GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 22, 2021

Jacquelyn Gillum
Henlyn Care, Inc.
P O Box 2562
Ann Arbor, MI 48106

RE: License #: AS810014833
Investigation #: 2022A0575001
Clair House

Dear Ms. Gillum:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On October 13, 2021, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9720.

Sincerely,

Jeffrey J. Bozsik, Licensing Consultant
Bureau of Community and Health Systems
(734) 417-4277

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

I. IDENTIFYING INFORMATION

License #:	AS810014833
Investigation #:	2022A0575001
Complaint Receipt Date:	10/12/2021
Investigation Initiation Date:	10/12/2021
Report Due Date:	11/11/2021
Licensee Name:	Henlyn Care, Inc.
Licensee Address:	P O Box 2562 Ann Arbor, MI 48106
Licensee Telephone #:	(734) 545-0188
Administrator:	Jacquelyn Gillum
Licensee Designee:	Jacquelyn Gillum
Name of Facility:	Clair House
Facility Address:	1132 Clair Circle Ann Arbor, MI 48103
Facility Telephone #:	(734) 545-0188
Original Issuance Date:	03/17/1993
License **Status:**	REGULAR
Effective Date:	06/10/2021
Expiration Date:	06/09/2023
Capacity:	6
Program Type:	PH; DD; MI; AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was tied to a chair with a gait belt.	Yes

III. METHODOLOGY

10/12/2021	Special Investigation Intake 2022A0575001
10/12/2021	APS and ORR Referral-received
10/12/2021	Special Investigation Initiated - Telephone
10/13/2021	Inspection Completed On-site-interviews with (a) Jacquelyn Gillum- licensee designee; (b) Residents A, B, C and D.
10/13/2021	Inspection Completed-BCAL Sub. Compliance
10/13/2021	Corrective Action Plan Requested and Due on 10/14/2021
10/13/2021	Corrective Action Plan Received
10/13/2021	Corrective Action Plan Approved
10/13/2021	Contact - Telephone call made-James Baker-Resident A's guardian
10/13/2021	Exit Conference with Jacquelyn Gillum-licensee designee

ALLEGATION:

Resident A was tied to a chair with a gait belt.

INVESTIGATION:

APS and ORR referrals were received on 10/12/21. The complainant was anonymous and therefore not interviewed.

I interviewed Residents A-D on 10/13/21. Residents A, C and D could not credibly answer questions, however, Resident B was found to be credible, and he stated he did witness Resident A tied to a chair, although he could not state which day.

I interviewed Jacquelyn Gillum on 10/13/21 and she admitted her staff had used a gait belt, which she provided for my inspection, to restrain Resident A in a chair in the living room on 10/12/21, as alleged by the complainant. The complainant alleged and Jacquelyn Gillum stated that Resident A was/is an elopement risk, however, when I reviewed Resident A's AFC assessment plan dated 3/26/21, there is no record of him being an elopement risk and/or a fall risk. Resident A's AFC assessment states that he cannot move independently in the community but does not state how the licensee will address the need.

I interviewed James Baker, Resident A's guardian, on 10/13/21 and he stated he did not know Resident A was being tied to a chair and he would not approve of such action.

I conducted an exit conference with Jacquelyn Gillum on 10/13/21. She signed a corrective action plan dated 10/13/21, which states she will not use any type of restraint to limit Resident A's mobility.

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: **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.**
ANALYSIS:	The licensee admits to using an unapproved, unauthorized, and unnecessary gait belt to restrain Resident A's movement in violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan was received; therefore, I recommend no changes to the status of the license.

Jeffrey J. Bozsik — Date: 10/20/21
Licensing Consultant

Approved By:

Ardra Hunter — Date: 10/22/21
Area Manager