RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

January 23, 2019

Barry Bruns
HomeLife Inc
PMB #360
5420A Beckley Rd.
Battle Creek, MI 49015

RE: License #: AS390080967
Investigation #: **2019A0578012**
8038 Interlochen AFC

Dear Mr. Bruns:

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 (616) 356-0183.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 251-4091

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS SEXUALLY EXPLICIT LANGUAGE

I. IDENTIFYING INFORMATION

License #:	AS390080967
Investigation #:	2019A0578012
Complaint Receipt Date:	12/04/2018
Investigation Initiation Date:	12/05/2018
Report Due Date:	02/02/2019
Licensee Name:	HomeLife Inc
Licensee Address:	3 Heritage Oak Lane Battle Creek, MI 49015
Licensee Telephone #:	(269) 660-0854
Administrator:	Barry Bruns
Licensee Designee:	Barry Bruns
Name of Facility:	8038 Interlochen AFC
Facility Address:	8038 Interlochen Road Kalamazoo, MI 49009
Facility Telephone #:	(269) 353-6941
Original Issuance Date:	08/01/1998
License Status:	REGULAR
Effective Date:	02/14/2017
Expiration Date:	02/13/2019
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A keeps touching Resident B's breast. Its alleged this is done in a playful manner, but Resident A reports the behavior sometimes makes her uncomfortable and direct care staff are not intervening.	No
Additional Findings	Yes

III. METHODOLOG

12/04/2018	Special Investigation Intake 2019A0578012
12/04/2018	APS Referral Completed
12/05/2018	Special Investigation Initiated - On Site
12/05/2018	Inspection Completed On-site Interviewed Resident A, Resident B, staff member Katlyn Jehner
12/05/2018	Contact -Documents Received
12/05/2018	Contact-Telephone -With staff member Emily Taylor
12/10/2018	Inspection Completed On-site -Documents Received *AFC Incident / Accident Report*
12/11/2018	Contact-Telephone -With staff member Emily Taylor
12/11/2018	Contact-Telephone -With Lifeways Recipient Rights
12/11/2018	Contact-Telephone -With recipient rights officer Clevester Moten
12/11/2018	Contact-Telephone -With staff member Emily Taylor
12/11/2018	Exit Conference

	-With licensee Barry Bruns
01/03/2019	Additional Allegations, BCHS On-line Complaint System
01/16/2019	Exit Conference -With licensee Barry Bruns

ALLEGATION:
Resident A keeps touching Resident B's breast. Its alleged this is done in a playful manner, but Resident A reports the behavior sometimes makes her uncomfortable and direct care staff are not intervening.

INVESTIGATION:
On 12/04/2018, I received this complaint through the BCHS On-line Complaint System. Complainant alleged that Resident A and Resident B have no guardian or power of attorney. Complainant alleged that Resident A keeps touching Resident B's breasts. Complainant stated that Resident A does this in a joking manner, but it does sometimes make Resident B uncomfortable. Complainant states that Resident B did not report the present occurrence of behavior as a concern to staff but Resident B did report similar behavior to staff approximately a month ago.

On 12/04/2018, I reviewed the details of this investigation with staff member Emily Taylor. Ms. Taylor serves as the program director for the facility. Ms. Taylor reported that Resident C reported the behavior occurring between Resident A and Resident B to staff. Ms. Taylor reported it was undetermined if the behavior was aggressive or sexual, but staff reviewed the behavior with Resident B, who acknowledged the behavior had been occurring. Ms. Taylor reported that a month previously, Resident B had reported this behavior to staff and it was reviewed with Resident B's case manager. Ms. Taylor clarified that during this initial report by Resident B, Resident B initially wanted to make a formal complaint to Recipient Rights but then changed her mind and no longer wanted to make a complaint about Resident A's behavior. Ms. Taylor reported that none of the staff had observed the behavior and since this initial report, there had been no additional complaints of the behavior until this most recent allegation. Ms. Taylor acknowledged an incident report relating to this initial report by Resident B was not completed or communicated to this department. Ms. Taylor reported that after being interviewed based on Resident C's observation, Resident B's reporting of the nature of the behavior has been inconsistent. Ms. Taylor reported that staff would be reviewing the behavior with Resident A and request that it stop. Ms. Taylor reported that Resident A and Resident B do not have guardians.

On 12/06/2018, I completed an unannounced on-site investigation at this facility and interviewed staff member Katlyn Zehner regarding the allegations. Ms. Zehner serves as the home manager for the facility. Ms. Zehner reported that Resident B had informed her and Ms. Taylor of the allegations. Ms. Zehner acknowledged that Resident B had previously reported the behavior, and this was addressed with the case manager and reported to Lifeways Community Health Recipient Rights. Ms.

Zehner reported that an *AFC Incident / Accident Report* for this incident could not be located. Ms. Zehner acknowledged some inconsistencies in the time and frequency of Resident B's reporting of the behavior.

While at the facility I interviewed Resident A regarding the allegations. Resident A acknowledged the allegations as reported, stating that she was "just playing around" with Resident B and denied this behavior was in a sexual or aggressive manner. Resident A denied that Resident B had ever told her not to engage in the behavior. Resident A stated that she had not engaged in the behavior since staff had reviewed the behavior with her and directed her to stop.

While at the facility I interviewed Resident B regarding the allegations. Resident B acknowledged that Resident A would pinch her breasts and reported this behavior had occurred in facility for a, "long time." Resident B was emotional in reporting that the behavior was painful. Resident B denied informing Resident A that the behavior was painful and did not want it to continue. Resident B reported that she had told staff about the behavior "a while ago" and the staff, "have done nothing about it." Resident B could not recall with accuracy when the last time the behavior occurred, stating it had happened as recently as "the previous day" and then changing her mind reporting Resident A had not touched her inappropriately since staff talked with her.

While at the facility, I reviewed case notes dated 10/03/2018 related to the behavior reported by Resident B and documented by staff member Katlyn Zehner, which included the following:

> "Jill Mullins, case manager came to Interlochen for meeting with [Resident B]. [Resident B] wanted to discuss moving into an apartment. Incident with [Resident A] pinching her nipples was addressed. [Resident B] reported it was happening every day and was not reporting to staff because she didn't want to get [Resident A] in trouble. [Resident B] said she had put an end to it and that it would no longer be a problem. After speaking with Emily (Taylor) [Resident B] was brought back into the office. Jill (Mullins) asked [Resident B] if she believed it was just horseplay or of sexual nature. [Resident B] said just horseplay saying sometimes she would do it and she would laugh and other times it would hurt. Jill (Mullins) asked if she thought rights had been violated, "No". Did she want to make a formal report? At first, she did not. Then she said she did. We brought in rights booklet and complaint form to help or help her make a verbal. [Resident B] changed her mind again and stated she did not want to make a complaint. I contacted Lifeways RR (Recipient Rights) and left a voice mail to follow-up…"

On 12/07/2018 I reviewed an *AFC Incident / Accident Report* completed relating to the allegations on 12/03/2018. Documented by staff member Tria Williams, it included the following information:

> "(Tria Williams) went to [Resident B] to follow up with her about any possible incidents that may have happened. [Resident B] told (Tria Williams) that [Resident A] had pinched her boobs multiple times. Once this morning [Resident A] came into [Resident B]'s room and woke her up messing with her boobs. She said it happened in [Resident A]'s room. (Tria Williams) asked [Resident B] why she was in [Resident A]'s room after she reported [Resident B] was pinching her boobs and she didn't like it. [Resident B] said [Resident A] asked her to come and lay with her. (Tria Williams) asked [Resident B] if she told [Resident A] to stop once she did it, she said yes and left [Resident A]'s room right after…"

On 12/11/2018 I interviewed Ms. Emily Taylor by phone. Ms. Taylor reported an *AFC Incident / Accident Report* was completed regarding Resident A's behavior towards Resident B on 10/01/2018. Ms. Taylor was informed there was no record of the report being provided to the department and no record available during two separate unannounced on-site investigations. Ms. Taylor acknowledged this report was not sent to the department. Ms. Taylor stated corrective actions from this report included reviewing the behavior plan for Resident A at a staff meeting. Ms. Taylor reported Kalamazoo Sheriff's Department interviewed Resident B on 12/10/2018 and Resident B denied being abused or pinched in any way.

On 12/12/2018, I reviewed the documents related to Resident B's initial report of harmful behavior on 10/01/2018. An *AFC Incident / Accident Report* completed by staff member Tria Williams included the following information:

> "[Resident B] came to the office and said [Resident A] pinched her nipples sometime earlier that morning. [Resident B] stated she said 'stop that hurts' but [Resident A] continued to do it. Shortly after she let go. (Tria Williams) reminded [Resident B] she should tell a staff immediately after it happens and also try to avoid isolated contact with [Resident A] to avoid [Resident A] continuing to pinch her."

On 12/12/2018, I reviewed the documents related to the review of Resident A's behavior plan by staff. This meeting occurred on 10/02/2018 with three staff in attendance excluding the meeting chair. A line item identified "personal space" and "inappropriate touching" related to Resident A and Resident B.

On 12/11/2018, I contacted Lifeways Community Health Recipient Rights and spoke with administrative assistant Taylor Horsch. Ms. Horsch denied having any information or assignments related to Resident B's complaint on 10/2/2018. Ms. Horsch reported the last incident report she received was today on 12/11/2018. Ms. Horsch reported that recipient rights investigator Clevester Moten would call to provide additional information.

On 12/11/2018, I interviewed recipient rights officer Clevester Moten regarding the allegations. Mr. Moten denied knowledge or record of the allegations, stating that reports related to resident rights violations are to be faxed or submitted by electronic

medical record to his department. Mr. Moten reported Resident B's record did not reflect any reports of inappropriate touching or pinching.

On 01/03/2019, additional allegations were reported involving Resident A and Resident B. Complainant reports that Resident B has a diagnosis of bipolar disorder and borderline personality disorder. Complainant reports that on 01/02/2019 and 01/03/2019, Resident A sat down next to Resident B on the couch and touched her from her leg to her breast. Complainant states the touching is believed to have occurred over the clothing because they were in the living room area. Complainant reports this made Resident B uncomfortable. Complainant stated another resident witnessed the interaction, but staff were not present. Complainant reports that Resident A touches Resident B when staff are not around.

On 01/03/2019, I interviewed Ms. Emily Taylor regarding the allegations. Ms. Taylor reported that Resident A and Resident B had a disagreement involving money. Ms. Taylor reported that shortly after Resident A refused to reimburse Resident B for money that she had borrowed, Resident B accused Resident A of touching her inappropriately.

On 01/03/2019, I completed an unannounced investigation at the facility on-site and interviewed Resident B regarding the allegations. Resident B reported that since my last investigation completed on-site, Resident A has touched her legs and breasts over clothing on three separate occasions, in three separate locations of the facility. Resident B denied that any staff had observed these events when they occurred, and Resident B denied reporting these events to staff at the time of their occurrence. When asked why she didn't report the events to staff, Resident B could not recall any reason and stated that she didn't know. Resident B reported that Resident C observed the behavior of Resident A on one occasion. Resident B denied having any additional concerns and reported that she would put a stop to Resident A's behavior. Resident B would not clarify how she would put an end to the behavior.

While at the facility, I interviewed Resident C regarding the allegations. Resident B reported that she had seen Resident A run her hand along Resident B's leg and breast. Resident C reported that staff were not present when this event occurred. Resident C reported that Resident A her roommate and she had observed this behavior one other time in their bedroom previously and reported this behavior to staff because she was afraid the behavior would occur with her.

While at the facility, I attempted to interview Resident A. Resident A refused to be interviewed.

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 interviews with staff members Emily Taylor, Katlyn Zehner and recipient rights officer Clevester Moten, in addition to the *AFC Incident /Accident Report* obtained during the investigation, Resident B reported behavior that was causing her harm to facility staff on 10/01/2018 and 12/03/2018. This behavior was addressed during a team meeting with Resident B and then separately with Resident A. Resident A's treatment plan was also addressed with staff members as a reminder and any additional occurrence of behavior between Resident A and Resident B was not observed or reported. When Resident C observed the behavior between Resident A and Resident B on 12/03/2018, staff members verified the occurrence with Resident B. Resident B acknowledged the occurrence of the behavior, but the frequency and location varied, and the most recent report appears to be behaviorally related. Resident B's most recent reports were forwarded to law enforcement, ORR and this department. As such, the licensee provided for Resident B's personal need for protection and safety.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:
A written *AFC Incident / Accident Report* completed on 10/01/2018 was not submitted to the department within 48 hours.

INVESTIGATION:
On 12/11/2018 I interviewed Ms. Emily Taylor by phone. Ms. Taylor reported an *AFC Incident / Accident Report* was completed regarding Resident A's behavior towards Resident B on 10/01/2018. Ms. Taylor was informed there was no record of the report being provided to the department and no record available during two separate unannounced on-site investigations. Ms. Taylor acknowledged this report was not sent to the department.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative,

	responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(iii) Attempts at self-inflicted harm or harm to others.**
ANALYSIS:	Based on interviews with staff members Emily Taylor, Katlyn Zehner and recipient rights officer Clevester Moten, in addition to the *AFC Incident /Accident Report* obtained during the investigation, a written report did not follow the facilities attempt to contact Lifeways Recipient Rights. Based on representatives of the licensee's own admission, a written report related to Resident B's initial reporting of the behavior on 10/01/2018 was not provided to the department.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

01/22/2018

Eli DeLeon Date
Licensing Consultant

Approved By:

01/23/2019

Dawn N. Timm Date
Area Manager