



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

June 30, 2023

Karmen Ball  
Hernandez Home LLC  
P.O. Box 277  
Bloomingtondale, MI 49026

RE: License #: AS800327951  
Investigation #: 2023A1031046  
Paulson Home

Dear Ms. Ball:

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 (616) 356-0183.

Sincerely,  
Kristy Duda, Licensing Consultant  
Bureau of Community and Health Systems  
Unit 13, 7th Floor  
350 Ottawa, N.W.  
Grand Rapids, MI 49503

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS800327951
<b>Investigation #:</b>	2023A1031046
<b>Complaint Receipt Date:</b>	06/06/2023
<b>Investigation Initiation Date:</b>	06/06/2023
<b>Report Due Date:</b>	08/05/2023
<b>Licensee Name:</b>	Hernandez Home LLC
<b>Licensee Address:</b>	44409 Baseline Road Bloomingtondale, MI 49026
<b>Licensee Telephone #:</b>	(269) 521-4130
<b>Licensee Designee/Administrator:</b>	Karmen Ball
<b>Name of Facility:</b>	Paulson Home
<b>Facility Address:</b>	27425 29th Street Gobles, MI 49055
<b>Facility Telephone #:</b>	(269) 628-4830
<b>Original Issuance Date:</b>	09/11/2012
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/08/2023
<b>Expiration Date:</b>	03/07/2025
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Staff did not treat Resident A with dignity.	Yes
Additional Findings	Yes

**III. METHODOLOGY**

06/06/2023	Special Investigation Intake 2023A1031046
06/06/2023	Special Investigation Initiated – Telephone Interview held with ORR Director Candice Kinzler.
06/13/2023	Contact - Telephone Interview with Marian Smith.
06/13/2023	Inspection Completed On-site
06/13/2023	Contact - Face to Face Interviews held with Resident A, Resident B, Abriannah Lindsey, and Constance Pierce.
06/15/2023	Contact - Telephone Interview with Candice Kinzler.
06/21/2023	Contact – Documents Requested.
06/30/2023	Exit Conference held with Licensee Designee Karmen Ball.

**ALLEGATION:**

**Staff did not treat Resident A with dignity.**

**INVESTIGATION:**

On 6/6/23, I received a telephone call from Van Buren Recipient Rights Director Candice Kinzler. Ms. Kinzler reported she was informed by Resident A’s case manager Marian Smith that she was on the phone with Resident A when she heard a staff yell and talk inappropriately to Resident A.

On 6/13/23, Ms. Kinzler and I interviewed Resident A’s case manager Marian Smith via telephone. Ms. Smith reported she heard a staff named “Bree” become verbally aggressive with Resident A. Ms. Smith reported “Bree” used a “rude tone” and was

“nasty” to Resident A. Ms. Smith reported Resident A and “Bree” were arguing back and forth and Resident A reported to her that staff was cussing at him.

On 6/13/23, Ms. Kinzler and I interviewed direct care worker Abrianna Lindsey in the home. Ms. Lindsey reported she goes by the nickname “Bree”. Ms. Lindsey admitted to raising her voice and cussing at Resident A. Ms. Lindsey acknowledged that she spoke to Resident A louder than she should have. Ms. Lindsey described her personality as being blunt and straight forward which could be misunderstood by others. Ms. Lindsey reported she was upset with Resident A because he stole her underwear out of her personal vehicle. Ms. Lindsey reported she was also upset with Resident A because he did not take responsibility for his actions when confronted about taking her underwear. Ms. Lindsey reported on multiple occasions that Resident A engages in “disgusting behaviors” and spoke negatively about him. Ms. Lindsey acknowledged that she should not have yelled at Resident A. Ms. Lindsey reported the home manager Constance Pierce was present when she and Resident A got into the argument. Ms. Lindsey reported Ms. Pierce did not intervene or have a conversation with her about how she treated Resident A. Ms. Lindsey reported she recently was spoken to by the licensee designee Karmen Ball about this incident. Ms. Lindsey reported she had a meeting with Ms. Ball, and they discussed her behaviors involving cursing and not engaging appropriately with Resident A. Ms. Lindsey reported she completed a recipient rights refresher training due to the incident with Resident A. Ms. Lindsey reported she has taken away community outings such as going to a restaurant for dinner when residents are not behaving appropriately. Ms. Lindsey reported she felt negative behaviors should not be rewarded and residents did not deserve to go out to dinner because it was “embarrassing” taking them out if they are not behaving well.

On 6/13/23, Ms. Kinzler and I interviewed Resident A in the home. Resident A reported he came home, and Ms. Lindsey had gone through his room without his permission. Resident A reported Ms. Lindsey “got in my face” because she went through his phone found and “inappropriate stuff”. Resident A reported Ms. Lindsey told him that he does not need to “do that stuff” because his phone can get taken away. Resident A reported he contacted his case manager Ms. Smith to tell her about what was happening because Ms. Lindsey was cursing at him and threatening him. Resident A reported he feels targeted by Ms. Lindsey because she does not treat him well.

On 6/13/23, Ms. Kinzler and I interviewed home manager Constance Pierce in the home. Ms. Pierce reported there was one occasion where she witnessed Ms. Lindsey cuss and yell at Resident A. Ms. Pierce reported she could not recall exactly what Ms. Lindsey said due to being on a telephone call. Ms. Pierce acknowledged that she would never speak to Resident A in the manner that Ms. Lindsey did. Ms. Pierce reported Ms. Lindsey was upset with Resident A for stealing her underwear out of her car. Ms. Pierce reported she did not address or discuss Ms. Lindsey’s inappropriate behaviors Ms. Pierce reported she did tell Resident A and Ms. Lindsey to stop arguing and told to go into different areas of the house.

On 6/15/23, I received a telephone call from Ms. Kinzler. Ms. Kinzler reported Resident A contacted her to inform her that Ms. Lindsey had confronted him about reporting his concerns. Resident A informed Ms. Kinzler that Ms. Lindsey said she is done with him, wants nothing to do with him, and she's done being nice and talking to him. Ms. Kinzler reported she spoke with Ms. Pierce and Ms. Pierce confirmed that Ms. Lindsey did go to Resident A's bedroom after recipient rights and licensing left the home. Ms. Pierce was not able to provide details about what was discussed between Ms. Lindsey and Resident A. Ms. Kinzler reported she asked to talk with Ms. Lindsey and Ms. Pierce provided Ms. Lindsey with the telephone. Ms. Lindsey reported she did go to Resident A's bedroom and told him that if he had any concerns that he is to go to Ms. Pierce and not her anymore. Ms. Lindsey reported that it upset her when Resident A "went behind her back and called recipient rights". Ms. Lindsey reported "I depend on this job, and I don't get a free ride like [Resident A] does". Ms. Lindsey reported she will no longer be left alone with Resident A will only provide the basic needs Resident A requires such as providing food and medications.

<b>APPLICABLE RULE</b>	
<b>R 400.14305</b>	<b>Resident protection.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	Based on interviews completed with staff, Resident A, and recipient rights, it has been determined that Resident A was not treated with dignity. Ms. Lindsey admitted to yelling at Resident A when she was upset about his behaviors. Ms. Pierce reported she witnessed Ms. Lindsey mistreat Resident A and had to intervene to stop the argument between the two of them. Ms. Lindsey also reported she confronted Resident A about sharing his concerns regarding how she was treating him and will only meet his basic needs in the home. Ms. Lindsey appears to lack the ability to manage her own emotions and does not have a clear understanding on how to appropriately treat residents when they demonstrate behaviors.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On 6/13/23, Ms. Kinzler and I had an in-depth conversation with Ms. Lindsey regarding treating residents in the home with dignity and respect as well as residents' rights. Ms. Lindsey was reminded that individuals that reside in AFC homes require different needs and all exhibit different behaviors. Ms. Lindsey was reminded to not take these behaviors personally as residents reside in the home due to their additional behaviors and needs. Ms. Lindsey was informed that residents cannot be punished or treated as children and have outings taken away. Ms. Lindsey appeared to be receptive to the conversation and acknowledged an understanding of resident rights and treating them with dignity and respect.

Ms. Lindsey reported she recently completed a recipient rights training following the incident that occurred with Resident A. Ms. Lindsey was not able to explain what she learned from the training she received regarding treating residents with dignity and respect. Ms. Lindsey reported that she takes away privileges for residents when she feels their behavior does not deserve to be rewarded.

Ms. Lindsey admitted to Ms. Kinzler that she did go to Resident A's bedroom and confront him about his concerns following the interview held with recipient rights and licensing. Ms. Lindsey reported she was upset with Resident A because he went behind her back and talked with recipient rights. Ms. Lindsey also reported that she depends on the job and does not get a free ride like Resident A does. Ms. Kinzler reported Ms. Pierce confirmed that Ms. Lindsey had went to Resident A's bedroom but was not able to provide details on what was discussed.

APPLICABLE RULE	
R 400.14204	<b>Direct care staff; qualifications and training.</b>
	<b>(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas:</b>  <b>(e) Resident rights.</b>
<b>ANALYSIS:</b>	Based on Ms. Lindsey's statements and behaviors, it has been determined that she lacks an understanding of resident rights and has not benefited from recipient rights training. Ms. Lindsey was not able to provide relevant information about what she learned from the recipient rights training she received. Ms. Lindsey continued to mistreat Resident A despite receiving training, having a conversation about her behavior with the

	licensee designee, and being informed by licensing and recipient rights of appropriate ways to treat residents in the home. Ms. Lindsey immediately confronted Resident A and made inappropriate statements directly following an interview and discussion held with her about the same concerns.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

6/22/23

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Kristy Duda  
Licensing Consultant

Date

Approved By:

6/23/23

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Russell B. Misiak  
Area Manager

Date