GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 18, 2023

Lynn Geresy
Affinity Health Management LLC
PO Box 438
Oshtemo, MI 49077

RE: License #: AS800237410
Investigation #: 2023A1031028
Affinity - Woodhenge

Dear Mr. Geresy:

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 #:	AS800237410
Investigation #:	2023A1031028
Complaint Receipt Date:	03/31/2023
Investigation Initiation Date:	03/31/2023
Report Due Date:	05/30/2023
Licensee Name:	Affinity Health Management LLC
Licensee Address:	48288 22nd St Mattawan, MI 49071
Licensee Telephone #:	(269) 544-1292
Administrator/ Licensee Designee:	Lynn Geresy
Name of Facility:	Affinity - Woodhenge
Facility Address:	48288 22nd Street Mattawan, MI 49071
Facility Telephone #:	(269) 668-2143
Original Issuance Date:	06/01/2001
License Status:	REGULAR
Effective Date:	08/15/2022
Expiration Date:	08/14/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff are verbally and physically aggressive towards Residents A and B.	Yes
Additional Findings	No

III. METHODOLOGY

03/31/2023	Special Investigation Intake 2023A1031028
03/31/2023	Special Investigation Initiated - Letter Email sent to ORR Director Candice Kinzler.
04/03/2023	APS Referral
04/03/2023	Contact - Telephone Interview with ORR Director Candice Kinzler.
04/20/2023	Inspection Completed On-site
04/20/2023	Contact - Face to Face Interviews held with Resident A, Resident B, Resident C, and Lysandra Townsell.
05/01/2023	Contact - Telephone Interview with ORR Director Candice Kinzler.
05/04/2023	Inspection Completed On-site
05/04/2023	Contact - Face to Face Interviews held with Resident A, Resident B, and Cory Tillison.
05/08/2023	Contact - Telephone Interview held with ORR Director Candice Kinzler.
05/08/2023	Contact - Telephone Interview with Licensee Lynn Geresy.
05/10/2023	Contact - Telephone Interview with Heather Baird.
05/15/2023	Contact - Telephone Interview with Gayle Sell.
05/18/2023	Exit Conference held with Licensee Lynn Geresy.

ALLEGATION:

Staff are verbally and physically aggressive towards Residents A and B.

INVESTIGATION:

On 4/3/23, I interviewed Van Buren Recipient Rights Director Candice Kinzler via telephone. Ms. Kinzler reported Resident A informed her that Direct Care Worker (DCW) Heather Baird slammed his arm on the table while taking his blood pressure. Ms. Kinzler was also informed by Resident B that Ms. Baird yells at him and does not treat him very well. Ms. Kinzler reported she interviewed Ms. Baird regarding these allegations, and she reported she did not slam Resident A's arm down and she does not yell at Resident B.

On 4/20/23, I interviewed Resident A in the home. Resident A reported Ms. Baird slammed his arm on the table while he was taking his blood pressure. Resident A reported he did not know why she did this, but it startled him. Resident A reported Ms. Baird "can get verbal" when speaking to the residents in the home. Resident A reported she raises her voice a lot when speaking with Resident B. Resident A reported Ms. Baird "has done better since being talked to".

On 4/20/23, I interviewed Resident B in the home. Resident B reported he did not witness Ms. Baird slam Resident A's arm on a table. Resident B reported Mr. Baird often yells at him or ignores him and this makes him upset. Resident B reported Ms. Baird will yell "stop" very loudly when he tries to talk to her. Resident B reported Ms. Baird is not very nice to him and he feels that she does not like him.

On 4/20/23, I interviewed Resident C in the home. Resident C reported he heard Ms. Baird "get loud" with Resident A while she was taking his blood pressure. Resident C reported Resident A was taking his blood pressure wrong and Ms. Baird got frustrated. Resident C reported he did not witness Ms. Baird slam Resident A's arm down. Resident C reported Ms. Baird "gets kinda loud sometimes with people". Resident C reported Ms. Baird has "gotten better" since "being talked to" by Ms. Kinzler and the licensee Lynn Geresy.

On 4/20/23, I interviewed DCW Lysandra Townsell in the home. Ms. Townsell reported there is only one staff on each shift and has not observed how other staff treat residents. Ms. Townsell reported Resident A informed her that Ms. Baird had slammed his arm down on the table because he was doing his blood pressure wrong. Ms. Townsell reported Resident A did not share any further information with her.

On 5/1/23, I received a telephone call from Ms. Kinzler. Ms. Kinzler reported she was informed that a Community Mental Health worker observed Ms. Baird yell at Resident B while visiting the home.

On 5/4/23, I interviewed Resident A in the home. Resident A reported he did observe Ms. Baird to yell at Resident B but could not remember exactly what she said. Resident A reported Ms. Baird will tell Resident B to “go away a lot” and raises her voice at him more than other residents in the home. Resident A reported he tries to help around the house because Ms. Baird is nice to him when he does.

On 5/4/23, I interviewed Resident B in the home. Resident B reported he believes Ms. Baird does not like him because she still yells at him a lot. Resident B reported he could not remember an exact incident that occurred with Ms. Baird and stated “she just does that all the time” to him.

On 5/4/23, I interviewed DCW Cory Tillison in the home. Ms. Tillison reported she has not observed any staff mistreat the residents as there is only one staff scheduled at a time. Ms. Tillison reported she sees Ms. Baird during shift changes. Ms. Tillison reported Ms. Baird does not yell but she uses a “stern voice” to redirect Resident B. Ms. Tillison reported the residents have not informed her of any incidents of being mistreated.

On 5/8/23, I interviewed licensee Lynn Geresy via telephone. Mr. Geresy reported he has never witness Ms. Baird mistreat the residents. Mr. Geresy reported he has always observed her to be pleasant and jokes around with the residents. Mr. Geresy reported the residents have not reported any concerns to him about staff mistreating them. Mr. Geresy reported a conversation was held with Ms. Baird regarding concerns on how she may represent the agency due to recent interactions with Recipient Rights.

On 5/9/23, I interviewed Van Buren County Community Mental Health Customer Assistance Specialist Gayle Sell via telephone. Ms. Sell reported she visits the home every Wednesday to take Resident B into the community. Ms. Sell reported she recently went to the home to pick up Resident B for his weekly community time. Ms. Sell reported she was in the office with Ms. Baird to sign in to take Resident B into the community. Ms. Sell reported Ms. Baird did not speak to her and took the paperwork out to the dining room. Ms. Sell reported Resident B had entered the office area at that time. Ms. Sell reported Ms. Baird began to yell loudly at Resident B telling him to get out of the office. Ms. Sell reported Resident B got upset and told Ms. Baird to “stop hollering at me”. Ms. Sell reported Ms. Baird “calmed down” after Resident B asked her to stop hollering at him. Ms. Sell reported Resident A was sitting at the table and put his head down when this happened. Ms. Sell reported the tone Ms. Baird use was very loud and not appropriate. Ms. Sell reported Ms. Baird exceeded the tone of what one would consider a “stern voice”. Ms. Sell reported she was very bothered by how Ms. Baird spoke to Resident B. Ms. Sell reported it appears that Ms. Baird “targets” Resident B. Ms. Sell reported she has witnessed

Ms. Baird lecture Resident B on multiple occasions about the purchases he makes with his money when he returns to the home. Ms. Sell provided an example and reported Ms. Baird will tell Resident B that he is not supposed to be buying items referencing juice and cigarettes.

On 5/10/23, I interviewed Ms. Baird via telephone. Ms. Baird denied slamming Resident A's arm on the table and reported that she does not yell at the residents in the home. Ms. Baird stated "people don't know me" referencing her having a strong personality and people taking her the wrong way when she speaks. Ms. Baird reported she does not know why someone would say she yells at the residents. Ms. Baird reported she does redirect Resident B frequently because he is persistent. Ms. Baird reported she will use a "stern voice" when needed because Resident B can be difficult to redirect. Ms. Baird expressed frustration with being involved in the investigation process because she does not like the residents blaming her for things that she is not doing.

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:	As a result of interviews with staff and residents, there is no evidence to support that staff are physically mistreating the residents in the home. There were consistent reports of Ms. Baird being verbally aggressive towards Resident B in the home. Ms. Baird was observed by a community agency worker and other residents in the home to not treat Resident B with dignity as she continuously yells at him and is not providing appropriate redirection when needed.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **For reference special investigation report #2022A1031005 dated 4/26/22 and CAP dated 5/6/22.**

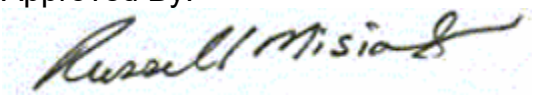
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

5/16/23

Kristy Duda Date
Licensing Consultant

Approved By:



5/16/23

Russell B. Misiak Date
Area Manager