GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 26, 2024

Justeen Blair
Bay Arenac Behavioral Health Authority
201 Mulholland
Bay City, MI 48708

RE: License #: AS090297031
Investigation #: 2024A0572017
Horizon Home

Dear Ms. Blair:

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 (517) 643-7960.

Sincerely,

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090297031
Investigation #:	2024A0572017
Complaint Receipt Date:	01/10/2024
Investigation Initiation Date:	01/10/2024
Report Due Date:	03/10/2024
Licensee Name:	Bay Arenac Behavioral Health Authority
Licensee Address:	201 Mulholland Bay City, MI 48708
Licensee Telephone #:	(989) 316-2200
Administrator:	Justeen Blair
Licensee Designee:	Justeen Blair
Name of Facility:	Horizon Home
Facility Address:	1717 Horizon Dr. Essexville, MI 48732
Facility Telephone #:	(989) 316-2200
Original Issuance Date:	09/17/2008
License **Status:**	REGULAR
Effective Date:	03/11/2023
Expiration Date:	03/10/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff, Ashley Andress struck Resident A in the head with a boxed cake mix.	Yes

III. METHODOLOGY

01/10/2024	Special Investigation Intake 2024A0572017
01/10/2024	Special Investigation Initiated - Letter
01/19/2024	Inspection Completed On-site Licensee Designee, Justeen Blair and Resident A.
01/22/2024	Contact - Telephone call made Staff, Ashley Andress.
01/23/2024	APS Referral Referral made to APS.
01/23/2024	Contact - Telephone call made Staff, Kaylee Rocha.
01/23/2024	Contact - Telephone call made Staff, Everleigh Wicker.
01/23/2024	Inspection Completed-BCAL Sub. Compliance
01/26/2024	Contact - Telephone call made Staff, Rebecca Moreau
01/26/2024	Exit Conference Licensee Designee, Justeen Blair.

ALLEGATION:
Staff, Ashley Andress struck Resident A in the head with a boxed cake mix.

INVESTIGATION:
On 01/10/1024, the local licensing office received a complaint for investigation. Adult Protective Services (APS) referred to licensing.

On 01/19/2024, I made an unannounced onsite to Horizon Home, located in Bay County Michigan. I Interviewed Licensee Designee, Justeen Blair and observed Resident A.

On 01/19/2024, I interviewed Licensee Designee, Justeen Blair regarding the allegation. Justeen Blair Informed that she walked in on Staff, Ashley Andress when the incident occurred. As Justeen Blair was walking towards the kitchen, when she witnessed Ashley Andress hit Resident A on the head with a box of cake mix. Ashley Andress then replied, “I know, I know, it’s a write up. I’ll take that write up.” Justeen Blair stood in shock and pointed for Ashley Andress to come over to her. They went into the office and Staff Andress was told that this incident was more than just a write up. Resident A is non-verbal and yells a lot. When Ashley Andress hit Resident A, it wasn’t meant to be a joke. It was more of an, “Shut up” type of hit. Resident A did not receive any marks or bruises. There were other staff who witnessed it also.

On 01/19/2024, I observed Resident A standing in the kitchen area of the home. Resident A is non-verbal and was letting out loud screeching sounds. However, Resident A appeared to be in relatively good health and being provided adequate care and supervision.

On 01/19/2024, I contacted Recipient Rights Officer, Melissa Prusi. She informed that she closed her investigation and Staff, Ashley Andress was terminated.

On 01/22/2024, I contacted Staff, Ashley Andress regarding the allegation. Ashley Andress refused to speak with me regarding the allegations due to being terminated from employment and already speaking with Recipient Rights. Ashley Andress informed that she had nothing further to say to anyone on this matter.

On 01/23/2024, I contacted Staff, Kaylee Rocha regarding the allegation. Kaylee Rocha informed that she was present when the incident occurred. Staff Rocha initially thought that Resident A had hit his hand on the counter or kicked a wall, but then came to realize that Ashley Andress had actually hit Resident A with a box of cake mix. Kaylee Rocha is not sure if Ashley Andress was trying to hurt Resident A, but she was definitely trying to get Resident A to stop yelling. This is not a normal way of communicating with Resident A. They normally will have Resident A do puzzles or try to figure out what Resident A would like to do. Kaylee Rocha did not observe any marks or bruises.

On 01/23/2024, I contacted Everliegh Wicker regarding the allegation. Everliegh Wicker was there when the incident occurred. Everliegh Wicker was sitting at the table when she heard a “thump” sound behind her. Justeen Blair was just walking into the kitchen. When she turned around, Resident A had a surprised look and Justeen Blair was starring at Ashley Andress. As Ashley Andress was sitting the cake mix box down, she stated, “You saw that, I’ll take the write-up.” Resident A was hit on the head with a box of cake mix by Ashley Andress. The home has policies in place that indicates that staff must redirect, and this has proven to be very effective. Everliegh Wicker does not believe that Ashley Andress was trying to cause great bodily harm to Resident A but believes that she was frustrated when she hit Resident A. Resident A was yelling prior to and after the incident. Staff Rebecca Moreau had been attempting to get Resident A’s attention to calm the behaviors.

On 01/23/2024, I reviewed the Incident Report. It indicates that Staff, Ashley Andress hit Resident A with a box of cake mix as a way to get Resident A to stop yelling. The action taken was Ashley Andress was called into the office, informed that the incident was abuse. She was sent home and taken off the schedule. The corrective measure was that a complaint was filed, Human Resources was notified of the incident and Ashley Andress was removed from the schedule pending investigation.

On 01/26/2024, I contacted Staff, Rebecca Moreau regarding the allegation. Rebecca Moreau informed that her and her other co-workers were all in the dinning room area of the home. Resident A was shouting and head banging during this time. She was trying to get Resident A’s attention by talking to Resident A. Resident A continued to shout but was not being aggressive. Ashley Andress then grabbed a box of cake mix and tapped Resident A directly on the face. Rebecca Moreau does not believe that Ashley Andress was trying to hurt Resident A, but she appeared to be frustrated with the shouting and hit him on the face with the cake mix box.

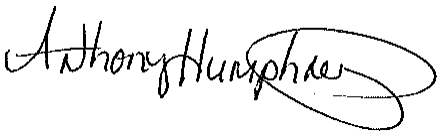
APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat 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 my interviews during this investigation, there is substantial evidence to establish a violation. The Licensee Designee and all the staff that were interviewed had the same statements in regard to the incident and confirmed Staff Andress hit Resident A on the head with a cake box mix. Staff, Ashley Andress refused to be interviewed.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/26/2024, an Exit Conference was held with Licensee Designee, Justeen Blair regarding the allegation. Justeen Blair was informed of the results of the special investigation and that she will need to submit a corrective action plan.

IV. RECOMMENDATION

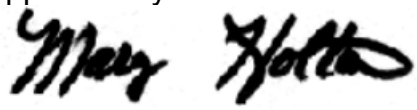
I recommend that no changes be made to the licensing status of this small adult foster care group home pending the receipt of an acceptable corrective action plan (Capacity 1-6).



01/26/2024

Anthony Humphrey — Date
Licensing Consultant

Approved By:



01/26/2024

Mary E. Holton — Date
Area Manager