GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 11, 2023

Kelly Devereaux
Mentors Of Michigan, Inc.
3812 Finch
Troy, MI 48084

RE: License #: AS630287813
Investigation #: 2023A0611024
Chester Hills

Dear Ms Devereaux:

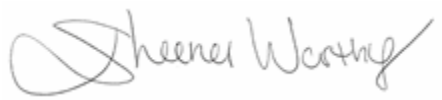
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Sheena Worthy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630287813
Investigation #:	2023A0611024
Complaint Receipt Date:	06/21/2023
Investigation Initiation Date:	06/23/2023
Report Due Date:	08/20/2023
Licensee Name:	Mentors Of Michigan, Inc.
Licensee Address:	3812 Finch Troy, MI 48084
Licensee Telephone #:	(248) 632-3534
Administrator:	Kelly Devereaux
Licensee Designee:	Kelly Devereaux
Name of Facility:	Chester Hills
Facility Address:	404 Arlington Rochester, MI 48307
Facility Telephone #:	(248) 651-6820
Original Issuance Date:	02/04/2008
License Status:	REGULAR
Effective Date:	09/03/2021
Expiration Date:	09/02/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident B walked away from the facility around 3:30am-6:30am. Ashley was on staff and fell asleep.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/21/2023	Special Investigation Intake 2023A0611024
06/23/2023	APS Referral An Adult Protective Services (APS) referral was denied for investigation on 06/17/23.
06/23/2023	Special Investigation Initiated – Telephone I left a message for the reporting source requesting a call back.
06/28/2023	Inspection Completed On-site I completed an unannounced onsite. I interviewed Resident B, staff member, Ashley Duel, staff member, Nick Duel, and Resident G. I received a copy of Resident B's individualized plan of service (IPOS).
07/05/2023	Contact - Telephone call made I made a telephone call to staff member, Alton Davis. The allegations were discussed.
07/05/2023	Contact - Telephone call received I received a phone call from the licensee designee, Kelly Devereaux. Ms. Devereaux provided additional information.
07/05/2023	Exit Conference I completed an exit conference with the licensee designee, Kelly Devereaux. The allegations were discussed.

ALLEGATION:

Resident B walked away from the facility around 3:30am-6:30am. Ashley was on staff and fell asleep.

INVESTIGATION:

On 06/22/23, a complaint was received and assigned for investigation alleging that last night sometime between 3:30 am-6:30 am Resident B walked away from the home. Police were called by staff when they realized he was gone. It is unknown what time he left or how long he was gone. Ashley Duel was the staff on shift. She fell asleep which is against policy. Resident B was found a mile and a half from the group home. This is not the first time someone has wandered from the home. This is the fourth or fifth person since January 2023.

Note: There were no previous special investigations documented in the AFC group home's file regarding any residents eloping from the home in 2023.

On 06/28/23, I completed an unannounced onsite. I interviewed Resident B, staff member, Ashley Duel, staff member, Nick Duel, and Resident G. I received a copy of Resident B's individualized plan of service (IPOS).

On 06/28/23, I interviewed Resident B. Resident B stated he has lived at the AFC group home for six months. Resident B stated he doesn't like living at the AFC group home because he wants to live with his family. Resident B stated the staff are good to him. Resident B stated there is nothing he doesn't like about the staff. Resident B stated last week he spent six nights in the hospital because he got some of his teeth pulled. Resident B returned to the AFC group home about four or five days ago.

Resident B denied wandering off from the AFC group home. Resident B stated he is not allowed to leave the AFC group home because he is court ordered to stay at the AFC group home. Resident B stated he cannot go walking or go to the store even if he has permission from the staff. Resident B then stated he did leave the AFC group home and the police picked him up and brought him back to the AFC group home. Resident B stated this has happened a few times and the last time was a month ago. Resident B stated the last time he left the AFC group home, he does not know if the staff knew he was gone. Resident B stated he does not know what staff was doing when he left the AFC group home. Resident B stated when he left he went for a walk and he planned on returning to the AFC group home. Resident B denied observing any staff member sleeping while on duty. There is always a staff member at the AFC group home.

On 06/28/23, I interviewed staff member Ashley Duel. Mrs. Duel has worked at the AFC group home since September 2022. Regarding the day in question, Mrs. Duel was working the midnight shift from 8:00am (Friday) until 10:00am (Saturday). Resident B was up all night sitting outside and smoking. Mrs. Duel thought Resident B went to bed at 5:00am. Mrs. Duel stated she had a headache and she dozed off on the couch at 5:30am and woke up at 6:00am. Mrs. Duel noticed that the blinds were open on the sliding porch door and the door was unlocked. Mrs. Duel went to check on the residents and saw Resident B was gone. Mrs. Duel called her supervisor, Patrice Green. Ms. Green advised Mrs. Duel to call the police. Mrs. Duel spoke to the police when they arrived to the home. Resident B was found by the police in downtown Rochester, which is a five-minute drive from the AFC group home.

Mrs. Duel stated Resident B has eloped from the AFC group home more than five times since he has been admitted eight months ago. Resident B doesn't always elope at night time. There has been instances where Resident B gets upset and starts walking away from the home and; the staff will try to bring him back. Resident B always goes downtown when he leaves the AFC group home. Resident B is on 1:1 staff supervision. Mrs. Duel stated today staff member Nick Duel is assigned to supervise Resident B. There is two staff present every shift for 14 hours and there is one staff present during the midnight shift. Mrs. Duel denied ever falling asleep while on duty before. Mrs. Duel stated she will not fall asleep on duty again.

On 06/28/23, I interviewed staff member, Nick Duel. Regarding the allegations, Resident B is assigned 1:1 staff supervison. Mr. Duel stated while he is assigned to supervise Resident B, he is required to socialize with him, keep him calm, and ensure he has what he needs. Mr. Duel offers to go walking with Resident B but he denies to go. Mr. Duel stated he was not present when Resident B eloped from the AFC group home as this is his third day working at the AFC group home. Mr. Duel denies falling asleep while on duty. Mr. Duel stated sometimes he will go to sleep at the AFC group home when he is off duty because he is waiting for Mrs. Duel to get off work because they ride home together. Mr. Duel denied ever seeing Mrs. Duel fall asleep on duty.

On 06/28/23, I interviewed Resident G. Resident G has lived at the AFC group home for a couple of years. Resident G is his own guardian. Resident G likes living at the AFC group home, and he does not have any complaints. Resident G denied ever seeing a staff member fall asleep while on duty. Resident G stated there is always one staff at the AFC group home. Resident G stated now there is two staff because Resident B is on 1:1 as he likes to leave the AFC group home and go walking. Resident G stated he goes to bed at 8:00pm and wakes up at 8:00am. Resident G denied seeing any staff member asleep when he goes to bed or when he wakes up in the morning.

On 07/05/23, I made a telephone call to staff member, Alton Davis. Regarding the allegations, Mr. Davis stated he has worked at the AFC group home for 2-3 months. Mr. Davis was unsure of the exact date of the incident however; he stated he worked from 10:00am to 10:00pm. Mr. Davis stated during his shift he worked with Mrs. Duel. Mr. Davis stated neither him or Mrs. Duel slept during their shift. Mr. Davis stated when his shift ended, Resident B was in the AFC group home and Mrs. Duel was still on duty.

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, Mrs. Duel did not ensure the residents safety and/or protection when she fell asleep while on duty. Mrs. Duel admitted to dozing off on the couch at 5:30am and waking up at 6:00am. When Mrs. Duel woke up she noticed that Resident B eloped from the AFC group home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/28/23, I observed Resident B sitting outside of the AFC group home on the front porch smoking a cigarette. The front door was open, but the screen door was closed. A staff member was not observed supervising Resident B.

On 06/28/23, Mr. Duel stated he does not necessarily have to have eyes on Resident B while he is inside the AFC group home. Mr. Duel stated when Resident B is sitting outside the AFC group home, he does have to have eyes on him. When I asked Mr. Duel where he was when I arrived to the AFC group home and Resident B was sitting outside by himself, he stated he was in the back of the home at the staff desk. Mr. Duel was not sure where Mrs. Duel was, but she could have been in the living room.

On 06/28/23, I received a copy of Resident B's IPOS. According to the IPOS, the staff are required to provide 1:1 staffing for Resident B to decrease the chances of Resident B walking away from the home without returning. Resident B is required to have 1:1 staffing for 16 hours per day. The AFC group home is required to monitor Resident B closely and to complete a missing person report, an incident report, and notify recipient rights if Resident B is missing from the home for 24 hours.

On 07/05/23, I completed an exit conference with the licensee designee, Kelly Devereaux. Ms. Devereaux stated she had not spoken to Mrs. Duel about the allegations however; Mrs. Duel admitted to the police that she dozed off for a second when Resident B eloped from the home. Ms. Devereaux confirmed that Resident B receives 1:1 staffing from 8:00am to 12:00am. Ms. Devereaux stated staff are required to have eyes on Resident B at all times during his 1:1 staffing timeframe; which includes when he is outside of the home. Mrs. Duel received disciplinary action for falling asleep while on duty and; she was suspended for two days. Mrs. Duel will also complete another training pertaining to working with people with special needs and behavioral plans. Ms. Devereaux was informed the allegations will be substantiated and a corrective action plan will be required. Ms. Devereaux stated she will retrieve the exact date of the incident and will contact me with that information.

On 07/05/23, I received a phone call from the licensee designee, Kelly Devereaux. Ms. Devereaux stated the incident occurred on 06/17/23. Ms. Devereaux spoke to Mrs. Duel and Mrs. Duel stated she dozed off for about 10 minutes. Mrs. Duel fell asleep on the couch after Resident B came inside after smoking in the backyard.

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:	According to Resident B's IPOS, staff are required to monitor him closely as he is assigned 1:1 staffing. On 06/28/23 during the onsite, I observed Resident B sitting on the front porch. There was no staff around supervising Resident B. When I interviewed staff member, Nick Duel, he stated upon my arrival to the AFC group home he was in the back of the home at the staff desk. Mr. Duel was not sure where Mrs. Duel was but she could have been in the living room. Mr. Duel admitted that when he is assigned as Resident B's 1:1 staff he has to have eyes on him when he is outside the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

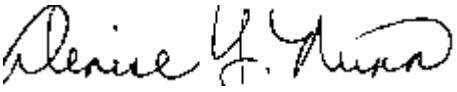
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

07/05/23

Sheena Worthy
Licensing Consultant

Date

Approved By:



07/11/2023

Denise Y. Nunn
Area Manager

Date