GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 20, 2021

Rashalle Austin
Unity Group V, LLC
163 N. Fiske Road
Coldwater, MI 49036

RE: License #: AS120385673
Investigation #: 2021A0007019
Unity Group V, LLC

Dear Ms. Austin:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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 (313) 456-0380.

Sincerely,

Mahtina Rubritius

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604

Enclosures

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS120385673
Investigation #:	2021A0007019
Complaint Receipt Date:	07/23/2021
Investigation Initiation Date:	07/23/2021
Report Due Date:	09/21/2021
Licensee Name:	Unity Group V, LLC
Licensee Address:	163 N. Fiske Road Coldwater, MI 49036
Licensee Telephone #:	(517) 617-9591
Administrator:	Rashalle Austin
Licensee Designee:	Rashalle Austin
Name of Facility:	Unity Group V, LLC
Facility Address:	69 Wood Drive Coldwater, MI 49036
Facility Telephone #:	(517) 924-1462
Original Issuance Date:	01/29/2018
License Status:	REGULAR
Effective Date:	10/04/2019
Expiration Date:	10/03/2021
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED

	MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Ms. Edwards, Direct Care Staff, verbally threatened Mr. Burdette, House Supervisor. Resident A witnessed the incident and had taken a video of it, causing concern for her safety. Resident A feels unsafe in the home.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/23/2021	Special Investigation Intake - 2021A0007019
07/23/2021	APS Referral Received.
07/23/2021	Special Investigation Initiated – Letter - Email to APS Supervisor #1.
07/23/2021	Contact - Document Received Email from APS Supervisor #1.
07/23/2021	Contact - Document Sent - Email to MDHHS Supervisor #1.
07/23/2021	Contact - Document Received - Email from MDHHS Supervisor #1.
07/26/2021	Inspection Completed On-site - Unannounced - Face to Face contact with Employee #1 and Resident B.
09/07/2021	Contact - Telephone call made to Ms. Filmore, Administrative Staff. I requested a copy of Resident A's file.
09/09/2021	Contact - Telephone call received from Ms. Filmore, regarding the file.
09/10/2021	Contact - Telephone call received from Ms. Filmore; fax is not going through. It may be an issue with the fax machine in the office.
09/15/2021	Contact - Face to Face contact with Ms. Filmore, Administrative Coordinator. She also provided me with copies of Resident A's file.

09/16/2021	Contact - Telephone call made to Ms. Poulsen, Foster Care Worker. Voicemail indicates she no longer works for MDHHS.
09/16/2021	Contact - Document Sent - Email to Ms. Pennock, Supervisor at MDHHS. I requested the phone number of the new home where Resident A was located.
09/16/2021	Contact - Document Received- Email from Ms. Pennock, Supervisor at MDHHS.
09/16/2021	Contact - Telephone call made - Interview with Ms. Filmore.
09/20/2021	Contact - Telephone call made - Interview with Resident A. I also spoke with Ms. Powell, Home Manager.
09/20/2021	Contact - Telephone call received from Ms. Baker, Case Manager, Placing Agency.
09/20/2021	Contact - Telephone call made to Ms. Edwards (x2), Direct Care Staff. Interview.
09/20/2021	Contact - Telephone call made to Mr. Burdette, Previous Staff. Interview.
09/20/2021	Contact - Telephone call made to Ms. Filmore.
09/20/2021	Exit Conference - conducted with Ms. Austin, Licensee Designee.

ALLEGATIONS:

Ms. Edwards, Direct Care Staff, verbally threatened Mr. Burdette, House Supervisor. Resident A witnessed the incident and had taken a video of it, causing concern for her safety. Resident A feels unsafe in the home.

INVESTIGATION:

As a part of this investigation, I reviewed the written complaint, and the following additional information was noted:

On July 20, 2021, late in the afternoon, Ms. Edwards, DCS (Direct Care Staff), verbally threatened the house supervisor, Mr. Burdette. Ms. Edwards swore at Mr.

Burdette made threats to have her people come and do bodily harm to Mr. Burdette. Resident A witnessed the incident and had taken a video of it. There is a concern for Resident A's safety as Ms. Edwards showed up at work again today. Resident A feels unsafe being in the home, as it is unknown what has or will happen to Ms. Edwards (regarding her threats against the supervisor yesterday). Several other staff members have since quit and there is concern that the home will not be properly staffed due to this incident. Resident A was given permission to leave the home for a few hours today as she felt unsafe. Resident A will likely need to be moved to a new home and this is done through the Community Mental Health.

On July 26, 2021, I conducted an unannounced on-site investigation at the facility. I made face-to-face contact with Employee #1 at Unity Group V. Employee #1 informed me that Resident A was not there as she had been moved to another home. Employee #1 did not have specific information but reported that the new home was located somewhere in Centerville. I inquired about staff cursing during a disagreement and Employee #1 stated that she did not hear about the cursing; however, Mr. Burdette was mad enough that he didn't want to work with Ms. Edwards again. I inquired about Employee #1's experience working with Ms. Edwards, and she reported it was positive. I inquired about staffing, and Employee #1 informed me that three staff had quit. These staff were Jessica Johnson**,** Manager, Crystal Rose, Direct Care Staff, and Mr. Burdette, Direct Care Staff. According to Employee #1, Mr. Burdette and Ms. Rose were saying they got fired because Mr. Burdette did not want to work with Ms. Edwards.

On July 26, 2021, while at the facility, I observed Resident B sitting in the living, utilizing her tablet. Employee #1 informed me that Resident B was the only resident in the home and that she did not require 1:1 staff supervision.

On September 15, 2021, I made face-to-face contact with Ms. Filmore, and she provided me with a copy of Resident A's file. Ms. Filmore informed me that Resident A was admitted into Unity Group V on May 14, 2021, and she was discharged on July 23, 2021. Her new placement information was unknown.

I reviewed the resident file information for Resident A. Resident A is an 18-year-old, female. She has been diagnosed with PTSD, ADHD, Major Depressive Disorder, Oppositional Defiant Disorder, and a Moderate Intellectual Disability. According to the *Assessment Plan for AFC Residents*, Resident A can move about independently in the community. It was also noted that visitation guidelines included Resident A not leaving with anyone but staff.

On September 16, 2021, I interviewed Ms. Filmore. She informed me that there was a lot going on at the Unity Group V home. The previous home manager, Ms. Johnson, got married and she purchased a home with two apartments. Ms. Filmore stated that two residents, Resident C and Resident D, had moved out of Unity Group V home into the apartments. Ms. Johnson no longer works for Unity Group Homes. Two other staff, Mr. Burdette and Ms. Rose left their employment at Unity Group

Homes and went to work and help to take care of Resident C and Resident D in their apartments.

I further inquired Ms. Filmore about the incident involving Ms. Edwards. Ms. Filmore informed me that Mr. Burdette started yelling at Ms. Edwards when she walked into the home. Resident A was recording but she didn't record what Mr. Burdette was saying to Ms. Edwards. I inquired if Resident A was physically harmed during the incident and Ms. Filmore stated she was not. I asked if Resident A expressed that she was afraid, and Ms. Filmore stated that she didn't know. According to Ms. Filmore, Resident A tried to say that Ms. Edwards yelled at her, but that was not true. Ms. Edwards admitted to cursing in front of Resident A and ORR substantiated the case. According to Ms. Filmore, Ms. Edwards received a verbal reprimand.

On September 20, 2021, I called the new facility where Resident A was placed and spoke to Ms. Powell, Home Manager. I provided my name and title and explained to her that I needed to speak with Resident A regarding an alleged incident that occurred at a different AFC home. Ms. Powell explained this information to Resident A and then handed her the phone.

On September 20, 2021, once on the phone, I provided my name, the reason for my call and explained that I had some questions for her (Resident A). I also informed Resident A that she was not in trouble. To begin the interview, I asked some general questions and Resident A replied with one-word answers. I then asked about the time when she lived at Unity Group V; specifically, the incident between Ms. Edwards and Mr. Burdette. She acknowledged that an incident occurred, and I then asked, "can you tell me more about that?" Resident A replied "no." I asked if there was ever a time when she felt unsafe in the home and Resident A replied "yeah, sure." I asked, if she could tell me more about why she felt unsafe and she replied, "People don't know how to do their jobs." When I asked who she was specifically referring to, Resident A replied "staff." No additional information was provided. During the interview, I attempted to ask a few more questions without much success. At this point, I concluded the interview by asking if she (Resident A) had any questions for me, and she did not. I asked her to hand the phone to Ms. Powell.

On September 20, 2021, I spoke to Ms. Powell, and she stated that Resident A was "triggered and done" with the interview. I informed her that it appeared that way to me as well, which is why the interview was concluded.

On September 20, 2021, I spoke with Ms. Baker, Case Manager. Ms. Baker informed me that Resident A was not talkative. In addition, that Resident A wasn't happy with her recent placements.

On September 20, 2021, I interviewed Ms. Edwards, Direct Care Staff. She stated that she had a family emergency and Mr. Burdette had to work in her place. When she arrived at work (on July 20, 2021), and walked into the door, Mr. Burdette said to her "you fucked me over" and "don't say shit else to me while I'm working." At one

point, Mr. Burdette had his fist balled up when he was talking to Ms. Edwards. Mr. Burdette also told her to “shut the fuck up,” and Ms. Edwards replied, “no you shut the fuck up.” Ms. Edwards stated that she wasn’t going to do this, and she stepped outside, as she was going to leave, but she did not. I asked if Resident A witnessed this incident and Ms. Edwards confirmed that she did. During the incident, Ms. Edwards stated that she was talking to Mr. Burdette not Resident A, but she (Resident A) did observe everything that happened. Ms. Edwards expressed remorse for her actions and stated that she was bombarded and attacked when she arrived at work. Ms. Edwards reported that her response to the situation was out of character for her and that she was embarrassed. As a consequence, Ms. Edwards described receiving a verbal reprimand. Ms. Edwards expressed concerns about being fired and stated that this will never happen again. Ms. Edwards reiterated that this was out of character for her. Ms. Edwards also informed me that she was interviewed by the Office of Recipient Rights regarding this matter.

On September 20, 2021, I interviewed Mr. Burdette. He informed me that when Ms. Edwards returned to work; she had an attitude after not showing up for two days. Mr. Burdette stated that Ms. Edwards started yelling about things not being done. He assumed that he had more time to complete the work, since he was scheduled to work until midnight. Mr. Burdette made a comment that if Ms. Edwards had shown up to work, this wouldn’t have been an issue. I inquired if he was cursing at Ms. Edwards, and he stated not then, but later. Mr. Burdette stated that he told Ms. Edwards that she needed to “shut the fuck up.” Ms. Edwards then said, “what did you say?” Ms. Edwards then ran to the desk and was yelling at him for a while. I asked if she used profanity and Mr. Burdette stated he thought so but couldn’t recall. He confirmed that Resident A was present and recorded the conversation when he was getting yelled at. Mr. Burdette stated that Ms. Edwards went to wash the dishes and made the statement that nobody should say anything. Mr. Burdette confirmed that he was also interviewed by ORR regarding this incident. Mr. Burdette no longer works for Unity Group Homes.

On September 20, 2021, I conducted the exit conference with Ms. Austin, Licensee Designee. I informed her of the findings and my recommendations. Ms. Austin expressed that she was frustrated about the ex-staff members, their choices, and how they’re now being cited. I acknowledged her frustration but informed that the violations still occurred. Therefore, I would be requesting a written corrective action plan. Ms. Austin agreed to submit a corrective action plan.

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:	On July 20, 2021, there was a verbal disagreement between Mr. Burdette and Ms. Edwards. Both the staff used profanity in front of Resident A. During my interview with Resident A, I asked if there was ever a time when she felt unsafe in the home and Resident A replied "yeah, sure." I asked, if she could tell me more about why she felt unsafe and she replied, "People don't know how to do their jobs." When I asked who she was specifically referring to, Resident A replied "staff." Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Resident A was not treated with dignity and her personal needs, including protection and safety, were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On September 20, 2021, I spoke with Ms. Filmore and inquired if an incident report had been written regarding the incident on July 20, 2021. She stated that it had not, but that Ms. Edwards was given a verbal reprimand.

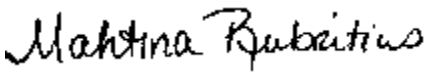
On September 20, 2021, I spoke with Ms. Edwards again and inquired if she had completed an incident report and she informed me that she did not.

During the exit conference with Ms. Austin, I provided the rule and information regarding when an incident report is required. I requested that Ms. Austin submit a written corrective action plan to address the established violation, and she agreed to do so.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information: **(a) The name of the person who was involved in the accident or incident.** **(b) The date, hour, place, and cause of the accident or incident.** **(c) The effect of the accident or incident on the person who was involved and the care given.** **(d) The name of the individuals who were notified and the time of notification.** **(e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.** **(f) The corrective measures that were taken to prevent the accident or incident from happening again.**
ANALYSIS:	On July 20, 2021, Resident A was present and witnessed a verbal disagreement between Mr. Burdette and Ms. Edwards. Both staff used profanity. An incident report was not completed, as required by the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

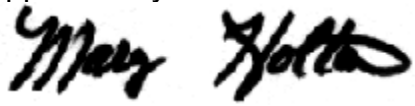
Contingent upon receipt of an acceptable written corrective action plan, I recommend no change to the status of the license.



9/20/2021

Mahtina Rubritius Date
Licensing Consultant

Approved By:



09/20/2021

Mary Holton Date
Area Manager