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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 23, 2021

Jonathan Harland
Community Home & Health Services LLC
657 Chestnut Ct
Gaylord, MI 49735

RE: License #: AS690382148
Investigation #: 2021A0009035
Pinehaven Red

Dear Mr. Harland:

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 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 (231) 922-5309.

Sincerely,

A handwritten signature in cursive script that reads "Adam Robarge".

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS690382148
Investigation #:	2021A0009035
Complaint Receipt Date:	08/05/2021
Investigation Initiation Date:	08/05/2021
Report Due Date:	09/04/2021
Licensee Name:	Community Home & Health Services LLC
Licensee Address:	657 Chestnut Ct Gaylord, MI 49735
Licensee Telephone #:	(989) 732-6374
Administrator:	Jonathan Harland
Licensee Designee:	Jonathan Harland, Designee
Name of Facility:	Pinehaven Red
Facility Address:	118 McLouth Rd Gaylord, MI 49735
Facility Telephone #:	(989) 732-1614
Original Issuance Date:	05/31/2016
License Status:	REGULAR
Effective Date:	07/02/2021
Expiration Date:	07/01/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A has engaged in unwanted sexual activity with Resident B. He has snuck into her room, kissed and touched her, and bribed her with snacks afterwards. He has not been supervised properly by staff even though his past, predatory behavior is well-documented.	Yes

III. METHODOLOGY

08/05/2021	Special Investigation Intake 2021A0009035
08/05/2021	APS Referral
08/05/2021	Special Investigation Initiated - On Site Interviews with home manager Mr. Shawn Goosen, Ms. Chris Rambo, Community Home & Health Services administrator and Ms. Chris Hastings, North Country Community Mental Health (CMH). Face to face with Resident A and Resident B
08/05/2021	Contact – Document (email) received from Ms. Amanda Dixon, North Country CMH recipient rights
08/05/2021	Contact – Document (email) sent to Ms. Amanda Dixon, North Country CMH recipient rights
08/19/2021	Contact – Telephone call received from Ms. Amanda Dixon, North Country CMH recipient rights
08/20/2021	Exit conference with licensee designee Jonathan Harland

ALLEGATION: Resident A has engaged in unwanted sexual activity with Resident B. He has snuck into her room, kissed and touched her, and bribed her with snacks afterwards. He has not been supervised properly by staff even though his past, predatory behavior is well-documented.

INVESTIGATION: I conducted an unannounced site inspection at the Pinehaven Red adult foster care (AFC) home on August 5, 2021. I wore personal protection equipment to protect myself and others. The home manager, Mr. Shawn Goosen, was present at the home along with Ms. Chris Hastings and Ms. Chris Rambo. Ms. Hastings is the adult behavior specialist with North Country Community Mental

Health (CMH) who is involved with Resident A. Ms. Rambo is an administrator with Community Home & Health Services. Ms. Hastings reported that she has been involved with Resident A and Resident B and is aware of the latest incidents of unwanted sexual activity. Resident B disclosed that Resident A was in her bedroom kissing her and inappropriately touching her. He was trading her snacks for “favors”. Ms. Hastings reported that Resident A has a history of sexual behavior and should not have been in Resident B’s bedroom. Ms. Hastings also said that Resident B is unable to understand what was happening to her. I asked how Resident A was supposed to be monitored to ensure that he did not victimize other residents. Ms. Hastings reported that door alarms were put in place so that staff would be alerted when Resident A left his bedroom or if he attempted to enter another resident’s bedroom. Staff were also supposed to be checking on Resident A every 20 minutes. Mr. Goosen stated that he had believed that checking on Resident A was to happen every 30 minutes. Ms. Rambo and Ms. Hastings reported that Resident A is being moved from the home now because the home is unable to provide “one-on-one” supervision that he now requires.

I spoke with Mr. Goosen about staffs’ supervision of Resident A. He replied that he felt that they were diligent in watching him. I asked him when he believed the latest incident between Resident A and Resident B occurred. He stated that Resident B disclosed the activity on August 4, 2021, so he believed it happened the day or night before. I asked to see the log they keep to document that Resident A was being checked on. Mr. Goosen provided me with two log sheets corresponding to Resident A and Resident B. The logs were completely blank from 9:30 p.m. until 11:30 p.m. on August 1, 2021 and also completely blank from 9:00 p.m. on August 2, 2021 until 6:30 a.m. on August 4, 2021. There were no initials on the logs indicating that anyone had checked on either Resident A or Resident B between those times. I asked Mr. Goosen about the logs not having proper documentation. He replied that the staff involved have been “written-up” and showed me that documentation for Resident A and Resident B started up again at 9:00 p.m. on August 4, 2021. Mr. Goosen stated that besides checking on Resident A every 30 minutes, they are also supposed to check on him every time they hear an activated door alarm. He went on to say that he believed that Resident A had figured out a way to deactivate the door alarms to his and Resident B’s bedroom. Mr. Goosen demonstrated that he believed Resident A had taken the bottom piece out of the door alarm while the door was open and had possibly done the same with Resident B’s door alarm. He said that a staff person had found the bottom piece of Resident A’s door alarm missing about a month ago and found that Resident A had the missing piece in his pocket. Mr. Goosen also demonstrated that the bottom section of the door alarm to both Resident A and Resident B’s doors were loose possibly from being taken apart on several occasions. He showed me that the bottom section of a third resident’s door alarm was very tight as if it had never been taken apart. The third resident is a male. Mr. Goosen acknowledged that staff have not been specifically instructed to check the door alarms each night. Mr. Goosen reported that there is now a safety plan in place to monitor Resident A and Resident

B until Resident A is moved to another facility. Mr. Goosen provided me with Resident A's Behavior Assessment and Support Plan dated February 26, 2021.

I reviewed Resident A's Behavior Assessment and Support Plan dated February 26, 2021. It reported, "(Resident A) has a history of hypersexual behavior with housemates, both males and females." It further reported, "Records show that Emergency Services for NCCMH was called due to his inappropriate sexual engagement with a female housemate and he was asked to be removed from the facility and located elsewhere." This was in reference to the last facility Resident A lived at before being moved to the Pinehaven Red AFC home. Resident A's Objective 1 in the plan is that he "will demonstrate appropriate social skills, respecting the boundaries of others as evidenced by 0 (zero) incidents of sexually inappropriate behavior each month during the next year". This was to be accomplished by "(Resident A) and his female housemate have door alarms on their bedroom doors so that staff can hear when (Resident A) is entering or leaving his and attempting to enter her bedroom. (Resident A) requires line of sight supervision in the home due to his history of sexualized inappropriate behaviors that include entering female housemates' bedroom without permission and unwanted sexualized comments to females." The plan also required the continued use of door alarms and bed checks every 20 minutes to ensure Resident A is in his room and not in a housemate's room.

Ms. Amanda Dixon with CMH recipient rights emailed me on August 5, 2021. In her email, she documented that she was also investigating the matter of Resident A and Resident B. She stated that she would be starting her interviews soon.

I spoke with Ms. Amanda Dixon with CMH recipient rights by phone on August 19, 2021. She stated that she had interviewed Resident A regarding the allegation of him being in Resident B's bedroom and touching her inappropriately. Ms. Dixon stated Resident A admitted that he had been in her bedroom and said that he thought that he had gone in there six times and that it was at night. Ms. Dixon also stated that Resident A informed her he had given Resident B hugs and then gave her snacks but didn't remember if he gave her kisses or not. Ms. Dixon went on to say that she believed there is a preponderance of evidence that the facility staff did not follow Resident A's Behavior Plan. Staff did not check on Resident A every 20 minutes as directed and did not provide "line of sight" supervision at all times. The home manager, Mr. Shawn Goosen, reportedly admitted to her on two separate occasions that they had not provided "line of sight" supervision and that they had not been trained on "line of sight" supervision. Ms. Dixon stated that the facility staff were trained on three separate occasions since February of 2021 on Resident A's Behavior Plan and specifically on the "line of sight" supervision needed for Resident A. The "line of sight" supervision is a requirement for Resident A because he is a risk to others due to his history of pursuing unwanted sexual activity. Ms. Dixon was also provided with the bed check logs which had large areas of missing documentation from August 1 until August 4, 2021. The missing documentation corresponded to the time-frame immediately prior to Resident B disclosing the

unwanted sexual contact. Ms. Dixon stated that the 2021 contract between North County CMH and Community Home & Health Services LLC states, “Services not documented will be considered services not provided.”

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:	It was confirmed through this investigation that the licensee did not provide supervision as specified in Resident A’s written assessment plan. Resident A’s CMH Behavior Assessment and Support Plan dated February 26, 2021, required that Resident A receive “line of sight” supervision and 20-minute supervision checks. The home manager initially admitted that they did not provide line of sight supervision for Resident A. He also reported that the supervision checks were only done every 30 minutes. Even the 30-minute supervision checks were not documented properly with large gaps between August 1 and August 4, 2021. These gaps in documentation were immediately preceding Resident B disclosing the unwanted sexual contact from Resident A.
CONCLUSION:	VIOLATION ESTABLISHED

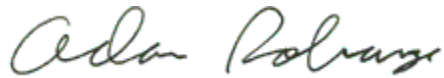
APPLICABLE RULE	
R 400.14305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	It was confirmed through this investigation that Resident A and Resident B’s personal needs, including protection and safety, were not attended to at all times. Resident A has a well-documented history of unwanted sexual contact with other residents. CMH required line of sight supervision, 20-minute supervision checks when he was in his bedroom and door alarms. The line of sight supervision and 20-minute supervision checks did not occur as required. Resident A had previously been found to have disabled his door alarm. Steps were not

	taken after this to ensure that he was not further disabling his or Resident B's door alarm to gain access to her.
CONCLUSION:	VIOLATION ESTABLISHED

An exit conference was conducted with licensee designee Mr. Jonathan Harland by phone on August 20, 2021. He was told the findings of my investigation. He was given the chance to ask questions.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



08/23/2021

Adam Robarge
Licensing Consultant

Date

Approved By:



08/23/2021

Jerry Hendrick
Area Manager

Date