GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 27, 2020

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

RE: License #: AS390392120
Investigation #: 2020A0783023
New Post

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 (517) 284-9730.

Sincerely,

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390392120
Investigation #:	2020A0783023
Complaint Receipt Date:	04/10/2020
Investigation Initiation Date:	04/13/2020
Report Due Date:	06/09/2020
Licensee Name:	Residential Opportunities, Inc.
Licensee Address:	1100 South Rose Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-3731
Administrator:	Sarah Anglemyer
Licensee Designee:	Scott Schrum
Name of Facility:	New Post
Facility Address:	612 Landsdowne Ave. Portage, MI 49002
Facility Telephone #:	(269) 375-6265
Original Issuance Date:	11/08/2018
License Status:	REGULAR
Effective Date:	05/06/2019
Expiration Date:	05/05/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
A staff member left household cleaner in Resident A's bedroom and the container was later found empty.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/10/2020	Special Investigation Intake 2020A0783023
04/13/2020	Contact - Telephone call made Left message for complainant
04/13/2020	Special Investigation Initiated - Telephone Spoke to Complainant
04/13/2020	Contact - Telephone call made To direct care staff member Brooke Pepin
04/14/2020	Contact - Document Received *Incident/Accident Report* for Resident A dated April 6, 2020
04/14/2020	Contact - Document Received *After Visit Summary* for Resident A dated April 6, 2020
04/14/2020	Contact - Telephone call made To administrator Sarah Anglemyer
04/14/2020	Contact - Telephone call made To assistant administrator and direct care staff member Eric Hall
04/15/2020	Contact - Document Received Resident A's resident record
04/15/2020	Contact - Document Received Employee record for Brooke Pepin
04/20/2020	Contact - Telephone call made To direct care staff member Lola Williams

04/20/2020	Exit Conference With licensee designee Scott Schrum who stated he understood the findings in this report

ALLEGATION:

A staff member left household cleaner in Resident A's bedroom and the container was later found empty.

INVESTIGATION:
On April 13, 2020 I received a complaint via central intake that stated, "Staff left Lysol cleaning product in the bedroom with [Resident A] and when it was retrieved by staff it was empty."

On April 14, 2020 I reviewed a written *Incident/Accident Report* concerning the allegation that stated on April 5, 2020 staff member Lola Williams found an empty bottle of Lysol with hydrogen peroxide in Resident A's bedroom with the spraying mechanism removed. The written report stated Ms. Williams telephoned poison control and was directed to take Resident A to the emergency room and Resident A was taken to Bronson Emergency Department for evaluation. The written incident report stated Resident A was diagnosed with ingestion of substance accidental or unintentional.

On April 14, 2020 I reviewed Resident A's *After Visit Summary* from Bronson Emergency Department dated April 6, 2020. The reason for visit was listed as "drug overdose." The diagnosis was "ingestion of substance, accidental or unintentional." The written document indicated Resident A was tested for Ethanol and no concerns were noted. The document indicated Resident A should resume her normal schedule and routine and no restrictions were noted. Resident A was instructed to return to the emergency department if she became unable to swallow, had difficulty breathing, chest pain or any other new or concerning symptoms.

On April 13, 2020 I spoke to Complainant who said Resident A is a Community Mental Health (CMH) consumer and complainant is aware of Resident A in that capacity. Complainant said Resident A has a behavior plan that may deal with "pica like behavior," but that she had not read the behavior plan. Complainant said, "swallowing things isn't abnormal for [Resident A], which is why this is an issue." Complainant stated the bottle of Lysol cleaning product was left in Resident A's bedroom between 8:00 pm on April 5, 2020 and 12:00 am on April 6, 2020. Complainant stated another staff member found the empty bottle of Lysol cleaning product in Resident A's bedroom. Complainant said a staff member telephoned poison control and ultimately took Resident A to the emergency room where her blood was tested for Ethanol. Complainant said she had not seen Resident A's

hospital discharge summary. Complainant described Resident A as non-verbal and said she is known to “grab and drink things that are left out.”

On April 13, 2020 I spoke to direct care staff member Brooke Pepin who stated she has worked at the facility for six months, nearly every day. Ms. Pepin said she typically works second shift from 3:00 pm to 10:00 pm. Ms. Pepin said on April 5, 2020 at approximately 8:00 pm when the second staff member, Eric Hall left for the night she noticed that Resident A urinated over her clothing, bedding, and mattress so she assisted Resident A with toileting and set about cleaning the urine from Resident A’s mattress. Ms. Pepin stated she “grabbed whatever [cleaning] supplies [she] could find” and took them into Resident A’s room to clean the mattress but she thought she left behind a bottle of Clorox Essentials. Ms. Pepin said she successfully cleaned everything and assisted Resident A into bed and left the room, leaving behind the cleaning product(s). Ms. Pepin said she did not intentionally leave the cleaning product(s) and she is aware of Resident A’s tendency to consume non-edible things such as bleach and prescription mouth wash. Ms. Pepin explained that she was working alone and trying to get Resident A back into bed so she could administer another resident’s medication and complete paperwork and cleaning responsibilities before the end of her shift. Ms. Pepin said she was not aware that she left the cleaning product(s) in Resident A’s bedroom until a third shift staff member located an empty bottle of cleaner in Resident A’s bedroom and administrator Sarah Anglemyer telephoned her to ask questions. Ms. Pepin acknowledged that she did not safeguard Resident A from poisons, caustics, and other chemicals when she left cleaning product(s) in Resident A’s bedroom rather than putting them in a locked cabinet where staff members have been told to store them at all times.

On April 14, 2020 I spoke to direct care staff member and assistant administrator Eric Hall who stated he worked with Ms. Pepin on April 5, 2020 and that his shift ended at 8:00 pm and Ms. Pepin was there alone from 8:00 pm to 10:00 pm. Mr. Hall stated before he left he observed that Resident A wet her bed and Ms. Pepin was cleaning Resident A’s mattress with cleaner that is “normally locked in a kitchen cabinet when not in use.” Mr. Hall said Resident A has a history of consuming things that are not edible and that staff members have been instructed to take special precautions to prevent Resident A from “getting anything hazardous.” Mr. Hall said he was told that the overnight staff person discovered the cleaner in Resident A’s bedroom and “because of [Resident A’s] history” there was concern that Resident A consumed the cleaner so she was taken to the emergency room where a toxicology screening was done and “nothing was found.” Mr. Hall stated staff members continued to monitor Resident A for oral burns or any pain and were “diligent” about ensuring her wellbeing. Mr. Hall denied having any concerns regarding Ms. Pepin’s overall performance and described this incident as “an oversight.”

On April 14, 2020 I spoke to administrator Sarah Anglemyer who stated she was at home on April 5, 2020 when direct care staff member Lola Williams telephoned her and explained that she found an open, empty bottle of Lysol cleaner in Resident A’s

bedroom and a small puddle on the floor of what appeared to be the cleaner. Ms. Anglemyer said she advised Ms. Williams to telephone the poison control center and follow the direction provided, which was to take Resident A to the emergency room. Ms. Anglemyer said Ms. Williams inspected Resident A's mouth and throat and did not detect any abnormalities but due to Resident A's history of ingesting inedible things Resident A was taken to the emergency room where her blood was tested for Ethanol. Ms. Anglemyer said Resident A's "blood test came back clear." Ms. Anglemyer said she telephoned Ms. Pepin who told her she used the cleaner to sanitize Resident A's mattress after she urinated on it and the bottle was approximately ¼ full when she accidentally left it in Resident A's bedroom with Resident A. Ms. Anglemyer said Resident A has "known behaviors" that consist of consuming soap, bleach, household cleaners, or "anything she could open and drink." Ms. Anglemyer said because of that "all liquid is to be kept locked behind a keyed door," and staff members carry a key. Ms. Anglemyer said Ms. Pepin made an error when she left a liquid cleaning product in Resident A's bedroom with Resident A and she will be formally disciplined. Ms. Anglemyer said, "if there is another incident," Ms. Pepin would be suspended and/or discharged from her position.

On April 20, 2020 I spoke to direct care staff member Lola Williams who stated on April 5,2020 when she arrived at work at 9:00 pm Resident A was already in bed. Ms. Williams stated at approximately 10:30 she went into Resident A's room to check on her and found an open, empty bottle of Lysol cleaning product in Resident A's bedroom. Ms. Williams said she questioned Resident A who denied drinking the Lysol cleaning product, but she telephoned the poison control hotline "immediately." Ms. Williams said she was directed to seek emergency medical treatment for Resident A, and she was taken to the emergency room. Ms. Williams stated hospital staff determined Resident A did not consume the Lysol cleaner. Ms. Williams said Resident A "will drink anything liquid," and all cleaning products and liquids that could harm Resident A if ingested are supposed to be locked in a cupboard in the kitchen.

On April 15, 2020 I received Resident A's resident record and noted that she has been formally diagnosed with intellectual disability, intermittent explosive disorder, mood disorder, and she is legally blind. Resident A's *Supervision Protocols* dated February 6, 2020 stated, "due to PICA like behaviors staff are to insure (sic) all liquids/soaps are locked when not in use."

On April 15, 2020 and reviewed Ms. Pepin's employee record which contained a written document entitled *Performance Deficiency Report* dated April 13, 2020. According to the written report on April 6, 2020 Ms. Pepin "failed to remove a liquid cleaning product spray bottle from an individual's room after use and lock it up. This resulted in an ER trip for the individual for possible ingestion of the product." The document was signed by Ms. Pepin.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.
ANALYSIS:	Based on written documentation maintained at the facility as well as interviews with Complainant, Ms. Pepin, Mr. Hall, Ms. Anglemyer, and Ms. Williams it is evident that on April 5, 2020 direct care staff member Brooke Pepin did not ensure that poisons, caustics, and other dangerous materials were stored and safeguarded in a non-resident area when she left a bottle of household cleaner in Resident A's bedroom with Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On April 13, 2020 I spoke to Complainant who said direct care staff member Brooke Pepin "left out medical mouthwash" approximately six months ago, which was consumed by Resident A who had to receive medical attention as a result.

On April 13, 2020 I spoke to direct care staff member Brooke Pepin who acknowledged that when she was a new staff member, approximately six months ago she left the door to the closet where medication is stored open and unlocked and Resident A ingested prescription mouthwash that was prescribed to another resident.

On April 13, 2020 I spoke to administrator Sarah Anglemyer who said direct care staff member Brooke Pepin was formally disciplined in November 2019 for "leaving the med room unlocked" which resulted in Resident A drinking prescription mouthwash that contained hydrogen peroxide which was prescribed to another resident. Ms. Anglemyer said Ms. Pepin was "retrained on locking procedures" after the November 2019 incident.

On April 13, 2020 I spoke to assistant administrator and direct care staff member Eric Hall who stated approximately five months ago direct care staff member Brooke Pepin "left the med cabinet open," and Resident A consumed another resident's "oral rinse." Mr. Hall said after that incident Ms. Pepin was retrained on the facility policies regarding what must always be locked . Mr. Hall stated there is a written reminder on the medication cabinet door to remind staff members to lock the door. On April 15, 2020 I received and reviewed Ms. Pepin's employee record which contained a written document entitled *Performance Deficiency Report* dated

November 12, 2019. According to the written report Ms. Pepin, “failed to lock the med room door, this resulted in an individual served getting to and ingesting Peridex oral rinse.” The document indicated Ms. Pepin received training and verbal counseling after she failed to keep resident medications locked. The document was signed by Ms. Pepin.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on statements from Complainant, Ms. Pepin, Ms. Anglemyer, Mr. Hall and written documentation in Ms. Pepin’s employee record there is sufficient evidence to indicate that on November 11, 2019 Ms. Pepin neglected to lock the cabinet where resident medications were stored.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on statements from Ms. Pepin, Mr. Anglemyer, and Mr. Hall, Ms. Pepin did not take reasonable precautions to ensure that prescribed medication was not used by a person other than the resident for whom the medication is prescribed on November 11, 2019 when the cabinet housing all resident medications was left unlocked and Resident A ingested prescription mouthwash that was prescribed to another resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in the status of the license.

4/20/20

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Leslie Herrguth Date
Licensing Consultant

Approved By:

04/27/2020

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Dawn N. Timm Date
Area Manager