GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 26, 2021

Patti Holland
801 W Geneva Dr.
Dewitt, MI 48820

RE: License #: AM330073582
Investigation #: 2021A1029013
Simken Adult Foster Care

Dear Patti Holland:

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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM330073582
Investigation #:	2021A1029013
Complaint Receipt Date:	06/01/2021
Investigation Initiation Date:	06/03/2021
Report Due Date:	07/31/2021
Licensee Name:	Patti Holland
Licensee Address:	801 W Geneva Dr. Dewitt, MI 48820
Licensee Telephone #:	(517) 669-8457
Administrator:	Patti Holland
Licensee Designee:	NA
Name of Facility:	Simken Adult Foster Care
Facility Address:	3600 Simken Lansing, MI 48910
Facility Telephone #:	(517) 394-3058
Original Issuance Date:	03/12/1997
License **Status:**	REGULAR
Effective Date:	03/15/2020
Expiration Date:	03/14/2022
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was physically abused by a direct care staff member when she was dragged down the stairs.	No
Resident A was locked in her bedroom by a direct care staff member.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/01/2021	Special Investigation Intake 2021A1029013- Denied APS referral
06/02/2021	Contact - Telephone call made to Complainant
06/03/2021	Special Investigation Initiated - On Site - face to face with direct care staff members, Jeffrey Sunder, Sara Dzik, and Residents A, B, C, D
06/03/2021	Contact - Telephone call received from Ashlee Bailey, Recipient Rights Specialist from CMH Authority of Clinton, Eaton, and Ingham.
06/03/2021	Contact - Document Received - Email from Ashlee Bailey, CMH with Resident B's statement regarding the incident and reviewed incident report.
06/07/2021	Contact - Telephone call made to Ashlee Bailey, CMH Recipient Rights
06/18/2021	Contact - Telephone call made to direct care staff member, Salina Morris
06/18/2021	Contact - Telephone call made to Guardian A1, left a voicemail
06/18/2021	Contact - Telephone call made to Taliya Etchison, left a voicemail.
06/18/2021	Contact - Telephone call made to Roel Montano
06/18/2021	Contact - Telephone call made to Taliya Etchison - left a voice mail for her.
06/21/2021	Contact - Telephone call made to Guardian A1

06/29/2021	Contact - Telephone call made to Taliya Etchison
07/07/2021	Contact – Telephone call from Guardian A1.
07/09/2021	Exit conference with licensee, Patti Holland.

ALLEGATION:

Resident A was physically abused by a direct care staff member when she was dragged down the stairs.

INVESTIGATION:

On June 1, 2021, a complaint was received via a denied APS referral from Centralized Intake. The complaint alleged Resident A was physically abused by direct care staff member Taliya Etchison.

On June 2, 2021, I interviewed Complainant for more information. Complainant stated Resident A has a legal guardian and is verbal but does have difficulty communicating the concerns. Complainant stated Resident A's bedroom is in the basement and she has a condition which causes her to shout "No" over and over throughout the day. Complainant reported Resident A was taken to urgent care after the incident but he did not know the outcome of this appointment.

On June 3, 2021, I spoke with Ashlee Bailey from Recipient Rights. Ms. Bailey interviewed Resident A at Simken Adult Foster Care home on June 2, 2021. Ms. Bailey stated that although she is verbal, Resident A was limited with how descriptive she could be regarding what happened. Ms. Bailey stated she interviewed Ms. Etchison who was the only direct care staff member working during the incident. Ms. Bailey stated Resident B refused to talk to her about the incident and that Resident C also allegedly witnessed the incident and agreed to speak with Ms. Bailey. Ms. Bailey stated Resident C told her Ms. Etchison told her to shut up during the incident and she was mean to her. The incident took place on Sunday, May 30, 2021, around 4:15 p.m.

On May 29, 2021, Resident B sent the following email to Robert Cheatham, his case manager from Community Mental Health, on May 30, 2021.

> *"We keep on having to drag her (Resident A) downstairs by her ankles and arm pits. Maybe you or someone should come over. This is the 4th time today that Taleah dragged her by her ankles and armpits. But the doors are being locked and she keeps banging on the doors to come up. I think she's so bad I wonder if she'll call the police and no one will answer Patti or Jeff won't answer the phone."*
>
> *On Sunday, May 30, 2021, Resident B wrote:*

“Why aren't you still able to stop [Resident A] at all. It's because of her everyone is in a bad mood. And the constant saying don’t make a mess a phone calls of arguments. What's wrong with [Resident A]?”

On Sunday, May 30, 2021, Resident B wrote:
“I'm totally scared now. Taleah Sara and Salina are nothing but only angry and in a bad mood only all the time now. I don’t feel safe being near them anyone more [sic]. Do they hate being here and is it all because of [Resident A]? And can someone just tell them to calm down that they are overdoing the bad mood?”

On June 3, 2021, I interviewed Resident B at Simken AFC. He stated everything is okay now. He said Resident A screams “No” a lot and it is hard for the other residents to listen to, but she has been better the last couple days. Resident B was not sure what had happened but stated he thought maybe Resident A fell down the stairs or was dragged up and down the stairs because of her continual screaming. Resident B stated he is treated well by direct care staff. Resident B denied being involved in the incident on the stairs and refused to give further information.

I interviewed Resident C at Simken AFC who stated Ms. Etchison locked the door so Resident A could not come up the stairs. She stated there is a bathroom downstairs but if Resident A were locked in her room, she could not use the restroom. Resident C stated the incident all started because Resident A was upset her tablet was not charged. Resident A was standing on a chair by the stairwell and Resident B was trying to get her to come down off the chair. During the incident, she heard Ms. Etchison tell Residents A and B she was a “gangster,” and she was going to “whip their asses” when she was in the doorway.

Resident C denied having any issues with any of the direct care staff members in the past. However, she has observed Ms. Etchison tell Resident A to “shut up, be quiet, and she was bothering people” in the past. Ms. Etchison has told Resident A other residents “could not stand her.” Resident C also stated she did not know if Resident A fell down the stairs or was pushed. She denied seeing the incident or having any further information other than when Resident A was standing on the chair.

I interviewed Resident A at Simken AFC. She initially stated she did not remember what happened and seemed nervous to be interviewed. Resident A then stated Resident B pushed her on the stairs. She said while this happened Ms. Etchison was upstairs watching television and she heard them arguing and came over. Resident A stated Ms. Etchison wanted her to go into the bedroom. Resident A was asked how she got into her room, and she said Resident B had her arms and brought her into her room while Ms. Etchison carried her feet. Resident A stated this has not happened before with Ms. Etchison as Ms. Etchison is usually nice to her. She did not know how long she was in her room or if she ate dinner. Resident A stated she was scared while this happened to her.

I interviewed Resident D at Simken AFC. She stated while she was sitting in the living room Resident A and Ms. Etchison got into an argument. At some point during the argument Resident B and Ms. Etchison pushed Resident A down the stairs. Resident A stated she did not want to go downstairs so she was pushed off the brown chair in the living room. Resident D does not think she was hurt and did not remember any other details. Resident D did not see what was happening on the stairwell and does not know if anyone had Resident A's ankles but she does not think so.

I interviewed direct care staff member, Jeff Sunden at Simken Home. He stated he is the transportation and activities staff and has worked for Simken Home for over seven years between the three homes. He stated Resident A has an agitation and compulsion issue which causes her to yell "no" throughout the day. She has lived in the home since February 2020. Mr. Sunden stated Resident A had an evaluation at Sparrow Hospital and there was no determination what causes her doing this. He stated the other residents are stressed by the behavior.

When asked about the incident on the stairs between Residents A and B, he expressed he was surprised Ms. Etchison did not call anyone to assist. She could have called Ms. Holland, Guardian A1, or himself to assist in the situation and no one was called.

He described Ms. Etchison as "not a team player" and she liked to work alone. She is quick to use commands with the residents but he has never seen her be disrespectful.

Mr. Sunden described Resident B as being autistic and narcissistic and stated he could see Resident B getting upset and pushing Resident A down the stairs. The direct care staff members have been worried about her getting attacked in the past due to her behaviors and how the residents seem bothered by her. He stated he was not there for the incident so he cannot say for sure what happened. Typically, there would have been two direct care staff member working Sunday evening, but one called in sick.

I also interviewed home manager, Sara Dzik. She stated when she came in on Monday after the incident, she could tell Resident A was very upset. Ms. Dzik reported Resident A stated Resident B pulled her out of the chair and pushed her down the stairs, and then she was put in her room. Ms. Dzik stated the basement doors coming upstairs used to lock until yesterday when maintenance came to fix the lock. The two upstairs doors on the stairway on the main floor where the ones which locked. The ones on the bottom of the stairs did not lock before. She stated she did not realize the doors locked until then because they have always been hard to close. Ms. Dzik stated she has not heard any of the residents being "cussed at" by the other direct care staff members. The room in the basement has not always been Resident A's room. She stated they moved her downstairs a couple months ago. The lock on the bedroom room which was hers was previously a non-locking against egress lock. Ms. Dzik is wondering if the person who resided in the room before Resident A changed the lock on the door.

I reviewed the *AFC Licensing Division - Incident / Accident Report (BCAL 4607)* dated June 2, 2021 from Simken AFC signed by licensee, Patti Holland. According to the incident report written by Ms. Etchison:

> "On 5/30/2021, [Residents A and B] were upset with each other in the stairwell. [Resident B] asked [Resident A] to stop yelling because she was upsetting the other residents. [Resident A] stated she didn't want to and started to hit [Resident B]. Ms. Etchison walked from the kitchen to the stairs and observed the two residents on the stairs. She went between them to get them to stop and by this time they were two steps down the stairs fighting and it was a hazard of falling. After asking them to stop [Resident A] turns and is facing Ms. Etchison and [Resident B] steps back and noticed [Resident A] is falling down on the stairs. He caught her by her arms and Ms. Etchison grabbed her legs to softly sit her down on the landing of the stairs. [Resident B] then walked away. [Resident A] was asked by Ms. Etchison to go to her room and calm down and [Resident B] went to his room. As Ms. Etchison went the rest of the way downstairs with [Resident A] she yelled at Ms. Etchison and calls her names. [Resident A] was blocking the doorway for the other residents to come up the stairs for dinner. She tells the other residents to use the other stairway and as she said Resident A lunges at her like she was going to fight her. She blocked with her arms to avoid getting hit crossing her arms over her face. [Resident A] was asked to go to her room again and she refused. Ms. Etchison walked away and went upstairs to serve dinner. There are additional comments said she grabbed her by the feet in order to make her more secure since she couldn't get to her arms or her waist to pull her up so she thought this would make both the most secure.

I reviewed the documentation from Sparrow Hospital on May 31, 2021, when Resident A was seen and evaluated by Kellie M. Donahue, MD. She did not have an x-ray but the diagnosis was a muscle strain of chest wall, initial encounter. There were no concerning findings on exam and there were instructions to continue to observe for bruising/pain and recheck within 24 hours while using ice to treat for comfort.

On June 21, 2021, I interviewed Guardian A1. Resident A has a condition where she yells "No" all the time. Sometimes it is quiet and sometimes it is very loud. This has been very disruptive to the staff and the other residents in the home. In the past when this is occurring she can typically talk to Resident A and she will calm down. Guardian A1, stated she never received a phone call the night of the incident to indicate anything was wrong. Guardian A1 stated Resident A told her she was carried by her arms and legs and said it hurt. Guardian A1 was not told she lost her balance at any time but read that in the incident report statement. Resident A does not have the strength or dexterity to peel someone's hands off of her or punch her so she can see her losing her balance in this situation. Resident A has resided at Simken Home for two years. Guardian A1 has never observed any of the direct care staff members yell at or mistreat her.

On June 29, 2021, I interviewed direct care staff member, Taliya Etchison. She stated she was in the kitchen cooking dinner around 4:30 p.m. when the incident occurred. The stairway echoes and she heard someone yelling “no, stop, no, no.” As she was approaching the doorway, Resident A and Resident B were fighting on the stairs. Ms. Etchison told them both they could not do fight with each other on the stairs and then stepped in between them like she learned in the recipient rights class to “professionally intervene” and help them stop fighting. Resident B stepped back while all three of them were on the stairs and Resident A fell like she was going to go down the stairs with Resident B catching her arms. Ms. Etchison then grabbed her feet because they were close to her and she was unsteady and they sat her down at the landing. After, Ms. Etchison stated she went back upstairs to finish dinner. The next day she was told she needed to create an incident report. Currently she is not working at the home while the investigation is pending. Guardian A1 said she did not want her working with Resident A while the investigation was going on. She typically works 52 hours per week. There have been incidents before between Resident A and Resident B. Ms. Etchison believed Resident B was upset with Resident A and attacked her on the stairs. Resident A does not typically fight or assault anyone. She is very sweet but has anxiety. It is hard for people to talk with her because she gets frustrated, and she will scream “No” throughout the day.

Ms. Etchison denied she pushed her down the stairs at any point but stated she grabbed her legs to help her set her down as Resident A started to fall down the stairs. As Resident A was falling back, Ms. Etchison stated Resident A’s feet came up so she grabbed her legs because it was the safest thing she could think of and her feet were closest to her. She was at the top of the stairs and Resident B was closer to the bottom. Ms. Etchison stated Resident A was mad and upset after the incident but she did not go to her room, she went back upstairs and continued to scream “no.” Resident B was still antagonizing her and making her feel more anxious about the situation. She did not call anyone when the incident occurred but called the licensee Patti Holland the next morning. As far as she knows, Resident B usually just antagonizes and picks on the other residents but does not typically get physically assaultive. Ms. Etchison considers herself caring and understanding to the residents and feels the energy when she is working is different than the other staff. Typically, she will take Resident A outside when she is having a hard time. She denied cussing at the residents or telling anyone in the home to shut up.

On July 9, 2021, I spoke with licensee, Patti Holland. Ms. Holland has not had any concerns with Ms. Etchison in the past. She did not feel she has been aggressive toward the residents. She thought the residents liked her. She never had any concerns with Resident B being physically assaultive to other residents in the past. Typically, most of the concerns of aggression was toward staff. She stated Ms. Etchison has not been working in any of her homes since the incident. Ms. Holland explained the incident as it was written on the incident report both residents were on the stairs and Ms. Etchison was helping her by holding her feet because she was unsteady.

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:	Although there was an incident on the stairs between Resident A and B, there is no indication Ms. Etchison dragged Resident A by her feet or pushed her down the stairs at any time. According to Ms. Etchison, she was assisting her by holding her feet because she was unsteady.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was locked in her bedroom by a direct care staff member.

INVESTIGATION:

On June 1, 2021, a complaint was received via a denied APS referral from Centralized Intake. The complaint alleged Resident A was locked in her room by direct care staff member Taliya Etchison.

Resident B sent the following email to caseworker from Community Mental Health, Robert Cheatham on May 20, 2021 after the incident which indicated Resident A was locked either in the basement or in her room.

> *"We keep on having to drag her (Resident A) downstairs by her ankles and arm pits. Maybe you or someone should come over. This is the 4th time today that Taleah dragged her by her ankles and armpits. But the doors are being locked and she keeps banging on the doors to come up. I think she's so bad I wonder if she'll call the police and no one will answer Patti or Jeff won't answer the phone."*

On June 3, 2021, I interviewed Resident B at Simken AFC. He stated Resident A was not locked in her room because he did not think that could happen because the doors do not lock. He denied anyone has locked him in his bedroom.

I interviewed Resident A. She stated she was locked in her room after the incident. Resident A knew how to unlock her door but she was not able to get out of her room. She stated she has been locked in her room in the past but she could not remember when. Resident A stated it was scary when she could not get out of her bedroom. Resident A stated she did not know how long she was in there.

I interviewed Resident D at Simken AFC. Resident D stated she thought Resident A was in her bedroom after the incident because she was locked in her room. She stated Ms. Etchison came downstairs and locked the door. Resident D was in her bedroom upstairs during the incident so she did not see her lock the door. Ms. Etchison was upset with Resident A and told her to "get her butt downstairs and she did not want to hear it." Resident D felt the whole thing was kind of mean and knew Resident A was upset. She did not know where Resident A went after the incident happened but she thinks in the hospital. Resident D stated Resident A went in her room but Resident D does not know if she was locked in there.

I interviewed direct care staff member, Jeff Sunden at Simken Home. He stated he was not aware if she was locked in the room or not since he was not there. He has not observed residents to be locked in their rooms in the past.

On June 18, 2021, I interviewed direct care staff member, Salina Morris regarding the incident. She stated she was not there during the incident. She did not know if Resident A's room had a lock but she did not think so. Typically, Resident A leaves her door open because it is hard to get her door open. She has never thought to look and see if there was a lock on the door or not. Ms. Morris has not seen Ms. Etchinson lock Resident A in her room or any of the residents locked in the room in the past. However, Ms. Morris stated she has known Ms. Etchison to allow the other residents to lock Resident A out of the upstairs.

On June 21, 2021, I interviewed Guardian A1. Guardian A1 was also told she was "closed into her room" but no one mentioned that she was locked in. Resident A has never told her she was locked in her room.

On June 29, 2021, I made a telephone call to Taliya Etchison. She stated she heard the residents' doors do not lock. She said Resident A was not locked into her room. She never went into her room on Sunday night after the incident and she was not locked in the room. She denied ever locking Resident A or any other resident in their room.

On July 9, 2021, I spoke with licensee Patti Holland. She stated she did not know if Ms. Etchison locked the door. None of the staff ever locked the residents in the rooms. She was not aware of Ms. Etchison locking Resident A in her room during this incident.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:

	(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.
ANALYSIS:	Resident A and the emails from Resident B both indicate Resident A was confined or restricted in an area during this incident where egress was prevented after the incident on the stairs. Resident A stated she was locked in her room. Resident B's emails indicate she was banging on the doors to come upstairs. Guardian A1 was told that she was "closed into her room" after the incident. Although it is not clear if Resident A was actually locked in her bedroom, Resident A could not get out of her bedroom for some reason and therefore was confined to her room and restricted to the downstairs area of the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

During the on-site investigation on June 2, 2021, Resident A's bedroom did not have a door equipped with positive latching non locking against egress hardware. The other resident bedrooms and bathrooms that were checked all had non-locking against egress door hardware. The doors located at the basement entrance at the top of the stairs leading to resident bedrooms at the basement level did not lock but were hard to open/close at the time of the onsite investigation.

On June 3, 2021, I interviewed home manager, Ms. Dzik at Simken AFC who stated the basement doors coming upstairs used to lock until yesterday when maintenance came to fix the lock. She stated she did not realize that the doors locked until then because they have always been hard to close. Ms. Dzik stated she was informed Resident A's door had non-locking against egress door hardware. She stated she would have the maintenance staff come fix the lock. Ms. Dzik stated she was not aware that door did not have the correct door hardware on it.

On June 7, 2021, I interviewed Ashlee Bailey, Community Mental Health Recipient Rights. Ms. Bailey stated the maintenance staff for Simken AFC came out on last week before the onsite inspection and changed out the locks. Ms. Bailey spoke with Mr. Montano who confirmed he was changed the locks on the two locks on the top of the stairs leading into the basement. There was a knob with a lock on it and they changed it to one that was non-locking against egress door hardware. Resident A's door was also changed to a non-locking against egress door hardware on June 7, 2021.

On June 18, 2021, I interviewed Roel Montano, who does all maintenance for Simken AFC. He said that the lock was changed to non-locking against egress last year due to a request from licensing but at some unknown point someone changed the locks back.

He was unsure who could have done this since he typically handles any maintenance requests. He confirmed that on June 7, 2021, the door hardware was changed to the correct non locking against egress door hardware on Resident A's room. He said that the ones at the top of the stairs were also changed out so they were non locking against egress as well.

On June 29, 2021, I interviewed direct care staff member, Taliya Etchison. She stated that she heard that the residents' doors do not lock. She denied knowing why Resident A would have a door that did not include positive latching, non-locking against egress hardware. She denied knowing Resident A had the wrong lock on her door.

On July 9, 2021, I spoke with licensee, Patti Holland. She stated Resident A changed into that room about two months ago. She stated that none of the residents would know how to change the lock on the bedroom door. She did not know if the wrong one was put on by accident. Ms. Holland stated direct care staff also said they were not aware of it. She did not think the basement doors locked either. Ms. Holland thought the doors on the top of the stairs were broken and did not lock.

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:	During the on-site inspection on June 2, 2021, Resident A's bedroom did not have a door equipped with positive latching non locking against egress hardware. Roel Montano, from maintenance/ confirmed that he changed the lock to a positive locking non locking against egress on June 7, 2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

_____7/12/2021_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

07/26/2021

_____

Dawn N. Timm
Area Manager

Date