GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 13, 2023

Charles Kelly
R & B Living Supports, Inc.
130 45th Street
Bloomingdale, MI 49026

RE: License #: AS030390275
Investigation #: 2023A1024022
Blue Sky AFC

Dear Mr. Kelly:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On March 16, 2023, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS030390275
Investigation #:	2023A1024022
Complaint Receipt Date:	02/16/2023
Investigation Initiation Date:	02/17/2023
Report Due Date:	04/17/2023
Licensee Name:	R & B Living Supports, Inc.
Licensee Address:	130 45th Street Bloomingdale, MI 49026
Licensee Telephone #:	(269) 521-4500
Administrator:	Charles Kelly
Licensee Designee:	Charles Kelly
Name of Facility:	Blue Sky AFC
Facility Address:	331 49th Street Grand Junction, MI 49056
Facility Telephone #:	(269) 521-6789
Original Issuance Date:	06/27/2018
License **Status:**	REGULAR
Effective Date:	12/27/2022
Expiration Date:	12/26/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Jeremy Meinecke left residents unattended without staff supervision for 30 minutes.	Yes

III. METHODOLOGY

02/16/2023	Special Investigation Intake 2023A1024022
02/17/2023	APS Referral APS denied complaint for investigation
02/17/2023	Special Investigation Initiated – Telephone call with direct care staff member Sara Cooley and Resident A
03/14/2023	Inspection Completed On-site with direct care staff member Cherri Klifman, Resident B, and Resident C
03/14/2023	Contact - Telephone call made with licensee designee Charles Kelly
03/15/2023	Exit Conference with licensee designee Charles Kelly
03/15/2023	Inspection Completed-BCAL Sub. Compliance
03/15/2023	Corrective Action Plan Requested and Due on 04/05/2023
03/16/2023	Corrective Action Plan Received
03/16/2023	Corrective Action Plan Approved

ALLEGATION:

Direct care staff member Jeremy Meinecke left residents unattended without staff supervision for 30 minutes.

INVESTIGATION:

On 2/16/2023, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged direct care staff member Jeremy Meinecke left residents unattended without staff supervision for 30 minutes.

On 2/17/2023, I conducted interviews with direct care staff member Sara Cooley and Resident A. Ms. Cooley stated on 3/13/2023 she called the facility to inform direct care staff member Jeremy Meinecke that she was not feeling well and would not be coming in to work. Ms. Cooley stated she later learned from another direct care staff member that Mr. Meinecke did not want to wait for the next staff person to arrive, so he left the facility with no direct care staff member present with the residents when his shift ended. Ms. Cooley stated prior to Mr. Meinecke leaving the facility, an exterminator arrived at the facility at 8am to treat the facility for bed bugs and Mr. Meinecke gave his facility keys to one of the exterminators who were in the facility treating bed bugs. Ms. Cooley stated she believes the exterminator then called licensee designee Mr. Kelly to inform him Mr. Meinecke left the facility. Ms. Cooley stated at that time Mr. Kelly immediately came to the facility to be with the residents. Ms. Cooley stated Mr. Meinecke was terminated after this incident and no residents were harmed from this incident.

Resident A stated Mr. Meinecke left them unsupervised on 3/13/2023 because he had another job to go to. Resident A stated he was in his bedroom and when he came out to the living room, he could not find staff at which time the “bed bug guy” informed him that Mr. Meinecke had to leave and gave him the facility keys. Resident A stated another staff member eventually came to the facility. Resident A stated he and the other residents just stayed in their bedrooms when they learned that no direct care staff member was present in the facility. Resident A stated this incident has never occurred before and he has not had any issues in the facility.

On 3/14/2023, I conducted an onsite investigation at the facility with direct care staff member Cherri Klifman, Resident B, and Resident C. Ms. Klifman stated she was informed by direct care staff and residents on 3/13/2023 that Mr. Meinecke gave his facility keys to an exterminator, while he was treating bed bugs at the facility, and left the facility thus leaving the residents without direct care staff supervision. Ms. Klifman stated Mr. Kelly had to come to the facility to be with the residents after being notified by the exterminator that the residents were left alone without direct care staff member supervision. Ms. Klifman stated she has no knowledge of residents ever being left alone in the past.

Resident B stated he does not remember ever being left in the home unsupervised. Resident B stated he remembers being in the facility with maintenance while they were treating bed bugs in the facility however, he cannot remember if direct care staff were present or not. Resident B stated he has no issues in the home.

Resident C stated when he woke up on the morning of 3/13/2023, he discovered that Mr. Meinecke had left the facility and gave the facility keys to the “exterminator guy” who was in the home treating bed bugs. Resident C stated he believes he was unsupervised with no direct care staff member present for about 45 minutes until licensee designee Mr. Kelly arrived. Resident C stated he has never had any issues with being left unsupervised in the past.

On 3/14/2023, I conducted an interview with licensee designee Charles Kelly. Mr. Kelly stated on 3/13/23 direct care staff member Jeremy Meinecke left the AFC home at 7:50am before the next staff person arrived to care for the residents. Mr. Kelly stated an exterminator that was scheduled to come, arrived at the facility to treat for bed bugs and Mr. Meinecke gave the exterminator the keys to the facility and left the residents unattended. Mr. Kelly stated the residents were left unattended by a direct care staff member for 30 minutes. Mr. Kelly stated staff member Mr. Meinecke was immediately terminated and will not have any contact with the residents.

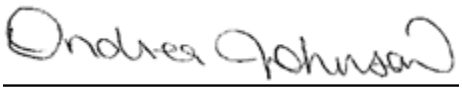
APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Based on my investigation which included interviews with direct care staff members Sara Cooley, Cherri Klifman, licensee designee Charles Kelly, Resident A, Resident B, and Resident C, direct care staff member Mr. Meinecke left the residents unattended without staff supervision for approximately 30 minutes on 03/13/2023. Ms. Cooley, Ms. Klifman, Residents A and C all stated that Mr. Meinecke left the facility prior to the next direct care staff member arriving, leaving the residents unsupervised, and left the facility keys with a licensed professional exterminator who arrived at the facility to treat bed bugs. Mr. Kelly stated Mr. Meinecke was immediately terminated after this incident and will no longer have access to the residents. Due to this occurrence, the ratio of direct care staff to residents were not adequate to carry out the responsibilities defined in the act and licensing rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/15/2023, I conducted an exit conference with Mr. Kelly. I informed Mr. Kelly of my findings and allowed him an opportunity to ask questions and make comments.

On 3/16/2023, I approved an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action plan was received therefore I recommend the current license status remain unchanged.



Ondrea Johnson — 4/5/2023

Ondrea Johnson
Licensing Consultant

Date

Approved By:

Dawn N. Timm — 04/13/2023

Dawn N. Timm
Area Manager

Date