GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 11, 2025

Hernandez Home LLC
P.O. Box 277
Bloomingdale, MI 49026

RE: License #: AS800316739
Investigation #: 2025A1031012
Baseline Home

Dear Licensee Designee:

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 (616) 356-0183.

Sincerely,
Kristy Duda, 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 #:	AS800316739
Investigation #:	2025A1031012
Complaint Receipt Date:	12/17/2024
Investigation Initiation Date:	12/17/2024
Report Due Date:	02/15/2025
Licensee Name:	Hernandez Home LLC
Licensee Address:	44409 Baseline Road Bloomingdale, MI 49026
Licensee Telephone #:	(269) 521-4130
Licensee Designee/Administrator:	Karmen Ball
Name of Facility:	Baseline Home
Facility Address:	44409 Baseline Road Bloomingdale, MI 49026
Facility Telephone #:	(269) 521-4130
Original Issuance Date:	04/23/2012
License Status:	REGULAR
Effective Date:	10/23/2024
Expiration Date:	10/22/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff did not treat Resident A with dignity and respect.	Yes

III. METHODOLOGY

12/17/2024	Special Investigation Intake 2025A1031012
12/17/2024	APS Referral
12/17/2024	Special Investigation Initiated – Telephone Interview with Karmen Ball.
01/02/2025	Contact - Telephone Interview with Brandy Marvin.
01/08/2025	Inspection Completed On-site
01/08/2025	Contact - Face to Face Judith Cupani and Resident A.
01/09/2025	Contact - Document Sent Email Exchange with Brandy Marvin.
01/17/2025	Contact - Telephone Interview with Crystal Grodi.
01/17/2025	Contact – Voicemail left with Cameo Locker.
01/23/2025	Contact - Telephone call made Interview with Cameo Locker and Logan Page.
01/23/2025	Inspection Completed-BCAL Sub. Compliance
01/30/2025	Exit Conference held with Karmen Ball.

ALLEGATION:

Staff did not treat Resident A with dignity and respect.

INVESTIGATION:

On 12/17/24, I received a telephone call from licensee designee Karmen Ball. Ms. Ball reported she received allegations that direct care worker (DCW) Logan Page mistreated Resident A. Ms. Ball reported she was informed that Mr. Page may have put Resident A outside in the snow wearing minimal clothing, put him in his bedroom by pulling his arm, and threw an object at him. Ms. Ball reported Mr. Page is not currently working in the facility pending the investigation.

On 1/2/25, I interviewed recipient rights officer Brandy Marvin via telephone. Ms. Marvin reported she interviewed two staff members and believes that Resident A was mistreated. Ms. Marvin reported it was reported to her that Mr. Page had put Resident A outside in the snow while wearing a t-shirt and underpants, threw a pen at Resident A, pulled Resident A by his arms and put Resident A in his bedroom, and cursed at Resident A.

On 1/8/25, I conducted an unannounced visit to the facility. I interviewed the home manager Judith Cupani, and she reported she was not working when the alleged incident occurred. Ms. Cupani reported Mr. Page is not currently working in the home. Ms. Cupani reported two staff members informed her of their observations which were consistent with the allegations Ms. Ball provided.

I was not able to interview Resident A or any other residents in the home due to them being nonverbal.

On 1/9/25, I exchanged emails with Ms. Marvin. Ms. Marvin reported she did substantiate against Mr. Page for abuse, freedom of movement, and dignity and respect.

On 1/17/25, I interviewed DCW Crystal Grodi via telephone. Ms. Grodi reported she observed Mr. Page pull Resident A by his arms and put him in his bedroom and shut the door. Ms. Grodi reported when she would work with Mr. Page the residents in the facility would go to their rooms unprompted and Mr. Page would often direct them to their bedrooms. Ms. Grodi reported she witnessed Mr. Page put Resident A outside of the facility when it was cold and snowy. Ms. Grodi reported Mr. Page pushed him outside and shut the door and found this to be funny. Resident A was wearing only a shirt and shorts and was not dressed appropriately for the weather. Ms. Grodi reported Mr. Page later threw a pen at Resident A but she could not see where the pen hit him. Ms. Grodi reported Mr. Page stated that throwing something at Resident A is how he gets his attention.

On 1/23/25, I interviewed DCW Cameo Locker via telephone. Ms. Locker reported she is no longer working at the facility as the behaviors Mr. Page demonstrated made her uncomfortable. Ms. Locker reported Resident A was asking Mr. Page for something and Mr. Page got frustrated and threw a pen at Resident A. The pen hit Resident A in the face then Mr. Page proceeded to cuss at Resident A and give him the middle finger. Ms. Locker reported later in the day Resident A asked Mr. Page for something else and again got frustrated and yelled at Resident A to go to his

bedroom. Mr. Page then grabbed Resident A's arms and put him in his bedroom and shut the door. Ms. Locker reported she observed Resident A point outside, and Mr. Page thought it would be funny to put him outside in his shirt and underwear. Ms. Locker reported it was cold outside and there was snow on the ground. Ms. Locker reported Mr. Page pushed Resident A outside and then shut the door.

On 1/23/25, I interviewed Mr. Page via telephone. Mr. Page denied the allegations that were made against him. Mr. Page reported he felt he was being targeted by the other staff because the facility manager stated she only wanted female staff working in the home. Mr. Page reported Resident A did want to go outside and he could not prevent him from doing so or he would be violating Resident A's rights. Mr. Page reported he did allow Resident A to go outside and opened the door for him. Mr. Page reported he did not encourage Resident A to wear weather appropriate clothing because Resident A does not like to wear pants because he likes to masturbate outside. Mr. Page reported there was no snow outside and it was 50 degrees Fahrenheit. Mr. Page reported Resident A was outside for approximately five minutes as he wanted to run around in circles. Mr. Page denied throwing a pen at Resident A. Mr. Page reported he was sitting at the desk and throwing a pen up in the air directly above him, but it never hit Resident A. Mr. Page denied pulling Resident A by his arms and putting him in his room. Mr. Page reported there was a moment where another resident was exhibiting behaviors, and he asked Resident A to go to his room to ensure his safety so he would not be attacked. Mr. Page reported he was terminated from employment from the facility because of these allegations.

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:	Based on interviews with staff, it has been determined that Resident A was not treated with dignity and staff did not ensure Resident A's protection and safety. Two staff were consistent in reporting that Mr. Page mistreated Resident A on multiple occasions.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR 2023A1031009 and SIR 2024A1031023**

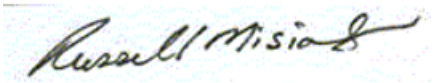
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

1/29/25

Kristy Duda — Date
Licensing Consultant

Approved By:



2/5/25

Russell B. Misiak — Date
Area Manager