GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

Michelle Helmuth-Charles
LADD, Inc.
300 Whitney Dr.
Dowagiac, MI 49047

December 13, 2023

RE: License #: AS140010484
Investigation #: 2024A1030007
Country Manor Home

Dear Ms. Helmuth-Charles:

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.

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 (616) 356-0183.

Sincerely,

Nile Khabeiry, LMSW

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS140010484
Investigation #:	2024A1030007
Complaint Receipt Date:	11/29/2023
Investigation Initiation Date:	11/29/2023
Report Due Date:	12/29/2023
Licensee Name:	LADD, Inc.
Licensee Address:	300 Whitney Dr. Dowagiac, MI 49047
Licensee Telephone #:	(269) 240-1473
Administrator/ Licensee Designee:	Michelle Helmuth
Name of Facility:	Country Manor Home
Facility Address:	23250 Hospital Road Cassopolis, MI 49031
Facility Telephone #:	(269) 445-2462
Original Issuance Date:	11/01/1992
License Status:	REGULAR
Effective Date:	05/02/2022
Expiration Date:	05/01/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was verbally abused by a staff member.	Yes
Resident A was pushed in the back by a staff member.	No
Additional Findings	No

III. METHODOLOGY

11/29/2023	Special Investigation Intake 2024A1030007
11/29/2023	APS Referral Received referral from APS
11/29/2023	Special Investigation Initiated - Telephone Interview complainant
11/30/2023	Contact - Face to Face Attempted interview with Resident A
11/30/2023	Contact - Face to Face Interview with Rhonda Deckart
11/30/2023	Contact – Telephone call made Interview with Kara Ciesiolka by phone
11/30/2023	Contact - Telephone call made Interview with home manager Allison Robbles by phone
11/30/2023	Contact - Telephone call made Interview with Justin Ottinger by phone
11/30/2023	Contact - Document Received Received and review Incident Report
12/03/2023	Contact - Telephone call made Interview with Guardian A1 by phone
12/13/2023	Exit Conference Exit conference by phone.

ALLEGATION:

Resident A was verbally abused by a staff member.

Resident A was pushed in the back by a staff member.

INVESTIGATION:

On 11/29/23, I interviewed the complainant by phone. She indicated staff member Kara Ciesiolka witnessed it. The complainant reported she also made a referral to law enforcement and Recipient Rights.

On 11/30/23, I attempted to interview Resident A at the home however she was nonverbal. She appeared to be in good health without any noticeable injuries. I attempted to interview the other residents in the home however none of the residents were able to be interviewed due to cognitive disabilities.

On 11/30/23, I interviewed Direct Care Staff Member (DCSM) Rhonda Deckert at the home. Ms. Deckert reported she is aware of the incident however was not working and did not witness anything between Resident A and DCSM Justin Ottinger.

On 11/30/23, I interviewed DCSM Kara Ciesiolka by phone. Ms. Ciesiolka reported she was working second shift with Justin Ottinger on Monday 11/27/23 when this incident occurred. Ms. Ciesiolka reported Mr. Ottinger began yelling at Resident A and was saying “your so fucking annoying” and that Resident A “makes him want to punch babies.” Ms. Ciesiolka reported she asked Mr. Ottinger to stop yelling at Resident A and that his comments were “disturbing.” Ms. Ciesiolka reported later in the shift she heard some yelling and walked into the kitchen and saw Resident A in another resident’s personal space and Mr. Ottinger push her in the back out of the kitchen. Ms. Ciesiolka reported she stepped in between him and Resident A and directed her to sit on the couch next to her. Ms. Ciesiolka reported she texted the home manager at the end of her shift about what happened and later had a conference call with a couple of “higher ups” about the situation.

On 11/30/23, I interviewed home manger, Allison Robbles by phone. Ms. Robbles reported she did receive a text message from Ms. Ciesiolka and had a subsequent conversation a short time later on the phone. Ms. Robbles reported Mr. Ottinger has been suspended pending the investigation. Ms. Robbles reported this is the first time there has ever been any concerns with Mr. Ottinger behavior.

On 11/30/23, I interviewed Justin Ottinger by phone. Mr. Ottinger reported he was suspended for what happened between he and Resident A. Mr. Ottinger reported he

has worked in the home for some time and was the more experienced DCSM on duty. Mr. Ottinger reported Resident A has issues getting into other resident's personal space and was reminded to use "nice hands." Mr. Ottinger reported he was "doing his job" and redirected Resident A with his left hand on her left elbow. Mr. Ottinger denied pushing her or using any inappropriate physical force. Mr. Ottinger reported Resident A also makes lots of noises which can be very annoying. Mr. Ottinger reported he did say to her "you make me want to punch babies" but was joking and even laughed as he made that statement. Mr. Ottinger reported that his family often says that to each other in a joking manner.

On 11/30/23, I received an Incident Report (IR) dated 11/27/23 regarding the incident between Resident A and Justion Ottinger. The IR documented Ms. Ciesiolka witnessed Mr. Ottinger push Resident A away from another resident and stated multiple times, "your so fucking annoying." The IR also indicated Resident A was not injured.

On 12/4/23, I interviewed Resident A's legal guardian by phone. Guardian A1 reported Resident A has lived at the home for four years and she believes they usually provide good care to Resident A. Guardian A1 reported she was contacted by the home manager about what happened and was very concerned about the DCSM's behavior and does not want him working with Resident A. Guardian A1 reported she never had any past concerns about the care Resident A receives at the home.

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:	It was alleged Resident A was verbally abused and pushed in the back by a DCSM. Based on interviews and review of an Incident Report the allegation regarding Resident A being verbally abused will be established. However, the allegation regarding Resident A being pushed in the back will not be established. During the course of the investigation, I was only able to interview the DCSM (Justin Ottinger) accused of the mistreatment of Resident A and the DCSM (Kara Ciesiolka) who witnessed the mistreatment of Resident A as the other

	individuals present in the home were not able to be interviewed due to their cognitive disabilities including Resident A. While it was confirmed that Mr. Ottinger verbally abused Resident A based on his admission and the witness statement, the inconsistencies regarding Mr. Ottinger and Ms. Ciesiolka statements simply make it impossible for me to determine he pushed the Resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/11/23, I shared the findings of my investigation with licensee Michelle Charles by phone. Ms. Charles acknowledged and agreed with the finds and will submit a corrective action plan.

IV. RECOMMENDATION

Based on the submission of an acceptable corrective action plan, I recommend no change in the current license status.

Nile Khabeiry, LMSW

12/13/23

Nile Khabeiry Date
Licensing Consultant

Approved By:

Russell Misiak

12/20/23

Russell B. Misiak Date
Area Manager