



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 15, 2023

Donald King
Alternative Community Living, Inc.
P. O. Box 190179
Burton, MI 48519

RE: License #: AS500381453
Investigation #: 2023A0604021
Otter Home

Dear Mr. King:

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,

A handwritten signature in cursive script that reads "Kristine Cilluffo".

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 West Grand Blvd Ste 9-100
Detroit, MI 48202
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500381453
Investigation #:	2023A0604021
Complaint Receipt Date:	05/15/2023
Investigation Initiation Date:	05/16/2023
Report Due Date:	07/14/2023
Licensee Name:	Alternative Community Living, Inc.
Licensee Address:	P. O. Box 190179 Burton, MI 48519
Licensee Telephone #:	(248) 505-1987
Administrator:	Donald King
Licensee Designee:	Donald King
Name of Facility:	Otter Home
Facility Address:	34410 Lillian Chesterfield, MI 48047
Facility Telephone #:	(586) 273-7847
Original Issuance Date:	04/15/2016
License Status:	REGULAR
Effective Date:	10/15/2022
Expiration Date:	10/14/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A has physically abused Resident B and other residents by throwing stuff, hitting and punching them. Home Manager does not do anything about it.	Yes

III. METHODOLOGY

05/15/2023	Special Investigation Intake 2023A0604021
05/15/2023	APS Referral Intake received on 05/15/2023 indicates that Adult Protective Services (APS) referral was denied on 05/13/2023
05/16/2023	Special Investigation Initiated - On Site Completed unannounced onsite investigation. Interviewed Staff, Cherri Robinson, Resident B, Resident C and Resident D.
05/17/2023	Contact - Telephone call received Received message from Home Manager, Dawn Doetsch
05/17/2023	Contact - Document Received Received copies of incident reports from Home Manager, Dawn Doetsch by email.
05/18/2023	Contact - Telephone call made TC to Home Manager, Dawn Doetsch
05/18/2023	Contact - Document Received Received incident report from Otter Home. Resident A sent to hospital
06/28/2023	Contact - Document Sent Email to Dawn Doetsch. Received return email from Ms. Doetsch with Resident A's Individual Plan of Service (IPOS)
07/07/2023	Contact- Document Sent Email to Dawn Doetsch. Received return email.
07/07/2023	Contact- Telephone call made Left message from Macomb County Community Mental Health Case Manager, Tinisha Meadows

09/13/2023	Exit Conference Completed exit conference by phone with licensee designee, Donald King
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ALLEGATION:

Resident A has physically abused Resident B and other residents by throwing stuff, hitting and punching them. Home Manager does not do anything about it.

INVESTIGATION:

I received a licensing complaint regarding the Otter Home on 05/15/2023. It is alleged that Resident B lives at a group home. Resident B has a seizure disorder and is bipolar. Resident A is a resident who also resides in the group home. For an unknown amount of time, Resident A has physically abused Resident B and other residents by throwing stuff, hitting, and punching the residents. Dawn is the group home manager. Dawn does not do anything about it. Dawn is not trying to rectify the issue between the residents. APS referral was denied on 05/13/2023.

On 05/16/2023, I completed an announced onsite investigation. I interviewed Staff, Cherri Robinson, Resident B, Resident C and Resident D.

On 05/16/2023, I interviewed Staff, Cherri Robinson. Ms. Robinson stated that Resident A was currently at job training. She stated that when Resident A gets angry, she does shove, hit and punch. Ms. Robinson stated that Resident A has pushed her before. Ms. Robinson indicated that Resident A is going to therapy to address behavior.

On 05/16/2023, I interviewed Resident B. She stated that Resident A is really aggressive and mean. Resident A is also aggressive towards Resident C. She stated that four months ago she was hit in the mouth. Staff really did not do anything but tried to calm Resident A down. Resident A makes her feel very uncomfortable. If Resident A does not get what she wants she hits. She also pushes people and throws things. Resident B indicated that home is "OK", but she is scared being here because of Resident A's behavior and it is happening more.

On 05/16/2023, I interviewed Resident C. She stated that she has lived at home for three years. Resident C stated that Resident A has hit her in the head and back a couple of times. This occurred a few months back. Resident C stated that Resident A does not keep her distance or personal space. Resident A is easily frustrated and will get mad, throw stuff and hit people. Resident A cannot keep her hands off people and has a very bad temper and tells people off. Resident C stated that staff give Resident A warnings, and Resident A has been sent to the hospital. Resident C stated that she does not always feel safe at home.

On 05/16/2023, I attempted to interview Resident D. Resident D stated that no one is hitting her.

On 05/18/2023, I interviewed Home Manager, Dawn Doetsch, by phone. She stated that Resident A has hit and kicked people. They are trying to get her assigned a behaviorist. Ms. Doetsch stated that Resident A's case manager and psychiatrist are aware of her behavior. Resident A has refused any medication increases and changes. Ms. Doetsch indicated that Resident A's plan of services indicates that staff are to use redirection. Staff can also call police and then police decide what to do regarding situation.

On 05/18/2023, I received an incident report from Home Manager, Dawn Doetsch. On 05/16/2023, Resident A kicked another resident in upper right thigh. The resident called police and police stated to petition Resident A to hospital. Resident A was taken by ambulance to McLaren Macomb Hospital. Incident report indicates that staff will continue to inform psychiatrist and case manager of aggressive behaviors. Resident A is also still on waiting list for a behaviorist.

On 05/17/2023, I received incident reports for Otter Home from Home Manager, Dawn Doetsch. On 03/09/2023, Resident A hit another resident in back of head and attempted to hit staff. Staff attempted to redirect, and police were called. Incident report states that case manager was also contacted. Resident A has a peer support and therapist and is on the waiting list for a behaviorist. On 02/07/2023, Resident A pinched another resident's neck. Case manager was contacted, and decision was made to petition for resident to be taken to hospital as she had also been aggressive on 01/31/2023, 12/13/2022 and 10/24/2022. Med Star transported Resident A to McLaren Macomb Hospital. On 01/31/2023 Resident A pushed a resident and staff. Case Manager was contacted, and home requested addendum to treatment plan for staff to handle Resident A's behaviors.

On 06/28/2023, I received a copy of Resident A's Person Centered Plan (PCP) dated 09/22/2022. Resident A's plan includes following through with therapy appointments and taking medications as prescribed. On 02/09/2023, an addendum to PCP was completed. The addendum indicates that multiple incident reports have been received concerning verbal as well as physical aggression including pinching, hitting, slapping and pushing housemates as well as staff. Case Manager will complete an updated crisis plan by 03/15/2023 for staff. Staff will encourage/prompt Resident A to use her coping skills. If behaviors continue causing injury to another person staff is to call 911 for additional intervention as law enforcement deem necessary. On 03/02/2023, a review of PCP was completed. Review indicates that psychotropic medication has been adjusted multiple times in the last six months. Resident A was sent to McLaren in February 2023 under petition due to physical aggression towards another resident.

On 07/07/2023, I received email from Home Manager, Dawn Doetsch. Ms. Doetsch stated that there have not been any recent physical altercations at the home. However, there have been verbal altercations.

I completed an exit conference with licensee designee, Donald King, by phone on 09/13/2023. I informed him of the violation found. I also informed him that a corrective action plan would be requested and a copy of the special investigation report would be mailed once approved. Mr. King indicated that a 30-day discharge notice has been issued for Resident A and they are awaiting placement.

APPLICABLE RULE	
R 400.14301	Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: (c) The resident appears to be compatible with other residents and members of the household.
ANALYSIS:	Resident A does not appear to be compatible with other residents in the household. Resident A has physically assaulted Resident B and Resident C. Resident B stated that Resident A makes her very uncomfortable. Resident C stated that she does not always feel safe at the home. On 9/13/2023, Mr. King indicated that a 30-day discharge notice has been issued for Resident A and they are awaiting placement.
CONCLUSION:	VIOLATION ESTABLISHED

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:	There is not enough information to support that Home Manager, Dawn Doetsch, is not doing anything regarding Resident A being physically aggressive towards other residents. Resident A has been hospitalized on at least two occasions on 02/07/2023

	and 05/16/2023 due to physical aggression. Staff are following the PCP and police are being contacted if Resident A injures another resident. Resident A's PCP review dated 03/02/2023 also indicates that her psychotropic medications were adjusted multiple times in the last six months. Resident A's case manager and psychiatrist have been made aware of her aggressive behaviors. She is also on the waiting list for a behaviorist.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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

Kristine Cilluffo

09/13/2023

 Kristine Cilluffo
 Licensing Consultant

 Date

Approved By:

Denise Y. Nunn

09/15/2023

 Denise Y. Nunn
 Area Manager

 Date