

GRETCHEN WHITMER GOVERNOR STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

MARLON I. BROWN, DPA DIRECTOR

April 10, 2024

Donald King Alternative Community Living, Inc. P. O. Box 190179 Burton, MI 48519

> RE: License #: AS500381453 Investigation #: 2024A0604008 Otter Home

Dear Mr. King:

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 (248) 975-5053.

Sincerely,

Kristine Cillufo

Kristine Cilluffo, Licensing Consultant Bureau of Community and Health Systems Cadillac Place 3026 West Grand Blvd Ste 9-100 Detroit, MI 48202 (248) 285-1703

Enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS BUREAU OF COMMUNITY AND HEALTH SYSTEMS SPECIAL INVESTIGATION REPORT THIS REPORT CONTAINS SEXUALLY EXPLICIT LANGUAGE

License #:	AS500381453
Investigation #:	2024A0604008
Complaint Receipt Date:	01/26/2024
Investigation Initiation Date:	01/29/2024
Report Due Date:	03/26/2024
Licensee Name:	Alternative Community Living, Inc.
Licensee Address:	P. O. Box 190179 Burton, MI 48519
Licensee Telephone #:	(989) 482-7039
Administrator:	Donald King
Licensee Designee:	Donald King
Licensee Designee.	
Name of Facility:	Otter Home
Name of Facility.	
Facility Address:	34410 Lillian Chesterfield, MI 48047
Tacinty Address.	
Facility Telephone #:	(586) 273-7847
Original Issuance Date:	04/15/2016
Original issuance Dale.	
License Status:	REGULAR
LICENSE SIAIUS.	
Effective Date:	10/15/2022
LIIGULIVE DALE.	
Expiration Data:	10/14/2024
Expiration Date:	10/14/2024
Capacity	
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED
	MENTALLY ILL

II. ALLEGATION(S)

Violation Established?

	Established?
Resident A hit Resident C on 12/09/2023.	Yes
Resident C reported being sexually assaulted by Resident A on unknown dates.	No

III. METHODOLOGY

01/26/2024	Special Investigation Intake 2024A0604008
01/29/2024	APS Referral Intake sent to licensing by Adult Protective Services (APS)
01/29/2024	Special Investigation Initiated - Letter Email to Home Manager, Dawn Doetsch and Licensee Designee, Donald King. Received return email from Dawn Doetsch.
01/29/2024	Contact - Document Sent Email to and from APS Worker, Vernece Warren
01/30/2024	Contact - Document Received Email from Home Manager, Dawn Doetsch. Sent return email.
01/31/2024	Inspection Completed On-site Completed onsite investigation. Interviewed Home Manager, Dawn Doetsch, Resident A and Resident B
03/06/2024	Contact - Telephone call made TC to Resident A and Resident B's Case Manager, Tanisha Meadows
03/06/2024	Contact- Document Sent Email to and from Home Manager, Dawn Doetsch. Received incident reports involving Resident A.
03/07/2024	Exit Conference Completed exit conference by phone. Left message for Licensee Designee, Donald King.

ALLEGATION:

- Resident A hit Resident C on 12/09/2023.
- Resident C reported being sexually assaulted by Resident A on unknown dates.

INVESTIGATION:

On 01/26/2024, I received a complaint regarding the Otter Home. Resident C reported that another resident, Resident A touched her breasts, vagina, and buttocks. It is unknown if any penetration occurred. This occurred in a common area and over clothes. It is unknown when this occurred. Resident A was hospitalized from 12/9-12/12, because Resident A had hit Resident C on 12/9. Resident C did not suffer injury. Resident C reported the sexual assault on 12/12 after learning that Resident A was returning from the hospital. Staff directed Resident A to stay at least six feet away from Resident C. Resident A has history of repeatedly hitting Resident C and is facing domestic assault charges regarding it on 12/12. Resident A was given a notice to vacate on 9/2/23, but the facility lacks the ability to evict Resident A, because of her mental illness. Staff is supposed to be keeping Resident A and Resident C separate. In addition, the complaint received indicated that this case will not be substantiated for physical abuse or sexual abuse. Overall, it appears that there is some behavioral differences with Resident A and the other roommates within the home. Resident C discussed incidents that appeared to be isolated, or accidents. When focused to give specifics, Resident C could not recall when a particular incident occurred. Perhaps, "a few months ago." Another incident, in which it is alleged Resident A has taken her leg and rubbed Resident C between her legs, Resident C's thigh area. APS worker asked Resident C to describe the incident at kitchen table where alleged incident occurred. No matter how close or far Resident C placed this worker and herself together or apart at table, there was no way for this worker to touch Resident C under the table between her legs using my leg. Resident C finally acknowledged that she knew that she could not "show" this worker. This worker guestioned if Resident C felt that the touching or contact was sexual. Resident C acknowledged that it was not. Staff are keeping them apart too.

NOTE: I completed Special Investigation Report #2023A0604021 dated 09/15/2023. It was alleged that Resident A has physically abused Resident B and other residents by throwing stuff, hitting, and punching them. It was alleged that the Home Manager does not do anything about it. The home was cited for R400.14301 due to Resident A not being compatible with other residents in the household. Resident A had physically assaulted Resident B and Resident C. A Corrective Action Plan was submitted on 10/03/2023 and the licensee issued a 30 day discharge notice for Resident A on 08/03/2023. A copy of the discharge notice was provided.

On 01/29/2024, I received an email from Home Manager, Dawn Doetsch. She stated that First Resources North has put out several placement referrals for Resident A, however, they have not been able to secure a single pre-placement visit.

On 01/29/2024, I received an email from APS Worker, Vernece Warren. She indicated that Resident C made the allegations as a result of Resident C becoming aware that Resident A was returning to the home after an incident. Ms. Warren indicated that Resident C and another roommate are higher functioning than Resident A and other roommates. They are verbally caustic. Ms. Warren will not be substantiating allegations. She indicated that she found nothing and believes allegations were made up and that brushing up against Resident C's breast was an accident. Resident C acknowledged that the past contacts were not sexually intentional. Law enforcement found nothing as well. Ms. Warren also stated that staff have been more than appropriate.

On 01/31/2024, I completed an onsite investigation at Otter Home. I interviewed Home Manager, Dawn Doetsch, Resident A and Resident C.

On 01/31/2024, I interviewed Home Manager, Dawn Doetsch. She stated that the case manager has not found any placements for Resident A since the discharge notice was issued. She stated that it has been a while since Resident A has hit anyone and this behavior seemed to have improved. She stated that Resident A will touch Resident C's hair and poke at her. Resident C does not want to be touched. Ms. Doetsch stated that she has not seen any sexual contact between the residents. Resident C stated that Resident A put her leg in her private area at kitchen table, however, they do not sit near each other. There were no witnesses to the incident. Ms. Doetsch stated that staff try to keep them at least six feet apart. Ms. Doetsch indicated that Resident A does not know how to stay out of peoples' personal space. She does not believe that Resident A is compatible with other residents in the home. She feels that this house is not going to settle down until Resident A moves to a new placement.

On 01/31/2024, I interviewed Resident A. She stated that she has lived at the Otter Home since 2016. She stated that no one wants her here. Resident A stated that she hit Resident C along time ago and has lots of issues with Resident C. Resident A indicated that her Case Manager, Tanisha Meadows, is looking for a new placement for her. The court and her case manager both say she must move. Resident A stated that sometimes she gets along with staff at the home.

On 01/31/2024, I interviewed Resident C. She stated that she has lived at the Otter home for four years. She stated that Resident A has hit her in the head and beat her last summer in the car. Resident A has not aggressively hit her recently. Resident C stated that Resident A gets in her face and pokes her in the arm, head, forehead and says, "the power of Christ compels you". Resident C stated that Resident A does not keep her distance. She tells her to back up, but Resident A does not listen. Resident C stated that staff do nothing about it and are not trying hard enough because Resident A

keeps getting in her space. Resident C stated that Resident A "grabbed her butt" last summer and made comments like telling her she has a "nice ass". Resident A also said if she was gay, she would go out with her. Resident C stated that Resident A grabbed her breast and said it was an accident. Resident C stated that Resident A rubbed her leg against hers and said it was an accident. Resident A also breathes near her face and comments on how her hair smells. She stated that no one witnessed these incidents occur. Resident C stated that she is the one Resident A is targeting in the home. Resident C stated that she wants to remain at the Otter Home.

On 03/06/2024, I interviewed Case Manager, Tanisha Meadows, from First Resources North. She stated that she is the Case Manager for both Resident A and Resident C. Ms. Meadows stated that they are sending referrals out, however, have not found a new placement for Resident A. They do have a home that is willing to accept Resident A, however, it is out of county and Resident A has stated that she wants to stay in Macomb County. Also, Resident A's guardian wants her to stay in a specialized residential home. Ms. Meadows stated that the main complaints she has seen regarding Resident A recently is her refusing to take morning medications. She is also doing things to annoy other residents like tapping their shoulders. She believes the last time Resident A hit someone was when she hit Resident C in December 2023. Resident A now has a domestic violence charge and non-reporting probation. The domestic violence charge is making it more difficult to find a placement for Resident A. Ms. Meadows believes the home is doing the best they can considering the circumstances. Ms. Meadows stated that Resident C has been experiencing mood changes as she is trying to quit smoking. She can become agitated. Ms. Meadows stated that Resident C goes to program and told staff there that Resident A touched her inappropriately. She did not state when, where or what happened and indicated that she did not initially report it because Resident A gets away with everything.

On 03/06/2024, I received copies of incidents reports involving Resident A by email from Home Manager, Dawn Doetsch. There was only one incident report regarding Resident A's aggression since the last investigation, dated 12/09/2023. The report indicates that Resident A was arguing with Resident C in the kitchen. Resident A then walked over and punched Resident C twice on the left shoulder. Resident C called 911. Staff spoke to police and Resident A was petitioned to the hospital per the police officer's suggestion. Ms. Doetsch confirmed in email that Resident C pressed charges against Resident A.

I completed an exit conference by phone on 03/07/2024 with Licensee Designee, Donald King. I left Mr. King a message informing him of findings and that a corrective action plan would be requested. I also informed him that a copy of the special investigation report would be mailed once approved.

APPLICABLE RUL	APPLICABLE RULE		
R 400.14301	Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.		
	 (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 continues to be incompatible with other residents in the home. I completed Special Investigation Report #2023A0604021 dated 09/15/2023. The home was cited due to Resident A not being compatible with other residents in the household. Resident A had physically assaulted Resident B and Resident C. A 30-day discharge notice was given for Resident A on 08/03/2023.		
	On 12/09/2023, Resident A was arguing with Resident C in the kitchen. Resident A then walked over and punched Resident C twice on the left shoulder. Resident C called 911. Staff spoke to police and Resident A was petitioned to the hospital per the police officer's suggestion. Resident C pressed charges against Resident A. Therefore, Resident A was involved in another physical altercation with Resident C resulting in Resident A being hospitalized for behavior and charged with domestic violence.		
	On 03/06/2024, case Manager, Tanisha Meadows indicated that referrals are being made for placement, however, a new placement has not been identified for Resident A. Ms. Meadows indicated that Resident A's due to the domestic violence charge, it has been more difficult to find a placement.		
CONCLUSION:	REPEAT VIOLATION ESTABLISHED Reference SIR dated 09/15/2023, CAP dated 10/03/2023		

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:	 There is not enough information to determine that Resident A has sexually assaulted Resident C. APS Worker, Vernece Warren, indicated that she and law enforcement did not find the allegations to be true. Resident C acknowledged to APS that the past contacts were not sexually intentional. On 01/31/2024, I interviewed Resident C and she did indicate that Resident A has touched her inappropriately and made sexual comments, however, stated that no one else witnessed these incidents occur. Home Manager, Dawn Doetsch, stated that staff try to keep Resident A and Resident C six feet apart. However, Resident A and Resident C six feet apart. However, Resident A and Resident C have had to remain in the same small group home since discharge notice was issued on 08/03/2023 as another placement has not been found. Case Manager, Tanisha Meadows, indicated that staff are doing the best they can considering the circumstances. 	
CONCLUSION:	VIOLATION NOT ESTABLISHED	

IV. RECOMMENDATION

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

Ristine Cillufo

03/07/2024

Kristine Cilluffo Licensing Consultant

Date

Approved By:

04/10/2024

Denise Y. Nunn Area Manager Date