



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

March 3, 2022

Angela Snyder  
ADAPT, Inc.  
202 Morse Street  
Coldwater, MI 49036

RE: License #: AS120359235  
Investigation #: 2022A0007011  
Wood Drive Home

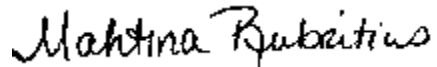
Dear Ms. Snyder:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,

A handwritten signature in black ink that reads "Mahtina Rubritius". The signature is written in a cursive style with a large initial 'M'.

Mahtina Rubritius, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Place  
3026 W. Grand Blvd., Ste. #9-100  
Detroit, MI 48202  
(517) 262-8604

Enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS120359235
<b>Investigation #:</b>	2022A0007011
<b>Complaint Receipt Date:</b>	01/07/2022
<b>Investigation Initiation Date:</b>	01/10/2022
<b>Report Due Date:</b>	03/08/2022
<b>Licensee Name:</b>	ADAPT, Inc.
<b>Licensee Address:</b>	202 Morse Street Coldwater, MI 49036
<b>Licensee Telephone #:</b>	(517) 279-7531
<b>Administrator:</b>	Angela Snyder
<b>Licensee Designee:</b>	Angela Snyder
<b>Name of Facility:</b>	Wood Drive Home
<b>Facility Address:</b>	52 Wood Drive Coldwater, MI 49036
<b>Facility Telephone #:</b>	(517) 278-4726
<b>Original Issuance Date:</b>	10/01/2014
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	04/01/2021
<b>Expiration Date:</b>	03/31/2023
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Allegations that a staff member yelled at a resident. Allegations that the staff member also grabbed the resident by his suspenders and yanked them up roughly. The staff member has been suspended without pay until further notice.	Yes

## III. METHODOLOGY

01/07/2022	Special Investigation Intake - 2022A0007011
01/07/2022	Contact - Document Received - Email from Ms. Snyder, Licensee Designee. Employee #1 yelled at one resident not all of them.
01/10/2022	Special Investigation Initiated - On Site
01/10/2022	APS Referral made.
01/10/2022	Inspection Completed On-site - Unannounced - Face to face contact with Ms. Wing, Home Manager and Resident A.
01/26/2022	Contact - Document Received - Document Received from Adult Protective Services. Case not assigned for investigation.
02/11/2022	Contact - Document Received - Email from Ms. Snyder, Licensee Designee. Status update.
02/28/2022	Contact - Document Sent - Email to Ms. Snyder, Licensee Designee. Information requested.
03/01/2022	Contact - Telephone call made to the facility. I spoke with Ms. Wing, Home Manager. Documentation requested.
03/01/2022	Contact - Document Received - Progress Notes.
03/01/2022	Contact - Document Received - Copy of ORR Investigative Report.
03/01/2022	Contact - Telephone call made to facility. I spoke to Ms. Wing and Resident A.

03/01/2022	Contact - Telephone call made to (Previous) Employee #1. Message left. I requested a returned phone call.
03/01/2022	Contact - Telephone call made to Employee #2. Interview.
03/02/2022	Contact - Telephone call made to (Previous) Employee #1. No answer.
03/02/2022	Contact – Document Sent - Email to Ms. Snyder, Licensee Designee. I requested a phone call to conduct the exit conference.
03/02/2022	Contact – Document Received – Email from Ms. Snyder, Licensee Designee. She apologized as it will be a bit before she could return my phone call.
03/02/2022	Content – Document Sent – Email to Ms. Snyder, Licensee Designee. I informed her that the allegations were substantiated and that I would be requesting a written corrective action plan. In addition, to give me a call if she had any additional questions.
03/02/2022	Exit Conference – Conducted with Ms. Snyder, Licensee Designee.

**ALLEGATIONS:**

**Allegations that a staff member yelled at a resident. Allegations that the staff member also grabbed the resident by his suspenders and yanked them up roughly. The staff member has been suspended without pay until further notice.**

**INVESTIGATION:**

On January 10, 2022, I conducted an unannounced on-site investigation and made face to face contact with Ms. Wing, Home Manager, and Resident A. Due to the rising number of COVID cases at that time, I conducted a brief on-site inspection. I made face to face contact with staff and Resident A in the garage of the facility.

Ms. Wing, Home Manager, informed me that Resident A was doing okay. She reported that Resident A had what appeared to be a thumb print on the inner right side of his arm. She reported that this information was documented in the medication book. She reported that Mr. Mitchell, Direct Care Staff, may have completed documentation on the Minor Injury Log.

I also made face to face contact with Resident A. He appeared to be doing okay.

As a part of this investigation, I reviewed the incident report and noted the following:

On January 6, 2022, Employee #2 documented that from the time she arrived to work until Ms. Wing, Home Manager arrived, she witnessed continuous altercations between Employee #1 and Resident A. It was noted that Employee #1 would raise her voice at Resident A and demanded that he stop walking and not to move. If Resident A kept walking that Employee #1 would get louder. On multiple occasions, Employee #1 told Resident A that if he could not keep his pants up, that she would not take him shopping tomorrow. This agitated and frustrated Resident A. Employee #2 (who was a new employee), intervened a couple different times. Employee #2 documented that she felt like the staff member was badgering and harassing Resident A. Employee #2 wrote "my heart hurt for the consumer, almost embarrassed." Employee #2 documented that Employee #1 yelled at Resident A stating, "Stop, don't you move. I said do not move." Then Employee #1 took both of her hands and grabbed Resident A by the collar of his shirt and shook him, while hollering at him. Employee #2 stepped in and told Employee #1 that they could not grab a consumer (resident) like that. Employee #2 then helped Resident A to use the toilet and adjust his clothes. Employee #2 then emailed supervision. Shortly after that, Ms. Wing, Home Manager #1 arrived. While Ms. Wing was in the home, Employee #1's entire demeanor changed.

The corrective measures, authored by Ms. Snyder, Licensee Designee, included Employee #1 being suspended without pay, pending the investigation. It was noted that Resident A appeared to be alright the following day. Employee #2 was provided with guidance from Mr. Porter, Office of Recipient Rights Officer, and her supervisor about how to handle a situation like this, should it occur in the future. It was noted that Employee #2 was a new employee and had just completed Recipient Rights training. Ms. Snyder also documented that Employee #2 did take appropriate action in stopping Employee #1 in her actions and treatment regarding grabbing and shaking Resident A; she also took appropriate actions in reporting the incident.

On February 11, 2022, Ms. Snyder, Licensee Designee, informed me that she terminated Employee #1 as of that date. It was also noted that Employee #1 had been suspended without pay, pending the ORR investigation. ORR substantiated one count of Abuse Class II, as well as one count of Dignity and Respect.

On March 1, 2022, I spoke to Ms. Wing, Home Manager, and inquired about the incident. She informed me that at the time of the incident, she received a call from supervision, who informed her that Employee #1 needed to go home. I requested that she send me a copy of the report that documented the mark on Resident A's inner arm. I also requested to speak with Resident A. Ms. Wing informed me that he had been awake during the night and recently went back to sleep. I informed her that I would call back later.

On March 1, 2022, I reviewed the Progress Notes/Minor Injury Log. Staff documented that on January 7, 2022, Resident A had a small purple circular bruise on his right upper arm.

On March 1, 2022, I attempted to interview Resident A. During the interview, Resident A did not provide any information to confirm or refute the allegations.

On March 1, 2022, I interviewed Employee #2. She informed me that she was in training, and it was her second day of work when the incident occurred. Employee #2 stated that she felt like Resident A was being targeted. Employee #1 was yelling at him to pull his pants up. Employee #2 informed me that Resident A wore suspenders, but she was not sure if he had them on that day. According to Employee #2, Employee #1 was being rude and continuing to yell at Resident A. Employee #2 observed that Resident A had put on his coat, but that it was upside down. Employee #1 went over to Resident A, and Employee #2 thought she was going to assist him with putting his coat on correctly. Employee #2 stated that Employee #1 grabbed Resident A by the collar of his shirt and shook him. Resident A stood there, and his face was red. Employee #2 expressed that her heart was hurt for the resident. Employee #2 informed me that she knew this should not be occurring and was thankful that the matter was investigated.

During the course of this investigation, I received and reviewed the Office of Recipient Rights' Investigative Report. As a part of their investigation, Employee #1 and Employee #2 were interviewed. It was noted that during the interview with Employee #1, she admitted to grabbing Resident A by his coat, around the elbow; Resident A then pulled up his pants. She also admitted to making him hold his hands together (while staff assisted with fixing his pants). Employee #1 did not confirm the allegations that she shook Resident A.

It was noted that ORR substantiated one count of Abuse Class II and one count of Dignity and Respect against Employee #1.

On March 2, 2022, I conducted the exit conference with Ms. Snyder, Licensee Designee. Ms. Snyder stated that they could not have someone like this working for their homes; Employee #1 has been terminated. Ms. Snyder informed me that she had already submitted a CAP to ORR. She agreed to submit a written corrective action plan to AFC Licensing to address the established violation.

<b>APPLICABLE RULE</b>	
<b>R 400.14305</b>	<b>Resident protection.</b>
	<b>(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.</b>

<b>ANALYSIS:</b>	<p>Employee #2 documented that Employee #1 yelled at Resident A numerous times, and Employee #1 grabbed him by the collar of his shirt, shaking him.</p> <p>During the interview, Employee #2 stated that she felt like Resident A was being targeted.</p> <p>Staff documented that on January 7, 2022, Resident A had a small purple circular bruise on his right upper arm.</p> <p>ORR substantiated one count of Abuse Class II and one count of Dignity and Respect against Employee #1.</p> <p>On February 11, 2022, Ms. Snyder, Licensee Designee, informed me that she terminated Employee #1.</p> <p>Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Resident A was not treated with dignity and his personal needs, including protection and safety, were not attended to at all times in accordance with the provisions of the act.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

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

*Mahtina Rubritius*

03/02/2022

Mahtina Rubritius  
Licensing Consultant

Date

Approved By:

*A. Hunter*

03/03/2022

Ardra Hunter  
Area Manager

Date