



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 20, 2021

Roxanne Goldammer
The Country House, LLC
110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #: AM040291143
Investigation #: 2022A0360007
Beacon Home at Ossineke

Dear Ms. Goldammer:

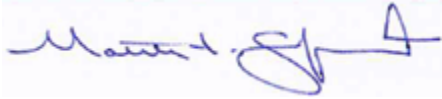
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (989) 732-8062.

Sincerely,

A handwritten signature in blue ink, appearing to read "Matthew Soderquist", is placed over a light blue rectangular background.

Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
Ste 3
931 S Otsego Ave
Gaylord, MI 49735
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM040291143
Investigation #:	2022A0360007
Complaint Receipt Date:	11/22/2021
Investigation Initiation Date:	11/23/2021
Report Due Date:	12/22/2021
Licensee Name:	The Country House, LLC
Licensee Address:	110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(989) 471-8482
Administrator/Licensee Designee:	Roxanne Goldammer
Name of Facility:	Beacon Home at Ossineke
Facility Address:	10685 Spruce Rd Ossineke, MI 49766
Facility Telephone #:	(989) 471-1192
Original Issuance Date:	12/17/2009
License Status:	REGULAR
Effective Date:	06/12/2020
Expiration Date:	06/11/2022
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A and staff Tiffany Throneberry have been having inappropriate relations with one another. This includes cuddling on the couch, texting one another, passing notes, and calling each other "babe".	Yes

III. METHODOLOGY

11/22/2021	Special Investigation Intake 2022A0360007
11/23/2021	Special Investigation Initiated - On Site
11/23/2021	Inspection Completed On-site Resident A, Home manager Sarah Patterson, DCS Kelly Evans, Haley Lesage
11/30/2021	Contact - Telephone call made Ruth Hewitt, ORR
12/01/2021	Contact - Face to Face Ruth Hewitt ORR, DCS Haley Lesage, DCS Kelly Evans, DCS Tiffany Thornberry
12/01/2021	Contact - Telephone call made Resident A, DCS Ashley Goden, DCS Dylan Potvin
12/07/2021	Contact - Telephone call received Ruth Hewitt, ORR
12/10/2021	Contact - Telephone call received licensee designee Roxanne Goldammer
12/20/2021	Exit Conference With licensee designee Roxanne Goldammer

ALLEGATION: Resident A and staff Tiffany Throneberry have been having inappropriate relations with one another. This includes cuddling on the couch, texting one another, passing notes, and calling each other "babe".

INVESTIGATION: On 11/22/2021 I was assigned a complaint from the LARA online complaint system.

On 11/23/2021 I conducted an unannounced onsite inspection at the facility. The home manager Sarah Patterson stated it was reported to her that Resident A and direct care staff Tiffany Throneberry have been texting each other, hugging and kissing. Ms. Patterson stated she did not witness any of that behavior between Resident A and Ms. Throneberry. She stated Ms. Throneberry is off the schedule until the investigation is complete per Beacon policy. Ms. Patterson stated Resident A has a history of attempting inappropriate sexual contact with staff and currently has a behavior treatment plan specifically addressing grooming type behavior with staff. Ms. Patterson provided me a copy of Resident A's behavior treatment plan developed by Northeast Michigan Community Mental Health and dated 11/9/2021. The plan documented that Resident A was re-referred for behavior management due to an ongoing number of problems including inappropriate sexual acting out behaviors toward staff and peers. It indicated that Resident A engages in "grooming" behaviors testing the limits regarding inappropriate touching that staff will tolerate and then increasing the behavior. The interventions documented that, *"Staff should remind (Resident A), each and every time, when he encroaches into their personal space by giving a clear, firm, but respectful directive: Please back-up (Resident A)."* It also stated that, *"Staff should not provide (Resident A) with hugs as he has a history indicates that he may have problems distinguishing between appropriate and inappropriate physical contact. Also, his history indicates that he may interpret any physical contact as approval and thus he may feel embolden to move further. Related to the "grooming" identified by staff, (Resident A) may attempt to discern what staff will tolerate and then move beyond this."* Ms. Patterson provided a behavior plan signature sheet which documented that direct care staff Tiffany Throneberry signed on 11/17/2021 confirming that she read, understand, and have had the opportunity to ask questions about the plan.

While at the facility on 11/23/2021 I interviewed direct care staff Kelly Evans. Ms. Evans stated Ms. Throneberry seems to treat Resident A favorably. She stated Ms. Throneberry will sit on the couch with Resident A. She stated while they are sitting on the couch their legs will be touching. She stated Ms. Throneberry told her she was not going to follow the behavior plan. She stated she has come into the living room and seen Resident A and Ms. Throneberry "resting" on the couch together. She stated she has witnessed Resident A and Ms. Throneberry hug each other. I then interviewed direct care staff Haley Lesage. Ms. Lesage stated Resident A and Ms. Throneberry will pass notes to each other. She stated they text each other while Ms. Throneberry is outside of work. She stated she has witnessed Resident A message Ms. Throneberry on her personal cell phone outside of work. She stated Ms. Throneberry will use Resident A's vape. She stated they spend a lot of time on the couch together. She stated she has witnessed Resident A and Ms. Throneberry hug each other. I then attempted an interview with Resident A. Resident A declined to be interviewed.

On 11/30/2021 I contacted Ruth Hewitt from Northeast Michigan Community Mental Health. Ms. Hewitt stated she was opening a rights investigation and scheduling interviews for tomorrow at the NEMCMH office.

On 12/1/2021 I met Ms. Hewitt at the NEMCMH office to conduct joint interviews with staff. Ms. Hewitt and I interviewed direct care staff Haley Lesage. Ms. Lesage again stated that Resident A and Ms. Throneberry pass notes to each other, message each other outside of work, sit on the couch together and have hugged each other. Ms. Hewitt and I then attempted a telephone interview with Resident A, but he again declined to be interviewed.

We then interviewed direct care staff Kelly Evans. Ms. Evans again stated that Ms. Throneberry and Resident A have sat on the couch together with their legs touching. She stated Ms. Throneberry does not allow other residents to hug her or be affectionate but she will hug Resident A and sit close with him on the couch. She stated Ms. Throneberry does not redirect this behavior as outlined in the behavior treatment plan for Resident A. Ms. Evans stated that Resident A's plan was reviewed with all staff and Ms. Throneberry told her that Resident A is just misunderstood, and she wasn't going to follow the plan.

Ms. Hewitt and I then called direct care staff Ashley Godin. Ms. Godin stated that she has witnessed Ms. Throneberry ask Resident A for a neck rub. She stated she has witnessed Ms. Throneberry fall asleep on the couch with Resident A at least 3 times during the midnight shift. She stated they were on the smaller "loveseat" couch and were resting on each other. Ms. Godin stated that Resident A will refer to Ms. Throneberry as "babe." She stated Ms. Throneberry does not redirect this behavior.

Ms. Hewitt and I then interviewed Ms. Throneberry. Ms. Throneberry stated when she first started working at the facility in October 2021 Resident A kissed her on the cheek. She stated she just kind of froze and didn't really know what was going on. She stated she tried to establish some boundaries with him after this incident. She stated a couple of weeks ago she was working an overnight shift and dozed off on the love seat. She stated when she woke up a short time later Resident A had snuggled up to her on the couch. She stated Resident A's head was laying on her side. She stated Ms. Patterson was working and when she noticed Resident A on the couch with her, she woke her up and asked her to move. She stated Resident A tries to take off her engagement ring while she is working. She stated he has taken her shoes when it is time for her to leave. She stated he has followed her out to her car and has tried to pin her against the car. She stated when he did this, she blocked him and got in her car and left. Ms. Throneberry denied texting or messaging Resident A. She offered her cell phone and showed she does not have him saved as a contact or any messages on her phone. She stated he has taken her phone from her in the past while at the home. She stated she understands Resident A's behavior plan but didn't understand the gravity of having to follow it.

Ms. Hewitt and I then contacted direct care staff Dylan Potvan. Mr. Potvan stated he has only worked a couple of shifts with Ms. Throneberry. He stated he has witnessed

Resident A try to invade Ms. Throneberry’s personal space. He stated she has always responded appropriately. He stated he hasn’t witnessed any inappropriate touching or sitting on the couch together.

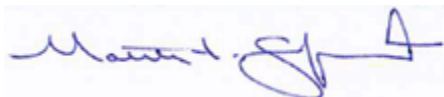
On 12/7/2021 I was contacted by recipient rights officer Ruth Hewitt. Ms. Hewitt stated she would be substantiating a rights violation due to not following the behavior treatment plan. She stated she also interviewed the home manager Sarah Patterson who confirmed that during one of Ms. Throneberry’s night shifts that she did fall asleep on the couch and witnessed Resident A sleeping on the couch with her.

APPLICABLE RULE	
R 400.14303	Resident care; licensee responsibilities.
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	<p>The complaint alleged that Resident A and staff Tiffany Throneberry have been having inappropriate relations with one another. This includes cuddling on the couch, texting one another, passing notes, and calling each other "babe".</p> <p>Resident A has a behavior treatment plan dated 11/9/2021 which outlines a history of inappropriate sexual contact and grooming behaviors towards staff. The behavior treatment plan interventions include that staff are to immediately redirect any of this behavior and are not to provide Resident A with hugs.</p> <p>Direct care staff Tiffany Throneberry has been witnessed by several direct care staff on multiple occasions not redirecting Resident A’s inappropriate contact with her including hugs.</p> <p>There is a preponderance of evidence that Resident a treatment plan was not follow as outlined.</p>
CONCLUSION:	VIOLATION ESTABLISHED

On 12/20/2021 I conducted an exit conference with the licensee designee Roxanne Goldammer. Ms. Goldammer stated she would review the report and submit a corrective action plan for approval.

IV. RECOMMENDATION

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

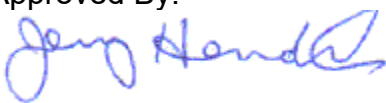


12/20/2021

Matthew Soderquist
Licensing Consultant

Date

Approved By:



12/20/2021

Jerry Hendrick
Area Manager

Date