GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 4, 2023

Stephen Williams
Unique Care Group Home Inc.
7102 Veronica St.
Kalamazoo, MI 49009

RE: License #: AS130393099
Investigation #: 2023A0581045
Unique Care Group Home

Dear Mr. Williams:

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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS130393099
Investigation #:	2023A0581045
Complaint Receipt Date:	07/17/2023
Investigation Initiation Date:	07/17/2023
Report Due Date:	09/15/2023
Name:	Unique Care Group Home Inc.
Address:	7102 Veronica St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 753-4494
Administrator:	Stephen Williams
Licensee Designee:	Stephen Williams
Name of Facility:	Unique Care Group Home
Facility Address:	254 Central St Battle Creek, MI 49017
Facility Telephone #:	(269) 753-4494
Original Issuance Date:	01/02/2019
License Status:	REGULAR
Effective Date:	07/02/2023
Expiration Date:	07/01/2025
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
A direct care staff pushed a male resident down the facility stairs.	No
Additional Findings	Yes

III. METHODOLOGY

07/17/2023	Special Investigation Intake 2023A0581045
07/17/2023	APS Referral APS received the allegations but denied investigating.
07/17/2023	Special Investigation Initiated - Telephone Interviewed Complainant.
07/18/2023	Contact - Telephone call made Left voicemail with Relative A1
07/18/2023	Contact - Face to Face Interview with Resident A.
07/18/2023	Inspection Completed On-site Interview with staff and residents.
07/18/2023	Contact - Telephone call received Interview with Relative A1
07/18/2023	Contact - Document Received Email from licensee designee
07/19/2023	Contact - Telephone call made Left message with licensee designee.
07/19/2023	Exit Conference with licensee designee, Stephen Williams.
07/19/2023	Contact - Document Sent Email to licensee designee
07/21/2023	Contact – Document Received Email from licensee designee.
07/31/2023	Inspection Completed-BCAL Sub. Compliance
08/01/2023	Contact – Telephone call made

	Attempted to contact Guardian B1; however, the voicemail box was full. Unable to leave a message.

ALLEGATION:

A direct care staff pushed a male resident down the facility stairs.

INVESTIGATION:

On 07/17/2023, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged Resident A, who has a diagnosis of schizoaffective disorder and chronic obstructive pulmonary disease (COPD), observed a direct care staff, Feley [Unknown], push an unknown male resident down the facility stairs. No additional information was provided in the complaint such as when the alleged incident occurred. The complaint also indicated Resident A was her own guardian and was currently hospitalized due to a mental health crisis.

On 07/17/2023, I interviewed Complainant. Complainant stated Resident A had been residing at the facility since approximately January 2020 after being released from a psychiatric facility. Complainant stated on or around 07/12/2023, Resident A was admitted to a local psychiatric hospital because she was experiencing delusions and psychosis and was expressing homicidal and suicidal ideation. Complainant stated Resident A's relative, Relative A1, has not reported any concerns regarding the facility, the facility's staff or the care which Resident A had received.

On 07/18/2023, I interviewed Resident A face-to-face at the inpatient psychiatric facility. Resident A appeared to be oriented to place and time as she was aware of the date and the day of the week. Resident A stated she "got sick" and was admitted to the psychiatric hospital on or around 07/05/2023. She stated she was not feeling better since being admitted.

Resident A identified the other residents at the facility as Resident B, Resident C, and Resident D. She stated Resident B was currently hospitalized; therefore, he wasn't in the facility at the time she was admitted to the psychiatric hospital. Resident A stated she'd lived in the facility for approximately three years. Resident A stated she couldn't recall the specific or even approximate date, but believed it was over two years ago when she observed direct care staff, Feley [Unknown], push Resident B down six steps within the facility. Resident A stated the facility was a tri level and the stairs in which he was pushed were from the middle of the home to the basement. Resident A stated Resident B was not hurt from the incident. She stated she couldn't recall where on Resident B's body he had been pushed, if direct care staff, Feley [Unknown] said anything to Resident B when the incident was occurring or if anyone else was around when the incident occurred. She stated Resident B stood back up after being pushed down the stairs.

Resident A was unable to provide any other details or information regarding the incident. Towards the end of my conversation with Resident A she appeared to be experiencing delusions as she was stating there were cameras in the facility's walls.

On 07/18/2023, I conducted an unannounced onsite inspection. I interviewed, Adetoyin Williams, the facility's identified director, direct care staff, and wife of the licensee designee. Ms. Williams was the only direct care staff working at the time of my inspection. She stated direct care staff, Feley Smith, hadn't worked in the facility for approximately two years. She stated she had no concerns with Ms. Smith and any of the residents. She denied being aware of any incidents like Ms. Smith pushing Resident B down the facility stairs. She stated she no longer had contact information for Ms. Smith and it was her understanding Ms. Smith moved out of state.

Ms. Williams stated Resident B wasn't currently in the facility. She stated he was in a hospital out of state for approximately the last two months. Ms. Williams stated Resident B was verbal and vocal and had something like the allegations occurred, she believes Resident B would have reported it to her.

Due to Resident B being in the hospital, I was unable to interview him. I attempted to interview Resident C and Resident D; however, both residents appeared to be experiencing mental confusion. Neither resident knew the date, month, or day of the week; however, both Resident C and Resident D reported they felt safe residing in the facility.

On 07/18/2023, I interviewed Relative A1, via telephone. She reported she was Resident A's Medical Durable Power of Attorney (MDPOA). She stated she visited with Resident A on a weekly basis at the facility. She stated she often spoke to staff, including direct care staff, Ms. Smith. Relative A1 confirmed it had been years since she'd seen Ms. Smith work in the facility. Relative A1 stated she feels confident Resident A would have reported to her any concerns like witnessing a direct care staff physically assault a resident. Relative A1 stated this type of concern was never brought to her attention while Resident A was residing in the facility. Relative A1 stated she didn't have any concerns staff were being physically, verbally, or mentally abusive towards residents.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or

	physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on my interviews with Resident A, Relative A1, Complainant, and direct care staff, Adetoyin Williams, there is no evidence supporting former direct care staff, Feley Smith, pushed Resident B or any other residents, down the facility's stairs, as alleged.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my unannounced inspection, I observed the facility's front door, which was a primary and required means of egress, to have locking against egress hardware on it. The inside door handle had a keypad lock on it and upon trying to turn the door handle, I discovered it wouldn't open unless the correct code was keyed in.

Ms. Williams stated there had been residents in the facility who would walk out the front door and it was a safety concern so the locks were put on. I informed Ms. Williams if the licensee wanted to be a secured setting or have locking hardware then a variance needed to be requested and approved prior to utilizing such hardware.

On 07/19/2023, emailed the licensee designee, Mr. Williams, regarding the locking against egress hardware. I requested he remove all locking against egress hardware and provide picture evidence showing it had been removed and new hardware installed.

On 07/21/2023, Mr. Williams sent me an email containing picture documentation the facility's front door hardware had been replaced with a door handle that no longer had a keypad on it.

APPLICABLE RULE	
R 400.14507	**Means of egress generally.**
	(5) A door that forms a part of a required means of egress shall be not less than 30 inches wide and shall be equipped with positive-latching, non-locking-against-egress hardware.

ANALYSIS:	The facility's front door, which is a primary means of egress, was observed with a keypad lock door handle, which made it locking against egress. On 07/21/2023, the licensee designee, Stephen Williams, provided picture documentation showing the door handle had been removed and replaced with one that had no lock.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/19/2023, I relayed my findings to the licensee designee, Stephen Williams, via email. On 07/21/2023, Mr. Stephens changed the locking against egress hardware on the facility's front door to non-locking against egress hardware.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

Cathy Cushman

08/01/2023

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Cathy Cushman Date
Licensing Consultant

Approved By:

Dawn Timm

08/04/2023

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Dawn N. Timm Date
Area Manager