GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 11, 2019

Wycliffe Opiyo
Mercy Homes Assisted Living LLC
2901 Asbury St.
Kalamazoo, MI 49048

RE: License #: AS390380979
Investigation #: **2019A0462012**
Mercy Homes Assisted Living

Dear Mr. Opiyo:

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 #:	AS390380979
Investigation #:	2019A0462012
Complaint Receipt Date:	11/16/2018
Investigation Initiation Date:	11/19/2018
Report Due Date:	01/15/2019
Licensee Name:	Mercy Homes Assisted Living LLC
Licensee Address:	2901 Asbury St. Kalamazoo, MI 49048
Licensee Telephone #:	(817) 781-6512
Administrator:	Wycliffe Opiyo
Licensee Designee:	Wycliffe Opiyo
Name of Facility:	Mercy Homes Assisted Living
Facility Address:	2901 Asbury St. Kalamazoo, MI 49048
Facility Telephone #:	(817) 781-6512
Original Issuance Date:	09/26/2016
License Status:	REGULAR
Effective Date:	03/24/2017
Expiration Date:	03/23/2019
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Residents use drugs in the facility.	No
Resident A is not receiving enough food to eat.	No
Additional Findings	Yes

III. METHODOLOGY

11/16/2018	Special Investigation Intake 2019A0462012
11/19/2018	Special Investigation Initiated - Voicemail left for Complainant.
11/20/2018	Contact- Telephone interview with Complainant.
11/28/2018	Investigation completed on-site. Interviews with Residents A, E and G, DCW Moses Omia and licensee designee Wycliffe Opiyo.
11/28/2018	Exit Conference with licensee designee Wycliffe Opiyo.

ALLEGATION:

Residents use drugs in the facility.

INVESTIGATION:

On 11/16/2018 the Bureau of Community and Health Systems (BCHS) received this compliant through the BCHS' on-line compliant system. The written complaint indicated that Resident A reported observing drugs in the facility. According to the written complaint it is unclear what kinds of drugs Resident A observed and/or who the drugs belonged to. The written complaint indicated that this allegation was also reported to Kalamazoo County Adult Protective Services (APS).

On 11/28 I conducted an unannounced investigation at the facility and interviewed Resident A. Resident A stated that two residents smoked marijuana and crack in the facility on a regular basis, after the third-shift direct care worker (DCW) Moses Omia went to bed for the evening. Resident A stated that he reported this information to licensee designee Wycliffe Opiyo and was informed that Mr. Opiyo would "do something" if he caught the residents using drugs in the facility. Resident A refused to disclose which residents were smoking marijuana and crack in the facility and/or provide any other information regarding the allegation.

I interviewed DCW Moses Omia who confirmed that he worked the facility's third shift. Mr. Omia stated that per facility policy, he slept during resident sleeping hours. However, according to Mr. Omia, he conducted resident safety checks approximately twice a shift, at random times. Mr. Omia stated that he had never observed drugs in the facility and had no reason to suspect any residents were using drugs in the facility.

I interviewed Mr. Opiyo who confirmed that Resident A reported that residents were smoking marijuana in the facility. However, according to Mr. Opiyo, Resident A never reported that residents were also smoking crack in the facility. Mr. Opiyo stated that Resident A refused to disclose which residents were smoking marijuana in the facility and/or provide any additional information to Mr. Opiyo regarding the allegation. Mr. Opiyo stated that on a few occasions, facility staff members caught Resident B smoking cigarettes in his bedroom. According to Mr. Opiyo, in June of 2018 Resident B was arrested for smoking marijuana in the park. During our interview, Mr. Opiyo called Resident B's case manager with the community mental health agency InterAct, Inc., Samuel Page. Mr. Page confirmed that Resident B was arrested on 06/02 for smoking marijuana in the park. According to Mr. Page, Resident B pleaded guilty to the charge. Mr. Page stated that during Resident B's court hearing the judge "let [Resident B] off." Mr. Opiyo stated that he and other facility staff members had no reason to believe Resident B was smoking anything other than cigarettes in his bedroom. According to Mr. Opiyo, he and facility staff members also had no reason to believe that any other residents were using drugs in the facility. Mr. Opiyo stated that the facility had a "no smoking policy" and that he reiterated this policy with Resident B.

Residents B, C and D were not present in the facility at the time of my investigation.

I interviewed Residents E and G who both denied smoking marijuana and/or crack in the facility. Resident E stated that he never observed other residents smoking marijuana and/or crack in the facility. Resident G refused to answer whether or not he observed other residents smoking marijuana and/or crack in the facility or provide any other additional information regarding the allegation.

Privately, Mr. Opiyo informed me that due to Resident E's mental health diagnosis, Resident E would more than likely refuse to allow me to enter his bedroom. I requested Resident E's permission to enter his bedroom and Resident E refused to allow me to enter. I conducted inspections of Resident A, B, C and G's bedrooms and did not observe and/or smell any evidence of drug use. During my on-site investigation, Resident D's bedroom was locked. According to both Mr. Omia and Mr. Opiyo, Resident D locked his bedroom when away from the facility and when at the facility kept his bedroom unlock. Mr. Omia and Mr. Opiyo stated that they did not have access to a key that would unlock Resident D's bedroom.

I inspected all other areas of the facility and did not observe and/or smell any evidence of drug use.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based upon my investigation, which included interviews with Residents A, E and G, DCW Moses Omia and licensee designee Wycliffe Opiyo, as well as an inspection of the facility, including Resident A, B, C and G's bedrooms, there is not enough evidence to substantiate the allegation that residents use drugs in the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A is not receiving enough food to eat.

INVESTIGATION:

This allegation was included in the written complaint. According to the written complaint, Resident A was eating and did not appear malnourished. The written complaint indicated that this allegation was also reported to Kalamazoo County APS.

During my on-site investigation on 11/28 I interviewed Resident A regarding this allegation. Resident A stated that he was served breakfast, lunch and dinner in the facility every day. According to Resident A, facility staff members did not give residents enough food to eat and that portion sizes were too small. Resident A stated that he was given a bowl of cereal for breakfast and had just eaten "only a bologna sandwich for lunch". Resident A stated that residents were never served fruits and vegetables and were served too many potatoes and rice. Resident A explained that at meal times residents could request more food if they were not full. However, he did not like requesting additional food and wanted facility staff members to serve him the correct amount of food the first time. Resident A also stated that he did not care for some of food items served at meal times. During my interview with Resident A, he did not appear to be malnourished.

I interviewed Mr. Opiyo who denied the allegation. Mr. Opiyo stated that Resident A reported not liking some of the food items served at the facility. According to Mr. Opiyo, he agreed to meet with Resident A prior to grocery shopping to obtain a list of

Resident A's meal preferences. Mr. Opiyo stated that it was unrealistic to expect facility staff members to know exactly how much food Resident A wanted served to him at meal times. However, moving forward, he would instruct facility staff members to ask Resident A how much food he wanted at meal times prior to serving Resident A.

I inspected the facility's refrigerator, freezer and pantry, as well as an additional deep freezer located in the facility's dining room and observed an adequate amount of food.

I interviewed Residents E and G who both stated that they were served breakfast, lunch and dinner in the facility everyday and that they received enough food to eat. During my interview with Residents E and G, they did not appear to be malnourished.

I conducted a second interview with Resident A who confirmed that Mr. Opiyo met with him prior to grocery shopping to obtain his meal preferences and that Mr. Opiyo had purchased several of the food items that Resident A requested. Resident A then stated that the sandwich he had just eaten for lunch was adequate and that he did not want any additional food.

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 Residents A, E and G, and licensee designee Wycliffe Opiyo, as well as an inspection of the facility's refrigerator, freezer, pantry and additional deep freezer, there is no evidence to substantiate the allegation that Resident A is not receiving enough food to eat. According to Resident A, at meal times residents could request more food if they were not full.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my on-site investigation on 11/28, both Resident A and Mr. Omia stated that residents were served goulash for dinner on 11/27. On 11/28 residents were served

cereal for breakfast and a sandwich for lunch. This was not consistent with what was indicated on the facility's posted menu. According to Mr. Opiyo, the facility attempted to follow a four-week menu cycle. However, facility staff members regularly deviated from the menu cycle when residents requested different meals. Mr. Opiyo admitted that neither he, nor other facility staff members, noted these menu changes and substitutions, as part of the original menu.

I requested to review residents' monthly weight records for August 2018 through November 2018. Mr. Omia and Mr. Opiyo were unable to locate August weight records for Residents A and B, as well as August and September weight records for Residents C, D and G. Mr. Omia and Mr. Opiyo both stated that residents were weighed once a month, and as needed. However, it appeared that facility staff members either failed to record residents' weights for some months or misplaced some residents' weight records.

I observed the scale used to weigh residents, which was located in the facility's dining room.

I interviewed Residents A, E and G who all confirmed that they were weighed in the facility once a month.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu. **(6) Records of menus, including special diets, shall be kept by the licensee for 1 calendar year.**
ANALYSIS:	Based upon my investigation, which included interviews with Resident A, E and G, DCW Moses Omia and licensee designee Wycliffe Opiyo, it has been established that neither Mr. Opiyo, nor other facility staff members, noted the changes and/or substitutions made to the facility's posted menu cycle.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(g) Weight record.**

ANALYSIS:	Based upon my investigation, which included interviews with Resident A, E, and G, DCW Moses Omia and licensee designee Wycliffe Opiyo, it has been established that the facility did not maintain August weight records for Residents A and B, as well as August and September weight records for Residents C, D and G. Therefore, the facility was unable to provide these records to the department when requested.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/28 I conducted a face-to-face exit conference with licensee designee Wycliffe Opiyo 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.

01/10/2019

Michele Streeter — Date
Licensing Consultant

Approved By:

01/11/2019

Dawn N. Timm — Date
Area Manager