GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 31, 2023

Nicole Deneweth
Homes of Opportunity Inc
P.O. Box 190179
Burton, MI 48519

RE: License #: AS630390326
Investigation #: 2023A0602020
Walbridge Home

Dear Ms. Deneweth:

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,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630390326
Investigation #:	2023A0602020
Complaint Receipt Date:	04/03/2023
Investigation Initiation Date:	04/04/2023
Report Due Date:	06/02/2023
Licensee Name:	Homes of Opportunity Inc
Licensee Address:	Suite C 1110 Eldon Baker Drive Flint, MI 48507
Licensee Telephone #:	(586) 675-0651
Administrator:	Nicole Deneweth
Licensee Designee:	Nicole Deneweth
Name of Facility:	Walbridge Home
Facility Address:	2650 Walbridge Rd. Rochester Hills, MI 48307
Facility Telephone #:	(248) 289-1592
Original Issuance Date:	06/27/2019
License Status:	REGULAR
Effective Date:	12/27/2021
Expiration Date:	12/26/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 3/31/23 Resident A was rushed to the hospital due to extremely high blood sugar levels and was unresponsive when she arrived.	No
Resident A's blood glucose test strips were expired and had an expiration date of May 2022.	Yes

III. METHODOLOGY

04/03/2023	Special Investigation Intake 2023A0602020
04/04/2023	Special Investigation Initiated - Telephone Call made to Resident A's guardian.
04/18/2023	Inspection Completed – On-site Interviewed the home manager, Kristina Jones
05/02/2023	Contact – Telephone call made Call made to Resident A's guardian.
05/09/2023	Contact – Telephone call made Message left for Resident A's supports coordinator.
05/10/2023	Contact – Telephone call made Call made to staff member, Leroy Harris.
05/10/2023	Contact – Telephone call made Call made to staff member, Roslyn Smith
08/31/2023	Exit Conference Spoke with the licensee designee, Nicole Deneweth by telephone.

ALLEGATION:

- **On 3/31/23 Resident A was rushed to the hospital due to extremely high blood sugar levels and was unresponsive when she arrived.**
- **Resident A's blood glucose test strips were expired and had an expiration date of May 2022.**

INVESTIGATION:

On 4/03/2023, a complaint was received and assigned for investigation alleging that on 3/31/2023 Resident A was rushed to the hospital due to extremely high blood sugar levels and was unresponsive when she arrived at the hospital.

On 4/18/2023, I conducted an unannounced on-site investigation at which time I interviewed the home manager, Christina Jones. Ms. Jones stated she has worked for the company since 2020 and was appointed as the home manager in 2021. On 3/29/2023 when she picked up Resident A from her workshop, she was informed that she had been moving slowly at the workshop. When they arrived at the home, Resident A had a snack (unsweetened apple sauce) and dinner shortly after that. After dinner, Resident A vomited but was not displaying any signs of distress. She was cleaned up and prepared for bed. Resident A usually awakes at 6 am but on 3/30/2023 she did not wake up until around 7 am but would not get out of bed. Ms. Jones said Resident A was conscious but did not look well so she called 911. The 911 operator instructed her not to move Resident A from her bed. Upon arrival, the emergency medical technicians (EMT) took Resident A's vitals and said her blood glucose levels were high but did not say what the exact reading was. Resident A was removed from the home by the EMT's and transported to the hospital. Ms. Jones said she followed the emergency medical service (EMS) to the hospital and remained with Resident A until she was admitted. Once admitted, Resident A was diagnosed with pneumonia and high blood glucose. Resident A's sister informed Ms. Jones that once Resident A is discharged from the hospital, she was going to take her home with her for a few days. Resident A went home with her sister and never returned to the facility. Her belongings were picked up by her sister (exact date unknown).

Ms. Jones stated that Resident A was prescribed Metformin and her blood glucose had to be checked every morning. If it was lower than 80 and higher than 140, staff were instructed to notify her primary care physician for further instructions. Ms. Jones said when Resident A's sister came to the home to pick up her blood glucose monitor and test strips, she informed her that the test strips were expired. Ms. Jones stated she was not aware that the strips were expired and contacted J & B Pharmacy and requested new test strips as soon as she was informed. J & B Pharmacy sent the request to Resident A's physician for a new order. The strips were delivered the same day (exact date unknown) sometime between 4 pm and 9 pm.

On 4/18/2023, I received and reviewed a copy of Resident A's medication administration record (MAR) dated February 2023 and March 2023 as well as her health care appraisal dated March 2023. According to the MARs, Resident A was prescribed the following medication:

- Hydrochlorot Tab 12.5mg
- Ketoconazole 2% Shampoo
- Lisinopril Tab 10mg
- Lovastatin Tab 20mg
- Metformin Tab 500mg
- Test Blood Sugar Daily at 8 am
- Weekly Weight
- Ibuprofen Tab 800mg
- Tussin Adult Liquid 100/5ml

I did not observe any discrepancies on either MAR. Resident A's blood sugar was checked and documented daily. I also received and reviewed a prescription written by Dr. Zakari Tata and dated 2021 documenting that Resident A's blood sugar should be checked every morning at 8 am before breakfast. Resident A's blood sugar should be between 80 and 140. Anything higher or lower, staff must notify the primary care physician. Resident A's blood sugar was within the normal range each day during the months of February and March 2023.

I was unable to interview Resident A as she no longer resides in the home.

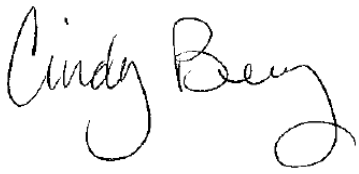
On 8/31/2023, I conducted an exit conference with the licensee designee, Nicole Deneweth by telephone. I informed Ms. Deneweth of the investigative findings and recommendation documented in this report. Ms. Deneweth agreed to submit a corrective action plan upon receipt of the report.

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 obtained during the investigation, Resident A's blood glucose levels were documented on the MAR's as normal (between 80 and 140) for the months of February and March 2023. However, Ms. Jones stated Resident A's blood glucose test strips were expired. It is unknown how long staff were using the expired test strips or if the expired test strips provided inaccurate blood glucose readings as Resident A was admitted to the hospital with very high levels.

CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

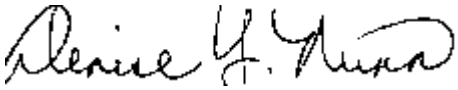
Contingent upon an acceptable corrective action plan, I recommend no change to the status of the license.



08/31/2023

Cindy Berry Date
Licensing Consultant

Approved By:



08/31/2023

Denise Y. Nunn Date
Area Manager