GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 5, 2023

Edward Lark
The Reach Foundation
1793 Charter
Lincoln Park, MI 48146

RE: License #: AS820283563
Investigation #: 2023A0116043
Welcome Home Ranch

Dear Mr. Lark:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820283563
Investigation #:	2023A0116043
Complaint Receipt Date:	08/15/2023
Investigation Initiation Date:	08/16/2023
Report Due Date:	10/14/2023
Licensee Name:	The Reach Foundation
Licensee Address:	1793 Charter Lincoln Park, MI 48146
Licensee Telephone #:	(313) 608-1324
Administrator:	Edward Lark
Licensee Designee:	Edward Lark
Name of Facility:	Welcome Home Ranch
Facility Address:	10420 Ozga Romulus, MI 48174
Facility Telephone #:	(734) 941-5729
Original Issuance Date:	06/26/2006
License Status:	REGULAR
Effective Date:	02/20/2023
Expiration Date:	02/19/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff, Eddie Morgan, has been taping up the sinks so that the residents are unable to use the water or even wash their hands after using the toilets.	Yes
Staff, Eddie Morgan, has been targeting Resident A and calling him names because of his relationship with his mother. Mr. Morgan's tone of voice with the residents is concerning.	No

III. METHODOLOGY

08/15/2023	Special Investigation Intake 2023A0116043
08/15/2023	APS Referral
08/16/2023	Special Investigation Initiated - On Site Interviewed staff, Linda Dapoz, and Resident's B and C.
08/16/2023	Referral - Recipient Rights
08/17/2023	Contact - Telephone call made Interviewed staff, Eddie Morgan.
08/17/2023	Contact - Telephone call made Interviewed staff, Melanie McDiarmid.
08/21/2023	Contact - Telephone call made Interviewed Relative A.
08/28/2023	Inspection Completed-BCAL Sub. Compliance Interviewed Resident A.
08/31/2023	Exit Conference With licensee designee, Edward Lark.

ALLEGATION:

Staff, Eddie Morgan, has been taping up the sinks so that the residents are unable to use the water or even wash their hands after using the toilets.

INVESTIGATION:

On 08/16/23, I conducted an unscheduled onsite inspection and interviewed home manager, Linda Dapoz, and Residents B and C. Ms. Dapoz reported that Resident A was out of the home at an appointment with Relative A. Ms. Dapoz reported that the one sink in the resident bathroom is taped up and has been since yesterday, 08/15/23 and reported not being aware if staff, Eddie Morgan, or Melanie McDiarmid taped up the sink. Ms. Dapoz reported that Resident A has issues with his sodium levels being extremely low and reported he is allowed 1500cc's of fluid per day which equates to 6 glasses of fluid. Ms. Dapoz reported that the staff monitor Resident A's fluid intake to prevent any issues with his sodium levels dropping too low but reported that he has been going in the bathroom, pretending to use it, and drinking water from the faucet. Ms. Dapoz reported that is probably why one of the staff decided to tape the faucet up trying to prevent Resident A from taking in additional fluid. I informed Ms. Dapoz that the measure was inappropriate and that it needed to be removed. I explained that Resident A along with the other residents should have full access to the sink in their bathroom for hygiene purposes and that they along with Resident A's physicians and care/support team need to come up with a better plan to try to prevent Resident A from consuming additional fluids outside what his doctor has ordered. Ms. Dapoz reported understanding and immediately went in the bathroom to remove the paper and duct tape that prevented use of the sink.

I interviewed Resident B and he reported that he told the staff that they were violating his rights and that the tape should be removed. Resident B reported that he should not have to go to the kitchen sink or the staff bathroom to wash his hands, especially after having a bowel movement. Resident B reported that he is glad that I came to the home and had the tape removed.

I interviewed Resident C and he reported that he has a bathroom in his room so the sink in the main bathroom being taped didn't directly impact him. Resident C reported that some of the other residents were complaining about it and reported that he believes it was a bad idea.

On 08/17/23, I interviewed staff, Eddie Morgan, and he reported that he was not the person that taped the sink up. Mr. Morgan reported that staff Melanie McDiarmid taped the sink up on 08/15/23 and reported that he was aware that it was removed the following day during my inspection. Mr. Morgan reported that Ms. McDiarmid taped the sink up to deter Resident A from drinking additional fluids from the sink, due to his health concerns surrounding his low sodium levels.

On 08/17/23, I interviewed staff, Melanie McDiarmid, and she admitted that on 08/15/23, she taped the bathroom sink up after Resident A suggested that she do so. Ms. McDiarmid reported that Resident A said that the other residents were setting him up and reported that he was not drinking out of the sink. Ms. McDiarmid reported Resident A thought by taping up the sink it would prevent any concern of

him drinking additional fluids while in the bathroom. I explained to Ms. McDiarmid that regardless of whose idea it was, it was an inappropriate measure and does not promote normalization or independence for the residents. Ms. McDiarmid reported an understanding and was very remorseful for her actions. Ms. McDiarmid reported that a meeting was held with Resident A and Relative A and reported they both reiterated to Resident A his fluid restrictions and the importance of him adhering to them.

On 08/21/23, I interviewed Relative A and she reported that she could not believe that the staff taped up the sink and prevented the use of it by all of the residents. Relative A reported that Resident A does have a history of excessive water intake, but this is not an appropriate way to help address it. Relative A reported that she is very involved and is constantly talking to Resident A about adhering to his doctor's orders.

On 08/28/23, I conducted an unscheduled onsite inspection and interviewed Resident A. Resident A reported that the sink was taped up for about a day but denied that he ever drank out of the it. Resident A reported that he is aware of his fluid restrictions and is doing his best to abide by them.

On 08/31/23, I conducted the exit conference with licensee designee, Edward Lark, and informed him of the findings of the investigation. Mr. Lark reported an understanding of the rule violation and reported he was not aware of the matter. Mr. Lark reported that he would submit a corrective action plan to address the violation upon receipt of the report.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident's physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.

ANALYSIS:	Based on the findings of the investigation, which included interviews with Ms. Dapoz, Residents A-C, Mr. Morgan, Ms. McDiarmid and consultant observation, I am able to corroborate the allegation. Ms. Dapoz and Residents A -C all confirmed that the bathroom sink was taped to prevent Resident A from drinking out of it. Mr. Morgan reported that Ms. McDiarmid was the staff who taped the sink. Ms. McDiarmid admitted to taping the bathroom sink to prevent Resident A from drinking out of it. During the onsite inspection on 08/16/23, I observed the sink covered with white paper and duct tape, preventing use of it. This violation is established as the staff failed to ensure and promote self-direction, independence, and normalization by taping up the bathroom sink in the resident's bathroom and preventing their use of it.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff Eddie Morgan has been targeting Resident A and calling him names because of his relationship with his mother. Mr. Morgan's tone of voice with the residents is concerning.

INVESTIGATION:

On 08/16/2023, I conducted an unscheduled onsite inspection and interviewed Ms. Dapoz and Residents B-C. Ms. Dapoz denied that she has ever observed or overheard Mr. Morgan call Resident A names or yell at him.

Residents A & Resident B reported that he has not heard Mr. Morgan calling Resident A names or any of the residents out of their names. Resident B reported that Mr. Morgan does talk loudly and will raise his voice at them if they are caught doing something that they are not supposed to do.

Resident C reported that he has not heard Mr. Morgan treat Resident A any different from any of them and denies that he has heard him call him names as alleged. Resident C reported that Mr. Morgan will raise his voice to get their attention if they

are doing something that they are not supposed to do. Resident C added that Mr. Morgan is not the friendliest staff but reported it doesn't bother him one bit.

On 08/17/23, I interviewed Mr. Morgan, and he denied the allegations. Mr. Morgan reported that he does not yell at any of the residents and does not call them names. Mr. Morgan reported that he will raise his voice to get their attention, when they are engaging in behavior that jeopardizes their safety.

On 08/21/23, I interviewed Relative A and she reported that she has had concern over how Mr. Morgan speaks to Resident A and the other residents. Relative A reported on one occasion she was at the home and felt that Mr. Morgan was being disrespectful to Resident A. Relative A reported she addressed her concern with Mr. Morgan and reported that he was disrespectful to her in the way in which he responded to her. Relative A reported that she will continue to address any and all concerns, however, reported that overall, the home and staff have been good to Resident A since he has been there these last few months.

On 08/28/23, I conducted an unscheduled onsite inspection and interviewed Resident A. Resident A reported that Mr. Morgan does not yell at him and reported that he is not being targeted by anyone. Resident A denied that Mr. Morgan calls him names. Resident A reported that staff Ms. McDiarmid would call out his name loudly when she thought he was in the bathroom drinking water out of the sink. Resident A denied having any concerns regarding the staff at the present.

On 08/31/23, I conducted the exit conference with licensee designee, Edward Lark and informed him of the findings of the investigation. Mr. Lark agreed with the findings.

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 findings of the investigation, which included interviews with Ms. Dapoz, Residents A-C and Mr. Morgan, I am unable to corroborate the allegations. Ms. Dapoz denied ever hearing Mr. Morgan call Resident A names or yell at him. Residents B-C denied hearing Mr. Morgan call Resident A names or mistreat him in anyway. Resident A denied that Mr. Morgan is targeting him or calling him names. He also denied that he yells at him. Mr. Morgan denied that he targets Resident A in any way, denied that he calls him names or yells at him or any of the residents. Mr. Morgan reported that he will raise his voice to get the residents attention when they are doing something that jeopardizes their safety. This violation is not established as the residents are being treated with dignity and their personal needs, including protection and safety are being attended to in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

09/01/23

Pandrea Robinson — Date
Licensing Consultant

Approved By:

09/05/23

Ardra Hunter — Date
Area Manager