RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

April 17, 2017

Joy Mbelu
Blessed Manor LLC
5517 Starflower Dr.
Haslett, MI 48840

RE: License #: AS330275174
Investigation #: **2017A0565008**
Blessed Manor LLC 2

Dear Ms. Mbelu:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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) 284-9720.

Sincerely,

Dawn M. Campbell

Dawn Campbell, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5607

Enclosure

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

*****THIS REPORT CONTAINS SEXUALLY EXPLICIT AND PROFANE LANGUAGE***

I. IDENTIFYING INFORMATION

License #:	AS330275174
Investigation #:	2017A0565008
Complaint Receipt Date:	03/28/2017
Investigation Initiation Date:	03/28/2017
Report Due Date:	04/27/2017
Licensee Name:	Blessed Manor LLC
Licensee Address:	5517 Starflower Dr. Haslett, MI 48840
Licensee Telephone #:	(517) 339-7906
Administrator:	Joy Mbelu
Licensee Designee:	Joy Mbelu
Name of Facility:	Blessed Manor LLC 2
Facility Address:	911 W. Hillsdale Lansing, MI 48915
Facility Telephone #:	(517) 484-5576
Original Issuance Date:	07/25/2005
License Status:	REGULAR
Effective Date:	12/09/2015
Expiration Date:	12/08/2017
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 3/21/17 Resident B was allegedly sexually harassed by Resident A. Staff members did not do anything to stop this behavior.	No
Staff refuse to give CMH the clients information so that he can receive services and he has schizoaffective disorder	No

III. METHODOLOGY

03/28/2017	Special Investigation Intake 2017A0565008
03/28/2017	Special Investigation Initiated - Telephone call made to Complainant. Interview completed.
03/29/2017	Contact - Document Received Police report received.
04/04/2017	Inspection Completed-BCAL Full Compliance
04/06/2017	Inspection Completed On-site
04/06/2017	Exit Conference Spoke with Licensee Joy Mbelu regarding the results of the special investigation.

ALLEGATION:

On 3/21/17 Resident B was allegedly sexually harassed by Resident A. Staff members did not do anything to stop this behavior.

INVESTIGATION:

On 03/28/2017, Area Manager Dawn Timm interviewed Complainant regarding this allegation. Complainant reported the allegation allegedly occurred on the front porch, while the staff member was inside passing medication. Complainant reported Resident punched Resident A in the face due to Resident A's verbally aggressive behavior. Resident A was later hospitalized in the psychiatric unit due to his unstable, aggressive behavior. The remainder of the investigation was completed by AFC Consultant Dawn Campbell.

I conducted an unannounced inspection at the facility on 04/05/2017. I spoke with Resident A, Resident C, direct care staff member Duane Ferris and the Licensee Joy Mbelu regarding the complaint allegations.

Resident A stated a couple of weeks ago he got into an argument with Resident B. Resident A stated he and Resident B were on the porch of the facility and Resident B started calling him a "faggot" and other names. He stated that he became angry with Resident B and hit him in the face. Resident A stated he and Resident B shared a room at the facility and did not have many problems before this happened. Resident A stated Resident B is no longer at this facility. Initially Resident A denied that he had exposed himself to Resident B or had sexually harassed Resident B. When asked directly if he exposed himself to Resident B, Resident A replied, "yeah, I did that, I don't know what I was thinking, and I am sorry." Resident A stated he was arrested but he does not know "what will happen at this point."

Resident C stated she was in the bedroom and heard Residents A and B yelling at one another. Resident C stated her bedroom window is right by the porch. Resident C stated Resident B came into the facility yelling and she told him "he needed to be quiet because the others were trying to sleep." Resident C stated Resident B told her to "shut-up." Resident C stated she did not know what the argument between the two were about but she did hear them on the porch arguing. Resident C stated Residents A and B were alone on the porch of the facility when the incident occurred.

Ms. Mbelu stated on the day after the incident 03/22/2017, Resident B told her Resident A hit him in the face while they were on the porch of the facility. Ms. Mbelu stated Resident B told her he and Resident A were on the porch of the facility smoking and Resident B "pulled out his penis." Ms. Mbelu stated Resident A told her he called Resident B "a faggot" and then Resident A hit him in the face. Ms. Mbelu stated she had not had any prior issues with Resident A or B fighting when this incident occurred. Ms. Mbelu stated Resident B told her he no longer wanted to be at the facility because of this incident.

Ms. Mbelu stated Resident B is currently hospitalized at the Bridges Crisis Unit because he needed to have his medication adjusted. Ms. Mbelu stated Resident B will be transferred to her other facility when he is discharged from the hospital. Ms. Mbelu stated she has not had any prior history of Resident A exposing himself to others. Ms. Mbelu stated she has not had any issue with Residents A and B becoming physically aggressive with one another but Resident B has had difficulty getting along with other residents at the facility.

Ms. Mbelu stated she spoke with all of the residents in the facility regarding the incident. Ms. Mbelu stated she did not learn any additional information from the other residents, as they were not on the porch with Residents A and B at the time of the incident. Ms. Mbelu stated since this incident occurred she has not had any incidents with either resident.

Mr. Farris stated he was getting medications for another resident when Resident B came into the facility yelling and cursing. Mr. Farris stated Resident B reported Resident A "punched him in the face." Mr. Farris stated before he "could even" respond Resident B called the police regarding the incident. Mr. Farris stated Resident B later reported Resident A exposed his penis to him and then hit him. Mr. Farris stated he did not see or hear the incident because he was in a different room getting medication for another resident.

Mr. Farris stated Residents A and B shared a room at the facility and had "few verbal arguments" but have never been physical with one another. Mr. Farris stated he has not had "a problem" with Resident A exposing himself to others. Mr. Farris stated Resident B tends to "bother" Resident A when they are at the facility and he has had to tell them to leave on another alone.

I reviewed the file of Resident A. Resident A has a diagnosis of paranoid schizophrenia and bipolar disorder. A review of Resident A's *Assessment Plan for AFC Residents* stated Resident A is able to move independently in the community. Resident A's file does not indicate a he has a history of exhibiting sexually inappropriate behavior.

I interviewed Resident B at his new adult foster care facility on 04/06/2017. Resident B stated he and Resident A shared a bedroom at the facility before he moved to the new facility. Resident B stated before this incident he did "not have a problem" with Resident A. Resident B stated on March 21, 2017, he and Resident A were on the porch of the facility smoking when Resident A "pulled out his dick and told him to go down on it." Resident B stated he called Resident A "a faggot and that he was gay." Resident B stated Resident A became angry and hit him in the face. Resident B stated he came into the facility and called the police immediately. Resident B stated police came to the facility and arrested Resident A. Resident B stated he spoke with Ms. Mbelu regarding the incident and told her he wanted to move to a new facility and did not want to be around Resident A.

I reviewed the file of Resident B. Resident B has a diagnosis of Schizoaffective Disorder, Chronic Kidney Disease and COPD. A review of Resident B's *Assessment Plan for AFC Residents* written Assessment plan indicates he is able to move independently in the community. Resident B's file does not indicate that he has a history of exhibiting sexually inappropriate behavior.

I conducted an exit conference with Ms. Mbelu on 04/06/2017. Ms. Mbelu stated she will continue to monitor Resident A to insure he does not "do this" with anyone else. Ms. Mbelu stated she has moved Resident B to another facility at his request.

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:	Residents A and B stated On 03/21/2017, Resident A exposed his penis to Resident A and an argument ensued resulting in Resident A hitting Resident A. All interviews indicate Resident A and Resident B did not have a history of being violent with one another or of Resident A being sexually inappropriate with Resident B or any other resident. Both Ms. Mbelu and Mr. Farris stated that they were not aware of Resident A ever exposing himself to Resident B or acting sexually inappropriately toward any other resident. Although all interviewed stated Residents A and B were on the porch alone and did not witness the incident, the local police were called and Resident A was arrested. Resident B was discharged from the facility, per his request, and Ms. Mbelu interviewed the remaining residents to assure their safety. Consequently, direct care staff member Mr. Farris and licensee designee Ms. Mbelu provided supervision and protection as defined in the act and in Resident A's and Resident B's written assessment plans.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff refuse to give CMH the client's information so that he can receive services and he has schizoaffective disorder

INVESTIGATION:

On 03/28/2017, I interviewed Complainant regarding this allegation. Complainant stated that this allegation was not reported accurately rather the issue appeared to be that the facility refused to turn over Resident B's prescription medications to his CMH case manager because it was not in compliance with their current corrective action plan.

During the unannounced investigation on 04/05/2017, Mr. Farris confirmed that he did not turn over Resident B's medication to Resident B's CMH case manager because he did not think this was in compliance with their current corrective action

plan as he had discussed with AFC Consultant Leslie Barner. Resident B's medications were turned over to the psychiatric hospital unit upon Resident B's admission to insure that the medication got to Resident B. Ms. Mbelu also reiterated that AFC Consultant Leslie Barner trained them not to turn over medication to individuals if they cannot insure that the resident is going to get those medications. Ms. Mbelu and Mr. Farris stated Resident B received all of his medication.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Licensee designee Joy Mbelu and direct care staff member Dewayne Farris provided Resident B's prescribed medications to the psychiatric hospital unit at the time of his admission rather than allowing providing it to his CMH case manager. Resident B received all of his medication.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend that the status of the license remains the same.

04/07/2017

Dawn Campbell Date
Licensing Consultant

Approved By:

04/17/2017

Dawn Timm Date
Area Manager