RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

October 30, 2017

Ruby Strudwick

Strudwick & Strode AFC Inc.
3726 Delta River Dr.
Lansing, MI 48906

RE: License #: AS230244372
Investigation #: **2017A0466025**
Strudwick AFC Inc #2

Dear Ms. Strudwick:

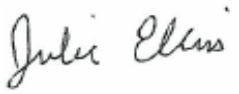
Attached is the AMENDED Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9727.

Sincerely,



Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

THIS REPORT CONTAINS SEXUALLY EXPLICIT LANGUAGE

I. IDENTIFYING INFORMATION

License #:	AS230244372
Investigation #:	2017A0466025
Complaint Receipt Date:	05/25/2017
Investigation Initiation Date:	05/25/2017
Report Due Date:	07/24/2017
Licensee Name:	Strudwick & Strode AFC Inc.
Licensee Address:	3726 Delta River Dr. Lansing, MI 48906
Licensee Telephone #:	(517) 896-9990
Administrator:	Ruby Strudwick
Licensee Designee:	Ruby Strudwick
Name of Facility:	Strudwick AFC Inc. #2
Facility Address:	1425 Elmwood Lansing, MI 48917
Facility Telephone #:	(517) 886-3898
Original Issuance Date:	10/10/2002
License Status:	REGULAR
Effective Date:	01/14/2016
Expiration Date:	01/13/2018
Capacity:	6
Program Type:	AGED DEVELOPMENTALLY DISABLED

	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A is sexually molesting Resident B and Resident B is not being protected by facility staff members.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/25/2017	Special Investigation Intake 2017A0466025
05/25/2017	Special Investigation Initiated - Telephone called assigned APS worker Shelly Stratz
05/26/2017	Contact - Document Sent email to Shelly Stratz
05/26/2017	Contact- telephone call from Shelly Stratz
05/26/2017	Contact- telephone call to Ruby Strudwick about a safety plan.
05/26/2017	Contact- fax received from Ruby Strudwick- safety plan
05/31/2017	Inspection Completed On-site
05/31/2017	Inspection Completed-BCAL Sub. Compliance
07/11/2017	Contact- Telephone call from Shelly Stratz
07/19/2017	Contact- Telephone call to Ken O'Dean guardian for Resident B.
07/19/2017	Contact Telephone call to Gina Sinn Case Manager for Resident B.
07/20/2017	Contact Telephone call to Gina Sinn Case Manager for Resident B.
08/11/2017	Exit interview with Ruby Strudwick

ALLEGATION: Resident A is sexually molesting Resident B and Resident B is not being protected by facility staff members.

INVESTIGATION:
On 05/25/2017, Complainant reported Resident A is sexually molesting Resident B and Resident B is not being protected by facility staff members. On 05/25/2017, I interviewed Complainant who had no additional details to report.

On 05/26/2017, Eaton County Department of Health and Human Services (DHHS) Adult Protect Services Worker (APS) Shelly Stratz contacted me to report that she interviewed Resident B who reported that his roommate Resident A would come into his bed at night and have sex with him. Ms. Stratz reported that Resident A touched Resident B's penis, put his penis in Resident B's mouth and tried to put his penis in Resident B's buttocks, in an attempt to have intercourse. Ms. Stratz stated she found Resident B to be truthful throughout the interview and contacted Resident B's guardian, Ken O'Deen after the interview to report the information. Ms. Stratz stated Mr. O'Deen reported that he is making plans to move Resident B to a different adult foster care (AFC) facility. Ms. Stratz reported filing a police report regarding the alleged sexual assault.

On 05/31/2017, Ms. Stratz and I conducted an unannounced investigation and interviewed Ruby Strudwick, licensee designee of Strudwick AFC Inc. #2. Ms. Strudwick reported that she did not believe that Resident A molested Resident B as Resident A and Resident B were roommates and got along. Ms. Strudwick reported the typical evening routine for Resident A and Resident B is to come home from day program about 4:30pm on the bus, have dinner, watch TV, take a shower if needed and go to bed between 7pm and 8 pm. Ms. Strudwick reported that Resident A and Resident B sleep with the bedroom door closed. If Ms. Strudwick woke up in the middle of the night, she might come up to take them to the bathroom. Ms. Strudwick reported that Resident B can't take his brief off without assistance. Ms. Strudwick reported that Resident A and Resident B get up about 6:30 am to get ready for program. Ms. Strudwick felt that if Resident B was being molested by Resident A that it occurred while she was on vacation as she stated that Resident B would have told her if something was happening. Ms. Strudwick denied that Resident B told her that Resident A was molesting him. Ms. Strudwick did report that Resident A has to be redirected for masturbating in the common areas of the home and this has occurred since Resident A was admitted in to the facility in December 2015. According to Ms. Strudwick, within the first month of Resident A being admitted, he was brought back from the Lansing Mall by a police officer who reported that Resident A was banned from the mall for inappropriate behavior. Ms. Strudwick reported that Resident A has always exhibited these inappropriate behavior challenges. Ms. Strudwick reported asking the doctor at the last physical exam if something could be prescribed for Resident A to "slow down the masturbating because it was happening so frequently." Ms. Strudwick reported that Resident B was not a problem in the home and if anyone needed to leave, it should have been Resident A. Ms. Strudwick reported that she would be giving a 30-day notice on Resident A.

On 05/31/2017, I reviewed Resident A's and Resident B's record. Resident A's record contained a notification dated 03/11/2016 that stated that Resident A was masturbating with genitals exposed in the workshop at program. This notification was shared with the case manager and Ms. Strudwick. Resident A's record contained a report named "*Assessment"* completed by Community Mental Health (CMH) of Clinton, Eaton and Ingham Counties completed on 10/18/16 authored by

April Pocalujka. The *Assessment* stated that Resident A has been receiving services from CMHA- CEI since 2001 and presents with an intellectual disability, schizophrenia, autism spectrum disorder, a history of inappropriate behaviors, at-risk sexual behaviors, disruptive/unusual behaviors and is at risk for wandering/eloping. Specifically the *Assessment* documented that:

> *"[Resident A] must have 24/hr. supervision and is not to be out in the community alone (per judge's order, guardianship paperwork, guardian request, CMH psychiatrist and case manager request). [Resident A] is inappropriate in public and or in the community. [Resident A] has peeked in neighbors' homes, attempted to masturbate in public, urinated on his bedroom floor/on top of his clothes/and out in the community, defecated in team spaces at T-North and reportedly out in the community. [Resident A] struggles to demonstrate socially appropriate behavior. In the past year Resident A has been sexually inappropriate. [Resident A] often has other bizarre behaviors at home and out in the community."*

Ms. Pocaluja also documented in the report called "*Assessment*" that "*Resident A must have 24 hour supervision. Dr. Brown agrees Resident A should be on line of sight supervision."* Although this was documented by Ms. Pocaluja, the *Assessment* provided to the AFC did not contain steps that should be taken to assure the safety of the other residents in the home except for 24-hour line-of-sight supervision with line of sight supervision. Resident A's *Assessment Plan for AFC Residents* was not available for review at the time of the investigation.

I reviewed Resident B's record and Resident B is a diagnosed with moderate cognitive deficits, urinary incontinence, and has a history of becoming physically aggressive in the past according to the 11/21/16 *Assessment* completed by Gina Sinn. Resident B's *AFC Assessment Plan* states that Resident B does not read, write, tell time or manage money. Resident B requires reminders to use the bathroom, bathe, and change briefs/clothes if an accident occurs. Resident B requires assistance with getting in and out of the tub, shaving and selecting clothing. Resident B has a history of urinary incontinence and has experienced symptoms for several years. Resident B does go to Transition North and Peckham during the week. Resident B has lived at this AFC since July of 2015 and has shared a room with Resident A for the past year. Resident B's record contained an *Assessment* completed by CMH of Clinton, Eaton and Ingham Counties completed on 11/21/16 authored by Gina Sinn that I reviewed. The *Assessmen*t stated that:

> *"[Resident B] has made great progress this reporting period.*
> *He has enjoyed higher level of independence that comes with his move to a less restrictive environment and has done well accessing his community independently. His taking things that do not belong to him have decreased for the most part except for a few minor incidents.'*

On 07/11/2017, Ms. Stratz informed me that based on the findings of her investigation the complaint was substantiated for sexual abuse and neglect as there is evidence to support that Resident A molested Resident B while sharing a room at this AFC. Ms. Stratz stated that Ms. Strudwick was being substantiated for neglect

of Resident B as there is evidence to support that Ms. Strudwick had knowledge that Resident A presented a risk to other's safety and little to nothing was done to assure the safety of Resident B.

On 07/19/2017, I interviewed Ken O'Dean Guardian for Resident B. Mr. O'Dean was aware of the allegation and that Resident B told Ms. Stratz and Eaton County Deputy Thomas that Resident A made Resident B participate in sex acts that he did not want to participate in on 05/26/2017 and as a result he moved Resident B to a different facility.

On 07/20/2017 I interviewed Gina Sinn CEI-CMH Case Manager for Resident B. Ms. Sinn reported that she transported Resident B to all medical appointment and was at the facility monthly to visit with Resident B. Ms. Sinn checked in with Resident B to see if everything "was ok" and Resident B always confirmed things "were ok" at the facility. Ms. Sinn stated that on 05/26/2017, Resident B told Ms. Stratz and Eaton County Deputy Thomas that Resident A made Resident B participate in sex acts that he did not want to participate in. Ms. Sinn reported that Resident B stated that he participated in these acts against his will, but did not tell anyone because Resident A threatened to kill Resident B if he did and he was scared.

On 08/15/2017, I reviewed the Eaton County Sherriff's department *Incident/Investigation Report* authored by Deputy Brian Thomas. It stated that:

> "*at 1335 hours on 05/26/2017 Deputy Brian Thomas was dispatched to a CSC report that occurred at 1425 Elmwood Road. I met Willie Moore, Jr. who told me that [Resident B] had been moved to the other side of the duplex to keep him separated and safe from [Resident A]. Moore introduced me to [Resident B] and we spoke in a private living room, away from other residents. The suspect in this matter, [Resident A] was not at the 1425 Elmwood Road at the time of this contact, and was not expected to return until 1600 hours on 05/26/2017. [Resident A], nor [Resident A's] legal guardian, knew that the police had been called. [Resident B] told me that [Resident A] would come to his bed at night, when everyone else was asleep. [Resident A] would have sex with him and it was not right. [Resident B] told me that it sometimes hurts, and it is unwanted. [Resident A] is his roommate. The last time this happened is maybe earlier this or last week, but has been ongoing for possibly the last year. There was difficulty in communicating with [Resident B] due to his mental and developmental impairments. [Resident B] looked at Moore almost the entire time he spoke to me, and also said many times to Moore that, 'this is good to tell the cops, right?' TOT to the Detective Bureau for their review, further instructions, and possibly follow-up. Victims, case manager, Gina Sinn, MSW will be taking him to Sparrow for intervention from the sexual abuse assault response team (SANE) examination. Contact will be made again with CPS to ascertain whether or not a taped forensic interview with the Victim took place. If not, arrangements will be made in order to get it taken care of." (sic)*

On 08/23/2017, I reviewed the APS report that was authored by Ms. Stratz in which she documented that:

"[Resident B] reported that [Resident A] would 'get on me' about one time per month. This occurred at night in their bedroom. According to [Resident B], they both would have their clothes on except for two occasions when [Resident A] was naked. [Resident B] reported that [Resident A] touched him, and put his hand and penis in his mouth and on one occasion 'kind of stuck it in my butt.' [Resident B] initially reported that he would tell staff if it happened again but then later in the interview process stated that he had not told staff about what was happening. Throughout the interview process, [Resident B] appeared to be truthful. Law enforcement and CMH attempted have a SANE exam performed on [Resident B]; however, one was not completed. Once the criminal investigation was assigned to Detective Buxton with the Eaton County Sherriff's Department, over five days had passed making a SANE exam ineffective."

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a residents, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.

ANALYSIS:	Based on Resident A's record review, the amount of supervision that Resident A required and interviews with Ms. Strudwick about Resident A's inappropriate behaviors, Ms. Strudwick had knowledge of Resident A's behaviors and did not provide the necessary supervision and protection that Resident A required. Per Resident A's CEI-CMH Assessment completed on 10/16/2016, Resident A had a long documented history of sexually acting out behaviors both within the facility and community setting. The assessment also documented that Resident A should be on "line-of-sight" supervision" due to his aggressive, sexually acting out behaviors. These behaviors included chronic masturbating during inappropriate times and in inappropriate places, public urination and defecation, and looking in neighbors' windows. Although this type of supervision was recommended for Resident A it was not provided to Resident A while he lived at Strudwick AFC Inc. #2.
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:	Licensee Ruby Strudwick allowed Resident A to have a roommate despite being aware of Resident A aggressive sexual behaviors. She also allowed the bedroom door to be closed during sleeping hours despite the documented need for Resident A to have "line-of-sight supervision." Then on or about 05/25/2017, Resident B reported to APS Worker Ms. Stratz and Eaton County Deputy Thomas that he unwillingly participated in sexual acts with Resident A including sexual penetration for at least a few weeks. Ms. Strudwick was aware of Resident A's history of aggressive and inappropriate sexual behavior, poor sexual boundaries and recent inappropriate public masturbation however no intervention was sought to protect Resident B who shared a bedroom with Resident A. Consequently, Resident B's protection and safety needs were not met by Strudwick AFC Inc #2 staff members when Resident A repeatedly sexually assaulted him in their shared resident bedroom and threatened to hurt Resident B if he reported the assaults.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 05/31/2017 an unannounced investigation was conducted. I asked Ms. Strudwick for a staff schedule. Ms. Strudwick began to verbally report who worked what shift, but at the time of the investigation a daily written schedule was not available for review.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**

ANALYSIS:	A daily written schedule was not available for review the day of the unannounced investigation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 05/31/2017 an unannounced investigation was conducted. Ms. Strudwick reported a new employee, Lori Leek, had been helping out while she was on vacation. When I reviewed Ms. Leek's employee file, the work force background check that was completed for Ms. Leek was run for another facility owned by Ms. Strudwick and not for the facility that she had been working at. This employee did not have the required training records available for review at the time of the inspection although she had assumed duties as a direct care worker on May 4, 2017 according to Ms. Strudwick as Ms. Leek worked shifts alone while Ms. Strudwick was on vacation.

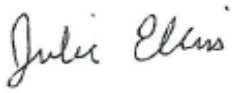
APPLICABLE RULE	
MCL 400.734	**400.734b. This amended section is effective January 9, 2009 except Section 734b(1)(e)(iv) after the word "or" which will not be effective until October 31, 2010.** **Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
ANALYSIS:	Ms. Leek did not have a work force background check from the facility that she was working at as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.**

	(e) Resident rights. **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Ms. Leek's employee file did not contain documentation that she had completed the required training prior to being assigned duties as a direct care staff at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.



09/05/2017

Julie Elkins Date
Licensing Consultant

Approved By:

09/06/2017

Dawn N. Timm Date
Area Manager