GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 13, 2020

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

RE: License #: AS390080967
Investigation #: 2020A0581008
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390080967
Investigation #:	2020A0581008
Complaint Receipt Date:	11/22/2019
Investigation Initiation Date:	11/22/2019
Report Due Date:	01/21/2020
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:	02/14/2019
Expiration Date:	02/13/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
• Resident A wasn't supervised and eloped from the facility.	Yes
• Resident A doesn't feel safe in the facility because Resident B sexually abuses other residents. • Resident C wasn't supervised in the facility and was subsequently touched inappropriately by Resident B.	No

III. METHODOLOGY

11/22/2019	Special Investigation Intake 2020A0581008
11/22/2019	Special Investigation Initiated - Telephone With program director Kevin Steve.
11/22/2019	APS Referral APS received the same allegations; however, denied the complaint for investigation. No referral necessary.
11/25/2019	Contact - Document Received Received additional allegations via BCHS online complaint system.
11/25/2019	APS Referral APS also received additional allegations – investigated; however, not substantiating.
11/27/2019	Contact – Telephone call received Interview with licensee designee, Barry Bruns.
12/02/2019	Inspection Completed On-site Interview with residents, direct care staff.
12/04/2019	Contact - Telephone call received Interview with Mr. Bruns
12/04/2019	Contact - Telephone call received Interview with program director, Emily Taylor
12/04/2019	Contact - Document Received

	Received via email, emergency discharge notice for Resident A.
12/20/2019	Contact – Telephone call made Interview with direct care staff, Iva Diagne.
12/20/2019	Contact – Telephone call made Left voicemail with direct care staff, Deangelo McShane.
01/03/2020	Contact – Telephone call made Left voicemail with direct care staff, Charmaine Hopkins.
01/03/2020	Contact – Telephone call made Interview with direct care staff, Deangelo McShane.
01/03/2019	Contact – Telephone call made Interview with direct care staff, Charmaine Hopkins.
01/07/2020	Contact – Telephone call made Interview with direct care staff, Marissa Deleone.
01/08/2020	Contact – Telephone call made Interview with program director, Emily Taylor and home manager, Megan Beers.
01/08/2019	Contact – Document received Email from Ms. Taylor containing emergency supervision policy.
01/08/2020	Exit conference with licensee designee, Barry Bruns.

ALLEGATION:

- **Resident A wasn't supervised and eloped from the facility.**
- **Resident A doesn't feel safe in the facility because Resident B sexually abuses other residents.**
- **Resident C wasn't supervised in the facility and was subsequently touched inappropriately by Resident B.**

INVESTIGATION:

On 11/22/2019, I received this complaint through Bureau of Community Health Systems (BCHS') on-line complaint system. The complaint alleged Resident A ran

away from the facility and was located out of state where she sought medical treatment. It was further alleged Resident A did not feel safe to return to the facility because Resident B sexually abuses other residents.

On 11/25/2019, an additional complaint came through BCHS' on-line complaint system alleging Resident C wasn't supervised in the facility and was touched inappropriately by Resident B. Kalamazoo Adult Protective Services investigated the complaint and did not substantiate as it was determined Resident B was acting "overly friendly" and did not find the incident was "sexual in nature."

On 11/27/2019, I received a telephone call from licensee designee, Barry Bruns. I coordinated with Mr. Bruns to have his facility program staff and direct care staff at the facility for an announced on-site investigation on 12/02/2019.

On 12/02/2019, I conducted an announced on-site investigation at the facility. I attempted to interview several residents, including Resident B, Resident C and Resident D. Resident A was not present at the facility because she eloped for a second time. Resident B refused to speak with me regarding any of the allegations in the complaints. I attempted to interview Resident C; however, he was limited in his ability to communicate with me and difficult to understand.

I interviewed Resident D. Resident D stated she did not visually see Resident A leave the facility for either elopement incident. Resident D stated she had not seen Resident B be in inappropriate with any of the residents in the facility. She stated Resident B can "get mouthy" with direct care staff; however, she hadn't seen her talk or by physically inappropriate, including being sexually inappropriate, with residents. She stated she's observed Resident B hug Resident C, but Resident D stated Resident A "lies about things." She stated Resident A lied about Resident D trying to kill Resident A, which Resident D stated wasn't true.

I also interviewed several facility program direct care staff members, including Megan Beers, the home manager, and Emily Taylor and Kevin Steve, facility program directors. Ms. Beers stated on 11/17/2019, Resident A eloped from the facility for the first time. She stated Resident A was in the facility's garage smoking a cigarette, but when direct care staff went back out, approximately "15 to 20 minutes later", to check on Resident A she wasn't there. Ms. Beers stated staff went to check on Resident A because they had received a call from another one of their facilities stating Resident A's sister had left their facility and they were concerned she was coming to get Resident A. Ms. Beers stated direct care staff had no indication Resident A had left the facility and acknowledged it being the first time she had eloped from the facility. She stated it was believed Resident A was picked up by Resident A's boyfriend. Ms. Beers and the additional program staff stated Resident A has free access to her cell phone, which is how she contacts people to pick her up. They stated Resident A was eventually found and brought back to the facility and was subsequently put on 15 minute checks during the day and 1 hour checks during sleeping hours.

Ms. Beers stated Resident A eloped again on 12/01/2019. Ms. Beers stated Resident A had been in her bedroom during sleeping hours, on her cell phone, and eloped from her bedroom window during the morning shift change. Ms. Beers stated direct care staff, Deangelo McShane, observed Resident A at approximately 6 am in her bedroom; however, when first shift direct care staff went to check on her again, she was no longer present in her bedroom and her window screen was observed to be out of place. Ms. Beers stated the police were immediately contacted to report her a missing person.

I discussed with Ms. Beers and the facility's program staff about implementing window alarms. Ms. Taylor stated a meeting was scheduled with Resident A's case manager and guardian to discuss such an implementation and issuing Resident A a discharge notice due to her recent elopements. Ms. Taylor believed Resident A needed a more secure environment than the facility is able to provide.

Ms. Beers also stated that each time Resident A left the facility, direct care immediately called police and filed a missing person's report. She stated the facility has gone to great lengths trying to locate Resident A each time she elopes, which includes attempting to contact her on social media.

Ms. Beers addressed the allegations of Resident B inappropriately touching other residents. She stated Resident B was observed by a direct care staff to touch Resident C on his groin with his clothes on. She stated Resident B has lived with Resident C for many years and engaged in similar behavior with a former female resident; however, Ms. Beers stated that resident was moved to a different facility. Ms. Beers stated Resident B acts differently with residents whom she has known and lived with for significant periods of time. She stated Resident B and Resident C have lived together for over 12 years, as did, Resident B and the former resident who moved out. She stated Resident B likes to hug these residents and engages in "horseplay"; however, direct care should redirect and talk to Resident B about her behavior. Ms. Beers stated direct care staff monitor Resident B when she is around Resident C to prevent her from inappropriately touching him. She stated Resident B has not seen engaging in inappropriate behavior with any of the other residents, including Resident A.

Ms. Beers and Ms. Taylor stated in order to prevent any additional instances of possibly inappropriate behavior, Resident B and Resident C are not allowed to sit next to one another in the facility's van or at the facility. In addition, Resident B's bedroom is downstairs and Resident C's bedroom is on the main level of the facility. Ms. Beers and Ms. Taylor both stated Resident B has been spoken to about her behavior towards Resident C and she "seems understanding."

I reviewed Resident A's *Assessment Plan for AFC Residents*, dated 11/27/2019. According to this assessment, Resident A had a behavior plan addressing her independent access within the community. I reviewed Resident A's *Woodlands*

Behavioral Health Behavior Assessment and Support Plan (assessment), dated 09/19/2019. The assessment stated prior to Resident A's placement at the facility, she was in a supported independent living placement. The assessment indicated Resident A has a history of meeting men on social media and allowing them to sneak into her bedroom or sneaking out to meet them. According to Resident A's assessment, she has "made allegations against other housemates", which included her stating other residents threatened to kill her, and/or other residents were being sexually inappropriate with other residents; however, the assessment stated Woodlands CMH was unable to determine if these allegations were true. Resident A's *Woodlands Behavioral Health Behavior Assessment and Support Plan* stated when Resident A is in the facility, "staff should have a general knowledge of her whereabouts if she is not on emergency supervision checks." The assessment later referred to "emergency supervision checks" as the facility's emergency supervision procedures. The assessment stated if Resident A is in the community then "she should remain within line of sight of staff."

I also reviewed Resident A's *Woodlands' Treatment Plan*, dated 05/08/2019; however, there was nothing noted in this treatment plan regarding Resident A's supervision within the community or the facility.

I reviewed Resident B's *Assessment Plan for AFC Residents* (assessment plan), dated 08/20/2019. There was no indication in Resident B's assessment plan she was sexually inappropriate towards other residents or people. It was indicated in Resident B's assessment plan that she had a *Behavior Support Plan* (BSP) through Kalamazoo Community Mental Health. I reviewed this BSP, dated 10/01/2019, which indicated in 2018 the biggest concern relating to Resident B was another resident in the facility complained about Resident B touching her breast and it "sometimes hurting"; however, it was indicated in the BSP that the other resident did not indicate she felt unsafe or threatened. It was noted the BSP that the resident and Resident B had not set clear boundaries with one another and would need to do so as they both wished to remain in the same facility. It also indicated in Resident B's BSP that the inappropriate touching usually took place during "horseplaying" or "being affectionate toward one another."

I reviewed Resident C's *Assessment Plan for AFC Residents*, dated 08/12/2019. According to Resident C's assessment, he's unable to control sexual behavior indicated by "history of patting staff breasts." I reviewed Resident C's Kalamazoo Community Mental Health Treatment Plan, dated 06/01/2019; however, there was nothing in the treatment plan to indicate Resident C has been sexually inappropriate with other people or if others have been sexually inappropriate with him.

On 12/04/2019, I received an emergency discharge notice for Resident A from the licensee because of Resident A's "elopement, drug use, and unsafe practices of sexual behavior towards others in the community." According to this discharge notice, Woodland's CMH was recommending Resident A be placed in a more independent living placement.

On 01/03/2019, I interviewed Deangelo McShane, via telephone. Mr. McShane stated he has worked at the facility for approximately two years and has worked third shift for the last year. He stated he was not working at the facility when Resident A eloped from the facility the first time. He stated he worked third shift the night before Resident A eloped the second time; however, he stated she was in the facility when he conducted checks on her. He stated he saw Resident A at approximately 5:45 am-6 am. Mr. McShane stated when first shift staff checked on Resident A, after he had left the facility, she was no longer in her bedroom and had left out of her window. Mr. McShane stated Resident A eloped from the facility again for a third time after taking her window alarm off.

Mr. McShane stated Resident B can be “touchy” with Resident C at times. He stated Resident B asks Resident C for hugs, which Resident C allows; however, Mr. McShane stated he has seen Resident B try and touch Resident C’s chest or try to kiss him; however, when direct care staff members redirect her she complies and leaves Resident C alone. Mr. McShane stated he’s never seen or heard about Resident B ever being in Resident C’s bedroom and stated they’re not left alone as direct care staff members are always out in the common areas of the facility. Mr. McShane stated Resident C has never appeared to be afraid of Resident B.

On 01/03/2020, I interview direct care staff, Charmaine Hopkins, via telephone. Ms. Hopkins stated she’s worked at the facility for 1.5 years and primarily works first shift. Ms. Hopkins stated she’s seen Resident B ask Resident C for hugs, but “never anything inappropriate.” She stated she’s never seen Resident B be inappropriate, including sexually inappropriate, with any of the residents. Ms. Hopkins stated she observed Resident B tuck a strand of hair back into Resident A’s ponytail once after she asked Resident A if she could. Ms. Hopkins stated after the incident, Resident A told Ms. Hopkins Resident B touched her inappropriately. Ms. Hopkins stated she observed the entire incident and did not believe it was inappropriate.

Ms. Hopkins stated she had not been working when Resident A eloped from the facility during any of the incidences, but she agreed per Resident A’s Behavior Assessment and Support Plan, Resident A’s general whereabouts were to be known while she was in the facility and Resident A needed to be with direct care staff while out in the community. She also stated since Resident A’s elopements from the facility she has been on 15 minute checks meaning direct care staff members are to check on her every 15 minutes to ensure she’s in the facility.

On 01/07/2020, I interviewed direct care staff, Marissa Deleone, via telephone. Ms. Deleone stated she was the direct care staff who observed Resident B attempt to grab Resident C’s groin. She stated when the incident happened, she had been working at that facility for approximately one month and believed Resident B was “testing” her to ensure she was being watched while in the living room. Ms. Deleone stated Resident B needs to be monitored and watched around Resident C because

she can be “touchy” with him. Ms. Deleone stated Resident B will talk in “baby voices” to Resident B, hug him, poke him, and “try to kiss him.” She stated as long as direct care staff are watching the two residents then Resident B responds to redirection and complies with staff. Ms. Deleone stated when the incident happened Resident B did respond to redirection from her and did not continue to be “touchy” with Resident C. Ms. Deleone denied ever seeing Resident B act inappropriately with Resident A.

Ms. Deleone stated she was not present during any of Resident A’s elopements from the facility. She stated Resident A is on “emergency checks” when she comes back which is 15 minute checks. She described these checks and finding Resident A within the facility every 15 minutes by laying eyes on her to ensure she’s in the facility and accounted for. Ms. Deleone stated Resident A has moved to a different room in the facility because the window drop is higher than her previous window. She stated a new window alarm had also been put on Resident A’s window and does not include a battery. Ms. Deleone stated the window alarm is audible throughout the facility.

On 01/08/2020, I conducted follow up interviews with Ms. Taylor and Ms. Beers via telephone. Ms. Beers stated on 12/01/2019 when Resident A eloped from the facility, third shift staff, Mr. McShane last observed Resident A in the facility at 5:45 am. She stated when first shift staff arrived, they did not complete their initial checks on Resident A until approximately 10 am, which is when they discovered she had eloped from the facility. Ms. Beers and Ms. Taylor stated that while the facility was implementing emergency supervision checks on Resident A, which included the day of 12/01/2019, they technically didn’t need to as Resident A had returned to “baseline” and there was no indication that she was going to elope again; hence, the emergency supervision checks could have been lifted. Ms. Taylor stated they had continued to implement these emergency supervision checks because of the licensing investigation. I requested Ms. Taylor send me the emergency supervision check protocol for my review.

Ms. Taylor sent the facility’s emergency supervision protocol via email, which I reviewed. The facility’s “emergency supervision” policy, dated 03/09/2019, confirmed elopement as a reason for emergency supervision. It stated once emergency was needed, then staff should complete a “Behavioral Emergency Supervision” form for the resident being placed on emergency supervision. The policy stated the following:

> “Once reviewed, staff should complete the top of the form by filling in the resident’s name, the start date/time, end (circle one: remainder of 1st & 2nd shifts or 24 hours) and the reason for the supervision. 15 Minute Checks [*sic*] will be implemented to maintain supervision on the resident while they de-escalate or until the situation or threat of harm is believed to be resolved.”

The emergency supervision policy further stated the emergency supervision could be discontinued at the end of 2nd shift or it could be discontinued or expanded for the following reasons:

a. The resident has returned to baseline prior to the end of 2nd shift and checks are no longer needed.
b. The resident is still awake or continues to show signs of behavioral issues on 3rd shift (should be verified during staff's 3rd shift eyes on environmental scan).
c. Post-Mandt restraint checks MUST continue for a minimum of 24 hours.
d. The resident has a history of elopement on the overnight shift.

The policy stated whenever a resident is placed on emergency supervision a memo should be completed and placed in the "Staff Communication binder". It also stated emergency communication should be verbally conveyed at each shift change and written in the shift debriefing form. The policy stated when the emergency checks have been completed, then the memo should be removed from the communication binder and filed with the emergency supervision tracking forms.

On 01/08/2020, I interviewed direct care staff, Iba Diagne, via telephone. Mr. Diange stated he only works weekends at the facility and confirmed he was working first shift at the facility on 11/30/2019 and12/01/2019 from 7 am until 11 pm. Mr. Diagne stated when he worked that Saturday, he was aware Resident A was on emergency supervision checks because he observed the emergency supervision check documents for direct care staff members to complete showing they had observed Resident A every 15 minutes during the day. He stated he later discovered after talking to the facility's home manager that it had been written in the Resident A's weekend notes instructing staff Resident A was still on emergency supervision. He stated he had not reviewed her weekend notes that thoroughly because usually "it's always the same thing." He stated when he worked that Saturday, he believed Resident A would no longer be on emergency supervision checks because the emergency supervision tracking forms only went through 12/01/2019 ending at 7 am. He said when he arrived at the facility on 12/01/2019, he knew there were no more tracking sheets so he didn't implement any emergency checks on Resident A. He stated he carried out his Sunday morning duties and when he went to administer Resident A's medication around 10 am he discovered she was not present in the facility. Mr. Diagne stated two other residents were on emergency supervision that weekend as well, but there was a combined memo for both residents instructing they were on emergency supervision checks until further notice. He stated both residents had excess supervision check forms, unlike Resident A.

In addition, Mr. Diagne stated he had never observed Resident B be inappropriate, including sexually inappropriate, towards Resident A or Resident C.

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 my interviews with Resident D, facility program staff, Megan Beers, Emily Taylor and Kevin Steve, and direct care staff, Iva Diagne, Deangelo McShane, Charmaine Hopkins, and Marissa Deleone, and my review of Resident A's, Resident B's and Resident C's *Assessment Plans for AFC Residents*, their corresponding Behavior Support Plans and Treatment Plans, and my review of the facility's policy on emergency supervision, there is evidence indicating the facility staff did not provide adequate supervision to Resident A while at the facility when she eloped on 12/01/2019 because the facility's emergency supervision policy was not followed as directed. Resident A eloped from the facility on multiple occasions despite attempts by the facility and direct care staff in providing additional supervision to her. After Resident A's elopement on 11/17/2019, the facility implemented increased supervision whereas direct care staff were to check on Resident A every 15 minutes during the day and at least every hour at night. According to Resident A's *Woodlands Behavioral Health Behavior Assessment and Support Plan*, dated 09/19/2019, staff are to know her general whereabouts within the facility unless she's on emergency supervision then she's to be on 15 minute checks, which according to the Ms. Taylor and Ms. Beers, Resident A was on emergency supervision checks the morning of 12/01/2019. On 12/01/2019, Resident A was last seen at the facility by 3rd shift staff, Mr. McShane, at 5:45 am; however, when 1st shift direct care staff, Mr. Diagne, came onto shift, he failed to implement emergency supervision checks on her until approximately 10 am because he believed the emergency supervision checks had ended despite learning later they were supposed to continue. When Mr. Diagne finally checked on Resident A to administer her medication, he discovered she had already eloped from the facility. Based on my investigation, the facility had implemented emergency supervision checks on Resident A; however, on 12/01/2019, the status of these checks was not effectively communicated to direct care staff and were subsequently seized for several hours. While the exact time of Resident A elopement is unknown, there is enough evidence to indicate Resident A was not provided with supervision and protection and eloped sometime between 5:45 am and 10 am on 12/01/2019 when emergency checks were not being completed on her.
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:	There is no evidence to suggest the facility or direct care staff did not provide protection and supervision to Resident A and Resident C from Resident B inappropriately touching them. According to Resident B's Kalamazoo CMH's Behavior Support Plan, dated 10/01/2019, whilst Resident B has a history of inappropriately touching a former resident it was usually while "horseplaying" or "being affectionate toward one another". Interviews with direct care staff and facility program indicate a similar situation/circumstance between Resident B and Resident C. There is also no direct evidence indicating Resident B was ever inappropriate with Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 01/08/2020, I attempted to conduct an exit conference with Barry Bruns, licensee designee, to discuss my findings and provide him an opportunity to ask questions or make comments.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the current status of the license remains unchanged.

Cathy Cushman

01/08/2020

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Cathy Cushman Date
Licensing Consultant

Approved By:

Dawn Timm 01/13/2020

_____

Dawn N. Timm Date
Area Manager