GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 25, 2021

Kelly Devereaux
Mentors Of Michigan, Inc.
3812 Finch
Troy, MI 48084

RE: License #: AS630277642
Investigation #: 2021A0991026
Mansfield

Dear Ms. Devereaux:

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 (248) 975-5053.

Sincerely,

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630277642
Investigation #:	2021A0991026
Complaint Receipt Date:	07/13/2021
Investigation Initiation Date:	07/13/2021
Report Due Date:	09/11/2021
Licensee Name:	Mentors Of Michigan, Inc.
Licensee Address:	3812 Finch Troy, MI 48084
Licensee Telephone #:	(248) 632-3534
Licensee Designee:	Kelly Devereaux
Name of Facility:	Mansfield
Facility Address:	6180 Wynford West Bloomfield, MI 48322
Facility Telephone #:	(248) 632-3534
Original Issuance Date:	09/12/2005
License Status:	REGULAR
Effective Date:	04/22/2020
Expiration Date:	04/21/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
There are times when the residents do not receive three meals a day and there are no groceries in the home.	Yes
The facility was out of toilet paper for two days.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/13/2021	Special Investigation Intake 2021A0991026
07/13/2021	Special Investigation Initiated - Telephone To Dawn Krull, Office of Recipient Rights (ORR) worker
07/13/2021	Referral - Recipient Rights Received from recipient rights
07/13/2021	Contact - Document Received Plans of service, food receipts
07/14/2021	Inspection Completed On-site Unannounced onsite inspection- interviewed staff and residents
07/14/2021	Contact - Telephone call made To licensee designee, Kelly Devereaux
07/17/2021	Contact- Telephone call made To director of maintenance, DJ Devereaux
07/20/2021	Contact - Document Received Pictures of repairs, new flooring, new blinds
07/29/2021	Contact - Document Received Pictures of repairs, new flooring, new mattress
08/02/2021	Contact - Document Received Pictures of new flooring, walls

08/09/2021	Contact - Document Received Pictures of repairs, new tile in kitchen
08/09/2021	Contact- Telephone call received From director of maintenance, DJ Devereaux
08/25/2021	Exit Conference Via telephone with licensee designee, Kelly Devereaux

ALLEGATION:

There are times when the residents do not receive three meals a day and there are no groceries in the home.

INVESTIGATION:

On 07/13/21, I received a complaint from the Office of Recipient Rights (ORR) alleging that the residents at Mansfield do not always get three meals a day, there are times when there are no groceries in the home, and the home was out of toilet paper for two days. I initiated my investigation on 07/13/21 by contacting the assigned ORR worker, Dawn Krull. Ms. Krull provided copies of the residents' plans of service and copies of food receipts that were provided by the licensee designee, Kelly Devereaux.

On 07/14/21, I conducted an unannounced onsite inspection at Mansfield. I interviewed the home manager, Cassandra Kellar. Ms. Kellar indicated that she has worked in the home since 05/25/21. She stated that the residents frequently complain about the food in the home, and they have expressed that they are tired of always eating the same things. Ms. Kellar stated that there is always food in the home and the residents can get three meals a day, but it is not always food that the residents want to eat. She stated that she does not have a company credit card yet, so she is not able to grocery shop for the home. On 05/26/21, Ms. Kellar sent a grocery list to Ms. Devereaux's husband, DJ Devereux. Mr. Deveraux brought groceries to the home within the next week, but it was not the food that she had requested. She stated that Mr. Devereux also delivered groceries to the home on Monday, 07/12/21, after the complaint was made to recipient rights. Prior to that, Mr. Devereaux only brought groceries twice since she has been working in the home. Ms. Kellar indicated that the staff and residents sometimes buy food for the home. Staff purchase fresh fruit and vegetables. The residents will purchase food if there are specific things that they want to eat. Staff do not typically follow the menu for meals, as the ingredients are not always available.

Ms. Kellar indicated that last week the power went out at the home around 2:00pm on Wednesday, 07/07/21. Mr. Devereaux brought food to the home for the residents to eat for dinner that evening. He purchased lunch meat for sandwiches, which needed to be refrigerated, so it could not be eaten the following day. On Thursday, 07/08/21, the power was still out, so Ms. Kellar brought orange juice, muffins, and pop tarts for the

residents to eat for breakfast. She texted Ms. Devereaux and told her that the residents would need food for lunch and dinner. She stated that she tried to order food to be delivered, but the restaurants in the area were also closed. Around 5:00pm, Mr. Devereaux brough subs, salads, and soda for the residents to eat for dinner. Ms. Kellar indicated that the residents only ate two meals that day. On Friday, 07/09/21, the residents ate cereal for breakfast and had pizza for lunch and dinner. The power came back on Friday night.

On 07/14/21, I interviewed Resident B. Resident B stated that they do not always get three meals a day. She stated that staff only cook one meal a day, which is usually dinner. The residents make oatmeal or cereal for breakfast. They sometimes have to put water on their cereal because there is no milk in the home. They typically eat sandwiches or canned ravioli for lunch. The staff sometimes cook dinner. Resident B stated that they always eat the same processed food. There is always food in the home, but it is not the food that they want to eat. There are no fresh vegetables. Staff do not follow the menu. Resident B stated that the power was out for four days, and they did not get three meals a day during that time.

On 07/14/21, I interviewed Resident C. Resident C stated that there is always food in the home and staff offer the residents three meals a day; however, it is not necessarily food that they like to eat. Resident C stated that there is a lot of food in the home now because recipient rights was called, and the owners brought more food to the home. Last week, the power was out for a few days. Mr. Devereaux brought food to the home, but it needed to be refrigerated so they could not eat it the next day. They didn't eat for a whole day until Resident C called and harassed Ms. Devereaux. Mr. Devereaux brought subs to the home later that day. Resident C stated that they only ate one meal that day.

On 07/14/21, I interviewed Resident D. Resident D stated that they usually get three meals a day, but there have been times when they only got two meals a day. She stated that there is always food in the home, but it is not what they prefer to eat. They eat mostly chicken, which she does not like to eat every day. There are times when there is no milk, so some of the residents put water on their cereal. She does not care to do that, so she will skip eating breakfast. Staff cook whatever they have, and they do not follow a menu. They mostly eat canned and processed food. They do not usually have fresh fruit or vegetables.

On 07/14/21, I interviewed Resident E. Resident E had limited cognitive and verbal abilities. She indicated that they get to eat three times a day, but she does not like the food.

During the onsite inspection, I observed an adequate supply of food in the pantry, refrigerator, and freezer including milk, eggs, fresh fruit, and vegetables. However, the

home manager and residents indicated that additional groceries were brought to the home on Monday, 07/12/21, after a complaint was made to recipient rights. I reviewed copies of the menu for July 2021. The menu only had substitutions written for breakfast on 07/02/21. There were no substitutions indicated for the time period when the power was out from 07/07/21-07/09/21.

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 on the information gathered through my investigation, there is sufficient information to conclude that the residents did not receive three meals a day when the power was out at the facility from 07/07/21-07/09/21. The residents all indicated that they do not always like the food that is being served in the home, so they will choose not to eat meals. The food that is served is often canned and processed and they do not have fresh fruits or vegetables on a regular basis.
CONCLUSION:	**VIOLATION ESTABLISHED**

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.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff are not following a menu and are not writing in substitutions. The staff and residents indicated that staff cook what is available in the home and do not follow a menu. The menus did not include substitutions from when the power was out from 07/07/21-07/09/21.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility was out of toilet paper for two days.

INVESTIGATION:

On 07/14/21, I interviewed the home manager, Cassandra Kellar. She indicated that the home ran out of toilet paper over the weekend. She stated that she does not typically work on the weekends, but she came in for a few hours on Sunday, 07/11/21, and there was no toilet paper. Aaliyah Tucker and Destiny Peoples were on shift over the weekend. They contacted DJ Devereaux Sunday morning, and someone dropped off toilet paper on Sunday afternoon. Mr. Devereaux brought additional toilet paper to the home on Monday, 07/12/21. Ms. Kellar stated that she did not know how they did not notice that the toilet paper supply was running low. They have one resident who puts toilet paper into the toilet excessively, so the extra toilet paper is locked in a supply closet. Staff typically monitor this and notify the owners when it is getting low.

On 07/14/21, I interviewed Resident B, Resident C, Resident D, and Resident E. Resident B, Resident C, and Resident D all indicated that the home ran out of toilet paper on Friday, 07/09/21, and they did not get more until Sunday, 07/11/21. They had to use napkins or paper towels instead of toilet paper. Resident E did not recall the home running out of toilet paper.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the personal hygiene needs of the residents were not met when the facility ran out of toilet paper from 07/09/21-07/11/21.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my unannounced onsite inspection on 07/14/21, I observed the following:

- The faucet handle on the sink in the half bathroom was missing.
- The blinds in the living room were broken.

- A wall plate was missing and there were wires sticking out from the wall in bedroom #3.

On 07/20/21, the director of maintenance, DJ Devereaux, sent pictures showing that the faucet handle, blinds, and wall were repaired.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based on my observations during my onsite inspection, there is sufficient information to conclude that the home was not maintained for the health, safety, and well-being of the residents. The bathroom faucet handle was missing, the blinds were broken, and there were wires coming from the wall in one of the bedrooms.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my unannounced onsite inspection on 07/14/21, I observed the following:

- The kitchen floor tile was cracked.
- The carpet throughout the facility smelled musty and was stained and dirty.
- The walls throughout the facility were scuffed and dirty.
- A piece of the bathroom floorboard was missing.
- There were holes and cracks in the bathroom walls and the toilet paper holder was missing.

On 07/20/21, Mr. Devereaux indicated that they are in the process of replacing the flooring throughout the facility, as well as repairing and repainting the walls. He provided pictures on 07/29/21, 08/02/21, and 08/09/21 showing the floors that were replaced in the bedrooms and kitchen and the repairs made to the walls.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair.
ANALYSIS:	Based on the information gathered through my investigation and onsite inspection, there is sufficient information to conclude that

	the floors and walls in the facility were not kept clean and in good repair. The floors and walls throughout the facility were stained, cracked, and dirty.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection, I observed that the mattresses in bedroom #1 and bedroom #2 were worn and sagging. There were springs poking out of the mattress in bedroom #3.

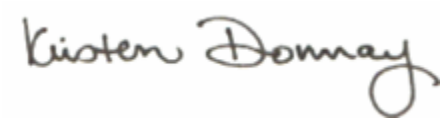
On 07/29/21, Mr. Devereaux sent a picture showing that new mattresses were provided.

On 08/25/21, I conducted an exit conference via telephone with the licensee designee, Kelly Devereaux. She indicated that they replaced all of the mattresses in the home, painted the bedrooms and living room areas, installed new flooring in the bedrooms, cleaned the carpet in the living room, and are in the process of completing the repairs in the bathroom. Ms. Devereaux indicated that she would submit a corrective action plan to address the violations. There is a new home manager at Mansfield who will be monitoring things on an ongoing basis to ensure continued compliance.

APPLICABLE RULE	
R 400.14410	**Bedroom furnishings.**
	(5) A licensee shall provide a resident with a bed that is not less than 36 inches wide and not less than 72 inches long. The foundation shall be clean, in good condition, and provide adequate support. The mattress shall be clean, comfortable, in good condition, well protected, and not less than 5 inches thick or 4 inches thick if made of synthetic materials. The use of a water bed is not prohibited by this rule.
ANALYSIS:	Based on the information gathered through my investigation and onsite inspection, there is sufficient information to conclude that the mattresses in bedroom #1 and bedroom #2 were not in good condition. I observed that the mattresses were sagging and had springs poking out.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

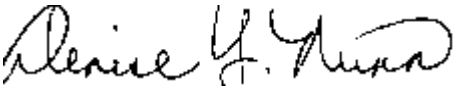
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



08/25/2021

Kristen Donnay Date
Licensing Consultant

Approved By:



08/25/2021

Denise Y. Nunn Date
Area Manager