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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 7, 2021

Shawn Brown
Domel Inc
Suite 112
39293 Plymouth Road
Livonia, MI 48150

RE: License #: AS820389327
Investigation #: 2021A0901028
Fitzgerald

Dear Mr. Brown:

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 (313) 456-0380.

Sincerely,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820389327
Investigation #:	2021A0901028
Complaint Receipt Date:	07/16/2021
Investigation Initiation Date:	07/19/2021
Report Due Date:	09/14/2021
Licensee Name:	Domel Inc
Licensee Address:	Suite 112 39293 Plymouth Road Livonia, MI 48150
Licensee Telephone #:	(734) 632-0125
Administrator:	Shawn Brown
Licensee Designee:	Shawn Brown
Name of Facility:	Fitzgerald
Facility Address:	16975 Fitzgerald Livonia, MI 48154
Facility Telephone #:	(734) 591-1261
Original Issuance Date:	11/14/2017
License Status:	REGULAR
Effective Date:	05/14/2020
Expiration Date:	05/13/2022
Capacity:	4

Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A is on a pureed diet and got into the pantry and was eating some uncooked noodles. Resident A is to be monitored when entering the kitchen, so he does not get food that is off his restricted diet.	Yes

III. METHODOLOGY

07/16/2021	Special Investigation Intake 2021A0901028
07/16/2021	Adult Protective Services Referral Denied
07/19/2021	Special Investigation Initiated - Telephone Resident A's psychologist
07/20/2021	Contact - Telephone call made Home Manager, Kelly Ekland
07/28/2021	Contact - Telephone call made Staff, Felicia Anderson
07/28/2021	Contact - Telephone call made Staff, Justina Saye
07/29/2021	Contact - Document Received Medical assessment
08/04/2021	Contact - Telephone call made Lisa Wilson, Community Living Services

08/04/2021	Contact - Telephone call made Resident A's Guardian
08/04/2021	Inspection Completed-BCAL Sub. Compliance
09/07/2021	Exit Conference Shawn Brown, Licensee Designee
10/07/2021	Referral - Recipient Rights

ALLEGATION:

Resident A is on a pureed diet and got into the pantry and was eating some uncooked noodles. Resident A is to be monitored when entering the kitchen so he does not get food that is off his restricted diet.

INVESTIGATION:

On 07/19/2021, I made a telephone call to Resident A's psychologist, Pamela Bernette, from Futures Health Core. She stated Resident A is on a pureed only diet. He recently got into the pantry and ate some dry noodles. She was concerned because his behavior treatment plan specifies that the pantry is supposed to be locked and he is supposed to be supervised when in the kitchen. Resident A is nonverbal.

On 07/20/2021, I made a telephone call to the home manager, Kelly Ekland. She stated staff, Felicia Anderson, observed the noodles in the back of the van when she picked Resident A up from workshop. The midnight staff person, Justina Saye, took the residents to workshop, so he had to get the noodles from the kitchen that morning before they left. Ms. Ekland stated it was unknown if he ate any of the noodles. She also indicated that he is on a pureed diet and supposed to be supervised around food and when in the kitchen, the pantry is supposed to stay locked.

On 07/28/2021, I made a telephone call to Ms. Anderson. She explained that when she went to pick the residents up from workshop that afternoon, she noticed uncooked noodles and noodle package in the back of the van. The residents were

not in the van at this time, so she assumed it was left in the van that morning when Ms. Saye took them to workshop.

On 07/28/2021, I made a telephone call to Ms. Saye. She said when she was taking the residents to workshop, Resident A had a pack of noodles. She stated as she was driving, she heard a crinkling noise as if someone was trying to open something. When she turned around, Resident A had dropped the noodle package on the floor. It was under his feet and some of the noodles were on the floor of the van. Ms. Saye did not think he ate any and did not know how he got the noodles. She stated the pantry is supposed to stay locked and he is supposed to be supervised in the kitchen. She indicated she did not see him go in the kitchen that morning.

On 07/29/2021, I received a copy of Resident A's medical assessment from Ms. Ekland. It verified that he is on a pureed diet only. He has oropharyngeal dysphagia. The condition is considered moderate and he has annual swallowing evaluations. His last evaluation was 05/19/2021. It indicated that Resident A engages in risky behaviors such as overfilling his mouth, shoveling, and swallowing whole foods.

On 08/04/2021, I made a telephone call to Resident A's case manager, Lisa Wilson, from Community living Services. She stated despite being on a pureed diet, Resident A has a history of sneaking food and is quick to grab food and eat it. For this reason, he is supposed to always be in within the eyesight of staff and is supposed to always be monitored when in the kitchen. This is all documented in his behavior treatment plan, which staff are aware of and are supposed to follow. Ms. Wilson stated due to this recent incident, she and Resident A's psychologist plan to re-train the staff again on his behavior treatment plan.

On 08/04/2021, I made a telephone call to Resident A's guardian, Damon Watkins, from Faith Connections. He stated Resident A is very quick and sneaky and that it only takes him seconds to get in the kitchen and grab something. He looks for opportunities to sneak in the kitchen and goes for it whenever he can. Mr. Watkins said staff are aware of this and supposed to always keep him in their line of sight and keep things locked up in the kitchen.

On 09/07/2021, I left a detailed message with the licensee designee, Shawn Brown, informing him of the outcome of my investigation and requesting that he call me if he had any questions.

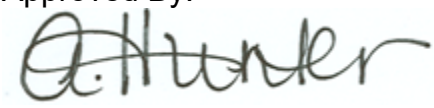
APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the information obtained during this investigation, Resident A was not supervised as specified in the behavior treatment plan. Everyone interviewed, staff, Resident A's case manager, psychologist, and guardian, all indicated that he is supposed to be kept within staff's eyesight, monitored in the kitchen, and the pantry should be kept locked. Although this is documented in his behavior treatment plan and staff admitted to being aware of it, Resident A was able to access a pack of noodles, which indicates he was not properly supervised.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

_____10/07/2021
Regina Buchanan Date
Licensing Consultant

Approved By:



_____10/7/2021
Ardra Hunter Date
Area Manager