GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 30, 2024

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

RE: License #: AM630397532
Investigation #: 2024A0605025
Hidden Acres Manor

Dear Mr. Byerly:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations in SIR #2024A0605021 and in this investigation, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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

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 #:	2024A0605025
Complaint Receipt Date:	04/17/2024
Investigation Initiation Date:	04/17/2024
Report Due Date:	06/16/2024
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:	1ST PROVISIONAL
Effective Date:	01/22/2024
Expiration Date:	07/21/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident C has been assaulted by Resident B on two separate occasions in a short period of time. Resident C was taken to the ER for follow up.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/17/2024	Special Investigation Intake 2024A0605025
04/17/2024	APS Referral Adult Protective Services (APS) made referral
04/17/2024	Special Investigation Initiated - Letter Emailed APS worker Precious Whitman
04/17/2024	Contact - Document Received Email from APS worker Precious Whitman
04/18/2024	Inspection Completed On-site Conducted unannounced on-site investigation with APS Precious Whitman
04/29/2024	Contact - Telephone call received Discussed allegations with Dr. Carl Byerly
05/09/2024	Contact - Telephone call made Interviewed Resident F's Copper County Community Mental Health case manager Joe Rivest. Left message for Resident F's therapist with Act Program Dan Lawton.
05/09/2024	Contact - Document Sent Email to Newaygo County ORR Jill McCay
05/09/2024	Contact - Telephone call received Received call from Copper County case manager Joe Rivest

05/09/2024	Contact - Telephone call made Discussed concerns regarding Resident F with Easterseals case manager Lorraine Guster
05/13/2024	Contact - Document Received Email from Newaygo County ORR Jill McKay
05/13/2024	Contact - Telephone call made Left messages for Resident B's case manager Pam Baron with Newaygo County and her supervisor Chris Briggs
05/14/2024	Contact - Document Received Email from APS worker Precious Whitman
05/14/2024	Contact - Document Received Email from Andrea Bliss case manager assisting Pam Baron from Newaygo County
05/15/2024	Contact - Document Received Email from the HM Jennifer Stancroff
05/15/2024	Contact - Telephone call made With Copper County ORR Sarah Rousseau regarding Residents' D, F, and G
05/20/2024	Exit Conference Left message for licensee designee Neiman Byerly.

ALLEGATION:

Resident C has been assaulted by Resident B on two separate occasions in a short period of time. Resident C was taken to the ER for follow up.

INVESTIGATION:

On 04/17/2024, intake #200505 was referred by Adult Protective Services (APS) regarding Resident C has been assaulted on two separate occasions by Resident B. Resident B has also assaulted another resident (Resident A) at Hidden Acres Manor.

On 04/17/2024, I emailed APS worker Precious Whitman the referral received. Ms. Whitman emailed back stating she will be conducting an on-site visit tomorrow 04/18/2024.

On 04/18/2024, I along with APS worker Precious Whitman conducted an unannounced on-site investigation. Present were the home manager (HM) Jennifer Stancroff,

compliance officer Simone Lewis, DCS Steven Redmond and DCS Sherry McLean. Also present were Residents C, D, E, F, and G. Resident B was at school. Resident B was in school during this visit. He is non-verbal and was not interviewed.

Resident C was interviewed in his bedroom located upstairs. Resident C is in a wheelchair. He moved upstairs since the incident between him, and Resident B. Resident C is verbal and can carry a conversation; however, information was minimal and sometimes his words were slurred, making it difficult to understand. He stated that before supper, unknown date, Resident B came to the table and “hit me.” He referred to Resident B as “the boy,” as he did not know Resident B’s name. He stated, “I didn’t do anything. I went to the hospital. I don’t know if I feel safe. I don’t know if anyone stopped him. I’m losing my memory.” At the hospital, his head was checked, and he came back home. He was unable to provide any further or details to the assault. There were scratches on his nose and a gash on his left leg. He does not know how he sustained the scratches or the gash on his leg.

Resident D was in his bedroom upstairs. He was only observed and not interviewed as he is non-verbal. They had good hygiene and no concerns noted.

Resident F was in his bedroom upstairs with the door wide open. He came to the door and stated, I was not part of it, it’s been happening for years, and I don’t want to talk about it. He then went into his room. He had good hygiene.

I interviewed DCS Steven Redmond who was working upstairs regarding the allegations. On 04/02/2024, Resident B arrived home from school around 2:30PM-3PM. Mr. Redmond picked Resident B from the bus stop and walked him home. Resident B went into his bedroom and Mr. Redmond went to grab a folder out of the room. By the time Mr. Redmond returned which was minutes later, he observed Resident B headbutting Resident C. Mr. Redmond immediately got in between Resident B and Resident C by using his body to block Resident B, which worked. Resident C was in his wheelchair and had his wheelchair locked so he couldn’t move. The HM came downstairs and assisted with moving Resident C into his room. DCS Sherry McLean was working upstairs at the time and did not witness what happened; however, she transported Resident C to the hospital. Resident C was checked out and discharged back to Hidden Acres Manor. Resident C was moved upstairs to keep Resident B away from him because Resident B had attacked Resident C last month too. Mr. Redmond was not present but knows that it happened. Resident B has attacked other residents and staff too. Mr. Redmond stated the gash on Resident C’s leg has been there for quite a while and he does not know how he sustained the gash. Mr. Redmond stated that Resident C eats all his meals downstairs and is wheeled out onto the ramp and taken downstairs from outside.

I went downstairs and observed Resident D sitting on the recliner. Resident D is non-verbal therefore he was not interviewed. He was observed to have good hygiene. No concerns were noted.

Resident G was in his bedroom and did not want to be interviewed. His room was messy with cigarette butts on the floor. The room had a strong musty smell. DCS Sherry McLean stated that Resident G does not smoke inside his bedroom and there is a smoke detector in the bedroom. He only smokes outside. Resident G does not allow staff to enter his room and clean it.

I interviewed DCS Sherry McLean who was working downstairs regarding the allegations. Ms. McLean was present on 04/02/2024, but she was working upstairs. She heard a commotion and when she came down the stairs to see what was going on, she was told to return upstairs. DCS Steven Redmond and the HM Jennifer Stancroff had the situation under control. She was informed that after Resident B arrived home from school, he went into his bedroom and as he was coming out, Resident C was in the hallway and then Resident B attacked Resident C by headbutting him. She took Resident C to the hospital where he was examined and then discharged back to Hidden Acres Manor. The plan for Resident B is to deescalate and redirect. Ms. McLean stated, “Only the male staff can deescalate because Resident B does not listen to female staff.” There are about two-three DCS per shift between upstairs and downstairs. This is not the first time Resident B has attacked Resident C as it has happened in the past. She does not have the details but heard that Resident B headbutted Resident C. Resident B has also assaulted several staff members.

I interviewed the HM Jennifer Stancroff and compliance officer Simone Lewis regarding the allegations. On 04/02/2024, Resident B returned home from school, he went into his bedroom to put his stuff away. Resident C was in the hallway in his wheelchair. Resident B came out of his bedroom and DCS Steven Redmond asked Resident B, “do you want a snack.” Resident B said, “yes,” and then immediately headbutted Resident C on the back of his head. Mr. Redmond blocked Resident B with his body and then Resident C was moved away from Resident B. DCS Sherry McLean transported Resident C to the hospital and then he was discharged back to Hidden Acres Manor. There was another incident on 03/06/2024 between Resident B headbutted Resident C during Resident B’s behaviors. There is no behavioral plan in place for Resident B because according to the Newaygo case manager, Pamela Baron, the criteria is one incident per month for six consecutive months; however, discussions have occurred in 01/2024 since there have been six incidents not per month but consistent with Resident B. Since that discussion, there has yet to be a behavioral plan in place for Resident B.

NOTE: I reviewed both incident reports (IR) dated 04/02/2024 and 03/06/2024 regarding Resident B headbutting Resident C. During both situations, staff tried to redirect Resident B, but Resident B continued to escalate and then staff used blocking techniques to get in between Resident B and Resident C when Resident B was headbutting Resident C.

On 05/02/2024, I received an email from the HM Jennifer Stancroff stating that Resident F has since started sleeping in his room again. She contacted Sarah Rousseau our Recipient Rights Officer for some guidance in the matter regarding the vitamins in

Resident F's bedroom. The HM and another DCS confiscated the vitamins while Resident F were present.

On 05/06/2024, I received an email from the HM Jennifer Stancroff stating that as of Saturday May 4, 2024, all staff are Certified Prevention Institute Certification (CPI) trained in physical and verbal de-escalation.

On 05/09/2024, I interviewed via telephone DCS Abby Weidel regarding the allegations. Ms. Weidel works both second and third shifts. She was not present during the incident on 04/02/2024 but was present during a prior incident. On 03/06/2024, the day of the alleged incident, Ms. Weidel was off, but heard what happened. She heard that Resident C was moved upstairs because "Resident B was targeting two staff (Terri Hall and Sherry McLean) and Resident C downstairs." In the past, the word "no," would "set him off," but now it can be anything that sets Resident B off. Resident B is asked if he wants dinner, he says yes and then the next minute "he goes off hitting staff or other residents." Ms. Weidel stated, "we follow protocol on redirection, offering showers and PRN's but they don't seem to work." She is CPI trained, but according to Ms. Weidel, CPI holds on Resident B do not work. The last time a CPI hold was used was by a past staff member, but Resident B got out of the CPI hold and attached the past staff member. Ms. Weidel stated that Ms. Hall is "terrified and refuses to come downstairs," because "she's scared of Resident B." Resident B assaulted Ms. Hall in the laundry room. Currently, Resident B has been targeting Ms. McLean. Ms. Weidel stated, "I'm scared to be around him too." Resident B tried to hit Ms. Weidel when Resident B was trying to get passed Ms. Weidel to go into staff's office. Ms. Weidel stated that following Resident B's behavioral plan to use "CPI hold while another staff gives Resident B a PRN," is not working. Ms. Weidel fears Resident B because his behaviors have been every other day, and these behaviors are escalating quickly.

Ms. Weidel stated that about a week ago, there was an incident involving Resident B and Resident D. Resident B was having a behavior during the afternoon shift. There were two staff members, one trying to diffuse the situation, while the other DCS Makalyn Caudell was with Resident D keeping him safe. Resident B continued to escalate and tried coming after Resident D, so Ms. Caudell took Resident D outside. Resident B followed them and began chasing Ms. Caudell and Resident D down the street, then Resident B turned around and returned home. He finally calmed down and went into his room. She did not witness this incident, just heard about it. Ms. Weidel stated these are the issues staff are dealing with regarding Resident B. During a meeting with Resident B's case manager Pamela Barron a couple of months ago, Ms. Weidel brought up all these concerns to Ms. Barron. Ms. Barron said, "he (Resident B) seems good," even though Ms. Baron has received numerous incident reports (IR) regarding Resident B's aggressive behaviors towards residents and staff. Ms. Weidel stated, "she (Ms. Barron) doesn't believe Resident B is as bad as what is being reported."

On 05/09/2024, I interviewed via telephone DCS Makayln Caudell regarding the allegations. Ms. Caudell has worked for this corporation for one-year. She works

downstairs second shift, but sometimes first shift too. She was not present during the incident on 04/02/2024 but was present during a prior incident. On 03/06/2024, she was working downstairs with DCS Terri Hall and DCS Abbey Weidel was working upstairs. Resident B went into the laundry room so both she and Ms. Hall followed him. He wanted a TV that was locked up. Ms. Caudell told him she did not have the key, Resident B got upset and pushed Ms. Hall against the dryer. Ms. Caudell got him out of the laundry room, and he pushed Ms. Hall again, against the wall. Ms. Caudell called Ms. Weidel for assistance from upstairs. Ms. Hall ran into the laundry room and locked herself in there as Resident B continued to go after her. Resident C was in his wheelchair that was locked in the living room. Ms. Caudell tried to get Resident C to move, but he refused. Resident B came behind Resident C and began headbutting Resident C and then Resident B pushed Ms. Caudell. Ms. Caudell unlocked Resident C's wheelchair and pushed him into the bathroom and closed the door keeping him safe from Resident B. She returned to Resident B and had him count and take deep breaths which helped him calm down. Ms. Hall had called 911 while she was in the laundry room. The police arrived as did the ambulance. Both Resident B and Resident C were taken to the hospital and later discharged back home.

On 04/30/2024, during Ms. Caudell's shift, Resident B asked for chips. The chips he liked had just ran out. Ms. Caudell told Resident B they will be purchasing some soon and offered him other chips he also liked. He said, "no," then he pushed and slapped DCS Sherry McLean. Ms. Caudell was in the kitchen and saw that Resident B continue to target Ms. McLean. Ms. Caudell told DCS Chimere Patrick who was present to get Resident D out of the room. She then called out to DCS Terri Hall who was working upstairs to call 911. She did not see what was happening but was told by Ms. McLean that Resident B was chasing Ms. Patrick and Resident D down the road. Resident B returned to the home and began to calm down. The police arrived and Resident B was sitting in the chair calm. She was informed that Resident B headbutted Resident D as Resident D was trying to get away. There was redness on Resident D's forehead. Resident D was transported to the hospital by the ambulance and Resident B sustained no injuries as he was checked out by EMS. The HM had just left the home when this incident occurred, so she was contacted and returned. Resident B took a shower, and a PRN was passed. There were no incidents after that. Ms. Caudell also reported that Resident B's behaviors have escalated and occurring more frequently. He switches back and forth on foods he likes and does not like to eat and when the food he wants is unavailable, he becomes upset and aggressive towards anyone in front of him. Resident B has episodes more often with female staff then male staff. She stated, "he escalates so quickly that we don't have time to redirect him. We are trying to keep the other residents safe and staff." She too reported that counting, showering, and PRNs are not as effective as they were in the past.

On 05/09/2024, I interviewed via telephone DCS Chimere Patrick regarding the allegations. She has been with this corporation for about a week working downstairs. She does not know about the incident involving Resident C other than hearing that Resident B headbutted Resident C. However, she was present during the incident on 04/30/2024 involving Resident D. She worked the afternoon shift when Resident B

asked for chips. DCS Makalyn Caudell advised that they did not have any more but offered him other chips he liked. He said, “no,” and then came after Resident D. Before Ms. Patrick could get Resident D away from Resident B, Resident B headbutted Resident D on the forehead. She grabbed Resident D and took him outside. Resident B followed them, and she and Resident D began running down the road while Resident B was running after them. He followed them for a period before Resident B turned around and returned home. She and Resident D returned, and the police arrived at the home. Resident D was transported to the hospital and Resident B had calmed down. The HM returned to the home, but everything was calm after Resident B received a PRN. Resident B has never hit her or came after her. This was an isolated incident for her where she observed Resident B’s aggressive behavior.

On 05/09/2024, I interviewed DCS Tya Vanderson regarding the allegations. Ms. Vanderson has been working for this corporation for one-year. She works second shift but usually upstairs, but once in a while has worked downstairs. When asked about Resident B, she stated, “I try to stay away from Resident B because I’m a small individual and I’ve heard he’s attacked other people in the home.” Ms. Vanderson has never observed Resident B become aggressive towards other residents or towards staff. Whenever she has worked downstairs with another staff member, Resident B is usually in his bedroom and calm. She stated, “to be honest, I’m scared of him because of what I’ve heard. I’ll interact with him, but from a distance.” She stated, “I was told that a staff ran out of the house and down the street. I’m unsure what happened but they said he was triggered and chased the staff who had the resident with her.” Ms. Vanderson recalls it happened on 04/30/2024, because she came on shift and was told this information.

On 05/09/2024, I interviewed the assistant HM Savonne Keys. Mr. Keys works third shift. He was not present during the incident on 04/02/2024 regarding Resident B and Resident C as he has not worked downstairs since he hurt his foot. Mr. Keys was unable to provide any information regarding any of the incidents that occurred with Resident B. However, he reported past aggressive behaviors by Resident B that occur “every now and then of Resident B hitting staff and other residents.” Therefore, a new policy was adopted recently where there is always a male staff on the schedule each shift downstairs to minimize Resident B’s escalations.

On 05/09/2024, I interviewed via telephone DCS Terri Hall regarding the allegations. Ms. Hall has been with this corporation for two months. She was not present during the incident on 04/02/2024 but was involved in the incident on 03/06/2024. Resident B walked into the laundry room wanting the TV on the wall that was locked up. She and DCS Makayln Caudell told him they did not have the key and could not get it now. He pushed Ms. Hall into the dryer, she redirected him out of the laundry room and then he pushed her again, pinning her against the wall. He then grabbed her hair from both sides and began hitting her headbutting her and punching her. Ms. Caudell and DCS Abbey Wiedel came to assist, got him off her, told Ms. Hall to go into the laundry room, lock the door and to call 911, which she did. About five minutes later, the police showed up, talked to Resident B, and then took Resident B and Resident C to the hospital. She

did not witness what happened to Resident C but was told that Resident B headbutted Resident C. Ms. Hall stated, “I don’t know what’s in his behavioral plan, but I know that there is always a male staff that is supposed to be working downstairs with a female staff, but unfortunately there wasn’t one scheduled.” A week ago, the HM and Dr. Carl Byerly began a policy where a male staff would always be scheduled to work downstairs each shift, but that day, there was no male staff downstairs, only female staff. Ms. Hall sustained several injuries; torn rotator cuff and tendon, upper tear of her right rotator cuff and the muscle had been pulled away from her right upper arm. She went to the hospital due to her injuries. She also reported another incident that occurred as recently as two weeks ago. She walked in to begin her shift when she observed the HM speaking with DCS Lawrence Harris while Resident B was in the living room. She went to punch in when she returned, Resident B came towards her, pushed her down on the floor. Mr. Harris intervened and redirected Resident B to his bedroom, gave him a snack and calmed him down.

On 05/13/2024, I received an email from ORR Jill McCay with Newaygo County. Ms. McCay stated that Resident B is not on a behavioral plan. However, she received information that Resident B is moving out of Hidden Acres Manor. Ms. McCay included the following note in her email: “05/10/2024 Progress Note: This worker (Andrea Bliss-Newaygo County case manager) spoke to Dr. Carl Byerly regarding Resident B’s potential move to Eastlawn Manor, and he stated that he spoke to Resident B’s guardian on 05/09/2024 and that she (guardian) is in agreement with the move. This worker contacted Resident B’s guardian to confirm that she is in agreement with the move, and she stated that she feels that the move to the six-bedroom home would be in Resident B’s best interest.”

On 05/14/2024, I received the following email from Andrea Bliss, case manager assisting Pam Baron from Newaygo County regarding Resident B: “I know that Pam Baron was at the home on 05/04/2024. However, I was not present at this meeting, so I don’t know what was discussed between Pam Baron and the home staff. Resident A’s behavior support plan is contained within his treatment plan, so he does not currently have a restrictive behavior plan.”

NOTE: According to Resident B’s Newaygo County plan of care treatment plan completed on 09/06/2023, there is no statement of CPI hold being a part of Resident B’s treatment plan. A snack, shower, or room are part of his treatment plan.” This treatment plan according to DCS interviewed is not working in deescalating Resident B’s behaviors.

On 05/14/2024, I received an email from APS worker Precious Whitman, she substantiated these allegations.

On 05/15/2024, I received the incident report from the HM Jennifer Stancroff regarding the incident on 01/20/2024 regarding Resident A and Resident B. Resident B continuously asked for Burger King. Redirection attempts were made as staff encouraged Resident B to take a shower to help calm him down. Resident B refused.

Staff administered a PRN due to Resident B showing multiple signs of aggression. Resident B immediately began attacking Resident A by punching him with both first and then Resident B headbutted Resident A. Several staff intervened, got in between Resident A and Resident B. The police were called, arrived at the home, and transported Resident A and Resident B to the hospital. The EMT informed the home that Resident B attacked a paramedic while in transport. Resident B was in an agitated state while at the hospital, asking for Burger King and to go home. The hospital administered medications; he was then transported back to the group home in a manic state crying on his way back with the paramedics.

On 05/15/2024, I contacted Copper County ORR, Sarah Rousseau. She received an incident report (IR) regarding Resident D on 05/03/2024 regarding an incident on 04/30/2024. The IR stated he was injured after being headbutted by another resident, but no other information was provided. She emailed the HM Jennifer Stancroff on 05/03/2024 requesting additional information regarding Resident D's injuries and has yet to receive any information from the home. Ms. Rousseau expressed several concerns pertaining to the lack of reporting by Hidden Acres Manor regarding all their consumers, Residents D, F, and G. She stated that there has been a decline in the care of their consumers since 2022 when several concerns were expressed regarding their reporting of incidents occurring at the home. Ms. Rousseau does not understand why Hidden Acres Manor waits until licensing is involved before reporting concerns to ORR. These issues have been discussed numerous times with the home and the home continues to not report or report minimal information regarding an incident. She will be speaking with the contractor of this home to assist in locating alternative placement of Residents D, F, and G. Ms. Rousseau emailed me the IR regarding Resident D. The incident occurred on 05/02/2024, not 04/30/2024. The IR only stated that DCS Chimere Patrick tried escorting Resident D outside and Resident B headbutted him. There is no mention of Resident B chasing Resident D and Ms. Patrick down the road.

On 05/15/2024, I received a telephone call from Pamela Baron's supervisor, Chris Briggs. He reviewed Ms. Baron's notes and reported that they have only received a total of four IRs since 01/2024 regarding Resident B. He does not see any discussion regarding a behavioral plan in the notes, but does see that on 05/04/2024, staff were reporting that Resident B was more agitated recently. Ms. Baron is currently on medical leave but has been responding to some emails.

On 05/15/2024, I received an email form Resident B's case manager Pamela Baron. Resident B is not on a behavioral plan. Ms. Baron reported that she is a CPI instructor that trained all the staff at Hidden Acres Manor on 05/04/2024. CPI provides training for de-escalation, disengagement, and holds. If there are any hands on, then an IR is written and submitted to her. Resident C was moved upstairs and potentially moving Resident B to this corporation's new home which is only a six-bed home was discussed. Ms. Baron was at the home all day on 05/04/2024 and there were no incidents with Resident B. She also spoke with Resident C who did not make any statements about feeling unsafe at this home. She has received two incident reports regarding Resident C getting headbutted by Resident B.

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, DCS at Hidden Acres Manor have made several attempts to keep Residents A, C, and D safe from Resident B. Recently, it has been reported that Resident B's aggression has escalated where he has assaulted Residents A, C, and D as well as multiple staff. According to his Newaygo County assessment plan completed on 09/06/2023, redirecting him, offering him a shower, or sending him to his room to calm down are part of his behavioral plan. DCS are utilizing these interventions; however, many DCS interviewed stated these interventions are not working anymore with Resident B. Resident B continues to escalate more frequently by assaulting both residents and staff. All the staff are now CPI certified by case manager Pamela Baron with Newaygo County due to Resident B's frequent aggression and assaults.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During my on-site investigation on 04/18/2024, I observed Resident F's bedroom at the doorway where he was interviewed. Resident F is a hoarder. His bedroom was full of groceries very neatly stacked. The groceries took over the entire room, leaving no place for his recliner or bed. His recliner was observed sitting outside his room. He reported he sleeps in the living room on the chair. I also observed a clear tote full of vitamins. Hidden Acres Manor had a bed bug infestation in 02/2024, which has been remedied; however, his bed was thrown away and a new bed was purchased. Resident F does not want to sleep in that bed, so it is still in the box. He continues to sleep in the living room.

On 04/18/2024, I interviewed the HM regarding Resident F's bedroom. The HM confirmed that Resident F has been sleeping in the living room ever since the home had bedbugs in 02/2024. The bedbug issue has been remedied, but Resident F refuses to sleep in a bed. In addition, he is a hoarder, and his bedroom is full of groceries. There is no behavioral plan for Resident F regarding his hoarding. I informed the HM that a living

room cannot be a sleeping room for Resident F. She stated she will reach out to Resident F's case manager for assistance.

On 04/18/2024, I interviewed DCS Steve Redman and DCS Sherry McLean regarding Resident F. Both stated that since the bedbug issue, Resident F refused to sleep in his bed, which a new bed was bought for him, but he continued to sleep in the living room. He has been hoarding groceries and he does not allow staff to enter his room to clean it.

On 04/29/2024, I received a telephone call from Dr. Carl Byerly regarding Resident F. Resident F has been sleeping in the living room for a couple of months since the bedbug issue. Orkin was out and remedied the issue. Resident F has obsessive compulsive disorder (OCD) and is a "hoarder." Dr. Byerly acknowledges there are too many "things," in Resident F's room. He contacted Resident F's case manager Joe Rivest on 04/19/2024 regarding Resident F's hoarding situation. Staff have offered Resident F numerous times to clean his room or to move next door as the bedroom is vacant but Resident F refuses. Mr. Byerly told Mr. Rivest that Resident F is not meeting his goals regarding his bedroom. He stated that he also reached out to Copper County ORR, Sarah Rousseau regarding this issue.

On 05/02/2024, I received an email from the HM stating that Resident F has started sleeping in his room again. The vitamin's have been removed from his bedroom.

On 05/09/2024, I interviewed DCS Abby Weidel, DCS Makalyn Caudell, DCS Chimere Patrick, DCS Tya Vanderson, assistant HM Savonne Keys and DCS Terri Hall regarding Resident F. All the staff reported that Resident F is a hoarder and has been a hoarder since they have worked at this home. Resident F has slept in the living room since the bedbug issue in 02/2024 and continues to sleep in the living room even after the bedbug issue was addressed. He has a new bed in the box but refuses to put it together and refuses to have staff enter his bedroom to clean it. Staff reported there are expired groceries in his bedroom but again, he refuses anyone to enter his room to throw them out. There is no intervention in his plan of service regarding his hoarding.

On 05/09/2024, I interviewed Resident F's case manager Joe Rivest with Copper County. He has not had a face-to-face with Resident F for years because they are 10 hours away from Hidden Acres Manor. Mr. Rivest was not aware of Resident F sleeping in the living room and was only made aware when Dr. Byerly contacted him a couple weeks ago. Dr. Byerly informed him that a new room was offered, but Resident F refused because that room did not have a bathroom like his current room does. Resident F is resistant to change. Mr. Rivest is concerned that Resident F is hoarding vitamins/medications in his bedroom as he was not aware of this. He stated that Resident F has a case manager, Lorraine Guster with Easterseals who has monthly contact with Resident F.

On 05/09/2024, I interviewed Resident F's case manager Lorraine Guster with Easterseals. Ms. Guster has been Resident F's case manager since 05/25/2022. It was

reported to her that there was a bedbug infestation in 02/2024 and Resident F's bed was thrown out and a new bed was purchased. Resident F does not want to take his new bed out because Resident F says, "I'm going to move out." Resident F wants to move closer to his family in Grand Rapids. Staff have been trying to go into Resident F's bedroom to move stuff, but he refuses and continues to sleep in the chair in the living room. Ms. Guster visits monthly, and she had not seen Resident F's bedroom because his door is always closed and refused to allow anyone inside. She was at the home on 04/22/2024 and found out that Resident F was a "hoarder." She stated, "his room looks like a gas station stock room." Ms. Guster stated that Resident F, "self-sabotages." Staff are trying to meet Resident F's goals, but Resident F makes it very difficult for staff. His goals are centered around his medical concerns which are a priority currently. However, she stated, "if the group home had reported any concerns of hoarding, then it would be in his plan of service and then a behavioral plan would have been implemented." This was not the case until licensing brought the concerns to Hidden Acres Manors attention.

On 05/09/2024, I reviewed Resident F's Copper County POS dated 02/29/2024 and there is no statement and/or intervention in place regarding hoarding.

On 05/15/2024, I interviewed Copper County ORR Sarah Rousseau regarding Resident F. Ms. Rousseau stated she was recently informed about Resident F's hoarding and was not aware of him sleeping in the living room. She is concerned about the home not bringing issues such as this to her attention until after licensing is involved. Ms. Rousseau expressed significant concerns of lack of reporting regarding their consumers residing at this home. She was mostly concerned about Resident F hoarding vitamins/ medications in his bedroom, and she was not contacted until recently.

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, Resident F has a diagnosis of OCD and is a hoarder; however, there is no intervention to address this unacceptable behavior in his plan of service. Resident F has been hoarding groceries in his bedroom and does not allow staff to enter his bedroom to assist in cleaning it out. I contacted his case managers Joe Rivest and

	Lorraine Guster with both Copper County and Easterseals who reported they were never informed about Resident F's hoarding until recently after licensing brought it to the home's attention. Ms. Guster stated if she would have been informed, then she would have implemented a behavioral intervention for the hoarding.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2024A0605005 dated 01/08/2024, CAP dated 01/23/2024** **SIR #2023A0991021 dated 08/10/2023, CAP dated 08/09/2023**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	During my on-site investigation on 04/18/2024, I observed dietary supplements in a tote in Resident F's bedroom instead of these supplements being in a locked cabinet or drawer.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(2) A living room, dining room, hallway, or other room that is not ordinarily used for sleeping or a room that contains a required means of egress shall not be used for sleeping purposes by anyone.
ANALYSIS:	Based on my investigation and information gathered, Resident F was sleeping in the living room since 02/2024 that is not ordinarily used for sleeping. There was a bedbug infestation in the home in 02/2024 and Resident F's bed was thrown out. Resident F began sleeping in the living room. Since then, the

	bedbug issue has been remedied, but Resident F continued to sleep in the living room, but according to the HM, he is now sleeping on a bed in his bedroom as of 05/02/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

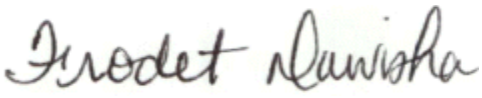
During my unannounced on-site investigation on 04/18/2024, as I was leaving the home, I observed the ramp on the side of the home as part of an egress. The wooden ramp appeared unsafe and unusable to the residents with wheelchairs. There were several areas of the ramp with rotted pieces of wood, pieces of boards were lifted from the ramp, plastic chairs flipped over on the ramp, tree debris covering a portion of ramp and rotted handrails throughout the ramp. There was a large piece of wood at the end of the ramp preventing someone from using the ramp.

On 05/20/2024, I attempted to reach licensee designee Neiman Byerly via telephone to conduct the exit conference but was unsuccessful as his voice mail box is full. I contacted Dr. Carl Byerly who stated he will have Neiman call me.

APPLICABLE RULE	
R 400.14509	**Means of egress; wheelchairs**
	(2) The slope of the ramp shall not be more than 1 foot of rise in 12 feet run and shall terminate on a firm surface or solid unobstructed ground which will allow the wheelchair occupant to move a safe distance away from the building. Ramps shall have handrails on the open sides and be constructed in accordance with the requirements specified in Section 816.0 of the BOCA National Building Code, 1990, eleventh edition.
ANALYSIS:	During the on-site investigation on 04/18/2024, I observed the ramp on the side of the home to be unsafe and unusable. There were rotted boards throughout the ramp, boards lifted from the ramp, tree debris underneath two plastic chairs that were flipped over on top of the debris and rotted handrails throughout.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

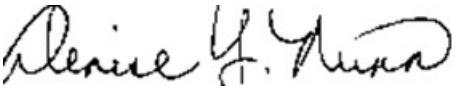
I recommend revocation of the license.



05/20/2024

Frodet Dawisha Date
Licensing Consultant

Approved By:



05/20/2024

Denise Y. Nunn Date
Area Manager