GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 18, 2023

Martha Lum
Horizon House Inc
5565 Kensington
Detroit, MI 48224

RE: License #: AS820094099
Investigation #: 2024A0121002
Horizon House

Dear Ms. Lum:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On November 27, 2023, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (313) 456-0380.

Sincerely,

K. Robinson

K. Robinson, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820094099
Investigation #:	2024A0121002
Complaint Receipt Date:	10/16/2023
Investigation Initiation Date:	10/26/2023
Report Due Date:	12/15/2023
Licensee Name:	Horizon House Inc
Licensee Address:	5565 Kensington Detroit, MI 48224
Licensee Telephone #:	(313) 640-1965
Administrator:	Martha Lum, Designee
Licensee Designee:	Martha Lum, Designee
Name of Facility:	Horizon House
Facility Address:	5565 Kensington Detroit, MI 48224
Facility Telephone #:	(313) 640-1965
Original Issuance Date:	11/01/2000
License **Status:**	REGULAR
Effective Date:	04/04/2023
Expiration Date:	04/03/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Two residents left unattended at Day Program.	Yes

III. METHODOLOGY

10/16/2023	Special Investigation Intake 2024A0121002
10/16/2023	APS Referral Made by ORR
10/16/2023	Referral - Recipient Rights From Rights, Tonia McMurray assigned.
10/26/2023	Special Investigation Initiated - Telephone Cynthia Warren with Services to Enhance Potential
10/30/2023	Contact - Telephone call made Left message for Ms. Lum; no response.
10/30/2023	Contact - Telephone call made Loretta Nesti with Wayne Center
10/31/2023	Contact - Document Received IPOS
11/01/2023	Contact - Telephone call made Martha Lum
11/02/2023	Contact - Telephone call made Scheduled onsite with Ms. Lum
11/08/2023	Inspection Completed On-site Direct Care Worker (DCW), Rick and Natasha
11/15/2023	Exit Conference Ms. Lum
11/27/2023	Corrective Action Plan Received/Approved

ALLEGATION: Two residents left unattended at Day Program.

INVESTIGATION: On 10/26/23, I initiated the complaint with a phone call to Cynthia Warren with Services to Enhance Potential (STEP). According to Ms. Warren, on 10/6/23 she observed Resident A and B in their lobby unsupervised. Ms. Warren expressed concern that both residents have 1:1 staffing assignments. In addition, Ms. Warren stated Resident A and B were not assigned to attend Program on this day, so she was puzzled when saw them. Specifically, Ms. Warren reported their treatment plans states the "1:1 have to be within 4 feet and hearing distance" from the resident. The added supervision is to protect the public since Resident A and B are "registered sex offenders." Ms. Warren reported direct care worker, Rezoand Dunbar, more commonly known as "Rick", was responsible for the resident's care while on the premises.

On 10/30/23, I contacted Loretta Nesti, Resident A and B's Supports Coordinator with Wayne Center. Mrs. Nesti explained, Resident A and B were assigned 1:1 staffing at STEP. However, due to recent behavior changes, their plans were updated with more specific language about the expectations surrounding supervision of the residents. The licensee entered into a verbal agreement with STEP to provide 1:1 supervision of Resident A and B with them remaining within 4 feet of Staff. Ms. Nesti stated the updated plan was not written until after this incident occurred. On 10/31/23, Ms. Nesti forwarded copies of Resident A and B's previous and current treatment plans to compare the old and new language. I was able to confirm both residents were assigned 1:1 staff while attending STEP program.

On 11/1/23, I interviewed licensee, Martha Lum by phone. Ms. Lum is aware of the incident. Ms. Lum stated the residents came inside the STEP building to use the bathroom.

On 11/8/23, I completed an onsite inspection at the facility. Direct care worker (DCW) Rick acknowledged that he took Resident A and B inside the building because he had to "use the bathroom," as well as Resident A and B. Although, Resident B was assigned to direct care worker, Natasha Cole, Rick said he thought it was best for him to take Resident A and B inside to use the bathroom while Natasha stayed in the van with Resident C who is no longer allowed to attend STEP. Rick explained, when they got inside the building the bathroom area was crowded, so he allowed Resident A and B to go first. Rick further explained that when Resident A and B were done using the bathroom, he escorted them to the front lobby to wait while he used the bathroom. Rick said he thought it would be okay to leave the residents in a common area where everyone could see them. Natasha confirmed Resident A and B had to use the restroom. Natasha also said she did not think it would be a problem for Rick to take both guys to the bathroom while she waited in the van with Resident C who is not allowed at STEP.

On 11/28/23, I interviewed Resident A and B. Resident A said his 1:1 staffing assignment is usually between the hours of 7:00 AM to 7:00 PM. Resident A stated

his 1:1 is provided as scheduled. In addition, Resident A reported Rick "stays closer to me now." Resident B reported his 1:1 staffing assignment is only required while at STEP; he works there. According to Resident B, his 1:1 staff person is usually Natasha or Gino. Resident reported both Natasha and Gino stay within eyesight of him when he's at STEP.

On 11/15/23, I completed an exit conference with Ms. Lum. Ms. Lum expressed concern that the new parameters around Resident A and B's 1:1 staffing assignments are too restrictive. Ms. Lum believes the restrictions stem from a recent comment Resident B made about a photo he saw on someone's desk at work. Ms. Lum said after the comment was made, action was taken to update Resident B's treatment plan, along with Resident A who had nothing to do with the incident. Ms. Lum does understand and agree with the department's findings. Ms. Lum submitted an acceptable corrective action plan on 11/27/23.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	• Resident A and B are required to have 1:1 supervision while at the STEP program. • On 10/6/23, Cynthia Warren observed Resident A and B at STEP with no Staff from the group home in sight. • DCW Rick acknowledged he left Resident A and B in the lobby area while he was in the restroom. • DCW Natasha was assigned to supervise Resident B at the time. • Therefore, Resident B was left without a 1:1 Staff while at STEP. • Both Resident A and B were without 1:1 staffing while Rick stepped away to use the restroom. • The department concluded the licensee did not provide the level of supervision required in accordance with Resident A and B's most recent behavior treatment plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend the status of this license remain unchanged.

12/13/23

Kara Robinson — Date
Licensing Consultant

Approved By:

12/18/23

Ardra Hunter — Date
Area Manager