GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 7, 2023

John & Rosie Thornton
2508 McIlwraith
Muskegon Heights, MI 49444

RE: License #:	AS610015096
Investigation #:	2023A0356037
	J.B.C. Home

Dear Mr. & Mrs. Thornton:

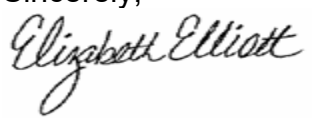
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610015096
Investigation #:	2023A0356037
Complaint Receipt Date:	05/10/2023
Investigation Initiation Date:	05/10/2023
Report Due Date:	07/09/2023
Licensee Name:	John S. Thornton & Rosie L. Thornton
Licensee Address:	2508 McIlwraith Muskegon Heights, MI 49444
Licensee Telephone #:	(231) 739-8820
Administrator:	Kaja Hunter
Licensee Designee:	John & Rosie Thornton
Name of Facility:	J.B.C. Home
Facility Address:	2508 McIlwraith Street Muskegon Heights, MI 49444-1633
Facility Telephone #:	(231) 737-0015
Original Issuance Date:	12/01/1993
License Status:	REGULAR
Effective Date:	06/01/2022
Expiration Date:	05/31/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A sustained bruises caused by staff at the facility.	Yes

III. METHODOLOGY

05/10/2023	Special Investigation Intake 2023A0356037
05/10/2023	APS Referral
05/10/2023	Special Investigation Initiated - Telephone Anna Mater, APS, Muskegon County DHHS.
05/12/2023	Inspection Completed On-site
05/12/2023	Contact - Face to Face Anna mater, APS, John Thornton, LD, D'Erika Woods, LeDrea Lewis, Dwight Quinn, Resident A, Resident B, Serinus Daniels.
05/12/2023	Contact-Face to Face Licensee Designee, John Thornton.
05/15/2023	Contact-Document received. Review of IR's (incident reports).
06/07/2023	Exit Conference-John Thornton, Licensee Designee.

ALLEGATION: Resident A sustained bruises caused by staff at the facility.

INVESTIGATION: On 05/10/2023, I received a complaint through Muskegon County, Department of Health and Human Services, Adult Protective Services. The complaint documented that on 05/09/2023, Resident A presented at the ER (emergency room) at Trinity Health due to altered mental status. Staff at the facility reported Resident A had been manic at the home after a change to Resident A's medication Seroquel was made. The complainant reported upon evaluation at the hospital, it was noted that Resident A was covered in bruises on his face and neck including a black eye. Staff accompanied Resident A to the ER and reported that Resident A was "whipping a belt around towards staff members that caused his injuries." Staff at the hospital expressed concern that the explanation of Resident A's injuries are not consistent with the observed injuries. A second referral was called in to CI (centralized intake, APS) on 05/09/2023 that documented Resident A was transported by EMS (emergency medical services) to Trinity Health hospital due to

reported aggression issues. The complainant reported that Resident A did not have a bag attached to his catheter, was covered in urine, and had two black eyes. The complainant reported that Resident A stated, “Papa” hit him and broke his glasses. It is unknown who “papa” is. Adult Protective Services assigned this to Anna Mater for investigation.

On 05/10/2023, I interviewed Ms. Mater via telephone. Ms. Mater stated she interviewed Resident A immediately at the hospital on 05/09/2023 and he presented with two black eyes and told her that “pawpaw” did it. Ms. Mater stated she does not know who pawpaw is and Resident A did not explain to her who pawpaw was. Ms. Mater stated on 05/09/2023, she referred this incident to law enforcement.

On 05/12/2023, Ms. Mater and I conducted an unannounced inspection at the facility to interview Resident A. Upon our arrival, while explaining to staff that Ms. Mater and I wanted to interview Resident A privately in his room, Resident B was standing next to staff and Resident A pushed Resident B down onto a couch stating, “they are here to see me, not you!” Ms. Mater and I interviewed Resident A in his room at the facility. Resident A had a catheter with the bag attached. He said that pawpaw is John Thornton and described Mr. Thornton as a tall, white male. Later, Resident A described Mr. Thornton as a tall black male. Ms. Mater and I observed an injury and black and blue mark to the outside corner of Resident A’s right eye and a full black eye on the left eye. Resident A stated he was “arguing and fighting pawpaw on the couch.” Resident A stated pawpaw was going to “call the police officer over here on me, hit me with a brown belt on my butt, Rose, is his wife, he broke my glasses, happened here in this house.” Resident A stated staff, LaDrea saw what happened and she said to “stop fighting with pawpaw.” Resident A stated Mr. Thornton, while still calling him pawpaw, “dragged him on the floor and I fought with him.” Resident A told Ms. Mater and I this all happened “yesterday”, and he does not know what they were fighting about. Resident A then reported he also got into a fight with “Victor” (another resident) who is “taller than me and is a black guy.” Resident A stated he sustained two black eyes and was hit twice in the back and in the eyes with a belt. Resident A pulled up his shirt to show Ms. Mater and I where he was struck on his back, but I did not observe any marks or injuries on Resident A’s back. Resident A saw staff pull up in the driveway and stated it was LaDrea and he wanted us to talk to her because she could tell us what happened. Resident A was becoming increasingly physically and verbally aggressive while Ms. Mater and I were interviewing him in his room. Resident A’s behaviors continued, he stayed in his room, but we could hear him yelling and throwing things around in his room for the duration of the time we were at the facility.

On 05/12/2023, Ms. Mater and I interviewed Direct Care Worker (DCW) LaDrea Lewis at the facility. Present during the interview was DCW, Dwight Quinn and home manager, D’Erika Woods. Ms. Lewis stated the first incident involving Resident A using his belt occurred on 05/07/2023 and another incident involving Resident A’s belt occurred on 05/9/2023. Ms. Lewis stated on 05/07/2023, she was getting residents ready for an outing when Resident A began “cussing and fussing” about

things. He took his belt off and began swinging the belt around. Ms. Lewis stated she got the other five residents together and got them out of the house and Mr. Thornton, who they call “pops,” was outside the facility and saw Resident A swinging the belt and came in to try and reason and de-escalate the situation with Resident A. Ms. Lewis stated Resident A was punching, kicking, and swinging the belt at Mr. Thornton. Ms. Lewis stated Mr. Thornton attempted to reason with Resident A saying, “we aren’t going to do this (Resident A)” but Resident A was punching, kicking, and hitting Mr. Thornton. Ms. Lewis stated Mr. Thornton held Resident A’s arms because he had the end of the belt in his hand and was swinging it so the belt buckle was at the hitting end. Ms. Lewis stated she did not see Mr. Thornton strike or harm Resident A; she only saw Mr. Thornton trying to defend himself and diffuse the escalated situation. Ms. Lewis and Ms. Woods stated Resident A did not go to the hospital on 05/07/2023 and 9-1-1 was not called. Ms. Woods and Ms. Lewis stated after an incident on 05/09/2023 when Resident A struck Resident B, they called 9-1-1 and sent Resident A out for evaluation and treatment and Resident A was returned to the facility. Ms. Woods stated they have been working with case manager Carly Campbell through Health West and last met on 05/02/2023 regarding updates to Resident A’s behavior treatment plan. Ms. Woods stated at that time, Resident A was being verbally aggressive, not physically aggressive, but things have progressed since then. Mr. Quinn stated he was not present during either incident or did he see what occurred, but that Resident A’s increasing violent behaviors are difficult for staff to handle. During the interviews with staff, Resident B and I were seated at the table in the common area when a large, three ring binder was thrown by Resident A towards us and landed on the table knocking over a glass of water. Ms. Woods called the Health West crisis team and requested they come out due to Resident A’s escalating behaviors. Ms. Woods stated she attempted to give Resident A a PRN (as needed) medication, to calm him, but he refused.

On 05/12/2023, I interviewed Mr. John Thornton at the house next door to the facility. Mr. Thornton is the Licensee Designee however, since he is 81 years old, his daughter Kaja Hunter oversees the daily operation of the facility but was not present when this incident occurred. Mr. Thornton stated he was outside the facility in the yard when he saw Resident A through the window swinging something. Mr. Thornton stated he thought Resident A was hitting Ms. Lewis’s small son who was at the facility at the time, so he went into the facility to intervene while Ms. Lewis got all the residents out. Mr. Thornton stated Resident A has been living in this facility since 1993-1994 and he has experience in reasoning with Resident A. Mr. Thornton stated because he is of advanced age and Resident A is much younger, he knew Resident A could easily overpower him. As a result, he (Mr. Thornton) was trying to hold Resident A’s arms to prevent him from swinging the belt and hitting him. Mr. Thornton stated Resident A was hitting and kicking him and they fell onto the couch. As this occurred, Mr. Thornton stated he was trying to reason with Resident A as he always did throughout the years that he has known him. Mr. Thornton stated Resident A’s glasses broke in the tussle and Resident A’s eye injury occurred from his glasses hitting his cheekbone. Mr. Thornton stated he accidentally hit Resident A on the left side of his face while defending himself from Resident A swinging the belt,

hitting, kicking, and punching at him. Mr. Thornton stated this could be what caused Resident A's left eye injury. Mr. Thornton stated Resident A was "out of control, swinging the belt around, hitting and kicking him" and as a result, he (Mr. Thornton) was in "defensive mode". Mr. Thornton reported that he has had training in physical intervention through Health West, but it was a long time ago.

I walked back to the facility with another direct care staff, Serinus "Mooney" Daniels, who stated Resident A's behaviors have escalated to the point where it is difficult for staff to handle him with redirection techniques. Once back at the facility, the Health West crisis team was no longer there, and Ms. Woods had called 9-1-1 and requested the police come out and transport Resident A to the hospital again as directed by Health West. The police arrived while I was at the facility and went to Resident A's room. Resident A was still highly agitated, yelling loudly and throwing things around his room. Resident A was transported to the hospital.

On 05/15/2023, I reviewed the Incident Reports (IR's) dated 05/07/2023 and 05/09/2023. The IR dated 05/07/2023 was written by Ms. Lewis and signed by Ms. Woods. The IR documented the following information, *'Staff was assisting another resident to prepare for an outing, (Resident A) was becoming aggravated using verbal and physical aggression (cussing & punching furniture). Staff let (Resident A) know that if he continued this behavior, he would not be able to participate in the outing and would have to go next door with the other staff support. (Resident A) proceeded to take off his belt and began swinging while cursing. Staff asked (Resident A) to calm down, during the situation Mr. Thornton noticed (Resident A's) behavior and came over and asked (Resident A) calmly what was going on and who was he upset with. (Resident A) ran towards Mr. Thornton and started to aggressively hit him with the belt as well as throwing punches and kicking Mr. Thornton. Staff proceeded to remove other residents to a safe space which was next door. Mr. Thornton is the previous owner of JBC Home where (Resident A) resides and has a long-standing relationship with (Resident A), so he also helps and provides support with (Resident A). After 30 minutes Mr. Thornton was able to calm (Resident A) down and talk with him, but (Resident A) decided to continuously physical punch & kick him (Mr. Thornton). Other staff came to help assist with deescalating the situation. (Resident A) refused to calm down and continued being physically and verbally abusive. (Resident A) went in his room and began to throw the furniture and his belongings along with his roommates. PRN was given after 20 mins of (Resident A) sitting and he stayed in his room the remainder of the day. The altercation lasted from 11:30am – 12:45pm. (Resident A's) eyeglasses broke during the incident which he has a cut under his right eye and bruised knuckles. ACTION TAKEN BY STAFF: Removing other residents to safe place, verbally gave him guidance to try and reach a calm mood. Gave him his space when needed. Gave a PRN. Staff also cleaned up his face and bruises. Home manager notified MD's Support Coordinator, Behavioral Specialist regarding the incident. Home manager will be implementing a safety protocol in the home, consult with (Resident A's) team of support on ways to help with de-escalation for (Resident A).'*

The IR dated 05/09/2023 was written by Ms. Lewis and signed by Mr. Serinus Daniels. The IR documented the following information, *'Staff was sitting and heard (Resident B) yelling "stop hitting me (Resident A)." When staff walked in the room (Resident A) was hitting (Resident B) with a belt in the head. Staff removed (Resident B), (Resident A) started yelling and cussing at staff. Upon arrival, another staff noticed the situation and stepped in to support. Staff was advised to remove weapon. Removed weapon (belt), gave PRN, called 911, removed roommate (Resident B), completed IR, communicated with supports coordinator and nurse. Home manager/staff implemented safety protocol by calling 911, continue to work with team to find a solution to (Resident A's) continuous behaviors.'* Resident A was transported to the hospital.

On 06/07/2023, I conducted an exit conference with Licensee Designee, John Thornton via telephone. Mr. Thornton stated he would like to have his daughter, Kaja Thornton-Hunter file an application for a new small group home license and close his existing license. Mr. Thornton stated he will get this started so it can be accomplished as soon as possible. Mr. Thornton stated he will submit an acceptable corrective action plan addressing the established violation.

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:	The complainant reported that Resident A has two black eyes and Resident A stated, "Papa" hit him and broke his glasses. Ms. Mater stated she saw Resident A with two black eyes and Resident A told her that "pawpaw" did it, but Resident A did not explain to her who pawpaw was. Resident A reported that paw paw hit him causing the black eyes and stated paw paw is Licensee, John Thornton. Ms. Lewis, Ms. Woods, Mr. Quinn, and Mr. Daniels reported they were not in the facility when Resident A sustained two contusions, but it occurred when Mr. Thornton intervened as Resident A was swinging a belt at staff and residents. Mr. Thornton stated Resident A was swinging a belt at staff and other residents and when he intervened, he and Resident A tussled. Resident A sustained a black eye on the left side and a contusion on the corner of the right eye from his glasses

	breaking. Mr. Thornton acknowledged that while attempting to physically manage Resident A and protect himself from being injured, he accidentally hit Resident A on the left side of his face. An IR dated 05/07/2023 documents Resident A swinging a belt and attempting to hit staff and residents and a second IR dated 05/09/2023 documented Resident A hitting Resident B with a belt. Based on investigative findings, Resident A's protection and safety were not attended to on 05/07/2023 and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain the same.

06/07/2023

Elizabeth Elliott — Date
Licensing Consultant

Approved By:

06/07/2023

Jerry Hendrick — Date
Area Manager