GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 21, 2024

Lisa Woodruff
Butterfly Oasis, LLC
34012 Fredrick Street
Paw Paw, MI 49079

RE: License #: AS390418040
Investigation #: 2025A1024001
Butterfly Oasis

Dear Lisa Woodruff:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On November 6, 2024, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390418040
Investigation #:	2025A1024001
Complaint Receipt Date:	10/03/2024
Investigation Initiation Date:	10/03/2024
Report Due Date:	12/02/2024
Licensee Name:	Butterfly Oasis, LLC
Licensee Address:	34012 Fredrick Street Paw Paw, MI 49079
Licensee Telephone #:	(269) 547-7630
Administrator:	Lisa Woodruff
Licensee Designee:	Lisa Woodruff
Name of Facility:	Butterfly Oasis
Facility Address:	3113 Parchmount Avenue Kalamazoo, MI 49004
Facility Telephone #:	(269) 547-7630
Original Issuance Date:	01/08/2024
License Status:	REGULAR
Effective Date:	07/08/2024
Expiration Date:	07/07/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was not issued a refund after an emergency discharge was issued. The licensee's refund policy is not in compliance with administrative rules.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/03/2024	Special Investigation Intake 2025A1024001
10/03/2024	Special Investigation Initiated - Face to Face with direct care staff member Amber Rickard
10/03/2024	Contact - Telephone call made with licensee designee Lisa Woodruff.
10/17/2024	Contact - Telephone call made with Relative A1
10/17/2024	Contact - Telephone call made with direct care staff member Tina Newman-Lock
10/25/2024	Contact - Telephone call made with licensee designee Lisa Woodruff
10/28/2024	APS Referral
10/28/2024	Exit Conference with licensee designee Lisa Woodruff
10/28/2024	Corrective Action Plan Requested and Due on 10/28/2024
10/28/2024	Inspection Completed-BCAL Sub. Compliance
11/06/2024	Corrective Action Plan Received
11/06/2024	Corrective Action Plan Approved

ALLEGATION: Resident A was not issued a refund after an emergency discharge was issued. The licensee's refund policy is not in compliance with administrative rules.

INVESTIGATION:

On 10/03/2024, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged Resident A was not issued a refund after an emergency discharge was issued therefore the licensee's refund policy is not in compliance with administrative rules.

On 10/03/2024, I conducted an onsite investigation at the facility with direct care staff member Amber Rickard who stated that Resident A was admitted to the facility on 9/6/2024 after being hospitalized at a behavioral health hospital for psychiatric issues. Amber Rickard stated after two weeks of being at the facility, Resident A began to demonstrate behavioral issues such as not following rules of the facility, talking sexually inappropriately to staff members and throwing cigarettes butts in non-designated areas. Amber Rickard stated on 9/20/2024, Resident A continued to show a disregard for the rules of the facility by being disruptive to other residents by talking loudly and by taking his pants down exposing himself in front of the other residents while in the living room. Amber Rickard stated the staff who was working with Resident A at the time contacted Lisa Woodruff because she did not feel safe with Resident A due to these behaviors and was advised to contact law enforcement. Amber Rickard stated when the police arrived, she asked law enforcement if Resident A could be removed from the home and sent to the hospital to be further psychiatrically evaluated at which they advised her to contact EMS. Amber Rickard stated she then contacted Resident A's mental health provider to consult with them regarding his behaviors and they advised her to petition the Court to have Resident A psychiatrically evaluated. Amber Rickard stated Resident A eventually voluntarily went with EMS to the hospital and Amber Rickard filed a petition with the Courts to have Resident A psychiatrically hospitalized. Amber Rickard stated while Resident A was in route to the hospital, she contacted Relative A1 and notified her that Resident A was going to the hospital and was not able to return to the facility as he was being discharged from the facility for his behaviors. Amber Rickard stated once she dropped off the petition, she never heard back from anyone, and Resident A did not return to the facility.

While at the facility, I reviewed the facility's *Refund Policy* signed by Resident A on 9/5/2024 which stated there is no refund or discount for partial month in the event of a resident's discharge or death. This policy also stated there is no refund for payments made to hold a room. It should be noted this policy does not mention any exceptions to emergency discharges.

I also reviewed the facility's *Charting Notes* for Resident A which stated on 9/20/2024 Resident A went to the Bronson Hospital as of 6am in the morning and Relative A1 was notified that Resident A was given a 24-hour eviction notice. Direct care staff member

Don Woodruff packed all Resident A's belongings, stripped his bed and staff members planned to perform deep cleaning of Resident A's bedroom during the night.

On 10/03/2024 and 10/25/2024, I conducted an interview with licensee designee Lisa Woodruff who stated that early morning on 9/20/2024 she was notified by staff member Tina Newman-Lock that Resident A was being blatantly defiant by not following the house rules and had masturbated in front of the other residents. Lisa Woodruff stated she advised staff to contact law enforcement and authorized to have staff petition the Court to have him psychiatrically hospitalized. Lisa Woodruff stated when Resident A voluntarily left with EMS to the hospital, staff notified Relative A1 that Resident A was being discharged from the facility due to his behaviors and would not be able to return to the facility. Lisa stated she did not give a refund to Resident A because her refund policy states that no refunds would be granted under any circumstance, and Resident A was made aware of this policy at admission. It should be noted Lisa Woodruff stated during this investigation after speaking with LARA she did give Resident A partial refund for a "community fee" that was charged to him in addition to the basic fee amount.

On 10/17/2024, I conducted an interview with Relative A1 who stated that Resident A was immediately evicted from the facility on 9/20/2024 and was not given a 24-hour notice. Relative A1 stated she was contacted via phone by staff who stated that Resident A was having behaviors therefore the staff was going to petition the Court to have Resident A hospitalized. Relative A1 stated staff informed her that Resident A was not able to return to the facility. Relative A1 stated Resident A was admitted to the facility on 9/6/2024 at which time she gave Lisa Woodruff $9500 for rent therefore she believed it unfair for Lisa Woodruff to not issue any sort of refund since Resident A did not stay the entire month at the facility. Relative A1 stated she is Resident A's guardian, and she requested a refund from Lisa Woodruff on more than one occasion and has been told that a refund was not permitted. Relative A1 stated she is seeking legal action and contacted Adult Protective Services to assist her in retrieving a refund.

On 10/17/2024 I conducted an interview with direct care staff member Tina Newman Lock who stated while working with Resident A on third shift she noticed he started demonstrating strange behaviors such as talking to people that was not there, exposing himself to other female residents, and repeatedly talking to her in a vulgar way. Tina Newman-Lock stated these behaviors made her uncomfortable therefore she called the home manager and Lisa Woodruff to get further guidance. Tiffany Newman-Lock stated she then contacted law enforcement and Resident A agreed to voluntarily go to the hospital by EMS at which Relative A1 was contacted and notified that Resident A was being discharged from the facility.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(14) A licensee shall have a written refund agreement with the resident or his or her designated representative. The agreement shall state under what conditions a refund of the

	unused portion of the monthly charge that is paid to the home shall be returned to the resident or his or her designated representative. The refund agreement shall provide for, at a minimum, refunds under any of the following conditions: **(a) When an emergency discharge from the home occurs as described in R 400.14302.** **(b) When a resident has been determined to be at risk pursuant to the provisions of sections 11 and 11a to 11f of Act No. 280 of the Public Acts of 1939, as amended, being SS400.11 and 400.11a to 400.11f of the Michigan Compiled Laws.** **(c) When a resident has been determined to be at risk due to substantial noncompliance with these licensing rules which results in the department taking action to issue a provisional license or to revoke or summarily suspend, or refuse to renew, a license and the resident relocates. The amount of the monthly charge that is returned to the resident shall be based upon the written refund agreement and shall be prorated based on the number of days that the resident lived in the home during that month.**
ANALYSIS:	Based on my investigation which included interviews with licensee designee Lisa Woodruff, direct care staff members Amber Rickard, Tiffany Newman-Lock, Relative A1, review of facility's *Refund Policy,* and charting notes there is evidence to support the allegation Resident A was not issued a refund after an emergency discharge was issued therefore the licensee's refund policy is not in compliance with administrative rules. Relative A1, Lisa Woodruff, Tina Newman-Lock and Amber Rickard all stated Resident A was given an emergency discharge from the facility on 9/20/2024 due to his behaviors. According to Relative A1, Resident A was not given a refund after multiple requests were made and Lisa Woodruff stated a refund was not permitted due to the facility's refund policy of no refunds under any circumstance. I reviewed the facility's refund policy signed by Resident A which stated there is no refund or discount for partial month in the event of a resident's discharge or death. Therefore licensee designee Lisa Woodruff did not have a refund policy agreement with the resident which stated under what conditions a refund of the unused portion of the monthly charge that is paid to the home shall be refunded to the resident as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

While at the facility, I reviewed Resident A's *Resident Care Agreement* dated 9/5/2025 signed by direct care staff member Amber Pickard and Resident A. The agreement did not include a fee for the services that will be provided and any additional cost in addition to the basic fee that is charged.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.** **(b) A description of services to be provided and the fee for the service.** **(c) A description of additional costs in addition to the basic fee that is charged.**
ANALYSIS:	While at the facility I reviewed Resident A's *Resident Care Agreement* dated 9/5/2025 signed by direct care staff member Amber Pickard and Resident A. The agreement did not include a fee for the services that will be provided and any additional cost in addition to the basic fee that is charged. Therefore it is unknown if the resident care agreement document was established between the resident and licensee due to the missing signature of Lisa Woodruff and the fee for services that the resident should pay is unknown due to missing fee amounts.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 10/03/2024, Amber Rickard stated that she contacted Relative A1 via telephone and notified her that Resident A was being transported to the hospital via EMS and was given an emergency discharge due to his behaviors and therefore could not return to the facility. Amber Rickard stated she did not write or send an emergency discharge notice to Resident A, Relative A1 or Resident A's mental health provider. It should also be noted that a written discharge notice was not sent to the department.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(4) A licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home.** **(b) Substantial risk, or an occurrence, of self-destructive behavior.** **(c) Substantial risk, or an occurrence, of serious physical assault.** **(d) Substantial risk, or an occurrence, of the destruction of property.** **(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident:** **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.** **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local**

	community mental health emergency response service regarding the proposed discharge. **If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency** **or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**
ANALYSIS:	On 10/03/2024, Amber Rickard stated that she contacted Relative A1 via telephone and notified her that Resident A was being transported to the hospital via EMS and was given an emergency discharge due to his behaviors and therefore could not return to the facility. Amber Rickard stated she did not write or send an emergency discharge notice to Resident A, Relative A1 or Resident A's mental health provider. It should also be noted that a written discharge notice was not sent to the department. Resident A was not discharged from the facility in accordance with AFC rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 10/03/2024, Amber Rickard stated on 9/20/2024 staff called EMS to the facility due to Resident A's challenging behaviors of disrupting the residents, exposing himself to other residents and not following the rules at which time Resident A voluntarily went to the hospital. Amber Rickard further stated she petitioned the Court for Resident A to be psychiatrically hospitalized and informed Relative A1, who is Resident A's spouse, via telephone of the incident. Amber Rickard stated neither she nor any other staff member documented the incident leading to Resident A being hospitalized therefore did not provide a written incident report to Relative A1 or anyone else.

While at the facility, I reviewed the facility's charting notes from 9/11/2024 to 9/20/2024. On 9/17/2024, Resident A needed to keep being reminded to smoke outside in the back

instead of in the front of the house. On 9/17/2024, Relative A1 notified the facility that she was appointed guardianship of Resident A. On 9/19/2024, staff gave Resident A one cigarette and lighter, but he asked for 2 cigarettes. Resident A then refused to give the lighter back and argued and said he never had the lighter. On 9/20/2024 Resident A went to Bronson and Resident A was given a 24-hour notice eviction. Resident A's belongings were all packed away and his bed was stripped. It should be noted there was no mention of Resident A's behaviors of being sexually inappropriate or precipitating factors of what led Resident A to go to the Bronson Hospital on 9/20/2024.

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(c) Physical hostility or self-inflicted harm or harm to others resulting in injury that requires outside medical attention or law enforcement involvement.**
ANALYSIS:	On 9/20/2024, staff contacted 911 and Resident A was sent to the hospital due to Resident A's behaviors. According to the facility's charting notes Relative A1 was appointed guardianship of Resident A on 9/17/2024. Amber Pickard stated she informed Relative A1 via telephone of the incident. Amber Rickard stated neither she nor any other staff member documented the incident leading to Resident A being hospitalized therefore licensee designee Lisa Woodruff did not provide a written incident report to Relative A1 or anyone else.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While at the facility I reviewed the Resident A's *Addendum to the Resident Care Agreement* dated 9/5/2024 which stated that the rental payment in the amount of $7000 is due on or before the 1st of each month.

While at the facility I also reviewed Resident A's *Resident Funds Part II* which documented that on 9/5/2024 the facility received $9500 from Resident A. On 10/17/2024, Relative A1 stated Resident A was admitted to the facility on 9/6/2024 and she gave Lisa Woodruff $9500 for rent.

On 10/03/2024, Lisa Woodruff stated she received $9500 from Resident A at admission because she charged $7000 for basic rent fee and charged an extra $2500 for a

"community fee" which she charges all residents. Lisa Woodruff stated she did not document this fee in any of her facility records for the resident to sign however she verbally communicated about this fee to Resident A during admission.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(12) Charges against the resident's account shall not exceed the agreed price for the services rendered and goods furnished or made available by the home to the resident.
ANALYSIS:	I reviewed the Resident A's *Addendum to the Resident Care Agreement* dated 9/5/2024 which stated that the rental payment in the amount of $7000 is due on or before the 1st of each month. Relative A1 stated Resident A was admitted to the facility on 9/6/2024 and she gave Lisa Woodruff $9500 for rent. Lisa Woodruff stated she received $9500 from Resident A at admission because she charged $7000 for Resident A's basic rent fee and charged an additional $2500 for a "community fee" which she charges all residents. Lisa Woodruff stated she did not document this fee in any of her facility records for the resident to sign however she verbally communicated about this fee to Resident A during admission. Resident A paid additional fees that were not documented therefore not agreed upon.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 10/3/2024, I reviewed Resident A's *Resident Funds Part II* form which documented licensee designee Lisa Woodruff received $9500 from Resident A and listed a check number. This document was signed by Lisa Woodruff but there was no signature from Resident A.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(8) All resident fund transactions shall require the signature of the resident or the resident's designated representative and the licensee or prior written approval from the resident or the resident's designated representative.

ANALYSIS:	I reviewed Resident A's *Resident Funds Part II* form which documented licensee designee Lisa Woodruff received $9500 from Resident A and listed a check number. This document was signed by Lisa Woodruff but no signature was shown from Resident A therefore this transaction did not include required signatures.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/28/2024, I conducted an exit conference with licensee designee Lisa Woodruff. I informed Lisa Woodruff of my findings and allowed her an opportunity to ask questions and make comments. On 11/6/2024, I received and approved an acceptable corrective action plan**.**

IV. RECOMMENDATION

An acceptable corrective action plan has been approved therefore I recommend the current license status remain unchanged.

Ondrea Johnson

11/19/2024

Ondrea Johnson
Licensing Consultant

Date

Approved By:

Dawn Timm

11/21/2024

_____

Dawn N. Timm
Area Manager

Date