GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 24, 2022

Keta Cowan
Synod Residential Services
P.O. Box 980465
Ypsilanti, MI 48197

RE: License #: AS630084857
Investigation #: 2022A0991033
Prosperity House

Dear Ms. Cowan:

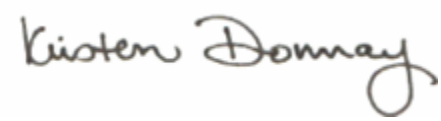
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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
Cadillac Place
3026 W. Grand Blvd., Ste. 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630084857
Investigation #:	2022A0991033
Complaint Receipt Date:	07/05/2022
Investigation Initiation Date:	07/05/2022
Report Due Date:	09/03/2022
Licensee Name:	Synod Residential Services
Licensee Address:	P.O. Box 980465 Ypsilanti, MI 48198-0465
Licensee Telephone #:	(734) 483-9363
Licensee Designee:	Keta Cowan
Name of Facility:	Prosperity House
Facility Address:	273 S Coats Rd Oxford, MI 48371
Facility Telephone #:	(248) 969-1553
Original Issuance Date:	04/29/1999
License Status:	REGULAR
Effective Date:	12/23/2021
Expiration Date:	12/22/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident J was diagnosed with polydipsia (an uncontrollable urge to drink water). Staff did not provide appropriate supervision and allowed Resident J to remain in the bathtub for hours causing Resident J to be transported to the hospital in critical condition.	Yes

III. METHODOLOGY

07/05/2022	Special Investigation Intake 2022A0991033
07/05/2022	Special Investigation Initiated - Telephone To Office of Recipient Rights (ORR)
07/05/2022	APS Referral Received from Adult Protective Services (APS)
07/05/2022	Referral - Recipient Rights Resident does not receive services through Oakland Community Health Network; referred to Washtenaw County
07/07/2022	Inspection Completed On-site Unannounced onsite inspection- interviewed home manager
07/07/2022	Contact - Document Sent Email to/from APS worker, Tina Edens
07/15/2022	Contact - Document Received Collateral contacts from APS worker
07/19/2022	Contact - Telephone call made Left message for direct care worker, Lillian Malone
07/19/2022	Contact - Telephone call made Left message for direct care worker, Adam Aldridge
07/21/2022	Contact - Document Received Written statement from staff, Lillian Malone
07/25/2022	Contact - Telephone call made To Shaun Thompson, Washtenaw County Office of Recipient Rights

07/25/2022	Contact - Telephone call made To direct care worker, Adam Aldridge
07/25/2022	Contact - Telephone call made Left message for direct care worker, Lillian Malone
08/05/2022	Contact - Telephone call made Left message for direct care worker, Lillian Malone
08/05/2022	Contact - Telephone call made To case manager, Lisa Schmidtke
08/05/2022	Contact - Telephone call received From psychologist, Sabrina Corbin
08/08/2022	Contact - Telephone call made Left message for direct care worker, Lillian Malone
08/08/2022	Contact - Telephone call made Left message for home manager, Ozie Kirby
08/09/2022	Contact - Telephone call made Left message for direct care worker, Lillian Malone
08/09/2022	Contact - Telephone call made Left message at AFC home for Lillian Malone
08/10/2022	Contact - Telephone call made Interviewed Lillian Malone
08/11/2022	Contact - Telephone call made Left message for licensee designee, Keta Cowan, re: exit conference
08/12/2022	Contact - Telephone call made Left message for licensee designee, Keta Cowan, re: exit conference
08/15/2022	Exit Conference Held via telephone with licensee designee, Keta Cowan

ALLEGATION:

Resident J was diagnosed with polydipsia (an uncontrollable urge to drink water). Staff did not provide appropriate supervision and allowed Resident J to remain in the bathtub for hours causing Resident J to be transported to the hospital in critical condition.

INVESTIGATION:

On 07/05/22, I received a complaint that indicated Resident J experiences polydipsia (an uncontrollable urge to drink water). On multiple occasions, emergency medical services (EMS) responded to the group home where Resident J is currently living. Resident J drinks excessive amounts of water, which causes the need for medical treatment. Resident J lacks the ability to know when to stop drinking water before causing health issues. On 07/02/22, Resident J drank a significant amount of water causing cardia arrhythmia. Resident J was transported to McLaren Oakland in critical condition. The two staff members on duty at Prosperity House were aware of Resident J's condition, but stated, "they assumed he needed some privacy" and allowed him to take a bath for hours. The complaint alleged that Resident J was in the tub for several hours before he was found by the staff. There are concerns that Resident J is not receiving appropriate supervision. I initiated my investigation on 07/05/22 by contacting the assigned Adult Protective Services (APS) worker, Tina Edens, and by making a referral to the Office of Recipient Rights (ORR).

The assigned APS worker, Tina Edens, provided notes from her face-to-face visit with Resident J at McLaren Oakland Hospital on 07/02/22. The notes indicate that Ms. Edens spoke with the intensive care unit (ICU) doctor, Dr. Jalil Qari. Dr. Qari stated that Resident J was found drinking excessive amounts of bath water and is in critical condition and unresponsive. At the time of the hospital visit, Resident J was unresponsive and had a tube down his throat. A CAT scan of the head was completed, and the results came back good. Resident J was provided hypertonic saline, which is salt water with concentrates. Resident J was observed laying in the bed with breathing tubes down his throat. On 07/06/22, Ms. Edens made contact with the hospital social worker who informed her that Resident J died on 07/03/22 at 11:44pm after six rounds of CPR. The cause of death was hyponatremia, which is severely low sodium levels.

On 07/07/22, I conducted an unannounced onsite inspection at Prosperity House. I interviewed the home manager, Ozie Kirby. Ms. Kirby indicated that she has worked for the company for eight years, but she became the home manager of Prosperity House in 2019 or 2020. Ms. Kirby stated that Resident J had polydipsia and frequently drank too much water. He was hospitalized on 06/17/22 for this reason, but he returned to the home on 06/20/22. Ms. Kirby stated that Resident J usually stayed in the hospital for a longer period of time. Resident J had a follow up appointment with his primary care physician, Dr. Taylor, on 06/27/22. On 07/02/22, Ms. Kirby received a phone call and text message from direct care worker, Adam Aldridge, stating that Resident J “was in

the water again." Mr. Aldridge informed Ms. Kirby that Resident J was transported to the emergency room due to drinking too much water. Ms. Kirby stated that Lillian Malone was the staff on shift at the time of the incident. Ms. Malone was working the midnight shift and Mr. Aldridge came in to relieve her at 8:15am. Ms. Kirby stated that it was reported to her that around 4:00am Resident J said that he wanted to take a shower or bath. He went into the bath around 4:00am and then got out. A short time later, he wanted to take another bath. Ms. Kirby stated that she did not believe that Resident J was in the bathtub for hours. He was going in and out of the bathroom. He also went into the kitchen to try to drink water. Staff had to remove the cups from the kitchen. Around 7:00am, Resident J went back into the bathroom. Staff knocked on the door and found Resident J on the floor with his clothes half on. He had a rag that he was dipping into the water and drinking from. Staff tried to redirect Resident J. At that point, he was unstable and fell in the kitchen. Staff called 911. Ms. Kirby stated that Resident J had a behavior plan related to his polydipsia, but it only stated that staff were supposed to try to redirect Resident J. Resident J was his own guardian. He did not have any restrictions regarding bathing. He was able to take showers on his own and did not require staff supervision per his plan. Resident J typically showered in the morning and only took 10 minutes. Ms. Kirby stated that when Resident J was exhibiting signs of polydipsia, he went into the bathroom and locked the door, so there was nothing that staff could do to stop him from drinking water.

On 07/25/22, I interviewed direct care worker, Adam Aldridge. Mr. Aldridge stated that he has worked in the home since July 2021. On 07/02/22, Mr. Aldridge came in for his shift at 8:15am. When he arrived at the home, emergency medical services (EMS) was already at the home. The paramedics were with Resident J in the living room. Resident J was having difficulty speaking. His body was trembling, and he could not stand or bear weight. Mr. Aldridge gave them Resident J's medication list and helped clear a path for the gurney. Mr. Aldridge stated that this was the last time he saw Resident J, as he was transported to the hospital and later passed away. Direct care worker, Lillian Malone, told Mr. Aldridge that Resident J was going back and forth to the bathroom and the kitchen sink trying to drink water. He did not believe Resident J was in the bathroom for a prolonged period, but rather he had been taking multiple trips, which fits Resident J's behavior pattern. Resident J would frequently state that he needed to use the bathroom, and then he would hyper-consume water. Mr. Aldridge stated that Resident J's plan of service did not indicate that he needed supervision or monitoring while in the bathroom. If he was in the bathroom for a prolonged period of time, staff would knock on the door and ask him if he was okay or if he needed assistance. Mr. Aldridge stated that when Resident J was trying to consume too much water, he would talk to him and let him know that it is dangerous and could make him ill. Mr. Aldridge would try to get Resident J to participate in other activities or would ask Resident J to shadow him. Mr. Aldridge stated that the staff in the home were diligent about checking on Resident J. He was hospitalized approximately two weeks prior due to drinking too much water while Mr. Aldridge was on shift. Staff could tell that Resident J had consumed too much water by Resident J's speech pattern and the way he walked and talked. If they observed anything unusual in his speech or behavior, they called 911.

On 07/25/22, I interviewed the Office of Recipient Rights (ORR) worker from Washtenaw County Community Mental Health (CMH), Shaun Thompson. Mr. Thompson stated that he did not open a case for investigation, but he did review Resident J's death. He spoke with the provider and clinical team regarding the incident. Mr. Thompson stated that Resident J did not have a supervision requirement while he was in the bathroom. Staff were just supposed to keep an ear out for Resident J and redirect him if they heard him drinking water excessively. Mr. Thompson stated that typically residents with polydipsia have more restrictions, but Resident J's case was presented to the behavior treatment committee, and they felt the current plan was appropriate. Mr. Thompson was part of the team approving Resident J's behavior plan. Resident J had not been engaging in the behavior of drinking excessive water recently, so additional restrictions were not put in place. Mr. Thompson stated that he reviewed the written statement from the staff who was working, and he felt that staff responded appropriately. He stated that Resident J's death was a tragic accident.

On 08/05/22, I interviewed Resident J's case manager from Washtenaw County CMH, Lisa Schmidtke. Ms. Schmidtke stated that Resident J had a behavior plan in place to address his polydipsia, but he did not require supervision while in the bathroom. Staff were just supposed to listen and verbally redirect him. Resident J had a history of going in and out of the bathroom and drinking from the bathtub. At one point, he was drinking water from the toilet. Ms. Schmidtke stated that despite these behaviors, the behavioral committee did not put restrictions in place for staff to go into the bathroom with Resident J. They could remove large cups from his bedroom, but they could only redirect him if he was in the bathroom for a long period of time. Ms. Schmidtke stated that she visited the home monthly and talked to staff and the residents in the home. She reviewed the behavior plan with staff. She did not have any concerns about the home prior to this incident.

On 08/05/22, I interviewed Sabrina Corbin, the psychologist with Psych Resolutions who wrote Resident J's behavior plan. Ms. Corbin stated that Psych Resolutions is contracted with CMH to assist with behavior plans. Resident J had a behavior plan in place to address his polydipsia. His plan did not state that staff could go into the bathroom with Resident J. Ms. Corbin stated that staff should be listening and monitoring Resident J to see how long he is in the bathroom. The plan did not specify how long Resident J could be in the bathroom, or after what length of time staff should intervene. Staff were not required to document how long Resident J was spending in the bathroom. Ms. Corbin stated that if staff heard the water running for "a while" they should verbally redirect Resident J. She stated that other than using their voices to redirect Resident J, staff could not otherwise intervene. They were not permitted to physically touch Resident J to redirect him. Staff could offer Resident J hard candy or try to engage him in other activities. Ms. Corbin stated that when staff caught Resident J drinking excessively, they were able to redirect him, as Resident J typically responded to verbal redirection. Problems arose when staff did not catch him. Ms. Corbin felt that staff at Prosperity House were following Resident J's behavior plan "to the best of their abilities". Ms. Corbin stated that the behavior committee did not feel that additional

restrictions were necessary, as Resident J had not been hospitalized in a while for behaviors related to polydipsia. She was not aware of Resident J going to the hospital in June 2022. She stated that they contact the home monthly to review and retrain the behavior plan. Contact with the home likely occurred before Resident J's hospitalization in June. When they made contact in July, Resident J had already passed away. Ms. Corbin stated that there was no indication that Resident J needed additional restrictions in place, so the behavior treatment committee would not have approved additional monitoring in the bathroom, as this is considered very restrictive.

On 08/10/22, I interviewed direct care worker, Lillian Malone, via telephone. Ms. Malone also submitted a written statement dated 07/12/22. The following information is taken from my interview with Ms. Malone, as well as her written statement. Ms. Malone stated that she has worked in the home for 19 years. She typically works the third shift from 8:00pm-7:00am. Ms. Malone stated that Resident J did not require supervision while he was in the bathroom. Once he went into the bathroom, staff were not allowed to enter the bathroom. Staff gave Resident J verbal reminders to stay out of the water. On 07/02/22, Resident J was up between 4:00am and 4:30am to use the bathroom. Ms. Malone encouraged Resident J not to drink water from the bathroom sink. Resident J came out of the bathroom and asked for a cigarette. Ms. Malone told Resident J that it was not time yet and asked him to wait until 7:00am. Ms. Malone stated that the residents are allowed to smoke, but staff try to discourage it. Ms. Malone asked Resident J if he could clean his room or watch television until it was time to smoke. Resident J began walking back and forth from his room to the living room and then outside on the deck looking for a lighter and a cigarette butt to smoke. He came back into the house and stated that he was going to take a bath. Resident J got a towel out of the hall closet and went into the bathroom. Ms. Malone did not recall exactly how long Resident J was in the bathroom. She stated it was probably 30 minutes to an hour, which Ms. Malone stated would be an appropriate amount of time if he was taking a bath. Ms. Malone's written statement notes that Resident J stayed in the bathroom for "about an hour or so." Resident J came out of the bathroom fully dressed and began to walk back and forth from his bedroom to the living room and outside onto the deck.

Ms. Malone stated that she did not know if Resident J took a bath. She did not hear water running, and she did not hear Resident J slurping water. She was not listening at the door, as this is not required, and she was assisting other residents who were awake at that time. Resident J went outside and began smoking a cigarette butt that Ms. Malone had not given him. A short while later, he came back into the house and told Ms. Malone that he was going to take a bath. Ms. Malone told Resident J that he already took a bath. He said okay, but then he went into the bathroom and closed the door. After a little while, Ms. Malone noticed that Resident J was being very quiet and had not come out of the bathroom yet. She estimated that this was approximately 30 minutes later. She knocked on the door and told Resident J that it was time for him to smoke. Resident J opened the door and was half-dressed. Ms. Malone observed that the bathtub was half full of water. Resident J went outside to smoke and was shaking. He then went inside and went to the kitchen sink. He picked up a wet dishtowel and put it towards his mouth to squeeze the water out of it to drink. Ms. Malone asked Resident

J to put the dishtowel down. Resident J began to show signs of confusion and was having difficulty walking. He fell in the living room. Ms. Malone contacted EMS and stayed with Resident J until EMS arrived. Resident J was responding to questions when EMS was at the home. As EMS was taking Resident J out of the home, he told Ms. Malone that he was sorry.

Ms. Malone stated that she did not know what happened to Resident J after he was taken by ambulance to the hospital, but she was informed a few days later that he passed away. Ms. Malone stated that Resident J had restrictions in place regarding how much water he could drink every day; however, she worked the third shift and did not know how much water Resident J consumed throughout the day prior to her arriving on shift. Staff were not required to track Resident J's water consumption. Ms. Malone felt that she did everything she could to help Resident J. She denied telling the paramedics that Resident J had been in the bathtub for hours or that she left him in there because he required privacy. She stated that he was not in the bathroom for hours, but he was going back and forth. The only time she actually observed Resident J drinking water was when he was in the kitchen squeezing water from the dishtowel.

I reviewed a copy of Resident J's behavioral treatment plan dated 02/09/2022. The following relevant information was noted:

> Resident J has been diagnosed with polydipsia (excessive fluid intake). This condition may create imbalance to his electrolytes, sodium, and potassium levels, and may cause seizures, heart attack, coma, and other complications. Resident J was recently hospitalized due to excessive fluid intake which led to imbalance and confusion. This plan outlines the use of restrictive measures which have been approved to monitor Resident J's health and safety.
>
> Resident J has a fluid restriction in place for polydipsia; he is to have no more than 48 ounces of fluids in a 24-hour period, prescribed by his doctor. He will often try to sneak fluids from the bathroom sink at home, or on any other opportunistic basis. Staff state that the primary symptoms that become noticeable when Resident J has had too much water/juice/soda/coffee to drink are difficulty speaking (mumbling, garbled speech), as well as clumsy gait and trouble bearing weight.

These strategies are designed to reduce the likelihood of Resident J experiencing health problems or hospitalizations due to consuming excessive fluids:

> 1. Please refer to the primary care physician's most recent prescription regarding the allowable maximum fluid intake.
> 2. Keep sugar-free hard candy or gum available to give to Resident J. This may relieve some of the perceived thirst. He reportedly enjoys peppermint.
> 3. Staff will provide verbal prompts if staff hear him drinking excessively in the bathroom. If staff hear him slurping/drinking in the bathroom, staff will knock on the door to the restroom and remind him to exit the bathroom if he is finished.

4. Engage Resident J in preferred activities as frequently as possible, activities outside of the home may help decrease how much fluid he has access to. He may drink more when he js bored, tired, or anxious.
5. The house can stock the kitchen with 8-ounce cups (vs- tumblers or large cups)
6. Suggest activities that Resident J is known to enjoy. Suggest taking a short walk together, (during daylight) ask him to assist with a task such as grocery shopping, carrying groceries into the house, transporting peers, or to run errands, etc.
7. Staff will weigh Resident J according to the prescription provided by the primary care physician. (For example: staff may be asked to weigh him two to four times daily depending on what the need is based on how much he has been drinking and this will be established by the PCP). At this point in time the primary care physician has not recommended that he is weighed, however if this changes staff will weigh him according to the recommendation.
8. Monitor Resident J for the following symptoms, and if symptoms are present contact 911 for an immediate evaluation. (Symptoms may include: blurry vision, nausea, vomiting, confusion, seizures, restlessness, muscle spasms, unconsciousness, shortness of breath, unusual cough, dizziness, falling, swelling, unsteady gait, no urination in 24 hours).
9. Resident J maintains large cups in his bedroom and repeatedly fills this with water which contributes to drinking excessively. In an effort to limit how much Resident J drinks, the staff will remove cups in his room to reduce how much he drinks.

I reviewed a copy of the incident report completed by Lillian Malone and Adam Aldridge dated 07/02/2022. The incident report indicates that Resident J woke up at approximately 4:00am and took a bath. Around 7:00am, Resident J went back into the bathroom and was in there for a long time. Staff knocked on the door, entered the bathroom, and found Resident J half-dressed and leaning over a half-full bathtub, drinking the water from the tub with his hands and a drenched towel. Staff redirected Resident J to leave the bathroom and called 911. Staff stayed with Resident J to monitor for health and safety while EMS was enroute. Staff provided EMS with Resident J's current medication list. Resident J was transported to McLaren Hospital in Pontiac.

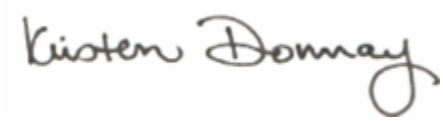
On 08/15/22, I conducted an exit conference via telephone with the licensee designee, Keta Cowan, to review my findings. Ms. Cowan stated that she felt staff were following Resident J's behavior plan and expressed frustration that the behavior committee did not put a better plan in place, as they viewed additional monitoring as being too restrictive. I provided technical assistance to Ms. Cowan regarding advocating for a more detailed behavior plan with the supports coordinator or issuing a 30-day discharge notice if the plan does not allow for an appropriate level of supervision/support in the future. Ms. Cowan agreed with these suggestions and indicated that she would submit a corrective action plan to address the violations identified in the report.

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 gathered through my investigation, there is insufficient information to conclude that staff did not provide supervision as specified in Resident J's assessment plan. Resident J's individual plan of service and behavior plan did not indicate that staff needed to supervise Resident J directly while he was in the bathroom. Staff were only required to provide verbal prompts if they heard Resident J slurping water. Resident J's behavior plan was insufficient to address his behaviors related to polydipsia.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(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.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident J's safety and protection were not attended to at all times. Resident J had a known condition of polydipsia (excessive fluid intake). Resident J's behavior plan indicated that he had fluid restrictions in place of no more than 48 ounces of fluids in a 24-hour period. Direct care worker, Lillian Malone, worked third shift and did not know how much water Resident J consumed throughout the day, as this was not tracked. During the night of 07/02/22, Resident J drank excessive amounts of water from the bathroom and was transported to the hospital where he later passed away. Although Resident J's plan did not permit staff to supervise him directly in the bathroom, staff in the home were aware of his condition and failed to ensure his safety and protection.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

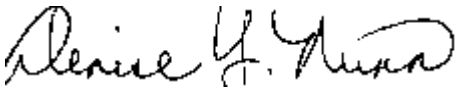
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



08/15/2022

Kristen Donnay Date
Licensing Consultant

Approved By:



08/24/2022

Denise Y. Nunn Date
Area Manager