GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 18, 2022

Simbarashe Chiduma
Open Arms Link
Suite 130
8161 Executive Court
Lansing, MI 48917

RE: License #: AM190409578
Investigation #: 2022A1029048
Open Arms Stoll

Dear Mr. Chiduma:

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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM190409578
Investigation #:	2022A1029048
Complaint Receipt Date:	06/22/2022
Investigation Initiation Date:	06/23/2022
Report Due Date:	08/21/2022
Licensee Name:	Open Arms Link
Licensee Address:	8161 Executive Court, Suite 130 Lansing, MI 48917
Licensee Telephone #:	(517) 483-4489
Administrator:	Mascline Chiduma
Licensee Designee:	Simbarashe Chiduma
Name of Facility:	Open Arms Stoll
Facility Address:	3285 W Stoll Rd, Suite, 130 Lansing, MI 48906
Facility Telephone #:	(517) 455-8300
Original Issuance Date:	08/25/2021
License Status:	REGULAR
Effective Date:	02/25/2022
Expiration Date:	02/24/2024
Capacity:	9
Program Type:	PHYSICALLY HANDICAPPED

	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

ALLEGATION(S)

	Violation Established?
Resident A is not treated with respect at Open Arms Stoll.	No
The facility did not know where to find Resident A's medication and did not prepare Resident A's Novolog with the correct amount of medication when she was at camp from June 5-7, 2022.	Yes
Additional Findings	Yes

II. METHODOLOGY

06/22/2022	Special Investigation Intake 2022A1029048
06/23/2022	Special Investigation Initiated – Telephone to AFC Licensing consultant Rodney Gill, he also had investigations regarding medication concerns.
06/24/2022	Contact - Telephone call received from Complainant
06/29/2022	Contact - Face to Face with Ms. Bolling, operations manager, and Ms. Bridgeman at Open Arms Stoll
06/29/2022	Inspection Completed-BCAL Sub. Non-Compliance
06/29/2022	Contact - Telephone call made to Mr. Perhase
07/27/2022	Contact - Telephone call received from Rodney Gill
07/27/2022	Contact - Document Sent to CMH case manager, Trsyr Friar, LLMSW
07/27/2022	Contact - Document Received from Guardian A1
07/28/2022	Contact - Document Received from Guardian A1
07/29/2022	Contact - Document Received Email from Trsyr Friar
08/01/2022	Contact - Document Sent to Samantha Johnson

08/03/2022	Contact - Face to Face with Resident A and Robin Bolling at Open Arms Stoll
08/09/2022	Contact - Telephone call made contacted Camp Sunshine Michigan and left a message
08/09/2022	Contact - Telephone call made Jada Moore, former home manager. Unable to leave message
08/09/2022	Contact - Telephone call made Misael Saldivar, former assistant home manager. Left a message.
08/09/2022	Contact - Document Received Misael Saldivar, former assistant home manager
08/09/2022	Contact - Telephone call made manager, Ms. Johnson
08/09/2022	Contact - Telephone call received to Director of Camp Sunshine, Kathy Rohlman
08/09/2022	Contact - Telephone call made to facility administrator Mascline Chiduma. Attempted to leave a message but VM was full.
08/11/2022	Contact - Telephone call made to Licensee designee Simbarashe Chiduma
08/11/2022	Exit Conference with licensee designee, Simbarashe Chiduma

ALLEGATION:

Resident A is not treated with respect at Open Arms Stoll.

INVESTIGATION:

On July 22, 2022, a complaint was received via the Bureau of Community and Health Systems online complaint system regarding concerns the direct care staff members are not treating Resident A well at Open Arms Stoll. There were no details regarding how she was mistreated or which direct care staff members were mistreating Resident A.

On July 27, 2022, I emailed Resident A's Clinton Eaton Ingham Community Mental Health (CEI-CMH) case manager, Trsyr Friar, LLMSW. Mr. Friar was asked if there were any concerns regarding direct care staff member treatment toward Resident A. Mr. Friar stated he had been in the home and observed interactions between Resident

A and direct care staff members. On July 29, 2022, Mr. Friar responded that he had no concerns about direct care staff treatment toward Resident A.

On July 28, 2022, an email was received from Guardian A1 stating a former manager did not use “Gentle Parenting” strategies with Resident A and was sometimes frustrated with her. However, there were no details provided and Guardian A1 stated the current home manager Samantha Johnson would have more details regarding how Resident A was treated.

On August 3, 2022, I completed an unannounced onsite investigation at Open Arms Stoll. I interviewed Resident A who stated she gets along well with the direct care staff members who work with her. She stated the previous manager, Ms. Moore was nice to her and described them to have a good relationship. Resident A did not have concerns regarding how she was treated while living at Open Arms Stoll.

On August 3, 2022, I interviewed Ms. Bolling at Open Arms Stoll. Ms. Bolling stated she had no concerns about interactions between the direct care staff members and Resident A. Ms. Bolling stated the previous manager was younger and lacked experience to deal with Resident A’s mood swings, however, Resident A was not mistreated. Ms. Bolling stated direct care staff members are trying to form relationships with her and work toward developing trust with Resident A. Recently, Resident A’s CMH caseworker, Mr. Friar, came to the staff meeting to complete a training regarding how to best work with Resident A.

On August 7, 2022, I received an email from Ms. Johnson, direct care staff member, whose current role is home manager. Ms. Johnson stated she had no concerns regarding the treatment of Resident A in the home. She stated she has not known any residents or staff who mistreated Resident A in any way. Ms. Johnson stated she knows Resident A does not always get along with other residents but nothing beyond what is expected in a behavioral home setting.

On August 9, 2022, I contacted Misael Saldivar, former direct care staff member and assistant home manager. Mr. Sandival stated he did not have concerns for how Resident A was treated in the home as Resident A sometimes threw small objects at direct care staff members when upset. When she would throw things at the staff, the direct care staff member let her go outside, smoke, and relax to calm herself down or redirected her. Mr. Sandival denied seeing any direct care staff push or pinch her in the home. He stated Resident A was verbally aggressive with him one time near the beginning of May 2022. Mr. Sandival denied he ever pushed, pinched, or punched Resident A or any other resident in the home nor was he verbally aggressive with any resident. After Resident A was verbally aggressive, he asked her to go inside the home because she was causing the other residents to get mad.

On August 9, 2022, I interviewed direct care staff member Ms. Johnson, whose current role is home manager. She stated if anyone were to report anything, she would notify her directors and adult protective services immediately. Ms. Johnson stated she and

Resident A have a great rapport. She stated Guardian A1, Mr. Friar, and her all have good communication so they can best meet Resident A's needs. Ms. Johnson is trying to focus on making sure Resident A has her needs met while she is at their facility. Ms. Johnson has been focused on training direct care staff members on how best to meet Resident A's needs.

On August 11, 2022, I contacted licensee designee, Simbarashe Chiduma. Mr. Chiduma stated he has never had any concerns regarding her treatment. He has been in the home many times and has never noticed direct care staff members not treating her well. Mr. Chiduma stated at times it is difficult to handle Resident A, however, she has never been mistreated in the home. They also try to keep her involved with many activities and keep her busy.

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: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	This investigation did not reveal any incidents where Resident A was not treated with respect while residing at Open Arms Stoll. Resident A stated she had a good relationship with the current direct care staff members including the former manager, Ms. Moore, and the current manager, Ms. Johnson. Resident A did not report any incidents of mistreatment.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not know where to find Resident A's medication and did not prepare Resident A's Novolog with the correct amount of medication when she was at camp from June 5-7, 2022.

INVESTIGATION:

On June 22, 2022, a complaint was received via Bureau of Community and Health Systems online complaint system regarding concerns Resident A did not have her prescribed medications when she went to an overnight camp.

On June 24, 2022, I interviewed Guardian A1. Guardian A1 stated Resident A attended an overnight camp from June 5, 2022-June 7, 2022 but only one Novolog Pen was sent to the camp and it was only half full. Guardian A1 has never had concerns the facility did not know where her medications were kept. Guardian A1 stated after the camp staff realized there was not enough Novolog for the whole weekend, Guardian A1 contacted the facility and spoke with the home manager, Jada Moore who apologized Resident A was not sent with the right amount of medication.

On June 29, 2022, I completed an unannounced onsite investigation at Open Arms Stoll and interviewed Robin Bolling. Ms. Bolling stated she was the new "operations manager" at the facility. She stated Resident A was at camp from June 5, 2022-June 7, 2022. I was able to review her Medication Administration Record (MAR) which documented a leave of absence (LOA) for the dates of camp. There was nothing on the back of the MAR regarding where she was or if she received medication during the leave of absence. According to Resident A's MAR, she is prescribed Novolog Mix 70-30 pen with instructions to inject 58 units under the skin every morning and 48 units every morning. The pen is a multiuse pen so they are able to use it more than once. While I reviewed the MAR for Resident A, I noticed there several days she did not receive her Novolog injection. Ms. Bolling stated during the medication administration training at Community Mental Health she stated they were instructed to put an "E" on the MAR with a note why the medication was missed. Ms. Bolling was able to show me the Novolog pens which were stored in the basement refrigerator in a locked box. Ms. Bolling initially did not know the code to open the lock box but was able to ask the direct care staff member Nickiua Bridgeman for the code. In the lock box, Resident A had two full boxes and one box with one Novolog pen left.

On June 29, 2022, I interviewed direct care staff member Ms. Bridgeman. Ms. Bridgeman stated she was a new direct care staff member the weekend Resident A went to camp. Ms. Bridgeman stated she packed Resident A's medications before she left for camp. Ms. Bridgeman stated she remembers going down to the basement refrigerator to get the Novolog pens. Ms. Bridgeman stated she was told to take everything that was in the medication closet. Ms. Bridgeman stated she does not know how many doses are in each Novolog pen or how long a pen would last for Resident A. Ms. Bridgeman stated she was not at the facility when camp staff called stating they did

not have enough medication. Ms. Bridgeman stated she does not know how long it took to bring the additional medication to the camp or who drove the medication there. Ms. Bridgeman stated Resident A receives Novolog three times per day and when she packed the medications up for camp, she gave the whole black box of Novolog pens.

On June 29, 2022, I interviewed direct care staff member, Brett Perhase. Mr. Perhase stated there was not enough insulin sent to the camp for Resident A. Mr. Perhase stated no refills were sent to the camp and there was a plan to transfer the prescription for her Novolog to a closer pharmacy. He stated Ascension Pharmacy was going to send the prescription to Meijer Pharmacy however, they could not fill the prescription. Mr. Perhase stated he has never heard any of the direct care staff members state they could not find the medications when they were needed. All direct care staff member who worked at Open Arms Stoll knew they could find her Novolog pens in the basement refrigerator lock box. Mr. Perhase stated he did not know how many Novolog pens were sent to the camp.

On July 27, 2022, I emailed Resident A's Clinton Eaton Ingham Community Mental Health (CEI-CMH) case manager, Mr. Friar, LLMSW. Mr. Friar was asked if there were any concerns regarding medication mismanagement. Mr. Friar has been in the home and observed interactions. On July 29, 2022, Mr. Friar responded that he had no concerns regarding Resident A not receiving her medications as prescribed.

On August 3, 2022, I completed an unannounced onsite investigation at Open Arms Stoll. I interviewed Resident A who stated she did not have enough Novolog insulin when she went to camp because only one pen was packed for her. When she arrived the camp staff noticed that she did not have enough. The next day direct care staff member, Mr. Sandival brought her more insulin. Resident A stated she missed one dose at breakfast and dinner on the second day of camp. Resident A stated she receives two doses of insulin a day in the morning and evening but she does not feel sick if she misses a dose. During this onsite investigation, I reviewed the MAR to confirm that she was receiving her Novolog medication.

I noted that in the month of July 2022, according to the written MAR, the following medications were not administered as prescribed:

- July 16, 19, 21, 22, 25, and 27 - Resident A's Novolog flex pen was not administered twice on those dates and according to the written physician's order and MAR the medication is to be administered every morning and every evening.
- July 27, 2022 - Resident A's Antacid was not administered on this date according to the MAR at noon and 4:00 p.m.
- July 27, 2022 -Pulmicort Flexhale was not administered at 8:00 p.m. and the written physician's order and MAR state the medication should be administered twice daily.

On August 3, 2022, I discussed the above medications that were not given as prescribed to Resident A with Ms. Bolling. Ms. Bolling stated she, Ms. Johnson, and

Ms. Chiduma review the MAR a couple times per week to ensure there are no entries that were missed. She stated they give progressive discipline to the direct care staff members that do not complete their charting. I mentioned to Ms. Bolling at this time they may need to do this daily since there were still blanks on the MAR and medications that were not given as prescribed.

On August 9, 2022, I interviewed Misael Saldivar, former assistant home manager. Mr. Saldivar stated he was familiar with Resident A and her medications. Mr. Saldivar stated she packed an insulin pen but Resident A was running low so they had to drive out to the camp to give another insulin pen. Mr. Saldivar stated Resident A was only given one insulin pen when she left for camp even though she was there for the whole weekend. He thought it was a misunderstanding with the staff regarding how many she needed for the weekend. Mr. Saldivar stated the camp called first and then Guardian A1 called to see if they could bring it out there. Mr. Saldivar stated they brought the medication to the camp the same day within about 3 hours. Mr. Sandival stated she did not miss any insulin doses because of them only sending one pen. Mr. Sandival stated he drove it to the camp. Mr. Sandival stated the camp was pleased they were able to get the medications to the camp as quickly as they could, but he could tell Guardian A1 was upset. Mr. Sandival believes Guardian A1 took her to camp. There was a printout of the MAR that was sent with the medications. Mr. Sandival stated the Resident A's Novolog is always locked in the downstairs refrigerator and all the direct care staff members know where this is. All of the medications are kept in the closet except for her Novolog and there is a sheet in the office that explains how and where to find this medication.

On August 9, 2022, I interviewed the director of the camp Resident A attended, Kathy Rohlman. She stated Resident A came with several medications that were checked into their camp. Ms. Rohlman shared with Guardian A1's husband, who dropped her off, that they did not have enough insulin because there was only one pen that was automatically dosed. Ms. Rohlman stated Resident A planned to be at camp for two nights/three days from 9am on Sunday morning, June 5, 2022 and departed on Tuesday June 7, 2022 by noon. When the medications were checked in, Ms. Rohlman stated they could tell there was not enough insulin. Ms. Rohlman stated camp staff made continuous calls within the next twenty four hours to the facility to get more medication. Ms. Rohlman stated Resident A did not miss any doses of insulin for any of the days she was at camp. Ms. Rohlman stated there was no point the home staff did not know where to find her medications. The insulin was delivered by Mr. Sandival on the second day of camp at 7 p.m. The camp provided insulin to her the evening of the first day and breakfast the second day. Ms. Rohlman stated before Resident A arrived at their Camp, they did not talk to anyone regarding her medications because she assumed the application was correct when it stated there were no behavioral issues, four medications, and no injectable medications. Ms. Rohlman stated the camp application was completed by Guardian A1.

On August 11, 2022, I contacted licensee designee, Simbarashe Chiduma. He stated the medications were driven to the camp and Resident A did not miss any dosages of

medications while at camp. Mr. Chiduma stated they met the time frame requirement to drive the medications to camp. Mr. Chiduma denied there were any concerns regarding them not knowing where to find the medication. Mr. Chiduma stated there were a lot of challenges in regard to the medication. It is possible she thought when she had that one pen in there, it would have been enough. Mr. Chiduma talked to the direct care staff member and administers regarding the blanks in the MAR and the direct care staff member will tell them they did give the medication but he explained it to them that if it is not marked, then it looks like it is not given. Ms. Chiduma is also going over the facility to make sure that it is logged correctly. Mr. Chiduma is also in the process of changing to an electronic MAR system which will assist with decreasing the errors.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	The facility was able to assure Resident A had enough insulin medication while at camp in June 2022 despite initially not including enough medication. Additional medication was brought to camp for Resident A and Resident A did not miss any doses of insulin medication. Lastly, Guardian A1 took possession and thus responsibility for all Resident A's medications when dropping her off for camp. The licensee was not responsible for completing the camp application or providing additional medication information.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based on statements from Guardian A1, Resident A, Ms. Bolling, and Mr. Chiduma along with a review of Resident A's July 2022 written medication administration records, I determined there were several different medications on various dates in July 2022 that were not administered as prescribed including medications prescribed by Resident A's mental health provider.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [REFERENCE SIR#2022A0790006 AND CORRECTIVE ACTION PLAN DATED 5/24/22 AND SIR#2022A0790006 AND CORRECTIVE ACTION PLAN DATED 6/29/22].**

ADDITIONAL FINDINGS:

INVESTIGATION:

On June 29, 2022, I completed an unannounced onsite investigation at Open Arms Stoll and interviewed Robin Bolling. While reviewing Resident A's record, I noticed Resident A's *Resident Weight Record* included over a 100 pound weight loss. Ms. Bolling stated this had to be wrong because she was recently at the doctor and she weighed 297 pounds. The documentation on her *Resident Weight Record* for May 2022 was 301 pounds and her weight for June 2022 was 190 pounds. There was no weight recorded for April 2022.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	Resident A's Resident Weight Record incorrectly showed a 100 pound weight loss and there was no weight recorded for April 2022. Ms. Bolling stated this had to be wrong because she was recently at the doctor and she weighed 297 pounds. The documentation on her *Resident Weight Record* for May 2022 was 301 pounds and her weight for June 2022 was 190 pounds. Monthly weight records were not maintained as required nor documented a correct weight.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

_____08/11/2022_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

08/18/2022

_____

Dawn N. Timm
Area Manager

Date