GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 22, 2024

Dominique Miller
Residential Options Inc.
2400 Science Parkway
Okemos, MI 48864

RE: License #: AS230010627
Investigation #: 2024A0581031
Kemler Road Home

Dear Dominique Miller:

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 (517) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS230010627
Investigation #:	2024A0581031
Complaint Receipt Date:	07/31/2024
Investigation Initiation Date:	08/01/2024
Report Due Date:	09/29/2024
Licensee Name:	Residential Options Inc.
Licensee Address:	2400 Science Parkway Okemos, MI 48864
Licensee Telephone #:	(517) 374-8066
Administrator:	Dominique Miller
Licensee Designee:	Dominique Miller
Name of Facility:	Kemler Road Home
Facility Address:	3138 Kemler Road Eaton Rapids, MI 48827
Facility Telephone #:	(517) 663-2556
Original Issuance Date:	12/01/1986
License Status:	REGULAR
Effective Date:	05/14/2023
Expiration Date:	05/13/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATIONS

	Violation Established?
The facility's residents were left unsupervised when a direct care staff quit in the middle of her shift.	Yes
A direct care staff hit Resident A and he fell on the floor.	No

III. METHODOLOGY

07/31/2024	Special Investigation Intake 2024A0581031
07/31/2024	APS Referral - APS received the allegations but denied investigating.
08/01/2024	Special Investigation Initiated - Telephone Interview with Guardian A1
08/05/2024	Inspection Completed On-site – Interviews with staff and residents.
08/05/2024	Contact – Document Received – Email from Licensee Designee.
08/12/2024	Contact - Telephone call made -Attempted contact with direct care staff, Kristi Myers.
08/12/2024	Contact - Telephone call made - Interview with licensee's quality control, Elizabeth Farnum
08/12/2024	Contact - Telephone call made - Left voicemail with direct care staff, Grace Chitiyo
08/12/2024	Inspection Completed-BCAL Sub. Compliance
08/12/2024	Contact – Document Sent - Requested police report from Eaton County Sheriff's Department.
08/12/2024	Contact – Document Received - Email from Eaton County Sheriff's Department FOIA Specialist. Police not involved.
08/21/2024	Exit conference with licensee designee, Nicky Miller, via email.
08/21/2024	Contact – Telephone call made – Attempted contact with Ms. Myers.

ALLEGATION: The facility's residents were left unsupervised when a direct care staff quit in the middle of her shift.

INVESTIGATION:

On 07/31/2024, I received the complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged on or around 07/30/2024, direct care staff, Kristi Myers, was on shift assisting in the care of residents; however, in the early morning she texted the licensee's management personnel she quit and was "done with Kemler." The complaint alleged management attempted to contact Ms. Myers, but attempts were unsuccessful. The complaint alleged shortly after Ms. Myers contacted management, two of the facility's higher functioning residents also contacted management to report Ms. Myers left them alone. They also reported Resident A was lying on the floor covered in feces. The complaint alleged the residents who contacted management did not know what had happened to Resident A.

The complaint also alleged Resident A was transported to the Emergency Room (ER) where he had a computed tomography (CT) scan, which determined he had no injuries. The complaint alleged Ms. Myers refused to help Resident A get up, left the facility, and Resident A defecated all over himself. The complaint documented Resident A has cognitive delays, requires total assistance with all his activities of daily living, and utilizes a walker for ambulating.

On 08/01/2024, I interviewed Resident A's public guardian, Guardian A1, via telephone. Guardian A1 stated she had limited information regarding the incident but was aware of the situation. Guardian A1 stated the licensee designee, Dominque "Nicky" Miller, contacted her reporting the residents had been left unattended for approximately 15 minutes on 07/30/2024. Guardian A1 stated it was reported to her Resident B assisted in contacting the licensee's management personnel to report Resident A's condition. Guardian A1 stated though Resident A is verbal, he is usually only verbal when he is mad or upset. Guardian A1 stated she visited Resident A on 08/01/2024 and attempted to interview him, but her attempts were unsuccessful. Guardian A1 stated Resident B reported to her she had been nervous when the incident took place. Guardian A1 stated Resident C had also been present when the incident occurred; however, she stated she did not interview him.

On 08/05/2024, I conducted an unannounced investigation at the facility. I interviewed the facility's home manager, Shawn Hose. Ms. Hose stated she was not working when the incident occurred; however, she stated she received a text message from Ms. Myers at 10:45 pm saying she quit working at the facility. Ms. Hose stated she was sleeping at the time she received the text message and did not respond to Ms. Myers. Ms. Hose showed me Ms. Myers' text to her, which documented at 10:45 pm, Ms. Myers texted, "I quit. I'm leaving now". Ms. Hose stated Ms. Myers started her shift at 10 pm and would have been working alone during the overnight shift that night.

I interviewed Resident B and Resident C during the investigation. Resident B stated at approximately 11:30 pm or 12 am, she was in her 2nd level bedroom when Resident C yelled for her assistance reporting the facility's staff left. Resident B identified the staff who was working the overnight shift as Ms. Myers. Resident B stated when she went downstairs, she observed Resident A on his back on the kitchen floor. She stated Resident A reported to her he had "an accident", but she stated she also observed Resident A covered in feces. Resident B stated she "freaked out" and asked Resident C what was happening. Resident B stated Resident C told her to contact the facility's Quality Control personnel, Elizabeth "Liz" Farnum, which she did. She stated Ms. Farnum asked her to go outside and see if she observed Ms. Myers vehicle, which she stated she saw leaving the facility's driveway. Resident B stated Ms. Farnum and another staff showed up that night; however, she was unsure of the time(s) they arrived. She stated staff bathed Resident A and then took him to the hospital. Resident B stated she did not observe any marks or bruises on Resident A when she observed him on the kitchen floor.

I interviewed Resident C whose statement to me was consistent with Resident B's statement. Resident C confirmed Ms. Myers was the only staff working in the facility on 07/30/2024 for the overnight shift and had arrived to work at 10 pm. Resident C stated he was unsure what Ms. Myers was doing in the facility from 10 pm until around 11 pm, but at approximately 11:05 pm, he heard Ms. Myers cussing and swearing. He stated when he came out of his bedroom, he observed Ms. Myers pick up her purse and leave out of the facility's front door. He stated he heard Ms. Myers say she was "done". He stated he then discovered Resident A in the kitchen on the floor. Due to Resident C's physical disabilities, he was unable to use the telephone, so he yelled to Resident B for assistance. Resident C stated Resident A reported to him he had "an accident" before Ms. Myers left the facility. Resident A reported to Resident C he had been trying to use the bathroom but fell. Resident C stated he did not observe Resident A fall to the floor. Resident C stated when he saw Resident A on the floor, he immediately had Resident B contact Relative C1, then the facility's home manager, Ms. Hose, and then Ms. Farnum. Resident C stated Ms. Farnum arrived at the facility around 11:30 pm and immediately assisted Resident A in getting up and in the shower. Resident C stated he observed Resident A with a black eye.

I was unable to interview Resident A during the inspection as he was sleeping. I observed Resident A with yellow bruising on his bottom left cheek and under his left eye.

During the inspection, Ms. Hose showed me staff's timesheets from 07/30/2024, which confirmed Ms. Myers arrived at 10 pm while direct care staff, Grace Chitiyo, left the facility at 10:15 pm. Upon review of Ms. Myers' timecard, she did not punch out when she left the facility; therefore, there was no record of when Ms. Meyers left the facility. My review of Ms. Farnum's and Ms. Chitiyo's timesheet established Ms.

Farnum arrived to the facility at 11:30 pm and left at 2:50 am while Ms. Chitiyo arrived at 12:30 am and left at 6 am.

I also reviewed the facility's "Medical Visit Form" for Resident A, dated 07/31/2024 at 12:45 am, where he was seen at Eaton Rapids Medical Center. According to the visit form, Resident A "Fell in home. Client said he hit his head". The doctor treating Resident A ordered a CT of Resident A's head, which showed no acute hemorrhage or fracture. The visit form documented Resident A could be discharged back to the facility with outpatient follow up.

On 08/05/2024, the facility's Licensee Designee, Nickey Miller, emailed me an incident report (IR) pertaining to the 07/30/2024 incident and copies of all the resident's *Assessment Plans for AFC Residents*. According to my review of the IR, which was completed by the facility's Quality Control personnel, Liz Farnum, Ms. Farnum received a text from Ms. Myers at 11:07 pm, which documented, "I quit, I'm done with Kemler." Ms. Farnum documented in the IR she asked Ms. Myers what was going on, but Ms. Myers would not respond to her. Ms. Farnum documented she also called Ms. Myers twice; however, Ms. Myers would not answer. Ms. Farnum documented she contacted the licensee's scheduling manager about Ms. Myers. Ms. Farnum documented after contacting the scheduling manager, she received a telephone call from one of Resident A's roommates who reported to her staff had left the facility and Resident A was on the floor. Ms. Farnum documented she asked Resident A's roommate to go outside and the resident confirmed the staff's car was gone. Ms. Farnum documented she made it to the facility in "10/15 minutes" and determined the residents were "good" except Resident A was on the floor and had a bowel movement on himself and the floor. She documented she got him up, proceeded to the bathroom, and was able to clean him up. Ms. Farnum documented when the additional staff arrived at the facility, they were able to shower Resident A and get him dressed. She documented she then took Resident A to the ER where he received a CT scan whereas the treating physician determined Resident A was "ok" and was sent home.

I reviewed Resident A's, B's, C's, D's, E's, and F's *Assessment Plans for AFC Residents* (assessment plan*)*, which confirmed all the residents require all the aspects of adult foster care services including personal care, supervision, and protection. Additionally, Resident A's assessment plan, dated 02/26/2024, documented Resident A "needs verbal prompts to use restroom, assist with BMs. Reminders to wash hands."

On 08/12/2024, I interviewed Ms. Farnum, via telephone. Her statement to me was consistent with what she documented in the facility's IR. Ms. Farnum stated when she arrived to the facility Resident D, Resident E, and Resident F were sleeping.

Ms. Myers did not answer or return my phone calls; therefore, I was unable to interview her regarding the incident.

In my review of the facility record, I determined a repeat violation of Adult Foster Care (AFC) licensing rule, R 400.14305(3). According to special investigation report # 2022A1033033, dated 11/03/2022, the facility was in violation of AFC Rule R 400.14305(3) when it established direct care staff members did not provide proper supervision, protection and safety to two residents on 09/03/2022 when an alleged sexual assault took place. The licensee's corrective action plan (CAP), dated 11/22/2022, documented as a result of inappropriate, undesired sexual conduct between two residents, a plan was created to keep sexual contact from reoccurring. The CAP documented if staff were unable to directly monitor the two residents, then the two residents would leave the facility's common areas and go their respective bedrooms to reduce impulsive reaction and to ensure there would be no potential coercion or sexual activity.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on my investigation, which included interviews with the facility's home manager, Shawn Hose, the facility's Quality Control, Elizabeth Farnum, Resident B, Resident C, and Guardian A1, and review of Ms. Hose's text message from direct care staff, Krisit Myers, and review of the facility's timesheets, Resident A's Medical Visit Form, dated 07/31/2024, the facility's IR, and resident assessment plans, there is evidence the facility was without any direct care staff for approximately 15 minutes on 07/30/2024 when Ms. Myers left the facility. Consequently, Ms. Myers left the facility unattended and failed to provide the residents with supervision, personal care and protection, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	On 07/30/2024, direct care staff, Kristi Myers, did not treat Resident A with dignity and respect or attend to his personal needs when she left the facility with him lying on the kitchen floor covered in feces after he experienced a bowel movement.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE SIR #2022A1033033, DATED 11/03/2022, CAP DATED, 11/21/2022]**

ALLEGATION: A direct care staff hit Resident A and he fell on the floor.

INVESTIGATION:

The complaint alleged on or around 07/30/2024, direct care staff, Kristi Myers did not assist Resident A in going to the bathroom. The complaint alleged when Resident A got up and began walking to the bathroom, Ms. Myers hit him, and he fell to the ground. The complaint documented it was unclear how Ms. Myers hit Resident A or what was used to hit him.

Resident B and Resident C were both in the facility when Resident A fell to the floor; however, neither resident was present when the incident occurred. Subsequently, neither Resident B nor Resident C observed Ms. Myers hitting Resident A causing him to fall to the ground. Additionally, due to Resident A's cognitive decline, he was unable to be interviewed regarding the incident.

Ms. Farnum stated on 07/30/2024, Resident A reported to her Ms. Myers hit him and he "bonked" his head. She stated he was unable to report what he hit his head on or how Ms. Myers hit him.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.

ANALYSIS:	Based on my investigation, there is no evidence direct care staff, Krisit Myers, hit Resident A on or around 07/30/2024 causing him to fall to the ground.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 08/21/2024, I conducted the exit conference with the licensee designee, Nicky Miller, via email. I explained my findings and provided an opportunity for questions or comments relating to the investigation.

IV. RECOMMENDATION

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

Cathy Cushman

08/21/2024

Cathy Cushman Date
Licensing Consultant

Approved By:

Dawn Timm

08/22/2024

Dawn N. Timm Date
Area Manager