STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

January 31, 2021

Jennifer Bhaskaran
Alternative Services Inc.
Suite 10
32625 W Seven Mile Rd
Livonia, MI 48152

RE: License #: AS150247007
Investigation #: 2022A0009008
Bay Springs

Dear Ms. Bhaskaran:

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 the violations.
- Specific time frames for the violations as to when the corrections 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.

611 W. OTTAWA • P.O. BOX 30664 • LANSING, MICHIGAN 48909
www.michigan.gov/lara • 517-335-1980

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,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS150247007
Investigation #:	2022A0009008
Complaint Receipt Date:	11/22/2021
Investigation Initiation Date:	11/22/2021
Report Due Date:	1/21/2022
Licensee Name:	Alternative Services Inc.
Licensee Address:	32625 W Seven Mile Rd, Suite 10 Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Jennifer Bhaskaran
Licensee Designee:	Jennifer Bhaskaran
Name of Facility:	Bay Springs
Facility Address:	232 Court Street Boyne City, MI 49712
Facility Telephone #:	(231) 582-0631
Original Issuance Date:	04/11/2002
License Status:	REGULAR
Effective Date:	10/11/2020
Expiration Date:	10/10/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
A staff person engaged in inappropriate behavior with residents.	Yes
Additional Finding	Yes

III. METHODOLOGY

11/22/2021	Special Investigation Intake 2022A0009008
11/22/2021	APS Referral
11/22/2021	Special Investigation Initiated - On Site Interview with home manager Ms. Amanda Smith Face to face contact with Resident A, Resident B, Resident C and Resident D
11/22/2021	Contact - Telephone call made to licensee designee Ms. Jennifer Bhaskaran
11/23/2021	Contact – Telephone call made to direct care staff Ms. Amanda Fehrlen
11/23/2021	Contact – Telephone call made to direct care staff Ms. Laurann Hill
11/23/2021	Contact – Telephone call made to direct care staff Ms. Shana Williams
11/24/2021	Contact – Telephone call made to administrator Ms. Jennifer Tilly
11/30/2021	Contact – Document received from licensee designee Ms. Jennifer Bhaskaran
12/09/2021	Contact – Telephone call made to Community Mental Health (CMH) caseworker Ms. Edith Soper
12/14/2021	Contact – Telephone call made to CMH recipient rights officer Ms. Amanda Dixon
12/14/2021	Contact – Documents received from CMH recipient rights officer Ms. Amanda Dixon

12/14/2021	Contact – Telephone call made to direct care worker Mr. John Hunt
12/15/2021	Contact – Telephone call received from direct care worker Mr. John Hunt
12/15/2021	Contact – Telephone call received from CMH recipient rights officer Ms. Amanda Dixon
12/15/2021	Contact – Telephone call made to adult protective services worker Ms. Louise Rohrer
12/16/2021	Contact – Telephone call received from licensee designee Ms. Jennifer Bhaskaran
12/17/2021	Contact – Telephone call received from licensee designee Ms. Jennifer Bhaskaran
01/07/2022	Contact – Telephone call received from CMH recipient rights officer Ms. Amanda Dixon
01/12/2022	Contact – Telephone call made to Ms. Mary Shepard, Charlevoix County Prosecutor's Office
01/12/2022	Contact – Telephone call received from Chief Kevin Spate, Boyne City Police Department
01/26/2022	Contact – Telephone call received from Ms. Mary Shepard, Charlevoix County Prosecutor's Office
01/31/2022	Exit conference with licensee designee Ms. Jennifer Bhaskaran

ALLEGATION: A staff person engaged in inappropriate behavior with residents.

INVESTIGATION: I conducted a joint site inspection with adult protective services (APS) worker Louise Rohrer at the Bay Springs adult foster care (AFC) home. We wore personal protective equipment to protect ourselves and others. The home manager Ms. Amanda Smith was present and agreed to speak with us. Ms. Smith stated that some of the staff have reported possible sexual behavior between direct care worker Mr. John Hunt and the residents. Mr. Hunt recently started working for them again but has worked on and off with the agency for several years. Ms. Smith stated that she had not known him before the recent rehire. Mr. Hunt's first day working there again was November 18, 2021. The agency, Alternative Services Inc., refers to Mr. Hunt as "emergency relief". Mr. Hunt worked a full shift on November

18 with direct care worker Ms. Amanda Fehrlen. On November 19, he worked alone until direct care worker Ms. Laurann Hill came in at 7:00 p.m. Ms. Hill reported that she found the home dirty and the residents "wound up" but nothing unusual. No one suspected that anything inappropriate might be going on after Mr. Hunt's first two shifts.

On November 20, direct care worker Ms. Shana Williams worked the day shift with Mr. Hunt. They both arrived that day for work at 9:00 a.m. Ms. Smith stated that Ms. Williams texted her (Ms. Smith) throughout the day complaining that Mr. Hunt would not do any chores or other work. Ms. Williams only complained that he wasn't helping around the house, nothing else. Ms. Hill arrived later that day for her shift at around 8:30 p.m. Ms. Smith stated that Ms. Hill called her (Ms. Smith) shortly after arriving and told her that she observed Resident A and Mr. Hunt sitting side by side and Mr. Hunt had his hand on Resident A's leg while Resident A was masturbating openly. Mr. Hunt was just sitting there watching him. Ms. Hill intervened at that time, asking Resident A to go to his bedroom. Ms. Smith stated Ms. Hill expressed concern about this because anytime Resident A touches himself in that manner, staff ask him to go to his bedroom, which is how Resident A's Community Mental Health (CMH) treatment plan directs staff to handle that specific issue.

Ms. Smith explained that Ms. Williams reported to her that she observed several disturbing things throughout the day before Ms. Hill arrived for her shift. Ms. Willams had earlier observed Mr. Hunt sitting side by side with Resident A while he (Resident A) masturbated openly. She reported that Mr. Hunt took off Resident A's brief to "make him more comfortable" so he could masturbate easily. Ms. Williams told Mr. Hunt that they do not make him more comfortable, they ask Resident A to go to his bedroom. When Resident A did go to his bedroom to continue masturbating, Mr. Hunt followed him in there. Ms. Williams also said that Mr. Hunt gave Resident A three separate showers that day which is very unusual. He told her that Resident A kept "getting food on himself". She had not seen any food on Resident A and pointed out that Resident A kept coming out of the bathroom with the same clothing on as he had on before. Mr. Hunt also gave Resident B a 45-minute shower which is much longer than is typical. Ms. Williams observed that all four of the residents were deliberately avoiding Mr. Hunt. Ms. Williams told all of this to Ms. Hill when she arrived for her shift. Ms. Hill contacted Ms. Smith who decided that they needed to get Mr. Hunt away from the residents immediately. When he was told to leave, Mr. Hunt at first refused saying that his shift was not done and that he would not leave. He also said that he needed to complete the medication log. As he was sitting at the dining room table, working on the medication log, they noticed that he had a soiled brief stuffed into the back of his pants. Resident A also saw it. Resident A grabbed the brief and threw it on the counter. Ms. Hill and Ms. Williams recognized it as one of Resident A's soiled briefs. Mr. Hunt tried to get the brief back but Ms. Williams blocked him from where it was on the counter. She kept telling him he couldn't have it but he kept trying to get it back from her. Ms. Williams was finally able to get him to leave by yelling at him and chasing him from the home. She then called law enforcement.

Ms. Smith continued by saying that law enforcement arrived and took statements from Ms. Williams and Ms. Hill. They asked that the residents be taken in for medical examinations. They also asked for Mr. Hunt to come back to the home and spoke with him in the parking area. Ms. Smith said that she contacted the licensee designee, Ms. Jennifer Bhaskaran. Ms. Smith denied that she had any paperwork for Mr. Hunt on-site. She said that was kept at the agency's main office.

I spoke with licensee designee Jennifer Bhaskaran by phone on November 22, 2021. She was aware of the allegations that were made regarding Mr. Hunt. Ms. Bhaskaran stated that Mr. Hunt has worked for the agency, off and on, for several years. She was not aware of any previous concerns regarding Mr. Hunt. Ms. Bhaskaran wanted me to know that Ms. Williams is a brand-new staff person and that she just quit. Ms. Bhaskaran stated there has been "quite a bit of drama between staff at the home". Ms. Williams and another staff person complained recently that the home is short-staffed. Ms. Bhaskaran brought in a home manager from another facility to help the staff at Bay Springs deal with resident behavior. Things have gone more smoothly at the facility since both Ms. Williams and Ms. Fehrlen resigned. Mr. Hunt has since sent her emails saying that he and Ms. Williams were not getting along during the day shift on November 20, 2021. He told her that Ms. Williams yelled at him in front of the residents and that they were having a lot of trouble redirecting Resident A. I asked Ms. Bhaskaran about the agency's definition of "emergency relief" staff. She said that it was the title of an employee who has a pattern of taking an extended leave while staying in their employ. I asked Ms. Bhaskaran to provide me with evidence of Mr. Hunt having had proper criminal history checks when he was hired and rehired.

I received incident reports from Ms. Bhaskaren by email on November 23, 2021. I noted that one staff who had accompanied the residents to the hospital reported that "there were no physical signs of trauma".

I spoke with former direct care staff Ms. Amanda Fehrlen by phone on November 23, 2021. She reported that she did work a shift with Mr. Hunt on November 18, 2021. Overall, nothing unusual happened that day. When Ms. Fehrlen worked again on November 21, 2021, it seemed like a lot had changed. She noticed that Resident A was masturbating openly which he hadn't done before. This included him masturbating openly in the living area which was not typical behavior for him. He also masturbated right in front of her when she toileted him. This also had not happened to her before that day. I asked her about typical bathing times for the residents. Ms. Fehrlen stated that Resident A, Resident B and Resident D do not like baths or showers and will try to get them over with as soon as possible. Resident C does like showers and will stand in the shower for as long as you allow him to. Ms. Fehrlen stated that she did not observe anything inappropriate between Mr. Hunt and the residents, she just noticed the change in Resident A masturbating more openly and with greater frequency.

I then spoke with direct care worker Ms. Laurann Hill by phone on November 23, 2021. She stated that she had seen Mr. Hunt during a shift change on November 19, 2021 and did not notice anything unusual at that time. The residents did seem quite agitated to her for the rest of the night, though. Resident A, in particular, was quite aggressive that night. The next day, she came in around 8:30 p.m. for her shift. Mr. Hunt and Ms. Williams had both been working the day shift. When she came in, Ms. Williams pulled her aside and told her of all the “weird things” that had been happening that day. Ms. Williams told her about observing Mr. Hunt sitting side by side with Resident A while Resident A masturbated openly. Ms. Williams told her that Mr. Hunt was watching Resident A masturbate and had his hand on Resident A’s leg. Upon hearing this, Ms. Hill realized that it might not be good for Mr. Hunt to be alone with the residents. Ms. Hill said as soon as she entered the living room, she observed the exact same thing that Ms. Williams had just described. She observed Resident A on the couch masturbating with Mr. Hunt sitting next to him, legs touching, watching him. Mr. Hunt’s hand was on Resident A’s leg. As soon as Mr. Hunt saw her enter the room, he pulled his hand away quickly. Ms. Hill said that they are supposed to ask Resident A to go to his bedroom to be alone when he engages in that type of behavior and all the other staff are consistent in doing this. Ms. Hill said that she called the home manager, Ms. Smith, and told her what was going on. Ms. Smith told Ms. Hill that Mr. Hunt needed to leave the home and told her to ask him to leave the premises. Ms. Hill stated that she told Mr. Hunt he needed to leave the home but he refused to leave, at first, saying that he needed to finish filling out the medication log. He grabbed the log and sat at the dining room table. Ms. Hill said that he was “shifting uncomfortably” in his chair while sitting there. She said that as she watched him, she noticed that he had what looked to be a soiled brief stuck in the back of his pants, which looked like Resident A’s brand of adult brief. Resident A also noticed the brief, grabbed it and threw it onto the counter. She confirmed that it was a soiled brief, not a new one. Ms. Williams then confronted Mr. Hunt about why he had that stuck into the back of his pants since she knew he hadn’t changed Resident A in over two hours. Ms. Williams kept asking him why he had the soiled brief but Mr. Hunt wouldn’t answer her. He just kept saying over and over that he wasn’t leaving. It looked as though Mr. Hunt wanted the brief back and kept trying to get around Ms. Williams who was standing in front of it. Ms. Williams wouldn’t get out of his way so that he could get it back. It seemed to her as if the two of them were fighting for the brief. Ms. Williams finally yelled at him to leave or she would call the police. Ms. Hill stated that she at first had a difficult time believing what Ms. Williams was telling her when she first came in until she saw it with her own eyes. She said that what she observed herself confirmed what Ms. Williams told her about Mr. Hunt. Ms. Willaims also told her that Mr. Hunt had Resident B in the bath for over an hour with the door closed. Ms. Hill said that, if true, that would be very unusual since Resident B does not like long baths.

I interviewed former direct care worker Ms. Shana Willaims by phone on November 23, 2021. I asked her about her shift with Mr. Hunt on November 20, 2021. Ms. Williams stated that she really hadn’t noticed anything unusual until later in the shift. Mr. Hunt was not helping her with any of the chores in the home and she was getting

frustrated about that. The residents were having difficult behavior. The first thing she noticed that day was the frequency and length of time that Mr. Hunt spent showering and bathing the residents. He showered Resident A three times during the day. This is unusual and when she asked Mr. Hunt about it, he told her that Resident A kept getting food all over himself. Ms. Williams had not noticed that herself. He also had Resident B in the bath for at least 45 minutes with the door closed. This was an extremely long period of time for Resident B to be in the bath. Mr. Hunt also showered Resident C for an extended period. She said that the residents started to display very difficult behaviors and that Resident D wouldn't leave her side. Ms. Williams said that she also observed Resident A openly masturbating in the living room with Mr. Hunt sitting right next to him, watching him. Mr. Hunt had his hand on Resident A's leg. When he saw her, he quickly took his hand off Resident A's leg. Mr. Hunt then took off Resident A's brief. She asked him why he did that and he replied, "To make it easier for him." Ms. Williams stated that she told Mr. Hunt that they do not "make it easier for him", they ask Resident A to go to his bedroom. Resident A did listen to her at that time and went to his bedroom. Mr. Hunt followed him back there, went into his bedroom and watched him masturbate. Later, she observed Resident A press his bottom into Mr. Hunt's groin area and Resident A grabbing Mr. Hunt's hand and putting it on his (Resident A's), groin area. This is unusual behavior for Resident A. Ms. Williams stated that what was especially strange about these incidents was that Mr. Hunt did not even comment about it or try to correct Resident A. He didn't move Resident A's hand away at that time. Mr. Hunt also went into Resident C's bedroom on several occasions while he was sleeping and woke him. Ms. Williams went on to say that when Ms. Hill came in at 8:30 p.m., she told her all she had observed. Ms. Hill called the home manager who told them to ask Mr. Hunt to leave. Ms. Williams stated that Mr. Hunt said that he wouldn't leave and grabbed the medication log to fill it out. They noticed the soiled brief in the back of his pants and Resident A also noticed it. Resident A grabbed the soiled brief which Ms. Williams recognized as being Resident A's. Resident A threw it on the counter. As soon as Ms. Willaims saw the soiled brief, she told Mr. Hunt that he needed to leave. He kept saying that he wasn't going to leave. Mr. Hunt kept coming closer to her and looking at the soiled brief. It was her impression that he wanted to take the soiled brief back. Ms. Williams said that she kept blocking him from the brief with her body. She said that she knew that he hadn't changed Resident A in over two hours so likely had it in his waist band for that long. Ms. Williams said that she finally yelled at him to leave and threatened that she was calling the police. When I asked her if there was anything else, Ms. Williams said that she heard that the administrator, Ms. Jennifer Tilly, had an experience with Resident A later that night that Ms. Tilly thought was unusual.

I spoke with administrator Ms. Jennifer Tilly by phone on November 24, 2021. She said that she was called in on the evening of November 20, 2021, to help with the situation at Bay Springs. When she arrived, law enforcement was on site and she helped the staff get the residents ready to be examined at the hospital. She said that the residents' behavior didn't seem unusual when she arrived. The officers suggested that the residents be examined medically with the guardians' permission.

I asked about anything unusual that she observed with Resident A. Ms. Tilly stated that she was helping Resident A get dressed to go to the hospital. He kept thrusting his pelvis back and forth and trying to put his privates right in her face. Ms. Tilly said that she had never seen him do anything like that before. She had also asked the other staff there about that and they denied that this was usual behavior for Resident A.

I received an email with attachments from licensee designee Ms. Jennifer Bhaskaran on November 30, 2021. She provided two separate Michigan Workforce Background Check forms dated September 19, 2019 and July 23, 2021. Both forms indicated that John Hunt "Is Eligible" to work in an AFC setting. Ms. Bhaskaran also explained that Mr. Hunt had previously worked at an AFC home that was not licensed by them any longer and also at an unlicensed facility.

I spoke with Community Mental Health (CMH) caseworker Ms. Edith Soper by phone on December 9, 2021. She stated that she had known Mr. Hunt on and off through the years as a staff person at Bay Springs. No allegations of sexual inappropriateness had ever come up. She did know that there was new staff in and out of the home and knew that there was often "drama" between staff there. Ms. Soper stated that all four residents at the home are "non-verbal". They are able to express themselves, just not with words. I asked Ms. Soper whether the issue of Resident A's masturbation in common areas of the home had come up before. Ms. Soper said that Resident A does sometimes masturbate in common areas and around staff. He sometimes masturbates while looking at staff. The staff are to direct him to go to his bedroom when this happens. She said that it was her understanding that Resident A does go to his bedroom after one or two prompts. Ms. Soper agreed that she would consider it very inappropriate if a staff were observed sitting right next to Resident A watching him masturbate without prompting him to go to his bedroom.

I spoke with CMH recipient rights officer Ms. Amanda Dixon by phone on December 14, 2021. She is conducting an investigation into resident rights violations at the Bay Springs AFC home. She said that she had used the Freedom of Information Act to obtain the law enforcement report and body-cam footage related to this matter. She received both items the day before. Ms. Dixon reviewed the body-cam footage. In the footage, Mr. Hunt told the officers that he had Resident A's brief in his pants because Resident A was trying to eat it and he wanted to keep it away from him. They did not ask him why he was trying to fight Ms. Williams for the brief and why he didn't just explain to her why he had it. Mr. Hunt told the officers that he was not getting along with Ms. Williams during their shift together. Ms. Dixon stated that one of the oddest points of the interview was when the officers asked Mr. Hunt about showering or bathing the residents. Mr. Hunt told them that he did wash the residents' private areas. When he made this statement, he also used a stroking motion up and down. As he was making the stroking motion, Staff 1 said, "Me giving them…" and then paused. Mr. Hunt seemed to understand that he was saying something inappropriate. Ms. Dixon stated that another officer went out to Mr.

Hunt's residence later. Without any prompting, Mr. Hunt told the officer that if they found any semen in the brief, it couldn't be his. He told the officer that he had undergone prostrate surgery and that he couldn't produce semen. Mr. Hunt kept telling the officers that they wouldn't find "anything forensic". On the other hand, Ms. Dixon stated that she wanted me to know that Ms. William's statements were all consistent. Her interview, written statement and what she said to the officers on the body-cam footage were all consistent. Ms. Williams told her that it was unusual for Resident A to get three showers in one day. Mr. Hunt told Ms. Williams that Resident A was getting food all over himself. Ms. Williams said that after each shower, Mr. Hunt put the exact same clothes back on Resident A. This is not consistent with the explanation of Resident A getting food on himself. Ms. Dixon stated that she would provide the law enforcement report to me but had agreed not to share the body-cam footage with anyone.

On December 14, 2021, I received the Boyne City Police Department report regarding this matter. Mr. Hunt was interviewed by the officers who responded to the complaint and later an officer who went to his home. Mr. Hunt denied any wrongdoing. He said, "You think I'm going to molest somebody with her watching?" He was referring to Ms. Williams. He complained that Ms. Williams was "critiquing" him all day. She accused him of "double-dosing" Resident C. He said that he had attempted several times to get Resident C to take his medication but that he had been sleeping during the attempts. He had gone into Resident C's bedroom several times and that was why Ms. Williams assumed he had given him his medication more than once. Mr. Hunt told them that Ms. Williams was "judging" him throughout the night and that it made him paranoid. He said that he was stressed by her. Regarding the showers and baths, he said that he was providing "direct care" to the residents at those times. He said that they need help with washing themselves. Regarding the masturbation, Mr. Hunt stated that he had tried to redirect Resident A to stop masturbating and that maybe he "got too close". He admitted that he sat right next to Resident A on the couch "to keep (Resident A) occupied so that he did not become physical with anyone else". He said that Resident A took his own brief off and then tried to eat it. He took the brief away from Resident A. When asked if he had the brief in his pocket, Mr. Hunt said he did not think he ever had it in his pocket but may have "stuck it over there". He did not elaborate on where "over there" was. Mr. Hunt said that he tried to use a "verbal redirect" to have Resident A go to his bedroom if he needed to masturbate. He denied having his hand on Resident A's lap while Resident A was masturbating. Mr. Hunt was asked if anything inappropriate had happened at the home that day. He replied, "No, other than me…" Mr. Hunt stopped himself at that point and would not say anything further regarding the subject.

I also received Resident A's CMH Behavior Assessment and Recommendations dated December 15, 2020. It directed that "<u>If (Resident A) begins to touch himself inappropriately while in the presence of staff, simply say '(Resident A), you need to do that when you are alone'.</u> Then redirect him back to task. Do this as often as necessary until he completes his task (toileting, showering)." I also noted in the

assessment that Resident A, “has been displaying signs of PICA and will eat ANYTHING he finds including, garbage, wrappers, plastic, paint, pieces of furniture, etc.”

I spoke with Mr. Hunt by phone on December 14, 2021. I identified myself and told him of my investigation. Mr. Hunt stated that he had been instructed by his attorney not to talk to anyone regarding the matter.

I received a phone call from Mr. Hunt on December 15, 2021. He said that he did want to make a statement to me about what had happened at Bay Springs. Mr. Hunt said that he started working there on November 18, 2021. He said that during his first shift, Ms. Williams had been talking with another staff behind closed doors. He said that he picked up that there was drama going on between the staff there. He did not believe that it had anything to do with him. Mr. Hunt said that there were a lot of new staff there who he did not know. On November 19, he worked most of the day alone. Home manager Ms. Amanda Smith was there for part of his shift but was in her office. He cared for the residents by himself. He denied that anything remarkable happened that day.

Mr. Hunt said that November 20 was when the issue with Ms. Williams occurred. He said that the problems began between them at around 2:00 p.m. He said that he went into Resident C’s room to give him his medication and saw that he was sleeping. He went back out and gave the other residents their medication. He decided he would need to wake Resident C up or his medication would be late so he did do that. Ms. Williams accused him of “double-dosing” Resident C since she noticed that he had gone into Resident C’s room twice. Mr. Hunt said that after she confronted him, he tried to show her the blister-pack that contained the medication and show her that only one dose was missing, but she did not seem to believe him. The next issue happened at around 5:00 p.m. during dinner. Ms. Williams told him to sit by Resident D and help Resident D with eating. Mr. Hunt said that in the past, one staff always sat by Resident A since he is the most difficult to keep on track. The second staff usually helped with the food and cleaning up when food fell on the floor. Mr. Hunt said that he was upset because he felt he had a lot more experience than Ms. Williams while she acted as if she knew everything. Mr. Hunt said that he was trying to help the residents eat and that Ms. Williams was on the phone with the home manager at the time. He believed she was complaining about him to her. Mr. Hunt said that at around 6:45 p.m., he gave Resident C a shower. When he came out, Ms. Williams was screaming at him that she was being attacked by Resident A the whole time he was in the bathroom. She said she was yelling for him to come help her. Ms. Williams told him that Resident A pulled her hair and grabbed her breast. Mr. Hunt told her that he couldn’t hear because of the water running. She told him that Resident A was trying to attack Resident B and Resident D and she put herself between them. Mr. Hunt said that for the next two hours he became a “human shield”, trying to prevent Resident A from attacking anyone else. I asked Mr. Hunt how long he had Resident C in the shower. He said 10 minutes at the most. I asked him why Ms. Williams reported that he was in there for 45 minutes or

longer. Mr. Hunt said that it was not that long and maintained that it was no longer than 10 minutes. I asked about him giving Resident A three showers that night. Mr. Hunt denied that he gave Resident A three showers. He said that the first two times he took him into the bathroom, Resident A fought with him about taking a shower. Mr. Hunt said that he did not feel it was a good idea to try to physically force him into the shower so did not pursue it. He said that the third time, Resident A did comply and took the shower. I asked him why Ms. Williams might think that he gave Resident A three showers. He said that he and Ms. Williams were not communicating well with each other at that point. He said that the first two times he was in the bathroom with Resident A only took two to three minutes. When he finally gave Resident A the shower it took five to ten minutes. I asked him if anything unusual happened while Resident A was in the shower. He said no. I asked him if Resident A was aroused at that time. He paused and said maybe a little but he did not have a "full erection". He said that he did soap up Resident A's private area because Resident A does not do this himself. He said this lasted for about three to five seconds at the most. He said that he just reached from behind and soaped him up "real quick". Mr. Hunt said that he gave both Resident B and Resident D a bath or a shower as well. Mr. Hunt said that it is a requirement that they give each resident a bath or a shower each night. He said that he would usually have the assistance of the other staff on duty but that he just thought he would do it himself and get it over with. This was due to him and Ms. Williams not getting along and her not helping him.

Mr. Hunt said that the night before, he had only given Resident B and Resident C a bath because he was working alone. He said that one has to keep a close eye on Resident A and that the two baths were all he was able to do that night. I asked Mr. Hunt about Resident A's masturbation. He said that he had seen that before but not to the extent that it was happening that night. Mr. Hunt said that both he and Ms. Williams spent 10 to 15 minutes trying to get Resident A to go to his room. He said that he was standing in the living room asking Resident A to go to his room and that Ms. Williams was asking him from the kitchen, but it was not working. I asked him about him sitting next to Resident A while he masturbated. Mr. Hunt said that he was about 20 feet away from Resident A and that the only time he went over to him was when he started ripping his brief off himself. Mr. Hunt said that Resident A had been trying to eat styrofoam from the couch earlier in the day and that Mr. Hunt believed that he would try to eat his brief. He went over to Resident A to take the brief away from him. He said that was the only time he went by him. He also said that the only time he would have had his hand on Resident A was when he was helping him with the brief. I asked Mr. Hunt what he did with the brief. He said that he threw it in the garbage. He said that he did not remember sitting by Resident A after Ms. Hill came in or having his hand on Resident A's leg. I asked him about the report that he was watching Resident A masturbate from the doorway of his bedroom. He said that if he was watching him it was only to keep him from attacking others or leaving the home. One door leading to the outside is right by Resident A's room. Resident A has been known to leave the home and wander the neighborhood. He denied that he was watching Resident A masturbate. I asked

him about the report of Resident A backing his bottom up against Mr. Hunt's groin area and Resident A grabbing Mr. Hunt's hand and putting in on Resident A's groin area. Mr. Hunt denied that he remembered anything like that happening. I asked him about being at the table with the medication log and what happened at that time. Mr. Hunt said that he was trying to make sure the medication log was correct. I asked him about what happened with the brief at that time. He said that it was on the counter. I asked him how it got there. He said he did not know. Mr. Hunt denied that he knew anything about it coming from his waistband or his pocket. He said that the only thing he could think of was that he might have grabbed a new one in the bathroom and stuck it back there. He did not remember that exactly, though. I told him that it was reported that the brief on the counter was the soiled brief from Resident A. He denied that he believed it was because that brief was "shredded" and he remembered throwing it in the garbage. I asked about him trying to grab the brief off the counter at that time. Mr. Hunt denied that he did. He said that Ms. Williams started yelling and screaming at him to leave and he said that he just wanted his jacket and would then leave. He said that if he was moving in that direction it was only to get his jacket. He said that his jacket was hanging down by Resident C's room where there is a hanger. Mr. Hunt said that Ms. Hill finally went to get his jacket for him and he left. I asked him if there was anything else that happened that he wanted me to know. Mr. Hunt wanted me to know that the only DNA that might be in any of the residents' briefs or underwear would only be from him helping them dress.

I spoke with CMH recipient rights officer Ms. Amanda Dixon by phone on December 15, 2021. She confirmed that medical examinations had not shown any sign of trauma to the four residents. She did say that Resident C had tested positive for syphilis. Ms. Dixon stated that they were looking into his records and there is a past report that he did have sexual contact with someone at the state hospital years ago. She said that they were still trying to assess this issue and she was looking for assistance from the CMH nurse.

I spoke with adult protective services worker Ms. Louise Rohrer by phone on December 15, 2020. She stated that she had not yet obtained any information from the hospital regarding the residents' examinations. I told her that according to the incident report I received as well as the report from Ms. Dixon, there was no evidence of physical trauma to any of the residents. I did tell her about Resident C testing positive for syphilis and that CMH was trying to assess this issue.

I spoke with licensee designee Ms. Jennifer Bhaskaran by phone on December 16 and 17, 2021. She reported that Mr. Hunt had resigned his position with the agency on December 15, 2021. Ms. Bhaskaran wanted to reiterate that Mr. Hunt had worked for them for several years with no complaints. Ms. Williams, on the other hand had only worked for the agency for a month but they had a lot of problems with her during that short time.

I spoke with CMH recipient rights officer Ms. Amanda Dixon by phone on January 7, 2022. She said that Resident C's blood work came back a second time as him being positive for syphilis. They are still looking into this issue but it looks like this might have been an existing condition. I asked Ms. Dixon about her interviews with Ms. Shana Williams. I asked about Ms. Williams' statements regarding Mr. Hunt trying to get the soiled brief back from the counter on November 20, 2021. She said that Ms. Williams was adamant that he was trying to get the brief back into his possession. He was reaching for it on the counter and trying to go around her and reach around her as she blocked him with her body. There was no doubt in her mind that he was trying to get the brief back.

I spoke with the Charlevoix Prosecutor's Office and the Boyne City Police Department by phone on January 12, 2022. The police department believed that the report had been sent and received by the prosecutor's office. The prosecutor's office did not have any record of it having been received. On January 12, 2022, the report was finally received by prosecutor's office.

I received a phone call from Ms. Mary Shepard with the Charlevoix County Prosecutor's Office on January 26, 2022. She said that the prosecutor finally had a chance to look at the case. He expressed concern about the allegations and that Mr. Hunt might work with vulnerable populations, but did not believe that charges would be pursued at this time due to the alleged victims having limited verbal skills.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: (a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.
ANALYSIS:	It was confirmed through this investigation that direct care worker Mr. John Hunt is not suitable to meet the physical, emotional, intellectual and/or social needs of each resident. He was reportedly observed by two different direct care workers, on two separate occasions, sitting side by side with Resident A watching him masturbate. Mr. Hunt was observed with his hand on Resident A's leg on both occasions. Both direct care workers reported separately that when Mr. Hunt saw them, he quickly took his hand off Resident A's leg. Mr. Hunt was also observed by the two direct care workers to have a soiled brief in his pocket or waistband from hours before. It was recognized as being Resident A's brief. Mr. Hunt fought to get the brief back into his possession without explaining why he had it or why he wanted it back.

	Other reported incidents of concern include Resident A backing his bottom into Mr. Hunt's groin area and grabbing Mr. Hunt's hand to put on his (Resident A's) groin area, Mr. Hunt watching Resident A masturbate in Resident A's bedroom and Mr. Hunt giving the residents extended showers and baths which is an unusual practice in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

Direct care workers Ms. Williams and Ms. Hill both stated that they each observed Mr. Hunt sitting by Resident A while Resident A masturbated openly in a common area of the home. These were two separate occasions that each observed in the home on November 20, 2021. Both Ms. Williams and Ms. Hill said that they observed Mr. Hunt sitting beside Resident A with his hand on his leg watching him masturbate. Mr. Hunt did not direct Resident A to go somewhere private.

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:	It was confirmed through this investigation that direct care worker Mr. Hunt did not address Resident A's unacceptable behavior properly when he sat beside Resident A in a common area while Resident A openly masturbated. Resident A's CMH Behavior Assessment and Recommendations dated December 15, 2020, addresses the issue of when Resident A "begins to touch himself". Staff are supposed to direct Resident A to do that when he is alone and keep him on task.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with licensee designee Ms. Jennifer Bhaskaran by phone on January 31, 2022. I told her of the findings of my investigation and gave the opportunity to ask questions.

IV. RECOMMENDATION

I recommend no change in the license status.

01/31/2022

Adam Robarge Licensing Consultant	Date

Approved By:

01/31/2022

Jerry Hendrick Area Manager	Date