RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

January 02, 2019

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

RE: License #: AS390314010
Investigation #: **2019A0462010**
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.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Michele Streeter

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 #:	2019A0462010
Complaint Receipt Date:	11/14/2018
Investigation Initiation Date:	11/15/2018
Report Due Date:	01/13/2019
Licensee Name:	Residential Opportunities, Inc.
Licensee Address:	1100 South Rose Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-3731
Administrator:	David Stedman
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?
On 11/13/2018 Direct Care Workers did not check on Resident A for approximately two hours while he was using the bathroom. Resident A was later observed laying on the bathroom floor covered with feces.	Yes

III. METHODOLOGY

11/14/2018	Special Investigation Intake 2019A0462010
11/15/2018	Special Investigation Initiated – Telephone Interview with Kalamazoo County RRO Michele Schiebel.
12/04/2018	Investigation conducted on-site. Interview with Assistant Program Manager Carla Beltran and Administrator David Stedman.
12/26/2018	Referral made to Kalamazoo County APS.
12/27/2018	Exit conference with Licensee Designee Scott Schrum.

ALLEGATION:

On 11/13/2018 Direct Care Workers did not check on Resident A for approximately two hours while he was using the bathroom. Resident A was later observed laying on the bathroom floor, covered with feces.

INVESTIGATION:

On 11/14/2018 the Bureau of Community and Health Systems (BCHS) received this compliant through the BCHS' on-line complaint system.

On 11/15 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. According to Ms. Schiebel, she interviewed Direct Care Workers (DCW) Nikki Maxam and Ki Edmonds, who were both working at the facility on 11/13, at time of the alleged incident. Ms. Schiebel stated that Ms. Maxam was unable to tell her where in the facility Resident A was on 11/13 between the hours of 1:00 PM and 3:00 PM. Ms. Schiebel stated that according to Ms. Edmonds, at approximately 1:00 PM on 11/13 Resident A was using the bathroom at the facility. According to Ms. Schiebel, Ms. Edmonds stated that "at one point" she

asked Resident A if he needed assistance and Resident A said, “no.” According to Ms. Schiebel, Ms. Edmonds’ stated that she then got busy and never checked on Resident A again.

On 12/04 I conducted an investigation at the facility and interviewed Assistant Program Manager Carla Beltran and Administrator David Stedman. Ms. Beltran stated that at approximately 1:00 PM on 11/13 she left the residents in the care of Ms. Maxam and Edmonds while Ms. Beltran ran errands. Prior to leaving the facility she observed Resident A using the bathroom. According to Ms. Beltran she later returned to the facility at approximately 3:00 PM and noticed that someone was in the facility’s bathroom. Ms. Beltran stated that upon knocking on the door, she entered the bathroom to find Resident A laying on the floor, covered with feces. Ms. Beltran stated, “there was poop everywhere”, including all over the toilet and on the corner of the bathtub. According to Ms. Beltran, Resident A was in the same clothing he had been wearing when she left to run errands at 1:00 PM. Ms. Beltran stated that Resident A did not experience any injuries and was not in any pain. Ms. Beltran stated that due to his diagnosis, Resident A was unable to tell her how long he was in the bathroom. Ms. Beltran stated that she got Resident A up, showered him, changed his clothing, and then cleaned the bathroom. According to Ms. Beltran, Ms. Maxam had left the facility for the day prior to Ms. Beltran’s return. Ms. Beltran stated Ms. Edmonds was unable to tell her how long Resident A was in the bathroom and/or if not in the bathroom, where else Resident A was in the facility between the hours of 1:00 PM to 3:00 PM.

Mr. Stedman stated that he was not at the facility at the time of this incident. However, once informed he directed Ms. Beltran to report the incident to the Kalamazoo County Office of Recipient Rights. Mr. Stedman stated that Ms. Schiebel asked that nobody from the facility speak with Ms. Maxam and/or Ms. Edmonds regarding the allegation, until Ms. Schiebel had completed her investigation. Both Ms. Beltran and Mr. Stedman stated that Ms. Edmonds’ employment was eventually terminated. Mr. Stedman stated that there were several other performance concerns, in addition to this incident, that lead to the decision to terminate Ms. Edmonds’ employment. According to Mr. Stedman, as part of the facility’s resident assessment process, “monitoring requirements” were established for each resident. Both Ms. Beltran and Mr. Stedman stated that while not within DCWs’ direct line of vision, Resident A was to be checked on every 15 minutes during awake hours, including while he was using the bathroom. Ms. Beltran stated that routine monitoring of Resident A was especially important since Resident A suffered from epilepsy.

I observed Resident A at the facility. Resident A did not appear to be injured and did not express any discomfort or pain.

Documentation on Resident A’s Kalamazoo County Community Mental Health *Behavioral Support Plan* indicated that Resident A had a diagnoses of Moderate Intellectual Developmental Disorder and Generalized Convulsive Epilepsy.

Documentation on Resident A's *Assessment Plan for AFC Residents* indicated that Resident A was able to 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.

I reviewed a document titled *Residential Opportunity's Inc.'s Monitoring Requirements for [Resident A]*, which indicated that DCWs were to know where Resident A was at all times. DCWs were responsible for monitoring Resident A's bowel health and were to provide hands-on assistance. Resident A's written monitoring requirements indicated that Resident A was not be left alone in the bathroom except for brief periods of time while showering and toileting.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based upon my investigation, which included interviews with RRO Michele Schiebel, Assistant Program Manager Carla Beltran and Administrator David Stedman, as well as a review of documents relevant to the allegation, there is enough evidence to support the allegation that on 11/13 DCWs Nikki Maxam and Ki Edmonds did not check on Resident A for approximately two hours while he was using the bathroom. Ms. Beltran later observed Resident A laying on the bathroom floor, covered with feces. As part of the resident assessment process, written monitoring requirements were established for Resident A. According to Resident A's written monitoring requirements, DCWs were to know where Resident A was at all times. DCWs were responsible for monitoring Resident A's bowel health and were to provide hands-on assistance. Resident A was not be left alone in the bathroom except for brief periods of time while showering and toileting. It has been established that on 11/13 Ms. Maxam and Ms. Edmonds did not provide Resident A with the supervision, protection, and personal care that he required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/27, I conducted an exit conference with Licensee Designee Scott Schrum 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.

12/27/2018

Michele Streeter — Date
Licensing Consultant

Approved By:

01/02/2019

Dawn N. Timm — Date
Area Manager