

Direct care workers leave Resident A in urine-soaked clothing and bedding.

INVESTIGATION:

On 09/18/2018 the Bureau of Community and Health Systems (BCHS) received this compliant through the BCHS' on-line complaint system.

On 09/19 I conducted a telephone interview with Kalamazoo County recipient rights officer Michele Schiebel who informed me that she was conducting an investigation regarding this allegation.

On 09/25 I met Ms. Schiebel at Residential Opportunities, Inc.'s (ROI) administrative office and together we interviewed direct care worker (DCW) Katelynn Salisbury. Ms. Salisbury explained that she worked at a different facility owned and operated by ROI. However, she was asked to cover open shifts at the facility on 09/03, 09/04, 09/05 and 09/10 from 1:00 PM to 9:00 PM. Ms. Salisbury stated that upon reporting to the facility on these dates Resident A was always soaked with urine. Ms. Salisbury stated that on one occasion while walking down the hallway to Resident A's bedroom, she could smell urine. Ms. Salisbury stated that she notified DCWs Kiyondra Edmonds and Ajani Rodgers that Resident A needed to be changed and was told that they were waiting for Resident A to get up from resting. Ms. Salisbury stated that after notifying Ms. Edmonds and Ms. Rodgers, a different DCW by the name of Sharnita Williams eventually got Resident A up, showered and changed his soiled brief. Ms. Salisbury stated that she reported this allegation to administrator David Steadman who then verbally reprimanded Ms. Edmonds and Ms. Rodgers.

Ms. Schiebel and I conducted separate interviews with DCWs Kiyondra Edmonds, Ajani Rodgers and Arrion Hill. Ms. Edmonds, Ms. Rogers and Ms. Hill all stated that Resident A used the bathroom independently but also wore an adult brief for added protection. Ms. Edmonds stated that when Resident A had an accident DCWs would ask Resident A if he wanted assistance with changing his brief. Ms. Edmonds stated that Resident A would almost always initially refuse to change his brief and/or decline assistance. However, when prompted a few times, Resident A would eventually either change his brief on his own or allow a DCW to assist him. Ms. Edmonds stated that Resident A typically had accidents in the evening time. According to Ms. Edmonds, because DCWs could not force Resident A to change his brief and/or accept assistance, DCWs would often offer to make Resident A an evening snack after he changed his brief and/or allowed a DCW to assist him. Ms. Edmonds also stated that upon waking up every morning Resident A was always urine-soaked. Resident A enjoyed hot cereal and DCWs would often offer to make Resident A his favorite breakfast after he showered and put a clean brief on. Ms. Rodgers stated that it was difficult to convivence Resident A to comply when he didn't want to do something, and that Resident A's urine had a strong order and could be smelled throughout the facility. Both Ms. Edmonds and Ms. Rodgers stated

that Ms. Salisbury never spoke to them about Resident A being urine-soaked and denied that Mr. Steadman ever addressed this allegation with them. Ms. Edmonds stated that the few times she worked with Ms. Salisbury, Ms. Salisbury "didn't do much" and "waited until everything was done and then offered to help." Both Ms. Rodgers and Ms. Hill also stated that Ms. Salisbury offered no help to her fellow DCWs when filling in at the facility.

I requested Resident A's *Assessment Plan for AFC Residents* (assessment plan). Documentation on Resident A's assessment plan indicated that Resident A was able to complete a variety of self-help skills on his own and Resident A toileted himself. However, if Resident A had a seizure he sometimes wore a "pull-up" and required increased staff assistance until he was able to toilet himself again. Documentation on Resident A's assessment plan indicated that since returning from rehabilitation Resident A required more assistance with toileting using a pivot transfer. Documentation on Resident A's assessment plan indicated that Resident A disliked being rushed.

I requested Resident A's Kalamazoo County Community Mental Health treatment plan. Documentation on Resident A's treatment plan indicated that DCWs were to remind Resident A that it was time to complete a hygiene task. Based on Resident A's level of abilities, which varied daily, DCWs were to offer opportunities for Resident A to participate as able and tolerated in all personal care tasks. Documentation on Resident A's treatment plan indicated that DCW may be required to provide full hands on assistance as needed.

On 10/09 I met Ms. Schiebel at ROI's administrative office and together we interviewed assistant home manager Carla Beltran, administrator David Steadman and DCW Andre Wilson. Ms. Beltran confirmed that Resident A was able to use the bathroom independently. However, according to Ms. Beltran Resident A occasionally preferred to go in his brief. Ms. Beltran stated that DCWs prompted Resident A to change his soiled brief and sometimes Resident A refused. Ms. Beltran stated that some DCWs were better than others at convincing Resident A to change his brief and to shower. According to Ms. Beltran, on a few occasions both Ms. Edmonds and Ms. Rodgers informed her that they tried convincing Resident A to change his soiled brief and/or to shower but were unsuccessful. Ms. Beltran stated that on those occasions she attempted and was eventually successful. Mr. Steadman confirmed that Ms. Salisbury reported this allegation to him on two different occasions and stated that he did address the issue with both Ms. Edmonds and Ms. Rodgers. Mr. Steadman also confirmed the statements made by Ms. Beltran and stated that it wouldn't be uncommon for Resident A's brief to be soiled. Mr. Steadman stated that his office was in the basement of the facility. However, he made himself present in the residents' living area approximately five times a day. Mr. Steadman stated that he had a strong relationship with Resident A and when others couldn't convince him to change his brief and/or shower, Mr. Steadman was successful. Mr. Steadman stated that while some DCWs' work performance could improve, he believed Resident A was not left in urine-soaked clothing and bedding and residents at the

facility were cared for. Mr. Wilson's statements were consistent with the statements provided to me by Ms. Beltran and Mr. Steadman. Mr. Wilson stated that he was always eventually able to convince Resident A to change his soiled brief and/or to take a shower.

Ms. Schiebel and I conducted an investigation at the facility and attempted to interview Resident A in his bedroom. Due to Resident A's developmental disability he was unable to answer questions regarding this allegation. Ms. Schiebel and I observed that Resident A, as well as his bedding and linens, were not urine-soaked. Resident A's bedroom did not smell of urine.

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:	It has been established that Resident A can use the bathroom independently but sometimes has accidents and/or prefers to go to the bathroom in his adult brief. Resident A dislikes being rushed and often refuses to change his soil brief and/or accept assistance. However, with several prompts from different DCWs, DCWs are eventually able to convince Resident A to change his soil brief and/or accept assistance with personal hygiene. Based upon my investigation, which included interviews with DCWs Katie Salisbury, Kiyondra Edmonds, Ajani Rodgers, Arrion Hill and Andre Wilson, assistant home manager Carla Beltron and administrator David Steadman, as well as an observation of Resident A and his bedroom, there is not enough evidence to substantiate the allegation that DCWs leave Resident A in urine-soaked clothing and bedding.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

A prescription pill was found on Resident B's stuffed animal without any explanation of why or how it got there.

INVSTIGATION:

This allegation was indicated in the written complaint.

During our interview on 09/25, Ms. Salisbury stated that while working at the facility on 09/05 she discovered one Klonopin tablet on Resident B's stuff animal. Ms. Salisbury stated that she questioned Ms. Edmonds and Ms. Rodgers who were both unable to provide any information regarding the found medication. Ms. Salisbury stated that she took the medication to Mr. Steadman who instructed her to complete an AFC Licensing Division-Incident/Accident Report (IR).

I reviewed a copy of an IR written by Ms. Salisbury and Mr. Steadman on 09/05 and 09/06. Documentation on the IR indicated that at 3:40 PM on 09/05 Ms. Salisbury found one 0.5mg Klonopin tablet on Resident B's stuffed Santa Clause doll. Documentation on the IR indicated that Resident B was prescribed this medication and it was unclear how long the medication was on Resident B's stuff Santa Clause. Documented on the IR indicated that the medication was disposed of and DCWs would continue to notify the office of recipient rights when a medication error occurred.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Documentation on an IR written by DCW Katelynn Salisbury and administrator David Steadman on 09/05 and 09/06 were consistent with the statements provided to me by Ms. Salisbury during my interview with her on 09/25. There is enough evidence to substantiate the allegation that a prescription pill was found on Resident B's stuffed animal without any explanation of why or how it got there.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

"Undercooked" meat was served to residents in the facility.

INVESTIGATION:

This allegation was indicated in the written complaint.

During an interview on 09/25, Ms. Salisbury stated that on one occasion while working in the facility Ms. Edmonds cooked hamburgers for the residents. Ms. Salisbury stated that she took a bite of a hamburger and notice it was raw. According to Ms. Salisbury she reported this to Ms. Edmonds who stated, "it's fine, I know what I am doing."

During interviews on 09/25, Ms. Edmonds, Ms. Rodgers and Ms. Hill all stated that Ms. Edmonds did most of cooking at the facility. Ms. Edmonds denied this allegation and stated that Ms. Salisbury never mentioned anything to her about undercooked hamburgers. Both Ms. Rodgers and Ms. Hill stated that they had no knowledge of the allegation and had never witnessed any undercooked meat served at the facility.

During interviews on 10/09, both Ms. Beltran and Mr. Steadman confirmed that Ms. Edmonds did most of the cooking in the home and stated they had never observed undercooked meat served at the facility. Both Ms. Beltran and Mr. Steadman stated that besides this allegation, they had received no previous reports of undercooked meat served at the facility.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based upon my investigation, which included interviews with DCWs Katie Salisbury, Kiyondra Edmonds, Ajani Rodgers and Arrion Hill, assistant home manager Carla Beltron and administrator David Steadman, there is not enough evidence to substantiate the allegation that “undercooked” meat was served to residents in the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

A direct care worker “forcibly” pulled Resident C into Resident A’s bedroom and tried to start a fight between Residents A and C.

INVESTIGATION:

This allegation was indicated in the written complaint.

During an interview on 09/25, Ms. Salisbury stated that on 09/04 Resident A had a “bad day.” Ms. Salisbury reported that Resident A was yelling profanities from his bedroom when Ms. Rodgers, in an attempt to “rile Resident C up”, grabbed Resident C by the arm and pulled him towards Resident A bedroom. However, according to Ms. Salisbury, Ms. Rodgers did not pull Resident A into Resident C’s bedroom as alleged in the written complaint.

During an interview on 09/25, Ms. Edmonds further explained that it was common for Resident A to use bad language when he was upset and confirmed that on 09/04 Resident A yelled profanities from his bedroom. Ms. Edmonds stated that Resident

C asked Ms. Rodgers to address Resident A's behavior. Ms. Edmonds stated that Ms. Rodgers "jokingly" grabbed Resident C by arm and told him, "you go tell [Resident A] to calm down." Ms. Edmonds denied the allegation Ms. Rodgers tried to "rile Resident C up" and/or "forcibly" pulled Resident C into Resident A's bedroom. According to Ms. Edmonds, during this exchange both Ms. Rodgers and Resident C smiled and laughed.

During an interview with Ms. Rodgers on 09/25, Ms. Rodgers confirmed that on 09/04 Resident A yelled profanities from is bedroom. Ms. Rogers stated that Resident C told her to "tell [Resident A] to calm down." According to Ms. Rodgers she grabbed Resident C's arm and said, "I don't want to go back there. Do you want to go back there with me?" Ms. Rodgers denied the allegations that she tried to "rile Resident C up" and/or "forcibly" pulled Resident C into Resident A's bedroom.

During an interview on 09/25, Ms. Hill stated that she did not witness the alleged incident. Ms. Hill stated that it was normal for Resident A to use bad language when he had a bad day, and sometimes his behavior upset other residents. According to Ms. Hill, Resident C was a "goofy, fun guy." Ms. Hill stated that she believed Ms. Rodgers was more than likely "joking and playing" with Resident C.

During an on-site investigation on 10/09, Ms. Schiebel and I attempted to interview Resident C. However, Resident C did not recall the incident.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based upon my investigation, which included interviews with DCWs Katie Salisbury, Kiyondra Edmonds, Ajani Rodgers and Arrion Hill, as well an interview with Resident C, there is not enough evidence to substantiate the allegation that Ms. Rodgers "forcibly" pulled Resident C into Resident A's bedroom and tried to start a fight between Residents A and C.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

A direct care worker verbally and physically mistreated Resident A resulting in Resident A breaking a window and obtaining an injury to his hand.

INVESTIGATION:

On 09/25 I conducted a telephone interview with Ms. Schiebel who informed me that according to an IR submitted to the Kalamazoo County Office of Recipient Rights, this allegation occurred on 09/24.

During an interview on 09/25, Ms. Edmonds stated that on 09/24 she was cooking dinner when Resident A, who often ambulated by crawling on the floor, approached Ms. Edmonds in the kitchen. According to Ms. Edmonds, Ms. Rodgers told Resident A to leave the kitchen. Resident A became upset and tried to bite Ms. Rodgers's ankles. Ms. Edmonds stated that instead of leaving Resident A alone, Ms. Rodger continued to approach Resident A, causing him to become more agitated and eventually physically aggressive. Ms. Edmonds stated that rather than deescalate the situation, Ms. Rodgers tried to "fight [Resident A] off" with a broom and a dust pan. According to Ms. Edmonds, Ms. Rodgers took her hand and pushed Resident A's head to the floor and held it there. Resident A attempted to lift his head up several times, and each time Ms. Rodgers pushed his head back down to the floor. According to Ms. Edmonds, at one point Ms. Rodgers got down on the floor and began mocking Resident A by making faces at him. Ms. Edmonds stated that Resident A became so upset that he punched the facility's front window, broke the glass and cut his hand. According to Ms. Edmonds, Ms. Rodgers called 911 and emergency first responders transported Resident A to the emergency room (ER). Ms. Edmonds stated that Ms. Rodgers volunteered to meet Resident A at the ER and stayed with him there. Ms. Edmonds expressed being bothered by the incident as "they" (DCWs) were not trained to handle physically aggressive residents in that manner. According to Ms. Edmonds, prior to this incident, she had never observed Ms. Rodgers "put her hands" on Resident A or other residents in the facility.

During an interview on 09/25, Ms. Rodgers stated that on 09/24 she and Ms. Edmonds asked Resident A several times to leave the kitchen while Ms. Edmonds was preparing dinner. Ms. Rodgers stated that she eventually attempted to remove Resident A from the kitchen by "lightly tapping" him. According to Ms. Rodgers, Resident A swung at her, missed, and then fell to the floor. Ms. Rodgers admitted to placing her hand on Resident A's head. However, only after Resident A tried to bite her. Ms. Rodgers denied continuously approaching Resident A and stated that it was Resident A who followed her around the facility. Ms. Rodgers stated that she was sweeping when Resident A tried to bite her and denied using a broom and dust pan to "fight [Resident A] off." According to Ms. Rogers, on two occasions Resident A grabbed her legs. On one occasion, upon the release of her legs, Ms. Rodgers fell to the floor. Ms. Rodgers denied lying on the floor and mocking Resident A by making faces at him. According to Ms. Rodgers, Resident A punched her in the face several

times. Resident A denied ever pushing Resident A's head to the floor. Ms. Rodgers stated that during the altercation Ms. Edmonds tried several times to verbally redirect Resident A while Mr. Wilson sat on the facility's couch and did nothing. Ms. Rodgers stated that she was upset that her coworkers didn't do more to assist her, and she walked out of the facility and to her car. However, Resident A could still see her through the facility's front window. Ms. Rodgers stated that Resident A pounded on the front window several times until the glass broke. Ms. Rogers confirmed that Resident A cut his hand, and upon calling 911, emergency first responders transported Resident A to the ER. Ms. Rodgers also confirmed that she met Resident A at the ER and accompanied him while medical staff treated his injury.

Following our interview with Ms. Rodgers, program director Bev Reed informed Ms. Rodgers that she was placed on suspension until further noticed.

During an interview on 10/09, Mr. Wilson stated that on 09/24 Resident A was on the living room floor "minding his own business" when Ms. Rodgers approached Resident A, "basically got in his face" and stated, "what are you looking at?" Mr. Wilson stated that he helped Resident A up off the floor and sat him at the dining room table. Mr. Wilson stated that he then sat down on the facility's couch to work on charting. A few moments later, Mr. Wilson stated that he witnessed Resident A crawl into the kitchen and attempt to speak with Ms. Edmonds about dinner. According to Mr. Wilson, Ms. Rodgers pushed Resident A and told him to "go away." Mr. Wilson stated that instead of just walking away Ms. Rodgers continued to antagonize Resident A with a broom and a dust pan. Resident A, who was still on the floor, swung his arms. According to Mr. Wilson, Ms. Rodgers held Resident A down to the ground and every time Resident A tried to get up, Ms. Rodgers push him back down again. Mr. Wilson stated that at one point he observed Ms. Rodgers punch Resident A in the side. Mr. Wilson confirmed that Resident A tried to bite Ms. Rodgers, but only after Ms. Rodgers continued to push him. Mr. Wilson stated that Ms. Edmonds tried to verbally deescalate the incident and once Ms. Edmonds realized what had occurred, she cried. Mr. Wilson confirmed that Resident A punched the facility's front window and injured his hand. Mr. Wilson stated that he believed Ms. Rodgers volunteered to accompany Resident A in the ER because she wanted to "manipulate the story" and ensure that Resident A didn't report what really occurred. Mr. Wilson stated that he was so bothered by what he witnessed that he texted Ms. Beltran who reported to the facility to obtain additional information and then met Resident A and Ms. Rodgers at the ER. Mr. Wilson stated that since Ms. Rodgers had been off work on suspension, the work environment at the facility was "much better."

During our on-site investigation on 10/09, Ms. Schiebel and I attempted to interview Resident A regarding this allegation. While it was apparent that Resident A tried to explain to us what occurred, due to his developmental disability, it was difficult to understand what Resident A tried to communicate.

On 10/12 I received notification from Ms. Reed, via email exchange, that Ms. Rodgers' employment was terminated.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based upon my investigation, which included interviews with DCWs Kiyondra Edmonds, Ajani Rodgers and Andre Wilson, as well an interview with Resident A, there is enough evidence to support the allegation that Ms. Rodgers intentionally both verbally and physically mistreated Resident A resulting in Resident A breaking a window and obtaining an injury to his hand.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/14 I conducted an exit conference with licensee designee Scott Schrum via telephone and shared with him the findings of this investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

11/13/2018

Michele Streeter — Date
Licensing Consultant

Approved By:

11/14/2018

Dawn N. Timm — Date
Area Manager