GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 20, 2021

Janice Hurst
Progressive Residential Services Inc
Suite # 165
6001 N. Adams Road
Bloomfield Hills, MI 48304

RE: License #: AS130359802
Investigation #: 2021A1024023
Homer Road House

Dear Mrs. Hurst:

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

NOTE: THIS REPORT CONTAINS SEXUALLY EXPLICIT LANGUAGE

I. IDENTIFYING INFORMATION

License #:	AS130359802
Investigation #:	2021A1024023
Complaint Receipt Date:	02/23/2021
Investigation Initiation Date:	02/26/2021
Report Due Date:	04/24/2021
Licensee Name:	Progressive Residential Services Inc
Licensee Address:	Suite # 165 6001 N. Adams Road Bloomfield Hills, MI 48304
Licensee Telephone #:	(248) 641-7200
Administrator:	Janice Hurst
Licensee Designee:	Janice Hurst
Name of Facility:	Homer Road House
Facility Address:	19030 Homer Rd. Marshall, MI 49068
Facility Telephone #:	(517) 781-3648
Original Issuance Date:	11/14/2014
License Status:	REGULAR
Effective Date:	05/14/2019
Expiration Date:	05/13/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A attempts to get out of the window due to lack of protection from staff.	No
A 3rd shift staff is sleeping and not checking on residents.	No
Resident A has missed his evening medications multiple times	No
Staff performed oral sex on Resident B while in shower.	No
Additional Findings	No

III. METHODOLOGY

02/23/2021	Special Investigation Intake 2021A1024023
02/26/2021	Special Investigation Initiated – Letter-email correspondence with Adult Protective Services Jennifer Stockford
03/11/2021	Contact - Telephone call made with direct care staff member Tina Robinson
03/12/2021	Contact - Telephone call made with home manager Nicole Bennett and Resident A
04/07/2021	Contact - Telephone call made with home manager William Chesney
04/07/2021	Contact - Telephone call made with administrator Lee Peters
04/08/2021	Contact - Telephone call made with direct care staff member Ricky Wotring
04/08/2021	Contact - Telephone call made with Recipient Rights Officer Barongiere Lovelace
04/09/2021	Contact - Telephone call made with direct care staff member Cindy Walters
04/09/2021	Contact - Telephone call made with APS Specialist Jennifer Stockford
04/12/2021	Contact - Telephone call made with Michigan State Police (MSP) Trooper Gantert

04/12/2021	Contact - Document Received-*AFC Licensing Division-Incident/Accident Report*, *Medication Administration Record* (MAR), Resident A's *Assessment Plan for AFC Residents*
04/13/2021	Contact - Document Received-Resident B's *Assessment Plan for AFC Residents* and *Behavior Treatment Plan*
04/14/2021	Contact - Telephone call made with Michigan State Police (MSP)
04/14/2021	Contact-Document Received-Police Report #54-1734-21
04/14/2021	Exit Conference with licensee designee Janice Hurst

ALLEGATION:

Resident A attempts to get out of the window due to lack of protection from staff.

INVESTIGATION:

On 2/23/2021, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged Resident A attempts to get out of the window due to lack of protection from staff.

On 2/26/2021, I spoke with APS Specialist Jennifer Stockford who confirmed that she was also investigating this allegation.

On 3/11/2021, I conducted an interview with direct care staff member Tina Robinson regarding this allegation. Ms. Robinson stated at the end of the summer of 2020 Resident A had an issue with attempting to open his bedroom window to touch a bush that was nearby his window. Subsequently, Resident A's bed was relocated to the opposite side of the bedroom away from the window due to number of times Resident A attempted to open his window to touch the bush which was about twice a week. Ms. Robinson stated Resident A was fascinated with this particular bush near his window and would walk around the house to touch and see the bush while accompanied by a direct care staff member. Ms. Robinson stated since relocating Resident A's bed away from his bedroom window, Resident A has not shown any desire to open his window to touch the bush within the past 6 months.

On 3/12/2021, I conducted an interview with home manger Nicole Bennett regarding this allegation. Ms. Bennett stated last year Resident A would sometimes open his bedroom window to touch a bush that was next to his window. Ms. Bennett stated Resident A never attempted to climb out of his window however since Resident A made attempts to open his window, his bed was relocated to the opposite side of the room away from the window which eradicated Resident A's desire to open his

bedroom window. Ms. Bennett stated this was a short-term minor issue that was immediately addressed and did not cause any harm to the resident.

On 4/7/2021, I conducted an interview with home manager William Chesney regarding this allegation. Mr. Chesney stated there has not been any issues with Resident A climbing out of any windows. Mr. Chesney stated last year Resident A would open his bedroom window to touch a bush nearby his window however Ms. Chesney has not seen Resident A make any attempts to open his window in the past year after Resident A's bed was relocated away from Resident A's bedroom window.

On 4/8/2021, I conducted an interview with direct care staff member Ricky Wotring. Mr. Wotring stated he has no knowledge of Resident A attempting to climb out of his bedroom window.

On 4/9/2021, I conducted an interview with direct care staff member Cindy Walters. Ms. Walters stated last during summer 2020, Resident A had instances of opening his bedroom window to touch a nearby bush outside of his window. Subsequently, Resident A's bed was relocated away from the window and there has not been any instances of Resident A attempting to open his window since November 2020. Ms. Walters stated Resident A never attempted to climb out of his window however would often look out of his window when his bed was positioned near his bedroom window.

On 4/9/2021, I conducted an interview with APS Specialist Jennifer Stockford who stated she found no substantial evidence to support this allegation.

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 my investigation which included interviews with direct care staff members Tina Robinson, Cindy Walters, Ricky Wotring, home managers Nichole Bennett, William Chesney, and APS Specialist Jennifer Stockford there is no evidence to support the allegation Resident A attempted to get out of the window due to lack of protection from staff. According to Ms. Robinson, Ms. Walters, Mr. Wotring, Ms. Bennett, and Mr. Chesney Resident A has never attempted to get out of his window however Resident A would open his window to touch a nearby bush located next to the window. Subsequently, a safety plan was put in place and Resident A's bed was relocated away from Resident A's bedroom window. It should be noted these incidents occurred last year and since the relocation of Resident A's bed there has not been any issues with Resident A attempting to open his window for at least 6 months. There are no reports of Resident A ever attempting to climb out of his window and the staff have put in appropriate protections of relocating Resident A's bed to ensure Resident A's safety is maintained.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

A 3rd shift staff is sleeping and not checking on residents.

INVESTIGATION:

This complaint also alleged a 3rd shift staff is sleeping and not checking on residents.

On 2/26/2021, I spoke with APS Specialist Jennifer Stockford who confirmed that she was also investigating this allegation.

On 3/11/2021, I conducted an interview with direct care staff member Tina Robinson regarding this allegation. Ms. Robinson stated she does not usually work on 3rd shift which is the timeframe when residents are sleeping and has no knowledge of any direct care staff members sleeping on 3rd shift. Ms. Robinson stated from her understanding when direct care staff members work during 3rd shift, they check on the residents every 30 minutes and clean the facility. Ms. Robinson stated when she arrives for her shift during the day, the facility is usually clean, and she has no evidence that the residents are not being checked.

On 3/12/2021, I conducted an interview with home manger Nicole Bennett regarding this allegation. Ms. Bennett stated she has no knowledge of direct care staff members sleeping during 3rd shift and there have not been any reports made to her of this allegation. Ms. Bennett stated on 3rd shift a direct care staff member has the

responsibility of checking in on the residents every 30 minutes, completing any paperwork and cleaning the facility. Ms. Bennett stated all the necessary responsibilities are usually completed and maintained sufficiently to her knowledge therefore she has no reason to believe direct care staff members are not fulfilling their job responsibilities while working.

On 4/7/2021, I conducted an interview with home manager William Chesney regarding this allegation. Mr. Chesney stated there is one direct care staff member to work during 3rd shift for six residents. Mr. Chesney stated Mr. Wotring and Ms. Walters are the two primary direct care staff members that work on 3rd shift and he has no knowledge that either of these staff members have fallen asleep while working. Mr. Chesney stated he has not had any reports made to him that there have been any direct care staff members sleeping on any shift of the day and not checking on the residents. Mr. Chesney further stated he has no reason to believe that direct care staff members are not fulfilling their job responsibilities while working on 3rd shift.

On 4/8/2021, I conducted an interview with direct care staff member Ricky Wotring. Mr. Wotring stated he previously worked at Homer Road AFC up until the end of February 2021. Mr. Wotring stated he primarily worked during 3rd shift hours without any issues. Mr. Wotring stated he checked on residents every 30 minutes and would tend to any resident care needs that was required when needed. Mr. Wotring stated residents are usually sleeping during 3rd shift hours however there have been times he had to provide care to residents such as if a resident becomes ill during the night. Mr. Wotring stated he has never fallen asleep while working during 3rd shift will usually complete paperwork and clean during this timeframe.

On 4/9/2021, I conducted an interview with direct care staff member Cindy Walters. Ms. Walters stated she has worked on 3rd shift and has never fallen asleep while working nor does she have knowledge of any other direct care staff members falling asleep. Ms. Walters stated she usually cleans and check on the residents every 30 minutes when working on 3rd shift. Ms. Walters stated the residents are usually sleeping during this timeframe.

On 4/9/2021, I conducted an interview with APS Specialist Jennifer Stockford who stated she has found no substantial evidence to support this allegation.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based on my investigation which included interviews with direct care staff members Tina Robinson, Cindy Walters, Ricky Wotring, home managers Nichole Bennett, William Chesney, and APS Specialist Jennifer Stockford there is no evidence to support the allegation a 3rd shift staff is sleeping and not checking on residents. There is sufficient staff on duty for supervision and protection of the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A recently missed his evening medications multiple times.

INVESTIGATION:

This complaint also alleged Resident A has recently missed his evening medications multiple times.

On 2/26/2021, I spoke with APS Specialist Jennifer Stockford who confirmed that she was also investigating this allegation.

On 3/11/2021, I conducted an interview with direct care staff member Tina Robinson who denied this allegation and stated she has no knowledge that Resident A has missed any of his medications. Ms. Robinson further stated she has administered Resident A's medication in the past without any issues.

On 3/12/2021, I conducted an interview with home manger Nicole Bennett regarding this allegation. Ms. Bennett stated Resident A is administered all his medications daily and regularly. Ms. Bennett stated recently on 2/3/2021, Resident A's dosage for one of his medications, Propranolol, was increased from 10mg to 20mg therefore Resident A had to discontinue taking the Propranolol 10mg medication on the evening of 2/3/2021. Ms. Bennett stated this medication was replaced with Propranolol 20mg therefore Resident A has not had any occurrences of missed medications.

On 4/7/2021, I conducted an interview with home manager William Chesney regarding this allegation. Mr. Chesney stated he has no knowledge of Resident A missing any of his medications or refusing to take any of his medications.

On 4/9/2021, I conducted an interview with direct care staff member Cindy Walters who stated she administers Resident A's medications regularly and has no knowledge that Resident A has missed any of his medications.

On 4/9/2021, I conducted an interview with APS Specialist Jennifer Stockford who stated she has found no substantial evidence to support this allegation.

On 4/12/2021, I reviewed Resident A's Medication Administration Record (MAR) for the month of February 2021 and March 2021. I reviewed an end date for Propranolol 10mg for 2/3/2021 and a start date for Propranolol 20mg on 2/4/2021. According to Resident A's MAR, Resident A is administered his medications as prescribed.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my investigation which included interviews with direct care staff members Tina Robinson, Cindy Walters, home managers Nichole Bennett, William Chesney, APS Specialist Jennifer Stockford and review of Resident A's MAR there is no evidence to support the allegation Resident A has recently missed his evening medications. Ms. Robinson, Ms. Walters, Mr. Chesney, and Ms. Bennett all report that Resident A has not missed any of his evening medications. Ms. Bennett stated recently on 2/3/2021, Resident A's dosage for one of his medications, Propranolol, was increased from 10mg to 20mg therefore Resident A had to discontinue taking the Propranolol 10mg medication on the evening of 2/3/2021. Ms. Bennett stated this medication was replaced with Propranolol 20mg therefore Resident A has not had any occurrences of missed medications. I reviewed Resident A's MAR and found Resident medications are administered and taken as prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff performed oral sex on Resident B while in the shower.

INVESTIGATION:

This complaint also alleged staff performed oral sex on Resident B while in the shower.

On 2/26/2021, I spoke with APS Specialist Jennifer Stockford who confirmed that she was also investigating this allegation and is waiting for Resident B to conduct a forensic interview facilitated by law enforcement due to Resident B's cognitive ability.

On 3/11/2021, I conducted an interview with direct care staff member Tina Robinson regarding this allegation. Ms. Robinson stated Resident B reported to Ms. Walters

that direct care staff member Mr. Wotring performed oral sex on him in the shower. Ms. Robinson stated Mr. Wotring usually works on 3rd shift therefore she cannot confirm or deny if this allegation is true since she or no other witnesses were present. Mr. Robinson stated she has worked with Mr. Wotring in the past on day shifts and have no concerns on how Mr. Wotring interacted with the residents.

On 3/12/2021, I conducted an interview with home manger Nicole Bennett regarding this allegation. Ms. Bennett stated Resident B reported to Ms. Walters that direct care staff Mr. Wotring performed oral sex on him while in the shower. Ms. Bennett stated Resident B did not give any further specifics when he made this statement to Ms. Walters. Ms. Bennett stated since this statement was made, Mr. Wotring was put on leave pending an investigation however Mr. Wotring chose to voluntarily terminate his employment with the company. Ms. Bennett stated Resident B has never made accusations regarding sexual abuse claims against a staff member in the past however has made claims that his father has sexually abused him in the past. Ms. Bennett stated Mr. Wotring usually works on 3rd shift when the residents are sleeping. Ms. Bennett further stated she has observed Mr. Wotring to be a quality direct care staff member. Ms. Bennett stated she nor anyone witnessed this allegation therefore she immediately notified APS, law enforcement and Recipient Rights when it was reported to her by Ms. Walters.

It should be noted I attempted to interview Resident B however was unable to conduct an interview due to his cognitive ability.

On 4/7/2021, I conducted an interview with home manager William Chesney regarding this allegation. Mr. Chesney stated Mr. Wotring chose to terminate his position when he was temporarily placed on leave while appropriate authorities conducted independent investigations regarding this allegation. Ms. Chesney stated he cannot confirm or deny if this allegation is true because he was not present nor were there any other witnesses. Mr. Chesney stated he has worked with Mr. Wotring in the past and has no concerns for Mr. Wotring and believe he is a “good staff member”.

On 4/7/2021, I conducted an interview with administrator Lee Peters regarding this allegation. Mr. Peters stated when Resident B reported this allegation to staff, Mr. Wotring was suspended as standard company policy while investigation was active. Mr. Peters stated APS, law enforcement and Recipient Rights were all immediately notified, and Mr. Peters is waiting for updates from each of these entities. Mr. Peters also stated he has interviewed direct care staff members and he has no evidence at this time to support this allegation. Mr. Peters further stated Mr. Wotring has a good employee record and has not had any issues while working at the home. Mr. Peters also stated Resident B has a history of making sexual complaints against others.

On 4/8/2021, I conducted an interview with direct care staff member Ricky Wotring. Mr. Wotring stated he terminated his employment with Homer Road AFC because he did not believe he was treated fairly when Resident B made an accusation

towards him. Mr. Wotring stated he works really hard and does not believe he should have been placed on leave. Mr. Wotring stated he works primarily on 3rd shift when the residents are sleeping. Mr. Wotring stated about 2 or 3 days before the allegation was made Mr. Wotring stated he gave Resident B a shower because Resident B vomited and defecated on himself due to having diarrhea. Mr. Wotring stated Resident B is able to wash his own genital areas therefore Mr. Wotring assisted mainly with rinsing and spraying water on Resident B's body parts. Mr. Wotring stated he did not touch Resident B's penis nor did he perform oral sex on Resident B. Mr. Wotring stated after Resident B was finished with his shower he went to bed. Ms. Wotring stated about three days later he was notified of this allegation.

On 4/8/2021, I conduced an interview with Recipient Rights Officer Barongiere Lovelace regarding this allegation. Ms. Lovelace stated she has also investigated this allegation and found no substantial evidence to support this allegation.

On 4/9/2021, I conducted an interview with direct care staff member Cindy Walters. Ms. Walters stated she did not witness this allegation however was notified by Resident B. Ms. Walters stated she immediately informed her supervisor and Mr. Wotring was suspended immediately in order for an investigation to be conducted. Ms. Walters stated Resident B did not disclose any other information to her and would not go into detail when he reported this allegation to her.

On 4/9/2021, I conducted an interview with APS Specialist Jennifer Stockford who stated she does not have substantial evidence to support this allegation. Ms. Stockford also stated Resident B does have history of making sexual abuse claims towards others such as towards family members.

On 4/12/2021, I conducted an interview with Michigan State Police (MSP) Trooper Gantert. Trooper Gantert stated Resident B was forensically interviewed at a children advocacy center and was unable to be interviewed due to his cognitive impairment. Trooper Gantert stated he has no substantial evidence to support this allegation at this time since there are no other witnesses. Trooper Gantert also stated Resident B has a history of making unwarranted sexual claims against others. Trooper Gantert stated he does not believe this case will be accepted by the prosecutor's office.

On 4/12/2021, I reviewed *AFC Licensing Division-Incident/Accident Report* (report) dated 2/23/2021 written by Cynthia Walters. According to this report, resident was sitting at the table and said he did not want to take showers anymore because staff "Ricky sucks his dick and touches him."

On 4/13/2021, I reviewed Resident B's *Assessment Plan for AFC Residents* that stated Resident B uses a walker and requires assistance with all self-care skills including bathing.

I also reviewed Resident B's Behavior Treatment Plan (plan) written by Sparks Behavioral Services, LLC. According to this plan, Resident B demonstrates a target behavior of verbal aggression. Examples of Resident B's verbal aggression include making racial slurs, threatening other people, and telling people to "suck his d***."

On 4/14/2021, I reviewed *MSP Police Report* #54-1734-21. According to this report, Resident B reported to staff that an adult foster care worker sexually assaulted him by touching and sucking his penis. According to this report, Trooper Gantert observed Resident B's mental capacity to be of a child and Resident B became extremely angry at the time of Trooper Gantert's visit. Trooper Gantert informed the staff that he would set up an interview to be conducted at the child advocacy center at a different time. According to the report, this status is open pending CIT interview and suspect interview.

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:	Based on my investigation which included interviews with direct care staff members Tina Robinson, Cindy Walters, Ricky Wotring, home managers Nichole Bennett, William Chesney, APS Specialist Jennifer Stockford, Recipient Rights Officer Barongiere Lovelace, review of Resident B's *Assessment Plan for AFC Residents*, *Behavior Treatment Plan*, *AFC Licensing Division-Incident/Accident Report, and Police Report* there is no evidence to support the allegation performed oral sex on Resident B while in the shower. According to Ms. Robinson, Ms. Walters, Ms. Bennett, and Mr. Chesney Resident A reported this allegation to staff however no other witnesses were present. Trooper Gantert, Ms. Bennett and Ms. Stockford all stated Resident B has a history of making sexual abuse claims towards others. Mr. Wotring denied this allegation and stated he gave Resident B a shower during the week the allegation was made against him. Mr. Wotring stated Resident B was able to wash himself therefore Mr. Wotring only assisted Resident B in the shower by spraying and rinsing Resident B with water after Resident B had vomited and defecated on himself. Mr. Wotring denied touching Resident B's penis or performing oral sex on Resident B. Mr. Chesney, Mr. Peters, and Ms. Bennett stated Mr. Wotring has been a good staff member and report of no concerns. According to Resident B's Behavior Treatment Plan, Resident B has target verbal aggressive behaviors of threatening others and saying sexually inappropriate comments to others. In addition, Ms. Lovelace, Ms. Stockford and Trooper Gantert has found no substantial evidence to support this allegation in their independent investigations therefore Resident B have not been mistreated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 4/14/2021, I conducted an exit conference with licensee designee Janice Hurst. I informed Ms. Hurst of my findings and allowed her an opportunity to ask questions or make comments.

IV. RECOMMENDATION

I recommend the current license status remain unchanged.

4/15/2021

Ondrea Johnson
Licensing Consultant

Date

Approved By:

04/20/2021

Dawn N. Timm
Area Manager

Date