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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 31, 2022

Angela Snyder
ADAPT, Inc.
202 Morse Street
Coldwater, MI 49036

RE: License #: AS120359239
Investigation #: 2022A1032003
Haven Home

Dear Ms. Snyder:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

A handwritten signature in black ink, appearing to read "Dwight Forde".

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616)-240-3850

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

I. IDENTIFYING INFORMATION

License #:	AS120359239
Investigation #:	2022A1032003
Complaint Receipt Date:	04/27/2022
Investigation Initiation Date:	04/28/2022
Report Due Date:	05/27/2022
Licensee Name:	ADAPT, Inc.
Licensee Address:	202 Morse Street Coldwater, MI 49036
Licensee Telephone #:	(517) 279-7531
Administrator:	Angela Snyder
Licensee Designee:	Angela Snyder
Name of Facility:	Haven Home
Facility Address:	232 Morse Coldwater, MI 49036
Facility Telephone #:	(517) 279-2049
Original Issuance Date:	02/01/2015
License Status:	REGULAR
Effective Date:	08/01/2021
Expiration Date:	07/31/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was mistreated by a staff member.	No
Additional Findings	No

III. METHODOLOGY

04/27/2022	Special Investigation Intake 2022A1032003
04/28/2022	Special Investigation Initiated - Face to Face
04/29/2022	Contact - Document Received
05/19/2022	Contact - Document Received Trainings
05/31/2022	Exit Conference

ALLEGATION:

Resident A was mistreated by a staff member.

INVESTIGATION:

On 4/26/22, I received an incident report via email from Angela Snyder regarding Haven Home. Detailed in the report was an incident where staff member Brenda Hooper was observed complaining about changing Resident A's colostomy bag. Brenda reportedly stated that the bag stinks, in response to fecal matter coming out while changing the bag. Brenda Hooper also reportedly wheeled Resident A's chair up to the dinner table in an aggressive manner. Brenda made these comments in Resident A's presence, resulting in her emotional distress.

On 4/28/22, I interviewed staff Cassandra Hegeman. Ms. Hegeman stated that she observed Ms. Hooper complaining about Resident A's colostomy Bag. Ms. Hegeman said that Ms. Hooper reportedly stated that her mother had a colostomy bag, and that Brenda hated that bag as well. Ms. Hegeman stated that staff were trained in changing the colostomy bag. She indicated that there was a fair process whereby

staff took turns while on shift changing the bag. She denied that Ms. Hooper was burdened by the assignment. Ms. Hegeman stated that she saw Ms. Hooper wheel Resident A's chair toward the table, then release it, allowing inertia to propel the chair to the table. Ms. Hegeman denied seeing any injuries on Resident A as a result.

On 4/28/22, I interviewed Resident A at the home. She stated that Ms. Hooper made derogatory remarks about the colostomy bag, saying that it stunk. Resident A further reported that Ms. Hooper pushed her into the table. Resident A stated, "She hurt my feelings."

On 4/29/22, I received email documentation from Angela Snyder, director at Adapt Inc. that Ms. Hooper was sent home early from her shift on the day in question because of her actions toward Resident A.

On 5/19/22, I received email documentation from Angela Snyder, director at Adapt Inc. detailing Ms. Hooper's training. The document read that Ms. Hooper was trained in all applicable domains that would qualify her to work in an AFC Home.

On 5/31/22, I interviewed administrator Angela Snyder by telephone. Ms. Snyder stated that Ms. Hooper was no longer employed at Adapt Inc or any of its homes. She stated that Ms. Hooper was instructed to make contact three days after her last shift, where she was sent home, but failed to do so. Ms. Snyder indicated that Ms. Hooper was provided the requisite training for her position.

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:	Interviews were conducted with staff and Resident A that revealed the event did occur and the home took reasonable steps to remove the resident from Ms. Hooper. A review of Ms. Hooper's training documentation revealed the home did provide adequate training. While the event did occur, it appears to have been an isolated incident that could not have been anticipated but the home took sufficient action to protect the resident from further mistreatment.
CONCLUSION:	VIOLATION NOT ESTABLISHED

I shared the findings of this investigation with licensee designee Ms. Snyder by telephone. Ms. Snyder stated that she was satisfied with the outcome of the investigation and agreed that the proper steps were taken to ensure resident protection.

IV. RECOMMENDATION

I recommend no changes to the status of this license.

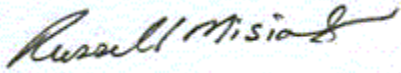


5/31/22

Dwight Forde
Licensing Consultant

Date

Approved By:



6/21/22

Russell B. Misiak
Area Manager

Date