GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 8, 2024

Neiman Byerly
Byerly Enterprises, LLC
4759 Owasco Ct.
Clarkston, MI 48348

RE: License #: AM630397532
Investigation #: 2024A0605005
Hidden Acres Manor

Dear Neiman Byerly:

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:

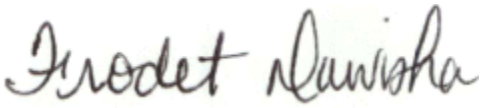
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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 (248) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM630397532
Investigation #:	2024A0605005
Complaint Receipt Date:	11/13/2023
Investigation Initiation Date:	11/13/2023
Report Due Date:	01/12/2024
Licensee Name:	Byerly Enterprises, LLC
Licensee Address:	4759 Owasco Ct. Clarkston, MI 48348
Licensee Telephone #:	(810) 691-6400
Administrator/Licensee Designee:	Neiman Byerly
Name of Facility:	Hidden Acres Manor
Facility Address:	8616 Hidden Acre Court Clarkston, MI 48348
Facility Telephone #:	(248) 241-6507
Original Issuance Date:	08/07/2019
License Status:	REGULAR
Effective Date:	02/07/2022
Expiration Date:	02/06/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A attends Clarkston's Adult Transition Program. Resident A has come to class on a few occasions with bruising on his face and arms with no reason communicated to the program. There are concerns about him getting injured and hurt at the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/13/2023	Special Investigation Intake 2024A0605005
11/13/2023	Special Investigation Initiated - Telephone Discussed allegations with reporting person (RP)
11/13/2023	Referral - Recipient Rights Email sent to Oakland County Office of Recipient Rights (ORR) worker Sarah Rupkus
11/13/2023	APS Referral Adult Protective Services (APS) referral made
11/14/2023	Inspection Completed On-site Conducted unannounced on-site investigation
11/14/2023	Contact - Face to Face With Resident A, his teacher and the transition coordinator
11/15/2023	Contact - Document Received APS denied referral
11/15/2023	Contact - Telephone call made Interviewed via telephone direct care staff (DCS) 4, DCS 5, and DCS 6 regarding the allegations. DCS 7 stated they will call me back later to discuss the allegations.
11/15/2023	Contact - Telephone call made Discussed allegations with Assistant Home Manager (HM) Shavor Walker

11/16/2023	Contact - Telephone call made With Jill McKay- Office of Recipient Rights (ORR) Newaygo County Left messages for registered nurse (RN) Kathleen Smith and case manager Pam Barron with Community Mental Health (CMH) in Newaygo County. Also left a message for Resident A's mother/guardian
11/16/2023	Contact - Telephone call made Made another referral to APS regarding new information received
11/20/2023	Contact - Telephone call received Discussed allegations with Resident A's case manager Pam Barron
11/20/2023	Contact - Telephone call made Left message for Detective Mance
12/06/2023	Contact - Telephone call made Discussed allegations with APS worker Carmen Smith and Resident A's mother/guardian Follow-up call with HM and left message for Resident B's case manager Aunica Bolen with Copper Country
12/07/2023	Contact - Telephone call received Discussed allegations with Resident B's case manager Aunica Bolen
12/07/2023	Contact - Telephone call made Discussed concerns with Resident B's public guardian Jim Stark and Chief Financial Officer of Hidden Acres Dr. Carl Byerly
12/08/2023	Contact - Telephone call received Dr. Carl Byerly left message
12/11/2023	Contact - Telephone call made Dr. Carl Byerly would like to have a face-to-face meeting regarding the concerns on 12/19/23 at Hidden Acres
12/11/2023	Contact - Telephone call received Discussed allegations with ORR in Copper County, Sarah Russo regarding Resident B

12/11/2023	Contact - Document Received Email from ORR Sarah Russo
12/18/2023	Contact - Face to Face Conference with Dr. Carl Byerly, Jeannine Byerly and the HM at Hidden Acres Manor
01/04/2024	Contact - Telephone call made I attempted to contact licensee designee Neiman Byerly but his voice mailbox is full. I contacted Dr. Carl Byerly who stated he will reach out to Neiman to have him call me
01/04/2024	Exit Conference Conducted exit conference via telephone with licensee designee Neiman Byerly with my findings.

ALLEGATION:

Resident A attends Clarkston's Adult Transition Program. Resident A has come to class on few occasions with bruising on his face and arms with no reason communicated to the program. There are concerns about him getting injured and hurt at the facility.

INVESTIGATION:

On 11/13/2023, intake #198451 was assigned for investigation regarding Resident A arrived at school with a red mark under his left eye and bruising on his left arm.

On 11/13/2023, I initiated this special investigation by contacting the reporting person (RP) via telephone and discussed the allegations. Resident A arrived at school with a red mark under his left eye and bruising on his left arm. Resident A had been out of school for about eight days and no one from Hidden Acres Manor contacted the school to advise why Resident A was out. The school contacted the home manager (HM) Jennifer Stancroff three different times asking why Resident A was not in school. The school was first advised that Resident A was filling out papers with his family, the second time the school was informed that “Resident A did not want to get out of bed,” and the third time the school was told, “Resident A wasn’t feeling well and had some kind of bug.” On 11/10/2023, the school received a doctor’s note via email from the HM stating that Resident A was seen by the doctor. The HM nor any other staff from Hidden Acres Manor informed the school how Resident A got the red mark under his eye.

On 11/14/2023, I made a face-to-face visit with Resident A at Renaissance High School located at 6558 Waldon Road in Clarkston. Resident A is non-verbal, so I was unable to interview him regarding these allegations. However, I did observe a red mark under his left eye and the bruise on his left arm. The mark under his eye was red/purple in color

and the bruise was on his left arm appeared yellowish/green in color and was larger than a quarter. I took pictures of the marks/bruises with my State of Michigan iPhone.

I discussed the allegations with Resident A's teacher who expressed concerns about Resident A not being in school for eight days and then showing up to school with the mark under his eye without any explanation. The teacher believes that the mark was a black eye and Hidden Acres Manor did not want the school to see the black eye, so Resident A was not sent to school. Resident A has arrived at school with three black eyes just this year with no explanation from Hidden Acres Manor as how Resident A sustained these black eyes. The teacher is concerned about Resident A's safety.

On 11/14/2023, I also discussed the allegations with the school's transition coordinator. The transition coordinator has asked the HM for open communication with the school regarding Resident A's injuries in the past, due to Resident A arriving at school with black eyes. The HM and staff at Hidden Acres Manor continue to not communicate with the school regarding Resident A's injuries or absence from school. This most recent incident, Resident A missed eight days of school with no communication received from Hidden Acres Manor. The school contacted Hidden Acres Manor three different days within the eight days Resident A missed school asking why Resident A was not in school. The HM provided three different reasons each time the school called. Then on 11/13/2023, Resident A arrived at school with a red mark under his left eye and bruising on his left arm with no explanation from Hidden Acres Manor. Yesterday 11/13/2023, Resident A used his iPad and pointed to his neck and shoulder but this morning he pointed to his eye. The transition coordinator is concerned about Resident A's wellbeing at this home. In the past, the HM reported to the school Resident A's aggressive behavior and self-harm, but the school has never observed these behaviors with Resident A. Resident A is calm and pleasant at school with no behaviors noted. The transition coordinator stated she reached out to the HM and offered to assist with a behavioral plan for Resident A since the HM was expressing Resident A's aggressive behaviors. The HM never reached back out to the school for help with Resident A.

On 11/14/2023, I conducted an unannounced on-site investigation at Hidden Acres Manor. Present were 10 residents, the HM Jennifer Stancroff and direct care staff (DCS) Sherry McLean, Steven Redmond, and Makayln Caudell. Residents A, C, D, E and F stay downstairs as they are more fragile and vulnerable and Residents B, G, H, I, and J stay upstairs as they are all verbal and higher functioning.

I interviewed Resident C outside. Resident C is verbal and was smoking a cigarette. He does not know how Resident A obtained the mark under his left eye. He did not see anyone hit Resident A nor did he see Resident A hit staff or another resident.

I interviewed Resident D regarding the allegations in his bedroom. Resident D is verbal and uses a wheelchair. Resident D was observed with fresh scratches on his forehead and on his left cheek. When asked what happened, Resident C stated, "The guy who lives upstairs did it." Resident D was unable to provide any further details. He does not know how Resident A sustained the mark under his left eye.

I was unable to interview Resident E as he is non-verbal and was sleeping in bed downstairs in his bedroom.

I was unable to interview Resident F as he too is non-verbal and sleeping in the recliner chair in the downstairs living room.

I attempted to interview Resident B, but he was in his bedroom upstairs and did not want to open the door.

I attempted to interview Resident G, but he left the home and went for a walk while I was interviewing the resident's downstairs.

I attempted to interview Resident H, but he did not want to speak to me. I attempted to interview Resident I, but he too was in his room and did not open the door.

I also attempted to interview J, but he too was in his room and did not want to speak with me.

On 11/14/2023, I interviewed DCS 1 regarding the allegations. DCS 1 was not present during the incident that resulted in Resident A having a left black eye because it occurred during second shift. DCS 1 does not recall the date of the incident. DCS 1 believes an incident report (IR) was written but they have not seen it. Resident A leaves the home from 6:30AM and does not return from school until 2:40PM. A couple of days after the incident, DCS 1 observed the mark under Resident A's left eye. DCS 1 asked the HM, "What happened?" The HM stated," it was a behavior." DCS 1 described Resident A's behaviors as "hitting his head on the wall or hitting a resident or staff." DCS 1 stated shortly after working here, Resident A "went after me, and I redirected him to the shower to calm down." Showers are a way to help Resident A calm down when he has a behavior which work. DCS 1 stated since the incident of Resident A coming after them, they have not witnessed Resident A have a behavior. DCS 1 stated Resident A was not in school for about eight days because "Resident A did not want to wake up." DCS 1 stated it is the HM's responsibility to call the school and advise them that Resident A was not attending school. DCS 1 is unsure if this was done. DCS 1 took Resident A to the doctor's on 11/09/2023 because he was not feeling well. Resident A had pneumonia. The doctor observed the mark under Resident A's left eye and asked, "What happened?" DCS 1 told the doctor, "it was a behavior." DCS 1 stated the doctor did not question it. DCS 1 stated they do not have any further information regarding the incident.

On 11/14/2023, I interviewed DCS 2 regarding the allegations. DCS 2 believes the incident occurred during second shift because they were not present when it happened. The incident may have occurred on 11/01/2023 because on 11/02/2023 DCS 2 worked and saw that Resident A was not in school and noticed he had a left black eye. DCS 2 was informed that "Resident A had a behavior," which is what the HM stated. DCS 2 explained that a "behavior happens when Resident A doesn't get what he wants, such

as McDonalds and attacks another resident like Resident F who is non-verbal and can't fight back." DCS 2 stated that a couple of months ago, Resident B assaulted Resident A, but now that Resident B's room was moved upstairs, there has not been any altercations between them that DCS 2 is aware of. However, DCS 2 does not know how Resident A got the black eye. DCS 2 believes that an IR was completed but they have not seen it. DCS 2 does not know if medical attention to Resident A's eye was sought immediately after the black eye became visible. DCS 2 stated the marks on Resident D were because Resident B attacked Resident D is what Resident D reported to DCS 2. DCS 2 did not witness the attack but stated that is what Resident D said. Resident B is supposed to stay upstairs because of past incidents between Resident A and Resident B, but sometimes Resident B still comes downstairs.

On 11/14/2023, I interviewed DCS 3 regarding the allegations. DCS 3 observed Resident A's eye around Halloween. They described the injury as a "black eye," and observed the bruise on Resident A's upper right arm and bruise on his right shin. DCS 3 did not see an IR but was informed by the HM and DCS 1 that the injuries sustained by Resident A were because, "Resident A had a behavior," during second shift and that the injuries were "self-inflicted wounds." DCS 3 was told by the HM that Resident A "ran into the wall next to his bedroom," which resulted in the black eye. DCS 3 believes Resident A received medical care but is not sure when he received care. DCS 3 has never witnessed Resident A run into a wall, bang his head against the wall or any self-harm." DCS 3 has observed Resident A attack other residents and staff, but never himself. DCS 3 believes another DCS inflicted these injuries. DCS 3 was told by DCS 1 that DCS 7 told DCS 1, "I tripped Resident A to stop the behavior." DCS 3 does not know what the behavior was but believes it was a behavior because of DCS 7 said "No," to Resident A. When Resident A hears the word "No," he explodes and has a behavior which is usually assaulting a resident or a staff. DCS 3 stated that Resident A did not go to school beginning 10/31/2023 for eight days is because Hidden Acres did not want the school to see Resident A's black eye. Resident A went to the doctor last week on 11/09/2023 not because of the black eye, but because Resident A was sick and has pneumonia. DCS 3 does not know what behavior occurred for Resident A to get a black eye.

On 11/14/2023, I interviewed the HM Jennifer Stancroff regarding the allegations. The HM stated on 10/25/2023, an IR was written regarding Resident A having a behavior that resulted in a self-inflicted mark under his left eye. Resident A was hitting his head on his bedroom door. Resident A also hit Resident D and DCS 6 and DCS 7 who were working downstairs. DCS 8 was working upstairs that day. The HM received a call from both DCS 6 and DCS 7 saying that Resident A had a mark under his left eye. The HM directed them to put an ice pack on his eye, which they did. Resident A was not taken to the hospital or the doctor as follow-up on his eye because it was "just a mark." The HM was never informed by DCS 6 or any other staff that DCS 7 stated they tripped Resident A which resulted in the mark under his left eye or bruises on his arm. DCS 7 quit on 11/13/2023 saying she found a better paying job. The HM stated she noticed the red mark under Resident A's eye on 10/26/2023. She then stated that on 10/31/2023, the mark turned purple in color. Resident A did not go to school this day because "he didn't

want to get out of bed." Resident A stayed in his room most of the day and staff were periodically checking on him. Resident A missed eight days of school because "he had difficulty getting up and refused each day." The HM stated that when Resident A does not attend school, the protocol is to call the school and the bus driver each day missed and inform them that Resident A was not attending school. This is the responsibility of the HM. The HM stated she did not follow protocol because she never informed the school any of the eight days that Resident A missed school and the school had to call to find out why Resident A was not there. Last week on 11/09/2023, Resident A missed school because he had a doctor's appointment. This appointment was not for the mark under his eye, but for Resident A not feeling well. Resident A had pneumonia.

Note: I reviewed the CLS logs from 10/01/2023-11/13/2023 and on 10/25/2023, the alleged incident date did not indicate that Resident A "head butted the wall," as reported in the IR. However, On 10/30/2023, DCS 7 documented in the CLS log that Resident A had a behavior and an IR was written, but the HM stated there is no IR for 10/30/2023.

I asked about the scratch marks on Resident D's face. The HM stated the marks on Resident D's face were caused by Resident B. Resident D spit on Resident B's face and Resident B hit Resident D. This incident occurred on 11/12/2023. The HM stated she does not have any other information other than what was written on the IR.

I reviewed the IR dated 10/25/2023, and it indicated the following: **Explain what happened/describe injury (if any)**: Resident A was asking to go to the Dollar Tree on his tablet. Staff verbally redirected Resident A unsuccessfully. Resident A hit staff and another resident. Staff removed the other resident out of the area and used blocking techniques with Resident A. There is an arrow on the IR to turn the IR over. The following was written on the back "Resident A has red mark under left eye and cheek from hitting head on his bedroom door (head butting.)"

Action Taken by staff/treatment given: PRN given, and staff redirected Resident A to shower which is a calming mechanism. HM was contacted. No injuries were sustained by staff or other resident.

Corrective Measures Taken to Remedy and/or Prevent Reoccurrence: CMH Notified

Note: The 10/25/2023 IR provided to me by the HM is different from the IR that was faxed to Newaygo County Office of Recipient Rights (ORR) Jill McKay. Ms. McKay emailed me the IR she received, and her IR did not have the arrow on the front of the IR, nor did it have the written information on the back of her IR. In addition, I reviewed the Community Living Services (CLS) logs and the IR written on 10/25/2023 is not consistent with the documentation on the CLS log for 10/25/2023 documented by DCS 6. According to the CLS log on 10/25/2023, there was no self-inflicted harm by Resident A that would correspond with the added information on the IR written by the HM Jennifer Stancroff that "Resident A had a red mark due to head butting the wall."

I also reviewed the IR's completed for both Resident B and Resident D on 11/12/2023. Resident B IR stated: **Explain what happened/describe injury (if any): Resident B's IR stated:** Another resident was having a behavior and went to walk pass the resident spit on Resident B. Resident B slapped the other resident extremely hard across the face.

Action Taken by staff/treatment given: Verbal redirection/staff looked at the other resident's face and took proper action to take care of the resident's face.

Corrective Measures Taken to Remedy and/or Prevent Reoccurrence: This section was blank.

Resident D IR stated: **Explain what happened/describe injury (if any):** Resident D was in the living room eating dinner. Resident D was agitated all day. He got upset because there wasn't any pop left. Resident D was spitting on staff and other housemates. He hit staff a few times.

Action Taken by staff/treatment given: Verbal redirection.
Corrective Measures Taken to Remedy and/or Prevent Reoccurrence: This section was blank.

On 11/15/2023, I interviewed DCS 4 regarding the allegations via telephone. DCS 4 was not present during the incident where Resident A had the black eye. DCS 4 usually works upstairs with the higher functioning residents. DCS 4 heard that there was an incident about two weeks ago when Resident A had a behavior and tried to attack another resident and staff. Staff who were present deescalated the situation and the HM informed DCS 4 that Resident A was "hitting the wall," which resulted in the black eye. Resident A missed eight days of school because of the "black eye," and that Resident A "wasn't feeling well." The protocol is that the HM must contact the school and the bus driver when Resident A is missing school, but DCS 4 does not know if this happened. DCS 4 stated they are unsure if the black eye was due to Resident A hitting the wall or if Resident B caused the injuries because DCS 4 heard from another staff (unknown name) that Resident B punched Resident A. DCS 4 stated that Resident B should not be allowed downstairs because of the several incidents that occurred between Resident A and Resident B. Resident A has gone after Resident B and Resident B hits Resident A which results in an injury. DCS 4 stated that Resident B "likes certain female staff downstairs," and these female staffs allow Resident B to remain downstairs with the lower functioning residents. DCS 4 stated it is unclear if the black eye was self-inflicted or caused by Resident B.

On 11/15/2023, I interviewed DCS 5 via telephone regarding the allegations. DCS 5 heard from another DCS (unknown name) that Resident B punched Resident A in the eye but then was informed by DCS 7 that DCS 7 "tripped Resident A on purpose," because "Resident A was having a behavior." DCS 5 was not present during the incident but stated that when Resident A has a behavior, there are a couple of female staff that work downstairs that call Resident B to assist them. DCS 5 has never

witnessed staff call Resident B downstairs but stated that DCS 6 and DCS 7 told DCS 5 that they call Resident B downstairs whenever Resident A has a behavior and to “take care of Resident A.” DCS 5 has never witnessed Resident B hit Resident A nor has DCS 5 observed DCS 7 trip Resident A. DCS 5 has never observed Resident A self-harm or head butt the wall. DCS 5 stated when they have worked, Resident A has not acted out or had a behavior.

On 11/15/2023, I interviewed DCS 6 via telephone regarding the allegations. DCS 6 worked downstairs and was present during the incident with DCS 7. DCS 8 was working upstairs. The incident occurred on 10/30/2023 during second shift. Resident A brought his tablet to DCS 7 wanting Burger King. DCS 6 and DCS 7 tried to redirect Resident A, but Resident A kept asking for Burger King. Resident B heard the commotion and then came downstairs and stood close to Resident A. Resident A then pulled on Resident B and then Resident B punched Resident A in the face. DCS 6 stated that DCS 7 ran out to their car because they were scared during this incident. DCS 8 heard the noise and came downstairs. DCS 6 stated that because they (DCS 6 and DCS 8) were not trained in Crisis Prevention Training (CPI), they were only allowed to use verbal redirection to get Resident B off Resident A. Resident B finally got off Resident A about two minutes later and then Resident B went outside for a walk. DCS 6 contacted the HM. The HM told DCS 6 to put an ice pack on Resident A’s eye and to complete an IR which DCS 6 did. The HM told DCS 6 she will assess Resident A when she comes in the next day. It took about 20-30 minutes to calm Resident A down. DCS 6 stated, “the bruise was already forming around Resident A’s left eye.” DCS 6 denied calling Resident B downstairs to assist with Resident A’s behaviors. DCS 6 stated there are a couple of staff members that do call Resident B downstairs, and those staff members are DCS 3 and DCS 7. DCS 6 stated they did not write on the IR that Resident A “hit his head on the wall,” and that the IR, “should have reflected what they just reported regarding the incident.” DCS 6 stated there have been multiple times where Resident B has attacked Resident A but staff “cover up for Resident B,” and “do not do anything to make Resident B stop.” There is no behavioral plan in place for Resident B even though the HM is aware of these concerns. DCS 6 stated that Resident A missed eight days of school “mostly because of the black eye,” and that “Resident A did not want to get up for school.” The protocol is for the HM to call the school and inform them that Resident A was not attending but DCS 6 is not sure if this was done.

On 11/15/2023, I contacted DCS 7 via telephone to discuss the allegations. DCS 7 stated they will call me back shortly. DCS 7 never called back this day.

On 11/15/2023, I interviewed DCS 8 regarding the allegations. DCS 8 works upstairs and not downstairs. They cannot recall what date it was when they observed the black eye on Resident A’s left eye. DCS 8 stated that there have been issues with DCS who work the first shift promising Resident A McDonalds or Burger King but never follow through with getting it for him. Then Resident A begins asking for McDonalds and Burger King during second shift which causes issues. DCS 8 recalls hearing “yelps,” coming from downstairs so he went downstairs to check on the noise. He observed Resident A in his bedroom holding his face and making yelping noises. DCS 8 asked

Resident A if he wanted a snack, and Resident A stated, “No.” DCS 8 asked if he wanted to take a shower to calm him down and Resident A stated, “No,” but then agreed to watch TV. DCS 8 then went back upstairs to pass medications. He then returned downstairs towards the end of his shift and observed the red mark and bruising around his left eye. He stated that the incident may have occurred around 5PM because he went back upstairs to pass medication. He was informed by DCS 6 and DCS 7 that there was a “behavior between Resident A and Resident B.” DCS 8 denied being downstairs during this behavior even though DCS 6 stated that DCS 8 was present. DCS 8 stated that Resident B was out riding his bike, so he did not know that Resident B had returned and was downstairs during the incident because DCS 8 never saw Resident B downstairs.

On 11/16/2023, I contacted Newaygo County ORR Jill McKay regarding the allegations. Ms. McKay stated that there have been concerns about Hidden Acres Manor lack of documentation. This has been an ongoing issue and discussed with the HM several times. Ms. McKay stated that Newaygo County’s registered nurse (RN) Kathleen Smith went to the home and observed Resident A’s black eye. The RN told Ms. McKay that the black eye was not consistent with the explanation given by the HM that “Resident A was picking at his eye.” I expressed concerns to Ms. McKay I have received several stories on how Resident A sustained the black eye and all have been inconsistent with the injury expect that Resident B punched Resident A in the face. I advised Ms. McKay that there have been at least two other incidents where Resident B punched Resident A in the face that resulted in black eyes. Ms. McKay stated the IR she received on 10/25/2023, did not reflect any documentation regarding Resident B’s involvement with Resident A and does not have any information written that the Resident A “head butt,” himself on the wall. The HM told Ms. McKay that the HM rewrote the IR on 10/25/2023 because of “DCS 6 handwriting was not legible.” Ms. McKay will follow-up with Pam Barron, Resident A’s case manager with Newaygo County.

On 11/16/2023, I contacted the RN Kathleen Smith via telephone regarding her visit at Hidden Acres Manor. The RN was at the home on 11/13/2023 and observed Resident A’s left eye. She received a call from Newaygo County ORR Jill McKay requesting an observation of Resident A. At the home, the RN observed Resident A’s left eye and asked the HM what happened. The RN stated that, “the HM looked at Resident A and said, he does pick.” The RN saw the abrasion and discoloring of yellow and purple around the eye and the eye lid that appeared in the healing stages and were not consistent of Resident A “picking at his eye.” The RN was informed that medical treatment for Resident A’s eye was not sought by Hidden Acres Manor. There were no other explanations offered by the HM on how the injury was sustained. The RN stated she was not too close to Resident D to observe his marks on his face even though he too receives services through Newaygo County.

On 11/16/2023, I went to Oakland County Sheriff's Substation at 6560 Citation Drive, Independence Township, 48346 and filed a police report regarding DCS 7 allegedly tripped Resident A on purpose which resulted in a black eye. I emailed pictures of

Resident A's injuries to Deputy Harris. Deputy Harris took the report and stated to call back to find out if the case has been assigned to a detective.

On 11/20/2023, I contacted Deputy Harris who stated that the case (23-288812) was assigned to Detective Mance. I left a message for Detective Mance to return my call. On 11/20/2023, I interviewed Newaygo County Community Mental Health (CMH) case manager Pam Barron regarding the allegations. Ms. Barron will be going to Hidden Acres Manor next week to see Resident A. Ms. Barron and the RN went out last year to Hidden Acres Manor and conducted a CPI training with staff, but there have been new staff that have not received the CPI training yet. Ms. Barron usually has Zoom meetings with Resident A given she is about nine hours from Hidden Acres Manor. She has not been informed by the HM that there have been incidents between Resident A and Resident B that resulted in Resident A getting injured or having black eyes. She stated there are concerns of lack of documentation by Hidden Acres Manor that has been discussed and they were getting better, but she too is concerned about the documentation of the CLS logs not matching the IR's written by staff. She stated she will continue to address these issues with the HM.

On 12/06/2023, I contacted DCS 7 again regarding the allegations via telephone but DCS 7 stated, "I have nothing to say to you guys," and then disconnected the call.

On 12/06/2023, I received a call from Adult Protective Services (APS) worker Carmen Smith regarding the allegations. Ms. Smith stated she has been involved in several investigations regarding Hidden Acres Manor "too many times regarding Resident B punching Resident A." She is investigating these allegations.

On 12/06/2023, I contacted the HM requesting Resident B's case manager and individual plan of service (IPOS)/crisis plan. Resident B's case manager is Aunica Bolen with Copper Country Mental Health. The HM stated that she does not believe that Resident B punched Resident A in the eye and that the black eye was self-inflicted even though the RN reported that the "picking at the eye," was not consistent with the discoloring observed around Resident A's eye. The HM stated that staff should never ask Resident B to assist with Resident A when Resident A is having a behavior. DCS 6, DCS 7, and DCS 8 have not been trained in CPI yet but were trained in verbal de-escalation. I received Resident B's IPOS and there is no behavioral plan or any statements regarding how to de-escalate Resident B when he is attacking another resident.

On 12/06/2023, I interviewed Resident A's mother/guardian regarding the allegations. The mother heard from the HM that they have had concerns getting Resident A to school but was told that it was due to pneumonia. The mother was told about the mark under Resident A's eye, but the mother never asked how it happened. The mother is concerned that staff have provided inconsistent stories regarding the black eye and that Resident A was not taken to the doctor immediately. The mother stated that an alternative placement is being sought for Resident A to be closer to family and she will follow up with Pam Barron.

On 12/07/2023, I received an email from the HM that stated, “none of our residents have behavioral plans.” However, I reviewed Resident A’s IPOS dated 09/06/2023 complete by Newaygo County Mental Health and he has a behavioral plan due to his aggressive behaviors by offering him snacks and/or showers.

On 12/07/2023, I received a return call from Resident B’s case manager Aunica Bolen with Copper Country Mental Health regarding the allegations. Ms. Bolen stated that Resident B has been in and out of foster care. He has been living at Hidden Acres Manor since 2020 or 2021. Resident B wants to move out and become more independent as he is higher functioning. There is no behavioral plan for Resident B because the HM has never reported any concerns with Resident B. Ms. Bolen was not aware of any incidents where Resident B attacked Resident A in the past. Resident B’s guardian is Macomb Oakland Guardian Inc (MOGI). Ms. Bolen met with Resident B, the HM, and Dr. Carl Byerly via Zoom on 11/22/2023. Ms. Bolen felt that the HM and Dr. Byerly were hesitant to have Resident B move to Marquette and live with a friend even though this would be a good placement for Resident B. Ms. Bolen expressed concerns that Resident B refers to the HM as “mom,” and Dr. Byerly as “dad.” Ms. Bolen expressed concerns that she was never informed of any of the incidents regarding Resident B punching another resident because if she would have known, then a behavioral plan would be appropriate to put in place for Resident B. Ms. Bolen stated she is moving forward with getting Resident B placed in Marquette because that is what Resident B wants.

On 12/07/2023, I left another message for Detective Mance but have yet to receive a return call regarding the complaint I filed on 11/16/2023.

On 12/07/2023, I contacted Resident B’s legal guardian, Jim Stark with MOGI. Mr. Starke met with Resident B at the Hidden Acres Manor a week ago. He met with the HM and Dr. Carl Byerly who reported that Resident B wanted to travel to Marquette and live by himself. Mr. Stark stated that the HM and Dr. Byerly expressed concerns about Resident B living by himself. Mr. Stark is working with Resident B’s case manager Aunica Bolen to see what is in the best interest of Resident B. He has no concerns.

On 12/07/2023, I contacted Dr. Carl Byerly via telephone regarding the allegations. Dr. Byerly stated that Resident A and Resident B have had past altercations but was informed that the black eye was because Resident A “hit his head on the floor.” Dr. Byerly stated that I should speak with the HM, which I advised Dr. Byerly I did and continue to receive inconsistent stories from the HM and DCS on how Resident A sustained the black eye. Dr. Byerly is also concerned about staff using Resident B to assist with Resident A’s behavior and will be having a staff meeting to address this issue. I also advised him about the IR that was provided to me regarding the incident on 10/25/2023 that was different from the one provided to Newaygo County ORR Jill McKay. He stated he will address documentation as he knows this has been a constant battle with staff to document better. Dr. Byerly stated that Resident A has inflicted self-

harm by head butting the walls, doors, and throws things in his room. He will investigate and contact me after his findings.

On 12/11/2023, I received a call from Sarah Russo, Copper Country Recipient Rights regarding Resident B. Ms. Russo believes that Resident B should be placed in Marquette so CMH can better service him. Ms. Russo has not received any concerns or IR's regarding Resident B's behavior of attacking other residents. There is a lack of inconsistent reporting to create an appropriate behavioral plan. Last year, concerns of lack of documentation were brought to the HM and it was agreed that the home with increase reporting and increase better documentation to address any concerns and to create behavioral plans; however, it seems that this was not completed because now Resident B has had another incident of aggression towards another resident that resulted in an injury. Ms. Russo will open a case against Hidden Acres Manor regarding these allegations and will investigate. Ms. Russo will send me the only two IR's she had received from Hidden Acres Manor.

On 12/11/2023, Sarah Russo emailed me two IR's regarding Resident B. The first IR dated 01/06/2023, regarding Resident B hearing another resident swearing at staff intervened and "rushed," the client when the resident was coming out of his room." The second IR was on 06/14/2023, where Resident B was assisting staff in locating a missing resident from the home.

On 12/11/2023, Dr. Carl Byerly would like to meet face-to-face at Hidden Acres Manor to address these allegations.

On 12/18/2023, I conducted a face-to-face conference at Hidden Acres Manor with the HM, Dr. Carl Byerly, and Chief Executive Officer (CEO) Jeannine Byerly. Dr. Byerly stated after speaking with all staff, it was stated that DCS 6 never called Resident B downstairs to assist with Resident A's behavior. I reviewed a statement written by DCS 6 stating that she never asked Resident A to come downstairs to assist with Resident A. Dr. Byerly stated that if the incident occurred on 10/25/2023, then the school would have observed the injured eye because Resident A went to school on 10/26/2023, 10/27/2023 and 10/30/2023. I advised Dr. Byerly that I would reach out to the school. Dr. Byerly and Mrs. Byerly agreed that documentation needed to be more detailed and consistent with the CLS logs and the IR's written. I discussed concerns that Resident B did not have a behavioral plan in place since there have been multiple incidents of aggression from Resident B towards Resident A resulting in several black eyes. Dr. Byerly stated Resident B will be moving out of Hidden Acres Manor on 12/19/2023 as it was determined that Marquette would be a better placement for Resident B. Mrs. Byerly and Dr. Byerly advised that they will be retraining staff which includes documentation, CPI training by Newaygo County and ensure that behavioral plans are implemented when necessary.

On 12/21/2023, I received the following email from Resident A's teacher regarding his absences during the black eye incident: "Thank you for reaching out. I apologize for the delayed response. Our team has a different timeline for the date/incident that you are

describing in your email. Based on what they are saying, it does not line up with our documentation and efforts to reach out to the group home. Below is the timeline of what we observed here at the program:

> **October**: 10/24/2023: Absent AM, 10/25/23: Here all-day, 10/26/23: Here all-day (no mark), 10/27/23: Here all-day (no mark), 10/30/23: Here all-day (no mark), 10/31/23: Absent all-day.
>
> **November:** 11/1/23: Absent all day, called the group home and they stated, "Resident A was working on paperwork with his family." 11/2/23: Absent all-day, emailed group home and they stated they were having trouble getting him up. 11/3/23: Absent all day, 11/6/23: Absent all day, 11/7/23: Absent all day, called group home and they stated, "Resident A was under the weather." 11/8/23: Absent all-day, emailed group home to check in. 11/9/23: Absent all day, received an email back from the group home manager with a doctor's note dated 11/9/23 saying that Resident A can return to school on Monday 11/13/23 and he has been having increased fatigue/sleeping most of the day, 11/10/23: No School for students and 11/13/23: Returned to school with faded marks under eye and on his arm. Pictures time stamped for proof. As you can see, aside from our dates not lining up with their timeline, we are also still the first to initiate a contact when he is absent or missing multiple days of school in a row."

On 01/04/2024, I sent an email to the HM requesting the IR dated 10/30/2023 as stated on the CLS log that DCS 7 had written due to Resident A not having a good day and had a behavior. The HM emailed back, "Attached you will find an in-house incident report for Resident A from 10/30/2023. These reports we keep in-house in the resident binders for any behaviors that do not include self-harm, any incidents that require hospital or urgent care visits, medication refusals, aggression towards others, or property destruction of the care home. These behavior reports are not sent to our client's CMH." I reviewed the in-house report and it indicated: "Resident A requested Burger King. We explained that we couldn't get Burger King and he had to wait until tomorrow after school. Resident A threw his tablet and cracked the screen." A picture of the cracked screen tablet was provided. However, there was no mention of Resident A and Resident B being in an altercation that resulted in Resident A's left black eye.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on my investigation and information gathered, the HM at Hidden Acres Manor does not possess all of the following qualifications to be suitable in meeting the physical, emotional, intellectual and social needs of Resident A. Resident A went to

	school on 11/13/2023 with no explanation from Hidden Acres Manor on how Resident A sustained the mark under his left eye and bruising to his right arm. I interviewed the HM and several DCS who reported different stories on how Resident A sustained the injuries. The HM provided me with an IR written on 10/25/2023 that was different from the IR submitted by the HM to Newaygo County ORR Jill McKay. The IR provided to me had additional information on the back written by the HM stating that the "red mark under the left eye was caused by Resident A head butting his head". However, the IR submitted to Ms. McKay did not have that information. I reviewed the CLS log dated 10/25/2023 and there was no mention of Resident A head butting the wall or any self-inflicted harm. DCS 6 stated that the IR they wrote regarding the incident was around Halloween regarding Resident B punched Resident A resulting in the black eye, but according to the HM, there was no IR written for 10/30/2023 only an in-house report that did not reflect Resident B punching Resident A in the face. Documentation is not consistent with what occurred nor what was being reported by DCS 6 who was present during the incident that resulted in Resident A's black eye. Therefore, there is concern about staff at Hidden Acres Manor can meet the physical, emotional, intellectual, and social needs of Resident A when there are inconsistencies with how Resident A sustained the injury.
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:	Based on my investigation and information gathered, Resident A's personal needs, including protection and safety were not attended to at all times during the incident dated 10/30/2023 that resulted in Resident A's left black eye and bruising to his left arm. It was alleged by the HM that the mark under Resident A's eye occurred on 10/25/2023 which was a result of Resident A

	"head butting the wall." However, the dates do not match with the dates Resident A missed eight days of school because of the black eye. If the incident occurred on 10/25/2023 and the mark appeared the next day, then on 10/26/2023 when Resident A was in school, the school staff would have noticed the mark, but according to Resident A's teacher, there was no mark on 10/26/2023, 10/27/2023 and the AM of 10/30/2023. It has been reported by multiple DCS that the black eye was the result of Resident B punching Resident A in the eye and not caused by self-inflicted harm by Resident A. Therefore, Resident A was not protected at all times by staff.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2023A0605006 dated 01/11/2023, CAP dated 01/24/2023** **SIR #2023A0990004 dated 04/21/2023, CAP dated 05/05/2023** **SIR #2023A0991021 dated 08/10/2023, CAP dated 08/09/2023**

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 resident, 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 my investigation and information gathered, interventions to address Resident B's unacceptable behavior were not specified in Resident B's IPOS/crisis plan. Resident B has had a history of assaulting Resident A and other residents at this home who are lower functioning. Within the last year, Resident B has punched Resident A in the face three times resulting in Resident A having black eyes. According to Resident B's case manager at Copper Country CMH, the HM nor any staff member at Hidden Acres Manor have reported these concerns to their attention. If they had, then a behavioral plan would have been implemented to address Resident B's aggressive behaviors towards other residents. The HM reported that there are no residents at Hidden Acres Manor with

	behavioral plans even though Resident A has a behavioral plan in place according to his IPOS dated 09/06/2023.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2023A0991021 dated 08/10/2023, CAP dated 08/09/2023**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on my investigation and information gathered, Hidden Acres Manor did not immediately obtain needed care for Resident A after an incident occurred that resulted in a black eye and/or red mark under his eye. DCS 6 reported that Resident A was punched in the face by Resident B during an incident around Halloween that resulted in Resident A's black eye. DCS 6 was only directed by the HM to put an ice pack on Resident A's eye, which she did. However, the HM reported that Resident A "head butted the wall," which resulted in the red mark under his left eye, but Resident A was not taken to the doctor to be examined although the physical condition of the eye changed as evident by the red mark and black eye. Resident A went to the doctor on 11/09/2023 because he was not feeling well. The doctor observed the red mark under the eye only and asked what happened, and DCS 1 told the doctor, "it was a behavior."
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2023A0605006 dated 01/11/2023, CAP dated 01/24/2023**

ADDITIONAL ALLEGATION:

INVESTIGATION:

On 11/14/2023, Resident A's teacher reported that Hidden Acres Manor is not consistent with Resident A's lunch. Resident A enjoys eating peanut butter and jelly uncrustable sandwich, a bag of chips and flavored water. Sometimes, Resident A arrives at school with no sandwich but just a bag of chips and water or other times with five sandwiches but no chips. Each time the teacher calls the HM and then the HM comes to the school with what Resident A needs for lunch. This has not recently been happening, but it was an issue with Hidden Acres Manor.

On 11/14/2023, I interviewed DCS 1 regarding the allegations. DCS 1 stated that third shift is responsible for making Resident A's lunch. Resident A only likes to eat fast food or peanut butter and jelly sandwiches without the crust, so the home purchases "uncrustable," peanut butter and jelly sandwiches for Resident A. Resident A does not like to drink water and only likes pop or orange juice. DCS 1 does not know anything about Resident A being sent to school without enough food because when they begin their shift, Resident A is already in school.

On 11/14/2023, I interviewed DCS 2 regarding the allegations. DCS 2 reported that third shift is responsible for making Resident A's lunch. Resident A usually gets two uncrustable peanut butter and jelly sandwiches, a fruit cup, and a drink. Resident A is very picky about what he likes to eat. Resident A is usually already in school when DCS 2 arrives at the home and has not heard any complaints about Resident A not getting enough food to eat at school.

On 11/14/2023, I interviewed DCS 3 regarding the allegations. DCS 3 reported that third shift is responsible for making Resident A's lunch. Resident A is gone to school before DCS 3 arrives at the home. DCS 3 has not heard from anyone that there is an issue with Resident A not receiving enough food at school for lunch.

On 11/14/2023, I interviewed the HM regarding the allegations. The HM stated that there have been times in the past when the school will email her stating that Resident A did not get a sandwich so she would drive to the school with additional food. She has not been informed recently of this issue by the school. Third shift is responsible for making Resident A's lunch and responsible for putting Resident A on the bus in the morning. Resident A is extremely picky and only eats peanut butter and jelly sandwiches without the crusts. Resident A should receive two sandwiches, chips or a fruit cup and flavored water for lunch. The HM stated that third shift was trained on what to pack Resident A for lunch and how much food to pack. The HM stated she will address this issue with third shift.

On 11/15/2023, I interviewed DCS 4 regarding the allegations. DCS 4 stated that third shift is responsible for making Resident A's lunch for school. There are a lot of new third shift staff working downstairs so the new staff may not know what to pack, but DCS 4 stated whenever the school calls them regarding Resident A not getting enough food for lunch, the HM or DCS 4 drive to the school with food. DCS 4 stated those were past concerns and DCS 4 has not heard of any current concerns about Resident A not getting enough food to eat for lunch.

On 11/15/2023, I interviewed DCS 5 regarding the allegations. DCS 5 reported that third shift is responsible for packing Resident A's lunch for school. DCS 5 has not heard there has been any issues with Resident A's lunch.

On 11/15/2023, I interviewed DCS 6 regarding the allegations. Resident A is extremely picky and does not eat the food that is made for him. The third shift is responsible for making Resident A's lunch and Resident A is usually not at home when DCS 6 begins

their shift. DCS 6 has never been informed there was an issue with Resident A not getting enough food sent with him to school.

On 11/15/2023, I interviewed DCS 8 regarding the allegations. Resident A is picky when eating food. DCS 8 stated they work third shift, and they always pack the correct amount of food for Resident A. They do not know of any concerns that Resident A arrived at school without enough food to eat. There are times when Resident A has returned from school and DCS 8 found his lunch untouched in the lunch box in Resident A's bag. DCS 8 has brought this issue of Resident A not eating lunch to the HM but does not know what the HM did with that information.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be a proper form, consistency, and temperature. Not more than 12 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on my investigation, Resident A is being sent to school with enough food. Whenever, Resident A does not have enough food for lunch, the school reaches out to the HM and food is immediately taken to the school.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 11/14/2023, I observed Resident A's nails at Renaissance High School, and they were long. Resident A's teacher reported that Resident A has a hygiene routine at school because Resident A has arrived at school with long nails and beard not trimmed. These concerns were expressed to the HM, but Resident A's hygiene continues to not be addressed.

On 11/14/2023, I interviewed DCS 1 regarding the allegations. DCS 1 stated there is no grooming schedule for any of the residents. They are unsure who is responsible for trimming Resident A's nails or beard. DCS 1 has never trimmed Resident A's nails or beard.

On 11/14/2023, I interviewed DCS 2 regarding the allegations. DCS 2 stated that all DCS are responsible for all residents' grooming needs including trimming nails and their beards. DCS 2 stated they have never trimmed Resident A's nails or beard.

On 11/14/2023, I interviewed DCS 3 regarding the allegations. DCS 3 stated it is third shift's responsibility for grooming Resident A because Resident A takes a shower during third shift. There is no schedule for when residents are groomed, but whenever residents are groomed, then DCS must document it on the CLS logs. DCS 3 has never trimmed Resident A's nails or beard.

On 11/14/2023, I interviewed the HM regarding the allegations. The HM stated that all DCS are responsible for grooming all residents. Resident A is groomed, but sometimes he does not tolerate trimming his nails and beard, but staff try. There is no grooming tracking sheet, but DCS do long grooming if it is done on the CLS logs.

Note: I reviewed 10/01/2023-11/13/2023, CLS logs for Resident A and there are no notes by any DCS within this timeframe regarding Resident A's nails and/or beard except for Resident A showering.

On 11/15/2023, I interviewed DCS 4 regarding the allegations. DCS 4 stated it is difficult grooming Resident A sometimes because Resident A will refuse. DCS cannot force Resident A to have his nails or beard trimmed, but all DCS are supposed to assist with all the residents' grooming needs. DCS are also supposed to document in the CLS logs whenever they groom a resident or if a resident denied any grooming needs that was offered.

On 11/15/2023, I interviewed DCS 5 regarding the allegations. DCS 5 has never clipped Resident A's nails or trimmed his beard. They are not sure who is responsible for the residents' grooming needs because they were never told that they had to trip Resident A's nails or beard.

On 11/15/2023, I interviewed DCS 6 regarding the allegations. DCS 6 stated they have attempted several times to trim Resident A's nails, the most recent time they tried was last night. Resident A would not allow them too, so DCS 6 did not press the issue because they were afraid this would result in Resident A having a behavior. DCS 6 stated they are responsible for documenting all grooming needs and refusals on the CLS logs.

On 11/15/2023, I interviewed DCS 8 regarding the allegations. DCS 8 reported that first shift is responsible for trimming Resident A's nails and beard during the weekends because Resident A is at school during the week. There is a list that says: showers, grooming, and laundry that began a couple weeks ago for all DCS to complete. This list states what specific shift is responsible for what task. DCS 8 has not trimmed Resident A's nails or beard because that is the task for first shift and DCS 8 does not work first shift.

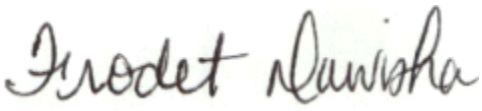
On 01/04/2024, I conducted the exit conference via telephone with licensee designee Neiman Byerly and the Chief Financial Officer Dr. Carl Byerly. I advised Mr. Byerly of my findings and that based on several repeat violations for quality-of-care deficiencies, my recommendation is to modify the license to a six-month provisional license. Dr.

Byerly expressed his dissatisfaction with the violations and stated that they will be appealing my recommendation.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(3) A licensee shall afford a resident opportunities, and instructions when necessary, to obtain haircuts, hair sets, or other grooming processes.
ANALYSIS:	Based on my investigation and observation of Resident A's nails on 11/14/2023, Resident A's grooming needs were not met by DCS. I observed Resident A's nails to be long and untrimmed. According to all the DCS and the HM interviewed; it is the responsibility of all DCS to meeting the grooming needs of all the residents including Resident A's nails. In addition, DCS must document on the CLS log when Resident A's nails were trimmed. However, I reviewed the CLS logs from 10/01/2023-11/13/2023, and there were no notes documented regarding Resident A's nails and/or beard being trimmed nor were there any notes regarding any attempts made to trim Resident A's nails or beard.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

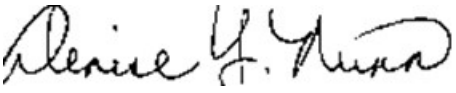
Contingent upon receiving an acceptable corrective action plan, I recommend modifying the license to a six-month provisional license.



01/08/2024

Frodet Dawisha Date
Licensing Consultant

Approved By:



01/08/2024

Denise Y. Nunn Date
Area Manager