GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 21, 2019

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

RE: License #: AM030387355
Investigation #: 2019A0350060
318 E. Hammond Street 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 was required. Prior to the mailing of this report 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. You have indicated in our 10/17/2019 telephone conversation that you anticipate selling Homelife Inc prior to the expiration date of your current provisional license. Contingent upon this sale occurring as planned, the status of this license will be modified from 1st Provisional to Regular status upon the verified sale of HomeLife, Inc. to Beacon Specialized Living.

To verify your implementation and compliance with this corrective action plan:

- *You have submitted a Statement of Correction.*

If you desire technical assistance in addressing these issues, please 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,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030387355
Investigation #:	2019A0350060
Complaint Receipt Date:	09/03/2019
Investigation Initiation Date:	09/03/2019
Report Due Date:	10/03/2019
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:	318 E. Hammond Street AFC
Facility Address:	318 E. Hammond Street Otsego, MI 49078
Facility Telephone #:	(269) 694-1601
Original Issuance Date:	10/30/2017
License Status:	1ST PROVISIONAL
Effective Date:	06/04/2019
Expiration Date:	12/03/2019
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, AGED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
During 3rd shift on 08/16/2019 staff member Daisy Atkins used an inappropriate restraint technique on Resident A.	Yes

III. METHODOLOGY

09/03/2019	Special Investigation Intake 2019A0350060
09/03/2019	Special Investigation Initiated - Letter I sent an email to Kathleen Woodworth, APS investigator, to try to coordinate our investigations.
09/03/2019	APS Referral
09/06/2019	Contact - Face to Face Interviewed staff
09/09/2019	Contact - Telephone call received I spoke with Barry Bruns, Licensee Designee
09/12/2019	Contact - Telephone call made I spoke with Barry Bruns, Licensee Designee
10/17/2019	Exit conference - Held with Barry Bruns, Licensee Designee

ALLEGATION: During 3rd shift on 08/16/2019 staff member Daisy Atkins used an inappropriate restraint technique on Resident A.

INVESTIGATION: On 09/03/2019, through emails, I arranged to meet Kathleen Woodworth, Adult Protective Services (APS) investigator at this home on 09/06/2019 at 1:30 p.m.

On 09/06/2019, I made an onsite inspection and participated in a meeting with Sjana Markusic, Home Manager, Kevin Steve, Program Manager, Lisa Smith, Recipient Rights Officer and Ms. Woodworth (APS). Michael McClellan, APS investigator, was also present; however, he was not assigned to this complaint; it was assigned to Ms. Woodworth. Mr. McClellan stated that Resident A was recently in jail on an assault charge and he attempted to interview him there. Mr. McClellan stated Resident A was “very disoriented” and at first, he didn’t know where he lived until Mr. McClellan reminded him. Mr. McClellan stated that Resident A “parroted” much of what Mr. McClellan said to him. Ms. Markusic then reported that Resident A had a court

appearance on 08/20/2019, but his case was transferred to the Mental Health Court. At this point, Ms. Woodworth, Ms. Smith, and I requested to interview the two Direct Care Workers who worked the shift of this alleged incident, Skylar Noora and Daisy Atkins, as well as Jamara White, Shift Lead.

On 09/06/2019, Ms. Woodworth, Ms. Smith, and I interviewed Ms. White, who stated that Ms. Noora told her she took a video on her phone using snapchat showing Ms. Atkins holding Resident A down with her arms and then sitting on him while he was lying on the couch. Ms. White reported that she observed the video and confirmed that Ms. Atkins did sit on Resident A. Ms. White did not have anything more to add.

On 09/06/2019, Ms. Woodworth, Ms. Smith, and I then interviewed Ms. Noora, who stated that on 08/16/2019, she was working the third shift with Ms. Atkins. She reported that Resident A punched Ms. Atkins in the eye for no reason, and Ms. Atkins eventually "backed him onto the couch" and then sat on him for about 5 minutes, while telling Resident A; "Not tonight, (Resident A); you won't get us." Ms. Noora said they both tried unsuccessfully to verbally redirect Resident A, but it took about 5 minutes before "things got better." Ms. Noora informed us that Resident A kept saying he wanted to go back to jail. Ms. Noora stated that Resident A has punched Ms. Atkins two or three times before, on different days. I asked Ms. Noora what would have been the appropriate hold or restraint in that situation, and she demonstrated on me by putting her arms around my waist and connecting them on the other side. Ms. Noora reported that you could not see Resident A in the video, just Ms. Atkins holding him down on the couch and sitting on him. She said that she was uncomfortable about taking the video and felt intimidated by Ms. Atkins, so she immediately deleted it and then deleted it from her deleted box.

On 09/06/2019, Ms. Woodworth, Ms. Smith, and I interviewed Ms. Atkins, who stated that during the third shift on 08/16/2019, Resident A "popped me in the eye twice." She said that Resident A was sitting on the couch and was upset, and Ms. Noora told her to move away from him, but before she could he "jumped up and tried to hit me." Ms. Atkins denied sitting on Resident A and insisted that she used the approved MANDT maneuver of holding him around the shoulders with her head on his back below his head. She demonstrated this hold on Ms. Smith (Recipient Rights Officer). Ms. Smith told Ms. Atkins that she did not do the maneuver correctly, that her head should have been below Resident A's. Ms. Atkins raised her voice at Ms. Smith and said, "You're not listening to me", and then she re-demonstrated the hold on Ms. Smith, this time with her head below Ms. Smith's. Ms. Atkins informed us that while she was holding Resident A she asked him if he was going to be good and he finally agreed that he was, so she released her hold of him. She said that he was sitting on the couch the whole time she was holding him which lasted for "one to three minutes" Ms. Atkins explained that Resident A showed signs of aggression and hit her in her right eye, causing her glasses to fly off. She stated that before she used the hold, she walked toward Resident A to guide him to the couch, and once sitting, she then applied the hold. Ms. Atkins told us that she has been in this line of

work since 1984 and knew what she was doing, including using the proper MANDT techniques, which she was trained to do.

On 09/06/2019, Ms. Woodworth, Ms. Smith, and I spoke further with Mr. Steve and Ms. Markusic, who reported that Resident A has two separate pending assault charges against him, including one from the former AFC home where he resided. She informed us that when he first moved into 318 E. Hammond Street AFC, he was "sweet," but after 5 days he became violent for no apparent reason; "He just up and hits people, but only staff." Ms. Markusic speculated that a possible reason for this may be that his Depakote was recently discontinued, and this may have caused him to have seizures. Mr. Steve and Ms. Markusic explained that Resident A was taken off Depakote and switched to Risperdal because his ammonia levels got too high. Ms. Markusic said that Resident A is scheduled for an EEG in late October. She added that two residents complained about Resident A, saying that they are afraid of him. I requested copies of the Incident Reports (IRs) and Resident A's Health Care Appraisal and Ms. Markusic provided me, Ms. Woodworth, and Ms. Smith with them.

On 09/09/2019, I reviewed Resident A's Health Care Plan, which shows his diagnoses as Schizophrenic, Borderline Intellectual Functioning, HTN (Hypertension), as well as several physical ailments, including severe migraines.

On 09/09/2019, I received a telephone call from Barry Bruns, Licensee Designee. He reported that he was going to issue a 30-Day Discharge Notice to Resident A because, after this complaint was made, he punched a resident in the face and that resident fell to the ground. I suggested to Mr. Bruns that he consider issuing a 24-Hour Emergency Discharge Notice because there are many frail residents at this home. He said he would do this instead of the 30-Day notice.

On 09/12/2019, I reviewed the IRs that were written on 08/015/2019. The one written by Ms. Noora states: *"(Resident A) walked out to common room (Living room) as staff attempted to redirect them back to their room. All he said was, "I wanna go to jail, take me to the jail house" and proceeded to sit down. The other staff comes into the living room after hearing (Resident A's) verbal aggression increase to monitor and was on stand by. (Resident A) gets up and walks toward the 2nd staff and starts hitting her. The 1st staff assists 2nd staff put (Resident A) in one arm standing support hold for 3-4 minutes while he settled down. Staff called Hammond on-call and admin. Will continue to monitor [sic]."* The 2nd staff Ms. Noora referred to in her IR was Ms. Atkins.

The IR written by Ms. Atkins states: *"I was in the hallway when (Resident A) (started?) to staff in a (frightening? fighting?) attitude. (Resident A) said he wanted to go to jail then I came into the living room and sat down. He came after staff and staff put him in a one arm standing support hold. He hit staff in the right eye. We kept the hold until calm down. (Resident A) said he wanted to go to bed. Staff let him go to bed. Staff will continue to monitor during the nite [sic]."*

On 09/12/2019, I spoke with Mr. Bruns by telephone. I informed Mr. Bruns that I was citing a violation of this rule because Ms. Noora observed Ms. Atkins sit on Resident A and video recorded it. She showed the video to Ms. White, who also said she observed Ms. Atkins sit on Resident A. Mr. Bruns acknowledged that Ms. Atkins inappropriately restrained Resident A.

On 10/17/2019, I called and held an exit conference with Barry Bruns, Licensee Designee, and informed him of my recommendation.

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:	During third shift on 08/15/2019, direct care worker Daisy Atkins, sat on Resident A while he was on the couch because he was verbally threatening and physically violent towards staff. This incident was observed and recorded by the staff member she was working with, Skylar Noora, who said it occurred for 3 to 5 minutes. Ms. Noora showed the video to Jamara White, a Shift Lead. Ms. White reported that she observed the video and confirmed that Ms. Atkins did sit on Resident A. My findings support that this rule has been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

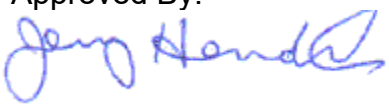
IV. RECOMMENDATION

I recommend that contingent on the sale of Homelife Inc to Beacon Specialized Living prior to the expiration of the current provisional license, the status of this license will be modified from 1st Provisional to Regular.

October 18, 2019

Ian Tschirhart Date
Licensing Consultant

Approved By:



October 21, 2019

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Jerry Hendrick Date
Area Manager