GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 11, 2019

Barry Bruns
HomeLife Inc
PMB #360
5420A Beckley Rd.
Battle Creek, MI 49015

RE: License #: AS390080967
Investigation #: 2019A0578044
8038 Interlochen AFC

Dear Mr. Bruns:

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,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390080967
Investigation #:	2019A0578044
Complaint Receipt Date:	06/10/2019
Investigation Initiation Date:	06/10/2019
Report Due Date:	08/09/2019
Licensee Name:	HomeLife Inc
Licensee Address:	3 Heritage Oak Lane Battle Creek, MI 49015
Licensee Telephone #:	(269) 660-0854
Administrator:	Barry Bruns
Licensee Designee:	Barry Bruns
Name of Facility:	8038 Interlochen AFC
Facility Address:	8038 Interlochen Road Kalamazoo, MI 49009
Facility Telephone #:	(269) 353-6941
Original Issuance Date:	08/01/1998
License Status:	REGULAR
Effective Date:	02/14/2019
Expiration Date:	02/13/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A and Resident B used liquid bleach to color their hair. Concern Residents are not being properly supervised because they were able to access and use bleach on their hair.	Yes

III. METHODOLOGY

06/10/2019	Special Investigation Intake 2019A0578044
06/10/2019	Special Investigation Initiated On-site -Interviewed Resident A, Resident B, staff member Imani Bush, Ahlana Lawshen, Megan Beers
06/10/2019	Document Review - *Incident / Accident Report Attachment.*
06/10/2019	Contact - Telephone call received -With KCMHSAS recipient rights officer Lisa Smith
06/10/2019	Document Review *-Kalamazoo Community Mental Health and Substance Abuse Services Incident Report.*
06/11/2019	APS Referral
06/11/2019	Exit Conference -With licensee Mr. Barry Bruns

ALLEGATION:
Resident A and Resident B used liquid bleach to color their hair. Concern Residents are not being properly supervised because they were able to access and use bleach on their hair.

INVESTIGATION:
On 06/10/2019, I received a verbal report from Complainant alleging that Resident A and Resident B has obtained liquid bleach while in the facility and used it to bleach their hair. Complainant added that no injuries were reported.

On 06/10/2019, I completed an unannounced investigation on-site at this facility and interviewed Resident A regarding the allegations with Kalamazoo Community Mental Health (KCMHSAS) recipient rights officer (RRO) Lisa Smith. Resident A reported

that she had dyed her hair a darker color several weeks before and didn't like it. Resident A reported that she had expressed this to a staff, who told her that her hair would need to be "bleached." Resident A stated she thought this meant that regular bleach could be used. Resident A stated that she told her roommate, Resident B, and they agreed to obtain bleach from the laundry room. Resident A stated that Resident B entered the laundry room, grabbed the bleach off the shelf and placed it underneath her clothing. Resident A stated they pored the bleach onto a rag in their hands, but this didn't work very well so they pored the bleach into the sink and dipped a rag in the bleach before applying it to their hair. Resident A stated she applied the bleach-soaked rag to her hair, and that as she was doing this, she felt "heady." Resident A denied getting any bleach in her eyes or mouth. I observed Resident A's hair to be unevenly lighter in a small section above her eyes and forehead. Resident A stated when they were both done, Resident B placed the bottle of bleach under her shirt and returned it to the laundry room. Resident A stated that bleach is always available in the laundry room for resident use while doing laundry, but since her report to her case manager, bleach is no longer present in this area. Resident A could not identify which direct care staff members were working but clarified they did not provide the bleach and were unaware of their activity.

While at the facility, I reviewed the details of the allegations with staff member Megan Beers. Ms. Beers serves as the home manager for the facility. Ms. Beers stated Resident A had reported to her case manager while at a medical appointment that she had used bleach to dye her hair. Ms. Beers stated the exact date of this occurrence was unknown, as the behavior was not observed by staff. Ms. Beers provided an *Incident / Accident Report Attachment* relating to the allegations.

While at the facility, I interviewed Resident B regarding the allegations with KCMHSAS RRO Lisa Smith. Resident B acknowledged that Resident A wanted to bleach her hair and told her to obtain bleach from the laundry room. Resident B stated she removed the bleach from the laundry room and took it to Resident A in the bathroom where they used it to bleach Resident A's hair. Resident B stated they poured the bleach on a rag but described this as not working well so they instead poured the bleach into the sink and dipped their rags in this sink before applying it to their hair. Resident B stated that when she did this the smell of the bleach burned her lungs but denied getting any bleach in her eyes or mouth. Resident B stated that during this event, direct care staff members Imani Bush and Ahlana Lawshew were present but did not provide the bleach and were unaware of their activity.

While at the facility I Interviewed staff member Ahlana Lawshew regarding the allegations with KCMHSAS RRO Lisa Smith. Ms. Lawshew stated she had worked for this facility for almost two weeks. Ms. Lawshew reported that liquid bleach is always stored underneath the kitchen sink in a locked cabinet. Ms. Lawshew denied any knowledge of Resident A or Resident B using bleach to dye their hair, but acknowledged that sometime last week, Resident A came out of her bedroom and asked Ms. Lawshew if her hair looked "lighter." Ms. Lawshew stated that she thought this meant that Resident A had dyed her hair on her own using a commercial

product. Ms. Lawshew reported that she could not recall who she was working with or what day this occurred, but this could have occurred on 06/02/2019, 06/03/2019, 06/04/2019 or 06/05/2019. Ms. Lawshew acknowledged that if she saw bleach unsecured in the facility, she would know this chemical would need to be stored in a locked cabinet instead.

While at the facility I interviewed staff member Imani Bush regarding the allegations with KCMHSAS RRO Lisa Smith. Ms. Bush denied having any knowledge of Resident A or Resident B using bleach from the facility to dye their hair. Ms. Bush stated that dangerous chemicals are usually locked or secured underneath the kitchen sink or the pantry in the basement. Ms. Bush acknowledged that sometimes bleach will be present in the laundry room when a resident does their own laundry and forgets it there. Ms. Bush stated giving residents access to laundry supplies was a result of the expectations of Home and Community Based Services (HCBS). Ms. Bush stated that most of the residents at this facility are “higher-functioning” and do not need staff supervision when completing laundry.

While at the facility, I reviewed an *Incident / Accident Report Attachment* relating to the allegations that was completed on 06/06/2019. Staff member Anthony Wilburn recorded that while at a medical appointment, Resident A described taking a container of bleach and dying her hair with Resident B.

While at the facility, I reviewed a *Kalamazoo Community Mental Health and Substance Abuse Services Incident Report* written on 06/06/2019 and provided by KCMHSAS RRO Lisa Smith. In this report, Resident A describes to her case manager how she obtained bleach to dye her hair. Resident A states, “my roommate & I snuck it from the cupboard above the dryer, put it on a rag and then rubbed my hair.”

On 06/11/2019, I completed an exit conference with the licensee, Mr. Barry Bruns. Mr. Bruns acknowledged that staff may have mistakenly left out liquid bleach due to confusion about allowing residents access to laundry facilities according to the expectations of Home and Community Based Services.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.

ANALYSIS:	During an unannounced investigation on-site at this facility, I interviewed Resident A and Resident B, who both acknowledged obtaining unsecured liquid bleach in the facility laundry room and using this bleach to dye their hair. Resident A and B's interviews were similar in the way they described first using a rag and then resorting to pouring the bleach in the sink and then dipping a rag in this bleach before applying it to their hair. During her interview, Resident A acknowledged that until recently informing her case manager, liquid bleach was stored in the laundry room, unsecured and available for resident use. On 06/06/2019, a *Kalamazoo Community Mental Health and Substance Abuse Services Incident Report* was completed regarding Resident A describing to her case manager how she obtained bleach from the cupboard in the laundry area of the facility. During an interview with staff member Imani Bush, Ms. Bush acknowledged that bleach can sometimes be found unsecured in the laundry room if left unattended by a resident. As such, there is enough evidence to support that liquid bleach was stored in an area of this facility that was accessible by residents and not safeguarded against improper and unsafe use.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

06/20/2019

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Eli DeLeon Date
Licensing Consultant

Approved By:

07/11/2019

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Dawn N. Timm Date
Area Manager