GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 1, 2023

Stephanie Riley
Valley Residential Serv Inc.
P O Box 186
St Charles, MI 486550186

RE: License #:	AS060275479
Investigation #:	2024A0123004
	Elm Home

Dear Stephanie Riley:

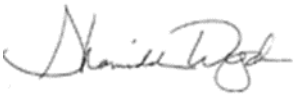
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (517) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS060275479
Investigation #:	2024A0123004
Complaint Receipt Date:	10/31/2023
Investigation Initiation Date:	11/01/2023
Report Due Date:	12/30/2023
Licensee Name:	Valley Residential Serv Inc.
Licensee Address:	300 S Saginaw St. Charles, MI 48655
Licensee Telephone #:	(231) 580-5204
Administrator:	Rachel Harmony
Licensee Designee:	Stephanie Riley
Name of Facility:	Elm Home
Facility Address:	141 Almont Street Standish, MI 48658
Facility Telephone #:	(989) 846-9700
Original Issuance Date:	07/25/2005
License Status:	REGULAR
Effective Date:	03/19/2022
Expiration Date:	03/18/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 10/19/2023, Resident A was in the bathtub. Staff Grace Atwater and her friend stopped by to use the restroom. Staff that was assisting Resident A stepped out to get a towel. Staff Atwater and her friend walked into the bathroom with Resident A naked in the tub. Staff Atwater was off shift at the time. Resident A's assessment plan states that Resident A should have supervision at all times in the bathtub for safety.	Yes

III. METHODOLOGY

10/31/2023	Special Investigation Intake 2024A0123004
11/01/2023	APS Referral APS referral completed.
11/01/2023	Special Investigation Initiated - Letter
11/01/2023	Contact - Telephone call made I spoke with recipient rights investigator Kevin Motyka via phone.
11/03/2023	Inspection Completed On-site I conducted an unannounced on-site at the facility.
11/20/2023	Contact - Telephone call made I interviewed staff Grace Atwater.
11/20/2023	Contact - Telephone call made I interviewed staff Jazmin Stagray.
11/20/2023	Contact - Telephone call made I spoke with Resident A's case manager.
11/20/2023	Contact- Telephone call made I made an attempted phone call to staff Alissa Miller. Her phone was not in service.
11/29/2023	Exit Conference- I spoke with licensee designee Stephanie Riley via phone.
11/30/2023	Contact- Telephone call made

	I made a call to the facility to interview staff Alissa Miller.

ALLEGATION: On 10/19/2023, Resident A was in the bathtub. Staff Grace Atwater and her friend stopped by to use the restroom. Staff that was assisting Resident A stepped out to get a towel. Staff Atwater and her friend walked into the bathroom with Resident A naked in the tub. Staff Atwater was off shift at the time. Resident A's assessment plan states that Resident A should have supervision at all times in the bathtub for safety.

INVESTIGATION: On 11/01/2023, I spoke with Kevin Motyka of recipient rights. He stated that Resident A was left alone in the bathroom. An incident report says a staff person stepped out to retrieve a towel. A nurse stated that this would be a neglect issue. It is also a confidentiality issue for the other staff bringing a friend.

On 11/03/2023, I conducted an unannounced on-site visit at the facility. I interviewed home manager Rachel Harmony. Staff Harmony reported the following:

Staff Harmony was not on shift when the incident occurred. Staff Alissa Miller called her that night asking what to do about the situation. Staff Harmony was under the impression that Staff Atwater's friend went into the bathroom while Resident A was in the tub. Staff Harmony has spoken with staff repeatedly about stopping by the facility while they are not scheduled to work, and that if they left something there, they should call first before stopping by. Staff Harmony stated that she had not heard anything about Staff Atwater stopping in regularly. Staff Atwater was out and needed to use the restroom. Staff Harmony stated that the witnesses were Staff Miller, staff Theresa Navarre, and staff Jazmine Stagray. Staff Harmony stated that per Staff Stagray, both Staff Atwater and the friend were in the bathroom at the same time, and Staff Stagray could hear the both of them discussing Resident A's diagnoses. Both bathrooms were occupied by residents at the time, as this occurred during personal care time. Staff Harmony does not know who was assigned to Resident A, but Staff Miller put Resident A in the tub, and Staff Navarre finished his care. Resident A requires one-on-one supervision while he is in the tub. Staff Atwater denied that her friend entered the bathroom, but the other staff stated otherwise.

During this on-site, I observed Resident A sitting in his wheelchair. I could not interview Resident A, as Resident A is non-verbal. He appeared clean and appropriately dressed.

During this on-site, I also obtained requested documentation. Resident A's Health Care Appraisal dated 08/31/2023 states Resident A is diagnosed with seizures, blindness, cerebral palsy, and scoliosis. Resident A uses a wheelchair. The appraisal also notes that Resident A has a shower chair with a safety belt and ARJO lift.

An *AFC Licensing Division- Incident/Accident Report* dated 10/19/2023 authored by staff Alissa Miller. The incident report states the following:

"[Resident A] was in the bathtub & Grace Atwater and her friend stopped by to use the restroom. Staff that was doing [Resident A] stepped out to get a towel. Grace and her friend walked into the bathroom with [Resident A] naked in the tub. Grace is off shift and her friend don't work here. Called manager and nurse and faxed IR. To ensure staff don't drop by off shift only staff member assisting in care in the bathroom with resident no visitor in between while resident is getting care."

Resident A's *Assessment Plan for AFC Residents* completed on 10/12/2022 states that Resident A requires full assistance with bathing. The assessment plan also indicates that Resident A uses an ARJO lift and shower chair with safety belt.

Resident A's Bay Arenac Behavioral Health Plan of Service dated 12/19/2022 under *Safety, Abuse, and Neglect Concerns* it notes that *"[Resident A] has no safety skills. He is monitored and supported by staff in his home at Elm. He requires assistance and monitoring in all daily living. He is provided with supervision at all times in the bathtub for safety and he uses the ARJO to put him in and out of the tub."*

On 11/03/2023, I interviewed staff Theresa Navarre at the facility. Staff Navarre reported the following:

Staff Navarre, Staff Miller, and Staff Stagray were present the day the alleged incident occurred. Staff were finishing up care. Staff Navarre and Staff Miller stepped outside because of a resident's behavior at the time. Staff Atwater pulled up with another individual. Staff Atwater announced they needed to use the restroom. Staff Navarre stated that Staff Miller told her that Staff Atwater's friend was in the bathroom. Staff Stagray opened the big bathroom's door and saw Staff Atwater and her friend in the bathroom. Staff Navarre asked her co-workers if she should say something to Staff Atwater, but Staff Miller called Staff Harmony. The nurse was called as well, and staff were instructed to write an incident report. She stated that Staff Harmony questioned them the following day. Staff Atwater was confronting everyone telling them that her friend was not in the bathroom but had stood outside the bathroom door. Staff Navarre also stated that Staff Atwater said, "*it doesn't matter he's (Resident A) blind anyway*." Staff Navarre stated that she witnessed Staff Atwater come out of the bathroom with her friend acting "*happy and giddy*." Staff Navarre stated that Resident A was never "*officially alone*" and that they do not have to stay in the bathroom with him, they just have to do checks on him.

On 11/20/2023, I interviewed staff Grace Atwater via phone. She stated that on the day of the alleged incident, she did come into the facility, because she had to use the restroom. She went to the small bathroom first, saw that it was occupied, then went to the large bathroom. Staff Atwater stated that she did not notice Resident A until she was already on the toilet. She stated that she had her friend with her who waited outside the bathroom door. Staff Atwater stated that she had not planned on

stopping by the facility but had to. She stated that Resident A was lying on his back, and the wall of the tub was above his head. She stated that there was no other person or staff person in the bathroom at this time, and that Resident A is not supposed to be left alone while in the tub. Resident A is non-verbal. She stated that all three staff on duty were outside sitting on the porch when she (Staff Atwater) arrived at the home, and that they were still outside when she came out of the restroom. She stated that she did receive written disciplinary action for that day. She stated that she is not aware of any of the other staff seeing her go in or come out of the bathroom.

On 11/20/2023, I interviewed staff Jazmin Stagray via phone. Staff Stagray stated that Staff Atwater showed up to the facility with another individual. They had to use the bathroom. Staff Stagray stated that she and the other staff on shift did not think anything of it, and they all had just walked outside. She stated that at some point staff Alissa Miller walked back inside to do meds. Staff Stagray and Staff Navarre followed. Staff Stagray stated that she heard people talking, so she walked down the hallway and did not see anyone. Staff Stagray stated that she told Staff Miller and Staff Navarre she heard people talking in the big bathroom. Staff Miller called management. Resident A was in the big bathroom's tub at the time. Staff Stagray stated that she had just arrived to the home as it was during shift change. She stated that Resident A cannot be left alone in the bathroom. She denied seeing Staff Atwater and Staff Atwater's friend exit the bathroom but stated that she knows what was done was wrong but did not know how to handle it.

On 11/20/2023, I interviewed Resident A's Bay Arenac Behavioral Health case manager Jennifer DeShano via phone. She stated that she was not aware of the allegations and did not see any incident report about the situation. She denied having any general concerns about Resident A. She stated that there are usually plenty of staff at the home, but it is very concerning that no one was in the bathroom with Resident A. Resident A is blind and non-verbal. Resident A can crawl but would not be able to get himself out of the tub. If he were to slip under the water, he would not be able to get himself up.

On 11/30/2023, I made a call to the facility to interview staff Alissa Miller. Staff Miller stated that she was on shift working. Staff Navarre and Staff Stagray were present. Resident A was in the bathtub. Staff Miller stated that she walked out of the bathroom to grab a towel. Staff Atwater was with a friend, and they stopped by the home. Both Staff Atwater and the friend walked into the bathroom with Resident A. Staff Stagray went down the hallway at some point to check if the friend was in the bathroom, and they were. Staff Miller stated that staff were taking turns taking "breathers" outside, but not all staff were outside at the same time. She stated that there is a staff to resident ratio of one to three, and that two staff should be inside at all times because they currently have six residents. Staff Miller stated that she was initially in the bathroom with Resident A when Staff Atwater arrived at the home. In the "split second" she walked out of the bathroom to get a towel, Staff Atwater and the friend went into the bathroom. Staff Miller stated that she was turned towards the

towels in the closet and did not directly see Staff Atwater and the friend enter the bathroom. She stated that the towel closet is right outside the bathroom in the hallway. Staff Miller stated that she called management, then the nurse, and was instructed to write an incident report. She stated that she made these calls while Resident A was still in the bathtub. She stated that she believes Staff Navarre took over Resident A's personal care for her. She stated that she thinks Staff Atwater has stopped by the home at least twice to use the bathroom, but only once with a friend. Staff Miller stated that she has no knowledge of Staff Atwater saying anything inappropriate about Resident A that day. Staff Miller stated that she thinks there was another resident who was having a behavior as well during this time, that was redirected by staff. When asked if Resident A can be left alone in the tub, Staff Miller stated that Resident A is very good in the tub, but typically they are not supposed to leave any residents alone in the bathroom. She stated that Resident A is very dependent in regard to personal care.

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:	I interviewed home manager Rachel Harmony She stated that staff Alissa Miller reported to her that staff Grace Atwater her a friend were in the bathroom while Resident A was in the tub. Staff Theresa Navarre was interviewed and reported witnessing Staff Atwater and her friend exit the bathroom Resident A was in. An *AFC Licensing Division- Incident/Accident Report* dated 10/19/2023 states that staff on shift witnessed Staff Atwater and her friend were in the bathroom while Resident A was naked in the tub. Staff Grace Atwater was interviewed. She denied her friend entered the bathroom but did admit that she used the bathroom while Resident A was in the tub. Staff Stagray was interviewed and reported hearing Staff Atwater and Staff Atwater's friend in the bathroom Resident A was in while he was in the tub. Resident A's case manager Jennifer DeShano was interviewed. She denied being aware of the allegations and having any general concerns about Resident A's care.

	Staff Alissa Miller was interviewed and reported that Staff Atwater and a friend entered the bathroom while Resident A was in the bathtub. There is a preponderance of evidence to substantiate a rule violation in regard to Resident A not being treated with dignity.
CONCLUSION:	**VIOLATION ESTABLISHED**

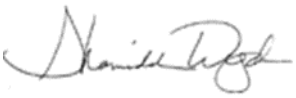
APPLICABLE RULE	
R 400.14302	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	On 11/03/2023, I interviewed home manager Rachel Harmony at the facility. She stated that Resident A requires one-on-one supervision while in the bathtub. A copy of Resident A's Bay Arenac Behavioral Health Plan of Service notes that Resident A requires supervision at all times while he is in the tub, and that he has no safety skills. Staff Theresa Navarre was interviewed and reported that staff only have to do checks on Resident A while he is in the tub. She also stated that she and Staff Miller had stepped outside due to another resident having a behavior. Staff Grace Atwater was interviewed. She stated that Resident A was not supposed to be left alone in the tub but was in the bathroom by himself when she entered the bathroom. She stated that all three staff working at that time were outside when she arrived at the home. Staff Stagray was interviewed and reported that Resident A cannot be left alone in the bathtub. She also reported that staff on shift were outside when Staff Atwater arrived at the home. Resident A's case manager Jennifer DeShano was interviewed. She denied being aware of the allegations and having any general concerns about Resident A's care. She stated that it is very concerning that Resident A was left alone in the bathtub.

	Staff Alissa Miller was interviewed and admitted to walking out of the bathroom to grab a towel. There is a preponderance of evidence to substantiate a rule violation in regard to staff not adhering to Resident A's care plan by leaving him unattended in the bathtub.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/29/2023, I conducted an exit conference with licensee designee Stephanie Riley via phone. I informed her of the findings and conclusions.

IV. RECOMMENDATION

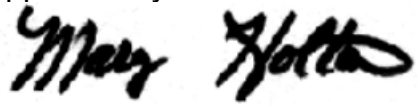
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 6).



12/01/2023

Shamidah Wyden Date
Licensing Consultant

Approved By:



12/01/2023

Mary E. Holton Date
Area Manager