GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 14, 2019

Bede Obasi, Jr.
Hanover Home Care Inc.
3055 Hanover Street
Hastings, MI 49058

RE: License #: AM080316994
Investigation #: 2020A0565001
Hanover Home

Dear Mr. Obasi, Jr.:

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) 284-9720.

Sincerely,

Dawn Campbell, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-9724

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM080316994
Investigation #:	2020A0565001
Complaint Receipt Date:	09/26/2019
Investigation Initiation Date:	10/01/2019
Report Due Date:	10/26/2019
Licensee Name:	Hanover Home Care Inc.
Licensee Address:	3055 Hanover Street Hastings, MI 49058
Licensee Telephone #:	(616) 498-6103
Administrator:	Pauline Obasi
Licensee Designee:	Bede Obasi, Jr.
Name of Facility:	Hanover Home
Facility Address:	305 S. Hanover Street Hastings, MI 49058
Facility Telephone #:	(269) 948-9057
Original Issuance Date:	12/16/2013
License Status:	REGULAR
Effective Date:	06/06/2018
Expiration Date:	06/05/2020
Capacity:	11
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Complainant concerned about suitability of direct care staff Carlene Straley.	No
Complainant concerned about the supervision that Resident B requires/receives due to direct care staff sleeping in the basement.	No
Resident A's room has a chain guard on it because Resident B went into her room nude on 9/25/2019.	Yes
On 10/01/2019, Resident A reported Resident D touched her on the inside of her thigh.	No
Additional Findings	Yes

III. METHODOLOGY

09/26/2019	Special Investigation Intake 2020A0565001
10/01/2019	Special Investigation Initiated - Face to Face
10/01/2019	Inspection Completed-BCAL Sub. Compliance
10/03/2019	Inspection Completed On-site
10/04/2019	Contact - Telephone call made Spoke with direct care staff Carlene Straley regarding the complaint allegations.
10/07/2019	Contact - Telephone call received Spoke with direct care staff Dozie Obasi regarding the complaint allegations.
10/07/2019	Contact - Telephone call made Spoke with Resident D's guardian Valerie Yargar regarding the incident with Resident D.
10/07/2019	Contact - Telephone call made Spoke with Resident E regarding the complaint allegations.
10/10/2019	Exit Conference with Licensee Designee Bede Obasi.

ALLEGATION:

Complainant concerned about suitability of direct care staff Carlene Straley.

INVESTIGATION:

This complaint was received on 09/26/2019 however no specific allegations were received regarding the actions of direct care staff member Carlene Straley toward any resident rather Complainant only listed being "concerned" if Ms. Straley was suitable to provide care to residents.

I reviewed the facility file and found that on 07/24/2019, Special Investigation Report #2019A0582031 was completed by Adult Foster Care Licensing Consultant Derrick Britton and the suitability of direct care staff member Carlene Straley was assessed. Mr. Britton assessed direct care staff member's suitability by reviewing Ms. Straley's employee file on 06/19/2019. Mr. Britton reviewed Ms. Straley's *Medical Clearance Request*. The *Medical Clearance Request* documented that Ms. Straley had an examination on 01/18/2019 and a negative tuberculosis skin test in 10/2018. The examination noted that direct care staff Ms. Straley had "no physical/mental condition or health problems" existing that would limit her ability to work with or around dependent adults. Mr. Britton also reviewed The *Michigan Workforce Background Check* for Ms. Straley which documented that Ms. Straley is eligible to work at the facility, effective 12/15/2018. Lastly, Mr. Britton reviewed Ms. Straley's staff orientation checklist, which documented that Ms. Straley received training in all the required areas and received personnel policies. Documented training areas completed by direct care staff member Ms. Straley included CPR/First Aid, personal care/supervision/protection, safety/fire prevention, medication administration, prevention/containment of communicable diseases, food preparation and weather emergencies. Direct care staff Ms. Straley signed off on receiving a job description of Direct Care Worker which documented that a direct care worker works "hands-on providing necessary support to implement a program designed to promote maximum development of each consumer's capabilities following guidelines specified on resident care plans."

On 10/01/2018, I conducted an unannounced onsite investigation at the facility. I interviewed facility administrator Pauline Obasi who stated she has no concerns about Ms. Straley. Ms. Obasi stated there are no issues with Ms. Straley working with residents.

On 10/03/2019, I spoke with Resident C who stated things are "going ok" at the facility and that she does not have any worries about Ms. Straley.

On 10/07/2019, I spoke with Resident E who stated Ms. Straley helped him when he had issues with Resident D. Resident E stated he does not have any concerns about Ms. Straley.

On 10/10/2019, I spoke with Licensee Designee Bede Obasi Jr. who stated he had no concerns about the care Ms. Straley was providing to residents.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on the above information, no issues were found regarding Ms. Straley's suitability. Ms. Straley's *Medical Clearance Request* dated 01/18/19 stated there is "no physical/mental condition or health problems" existing that would limit her ability to work with or around dependent adults. Ms. Straley has received the appropriate training to work with vulnerable adults. Mr. and Ms. Obasi stated they have no concerns regarding Ms. Straley. There is insufficient information to substantiate this complaint allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Complainant concerned about the supervision that Resident B requires/receives due to direct care staff sleeping in the basement.

INVESTIGATION:

On 10/01/2019, Ms. Obasi stated it was reported to her that Resident B went into the room of Resident A naked with a flashlight on 09/25/2019. Ms. Obasi stated Resident A reported that she asked Resident B what he was looking for and told him to leave her room. Ms. Obasi stated it was reported that Ms. Straley came and asked Resident B to go back to his room and to put on some clothing. Ms. Obasi stated Ms. Straley stayed with residents the remainder of the night to make sure Resident B did not go back into Resident A's room. Ms. Obasi stated Resident B is a longtime resident and has never exhibited this type of behavior before and she was surprised by it. Ms. Obasi stated Resident B has not required any type of increased supervision at night before. Ms. Obasi stated Resident B will go to the bathroom in the middle of the night but has never done anything like this. Ms. Obasi stated she has talked with Resident B's case manager at Barry County Community Mental Health and has requested that a behavior plan be developed for Resident B. Ms. Obasi stated if Resident B continues to exhibit this type of behavior that he will

be discharged from the facility because she cannot meet his needs. Ms. Obasi stated she called the police in response to Resident B's behavior however a police report was not filed.

Ms. Obasi stated the facility has sleeping staff at night because the type of behaviors of a resident admitted to the facility does not or cannot require direct care staff members to be awake during the nighttime shift because this is not something that is offered by this facility. Ms. Obasi stated she has always had sleeping staff and that it has not been an issue. Ms. Obasi stated direct care staff members sleep in a room in the basement area of the facility. Ms. Obasi stated sleeping staff use a baby monitor at night to hear what residents are doing. Ms. Obasi stated one monitor is placed in the kitchen area of the facility and the other is in the basement area with staff. Ms. Obasi stated she believes this is enough supervision for the residents at night.

On 10/01/2019, I reviewed the file of Resident B. Resident B's diagnoses include anxiety, autism, tremor, schizophrenia and mild mental retardation. I reviewed Resident B's *Written Assessment Plan* (assessment plan) dated 01/12/2019. Resident B's *Written Assessment Plan* documented that he controls his sexual behavior and that he does not need prompts for boundaries and privacy. The assessment plan also states that Resident B requires staff supervision while in the community.

On 10/01/2019, I interviewed Resident A who stated she was asleep in her room when Resident B came into her room with a flashlight and lifted the cover on her bed. Resident A stated Resident B had on underwear and that he didn't touch her. Resident A stated she told Resident B to get out of her room and that he was not supposed to be in there. Resident A stated Resident B left her room and didn't say anything to her. Resident A stated Ms. Straley was the direct care staff member working that night but sleeping downstairs, as allowed, when this incident occurred. Resident A stated Ms. Straley came upstairs and told Resident B to go to his room. Resident A stated after Pauline Obasi learned of Resident B coming into her bedroom in his underwear, Pauline Obasi put a chain lock on her door which has made her feel safer. Resident A stated Resident B has not come into her room anymore.

On 10/03/2019, I interviewed Resident B who stated he went into Resident A's room at night "butt naked." Resident B stated he had trouble sleeping that night and was planning to go into Resident A's room. Resident B stated he does not know why he went into Resident A's room naked. Resident B stated he went into Resident A's room with a flashlight and lifted her cover. Resident B stated Resident A told him he was not supposed to be in her room, and he left her room after that. Resident B stated Ms. Straley came upstairs and told him he was not supposed to be in Resident A's room. Resident B stated he has never previously gone into any resident's bedroom at night. Resident B stated the next day police were called and talked to him and told him if he "ever does that again, [he] is going to get arrested."

Resident B stated he talked with his caseworker regarding the incident and his caseworker was upset about what he did.

On 10/04/2019, I spoke with direct care staff Carlene Straley who stated Resident B went into the room of Resident A naked with a flashlight. Ms. Straley stated she was downstairs when she heard noise through the baby monitor, came upstairs and saw Resident B outside of Resident A's room naked. Ms. Straley stated she asked Resident B what he was doing while also advising Resident B to go back to his room and put some clothing on. Ms. Straley stated she remained upstairs for the remainder of the night to make sure Resident B did not go back into Resident A's room. Ms. Straley stated Resident B has never done anything like this before.

On 10/10/2019, Mr. Obasi stated he is aware of the incident in which Resident B went into Resident A's room naked. Mr. Obasi stated Resident B has never behaved like this before. Mr. Obasi stated Ms. Obasi is working with Resident B's caseworker to develop a behavior plan for Resident B to address this new behavior. Mr. Obasi stated Ms. Obasi has put a lock on Resident A's door since this incident occurred. Mr. Obasi stated he does not believe Resident B needs anything additional at this time. Mr. Obasi stated the facility will discharge Resident B if he exhibits this type of behavior in the future.

Mr. Obasi stated the facility has always had sleeping staff. Mr. Obasi stated that staff at night use a baby monitor to hear what residents are doing. Mr. Obasi stated he feels this is enough supervision for the residents in the facility as they do not require much supervision during night hours.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**

ANALYSIS:	Based on the above statements, Resident B went into Resident A's room during the middle of the night on 09/25/2019 while he did not have any clothing on and without Resident A's permission. All interviewed, including Resident B, stated Resident B has never exhibited this type of behavior before in this facility or any previous placement nor was this behavior documented in Resident B's *Assessment Plan for AFC Residents.* Further, once direct care staff member Carlene Straley heard commotion near Resident A's bedroom, she addressed the situation, directed Resident B back to his bedroom and remained awake to supervise Resident B's whereabouts for the remainder of the night as well as to assure the safety of the other residents. Pauline Obasi and Bede Obasi also immediately contacted Resident B community mental health case manager to request a behavior treatment plan to address this new behavior and installed a non-locking against egress lock on Resident A's bedroom door to increase her sense of safety. Resident B's *Assessment Plan for AFC Residents* did not require additional supervision at night at the time this incident occurred. Consequently, the amount of personal care, supervision and protection needed by Resident B was being provided at the time by direct care staff member given that this behavior was not a known behavior and could not be predicted.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's room has a chain guard on it because Resident B went into her room naked on 9/25/2019.

INVESTIGATION:

On 10/01/2019, I observed a locking-against egress chain lock on the door of Resident A's bedroom.

On 10/01/2019, Ms. Obasi stated that she put the chain lock on Resident A's door to keep Resident B out of Resident A's room. I advised Ms. Obasi that this type of lock did not meet the non-locking against egress hardware standard. Ms. Obasi stated she would remove the lock and put an appropriate lock on Resident A's door.

On 10/03/2019, I again observed a nonlocking-against egress lock on the door of Resident A's bedroom.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(4) Interior doorways of bedrooms that are occupied by residents shall be equipped with a side-hinged, permanently mounted door that is equipped with positive-latching, nonlocking-against-egress hardware.
ANALYSIS:	On 10/01/2019, a chain lock was observed on the door of Resident A. Consequently, Resident A's bedroom door was not equipped with nonlocking-against-egress door hardware at the time of the on-site investigation on 10/01/2019.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 10/01/2019, Resident A reported Resident D touched her on the inside of her thigh.

INVESTIGATION:

On 10/01/2019, Resident A stated Resident D touched her on the inside of her thigh while at the dinner table. Resident A stated direct care staff Dozie Obasi moved her to another table and monitored Resident D while they ate. Resident A stated Resident D has never touched her before. Resident A stated Resident D got "kicked out of the house." Resident A stated the police were called and came to the facility to talk to her. Resident A stated she told Ms. Straley and Ms. Obasi that Resident D touched her as well.

On 10/01/2019, Ms. Pauline Obasi stated Resident A reported that Resident D rubbed the inside of her thigh. Ms. Pauline Obasi stated Resident A reported they were eating breakfast when Resident D reached under the table and started rubbing her thigh. Ms. Pauline Obasi stated this incident occurred on 09/29/2019. Ms. Pauline Obasi stated she was contacted by Mr. Dozie Obasi and she came to the facility. Ms. Pauline Obasi stated she called the police who responded to the incident.

Ms. Pauline Obasi stated she also called Resident D's legal guardian Valerie Yargar regarding the incident. Ms. Pauline Obasi stated she was advised by Ms. Yargar to call Resident D's parole officer regarding this incident because this incident was in violation of Resident D's order of probation. Ms. Pauline Obasi stated she called Resident D's parole office Tammy Pawlowsi regarding the incident as well.

Ms. Pauline Obasi stated Ms. Yargar came to the facility on the same day of the incident to talk to Resident D. Ms. Pauline Obasi stated she asked Ms. Yargar to find a more appropriate placement for Resident D. Ms. Pauline Obasi stated

Resident D became angry and started moving his belongings out of the facility. Ms. Pauline Obasi stated Resident D was advised by Ms. Yargar that he could not leave the facility without her permission, but he left the facility. Ms. Pauline Obasi stated Resident D called a friend to pick him up, he left the facility and has not returned. Ms. Pauline Obasi stated she had not provided a discharge to Ms. Yargar regarding Resident D, but she spoke with her about issuing a discharge to Resident D before he left the facility. Ms. Pauline Obasi stated she was going to issue a 30-Day discharge to Resident D.

Ms. Pauline Obasi stated Resident D was admitted to the facility in March 2019 at the request of Adult Protective Services. Ms. Pauline Obasi stated when Resident D was admitted to the facility he came from a psychiatric hospital in Detroit. Ms. Pauline Obasi stated after Resident D was admitted to the facility, there was an incident in which he was arrested by the police. Ms. Pauline Obasi stated at that time she learned Resident D had two pending warrants in Kalamazoo County for Criminal Sexual Conduct. Ms. Pauline Obasi stated she was given no indication that Resident D had pending warrants for his arrest when he was admitted to the facility. Ms. Pauline Obasi stated Resident D did not exhibit a history of sexual misconduct while at the facility.

Ms. Pauline Obasi stated it was reported to her that Resident E and Resident D were touching each other on the buttocks. Ms. Pauline Obasi stated it was unclear what happened during this incident as Resident E and Resident D would not talk to her about the incident.

On 10/01/2019, I reviewed the file of Resident D. Resident D diagnoses include unspecified psychosis, anxiety, depression, unspecified cognitive disorder, rheumatoid arthritis, chronic pain syndrome, Addison's disease, hypothyroidism, hyperlipidemia and GERD. Resident D's written assessment plan was completed on 03/14/2019. Resident D's written assessment plan does not contain a history of Resident D exhibiting any behaviors. Resident D's file contained an order stating that Resident A was placed on probation after pleading no contest to assault and battery.

On 10/07/2019, I spoke with Ms. Yargar who stated she was contacted by Ms. Pauline Obasi who reported to her that Resident D touched a resident on the inside of her thigh. Ms. Yargar stated she advised Ms. Pauline Obasi to call the police as this was a violation of Resident D's order of probation. Ms. Yargar stated she came to the facility to talk to Resident D. Ms. Yargar stated when she arrived at the facility Resident D was angry and was moving his things from the facility. Ms. Yargar stated she told Resident D that he could not move from the facility, but he continued moving items against her wishes. Ms. Yargar stated Resident D called a relative who picked him up from the facility and allowed him to spend one night with him. Ms. Yargar stated she told Resident D not to leave the facility, but she knew it was better to let him go with his relative. Ms. Yargar stated since he left the facility, Resident D has been admitted to the hospital as he was depressed and threatening

suicide. Ms. Yargar stated she is looking for a more appropriate placement for Resident D.

Ms. Yargar stated Resident D had been non-compliant regarding his lab work and taking his psychiatric medications. Ms. Yargar stated she had already begun to look for a new placement for Resident D because he was having difficulty at the facility. Ms. Yargar stated Resident D was urinating outside of the facility and it was reported to her that Resident D touched another resident on the buttocks.

On 10/03/2019 I interviewed Resident C who stated no one has ever come into her room at night or touched her inappropriately. Resident C stated she feels safe at the facility and if she ever had a problem, she would tell someone. Resident C stated Resident D is no longer at the facility, but she never had a problem with him.

10/04/2019, Ms. Straley stated she did not have any issue with Resident D. Ms. Straley denied that she was told Resident D had inappropriately touched Resident E.

On 10/07/2019, I interviewed Resident E who stated he and Resident D were roommates. Resident E stated there was an incident in which Resident D got undressed and came up to him and asked him if he wanted to touch his penis. Resident E stated that he told Resident D, “no” in response to this question. Resident E stated he did not tell anyone about this incident. Resident E stated Resident D touched him on his buttocks when he was going up the steps in the facility. Resident E stated he told Ms. Straley that Resident E touched his buttocks and Ms. Straley “got after Resident D.” Resident E stated Resident D is no longer a resident at the facility.

On 10/10/2019, Mr. Bede Obasi stated it was reported to him that Resident D touched Resident A on the thigh. Mr. Bede Obasi stated direct care staff immediately intervened and monitored Resident A after she reported Resident D touched her. Mr. Bede Obasi stated Resident D did exhibit some behavioral issues such as urinating outside. Mr. Obasi stated Resident D also urinated and defecated on himself at times. Mr. Bede Obasi stated Resident D had not previously acted out sexually while he was a resident at the facility. Mr. Bede Obasi stated he was not told about an incident in which Resident D touched Resident E on the buttocks. Mr. Bede Obasi stated Resident E sometimes makes stories up and these incidents may not have occurred with Resident D.

On 10/10/2019, I conducted an exit interview with Mr. Bede Obasi. Mr. Bede Obasi stated Resident D is no longer a resident at the facility.

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 the above statements, Resident A reported that Resident D touched her on her inner thigh while at the dinner table. Mr. Bede Obasi, Ms. Pauline Obasi and Ms. Straley stated they did not have any previous issues with Resident D acting out sexually. Mr. Bede Obasi reported staff intervened after Resident A reported that Resident D touched her on the thigh. Resident D is no longer a resident at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/03/2019, I reviewed the file of Resident C. I questioned Ms. Obasi about Resident C's medications. Ms. Obasi stated Resident C takes supplements and multivitamins daily. Ms. Obasi stated Resident C does not take any other medications. Ms. Obasi stated she does not have a prescription from a licensed physician for Resident C to take vitamins and supplements daily.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	On 10/03/2019, Resident C's file was reviewed. Ms. Obasi stated Resident A takes multivitamins and supplements only, however Ms. Obasi did not have a prescription for Resident C to take vitamins and supplements daily.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Special Investigation #2019A0466001 dated 11/30/2018, recommended modification of the license to provisional status. Contingent upon receipt of an acceptable corrective action plan, the recommendation of 1st provisional license remains.


10/28/2019

Dawn Campbell Date
Licensing Consultant

Approved By:


11/14/2019

Dawn N. Timm Date
Area Manager