GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 5, 2022

Marla Garchow
Magnolia Care TC AFC LLC
1855m Carlisle Rd
Traverse City, MI 49686

RE: License #: AS280406473
Investigation #: 2023A0870009
Heart and Soul Living AFC

Dear Ms. Garchow:

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,

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS280406473 |
| | |
| **Investigation #:** | 2023A0870009 |
| | |
| **Complaint Receipt Date:** | 11/21/2022 |
| | |
| **Investigation Initiation Date:** | 11/21/2022 |
| | |
| **Report Due Date:** | 01/20/2023 |
| | |
| **Licensee Name:** | Magnolia Care TC AFC LLC |
| | |
| **Licensee Address:** | 1855m Carlisle Rd<br>Traverse City, MI 49686 |
| | |
| **Licensee Telephone #:** | (231) 421-3271 |
| | |
| **Administrator:** | Marla Garchow |
| | |
| **Licensee Designee:** | Marla Garchow |
| | |
| **Name of Facility:** | Heart and Soul Living AFC |
| | |
| **Facility Address:** | 1855 Carlisle Road<br>Traverse City, MI 49686 |
| | |
| **Facility Telephone #:** | (231) 421-3271 |
| | |
| **Original Issuance Date:** | 03/01/2021 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 09/01/2021 |
| | |
| **Expiration Date:** | 08/31/2023 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED, MENTALLY ILL<br>DEVELOPMENTALLY DISABLED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A stuck his hand down Resident B's pants causing injury to his scrotum. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 11/21/2022 | Special Investigation Intake<br>2023A0870009 |
| 11/21/2022 | APS Referral<br>This came from the Michigan Department of Health and Human Services, protective services centralized intake unit. They noted that they had dismissed the complaint and are referring the issue to Licensing and Regulatory Affairs. |
| 11/21/2022 | Special Investigation Initiated - Telephone<br>Referral made to Northern Lakes Community Mental Health Authority, Office of Recipient Rights. |
| 11/22/2022 | Inspection Completed On-site<br>Interviews with Licensee Designee Marla Garchow and facility staff members. |
| 12/05/2022 | Inspection Completed-BCAL Sub. Compliance |
| 12/05/2022 | Exit Conference<br>Conducted with Licensee Designee Marla Garchow. |

**ALLEGATION: Resident A stuck his hand down Resident B's pants causing injury to his scrotum.**

**INVESTIGATION:** On November 22, 2022, I conducted an on-site special investigation at the Heart and Soul Living AFC home. I met with Licensee Designee Marla Garchow and informed her of the above stated allegation. Ms. Garchow explained that Resident A was admitted to the facility on May 1, 2022, and has had behavior issues related to "stripping off his clothing and masturbating in public." She noted a behavior treatment plan was developed for Resident A in July 2022. Ms. Garchow stated that Resident A and Resident B share a bedroom. She noted that an incident occurred between Resident A and Resident B the afternoon of November 20, 2022, when staff found Resident A with his hands down Resident B's pants while both were in the living room area of the facility. Ms. Garchow stated that

facility staff separated the two residents and later noted that Resident B had a bleeding scratch on his scrotum. She noted two staff members, Roselle Stark and Bonnie Bardoni, were working in the facility at the time. Ms. Garchow stated Resident B was taken to the hospital for evaluation and treatment and returned home that same evening. She stated she issued an emergency discharge notice to Resident A's guardian on November 21, 2022, after consultation with the NLCMH caseworker for both Resident A and Resident B. Ms. Garchow provided me with a copy of Resident A's "Intrusive-Restrictive Behavior Plan" for my review.

On November 22, 2022, I reviewed Resident A's "Intrusive-Restrictive Behavior Plan" written by Joe Barkman, MA, LLP on July 25, 2022. This plan notes that Resident A has been diagnosed with Autism and Intellectual Developmental Disorder and that he "does not have any safety skills and for that reason, always requires supervision when he is in the community." One of the "target behaviors" addressed in this plan includes "sexual behaviors." It defines "sexual behaviors" as "sexual activity involving (Resident A) engaging in masturbation, disrobing and other inappropriate touching of himself in the common areas of the home or outside." Listed interventions in this plan state:

Step 4: When (Resident A) is in the common areas of the home or even outside of the home, and sexually vulnerable residents are present, staff are to provide line of sight supervision to help prevent (Resident A's) sexual behavior on the other residents. (Resident A) is to be redirected away from the resident he is targeting if he begins sexually interacting or propositioning them. Line of sight should continue until the behavior has stopped. If the other vulnerable residents are not present in the common areas with (Resident A), then line of sight supervision is not to be implemented.

The plan further states: The line of sight supervision requires the assigned staff to continuously keep (Resident A) within the staff person's visual range (either looking directly at Resident A or keeping him within the staff person's peripheral vision) at all times, so that they may be able to immediately intervene.

On November 22, 2022, I conducted a private in person interview with staff member Roselle Stark. Ms. Stark stated she was working at the facility the afternoon of November 20, 2022, along with staff member Bonnie Bardoni. She noted that Resident B had "an accident" and she took him into the bathroom to clean him up and change is undergarments and clothing. Ms. Start stated she then brought Resident B out of the bathroom into the facility living room and put him in a chair. She stated Resident A was walking around the living room area in the vicinity of where she had placed Resident B in a chair. Ms. Start stated that after she placed Resident B in the chair, she proceeded to the facility laundry room and put Resident B's clothing in the washing machine. She noted she was in the laundry room for "two or three minutes." Ms. Stark stated that when she came out of the laundry room, she observed Resident B walking to the bathroom saying, "ouch help." She also noted that Resident A was in his bedroom "laughing under his blanket." Ms.

Start stated she took Resident B into the bathroom, stripped him, grabbed another brief and noted blood on him. She stated she then called for Ms. Bardoni, who was in the facility medication room, for assistance.

On November 22, 2022, I conducted a private in-person interview with Bonnie Bardoni. Ms. Bardoni stated she worked the afternoon of November 20, 2022, along with Ms. Stark. She noted she was working in the medication room when she heard Resident B yelling ouch. Ms. Bardoni stated she walked out of the medication room and saw Resident A had his hands down Resident B's pants. She stated she told Resident A to remove his hands from Resident B's pants and Resident A "just laughed." Ms. Bardoni stated she told Resident A a second time to remove his hands from Resident B, he did and then he proceeded to walk to his bedroom. She stated that Resident B continued sitting in his chair in the living room saying ouch. Ms. Bardoni stated she called for Ms. Stark to help, as she was in the laundry room at the time. She noted that Ms. Stark and Resident B then walked together to the bathroom.

It is noted that due to the layout of the facility, the laundry room is not in visual range of the facility common use living room area.

| **APPLICABLE RULE** | |
|---|---|
| **R 330.1806** | **Staffing levels and qualifications.** |
| | **(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.** |
| A**NALYSIS:** | Resident A's "Intrusive-Restrictive Behavior Plan" requires staff to provide line of sight supervision to help prevent Resident A's sexual behavior on the other residents.<br><br>Ms. Stark stated that both Resident A and Resident B were present together in the facility common use living room area when she went to the laundry room for two or three minutes. She noted the other staff, Ms. Bardoni, was in the medication room.<br><br>Ms. Bardoni stated she was working in the medication room when she heard Resident B yell ouch. She stated she exited the room and observed Resident A with his hands in Resident B's pants, noting they were in the living room. Ms. Bardoni stated that Ms. Stark was in the laundry room at the time.<br><br>Resident A's plan of service, "Intrusive-Restrictive Behavior Plan" requirement that staff maintain line of sight supervision of |

| | |
|---|---|
| | Resident A when other facility residents are present with him in common area of the home, was not appropriately implemented. |
| **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:** | The facility staff failed to provide protection and safety to Resident B when they did not appropriately implement Resident A's "Intrusive-Restrictive Behavior Plan." |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On December 5, 2022, I conducted an exit conference with Licensee Designee Marla Garchow. I explained my findings as noted above. Ms. Garchow stated she understood and that she had no further information to provide concerning this special investigation.

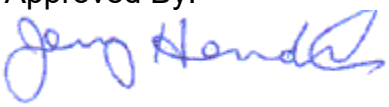
## IV. RECOMMENDATION

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

December 5, 2022

Bruce A. Messer Date
Licensing Consultant

Approved By:



December 5, 2022

Jerry Hendrick Date
Area Manager