STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 11, 2023

Robert Fulton Jr.
Fulton Residential Care Corp.
2945 E. Deckerville Road
Caro, MI 48723

RE: License #: AS790250948
Investigation #: 2023A0871061
Circle Drive Home

Dear Robert Fulton Jr.:

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) 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 #:	AS790250948
Investigation #:	2023A0871061
Complaint Receipt Date:	07/26/2023
Investigation Initiation Date:	07/27/2023
Report Due Date:	09/24/2023
Licensee Name:	Fulton Residential Care Corp.
Licensee Address:	2945 E. Deckerville Road Caro, MI 48723
Licensee Telephone #:	(989) 673-3969
Administrator:	Robert Fulton III
Licensee Designee:	Robert Fulton Jr.
Name of Facility:	Circle Drive Home
Facility Address:	1959 Circle Drive Fairgrove, MI 48733
Facility Telephone #:	(989) 693-6632
Original Issuance Date:	09/17/2002
License **Status:**	REGULAR
Effective Date:	04/22/2023
Expiration Date:	04/21/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
It was reported over the weekend that Resident A was being beaten by Staff Trina Carter. Resident A has bruises on his arms, chest, and the back of his left thigh. Resident A also has smaller bruises on his right calf.	No

III. METHODOLOGY

07/26/2023	Special Investigation Intake 2023A0871061
07/26/2023	APS Referral From Tuscola County MDHHS
07/27/2023	Special Investigation Initiated - Letter Received email information from Adult Protective Service Worker Tiffany Polaski
09/01/2023	Inspection Completed On-site Interviewed Staff Autumn Brown, observed Resident A
09/07/2023	Contact - Document Received Received photos of Resident A's bruising from Recipient Rights Officer Syndi Neeb
09/07/2023	Inspection Completed On-site Interviewed Licensee Rick Fulton, Home Manager Becky Oszust, Staff Autumn Brown
09/08/2023	Contact - Telephone call made Telephone call to Guardian A1
09/08/2023	Contact - Telephone call made Telephone call to Staff Karaleah DuRussel
09/08/2023	Contact - Telephone call made Telephone call to Staff Haley Skunda
09/08/2023	Contact - Telephone call made Telephone call to Staff Caspian Thompson

09/08/2023	Contact - Telephone call made Telephone call to Staff Trina Carter
09/08/2023	Contact - Telephone call made Telephone call to Police Chief of Akron, Police Chief Simerson, left voicemail message
09/11/2023	Exit Conference Telephone exit conference with Licensee Rick Fulton
09/11/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:
It was reported over the weekend that Resident A was being beaten by Staff Trina Carter. Resident A has bruises on his arms, chest, and the back of his left thigh. Resident A also has smaller bruises on his right calf.

INVESTIGATION:
On July 27, 2023, Adult Protective Service Worker Tiffany Polaski emailed me that she had visited Resident A the day before and he appears safe. Worker Polaski also indicated she contacted law enforcement that day as well.

On September 1, 2023, I conducted an unannounced onsite investigation and interviewed Staff Autumn Brown. Staff Brown indicated that Recipient Rights Officer Syndi Neeb and Akron Police Chief Simerson both took pictures of Resident A's bruising. Staff Brown stated she did observe a bruise on the back of Resident A's left thigh. Staff Brown indicated on that she also noticed some bruising on both arms. Staff Brown said she has no idea who did this to Resident A. Staff Brown indicated it was unusual for Resident A to have bruising like that. Regarding Staff Trina Carter, Staff Brown stated Staff Trina Carter hurt her back and had been off work for a couple of weeks and just had come back to work. Staff Brown has worked with Staff Carter and has never witnessed her be aggressive with the residents.

On September 1, 2023, I observed Resident A, and he is severely cognitively impaired and unable to be interviewed. No bruising or marks were noted on him, and he appeared to be receiving adequate care.

On September 7, 2023, I Recipient Rights Officer Neeb emailed me pictures of the bruising on Resident A. I observed bruising on the back of Resident A's left bicep, left calf, faint bruising on his upper left chest and right forearm. Resident A also had bruising on the back of his left thigh.

On September 7, 2023, I conducted an onsite investigation and interviewed Licensee Rick Fulton. Licensee Fulton stated Police Chief Simerson is conducting lie detector tests for the staff members that were alleged to have bruised Resident A. Licensee Fulton stated Staff Trina Carter hurt her back on July 9th, 2023, and returned to work on July 21st. Staff Carter worked July 21, 22, and 25th on third shift because she was on restrictions. Licensee Fulton indicated that Chief Simerson is unsure of who bruised Resident A but is still investigating.

On September 7, 2023, Staff Autumn Brown indicated that when Recipient Rights Officer Neeb wanted to interview Staff Karaleah DuRussel, Staff DuRussel went outside and said, “I quit” and was not interviewed. Staff Brown also stated Staff DuRussel also changed her phone number but the facility was able to obtain her new number.

On September 8, 2023, I telephoned Guardian A1. Guardian A1 indicated Resident A “is a good kid but can wear on somebody’s patience.” Guardian A1 stated Resident A “can become annoying and can hoover around you.” Guardian A1 stated Resident A has lived in this facility since 2015 and is getting good care. Guardian A1 likes the home and trusts the staff but would like to know who did this to Resident A.

On September 8, 2023, I telephoned Staff Karaleah DuRussel. Staff DuRussel indicated she no longer works at the facility and said Staff Trina Carter “was really aggressive with [Resident A].” Staff DuRussel said she witnessed Staff Carter “push [Resident A] around and try to keep him from sitting in the chairs.” Staff DuRussel indicated she does not know how Resident A got the bruising and she did not witness anyone bruise him. I asked Staff DuRussel if she took a polygraph test and she said she did but had anxiety and could not finish it.

I telephoned Staff Haley Skunda on September 8, 2023. Staff Kunda indicated a while back, she would see “Kara pinching [Resident A] on the back of his arm and the back of his legs.” Staff Kunda stated another Staff Gage, who no longer works in the home, “threw [Resident A] on the couch.” Staff Kunda said Staff Carter “never did anything to [Resident A].” Staff Kunda did not see anyone hit Resident A and said, “I am not sure where those (bruises) came from.”

On September 8, 2023, I telephoned Staff Caspian Thompson. Staff Thompson said Staff Carter “was never mean to any of the residents.” Staff Thompson indicated Staff Carter would raise her voice but was never physical with the residents. Staff Thompson said she did not witness anyone hit Resident A and does not know how Resident A got the bruises.

I telephoned Staff Trina Carter on September 8, 2023. Staff Carter said she was off work for two weeks and she came back for three days. Staff Carter said Resident A “can be difficult” but denied ever abusing Resident A. Staff Carter indicated Resident A is a fall risk and he does fall a lot. Staff Carter said someone said it was

her that bruised Resident A, but she adamantly denied it. Staff Carter said she has never had a complaint on her and does not know why she is being accused of bruising Resident A. Staff Carter said she has not seen anyone get physical with Resident A and said she did not abuse Resident A.

On September 8, 2023, I telephone Police Chief Matt Simerson and left a voicemail message. On September 11, 2023, Chief Simerson returned my phone call and indicated he is still doing lie detector tests and does not have a definite perpetrator. Chief Simerson stated he will advise me of the results.

On September 11, 2023, I conducted a telephone exit conference with Licensee Fulton. Licensee Fulton was advised a perpetrator could not be identified but someone did leave bruises on Resident A, and this is a rule violation.

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:	Staff Members Karaleah DuRussel, Haley Skunda, Caspian Thompson and Trina Carter all denied abusing Resident A and did not witness anyone abuse him. Resident A had unexplained bruising on parts of his body that indicate someone did physically abuse him. There is substantial evidence to confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

09/11/2023

Kathryn A. Huber — Date
Licensing Consultant

Approved By:

09/11/2023

Mary E. Holton — Date
Area Manager