STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

July 31, 2023

Neiman Byerly
Byerly Enterprises, LLC
4759 Owasco Ct.
Clarkston, MI 48348

RE: License #: AM630397532
Investigation #: 2023A0991021
Hidden Acres Manor

Dear Mr. Byerly:

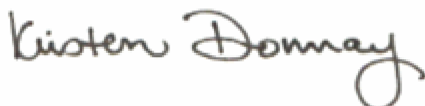
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM630397532
Investigation #:	2023A0991021
Complaint Receipt Date:	05/02/2023
Investigation Initiation Date:	05/02/2023
Report Due Date:	07/01/2023
Licensee Name:	Byerly Enterprises, LLC
Licensee Address:	4759 Owasco Ct. Clarkston, MI 48348
Licensee Telephone #:	(810) 691-6400
Licensee Designee:	Neiman Byerly
Name of Facility:	Hidden Acres Manor
Facility Address:	8616 Hidden Acre Court Clarkston, MI 48348
Facility Telephone #:	(248) 241-6507
Original Issuance Date:	08/07/2019
License Status:	REGULAR
Effective Date:	02/07/2022
Expiration Date:	02/06/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A came to his adult program with a black eye and scratches on his arm.	Yes

III. METHODOLOGY

05/02/2023	Special Investigation Intake 2023A0991021
05/02/2023	APS Referral Received from Adult Protective Services (APS) - denied for investigation
05/02/2023	Special Investigation Initiated - Telephone Call to school social worker
05/02/2023	Contact - Document Received Pictures of injuries
05/02/2023	Referral - Recipient Rights Referred to Office of Recipient Rights (ORR)
05/03/2023	Inspection Completed On-site Unannounced onsite inspection- interviewed residents and staff
05/04/2023	Inspection Completed On-site Unannounced onsite inspection- interviewed staff and Resident B
05/04/2023	Contact - Document Received Copy of plan of service, behavior logs, medical documentation
06/23/2023	Exit Conference Via telephone with licensee designee, Neiman Byerly

ALLEGATION:

Resident A came to his adult program with a black eye and scratches on his arm.

INVESTIGATION:

On 05/02/23, I received a complaint from Adult Protective Services (APS) alleging that Resident A went to school on 05/01/23 and had a black eye and scratches on his arm. There was no communication from the group home regarding what occurred. School personnel followed up with the group home and they expressed that Resident A physically aggressed towards a staff member and the group home property. They stated that the bruising must have occurred while he was being aggressive and swinging at staff. APS denied the complaint for investigation. I referred the complaint to the Office of Recipient Rights (ORR) on 05/02/23. I initiated my investigation on 05/02/23 by contacting the school social worker with the Clarkston Adult Transition Program, Jena Menges.

Ms. Menges stated that Resident A is non-verbal and sometimes uses a device to communicate. She stated that this is the second or third time that Resident A came to school with marks on him. There was a previous incident that was investigated in November 2022. Following that investigation, the group home agreed to communicate with the school if there were any unusual incidents or if Resident A had any marks on his body. Ms. Menges stated that the staff at the group home failed to communicate with the school regarding what happened to him on 05/01/23. Resident A had marks on his left arm and bruising around his eye. He was wearing a collared shirt on 05/01/23, but on 05/02/23 they observed that he also had marks on his neck. She stated that Resident A’s transition coordinator contacted the group home to find out what happened. The transition coordinator felt the staff downplayed what happened and provided a very vague explanation, stating that Resident A was upset and being aggressive, and implying that he might have hit himself. Ms. Menges stated that Resident A could not tell anyone what happened. He only pointed and gestured towards his eye. Resident A has never aggressed towards staff or peers in the school setting. She stated that staff may not be protecting Resident A from other aggressive adults in the home.

On 05/03/23, I conducted an unannounced onsite inspection at Hidden Acres Manor. I interviewed direct care worker, Tashona Robinson. Ms. Robinson stated that she was not working over the weekend when the incident with Resident A happened. She was told by staff that Resident A was pointing at his tablet saying “people.” Staff did not know what that meant and Resident A became agitated and attacked staff. Ms. Robinson stated that “people” is a trigger word and means that Resident A will start attacking. She stated that if Resident A gets agitated, they usually tell him to go get in the shower, as this calms him down. He will stay in the shower for up to 30 minutes and then staff give him a snack. Ms. Robinson stated that some of the newer staff do not know how to appropriately address Resident A’s behaviors. Ms. Robinson stated that Steven Redmond and Sherry McLean were the staff on shift when the incident happened. She has never seen them being aggressive towards any of the residents in the home. Ms. Robinson stated that the home manager is responsible for notifying the school if something happens at the home.

On 05/03/23, I interviewed direct care worker, Steven Redmond. Mr. Redmond stated that he has worked in the home since February 2023 and is fully trained. He stated that he was working in the morning on 04/30/23 when the incident with Resident A happened. Mr. Redmond was upstairs and direct care worker, Sherry McLean, was covering downstairs. Resident A showed Ms. McLean his tablet and said, “people.” Ms. McLean was not sure what that meant. Resident A got upset and started to punch her. Ms. McLean was “just taking it.” Mr. Redmond stepped in between Resident A and Ms. McLean and Resident A reached out for him and was trying to head butt him. Mr. Redmond was trying to redirect Resident A to his bedroom. Resident B then came into the room. Mr. Redmond stated that he could not recall exactly what happened, but Resident B had Resident A in a head lock or chokehold with his arm around Resident A’s neck. Mr. Redmond was trying to use his body position to break up Resident A and Resident B. Mr. Redmond stated that Ms. McLean was in the chair in the living room while this was happening. Resident D and Resident E were in the living room, but they are both nonverbal. No other residents observed what happened. Mr. Redmond stated that this was the first time Resident A had a behavior since he has been in the home. His behavior escalates if staff do not do what he wants to do right away. Mr. Redmond stated that he is not sure what Resident A’s plan says with regards to behavior management or whether or not staff can physically manage the residents. Mr. Redmond stated that Resident B is higher functioning and sometimes feels like he has to protect staff, which is why Resident B intervened.

On 05/03/23, I observed Resident A. He had bruising on his arm, neck, and around his left eye. I attempted to interview Resident A, but Resident A has limited verbal abilities. He pointed to his black eye and said “eye.” I tried to ask Resident A questions by typing on his computer, but he only responded, “eye black” and could not provide any information regarding how the injury occurred. Resident A was fixated on going to Target to buy quarters and did not engage in any other questions.

On 05/03/23, I attempted to interview Resident B, but he refused to participate in an interview.

On 05/03/23, I interviewed Resident C. Resident C stated that he did not see anything happen between Resident A and staff or any other resident. He stated that staff treat the residents well. He never saw any of the other residents fighting each other. He stated that he does not pay attention to what anyone else is doing.

On 05/04/23, I conducted an unannounced onsite inspection at Hidden Acres Manor. I interviewed direct care worker, Sherry McLean. Ms. McLean stated that she has worked at the facility for one month. On 04/30/23, Resident A brought out his tablet and kept saying “people.” Ms. McLean stated that she did not understand what that meant. Resident B was downstairs and told her that it was a warning that meant Resident A was going to go after staff. Resident A came out of his room and pushed her from behind, slamming her against the wall. She had him go to his room, where he was playing on his laptop. When he came out of his room, Ms. McLean was sitting in a chair

in the living room. Resident A reached out his hand and pushed her shoulder and chest really hard. She went to get up and Resident A began hitting her with an open hand and closed fist. He tried to head butt her, and she was blocking him with her arms. Ms. McLean stated that staff, Steven Redmond, and Resident B came downstairs. They pulled Resident A from her. Resident A started charging at Mr. Redmond and Resident B. They were trying to redirect him to his room and were attempting to restrain him. Ms. McLean stated that she was freaked out and stayed in the kitchen, so she did not see what happened during the altercation. She stated that she was not sure how Resident A got the black eye, it just happened during the struggles. Ms. McLean stated that Resident A eventually calmed down, took a shower, and received a PRN. Ms. McLean stated that she did not see Resident A and Resident B fighting, but Resident B was trying to keep Resident A from coming at her. She stated that Resident A was "like a bull" charging at her. She could not recall what his plan of service stated regarding behavior management and was unsure if staff could physically restrain Resident A. She stated that Mr. Redmond was holding Resident A back to stop him from attacking her. Ms. McLean stated that no other residents saw the altercation. Mr. Redmond called the home manager to report what happened. Ms. McLean stated that Resident A and Resident B typically get along. Resident A also gets along with Mr. Redmond. She never saw Mr. Redmond being physically aggressive towards any residents.

On 05/04/23, I interviewed Resident B. Resident B stated that he recalled the incident when Resident A went after staff, Sherry McLean. He stated that Resident A was swinging at staff and then later came after him. He pushed Resident A back in self-defense. Resident B stated that Resident A fell and hit his face. They were downstairs in the living room when this happened. He did not see staff hit Resident A. He stated, "staff can't hit residents." Resident B stated that he never put Resident A in a chokehold or put his hands on his neck. He stated that he put him a personal restraint by holding his wrists in a bear hug style restraint. Resident B stated that staff, Steven Redmond, was in the back room doing laundry when Sherry McLean called for help. Resident B restrained Resident A until Mr. Redmond came in and took over. Resident B then stated that he was focused on Ms. McLean and did not push Resident A.

On 05/04/23, I interviewed direct care worker, Caroline Rowland. Ms. Rowland stated that she has worked in the home for two months. She was not working on the day of the incident with Resident A. She stated that she came into work and saw that Resident A had a black eye. He could not tell her what happened. Ms. Rowland stated that Resident A gets fixated on things. If staff are too busy, they tell him to be patient. "People" means Resident A is irritated and that he is just irritated with everybody. Ms. Rowland stated that she never saw staff put their hands on Resident A. Ms. Rowland stated that she was not sure if there was a behavior plan in place for Resident A. She stated that she never observed him having a behavior. Ms. Rowland stated that Resident A and Resident B typically get along. Resident B sometimes acts like he is a staff person and puts himself in that mindset when things get chaotic in the home.

I reviewed a copy of an incident report dated 04/30/23. It notes that early in the morning around 10:00am, Resident A walked up to staff saying “people.” After Resident A said “people” a few times, he proceeded to walk up to staff shoving and hitting. Another staff and peer helped. In the process, Resident A was hit in the eye by his peer, causing it to be black and blue. Staff from both floors broke it up and redirected both residents away from each other. Both residents and staff were monitored for health and safety. Resident A was talked to urgent care on 05/01/23. An x-ray showed no broken bones or dislocation of the eye socket.

I reviewed a copy of the discharge instructions from McLaren Clarkston Emergency Department from 05/01/23. The document notes that Resident A was diagnosed with a periorbital contusion of the left eye, or deep bruising around the eye.

I reviewed a copy of Resident A’s individual plan of service dated 09/09/2022. It notes that Resident A has a goal of decreasing physical aggression in the home and at school to no more than one episode per month for six consecutive months. Home staff will monitor Resident A for signs that he is getting frustrated or upset. If signs appear, they will offer distraction or redirection to another activity (he prefers a snack or shower). If the environment is too stimulating, Resident A should be offered the opportunity to go to an area he feels safe, such as his room, and be allowed some time in the safe area to calm himself. Staff should offer praise when Resident A is able to calm himself or accept an alternative activity. Staff should document incidents as they occur and provide ABC (antecedent, behavior, consequence) data regarding the incident. Indications that Resident A is frustrated or agitated include shaking, clenching teeth, facial grimacing, balling his fists, heavy breathing, holding his ears tight to his head, and yelping.

On 06/23/23, I conducted an exit conference via telephone with the licensee designee, Neiman Byerly. Mr. Byerly stated that he would submit a corrective action plan to address the violations identified during the investigation and that staff would be trained regarding appropriate behavior interventions for Resident A.

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 on the information gathered through my investigation, there is sufficient information to conclude that staff did not ensure Resident A’s protection and safety on 04/30/23 when he

	was having a behavior and being physically aggressive towards staff. Resident A sustained a contusion to his left eye and had marks and bruises on his arm and neck. Staff did not protect Resident A from Resident B who intervened during the altercation and restrained Resident A. Staff could not provide a clear explanation as to how the injuries occurred, stating that they must have been sustained "during the struggles."
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report Dated: 01/11/2023; CAP Dated 01/24/23**

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:	Based on the information gathered through my investigation, there is sufficient information to conclude that the interventions used to address Resident A's behavior did not ensure his safety and welfare were adequately protected. Resident A sustained injuries to his eye, arm, and neck following an incident in which he was being physically aggressive towards staff. Staff were unable to deescalate the situation and Resident B intervened during the altercation putting Resident A in a chokehold or restraint. During my interviews with direct care workers, Steven Redmond, Sherry McLean, and Caroline Rowland, staff did not know if Resident A had a behavior plan in place or what his plan of service stated regarding how to manage his unacceptable behaviors including whether or not physical restraint could be used.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

06/23/23

____

Kristen Donnay Date
Licensing Consultant

Approved By:

07/31/2023

____

Denise Y. Nunn Date
Area Manager