GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 12, 2021

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

RE: License #: AS390307863
Investigation #: 2021A1024032
Fair Oaks

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 was required. On May 27, 2021, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390307863
Investigation #:	2021A1024032
Complaint Receipt Date:	05/20/2021
Investigation Initiation Date:	05/21/2021
Report Due Date:	07/19/2021
Licensee Name:	Residential Opportunities, Inc.
Licensee Address:	1100 South Rose Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-3731
Administrator:	Jennifer Risselmann
Licensee Designee:	Scott Schrum
Name of Facility:	Fair Oaks
Facility Address:	3312 Fair Oaks Drive Kalamazoo, MI 49008
Facility Telephone #:	(269) 382-6230
Original Issuance Date:	07/12/2010
License Status:	REGULAR
Effective Date:	01/09/2021
Expiration Date:	01/08/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff blocked resident in bedroom by placing bed against bedroom door.	Yes
Additional Findings	No

III. METHODOLOGY

05/20/2021	Special Investigation Intake 2021A1024032
05/21/2021	Special Investigation Initiated – Telephone via Microsoft Teams with direct care staff members Abayomi Ogunoyei, Andre Moore, home manager Precillia Williams, and program director Susan Clayborn
05/22/2021	Exit Conference with licensee designee Scott Schrum and program director Susan Clayborn
05/22/2021	Corrective Action Plan Requested and Due on 07/12/2021
05/24/2021	Inspection Completed-BCAL Sub. Compliance
05/24/2021	Inspection Completed On-site
05/27/2021	Corrective Action Plan Received
05/27/2021	Corrective Action Plan Approved

ALLEGATION:

Staff blocked resident in bedroom by placing bed against bedroom door.

INVESTIGATION:

On 5/20/2021, I reviewed AFC Licensing Division-Incident/Accident Report (report) dated 5/16/2021 written by Abayomi Ogunoyei. According to this report, Mr. Ogunoyei went to check on Resident A and noticed that Resident A's bed had been used to block the door from being opened. Staff member Mr. Moore told Mr. Ogunoyei that he blocked the door to stop Resident A from coming out of his room disturbing the home with noise. According to the report, Mr. Ogunoyei told Mr. Moore this was wrong and pushed the bed back where it belonged thus allowing Resident A's bedroom door to open.

On 5/21/2021, I conducted interviews with Recipient Rights Officer Lisa Smith, direct care staff members Abayomi Ogunoyei, Andrea Moore, and home manager Precillia Williams. Mr. Ogunoyei stated when he arrived to work for his overnight shift during the evening of 5/16/2021, Mr. Ogunoyei noticed that he did not hear or see Resident A which was unusual because Resident A is usually out pacing in the common areas and making loud noises as normal routine behavior. Mr. Ogunoyei stated he then went to Resident A's bedroom to check on Resident A and discovered Resident A's door was not able to fully open therefore he could not fully see inside of Resident A's bedroom. Mr. Ogunoyei stated he could see that Resident A's bed was placed against the door to prevent the door from fully opening. Mr. Ogunoyei stated he spoke to direct care staff on shift, Andre Moore, who informed him that the bed was placed against the door to prevent Resident A from coming out of his room because Resident A was disturbing the other residents by making loud noises. Mr. Ogunoyei stated after speaking to Mr. Moore, he forcefully opened the door and found Resident A pacing around in his room. Mr. Ogunoyei stated he placed Resident A's bed back against the opposite wall of the door where it is normally located, and Resident A eventually went to sleep.

I interviewed direct care staff member Mr. Moore who stated he worked on the evening of 5/16/2021. Mr. Moore stated he began to start cleaning and noticed Resident A continuously making noises while walking around the house as the other residents were in their bedrooms. Mr. Moore stated to prevent Resident A from waking up the other residents and to mop the floors without interruption, he repositioned Resident A's bed by placing it against his bedroom door so Resident A would not be able to comfortably get out of his bedroom. Mr. Moore stated after he placed the bed against the door, Mr. Moore was able to squeeze out of the door because he allowed the door to partially open. Resident A did not attempt to leave the room after the door was placed against his bedroom door and eventually went to sleep. Mr. Moore stated after Resident A went to sleep, Mr. Moore squeezed back into the bedroom through the small opening and repositioned the bed back in the normal location area against wall. Mr. Moore stated no other staff member questioned him about the bed being placed against the door. Mr. Moore stated he placed the bed against the bedroom door around 10pm and repositioned the bed back away from the door at around 1am.

Mr. Williams stated when she arrived to work the morning of 5/16/2021, Mr. Ogunoyei reported to her that Mr. Moore blocked Resident A in his room by placing his bed against his bedroom door. Ms. Williams stated she immediately had Mr. Ogunoyei write an incident report and contacted Recipient Rights. Ms. Williams further stated subsequently, Mr. Moore was suspended pending further investigation.

I also conducted an interview with program manager Susan Clayborn. Ms. Clayborn stated Mr. Moore is a quality staff member that has been working for her facility for many years. Ms. Clayborn stated Mr. Moore works very well with the residents and

does not believe he positioned the bed against the door out of malice intent. Ms. Clayborn stated she will speak with Mr. Moore about finding better strategies to get his cleaning responsibilities completed when the residents are awake.

On 5/24/2021, I conducted an onsite investigation at the facility and observed the residents and home to be clean and appropriate. It should be noted no resident was able to be interviewed due to their cognitive impairments.

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: **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.**
ANALYSIS:	Based on this investigation which included interviews with direct care staff members Abayomi Ogunoyei, Andrea Moore, home manager Precillia Williams, and program director Susan Clayborn there is evidence to support the allegation direct care staff member Mr. Moore blocked Resident A in bedroom by placing bed against the bedroom door. Mr. Ogunoyei stated he observed Resident A's bed repositioned against Resident A's bedroom door causing the door to only partially open. Mr. Ogunoyei stated Mr. Moore informed him that he placed the bed against the door to prevent Resident A from leaving his room disturbing the other residents. Mr. Moore also stated he placed Resident A's bed against his bedroom door to prevent Resident A from leaving his room in order for Mr. Moore to clean and to prevent Resident A from waking up the other residents due to Resident A making loud noises. Both Mr. Ogunoyei and Mr. Moore stated Resident A was not able to leave his room and eventually fell asleep. Resident A was confined in his bedroom by staff member placing Resident A's bed against his bedroom door.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/22/2021, I conducted an exit conference with licensee designee Scott Schrum and program director Susan Clayborn. I informed Mr. Schrum and Ms. Clayborn of my findings and allowed them an opportunity to make comments or ask questions.

On 5/27/2021, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action was approved; therefore, I recommend the current license status remain unchanged.

7/12/2021

Ondrea Johnson — Date
Licensing Consultant

Approved By:

07/12/2021

Dawn N. Timm — Date
Area Manager