GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 20, 2023

Amber Hernandez-Bunce
Hernandez Home LLC
P.O. Box 277
Bloomingdale, MI 49026

RE: License #: AS800327951
Investigation #: 2023A1031018
Paulson Home

Dear Ms. Hernandez-Bunce:

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 (616) 356-0183.

Sincerely,

Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AS800327951
Investigation #:	2023A1031018
Complaint Receipt Date:	02/28/2023
Investigation Initiation Date:	02/28/2023
Report Due Date:	04/29/2023
Licensee Name:	Hernandez Home LLC
Licensee Address:	44409 Baseline Road Bloomingdale, MI 49026
Licensee Telephone #:	(269) 521-4130
Administrator:	Karmen Ball
Licensee Designee:	Amber Bunce-Hernandez
Name of Facility:	Paulson Home
Facility Address:	27425 29th Street Gobles, MI 49055
Facility Telephone #:	(269) 628-4830
Original Issuance Date:	09/11/2012
License Status:	REGULAR
Effective Date:	03/08/2023
Expiration Date:	03/07/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff and Resident A got into a physical altercation.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/28/2023	Special Investigation Intake 2023A1031018
02/28/2023	Special Investigation Initiated - Telephone interview completed with Karmen Ball.
03/02/2023	Inspection Completed On-site
03/02/2023	Contact - Face to Face interview completed with Resident A.
03/03/2023	Contact - Telephone call made to Jeson Perez-Gonzalez.
03/03/2023	Contact - Police report requested.
03/03/2023	APS Referral
03/03/2023	Contact - Email sent to APS worker Mike Hartman.
03/07/2023	Contact - Police report received and reviewed.
03/07/2023	Contact - Telephone interview completed with Jeson Perez-Gonzalez.
03/07/2023	Reviewed incident report.
03/07/2023	Inspection Completed-BCAL Sub. Compliance
03/07/2023	Telephone interview completed with Karmen Ball.
03/07/2023	Exit Conference held with licensee designee Amber Bunce-Hernandez.

ALLEGATION:

Staff and Resident A got into a physical altercation.

INVESTIGATION:

On 2/28/23, I received a telephone call from Karmen Ball. Ms. Ball reported there was an incident that occurred between direct care worker (DCW) Jeson Perez-Gonzalez and Resident A. Ms. Ball reported she was informed that Resident A was making threats towards staff and residents in the home the evening the incident occurred. Ms. Ball reported Mr. Perez-Gonzalez informed her that Resident A had left the slider door open, and Mr. Perez-Gonzalez shut the door which upset Resident A. Ms. Ball reported Mr. Perez-Gonzalez admitted to yelling at Resident A when Resident A got upset with him. Mr. Perez-Gonzalez informed her that Resident A had pushed him and he pushed Resident A back. Resident A then grabbed Mr. Perez-Gonzalez's jacket and they both fell to the ground. While Mr. Perez-Gonzalez was on the ground, Resident A started hitting and kicking him. Ms. Ball reported Mr. Perez-Gonzalez reported he must have grabbed Resident A's face at some point when he was trying to get Resident A off of him. Ms. Ball reported the police and EMT were called because of the altercation. Mr. Perez-Gonzalez was transported to the hospital and Resident A refused to go to the hospital when offered. MS. Ball reported she later went to the home and did observe Resident A to have a mark under his eye. Ms. Ball reported there have not been any previous concerns regarding Mr. Perez-Gonzalez mistreating residents in the home.

On 3/2/23, I interviewed Resident A in the home. Resident A reported Mr. Perez-Gonzalez was trying to steal his personal belongings and shut a screen door when he was outside. Resident A reported this made him very upset and he confronted Mr. Perez-Gonzalez. Resident A reported he touched Mr. Perez-Gonzalez's shoulder and told him to calm down. Resident A reported Mr. Perez-Gonzalez told him not to touch him. Resident A reported he then pushed Mr. Perez-Gonzalez and Mr. Perez-Gonzalez pushed him back. Resident A reported he grabbed onto Mr. Perez-Gonzalez, and they fell to the ground. Resident A reported he punched Mr. Perez-Gonzalez two to three times in the face, kicked him while he was on the ground, and bent his fingers back. Resident A reported Mr. Perez-Gonzalez then punched him in the face and pointed to his right eye. Resident A reported he had a mark under his eye after being hit by Mr. Perez-Gonzalez. Resident A reported Mr. Perez-Gonzalez called the police and they arrived at the home. Resident A reported he refused to go to the hospital when offered by the EMT.

On 3/7/23, I reviewed the police report completed by the Van Buren Sheriff's Department. The report indicates a police officer was called to the home due to an alleged assault. The officer interviewed Resident A and he reported he was confronted by a staff member and staff were making threats towards him. Resident A reported the staff member punched him in the face and he acted in self-defense by punching staff back. Resident A reported he had an injury to his right eye and the

officer observed slight swelling but no bruising or redness in color. The officer interviewed Mr. Perez-Gonzalez and Mr. Perez-Gonzalez reported he noticed the sliding glass door open and shut it. Resident A then entered back into the home to confront Mr. Perez-Gonzalez. Mr. Perez-Gonzalez reported Resident A started cursing at him and he cursed back at Resident A. Mr. Perez-Gonzalez reported Resident A started threatening to assault him and he told Resident A not to touch him or they would have a problem. Mr. Perez-Gonzalez reported Resident A then pushed him and then he pushed Resident A back. Mr. Perez-Gonzalez reported Resident A then grabbed him by the shirt and they both fell to the floor. Mr. Perez-Gonzalez reported his knee was injured when they fell. Mr. Perez-Gonzalez reported he and Resident A then began fighting on the ground, punching each other, and grabbing each other. The report was submitted to the Van Buren County Prosecutor's office for charges against both parties.

On 3/7/23, I interviewed Mr. Perez-Gonzalez via telephone. Mr. Perez-Gonzalez reported Resident A was demonstrating threatening behaviors towards him and the other residents in the home. Mr. Perez-Gonzalez reported he noticed the screen door was open and shut the door. Mr. Perez-Gonzalez reported Resident A got upset with him for shutting the door and confronted him about it. Mr. Perez-Gonzalez reported Resident A then started accusing him of stealing his belongings. Mr. Perez-Gonzalez reported Resident A started threatening to beat him up. Mr. Perez-Gonzalez reported he reminded Resident A not to touch him again because there was a previous incident where Resident A touched him. Mr. Perez-Gonzalez reported Resident A pushed him and then he pushed Resident A back. Resident A then grabbed his jacket and they both fell to the ground. Mr. Perez-Gonzalez reported Resident A was on top of him punching him and kicking him. Mr. Perez-Gonzalez reported he tried to get Resident A off of him by pushing him. Mr. Perez-Gonzalez reported he believes he pushed Resident A's face when he was trying to get Resident A off of him. Mr. Perez-Gonzalez reported the police were called and he was taken to the hospital to receive treatment for his knee. Mr. Perez-Gonzalez reported he was not able to successfully use CPI behavior management due to Resident A being on top of him and attacking him while he was on the ground. Mr. Perez-Gonzalez reported the other residents were in their bedrooms due to Resident A threatening them earlier in the night and no one else was harmed.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional

	harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on interviews and review of the police report, there is sufficient evidence to support Resident A was mistreated by staff as Mr. Perez-Gonzalez intentionally used physical force against Resident A. Mr. Perez-Gonzalez admitted to pushing Resident A after he was initially pushed by Resident A which led to an altercation between the two.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Mr. Perez-Gonzalez reported he was injured by Resident A which resulted in him having to receive medical treatment. Mr. Perez-Gonzalez reported he was not able to successfully implement appropriate behavior management due to Resident A hitting and kicking him while he was on the ground. Mr. Perez-Gonzalez reported Resident A was threatening other residents in the home which resulted in them isolating themselves to their bedroom.

Resident A reported assaulting Mr. Perez-Gonzalez by hitting, kicking, and punching him. Resident A reported that he did make threats towards the other residents in the home because he believed they were stealing his personal belongings.

On 3/7/23, I had a telephone conversation with Ms. Ball. Ms. Ball reported the home has issued notices to have Resident A moved from the home due to his ongoing behaviors. Ms. Ball reported community mental health has not been able to find an alternative placement for Resident A. Ms. Ball reported Resident A does have significant behaviors that are becoming more difficult for staff to manage.

On 3/7/23, I completed an exit interview with licensee designee Amber Bunce-Hernandez. Ms. Bunce-Hernandez reported the home has taken appropriate steps to request for Resident A to be placed in another home due to his ongoing behaviors. Ms. Bunce-Hernandez reported she has submitted a 30-day notice to have Resident A move from the home nearly one year ago and community mental health has not found an alternative placement for him. Ms. Bunce-Hernandez reported staff and residents are not comfortable around Resident A due to him making allegations and threats to harm them.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria;**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(c) The resident appears to be compatible with other residents and members of the household.**
ANALYSIS:	Resident A has demonstrated behaviors that have been harmful to both staff and residents in the home. Resident A assaulted a staff member which resulted in them receiving medical treatment. Resident A admitted to threatening other residents in the home and continuously accuses them of stealing their personal belongings. Resident A has been involved in previous investigations due to allegations made towards staff and other residents in the home. As a result of this investigation and extreme behaviors demonstrated by Resident A, it has been determined that Resident A does not appear to be compatible with other residents in the home and the licensee should not retain the resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

3/7/23

Kristy Duda Date
Licensing Consultant

Approved By:

3/13/23

Russell B. Misiak Date
Area Manager