STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

August 30, 2021

Paula Ott
Central State Community Services, Inc.
Suite 201
2603 W Wackerly Rd
Midland, MI 48640

RE: License #: AM320379300
Investigation #: 2021A0871035
Genesis CLF

Dear Ms. Ott:

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 (989) 732-8062.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM320379300
Investigation #:	2021A0871035
Complaint Receipt Date:	08/10/2021
Investigation Initiation Date:	08/11/2021
Report Due Date:	10/09/2021
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Brett Perhase
Licensee Designee:	Paula Ott
Name of Facility:	Genesis CLF
Facility Address:	4440 Washington Ubly, MI 48475
Facility Telephone #:	(989) 658-8721
Original Issuance Date:	04/04/2016
License **Status:**	REGULAR
Effective Date:	10/04/2020
Expiration Date:	10/03/2022
Capacity:	7
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Home Manager Kelly Smith witnessed Staff Mikhail Mattson tie two doors together to restrict Resident A’s movement.	Yes

III. METHODOLOGY

08/10/2021	Special Investigation Intake 2021A0871035
08/11/2021	Special Investigation Initiated - On Site Interviewed Staff Cammie Chafin and Staff Nicki Swartzendruber
08/26/2021	Contact - Document Received Received written statements from Staff Nicole Swartzendruber and Cammie Chafin
08/27/2021	APS Referral Through Central Intake to Huron County MDHHS
08/27/2021	Contact - Telephone call made Telephone call to Staff Mikhail Mattson
08/27/2021	Inspection Completed-BCAL Sub. Compliance
08/27/2021	Exit Conference Telephone exit conference with Licensee Designee Paula Ott

ALLEGATION:

Home Manager Kelly Smith witnessed Staff Mikhail Mattson tie two doors together to restrict Resident A's movement.

INVESTIGATION:

On August 8, 2021, I received a voicemail message from Administrator Brett Perhase indicating that Staff Mikhail Mattson was suspended pending information that was received. Administrator Perhase said he was told by Home Manager Kelly Smith that Mr. Mattson tied two doors together to restrict Resident A.

On August 9, 2021, I telephoned Manager Smith and she reported that she saw Mr. Mattson tie an extension cord from one door to another to restrict Resident A to his room. Manager Smith told Mr. Mattson "you cannot do that." Manager Smith indicated she informed Administrator Perhase about the incident and Mr. Mattson was suspended pending an investigation.

On August 11, 2021, I conducted an onsite investigation and interviewed Staff Cammie Chafin. Ms. Chafin stated that she worked from 6 am to 10 pm on August 6, 2021. Ms. Chafin said she worked with Manager Smith and Mr. Mattson. Ms. Chafin said it was about 5 pm on August 6, 2021, and they were all sitting in the living room. Ms. Chafin said Resident A "started head butting" Manager Smith in the leg. Manager Smith redirected Resident A, but Mr. Mattson got up and said, "I just had enough." Ms. Chafin said Mr. Mattson walked away with Resident A and then came back into the living room. Ms. Chafin and Manager Smith then "just looked at each other." When Ms. Chafin and Manager Smith got up and walked out by the kitchen, they both saw Resident A's door tied with an extension cord across the hall to Resident B's door. Ms. Chafin said Manager Smith went outside and made a phone call to Administrator Perhase. Mr. Mattson asked Ms. Chafin if she turned him in. Ms. Chafin indicated Manager Smith untied the door.

I then interviewed Staff Nicole Swartzendruber. Ms. Swartzendruber stated she worked from 10 pm until 6 am on August 6, 2021, with Mr. Mattson. Ms. Swartzendruber indicated Resident A "was having high behaviors that day." Mr. Mattson told Ms. Swartzendruber "you always have the option of tying his door." Ms. Swartzendruber was quite surprised and told him "you can't do that."

On August 8, 2021, I received an *AFC Licensing Division/incident-Accident Report* that was signed and dated by Administrator Brett Perhase on August 8, 2021. It indicates what happened and action taken by staff, 'See Attachment.' The attachment indicates "On Sunday, August 8, 2021, Program Coordinator at Central State Community Services, Brett Perhase, came to Genesis House to meet with Home Supervisor, Kelly Smith, after receiving allegations that staff member, Mikhail Mattson, was aggressive towards the individual, [Resident A], who resides at the

house. Once Mikhail arrived for his shift at 2pm, he was called to the office to meet with Brett and Kelly. Brett stated that Mikhail was not allowed to work and was being put on suspension, pending investigation. Brett then notified Catherine Jaskowski, Office of Recipient Rights for Huron County and left a message. Brett then called Kay Huber, Adult Foster Care Licensing Consultant and left a message. Lastly, Brett called [Guardian 1], Guardian for [Resident A] and left a message. Once everyone was notified, Brett completed an incident report and faxed it to both the Office of Recipient rights and Licensing."

On August 11, 2021, I observed Resident A as he is severely mentally impaired and unable to provide any information. He appeared clean and healthy.

On August 10, 2021, Recipient Rights Officer Cathy Jaskowski emailed me a statement that indicated the staff at Genesis are doing a great job. Ms. Jankowski had no concerns about the care the residents receive there.

On August 26, 2021, I received written statements from Staff Nicole Swartzendruber and Cammie Chafin. The written statement confirmed the information that I obtained during previous interviews.

On August 27, 2021, I telephoned Staff Mikhail Mattson. Mr. Mattson asked if he was going to be charged with a crime and I advised him I only regulate the license. I asked Mr. Mattson if he knew anything about an extension cord being tied to a door and he replied, "I don't answer questions." I advised him he did not have to provide any information.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.**

ANALYSIS:	Home Manager Kelly Smith and Staff Cammie Chafin both observed an extension cord tied across the hall to another resident's room. Resident A could not get out of his room. Staff Mikhail Mattson had just walked Resident A back to his room when the extension cord was noticed. Mr. Mattson told Staff Nicole Swartzendruber that she had the option of tying Resident A's door so he could not get out. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On August 27, 2021, I conducted a telephone exit conference with Licensee Paula Ott. I advised Licensee Ott that there would be a rule violation regarding this complaint.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care small group home remain unchanged (capacity 1-6).

Kathryn Huber 08/30/2021

Kathryn A. Huber Date
Licensing Consultant

Approved By:
Mary Holton 08/30/2021

Mary E Holton Date
Area Manager