GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 28, 2020

Kevin Kalinowski
HomeLife Inc
PMB #360
5420A Beckley Rd.
Battle Creek, MI 49015

RE: License #: AM030387355
Investigation #: 2020A0350018
318 E. Hammond Street AFC

Dear Mr. Kalinowski:

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 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,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030387355
Investigation #:	2020A0350018
Complaint Receipt Date:	01/21/2020
Investigation Initiation Date:	01/21/2020
Report Due Date:	02/20/2020
Licensee Name:	HomeLife Inc
Licensee Address:	3 Heritage Oak Lane Battle Creek, MI 49015
Licensee Telephone #:	(269) 660-0854
Administrator:	Kevin Kalinowski
Licensee Designee:	Kevin Kalinowski
Name of Facility:	318 E. Hammond Street AFC
Facility Address:	318 E. Hammond Street Otsego, MI 49078
Facility Telephone #:	(269) 694-1601
Original Issuance Date:	10/30/2017
License Status:	REGULAR
Effective Date:	12/04/2019
Expiration Date:	12/03/2021
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff Alex Finalyson yelled at and pushed Resident A into her room and told her to stay there until she acted "the right way."	Yes

III. METHODOLOGY

01/21/2020	Special Investigation Intake 2020A0350018
01/21/2020	APS Referral
01/21/2020	Special Investigation Initiated - Letter I received an email from Sjana Markusic, Home Manager
01/22/2020	Contact - Face to Face I made an onsite inspection and interviewed staff and residents
01/22/2020	Contact - Telephone call made I spoke with Faith Geesaman, DCW
01/22/2020	Contact - Telephone call made I spoke with Danielle Robinson, DCW
01/23/2020	Contact – Document Received I received an email from Lisa Smith, Recipient Rights Officer
01/23/2020	Contact – Document I sent an email to Lisa Smith
01/24/2020	Contact – Document Received I received an email from Lisa Smith, Recipient Rights Officer
01/28/2020	Exit conference – Held with Kevin Kalinowski, Licensee Designee

ALLEGATION: Staff Alex Finalyson yelled at and pushed Resident A into her room and told her to stay there until she acted "the right way."

INVESTIGATION: On 01/21/2020, a referral was made to Adult Protective Services, Recipient Rights, and Licensing regarding these allegations.

On 01/21/2020, I received an email from Sjana Markusic, the Home Manager, informing me of these allegations.

On 01/21/2020, I sent an email to Ms. Markusic, stating that I would be at this home the following day at 11 a.m.

On 01/22/2020, I conducted an onsite inspection and initially met with Ms. Markusic, who made arrangements for me to interview Resident A. I also requested copies of Resident A's Assessment Plan and Health Care Appraisal from Ms. Markusic, who furnished them to me.

On 01/22/2020, I spoke with Resident A, who told me that when she came back to the home last Friday (January 17) after running errands, she asked a staff member (did not say who) for a cigarette and was told she couldn't have one because it was too early, according to her plan. Resident A stated that Direct Care Worker (DCW) Alex Finalyson started yelling at her and "roughly took me to my room." Resident A said that she almost fell three times while Ms. Finalyson was pushing her. I asked Resident A to demonstrate on me how Ms. Finalyson pushed her, and she did. It did not seem excessively forceful to me. Resident A informed me that she was not injured during this incident.

On 01/22/2020, I interviewed Resident B, who said she witnessed this incident. Resident B reported that she witnessed Resident A ask for a cigarette and Ms. Finalyson "shoved her (Resident A) all the way to her room," and that she "raised her voice" while speaking with Resident A during this incident. I asked Resident B to demonstrate on me how she observed Ms. Finalyson push Resident A, and she did. It felt more like guiding than shoving, as Resident B had one hand on my shoulder and one on my lower back and gently nudged me.

On 01/22/2020, I interviewed Ms. Finalyson, who stated that on that Friday, January 17, Resident A asked for a cigarette, but she told her she couldn't have one because it was too early as her plan allows her to have only one cigarette every two hours. Ms. Finalyson told me that Resident A got very upset about this so she told Resident A that she could have two cigarettes at 7 p.m. or one at 7 p.m. and one at 9 p.m. Ms. Finalyson reported that Resident A "escalated" and began hitting herself in the face and screaming, so she "guided her back to her room" so that none of the other residents would get upset. Ms. Finalyson said that she told Resident A that when she calmed down they could talk. I asked Ms. Finalyson to demonstrate on me how she "guided" Resident A to her room, and she did. Ms. Finalyson put each of her hands on my upper back and gently nudged them. I did not think it to be overly forceful. Ms. Finalyson denied yelling at Resident A.

On 01/22/2020, I called and spoke with Danielle Robinson, DCW, who stated that she worked with Ms. Finalyson that evening and witnessed what happened. Ms. Robinson told me that Ms. Finalyson "kind of went a little overboard" during this incident. Ms. Robinson said that Ms. Finalyson yelled at Resident A when she asked for a cigarette, telling her, "Hold on a second; it's not time yet." Ms. Robinson reported that Ms. Finalyson guided Resident A to her room with her hands and

walking behind her. Ms. Robinson said that Ms. Finalyson did not push Resident A but she did demand that she go to her room.

On 01/22/2020, I called and spoke with Faith Geesaman, DCW, who stated that she worked with Ms. Finalyson that evening and witnessed what happened. Ms. Geesaman said that after she brought Resident A home from an outing, Resident A asked Ms. Robinson for a cigarette and she gave her one. However, Ms. Finalyson took the lighter away because it was not time for Resident A to have a cigarette. Resident A began yelling and so did Ms. Finalyson, causing the situation to "escalate." Ms. Geesaman informed me that she heard Ms. Finalyson say to Resident A, "If you're not going to be calm, you'll have to go to your room;" then Ms. Finalyson "shoved" Resident A all the way back to her bedroom. Ms. Geesaman reported that Resident A told Ms. Finalyson that she didn't want to go to her room, but Ms. Finalyson made her.

On 01/23/2020, I reviewed Resident A's Assessment Plan, which states that she has a "History of verbal and physical aggression;" "History of head banging and hitting herself;" and "Staff will hold onto cigarettes and lighter." Her Health Care Appraisal states that she was diagnosed with: Schizophrenia, Borderline Intellectual Function-unspecified, and OCD.

On 01/23/2020, I received an email from Lisa Smith, Recipient Right Officer, asking for my assessment of this situation. On the same day, I sent this response to Ms. Smith: "(Resident A), another resident, and a staff member said Alex shoved (Resident A) to her room; another staff member said she only guided her to her room but did say that Alex "demanded" she go to her room. Is it in (Resident A's) Treatment Plan that she should go to her room when she gets upset and acts out?" Ms. Smith responded on this same day that she would look into this and let me know what she finds out.

On 01/24/2020, I received an email from Ms. Smith with Resident A's Treatment Plan attached.

On 01/27/2020, I reviewed Resident A's Treatment Plan, which includes her Behavior Support Plan. A quote from Resident A in the report states, "I will wait patiently until it's my time to smoke. I will know this is working if I can wait two hours between cigarettes." The report also lists Resident A's diagnoses as Schizophrenia, unspecified Obsessive-Compulsive Disorder, and Borderline Intellectual Functioning. Some of the symptoms Resident A has include delusional thinking, self-harm thoughts and behaviors, excessive worry, and impulse control. The report says that Resident A, "continues to perseverate on cigarettes and frequently wants reassurance that she will get her next scheduled cigarette." Some of the ways the report mentions that staff can assist, or redirect, Resident A include prompting her to take deep breaths and counting breaths; engage her in structured activity and conversation about her interests; providing praise; granting points when she engages is appropriate behaviors and constructive activities; and prompting her to

think about positive things, among other methods. Staff are recommended to encourage Resident A “vent” her frustrations in another area of the home, not in front of other residents. It is further stated in Resident A’s Treatment Plan that “Staff are not to ‘direct’ her to go to her room.”

On 01/28/2020, I called and held an exit conference with Kevin Kalinowski, Licensee Designee. I informed Mr. Kalinowski that I was citing a violation of this rule. Mr. Kalinowski stated that he wondered why Ms. Finalyson reacted the way she did in this situation because she was a long-term employee with a good record with the company.

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	Direct Care Worker, Alex Finalyson, physically guided Resident A to her bedroom against her will during an incident in which Resident A was yelling and threatening to harm herself. Resident A’s Treatment plan documents that “Staff are not to ‘direct’ her to go to her room as a form of behavior intervention. My findings support that this rule has been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

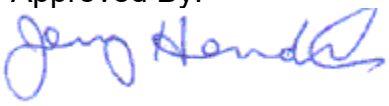
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remain unchanged, and that this special investigation be closed.

January 28, 2020

Ian Tschirhart — Date
Licensing Consultant

Approved By:



January 28, 2020

Jerry Hendrick — Date
Area Manager