GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 30, 2024

Blake Ewing
A Home Away From Home, LLC
3121 East Grand Ledge Hwy
Grand Ledge, MI 48837

RE: License #: AS230396089
Investigation #: 2024A1033051
A Home Away From Home

Dear Mr. Ewing:

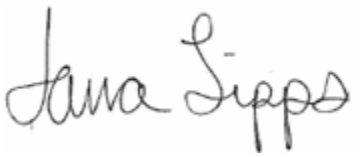
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9730.

Sincerely,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS230396089
Investigation #:	2024A1033051
Complaint Receipt Date:	07/29/2024
Investigation Initiation Date:	07/29/2024
Report Due Date:	09/27/2024
Licensee Name:	A Home Away From Home, LLC
Licensee Address:	3121 East Grand Ledge Hwy Grand Ledge, MI 48837
Licensee Telephone #:	(517) 582-1472
Administrator:	Blake Ewing
Licensee Designee:	Blake Ewing
Name of Facility:	A Home Away From Home
Facility Address:	3121 Grand Ledge Highway Grand Ledge, MI 48837
Facility Telephone #:	(517) 925-1777
Original Issuance Date:	10/07/2018
License Status:	REGULAR
Effective Date:	04/07/2023
Expiration Date:	04/06/2025
Capacity:	6
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff, Greg Lehman, did not treat Resident A with dignity and respect by yelling at Resident A and grabbing him by the face. Mr. Lehman also caused injury to Resident A's lip with a fork.	Yes
ADDITIONAL FINDINGS	Yes

III. METHODOLOGY

07/29/2024	Special Investigation Intake- 2024A1033051
07/29/2024	APS Referral- Assigned to Adult Services Worker, Carol Stahl.
07/29/2024	Special Investigation Initiated – Letter- Email correspondence conducted with APS, Adult Services Worker, Carol Stahl.
07/31/2024	Inspection Completed On-site- Interviews with direct care staff, Ashleigh Baker, and Resident A. Review of Resident A's resident record initiated.
07/31/2024	Contact - Document Sent- Email correspondence sent to licensee designee, Blake Ewing.
07/31/2024	Contact - Telephone call received- Interview conducted with licensee designee, Blake Ewing, via telephone.
08/23/2024	Contact - Telephone call received- Voicemail message received from Detective Troy Gardner with Eaton County Sherrif's Office.
08/27/2024	Contact - Telephone call made- Returned call to Detective Gardner, left message awaiting response.
08/27/2024	Contact - Document Sent- FOIA request for police report #2024-3956, sent to Eaton County Sherrif's Office Records Department.
08/27/2024	Contact - Telephone call received- Interview with Detective Gardner, conducted via telephone.
08/27/2024	Contact - Telephone call made- Update provided to APS, Carol Stahl, via telephone.

08/27/2024	Exit Conference- Conducted via telephone with licensee designee, Blake Ewing.
08/27/2024	Inspection Completed-BCAL Sub. Compliance
08/29/2024	Contact – Document Received- Email correspondence with licensee designee, Blake Ewing.

ALLEGATION: Direct care staff, Greg Lehman, did not treat Resident A with dignity and respect by yelling at Resident A and grabbing him by the face. Mr. Lehman also caused injury to Resident A's lip with a fork.

INVESTIGATION:

On 7/29/24 I received an online complaint regarding the A Home Away From Home, adult foster care facility (the facility). The complaint alleged that direct care staff member Greg Lehman, became angry with Resident A, on 6/29/24, and grabbed him by the face, squeezed his face, and yelled at Resident A. This encounter allegedly caused facial bruising and Resident A's lip to bleed. There were further allegations that Mr. Lehman grabbed for Resident A's fork, while he was eating, and the fork hit Resident A in the mouth causing additional injury to Resident A. On 7/29/24 I had email correspondence with Adult Protective Services, Adult Services Worker, Carol Stahl, who reported she had been assigned to this investigation. Ms. Stahl reported that she has contacted Guardian A1, who also reported that Resident A sustained a broken arm at the facility in November or December of 2023.

On 7/31/24 Ms. Stahl and I conducted an unannounced, on-site investigation at the facility. We interviewed Resident A at this time. Resident A is diagnosed with Cerebral Palsy, and it can be difficult to understand his verbal communication at times. Resident A reported that he and Mr. Lehman had an altercation at the facility (date unknown to Resident A). He reported that he needed to urinate and requires a direct care staff member to assist him with this task. Resident A reported that he did not want to wait for assistance and wanted to go immediately. Resident A reported that Mr. Lehman came into the room and was upset and went to punch him but instead grabbed him by the face. Resident A reported that Mr. Lehman, "lost his temper" when he grabbed Resident A by the face. Resident A further reported that about a month ago, Mr. Lehman went to transfer him from his powerchair and twisted his arm and fractured his arm. Resident A could not articulate whether he felt his arm being fractured during this incident was an accident and not a result of careless actions. Resident A reported that he used to like Mr. Lehman but since Mr. Lehman grabbed him by the face, he does not like him any longer. Resident A reported that this incident occurred in his resident bedroom and that there were no other witnesses to this incident. Resident A reported that he can feed himself if a direct care staff member places his utensils in his hand. He reported that there was

also an incident where he was eating, and Mr. Lehman grabbed his fork from his hand and his fork hit his mouth. It was not clear whether Resident A felt that this was an intentional act of aggression toward Resident A. Resident A was also not clear whether these were two separate incidents or the same incident in which Mr. Lehman grabbed him by the face.

During the on-site investigation on 7/31/24 Ms. Stahl and I interviewed direct care staff, Ashleigh Baker. Ms. Baker reported direct care staff members at the facility work solo on their shifts. She reported that there is not much overlap of their shifts as they work one staff member per shift. Ms. Baker reported that she has never received complaints from other residents regarding Mr. Lehman being rude or aggressive with them. Ms. Baker reported she had no information about the current allegations of physical abuse from Mr. Lehman toward Resident A. Ms. Baker reported that the only other resident at the facility who is capable of being interviewed is Resident B. She asked Resident B if he would be willing to be interviewed today and Resident B declined. Ms. Baker reported that due to diagnoses of Dementia/Alzheimer's Disease, the other residents would not be reliable historians. Ms. Baker reported that Resident A eats his meals in his resident bedroom. She reported that Resident A can feed himself but requires a direct care staff member to place the utensil in his hand. Ms. Baker reported that Resident A did suffer a fractured arm as the result of an incident which occurred during a Hoyer lift transfer at the facility. Ms. Baker reported that she did not have any additional information about this incident. Ms. Baker reported that to her knowledge, Mr. Lehman was terminated from employment due to the allegations of suspected abuse toward Resident A. She had no further information to provide regarding these allegations.

On 7/31/24 I interviewed licensee designee, Blake Ewing, via telephone. Mr. Ewing reported that Mr. Lehman has worked for him for about 13 years on the weekend shift. He reported that Mr. Lehman has a kind demeanor, and he has never received any allegations that Mr. Lehman has been suspected to be verbally or physically abusive toward the residents. Mr. Ewing reported that he currently has Mr. Lehman suspended from the facility pending the results of this complaint investigation. He reported that he suspended Mr. Lehman when the allegations were originally brought to his attention by Resident A's family members. Mr. Ewing has no direct knowledge of the alleged abuse from Mr. Lehman toward Resident A. Mr. Ewing reported that he interviewed Mr. Lehman and Mr. Lehman denied grabbing Resident A by his face. He reported that Mr. Lehman stated that he went to grab Resident A's fork, and the fork slipped and hit Resident A in the mouth. Mr. Ewing reported that he received a text message from Guardian A1 which contained a photograph of Resident A's mouth, which appeared bruised. Mr. Ewing reported that Mr. Lehman stated Resident A had just been toileted and had returned to his resident bedroom to eat his meal. Mr. Ewing reported that Mr. Lehman denied physically abusing Resident A by grabbing his face. Mr. Ewing reported that Resident A did have an incident in the Fall of 2023 where his arm was fractured during a Hoyer lift transfer. Mr. Ewing reported that there was not any speculation that Resident A was

physically abused or treated carelessly during this transfer. Mr. Ewing discussed that he had given Guardian A1 and A2 a discharge notice for Resident A due to his level of care needs increasing. Mr. Ewing had previously shared this information with this licensing consultant prior to this conversation. Mr. Ewing reported that his decision to issue the discharge notice was in no way impacted by these allegations but is strictly due to Resident A's level of care being too advanced for his current direct care staff to handle.

On 8/1/24 I had email correspondence with Ms. Stahl regarding the allegations. Ms. Stahl reported that she was able to interview Resident B via telephone on this date. Ms. Stahl reported that Resident B had no knowledge of the alleged incident and reported that he stays in his resident bedroom most of the time. Resident B had no knowledge of Mr. Lehman being verbally or physically abusive toward any of the residents at the facility.

On 8/1/24 I received documents, via email, from Mr. Ewing. I reviewed these following documents:

- *Letters of Guardianship of Individual with Developmental Disability*, for Resident A. This document is issued on 9/13/21 and appoints Guardian A1 & A2 as co-guardians for Resident A.
- *Assessment Plan for AFC Residents*, for Resident A, dated 3/5/24. On page one, under section, *I. Social/Behavioral Assessment*, subsection, *I. Controls Aggressive Behavior*, it reads, "yes", "He'll have outlashes not many but a few. Staff will try to calm him down." On page two, under section, *II. Self Care Skill Assessment*, subsection, *A. Eating/Feeding*, it notes that Resident A does not require assistance with this task with the narrative, "Eats himself. We staff help place fork/spoon and plate in front of him." Under subsection, *B. Toileting*, it is noted that Resident A does require assistance from direct care staff with this task with the narrative, "Full assistance by staff." Under section, *III. Health Care Assessment*, subsection, *D. Special Equipment Used (Wheel chair, walker, Cane, Etc.)*, the document notes "yes" with the narrative, "Electric Wheelchair". This document is signed by Guardian A1.
- *AFC Licensing Division – Incident/Accident Report,* for Resident A, dated 9/17/23. This document was completed by Mr. Lehman. Under the section, *Explain What Happened/Describe Injury (if any)*: "When transferring resident to commode for BM, in the process Rt arm got twisted in a hurry to get resident transferred." Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, "Going to take more time with transferring resident".
- *AFC Licensing Division – Incident/Accident Report,* for Resident A, dated 6/30/24. This document was completed by direct care staff, Elena Ramirez. Under the section, *Explain What Happened/Describe Injury (if any),* it reads, "[Mr. Lehman] fed all 6 residents dinner, [Resident A] finished his meal. [Mr. Lehman] was cleaning up [Resident A] from his meal, [Mr. Lehman] ask [Resident A] to drop his silverware. [Resident A] wouldn't (very common) so [Mr. Lehman] went to grab the silverware out of [Resident A's] hand, while he

grabbed the silverware he pulled up and caught [Resident A] in the lip. Once he grabbed the silverware that's when [Resident A] decided to let go." Under the section, *Action taken by Staff/Treatment Given*, it reads, "[Mr. Lehman] called management & [Mr. Ewing] and notified us on what happen. [Mr. Lehman] also apologized to [Resident A]". Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, "Staff will not be touching [Resident A's] silverware or table, etc. until [Resident A] decides to drop the silverware."

- *Michigan Workforce Background Check,* for Mr. Lehman, completed on 3/25/19.

On 8/4/24 I received email correspondence from Mr. Ewing regarding the allegations. Mr. Ewing reported that Mr. Lehman has never received any disciplinary action while working at the facility. Mr. Ewing further reported that the video cameras at the facility are only stationed in the common areas, not in resident bedrooms and the cameras are on a seven-day loop, which means they automatically record over themselves every seven days. He reported having no surveillance footage available from 6/29/24.

On 8/12/24 I had email correspondence with Ms. Stahl. Ms. Stahl reported that she interviewed Mr. Lehman via telephone regarding the allegations. She reported that Mr. Lehman stated, Resident A was struggling to keep his fork while Mr. Lehman was trying to take the fork from him. He reported that Resident A suddenly let go of the fork and the fork came back and hit Resident A in the lip which caused a laceration to Resident A's lip. Ms. Stahl reported that Mr. Lehman denied having any knowledge about a bruise to Resident A's face. Ms. Stahl reported that Mr. Lehman indicated that Resident A did suffer a fracture to his arm in September of 2023 while Mr. Lehman was trying to transfer Resident A with his Hoyer lift. Ms. Stahl reported that Mr. Lehman made a statement that he was in a hurry when this happened and probably should have paid better attention to the task at hand. Ms. Stahl reported that this complaint has been assigned to law enforcement for investigation.

On 8/27/24 I interviewed Detective Troy Gardner with the Eaton County Sheriff's Office, via telephone. Detective Gardner reported that he has been investigating this allegation and was able to interview Resident A on 8/19/24 and Mr. Lehman on 8/23/24. Detective Gardner reported that Resident A stated that Mr. Lehman grabbed him in the face after saying, "I'm gonna punch you in the face!" Detective Gardner reported that Resident A also made a claim that Mr. Lehman broke Resident A's arm. Detective Gardner reported that he interviewed Mr. Lehman and he initially denied having grabbed Resident A by his face. He reported that Mr. Lehman did acknowledge that an incident occurred with Resident A and his fork which caused Resident A to cut his lip, but Mr. Lehman reported that this was an accident. Detective Gardner reported that he spoke with Mr. Lehman about the possibility of a polygraph test and then Mr. Lehman admitted that there are times he becomes frustrated with Resident A and that the day of 6/29/24 when Resident A's fork hit his lip and caused injury, Mr. Lehman admitted that he did become frustrated

with Resident A and grabbed him by the face. Detective Gardner reported that he asked Mr. Lehman whether he had stated to Resident A that he was going to punch Resident A in the face and Mr. Lehman reported that he probably said this, but he was joking around. Detective Gardner reported that he was completing a police report regarding the investigation, and he was forwarding this report to the prosecuting attorney's office seeking charges for assault against Mr. Lehman. He reported he would have a copy of the report sent to this licensing consultant.

On 8/27/24 I received, via email, the document, *Incident/Investigation Report* (2024-0003956), from the Eaton County Sheriff's Department, dated 8/27/24, and completed by Detective Gardner. This document includes the investigative evidence Detective Gardner obtained during his investigation of these allegations. Detective Gardner documented interviewing Mr. Lehman, who admitted that he has lost his patience with Resident A on multiple occasions and has in the past grabbed Resident A by the face out of frustration, and made jokes toward Resident A stating, "[Resident A], I'm going to kick your ass." Detective Gardner noted in his interview with Mr. Lehman that there were statements made by Mr. Lehman about becoming "frustrated" with Resident A, and needing to have more "patience" when working with Resident A. During this interview it is noted that Mr. Lehman states he has never intentionally injured a resident, but he does admit to grabbing Resident A by the face out of frustration on 6/29/24. On page 8 of this report, paragraph two, it reads, "I asked [Mr. Lehman] if there would be any other times when he would have harmed [Resident A] out of frustration. He said, "Not other than this" and he put his hand over his face like he would be grabbing someone by the mouth. I asked [Mr. Lehman] how many times he has grabbed [Resident A] by the mouth like that. He said, "Maybe 3 or 4 times." I stated that [Resident A] has been there for 2 years."

On 8/27/24 and exit conference was completed with Mr. Ewing regarding the findings of the allegations. Mr. Ewing reported that he was planning to bring Mr. Lehman back to the facility as a direct care staff member, but since speaking with Detective Gardner he has decided against this, and Mr. Lehman's employment has been terminated at the facility.

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 upon interviews with Ms. Stahl, Ms. Baker, Resident A, Mr. Ewing, & Detective Gardner, as well as review of documentation provided by Mr. Ewing from Resident A's resident record and Mr. Lehman's employee file, it can be determined that there is a preponderance of evidence to suggest that Mr. Lehman was not treating Resident A with dignity and respect on 6/29/24 by admittedly grabbing Resident A by the face and making statements toward Resident A implying he was going to punch Resident A in the face, which all aligns with Resident A's statement of the events from that day. Even though, Mr. Lehman noted that these statements were made in a joking manner, it was also reported that Mr. Lehman admitted to grabbing Resident A by the face on 3 to 4 other occasions, which demonstrates that Mr. Lehman has physically assaulted Resident A and made statements causing Resident A to feel physically unsafe at the facility. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site investigation on 7/31/24 Ms. Stahl and I interviewed Resident A. Resident A reported that his arm had been fractured during a transfer involving his Hoyer lift. Resident A could not recall the date of this incident.

During the on-site investigation on 7/31/24 Ms. Stahl and I interviewed Ms. Baker. Ms. Baker reported that Resident A did suffer a fractured arm as the result of an incident which occurred during a Hoyer lift transfer at the facility.

On 7/31/24 I interviewed Mr. Ewing, via telephone. Mr. Ewing reported that Resident A did have an incident in the Fall of 2023 where his arm was fractured during a Hoyer lift transfer. Mr. Ewing reported that there was not any speculation that Resident A was physically abused or treated carelessly during this transfer.

On 8/1/24 I received documents, via email, from Mr. Ewing. I reviewed these following documents:

- *Assessment Plan for AFC Residents*, for Resident A, dated 3/5/24. On page two, Under section, *III. Health Care Assessment*, subsection, *D. Special Equipment Used (Wheel chair, walker, Cane, Etc.)*, the document notes "yes" with the narrative, "Electric Wheelchair". This document is signed by Guardian A1.
- *AFC Licensing Division – Incident/Accident Report,* for Resident A, dated 9/17/23. This document was completed by Mr. Lehman. Under the section,

Explain What Happened/Describe Injury (if any): “When transferring resident to commode for BM, in the process Rt arm got twisted in a hurry to get resident transferred.” Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, “Going to take more time with transferring resident”.

On 8/29/24 I had email correspondence with Mr. Ewing regarding Resident A’s Hoyer lift. I inquired whether Mr. Ewing had a signed physician’s order in Resident A’s resident record for this assistive device. Mr. Ewing reported that Resident A admitted to the facility with a Hoyer lift and the only documentation he has for this Hoyer lift came from the Tri County Office on Aging nursing assessment document. This document was completed by a nurse and not the prescribing physician for the Hoyer lift.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	Based upon interviews with Ms. Baker, Resident A, & Mr. Ewing, as well as review of Resident A’s resident record, specifically the *Assessment Plan for AFC Residents* form dated 3/5/24, it can be determined that Resident A’s Hoyer lift, used for the purpose of transferring the resident from his electric wheelchair, was not listed on his current assessment plan. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.

ANALYSIS:	Based upon the correspondence with Mr. Ewing, it can be determined that there was not an existing order for Resident A's Hoyer lift, signed by a licensed physician, available to be reviewed in Resident A's resident record. All assistive devices/therapeutic supports shall by authorized, in writing, by a licensed physician, therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the current status of the license recommended at this time.

8/29/24

_____

Jana Lipps Date
Licensing Consultant

Approved By:

08/30/2024

_____

Dawn N. Timm Date
Area Manager