STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

June 2, 2023

Caleb Brokaw
Sunnyside Assisted Living II, LLC
3025 W Birch Run Road
Burt, MI 48417

RE: License #: AM730340435
Investigation #: 2023A0871034
Sunnyside Home

Dear Ms. Brokaw:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 643-7960.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM730340435
Investigation #:	2023A0871034
Complaint Receipt Date:	04/11/2023
Investigation Initiation Date:	04/12/2023
Report Due Date:	06/10/2023
Licensee Name:	Sunnyside Assisted Living II, LLC
Licensee Address:	3025 W Birch Run Road Burt, MI 48417
Licensee Telephone #:	(989) 770-4760
Administrator:	Caleb Brokaw
Licensee Designee:	Caleb Brokaw
Name of Facility:	Sunnyside Home
Facility Address:	3025 Birch Run Road Burt, MI 48417
Facility Telephone #:	(989) 770-4760
Original Issuance Date:	12/12/2014
License **Status:**	REGULAR
Effective Date:	06/12/2021
Expiration Date:	06/11/2023
Capacity:	8
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Around two weeks ago, Resident A's roommate touched her breast. Resident A feels like nothing has been done about it after she told staff.	No
Additional findings	Yes

III. METHODOLOGY

04/11/2023	Special Investigation Intake 2023A0871034
04/11/2023	APS Referral
04/12/2023	Special Investigation Initiated - Letter Received information from Adult Protective Service Worker Alan Neilson
04/21/2023	Inspection Completed On-site Interviewed Staff Tabitha Harris
05/16/2023	Inspection Completed On-site Interviewed Home Manager Kelsey Brokaw, Residents A-B
05/22/2023	Contact - Telephone call made Telephone call to Resident B's Case Manager Grace Kemp
06/01/2023	Contact – Document received Received Resident A and Resident B's assessment plans
06/02/2023	Contact – Telephone call made Telephone call to Staff Chelsea Brokaw
06/02/2023	Exit Conference Telephone exit conference with Licensee Caleb Brokaw

ALLEGATION:
Around two weeks ago, Resident A's roommate touched her breast. Resident A feels like nothing has been done about it after she told staff.

INVESTIGATION:
On April 12, 2023, I telephoned Adult Protective Service Worker Alan Neilson. Mr. Neilson indicated Resident A thought Resident B was seeing her boyfriend, who also lives in the facility. Mr. Neilson said Resident A "lied to the police about being molested" and that he did not find this allegation to be true. Mr. Neilson reported that Resident A "will make things up to get her way." Resident A reported to Mr. Neilson that Resident B "stole my boyfriend" and accused Resident B of touching her breast. Mr. Neilson did not substantiate abuse in this case.

On May 31, 2023, Mr. Neilson indicated the police were not involved with this incident but have been involved in the past with allegations that Resident A had made.

On June 1, 2023, I received a copy of Resident A and Resident B's *Assessment Plan for AFC Residents.* Resident A's assessment plan was signed and dated by Guardian A1 and Licensee Caleb Brokaw on 03/14/23. Indicates "Controls Sexual Behavior – [Resident A] is at risk of practicing unsafe sex. Staff will monitor as needed." Resident B's assessment plan was signed and dated by Guardian B1 and License Caleb Brokaw on 01/02/23. It indicates "Controls Sexual Behavior – Resident B has a history of being sexually active, sexually promiscuous and also vulnerable. Staff will work to make sure [Resident B] is safe at all costs."

On April 21, 2023, I conducted an unannounced onsite investigation and interviewed Staff Tabitha Harris. Ms. Harris said there "is a love triangle" with Residents A, B and Resident C. Ms. Harris said Resident A and Resident B now get along well. Ms. Harris was aware of this allegation and believes it is not true. Ms. Harris reported Resident A and Resident B do not require 1:1 staff.

On May 6, 2023, I conducted an onsite investigation and interviewed Home Manager Kelsey Brokaw. Manager Brokaw indicated both Resident A and Resident B "liked the same guy." Manager Brokaw said Resident A and Resident B "get along just fine now." Manager Brokaw Resident A does not like Resident C anymore. Manager Brokaw also reported that neither Resident A nor Resident b require 1:1 care.

I then interviewed Resident A. Resident A said "[Resident B] touched my boob by accident." Resident A said, "she didn't mean to" and that it happened just one time. Resident A said she now has a good relationship with Resident B. Resident A said staff did talk to Resident B about the situation.

On May 6, 2023, I then interviewed Resident B. Resident B is somewhat verbal and could provide some information. Resident B said she "likes [Resident A]" and that she never did anything to her.

On May 22, 2023, I telephoned Resident B's Case Manager Grace Kemp. Ms. Kemp indicated Resident B has a disease causes her to be a choking hazard. Ms. Kemp said she is the case manager for three residents in the facility and visits them frequently. Ms. Kemp was surprised at the allegation and said she "would have never thought [Resident B] to do anything like that." Ms. Kemp has no other concerns about the care she is receiving at the facility.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Resident A said Resident B touched her breast by accident. Resident B denied that she touched Resident A. Resident B's Case Manager Grace Kemp said she did not think that Resident B would ever do anything like that and was surprised at the allegation. There is no evidence to confirm violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTBLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On June 1, 2023, I telephoned Staff Chelsea Brokaw. Ms. Brokaw indicated Resident A did not tell staff about the incident but called Recipient Rights. An *AFC Licensing Division – Incident/Accident Report* was not completed.

On June 2, 2023, I conducted a telephone exit conference with Licensee Caleb Brokaw. He was advised that an incident report must be completed when a resident alleges that another resident touched them inappropriately and this would be a rule violation.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information: (a) The name of the person who was involved in the accident or incident. (b) The date, hour, place, and cause of the accident or incident. (c) The effect of the accident or incident on the person who was involved and the care given. (d) The name of the individuals who were notified and the time of notification. (e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved. (f) The corrective measures that were taken to prevent the accident or incident from happening again.
ANALYSIS:	An *AFC Licensing Division – Incident/Accident Report* was not completed in regard to Resident A alleging that Resident B touched her breast. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of correction, I recommend the status of this adult foster care small group home remain unchanged (capacity 1-6).

06/02/2023

Kathryn A. Huber — Date
Licensing Consultant

Approved By:

06/02/2023

Mary E. Holton — Date
Area Manager