STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

October 22, 2021

Thomas Watts
Tommie Inc.
20184 Ward
Detroit, MI 48235

RE: License #: AS820294975
Investigation #: 2021A0782029
Ruby 1 AFC

Dear Mr. Watts:

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 (313) 456-0380.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820294975
Investigation #:	2021A0782029
Complaint Receipt Date:	07/26/2021
Investigation Initiation Date:	07/27/2021
Report Due Date:	09/24/2021
Licensee Name:	Tommie Inc.
Licensee Address:	20184 Ward Detroit, MI 48235
Licensee Telephone #:	(313) 748-2500
Administrator:	Thomas Watts
Licensee Designee:	Thomas Watts
Name of Facility:	Ruby 1 AFC
Facility Address:	20184 Ward Detroit, MI 48235
Facility Telephone #:	(313) 862-3519
Original Issuance Date:	05/02/2008
License Status:	REGULAR
Effective Date:	10/18/2020
Expiration Date:	10/17/2022
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was sexually assaulted by Resident B on 7/24/2021. There are concerns regarding supervision.	Yes

III. METHODOLOGY

07/26/2021	Special Investigation Intake 2021A0782029
07/26/2021	APS Referral APS complaint received.
07/27/2021	Special Investigation Initiated - Telephone Telephone call to complainant.
09/22/2021	Contact - Telephone call made Complainant was not available, message left.
09/22/2021	Contact - Telephone call made Thomas Watts, licensee designee
09/22/2021	Contact - Telephone call received Complainant
09/24/2021	Inspection Completed On-site Lorene Parrish, administrator assistant and Resident A
09/27/2021	Contact - Telephone call received Francis Obannon, home manager
09/27/2021	Contact - Telephone call made Kathryn Bennett, direct care staff
10/05/2021	Contact - Document Received Resident B's individual plan of service (IPOS) and incident report.
10/05/2021	Contact - Telephone call made Marcella Harris, Resident A and B's guardian with Faith Connection
10/12/2021	Contact - Document Received Resident B's adult foster care assessment

10/13/2021	Contact - Document Received Resident B's adult foster care assessment plans.
10/14/2021	Exit Conference Mr. Watts
10/19/2021	ORR Referral

ALLEGATION: Resident A was sexually assaulted by Resident B on 7/24/2021. There are concerns regarding supervision.

INVESTIGATION: On 09/22/2021, I contacted Thomas Watts, licensee designee and proceeded to interview him regarding the allegations. Mr. Watts said he's familiar with the allegations but for specific information he suggested I contact Francis Obannon, home manager, as far as where the residents were when the incident occurred or who was all present. Mr. Watts said Ms. Obannon will be able to provide that information and/or a copy of the reports or any other documents needed for the investigation.

On 09/22/2021, I made contact with the Complainant and proceed to discuss the allegations. The Complainant said Resident A is non-verbal. The Complainant said an incident report was received regarding the incident and as a result licensing was contacted. The Complainant said the home has issued Resident B a 30-day notice, but a placement has not been secured yet. The Complainant said a safety plan has been put in place to further protect Resident A and any of the other residents by providing additional male staff for supervision of Resident B.

On 09/24/2021, I completed an unannounced onsite inspection. At the time of arrival, Lorene Parrish, administrator assistant, made me aware that Ms. Obannon was at a doctor's appointment with Resident B. I proceeded to interview Ms. Parrish regarding the allegations. She said she didn't witness the reported incident, but from what she understands, the residents were outside for activities when the incident occurred. She said Kathryn Bennett, direct care staff was on shift and completed the incident report. Ms. Parrish proceeded to show me the backyard where the residents have outside activities. I observed the spacious backyard to be fenced-in with two separate patio tables with ample seating to accommodate the residents. As far as Resident B, Ms. Parrish said he has sexual behaviors which include masturbating and/or exposing his genitalia. As far as a safety plan, Ms. Parrish said Resident B doesn't live at Ruby I, he resides at Ruby II. However, she said Resident B visits Ruby I during the day for activities. She also mentioned that there's male staff on shift to assist with supervision because Resident B tends to try and intimidate the women staff but not the men. Ms. Parrish identified Resident A and B's guardian as Faith Connections. She agreed to have Ms. Obannon contact me when she returns.

While onsite, I observed Resident A. Resident A has limited verbal skills and is not capable of being interviewed. I asked Resident A how he's doing but was unable to make-out his response. I did observe him to be clean and adequately dressed.

On 09/27/2021, I received a call from Ms. Obannon; I proceeded to interview her regarding the allegations. Ms. Obannon explained that Ruby II residents come over to the Ruby I home during the day for activities and that's when the incident occurred. She said she didn't witness the incident, but Ms. Bennett did, and she completed an incident report based on what she witnessed. Ms. Obannon said this is the only encounter she's aware of; however, she said Resident B has inappropriate sexual behaviors. She said prior to the Covid-19 Pandemic, Resident B required 1:1 staffing but was discontinued when Detroit Wayne Integrated Health Network (DWIHN) took over. Ms. Obannon said as a result, Resident B is monitored closely but he's not receiving 1:1 staffing. As it pertains to supervision, I asked Ms. Obannon about the staffing ratio. She said in the morning, there's one staff from 8:00 a.m. to 11:00 a.m. She said a second staff comes in at 11:00 a.m., so there's two staff on shift; then another staff comes in at 2:00 p.m. to relieve the initial morning staff. I requested a copy of Resident B's individual plan of service (IPOS), adult foster care assessment plan and a copy of the incident; in which she agreed to provide.

On 09/27/2021, I interviewed Ms. Bennett, regarding the allegations. Ms. Bennet confirmed she was on shift when the incident occurred. She said the residents were outside for activities, Resident A was putting a puzzle together and Resident B was drawing. Ms. Bennett said she went to toilet another resident and when she returned, Resident B had his hands down Resident A's pants. Ms. Bennett said Resident B has hypersexual behaviors which include masturbating and/or exposing his genitalia. As it pertains to supervision, I asked about the staffing ratio. Ms. Bennett said typically there's always two staff on shift. However, she said on Saturday mornings she's typically the only staff on shift for a couple hours. She said she works 7:00 a.m. to 11:00 a.m. alone and then another staff comes in at 11:00 a.m. (It should be noted that the incident occurred on 7/24/2021, which was a Saturday). Ms. Bennett said as a safety plan Resident B is separated from the other residents if she's working alone, and he has to follow her around just to ensure he's adequately supervised, and the other residents are safe. However, Ms. Bennett said most times there are two staff per shift.

On 10/13/2021, I reviewed Resident B's individual plan of service (IPOS) and incident report. Per Resident B's IPOS decreasing inappropriate sexual behaviors is an objective. The following is identified as one of Resident B's goals on his IPOS: Resident B "will reduce his impulsive behavior from 5x to 1x engaging in coping skills for self-control through participation through 2/1/2022. It further states Resident B's objective is to "reduce the frequency of sexual inappropriate language, aggressive behavior, food seeking and noncompliance with verbal directives from 4 times/week to 1-2 times per week, as evidence by respecting personal boundaries and improved upon his self-awareness of others as it relates to food."

On 10/05/2021, I contacted Marcella Harris, Resident A and B's guardian with Faith Connection regarding the allegations. Ms. Harris said she's not familiar with the allegations. She said Residents A and B were assigned to her caseload in July 2021. She said it's very well possible that the incident report was sent to Faith Connections, but because they were new to her caseload, she didn't receive the incident report directly. Ms. Harris said she knows placement has been an issue for Resident B in the past, so her focus has been trying to maintain placement. Ms. Harris agreed to follow-up with the facility regarding this matter.

On 10/13/2021, I received a copy of Resident B's adult foster care (AFC) assessments for 2020 and 2021. As it pertains to Resident B's ability to control sexual behaviors, his 2020 AFC assessment plan states that he "requires constant redirection by direct care worker. Consumer is predatory." Resident B's 2021 AFC assessment plan states he "is a sexual predator and requires constant redirection, requires :1 supervision." Based on the AFC assessments, it is duly noted that Resident B requires additional supervision due to his inappropriate sexual behaviors.

On 10/14/2021, I conducted an exit conference with Mr. Watts. I made him aware that based on the findings, there is sufficient evidence to support the allegations that there was insufficient staffing at the time the incident occurred. I explained that based on Resident B's IPOS and AFC assessment plan he has inappropriate sexual behaviors and at one point he even required 1:1 staffing. I informed him that although he no longer receives 1:1 staffing, he requires additional supervision. I further explained that both of Resident B's AFC assessment plans identify him as predatory, which means he has a tendency to perp on others and should be monitored closely. Due to the lack of staff, Resident A was not provided protection and Resident B was not provided the level of supervision he requires. I made Mr. Watts aware that if he is unable to provide the level of supervision that Resident B requires, he should be discharged. Mr. Watts explained that he has issued Resident B several 30-day discharges, but DWIHN has not found placement for him. He said he intends to follow-up with DWIHN regarding their efforts to move him. I further explained that based on the violation cited, a corrective action plan is required, in which Mr. Watts agreed. He denied having any questions and agreed to review the report once received.

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:	I interviewed the licensee designee, Thomas Watts; administrator assistant, Lorene Parrish; home manager, Francis Obannon; and Faith Connections Guardian, Marcella Harris regarding the allegations. Resident A and B have limited verbal skills and was not interviewed. There is evidence to support the allegations. Due to the insufficient staffing, Resident A was not provided protection from Resident B; and Resident B was not provided the level of supervision he requires. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend the status of the license remain unchanged.

10/19/2021

Denasha Walker Date
Licensing Consultant

Approved By:

10/23/2021

Ardra Hunter Date
Area Manager