GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 6, 2022

Drew Kersjes
CMHB Of CEI Counties
Suite 115
812 E Jolly Road
Lansing, MI 48910

RE: License #: AM330008421
Investigation #: 2023A1033002
Orchard Court

Dear Mr. Kersjes:

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 (517) 284-9730.

Sincerely,

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM330008421
Investigation #:	2023A1033002
Complaint Receipt Date:	10/14/2022
Investigation Initiation Date:	10/14/2022
Report Due Date:	12/13/2022
Licensee Name:	CMHB Of CEI Counties
Licensee Address:	Suite 115 812 E Jolly Road Lansing, MI 48910
Licensee Telephone #:	(517) 346-8200
Administrator:	Drew Kersjes, Designee
Licensee Designee:	Drew Kersjes, Designee
Name of Facility:	Orchard Court
Facility Address:	5725 Orchard Court Lansing, MI 48911
Facility Telephone #:	(517) 346-9596
Original Issuance Date:	08/22/1986
License **Status:**	REGULAR
Effective Date:	10/28/2021
Expiration Date:	10/27/2023
Capacity:	9
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 10/3/2022 Resident A was left at the hospital by direct care staff when they were to stay with him as he was having gallbladder surgery.	No
On 10/9/2022, unknown staff called Resident A “a crackhead” and kicked him out of the home and will not let him back in.	No
Additional Findings	Yes

III. METHODOLOGY

10/14/2022	Special Investigation Intake 2023A1033002
10/14/2022	APS Referral- Current APS investigation. No referral needed.
10/14/2022	Special Investigation Initiated – Telephone call made- Attempt to interview Complainant. Voicemail message left.
10/18/2022	Contact - Telephone call made- Interview with Complainant.
10/18/2022	Contact - Telephone call made- Interview with APS worker, Talaina Cummins, via telephone.
10/21/2022	Inspection Completed On-site- Interviewed Resident A, Resident B, direct care staff, Ashlee Gunn, Larisa Herdus, Aleeya Risner, Facility walkthrough completed. Review of resident records initiated. Review of staff schedule.
10/21/2022	Contact - Telephone call received- Interview with Home Manager, Shane Simone.
10/21/2022	Contact - Document Sent- Email sent to Licensee Designee, Drew Kersjes, regarding heating in the facility not working. Requesting immediate attention to this issue. Telephone call was attempted but did not go through to a voicemail.
10/24/2022	Contact - Telephone call made- Interview with direct care staff, - Aleeya Risner, via telephone.
10/24/2022	Contact - Telephone call made- Interview with direct care staff, LaDaryous Blocker, via telephone.

10/24/2022	Contact - Telephone call made- Attempt to interview Guardian A1, voicemail message left.
10/26/2022	Contact - Telephone call received- Interview with Guardian A1 and Guardian A2, via telephone.
10/26/2022	Inspection Completed-BCAL Sub. Compliance
12/06/2022	Exit Conference – Conducted with Licensee Designee, Drew Kersjes, via telephone.

ALLEGATION:

On 10/3/2022 Resident A was left at the hospital by direct care staff when they were to stay with him as he was having gallbladder surgery.

INVESTIGATION:

On 10/14/22 I received an online complaint regarding the Orchard Court adult foster care facility (the facility). The complaint alleged direct care staff at the facility took Resident A to Sparrow Hospital for gallbladder surgery on 10/3/22 and left him alone at the hospital. On 10/18/22 I interviewed the Complainant who reported there is an open Adult Protective Services (APS) investigation regarding the allegation.

On 10/18/22 I interviewed APS worker, Talaina Cummins. Ms. Cummins reported visited the facility on 10/10/22 and spoke with direct care staff members and Resident A. Ms. Cummins reported Resident A said direct care staff LaDaryous Blocker left him at the hospital and he was not supposed to leave him there. Resident A reported to Ms. Cummins that direct care staff member, Aleeya Risner, picked him up from the hospital after his surgery. Ms. Cummins reported Mr. Blocker reported to her that he had communicated with Home Manager Shane Simone regarding transporting Resident A to the hospital and was told by Mr. Simone that he could leave Resident A at the hospital and the hospital staff would call the facility when Resident A was ready to be discharged back to the facility.

On 10/21/22 I completed an on-site investigation at the facility. I interviewed Resident A regarding the allegation. Resident A reported that the date of his gallbladder surgery, 10/3/22, Mr. Blocker took him to the hospital, walked him downstairs to pre-op area and left. Resident A reported Mr. Blocker did inform the hospital staff that he would be leaving, and Resident A was in the care of hospital staff prior to Mr. Blocker leaving the hospital. Resident A reported that he was under the impression that a direct care staff member was to stay with him at the hospital since he would be under the effects of anesthesia when the surgery was completed. Resident A reported that there was no delay in being picked up after his surgery. He

reported that the Sparrow Hospital staff called the facility and Ms. Risner arrived shortly after to pick up Resident A.

During on-site investigation, on 10/21/22, I interviewed direct care staff, Ashlee Gunn. Ms. Gunn reported it is not a standard practice for direct care staff to stay with Resident A when he is at the hospital for a procedure. She reported she was unaware of there being any different protocol set in place for Resident A's gallbladder surgery, on 10/3/22. Ms. Gunn reported Mr. Blocker took Resident A to the hospital and Ms. Risner picked Resident A up from the hospital. Ms. Gunn reported that to her knowledge there was no delay in pick up and the hospital staff knew to call the facility for transportation back to the facility.

On 10/21/22 I interviewed Mr. Simone, via telephone, regarding the allegation. Mr. Simone reported Guardian A1 has not required Resident A to have a direct care staff stay with him when he goes to the hospital. Mr. Simone reported there was not a directive for any direct care staff to stay with Resident A during his surgery on 10/3/22. Mr. Simone reported Mr. Blocker took Resident A to the hospital for his surgery, but he cannot recall who picked Resident A up from the hospital on this date as Mr. Simone was not working on 10/3/22.

On 10/24/22 I interviewed Ms. Risner, via telephone, regarding the allegation. Ms. Risner reported that the date of Resident A's surgery, the hospital called the facility to inform them that Resident A was ready for discharge. Ms. Risner reported the hospital staff did not indicate that they anticipated the direct care staff would remain at the hospital with Resident A while he was in surgery.

On 10/24/22 I interviewed Mr. Blocker, via telephone, regarding the allegation. Mr. Blocker reported that the date of Resident A's surgery, 10/3/22, he reached out to Mr. Simone, via text message, to inquire whether he was needed to remain at the hospital throughout the surgery or whether he could return to the facility. Mr. Blocker reported Mr. Simone advised he did not have to remain at the hospital, and he could return to the facility. Mr. Blocker reported he remained with Resident A until he was sent to the pre-op area. He reported that the nurse (name unknown) reported he could leave at this time. Mr. Blocker reported he provided the phone number for the facility and was told a staff member would call when Resident A was ready for discharge.

On 10/26/22 I interviewed Guardian A1, via telephone, regarding the allegation. Guardian A1 reported that she works for Mid-Michigan Guardianship Services. Guardian A1 reported she was recently reassigned, and a new guardian has been appointed for Resident A, Guardian A2. Guardian A1 reported she and Guardian A2 work for the same agency. Guardian A1 reported that there are currently no restrictions on Resident A regarding needing someone to stay with him at medical appointments or while he is hospitalized. Guardian A1 reported it was not expected for the direct care staff to stay with Resident A during his surgery.

During on-site investigation, on 10/21/22, I reviewed Resident A's, *Assessment Plan for AFC Resident's* form, dated for 9/29/21. There are currently no noted restrictions or recommendations for Resident A to have an attendant or direct care staff member stay with him during medical appointments or at the hospital.

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:	Based upon interviews with Resident A, Mr. Blocker, Mr. Simone, Ms. Risner, Ms. Gunn, Complainant, Ms. Cummins, and Guardian A1, the facility did provide for the protection and safety of Resident A as is written in his *Assessment Plan for AFC Residents* form.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

On 10/9/2022, Unknown staff called Resident A "a crackhead" and kicked him out of the home and will not let him back in.

INVESTIGATION:

On 10/14/22 I received an online complaint alleging a direct care staff member called Resident A "a crackhead" and would not allow him back into the facility on 10/9/22. On 10/18/22 I interviewed the Complainant who reported that there is an open APS investigation regarding the allegation.

On 10/18/22 I interviewed APS Specialist Ms. Cummins who reported visited the facility on 10/10/22 and interviewed direct care staff and Resident A. Ms. Cummins reported Resident A stated to her that direct care staff, Larisa Herdus, told him to "Get out and don't come back." Ms. Cummins reported that Resident A stated Ms. Herdus then proceeded to call him "a crackhead." Ms. Cummins reported that she interviewed Ms. Herdus, regarding the allegation, and Ms. Herdus denied stating Resident A was "a crackhead."

On 10/21/22 I completed an on-site investigation at the facility. I interviewed Resident A regarding the allegation. Resident A reported there has never been a staff member who has asked him to leave the facility. Resident A further reported none of the direct care staff have ever referred to him as "a crackhead." Resident A

reported that some of the other residents call each other names and they have called him “a crackhead” but the direct care staff members have not.

During on-site investigation, on 10/21/22, I interviewed Ms. Gunn. Ms. Gunn reported that she is unaware of any staff member who would have asked Resident A to leave the facility and not return. She further reported she was unaware of any staff member who would have referred to Resident A as “a crackhead.” Ms. Gunn reported that she has heard other residents refer to Resident A as “a crackhead” but not staff members. Ms. Gunn reported that Resident A does have a history of substance abuse and does have to comply with random drug testing. She further reported that at times when direct care staff need to speak with him about his substance abuse, he may become defensive and feel as though he is being called names.

During on-site investigation, on 10/21/22, I interviewed Ms. Herdus. Ms. Herdus denied ever asking Resident A to leave the facility. Ms. Herdus also denied ever referring to Resident A as “a crackhead.”

On 10/21/22 I interviewed Mr. Simone, via telephone, regarding the allegation. Mr. Simone reported that he was unaware of any staff member who has ever referred to Resident A as “a crackhead.” Mr. Simone reported that Resident A does struggle with substance abuse and does comply with random drug testing.

On 10/24/22 I interviewed Ms. Risner, via telephone, regarding the allegation. Ms. Risner reported that she was unaware of any time that a direct care staff member has spoken to Resident A in a derogatory manner and has never heard of a staff member asking Resident A to leave the facility and not return.

On 10/24/22 I interviewed Mr. Blocker, via telephone, regarding the allegation. Mr. Blocker reported that he was unaware of any time when a direct care staff member has referred to Resident A as “a crackhead.” Mr. Blocker also reported that he was unaware of any time when a staff member has asked Resident A to leave the facility and not return.

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:	Based upon interviews with Ms. Cummins, Resident A, Ms. Gunn, Ms. Herdus, Ms. Risner, Mr. Simone, and Mr. Blocker, there was no evidence direct care staff members did not treat Resident A with dignity in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During on-site investigation, on 10/21/22, I interviewed Resident B who reported the window in her bedroom was “stuck open” and would not close. Resident B reported her bedroom had been very cold, and she has not been able to receive assistance getting this window to close. I observed the window was stuck in an open position and observed Ms. Gunn attempt to close the window. Ms. Gunn was unable to get this window to close. Ms. Gunn reported that maintenance would need to be contacted and a work order placed to get the window closed. Ms. Gunn reported that she was unaware Resident B’s window was stuck in an open position until this date.

On 10/24/22 I interviewed Ms. Risner, via telephone. Ms. Risner reported that the maintenance worker had come to the facility on 10/21/22 and closed Resident B’s window.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(4) A roof, exterior walls, doors, skylights, and windows shall be weathertight and watertight and shall be kept in sound condition and good repair.
ANALYSIS:	Resident B’s bedroom window was stuck in an open position and unable to be closed leaving her bedroom cold in temperature. Direct care staff members were also unable to remedy this issue during the time of this on-site investigation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During on-site investigation, on 10/21/22, I interviewed Resident A in his resident bedroom. Resident A reported that his room is very cold, and he must wear a winter jacket when he is sleeping at night. Resident A was laying on his bed bundled up in his jacket during the time of this investigation, around 10am. Resident A reported the heat in his resident bedroom does not work, and he has tried everything. He demonstrated, with the thermostat that the electric heating element does not turn on,

no matter to what temperature the heat is set. I attempted to operate the thermostat and had the same result. The bedroom did feel cold during this onsite investigation but there was not an accurate thermostat in the room to display the temperature. Resident A reported that he has not had heat in his bedroom since it began getting cold outside. Resident A reported that he has complained about the heat not working but “it doesn’t matter.” Resident A asked what could be done about the heat in the facility.

During the on-site investigation I interviewed Ms. Gunn regarding the heat not working in Resident A’s apartment/resident bedroom. A clock, that displays the room temperature, was taken from the kitchen and placed in Resident A’s apartment. After a period of ten minutes, I checked the clock, which read 67F. Ms. Gunn reported that she was unaware there was an issue with the heat at the facility. Ms. Gunn reported that she is unsure how to make the heat work and would need to put in a work order for maintenance to fix the heat. When asked how long it would take for maintenance to investigate the problem Ms. Gunn reported she did not know what their timeframe would be.

During on-site investigation I interviewed Resident B. Resident B reported that the heat in her apartment/resident bedroom was also not working. Resident B reported that it gets so cold she needs to wear a coat inside and she still feels cold. I observed the electric heating element in Resident B’s room was also not working. I attempted to engage the heating system by turning up the thermostat in Resident B’s apartment/resident bedroom and this did not work.

On 10/21/22 I interviewed Mr. Simone regarding the heating at the facility. Mr. Simone reported he was unaware the heat at the facility was not working until today. He reported he would need to call maintenance as he is unaware how to turn the heat on. He reported he was not sure how long it would take to obtain a response once the maintenance request was submitted.

During on-site investigation, on 10/21/22, Ms. Gunn, Ms. Risner, and Ms. Herdus were working at the facility. I inquired if any of the staff were knowledgeable about the heating at the facility or how to turn the heat on. None of the working staff members knew how the heating units functioned or how to turn the heat on for the residents.

On 10/21/22 I emailed Licensee Designee, Drew Kersjes, regarding the heat being off at the facility. Mr. Kersjes replied he had submitted the request regarding the heating issue to the maintenance department to have the issue addressed.

On 10/24/22 I interviewed Ms. Risner regarding the heat at the facility. Ms. Risner reported the heating issue had been resolved on 10/21/22. She reported the maintenance worker came to the facility and turned the heat on for the residents.

On 10/24/22 I interviewed Mr. Blocker regarding the heat at the facility. Mr. Blocker reported the heating issue has been resolved and the heat is now working.

APPLICABLE RULE	
R 400.14406	**Room temperature.**
	All resident-occupied rooms of a home shall be heated at a temperature range between 68 and 72 degrees Fahrenheit during non-sleeping hours. Precautions shall be taken to prevent prolonged resident exposure to stale, noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations from the requirements of this rule shall be based upon a resident's health care appraisal and shall be addressed in the resident's written assessment plan. The resident care agreement shall address the resident's preferences for variations from the temperatures and requirements specified in this rule.
ANALYSIS:	Based upon observations during on-site investigation and findings from facility walkthrough, as well as interviews with Resident A, Resident B, Ms. Gunn, Ms. Risner, Ms. Herdus, and Mr. Simone, the facility did not have a functioning heating system during the time of the on-site investigation and days prior. The direct care staff did not know how to operate the heat to turn the heat on for the residents. The staff were unable to remedy this issue during the time of this investigation and could not supply me with a timeline for when the issue could be resolved.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 10/18/22 I interviewed Ms. Cummins, via telephone. Ms. Cummins reported that it was reported to her, during her on-site investigation at the facility, on 10/10/22, that Resident A has been sharing a bedroom with Resident B. Ms. Cummins reported Resident A told her that he had been staying in "the basement" with another resident, but now he is back to staying in his own room.

During on-site investigation, on 10/21/22, I interviewed Ms. Gunn regarding the heating issue in Resident A's apartment. Ms. Gunn reported that the heat has probably not been used in Resident A's apartment/resident bedroom yet this year as he has been living with Resident B. Ms. Gunn reported that Resident A (male) and Resident B (female) had an intimate sexual relationship and had been living together in Resident B's apartment for multiple months. Ms. Gunn reported that this relationship has been going on since around June 2022.

During on-site investigation, on 10/21/22, I interviewed Ms. Risner. Ms. Risner reported that Resident A and Resident B had been living together in Resident B's apartment for several months. Ms. Risner reported that Resident A and Resident B had an intimate relationship but now Resident A is involved with Resident C (female).

During the on-site investigation, on 10/21/22, I interviewed Ms. Herdus. Ms. Herdus reported Resident A and Resident B are "on again, off again". Ms. Herdus reported Resident A had been living in Resident B's apartment/resident bedroom until the past couple of weeks when they broke off their relationship. Ms. Herdus reported there are two beds in Resident B's apartment/resident bedroom where she and Resident A slept.

During the on-site investigation, on 10/21/22, I interviewed Resident B in her apartment/resident bedroom. I observed she had two beds in her bedroom that are positioned side by side. Resident B reported that the smaller bed is for Resident A. She reported that Resident A was her boyfriend. Resident B reported that Resident A had been staying in her apartment since about June 2022 until two weeks ago when they ended their relationship.

On 10/21/22 I interviewed Mr. Simone, via telephone. Mr. Simone reported Resident A and Resident B are "on and off" boyfriend and girlfriend. Mr. Simone reported Resident A bounces between Resident B and Resident C for intimate sexual partners. Mr. Simone reported that his understanding is Resident A will sometimes sleep in Resident B's bedroom in a recliner or in the other bed in her bedroom. Mr. Simone reported, "They like the idea of being "married"."

On 10/24/22 I interviewed Mr. Blocker, via telephone. Mr. Blocker reported Resident A and Resident B had been in an intimate relationship. Mr. Blocker reported Resident A spent a lot of time with Resident B, in her apartment/resident bedroom. Mr. Blocker reported that when Resident A and Resident B argued Resident A returned to his own apartment/resident bedroom.

On 10/26/22 I interviewed Guardian A1. Guardian A1 reported she was not aware Resident A had stayed for an extended period of time (multiple months) with Resident B in her resident room at the facility. Guardian A1 reported Resident A does have a partial guardianship, which allows authorities over medical, psychiatric, living arrangements, educational and vocational options. Guardian A1 reported it has been reported to her, by Mr. Simone, that Resident A has made unwelcome sexual advances toward another resident. Guardian A1 reported that she has not been told that Resident A was sharing an apartment with another resident. Guardian A1 reported that the communication between the facility and the guardianship agency needs to be improved. Guardian A1 reported she does not feel she can limit Resident A's sexual relationships but reported she does have the ability to provide

sexual education to Resident A and feels this needs to be addressed and she does have authority to determine where Resident A resides.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(8) Residents of the opposite sex shall not occupy the same bedroom for sleeping purposes, unless they are husband and wife.
ANALYSIS:	Based upon interviews with Ms. Cummins, Resident B, Ms. Gunn, Ms. Herdus, Ms. Risner, Mr. Blocker, Mr. Simone, and Guardian A1, Resident A and Resident B, who are unrelated, male and female, both occupied Resident B's apartment for purposes of sleeping and maintaining an intimate relationship for multiple months and are not legally married.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

11/10/2022

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Jana Lipps Date
Licensing Consultant

Approved By:

12/05/2022

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Dawn N. Timm Date
Area Manager