GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 29, 2025

Timothy Van Dyk
Residential Opportunities, Inc.
1100 South Rose Street
Kalamazoo, MI 49001

RE: License #: AM390382663
Investigation #: 2025A0581021
Hoard Manor

Dear Timothy Van Dyk:

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) 335-5985.

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 #:	AM390382663
Investigation #:	2025A0581021
Complaint Receipt Date:	03/05/2025
Investigation Initiation Date:	03/05/2025
Report Due Date:	05/04/2025
Licensee Name:	Residential Opportunities, Inc.
Licensee Address:	1100 South Rose Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-3731
Administrator:	Allen Giese
Licensee Designee:	Timothy Van Dyk
Name of Facility:	Hoard Manor
Facility Address:	305 West Cork Street Kalamazoo, MI 49001
Facility Telephone #:	(269) 343-9726
Original Issuance Date:	01/25/2018
License Status:	REGULAR
Effective Date:	07/25/2024
Expiration Date:	07/24/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED AGED

II. ALLEGATIONS

	Violation Established?
Direct care staff did not change Resident A's incontinence brief prior to her attending her day program.	No
An overnight direct care staff yells at residents to go to bed.	No
Direct care staff did not administer Resident D's medication on or around 03/03/2025.	Yes
Menus are not posted in the facility.	Yes
Residents are unable to do their laundry because direct care staff are doing their own laundry in the facility.	No
Additional Findings	No

III. METHODOLOGY

03/05/2025	Special Investigation Intake - 2025A0581021
03/05/2025	Special Investigation Initiated – Telephone - Interview with Complainant
03/05/2025	Contact - Telephone call made - Interview with ISK rights, Kate Koyak.
03/05/2025	Referral - Recipient Rights - ISK
03/05/2025	APS Referral - After speaking to rights, resident retracted statement. No concerns of abuse/neglect. No referral necessary.
03/05/2025	Contact - Document Received - Received additional allegations: the menu is not posted in the home and staff members are using the recipients washing machine for their personal laundry
03/06/2025	Contact - Telephone call made - Left message with Kate Koyak. Also sent email requesting additional information
03/06/2025	Contact - Document Received - Email from Kate Koyak
03/07/2025	Contact - Document Received - Received additional allegations.
03/12/2025	Contact - Face to Face - Interviewed staff at licensee's main office with RRO ISK
03/14/2025	Contact - Document Received - Email from Allen Giese, Administrator

03/14/2025	Contact - Document Sent - Email to Allen Giese
03/17/2025	Contact - Document Received - Email from Kate Koyak
03/18/2025	Contact - Face to Face - Interview with Kate Coggins de Pablo via MiTeams
03/18/2025	Contact - Face to Face - Interview with Allen Giese via MiTeams
03/24/2025	Inspection Completed On-site - Interview with staff and residents
03/24/2025	Contact - Telephone call made - Interview with Resident A.
04/24/2025	Contact – Document Sent – Email to Allen Giese.
04/24/2025	Contact – Document Sent – Email to Kate Koyak.
04/28/2025	Exit conference with licensee designee, Tim Van Dyk.

ALLEGATION: Direct care staff did not change Resident A's incontinence brief prior to her attending her day program.

INVESTIGATION: On 03/05/2025, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged Resident A arrived at her day program on or around 02/13/2025 with dried feces in her incontinence brief. The complaint alleged Resident A had a bowel movement at the facility, which direct care staff were aware of, but did not address prior to Resident A being transported to her day program. The complaint alleged Resident A was told by direct care staff to wait until she arrived at her day program so staff there could assist her with being changed.

On 03/05/2025, I interviewed Integrated Services of Kalamazoo (ISK) Recipient Rights Officer (RRO), Kate Koyak, who stated she interviewed Resident A the previous week and Resident A reported to her she experienced a bowel movement on the bus and did not tell anyone about the incident or ask for assistance until she arrived at her day program. Resident A reported to Kate Koyak the allegations of having a bowel movement at the facility, but staff instructing her to continue to her day program with a soiled incontinence brief, were not true.

Kate Koyak stated she also interviewed overnight staff at the facility including Irene Munge and Lola Williams who both denied knowingly sending Resident A to her day program with a soiled incontinence brief.

On 03/12/2025, in conjunction with Kate Koyak, we interviewed multiple direct care staff and the facility's Administrator, Allen Giese, at the licensee's main office. Allen Giese stated he was not aware of any incident whereas staff knowingly sent Resident A to her day program with a soiled brief rather than encouraging or assisting her in changing it. He stated staff would smell a bowel movement, which would prompt them to talk to Resident A about changing her incontinence brief and/or assist her in cleaning up.

Direct care staff, Irene Munge's and Lola Williams', statements were consistent with what they reported to Kate Koyak. Their statements were also consistent with Allen Giese's statement.

On 03/24/2025, I interviewed Resident A via telephone. Resident A's statement was consistent with her statement to Kate Koyak; however, she reported to me she experienced incontinence after she arrived at her day program rather than on the bus to her day program. She stated the facility's staff provide assistance to her when she is incontinent.

I reviewed Resident A's *ISK's Annual Assessment,* 01/24/2024, which documented Resident A requires "Moderate Assistance" with her personal hygiene; however, it did not document or identify Resident A needing any assistance from staff with toileting. I reviewed Resident A's *ISK Individual Plan of Service* (IPOS), dated 02/05/2024, which documented staff are to "Encourage [Resident A] to use the toilet as needed and to remain seated on the toilet until she is finished. Remind her to be thorough in cleaning herself after toileti[*sic*]".

APPLICABLE RULE	
R 400.14303	**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:	Based on interviews with Integrated Services of Kalamazoo Recipient Rights Officer, Kate Koyak, direct care staff, Irene Munge and Lola Williams, Administrator, Allen Giese, and Resident A, and a review of her ISK IPOS, dated 02/05/2024, there is no supporting evidence Resident A experienced a bowel movement at the facility on or around 02/13/2025 and then staff knowingly sent her to her day program with a soiled incontinence brief. Additionally, Resident A denied the allegations were true.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: An overnight direct care staff yells at residents to go to bed.

INVESTIGATION: The complaint alleged an overnight staff speaks harshly to residents and tells residents to go to their rooms. No additional information was provided in the complaint.

The administrator, Allen Giese, stated the facility's overnight shift starts at 10 pm and while staff may encourage residents to wind down or watch TV in their bedrooms, staff are aware they cannot tell residents to go to bed. He stated residents are good at reporting when they are upset or have issues with staff and he stated none of them reported to him any concerns or issues with staff yelling or telling them to go to bed.

Irene Munge's and Lola Williams' statements were consistent with Allen Giese's statement. Lola Williams stated residents do not have bedtimes; however, after evening medications are administered, residents often retire to their bedrooms for the night on their own accord.

I also interviewed direct care staff, Aaliyah Stokes, whose statement was contradictory to the statements provided by Allen Giese, Irene Munge or Lola Williams. She stated many of the facility's residents are elderly and hard of hearing but stated both Irene Munge and Lola Williams yell at residents to go back in their rooms if they come out of their bedrooms at night. Aaliyah Stokes stated Irene Munge and Lola Williams were not treating residents respectfully by telling them to go back into their bedrooms.

I interviewed Resident A, B, and C during my inspection and none of them stated staff were yelling at them or telling them they needed to go to bed. The residents stated they were not aware of any staff yelling at other residents or telling other residents they needed to go to bed.

APPLICABLE RUL	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	There is no supporting evidence any direct care staff, including Irene Munge and Lola Williams, yell at or speak harshly to any residents in the facility. Additionally, there is no supporting evidence that any direct care staff instruct residents to their bedrooms or tell residents they have a specific bedtime.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff did not administer Resident D's medication on or around 03/03/2025.

INVESTIGATION: The complaint alleged Resident D missed his Risperdal (generic name Risperidone) medication on or around 03/03/2025 because staff did not count the medication the day it was delivered to the facility.

Administrator, Allen Giese, stated he was not aware of Resident D missing any Risperidone doses. He stated if a dose of medication was missed, or a resident received the wrong medication then staff are expected to complete an incident report. He stated the facility receives monthly medication deliveries, which upon delivery, staff are expected to count the medication to document how much has been received. He identified Brittany Coggins de Pablo as the primary staff who counts medications upon delivery; however, he stated all staff were trained to count medications. Allen Giese stated staff are expected to document on a "med contact sheet" when medications are in low supply. He stated the facility's supervisors should review these contact sheets daily. He stated a supervisor would then contact the pharmacy and/or physician when there are less than seven days of the medication. Allen Giese stated staff should also check the overflow cabinets in the basement.

Irene Munge and Lola Williams could not recall any issues with Resident D's medications.

Aaliyah Stokes stated she recalled administering Resident D's last dose of Risperidone medication on or around the weekend of 02/28-03/02. She stated she did not have any information as to whether or not Resident D missed any scheduled doses of his Risperidone after she administered the last dose, but believed he did because she did not observe a refill in the facility. Aaliyah Stokes stated on or around 03/03 medications were delivered to the facility; however, she stated it was not her responsibility to count medications. She stated the facility's supervisor, which she identified as Brittany Coggins de Pablo, was responsible for counting medications.

On 03/14/2025, Allen Giese emailed documenting there had been a medication error involving Resident D's Risperidone.

On 03/17/2025, Kate Koyak forwarded me the facility's completed *AFC Licensing Division – Incident / Accident Report* (IR), which was completed by direct care staff, Brittany Coggins de Pablo, on 03/16/2025. According to the IR, Resident D did not receive his "…risperdal .5 mg" on 02/28, 03/01, 03/02, or 03/03, which is to be taken once a day at 6 pm". The IR documented the medication was ordered on 02/28 and delivered 03/03 at 2:09 pm. The IR also documented "The medication procedures in place to prevent this type of error were reviewed at the staff meeting on 3/13/25".

Kate Koyak also forwarded a copy of the Resident D's March 2025 *Medication Administration Record* (MAR), which she obtained during her inspection. The MAR documented Resident A is prescribed Risperdal 0.5 mg tablet with the instruction of take 1 tablet by mouth every evening. The MAR documented staff did not administer this medication to Resident D on 03/01, 03/02, or 03/03.

Kate Koyak documented that she did not obtain a copy of Resident D's February MAR.

On 03/18/2025, in conjunction with Kate Koyak, I interviewed direct care staff and the facility's identified Assistant Program Coordinator, Brittany Coggins de Pablo, via MiTeams. Brittany Coggins de Pablo stated she was aware of Resident D's missed medication doses, which were identified on the IR. She stated Resident D did not have a refill on the medication so his physician needed to be contacted, and a new prescription requested before the pharmacy would fill it. Brittany Coggins de Pablo stated if a staff passes the last medication, then it would be the expectation the staff contact the pharmacy and request a refill or at least get a three day supply until the physician's office can send a new prescription order. She stated the staff who administers medications should document on a whiteboard in the medication room when medications have a supply of 7 days. She stated this would prompt her and allow enough time to contact the pharmacy for a refill or contact the physician and get a new order.

Brittany Coggins de Pablo stated she observed a note on the white board in the medication room on 02/28 documenting Resident D's Risperidone needed to be refilled. She stated she contacted the pharmacy, and they reported to her they would refill it that day; however, she stated that did not occur. She stated the staff who worked that evening should have contacted either her or Allen Giese to report the medication was not in the facility because either one of them could have contacted the pharmacy and obtained a limited supply.

Brittany Coggins de Pablo stated despite Resident D's Risperidone medication being delivered on 03/03 at approximately 2 pm, it was not administered to him that evening because the staff who received the medications did not review and sign off on them.

I conducted a follow up interview with Allen Giese after speaking to Brittany Coggins de Pablo. His follow up statement was consistent with Brittany Coggins de Pablo's

statement. He stated Aaliyah Stokes contacted Brittany Coggins de Pablo either 02/27 or 02/28 to report Resident D's Risperidone medication was out; however, Brittany Coggins de Pablo was in training and unable to immediately address the issue. Allen Giese stated Aaliyah Stokes should have then contacted the pharmacy to request a limited supply of the medication. Allen Giese stated medication procedures were reviewed with Aaliyah Stokes on May 2024 during an in service with facility staff.

Allen provided documentation confirming Aaliyah Stokes attended the 05/08/2024 facility staff meeting where medication procedures were addressed. The medication procedure was consistent with Allen Giese's statement.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my review of the facility's *AFC Licensing Division – Incident / Accident Report* and Resident A's March *Medication Administration Record* and interviews with direct care staff, Brittany Coggins de Pablo and Aaliyah Stokes, and Administrator, Allen Giese, Resident D did not receive his scheduled Risperdal 0.5 mg medication on 02/28, 03/01, 03/02, and 03/03, as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Menus are not posted in the facility.

INVESTIGATION: The complaint did not provide additional information other than what was identified in the allegations.

On 03/06/2025, Kate Koyak documented that she visited the facility on 03/06/2025 and did not observe a posted menu; however, she observed a binder in the kitchen with diet orders and substitutions.

Allen Giese, Irene Munge, Lola Williams, and Aaliyah Stokes all stated the facility menu is usually posted on the refrigerator in the kitchen.

I did not observe a posted menu during my unannounced inspection on 03/24/2025; however, staff were in the process of creating it. Allen Giese stated the menu is created on Monday mornings.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	The facility's menu was not written one week in advance and posted at the time of my 03/24/2025 inspection. At a minimum, menus for the current day and the next seven days must be posted.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents are unable to do their laundry because direct care staff are doing their own laundry in the facility.

INVESTIGATION: The complaint did not provide additional information other than what was identified in the allegations.

Kate Koyak documented she visited the facility on 03/06/2025 and observed the facility had multiple laundry machines that can be used by residents. She documented the facility's manager reported to her he allowed staff to wash their laundry because he wants to ensure everyone has their basic needs met; however, he only allows it with the understanding the residents have their clothing and bedding washed first and a washing machine is left available for resident use. Kate Koyak documented the manager reported there has never been a problem with this arrangement.

Allen Giese statement to me was consistent with what he reported to Kate Koyak. He stated staff are expected to also use their own laundry soap when doing their laundry. Allen Giese stated residents do not do their own laundry as this task is completed by staff. He stated he had not received any complaints from residents whereas they did not have clean clothes or bedding because staff were unable to complete their laundry in a timely manner.

Lola Williams and Aaliyah Stokes both stated staff do their personal laundry in the facility; however, Lola Williams stated it took her longer to complete resident laundry when staff were doing their laundry or there were incidences where staff left their clothes in the dryer too long. Aaliyah Stokes stated she was only aware of staff completing their own laundry after resident's laundry had already been done. She stated she had not experienced any inconveniences with staff doing their own laundry in the facility.

Brittany Coggins de Pablo's statement to me was consistent with other staff's statements. She stated there had been incidences where staff put a load of their own laundry in a washer or dryer and then went on an outing. She stated staff would leave notes on their laundry or the machine requesting no one touch it or switch anything over until staff did it themselves when they returned. Brittany Coggins de Pablo did not describe any significant incidences where staff were unable to carry out the task of completing resident's laundry.

Resident A, B, and C stated staff complete their laundry on a regular and consistent basis. They did not describe any issues their clothes or bedding were not being laundered.

APPLICABLE RULE	
R 400.14404	**Laundry.**
	A home shall make adequate provision for the laundering of a resident's personal laundry.
ANALYSIS:	Based on multiple interviews with staff and residents, there is no supporting evidence the facility is not making adequate provision for the laundering of resident's personal laundry, as required. Though there are reports staff may utilize the facility's washers and dryers for their personal laundry, there was no substantial evidence that these occurrences prevented residents from having access to clean clothes or bedding.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 04/28/2025, I conducted my exit conference with the licensee designee, Tim Van Dyk, via telephone, and explained my findings.

IV. RECOMMENDATION

Based upon an acceptable plan of correction, I recommend no change in the current license status.

04/28/2025

Cathy Cushman Date
Licensing Consultant

Approved By:

04/28/2025

Dawn N. Timm Date
Area Manager