GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 22, 2021

James Hoeberling
J&W Ventures, Inc.
10686 Wacousta Road
DeWitt, MI 48820

RE: License #: AM190338087
Investigation #: 2021A0783045
A Family Affair

Dear Mr. Hoeberling:

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 (517) 284-9730.

Sincerely,

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM190338087
Investigation #:	2021A0783045
Complaint Receipt Date:	08/03/2021
Investigation Initiation Date:	08/03/2021
Report Due Date:	10/02/2021
Licensee Name:	J&W Ventures, Inc.
Licensee Address:	10686 Wacousta Road DeWitt, MI 48820
Licensee Telephone #:	(810) 922-2938
Administrator:	James Hoeberling
Licensee Designee:	James Hoeberling
Name of Facility:	A Family Affair
Facility Address:	8990 E. M-78 Haslett, MI 48840
Facility Telephone #:	(517) 339-8968
Original Issuance Date:	04/09/2013
License Status:	REGULAR
Effective Date:	03/25/2020
Expiration Date:	03/24/2022
Capacity:	12
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was not protected when Resident B sexually assaulted Resident A at the facility on July 30, 2021.	Yes
Resident B was restricted to his bedroom after sexually assaulting another resident at the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/03/2021	Special Investigation Intake – 2021A0783045
08/03/2021	Special Investigation Initiated - On Site
08/03/2021	Contact - Face to Face interviews with Resident A, Resident B, direct care staff member and home manager Cindy Behrens, and officer Greg Welch
08/03/2021	Contact - Document Received – Resident B's resident record
08/03/2021	Contact - Document Received – Resident Register
08/04/2021	Contact - Telephone call made to licensee designee James Hoeberling
09/17/2021	Contact - Telephone call made to direct care staff member Stacy Little and Tonya Calhoun from Tri-County Guardianship Services
09/21/2021	Exit Conference left message for James Hoeberling

ALLEGATION:

Resident A was not protected when Resident B sexually assaulted Resident A at the facility on July 30, 2021.

INVESTIGATION:

On August 3, 2021, I received a complaint via centralized intake that stated on July 30, 2021, at 10:00 am, Resident A was sexually assaulted by Resident B. The complaint stated Resident A was in the main living area of the home and was sitting in her wheelchair when Resident B was observed standing in front of Resident A facing her with his hands on Resident A's waist. The complaint stated Resident A was found with her shirt lifted and both of her breasts exposed. The complaint stated a discharge notice was given to Resident B in January 2021, but he has not moved as his guardian has not been able to secure an alternative placement.

On August 3, 2021, I completed an unannounced onsite investigation at the facility and interviewed Resident A who said she was aware that I was there to discuss Resident B as a police officer already interviewed her. Resident A said Resident B put his hands on her neck and shoulders before moving his hands to her breasts as he stood behind her while she sat in her wheelchair in the living room at the facility. Resident A said Resident B stood behind her with his hands on her breasts "for a few minutes" until home manager and direct care staff member Cindy Behrens walked into the room, and Resident B stopped touching Resident A. Resident A said Resident B has touched her in this manner "probably every week for months." Resident A said she "was not okay with" Resident B touching her, but stated she never asked him to stop touching her. Resident A stated she did not tell anyone about the unwanted touching, and it was only discovered when Resident B was observed actively touching her. Resident A said since the incident staff members were protecting her at the facility, and she felt safe at the facility.

On August 3, 2021, I interviewed Resident B who stated he recalled an incident that occurred on July 30, 2021, when he was "messing around with" Resident A. Resident B said on July 30, 2021, he and Resident A were in the living room when no other residents nor staff members were present and Resident B kissed Resident A on the mouth and touched her breasts with his hands. Resident B said he and Resident A have "fooled around before" when staff members have been busy assisting other residents. Resident B denied that Resident A ever asked him to stop touching her but identified the touching as "inappropriate and wrong." Resident B said on July 30, 2021, home manager and direct care staff member Cindy Behrens walked into the room and "stopped" Resident B from kissing Resident A and touching Resident A's breasts.

On August 3, 2021, I spoke to home manager and direct care staff member Cindy Behrens who said there was a prior incident in January 2021 when Resident B "tickled" Resident A in a way that made Resident A uncomfortable and left bruises

on Resident A's breasts. Ms. Behrens said after that incident the licensee issued a 30-day discharge notice to Resident B but his guardian has not been able to secure an alternative placement for him so Resident B remains at the facility. Ms. Behrens said Resident B also has a history of inappropriately touching staff member as well. Ms. Behrens said since January 2021 when Resident B "inappropriately tickled" Resident A, Resident B was redirected to stay out of the formal living room where Resident A spends most of her time. Ms. Behrens said from January 2021 until July 30, 2021, Resident B abided by the restriction and stayed out of the formal living room. Ms. Behrens said she arrived for work at 6:00 am on July 30, 2021, and Resident A was awake and Resident B was asleep. Ms. Behrens said at approximately 9:00 am Resident B was redirected after touching direct care staff member Stacey Little's buttocks. Ms. Behrens stated at approximately 10:00 am Ms. Little was in the bathroom with another resident, and she walked into the formal living room and observed Resident A sitting in her wheelchair with her back to Ms. Behrens and Resident B standing behind Resident A with his hands in front of him, also with his back toward Ms. Behrens. Ms. Behrens said Resident A's shirt and bra were "pulled up" and her breasts were exposed. Ms. Behrens said Resident B stated, "I'm doing nothing," and Resident A's face was red, and she had tears in her eyes. Ms. Behrens said Resident B acknowledged that Resident A's shirt was up but denied touching Resident A. Ms. Behrens said when she asked Resident A if Resident B hurt her or touched Resident A said "no." Ms. Behrens stated Ms. Little later spoke with Resident A and Resident A told Ms. Little that Resident B "touched" her, and that the touching made Resident A "uncomfortable." Ms. Behrens said Resident A was told to "ring her bell" if Resident B was nearby. Ms. Behrens stated a police officer came to the facility and interviewed Resident A earlier that day and Resident A told the police officer that Resident B "sucked on [Resident A's] breast" and Resident B asked her to lean forward in her wheelchair so he could touch her buttocks and she leaned forward, and Resident B touched Resident A's buttocks in addition to touching her breasts. Ms. Behrens said Resident A told the police officer that she did not want to pursue criminal charges against Resident B. Ms. Behrens stated Resident A was observed with a bruise on her breast the day of the interview, which was several days after the incident on July 30, 2021.

On September 17, 2021 I spoke to direct care staff member Stacey Little who said there was a prior incident in January 2021 when Resident B seemingly touched Resident A's breasts so staff members have been trained to ensure Resident A wears a bra but did not provide any additional information concerning protecting Resident A. Ms. Little stated a 30-day discharge notice was issued to Resident B in January 2021 but his guardian had not placed Resident B elsewhere by July 30, 2021 when a second incident occurred. Ms. Little said when she arrived at work at 7:00 am on July 30, 2021, she did not observe any abnormal behavior from Resident A nor Resident B until approximately 9:00 am when Resident B touched her on the buttocks and she verbally redirected him. Ms. Little stated at approximately 10:00 am Ms. Behrens informed her that she observed Resident B with Resident A's breasts "in his hands," and that Resident B had "pulled up" Resident A's shirt and bra, exposing her breasts. Ms. Little said she spoke to Resident A who told her

Resident B touched Resident A's breasts, that Resident A did not consent to the touching, and that Resident B has touched her before. Ms. Little stated Resident A was crying and appeared very upset by being touched by Resident B. Ms. Little stated Resident A then agreed to spend time in another area of the facility where she could be more easily monitored by staff members and was told to "ring her bell" if Resident B came near her.

On August 4, 2021, I spoke to licensee designee James Hoeberling who stated Ms. Behrens informed him that on July 30, 2021, she observed Resident B with his hands on Resident A's breasts and Resident B had Resident A's shirt and bra pulled up and Resident A's breasts were exposed. Mr. Hoeberling stated he issued a written 30-day discharge notice in January 2021 because Resident B inappropriately touched Resident A at that time, and July 30, 2021, was the second known instance of Resident B inappropriately touching Resident A.

On September 17, 2021, I spoke to Tonya Calhoun who is Resident B's public guardian from Tri-County Guardianship Services. Ms. Calhoun said there have been prior incidents of Resident B "groping" female staff members at the facility. Ms. Calhoun stated the first incident occurred in January 2021 and the licensee issued a 30-day discharge but she had not been able to secure an alternative placement for Resident A by July 30, 2021, when the second incident of "groping" occurred. Ms. Calhoun said she was told that Resident B "sexually assaulted" another resident at the facility on July 30, 2021. Ms. Calhoun said she was told the resident who was assaulted was very upset because Resident B lifted her shirt and bra and exposed and touched [Resident A's] breasts. Ms. Calhoun stated following the incident a 24-hour emergency discharge notice was issued. Ms. Calhoun stated since the police and adult protective services were involved, she felt compelled to move Resident B into a motel, which she did on or about August 6, 2021. Ms. Calhoun said Resident B never told her he touched Resident A in any way but that Resident B "did this on purpose because he wanted to get kicked out of the home."

On August 3, 2021, I interviewed officer Greg Welch from the Bath Township Police Department and he stated Resident A told him Resident B sexually assaulted her by touching her breasts and buttocks. Officer Welch said Resident A declined to press criminal charges against Resident B and he informed Resident A she can change her mind at any time. Officer Welch said he advised Resident A to consider filing for a personal protection order from Resident B.

On August 3, 2021, I received a written *AFC Licensing Division Incident/Accident Report* dated January 17, 2021. The written report stated on January 17, 2021 "staff walked into front living room to check on [Resident A] and found [Resident B] bent over in front of [Resident A]. Staff asked [Resident B] was he was doing and [Resident B] replied he was tickling [Resident A's] tummy. [Resident A] has large breasts that hang down to her belly. Then [Resident B] tickled [Resident A] again in front of [staff member Ann Shultz], touching [Resident A's] breasts. Staff told [Resident B] to stop and made him leave the area. Ann Shults told [Resident B] that

it was inappropriate to touch [Resident A] in that way or anyone else and he has molested [Resident A]. Staff went back to talk to [Resident A] and she stated she did not like being touched that way and also stated that [Resident B] has done this to her on another occasion." There were no corrective measures listed on the written report. On August 4, 2021, I spoke to assigned licensing consultant Dawn Campbell who stated she spoke with Ms. Behrens after the incident and was under the impression that this was the first occasion of Resident B inappropriately touching another resident, staff members were present and immediately intervened, and that Residents A and B would be appropriately supervised moving forward. Ms. Campbell said an additional corrective measure was that a written 30-day discharge notice was issued to Resident B.

On August 3, 2021, I received a written *AFC Licensing Division Incident/Accident Report* dated July 30, 2021. According to the written report completed by direct care staff member and home manager Cindy Behrens, she "came into the formal living room [and] found [Resident A] in her wheelchair with her back to me. [Resident B] was standing in front of [Resident A] slightly bent over with his hands on [Resident A's] waist. I asked him what he was doing and he replied, 'I'm not doing anything.' I asked him to leave the formal living room. All the way out he kept saying he didn't do anything. I then went around [Resident A's] wheelchair to face her. I found her shirt pulled up above her bra with both breasts hanging out of her bra. ([Resident A] has large breasts and when out of her bra they hang almost to her waist). [Resident A's] face was red and she had tears in her eyes." In the "action taken by staff" section of the written report it stated, "Staff redirected [Resident B] from the room. [Resident A's] clothes were put back together. [Resident A] was reassured she was safe and we would keep [Resident B] away from her." In the "corrective measures taken" section of the written report it stated, "I called the owner James Hoeberling. Told him what happened. He called [Resident B's] guardian and asked for an emergency removal. Guardian is trying to find placement (has been since January)." Additionally, direct care staff member Stacy Little wrote, "When I talked to [Resident A] about [Resident B] she said she wanted him kept away from her. She was very shaken and crying."

On August 3, 2021, I received a copy of a written 30–day discharge notice referencing Resident B which was dated January 22, 2021 and stated, "[Resident B] and designated guardian is hereby notified that [Resident B] is being served with a 30-day notice to vacate [the facility]. The reasons for eviction are: 1. [Resident B] is verbally threatening harm to other residents. 2. [Resident B] is inappropriately touching staff and fellow residents."

On August 5, 2021, I received a copy of a written 24–hour emergency discharge notice referring to Resident B which was dated August 5, 2021 and stated, "[Resident B] and designated guardian are hereby notified that [Resident B] is being served with an emergency 24 hour eviction notice to vacate [the facility] effective immediately. The reasons for eviction are: 1. [Resident B] presents a substantial risk regarding the home's ability to meet his needs, as well as to the safety and wellbeing

of the other residents. 2. [Resident B] is inappropriately touching staff and fellow residents 3. [Resident B] and designated guardian were presented with a 30 day notice of eviction on January 22, 2021 and have not made arrangements for removal."

On August 4, 2021, I received and reviewed Resident B's written *Assessment Plan for AFC Residents* dated January 29, 2021. The written assessment plan stated Resident B controls sexual behavior "most of the time." The assessment stated, "Behavior management will be accomplished by listening, offer an explanation, close supervision, distraction, redirection with realistic expectations."

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 statements from Resident A, Resident B, Ms. Behrens, Ms. Little, Mr. Hoeberling, Ms. Calhoun, and Officer Welch along with written documentation at the facility it can be determined that Resident B inappropriately touched Resident A in January 2021 which was in part the reason a 30 – day written discharge notice was issued at that time. Despite this prior history no specific protective measures were put in place for Resident A and Resident B sexually assaulted her again on July 30, 2021, which was by all accounts deeply upsetting to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B was restricted to his bedroom after sexually assaulting another resident at the facility.

INVESTIGATION:

On August 3, 2021, I received a complaint via centralized intake that stated since sexually assaulting Resident A on July 30, 2021, Resident B has been made to stay in his bedroom. The complaint stated Resident B's meals are brought to his bedroom.

On August 3, 2021, I interviewed Resident B who said since he “messed around with” Resident A, which was “not right to do,” on July 30, 2021, he has been told to stay in his bedroom. Resident B referred to this arrangement as “punishment” for inappropriately touching Resident A. Resident B said he would like to leave his bedroom and move freely about the facility.

On August 3, 2021, I interviewed Resident B who said Resident A sexually assaulted her on July 30, 2021 and has been told to stay in his bedroom since the incident.

On August 3, 2021, I spoke to direct care staff member and home manager Cindy Behrens who said to protect Resident A who was sexually assaulted by Resident B on July 30, 2021, she received authorization from licensee designee James Hoeberling to tell Resident B to stay in his bedroom until he could be placed at another facility that could meet his needs. Ms. Behrens said Resident B is eating all meals in his bedroom. Ms. Behrens said if Resident B desires to leave his bedroom he “rings his bell” and a staff member will accompany Resident B to wherever he needs to go.

On August 4, 2021, I spoke to licensee designee James Hoeberling who confirmed as a protective measure for Resident A, Resident B has been redirected to his bedroom where he receives all his meals until his guardian can secure another placement for Resident B. Mr. Hoeberling stated he does not have enough staff members employed at the facility to assign a staff member specifically to monitor Resident B.

On September 17, 2021, I spoke to direct care staff member Stacy Little who said Resident B sexually assaulted Resident A on July 30, 2021 and since that time Resident B has been directed by staff members to remain in his bedroom. Ms. Little said Resident B was able to come out of his room when a staff member was available to directly supervise him. Ms. Little said Resident B was told to stay in his bedroom at the facility for approximately “one to two weeks” before discharging from the facility.

On September 17, 2021, I spoke to Tonya Calhoun who is Resident B’s assigned public guardian from Tri-County Guardianship Services. Ms. Calhoun said Resident B sexually assaulted another resident on July 30, 2021 and as a result Resident B “was put in his room and [Resident B] could not leave [the bedroom] without staff.” Ms. Calhoun said she was not given a choice regarding this arrangement but acknowledged there are not enough staff members employed at the facility to assign an employee directly to Resident B. Ms. Calhoun said she “agreed” to have Resident B stay in his bedroom at the facility because she could not find an alternative placement for Resident B and “wanted to keep the women safe.”

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(b) The right to exercise his or her constitutional rights, including the right to vote, the right to practice religion of his or her choice, the right to freedom of movement, and the right of freedom of association.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based on statements from Resident B, Resident A, Ms. Behrens, Ms. Little, Mr. Hoeberling, and Ms. Calhoun there is sufficient proof that Resident B's freedom of movement was restricted when he was told by staff members to stay in his bedroom to protect Resident A after Resident B sexually assaulted Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On August 3, 2021, I reviewed the Bureau Information Tracking System (BITS) and noted that the facility is licensed to care for individuals who are aged.

On August 3, 2021, I reviewed the written Program Statement for the facility which stated, "the population served will be aged adults who are unable to care for themselves."

On August 3, 2021, I reviewed the definition of aged per Act Number 218, which stated, "aged means an adult whose chronological age is 60 years of age or older or whose biological age, as determined by a physician, is 60 years of age or older."

On August 3, 2021, I reviewed the written license posted on the wall at the facility and noted that the facility is licensed to care for individuals who aged.

On August 3, 2021, I reviewed Resident B's resident record which listed his birthdate as January 23, 1971, which makes Resident B 50 years of age.

On August 3, 2021, I reviewed the resident register which indicated Resident B was admitted to the facility February 22, 2019.

On August 3, 2021, I reviewed Resident B's written *Health Care Appraisal* dated December 4, 2020. The diagnoses listed were traumatic brain injury (TBI), hypertension, gait abnormality, diabetes, neuropathy, obesity, and mood disorder. The document stated Resident B had impaired mood and behavior as well as impaired cognition.

On August 4, 2021, I spoke to licensee designee James Hoeberling who acknowledged that Resident B is not 60 years of age chronologically nor biologically as determined by a physician. Mr. Hoeberling also acknowledged that he nor the staff members who work at the facility have been trained to care for individuals diagnosed with a traumatic brain injury. Mr. Hoeberling stated he believed he gained "permission" from a licensing consultant to admit Resident B to the facility even though he is not aged but stated he could not provide anything in writing to document "permission" was granted.

On September 17, 2021, I spoke to Tonya Calhoun from Tri-County Guardianship Services who is Resident B's assigned public guardian. Ms. Calhoun confirmed Resident B's date of birth is January 23, 1971, that he is 50 years of age, and that his primary diagnosis is a traumatic brain injury (TBI).

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, and member of household on parole or probation or convicted of a felony; food service staff.**
	(2) A licensee shall have the financial and administrative capability to operate a home to provide the level of care and program stipulated in the application.

ANALYSIS:	According to the written license and program statement the population served at the facility is aged. Based on statements from Mr. Hoeberling and Ms. Calhoun as well as written documentation in Resident B's resident record it can be determined that Resident B is not aged according to the legal definition of the term. According to the application, license and facility program statement the licensee is not approved for nor experienced and qualified to care for individuals diagnosed with a traumatic brain injury. Consequently, Resident B should not have been admitted to the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

09/21/2021

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Leslie Herrguth — Date
Licensing Consultant

Approved By:

09/22/2021

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Dawn N. Timm — Date
Area Manager