GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 23, 2021

Charles Kelly
R & B Living Supports, Inc.
130 45th Street
Bloomingdale, MI 49026

RE: License #: AS030390275
Investigation #: 2021A0350047
Blue Sky AFC

Dear Mr. Kelly:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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) 356-0100.

Sincerely,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS030390275
Investigation #:	2021A0350047
Complaint Receipt Date:	07/12/2021
Investigation Initiation Date:	07/12/2021
Report Due Date:	08/11/2021
Licensee Name:	R & B Living Supports, Inc.
Licensee Address:	130 45th Street Bloomingdale, MI 49026
Licensee Telephone #:	(269) 521-4500
Administrator:	Charles Kelly
Licensee Designee:	Charles Kelly
Name of Facility:	Blue Sky AFC
Facility Address:	331 49th Street Grand Junction, MI 49056
Facility Telephone #:	(269) 521-4500
Original Issuance Date:	06/27/2018
License Status:	REGULAR
Effective Date:	12/27/2020
Expiration Date:	12/26/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, DEVELOP-MENTALLY DISABLED, MENTALLY ILL, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident B alleged that Home Manager LaShonda Bray discusses his medical and personal issues with other residents and the UPS driver.	Yes
Resident A alleged that Robert Boyer, DCW, punched him on 7/10/2021.	No
Resident B alleged that Home Manager LaShonda Bray verbally puts him down.	Yes
Robert Boyer, DCW, plays videos games with a headset while working and will not assist residents when they ask him for help while he's playing video games.	No

III. METHODOLOGY

07/12/2021	Special Investigation Intake 2021A0350047
07/12/2021	Special Investigation Initiated - Telephone I spoke with Charles Redman, Recipient Rights Officer
07/12/2021	Contact - Document Sent I sent an email to Samantha Kelly, Administrator
07/13/2021	Contact - Face to Face I made an onsite inspection and spoke with Resident A, Resident B, LaShonda Bray, Home Manager, and Robert Boyer, DCW
07/13/2021	Contact - Telephone call received I spoke further with Samantha Kelly
07/14/2021	Contact - Telephone call made I spoke with Cheryl Zellmer, Human Resources Administrator
07/14/2021	Contact - Telephone call received I spoke further with Resident A
07/14/2021	Contact - Document Received I received an email from Ms. Zellmer with an Incident Report attached

07/15/2021	Contact – Telephone call made I spoke with Relative 1
07/23/2021	Exit conference – Held with Charles Kelly, Licensee Designee

ALLEGATION: Resident B alleged that Home Manager LaShonda Bray discusses his medical and personal issues with other residents and the UPS driver.

INVESTIGATION: On 07/12/2021, I called and spoke with Samantha Kelly, Administrator, and informed her that a couple of complaints were made and that I would be going to this home the following day to interview staff and residents. I requested that Ms. Kelly make sure Robert Boyer, Direct Care Worker (DCW), be at the home that day at 10 a.m. Ms. Kelly said she would make sure he was there. Ms. Kelly further informed me that she was made aware of the complaints by Recipient Rights.

On 07/13/2021, I made an onsite inspection and met with LaShonda Bray, Home Manager, and informed her that some complaints were made and that I needed to speak with Resident A, Resident B, Mr. Boyer, and her, individually.

On 07/13/2021, I spoke with Resident B who stated that he believed Ms. Bray talks about his personal business with other residents and the UPS driver. When I asked him why he believed this he said he wasn't sure, but that "…it might have happened." Resident B was unable to provide any more information about this.

On 07/13/2021, I spoke with LaShonda Bray, Home Manager, who denied sharing Resident B's personal information with any of the other residents or anyone else outside the home, including the UPS driver.

On 07/15/2021, I called and spoke with Relative 1, a relative of one of the residents, but not of Resident B. Relative 1 informed me that Ms. Bray has spoken to her about some of Resident B's medical problems before, including that he has "fungus around his bottom, his backside."

On 07/23/2021, I called and held an exit conference with Charles Kelly, Licensee Designee. I informed Mr. Kelly that I was citing violation of this rule and that a corrective action plan was required. Mr. Kelly stated that he suspended Ms. Bray and would determine what the next course of action would be with her.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated

	representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(q) The right to confidentiality of records as stated in section 12(3) of the act.**
ANALYSIS:	Although Ms. Bray denied discussing Resident B's personal information with others, Resident B believed she has; and Relative 1, who is not the relative of Resident B, said that Ms. Bray told her about one of Resident B's medical conditions. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A alleged that Robert Boyer, DCW, punched him on 7/10/2021.

INVESTIGATION: On 07/13/2021, I made an onsite inspection and spoke with Resident A who stated that Mr. Boyer pushed him in his chest, but he was "just playing." I asked Resident A to demonstrate on me what Mr. Boyer did to him, and Resident A gently nudged my chest with one open hand. Resident A showed me a very faint, grape-sized bruise on his left upper arm, and gave me three different stories of how he got it, Mr. Boyer pinching him; and his mother and legal guardian pushing him out of the house (Blue Sky AFC). Resident A told me he wasn't sure if anyone saw Mr. Boyer pinch him.

On 07/13/2021, I spoke with Robert Boyer, DCW, who denied punching or pinching Resident A. Mr. Boyer reported that Resident A likes to have other people put their hands on his chest at the same time he puts his hands on theirs and they lightly jostle each other back and forth. Mr. Boyer informed me that Resident C snuck up and kissed Resident A recently and has also hit and grabbed Resident A without cause many times recently. Mr. Boyer told me that Resident A has called the police on Resident C and a few days ago because Resident C attacked Resident A without provocation and caused bruises on Resident A, and that he has called the police on him before. Mr. Boyer said that he called the police on Resident A recently because Resident A was beating on him (Mr. Boyer).

On 07/13/2021, I attempted to interview Resident C, but he would not wake up.

On 07/13/2021, I spoke with LaShonda Bray, Home Manager, who confirmed that Resident C has been sneaking up on Resident A and hitting him, and kissed him one time. Ms. Bray stated that she has spoken with Resident C's mother about this and his mother said that these behaviors are due to Resident C's autism. Ms. Bray

told me that because of these behaviors, whenever Resident A and Resident C are in the same room, a staff member has to be present. Ms. Bray said that Resident C admitted to grabbing Resident A recently, and that he also admitted it to the police.

On 07/13/2021, I reviewed the diagnoses. Resident A's Health Care Appraisal shows that he was diagnosed with Asthma, Schizophrenia, Autism, and Fetal Alcohol Spectrum Disorder. Resident C's Individual Plan of Service shows his diagnoses include Autism Spectrum Disorder, Attention-Deficit/Hyperactivity Disorder, Bipolar I Disorder, and Disruptive Mood Dysregulation Disorder.

On 07/14/2021, I called and spoke with Cheryl Zellmer. I informed Ms. Zellmer that I did not have any Incident Reports about Resident C hitting, grabbing, or kissing Resident A. Ms. Zellmer said that she would look through the last several Incident Reports and send me any that she finds pertaining to these incidents.

On 07/14/2021, I received a call from Resident A who said that it was Resident C who caused the bruise on him by grabbing him. He said this happened "a while ago" and that Mr. Boyer witnessed it happen.

On 07/15/2021, I received an email from Ms. Zellmer with an Incident Report dated 07/09/2021 attached. The Incident Report states that "(Resident A) stated that (Resident C) hugged and kissed him. He then asked to call the police. Then, there was a bruise found on (Resident A's) arm in which both (Resident A) and (Resident C) attributed to (Resident C) grabbing (Resident A's) arm. Police interviewed (Resident A) and (Resident C). No arrests were made." It further states in this Incident Report: "Talked with all the housemates. Both parents involved; and separated housemates."

On 07/23/2021, I informed Charles Kelly, Licensee Designee, that I was not citing violation of this rule.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**

ANALYSIS:	Resident A said that Mr. Boyer, DCW, pushed him in his chest, but that he "just playing." Mr. Boyer described a playful pushing back and forth that Resident A likes to do, but it's not done hard enough to leave a bruise. Resident A had a small, faint bruise on his upper left arm, which at first he gave two possibilities for: Mr. Boyer grabbing him; or Resident A's mother pushing him. Upon a second conversation with Resident A, he reported that Resident C caused the bruise by grabbing him. I was provided an Incident Report that states Resident C admitted to staff and the police that grabbed Resident A's arm. The report states a bruise was observed on Resident A's arm immediately after this incident. My findings do not support that this rule had been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident B alleged that Home Manager LaShonda Bray verbally puts him down.

INVESTIGATION: On 07/13/2021, I spoke with Resident B who stated that Ms. Bray called him "deformed" recently and that it was the only time she called him that.

On 07/13/2021, I spoke with Resident A who stated that he heard Ms. Bray call Resident B "deformed."

On 07/13/2021, I spoke with LaShonda Bray, Home Manager, who denied that she called Resident B "deformed," and told me that Resident B often claims she said or did something to him that she didn't because he is schizophrenic and may believe she did these things.

On 07/15/2021, I called and spoke with Relative 1, a relative of one of the residents, but not of Resident B. Relative 1 informed me that she has seen Ms. Bray "…be rude to him (Resident B)," and make faces at him sometimes after he turns away.

has spoken to her about some of Resident B's medical problems before, including that he has "fungus around his bottom, his backside."

On 07/23/2021, I called and held an exit conference with Charles Kelly, Licensee Designee. I informed Mr. Kelly that I was citing violation of this rule and that a corrective action plan was required. Mr. Kelly stated that he suspended Ms. Bray and would determine what the next course of action would be with her.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.**
ANALYSIS:	Although Ms. Bray denied calling Resident B deformed, both Resident A and Resident B said she did call him deformed. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Robert Boyer, DCW, plays videos games with a headset while working and will not assist residents when they ask him for help while he's playing video games.

INVESTIGATION: On 07/12/2021, I called and spoke with Samantha Kelly, Administrator, and informed her that a couple of complaints were made and that I would be going to this home the following day to interview staff and residents. I requested that Ms. Kelly make sure Robert Boyer, Direct Care Worker (DCW), be at the home that day at 10 a.m. Ms. Kelly said she would make sure he was there. Ms. Kelly further informed me that she was made aware of the complaints by Recipient Rights.

On 07/13/2021, I made an onsite inspection and spoke with Resident A who stated that Mr. Boyer often plays video games during his shift (2nd) and tells residents to "hold on" if they need something while he's playing a video game.

On 07/13/2021, I spoke with Resident B who stated that he has seen Mr. Boyer playing videos games during his shift, but if a resident needs something, Mr. Boyer will stop playing and assist the resident.

On 07/13/2021, I spoke with Robert Boyer, DCW, who told me that he does play video games during his shift and that he got this approved by Cheryl Zellmer, Human Resources Administrator. He stated that he only plays video games when all the residents are in their rooms, but if a resident comes out and asks him for something, he will turn the game off and assist the resident.

On 07/13/2021, I spoke with LaShonda Bray, Home Manager, who informed me that she has concerns about Mr. Boyer playing video games during his shift because some of the residents told her that Mr. Boyer will neglect the residents' needs sometimes when he is playing video games.

On 07/13/2021, I received a call from Ms. Kelly who was inquiring about the status of my investigation. I informed her that I needed to make a couple more contacts before I could determine the outcome. Ms. Kelly stated that the issue of staff playing video games during their shifts came up a couple of months ago, and a directive was written and disseminated to staff. I asked Ms. Kelly to forward that directive to me and she said she would. Ms. Kelly informed me that the issue of Mr. Boyer playing video games during his shift was addressed about a month ago. She stated that she wrote a directive stating that staff members were no longer allowed to bring video games to the home or to play video games while working. Ms. Kelly told me that this directive was provided to each staff member at their last staff meeting.

On 07/23/2021, I spoke with Charles Kelly, Licensee Designee, who confirmed what Ms. Kelly told me above. Mr. Kelly added that this directive is also posted at the home, and there has been no problem regarding this since it was addressed with staff about a month ago. Mr. Kelly reported that Mr. Bray's original intention was to play video games with the residents, and some did and some didn't, and those who didn't felt neglected so Mr. Kelly decided it was best not to have staff members play video games during their shift. Given this information, I informed Mr. Kelly that I was not citing violation of this rule in this exit conference. Mr. Kelly thanked me and had no further comments.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's representative, and provide to the resident or the resident's representative, a copy of all the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**

ANALYSIS:	Resident A reported that Robert Boyer, DCW, often plays video games during his shift and if a resident asks Mr. Boyer for assistance with something while he's playing, he will tell that resident to hold on. LaShonda Bray, Home Manager, said that some of the residents have told her that Mr. Boyer will sometimes neglect their requests for assistance when he is playing video games. When management found out that some residents felt neglected when a staff member played video games with other residents, they put a stop to staff members playing video games during their shifts. All staff members were notified of this at a staff meeting about a month before this was reported to Adult Foster Care Licensing. As this problem was addressed and rectified before the Licensing Consultant received this complaint, no violation is being cited.
CONCLUSION:	VIOLATION NOT ESTABLISHED

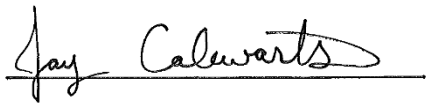
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remain unchanged, and that this special investigation be closed.

July 23, 2021

Ian Tschirhart — Date
Licensing Consultant

Approved By:



FOR July 23, 2021

Jerry Hendrick — Date
Area Manager