GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 10, 2025

Victor Gomez Jr.
Tuscola Behavioral Health System
P.O. Box 239
323 N. State St.
Caro, MI 48723

RE: License #: AS790309069
Investigation #: 2025A0572015
Maple Ridge Home

Dear Victor Gomez Jr.:

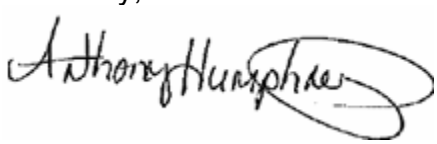
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,



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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS790309069
Investigation #:	2025A0572015
Complaint Receipt Date:	12/12/2024
Investigation Initiation Date:	12/13/2024
Report Due Date:	02/10/2025
Licensee Name:	Tuscola Behavioral Health System
Licensee Address:	P.O. Box 239 323 N. State St. Caro, MI 48723
Licensee Telephone #:	(989) 673-6191
Administrator:	Victor Gomez Jr.
Licensee Designee:	Victor Gomez Jr.
Name of Facility:	Maple Ridge Home
Facility Address:	1851 Dixon Rd. Caro, MI 48723
Facility Telephone #:	(989) 672-8098
Original Issuance Date:	07/19/2010
License Status:	REGULAR
Effective Date:	06/29/2023
Expiration Date:	06/28/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 11/24/2024, Resident A was observed with bruises on his ear. It was alleged that Resident A was hit by a staff Andrew Ritter.	Yes

III. METHODOLOGY

12/12/2024	Special Investigation Intake 2025A0572015
12/12/2024	APS Referral APS made referral.
12/13/2024	Special Investigation Initiated - Letter APS, Gerald Edwards.
12/23/2024	Inspection Completed On-site Licensee Designee, Victor Gomez and Resident A.
02/05/2025	Contact - Telephone call made Attempted phone call to Ex-Staff, Andrew Ritter.
02/05/2025	Contact - Telephone call made Attempted phone call to Staff, Chase Alexander.
02/05/2025	Contact - Telephone call made Attempted phone call to Staff, Leticia Ybarra.
02/06/2025	Contact - Telephone call made Ex-Staff, Andrew Ritter.
02/06/2025	Contact - Telephone call made Staff, Chase Alexander.
02/06/2025	Contact - Telephone call made Staff, Leticia Ybarra.
02/06/2025	Contact - Telephone call made Resident A's Case Manager, Mindy Novak.
02/07/2025	Exit Conference Licensee Designee, Victor Gomez.

ALLEGATION:

On 11/24/2024, Resident A was observed with bruises on his ear. It was alleged that Resident A was hit by a staff Andrew Ritter.

INVESTIGATION:

On 12/12/2024, the local licensing office received a complaint for investigation. Adult Protective Services (APS) made the referral to licensing for further investigation.

On 12/13/2024, I contacted APS Investigator, Gerald Edwards regarding the allegation. Gerald Edwards states, “On-call APS interviewed (Resident A) who disclosed being hit on the head by the alleged perpetrator, Andrew Ritter. I spoke with AFC manager, Sheila Canady, who advised (Resident A) disclosed this to her and she observed a bruise on (Resident A’s) ear area that was not there the day prior. (Resident A) was seen by a nurse who verified the bruise. Andrew (Ritter) has been suspended since the alleged incident and does not have contact with (Resident A). Andrew (Ritter) denied the allegations. Law enforcement notification was submitted but I am unsure if they will investigate. I plan to substantiate physical abuse of (Resident A) by Andrew (Ritter).”

On 12/23/2024, I made an unannounced onsite to Maple Ridge Home, located in Tuscola County Michigan. Interviewed were Licensee Designee, Victor Gomez and Resident A.

On 12/23/2024, I interviewed Licensee Designee, Victor Gomez regarding the allegation. Victor Gomez informed that former Staff, Andrew Ritter was terminated from employment. Andrew Ritter was first suspended, but ultimately terminated. During this incident, Resident A was getting ready to go on an outing with mom. While 1st shift staff were getting the shower ready for Resident A, they noticed a bruise on Resident A’s ear. When they asked what happened, Resident A told them that Staff, Andrew Ritter punched Resident A while Resident A was asleep. According to Victor Gomez, Resident A has been very consistent with this story. The other staff, on 3rd shift, Leticia Ybarra, reported not hearing or seeing anything. Resident A had reported about a year ago that Andrew Ritter had punched him in the stomach. Victor Gomez describes Resident A as a person who is brutally honest, so Resident A is not a person known for making up things. Resident A has issues with anxiety and will constantly pace the floor. When Victor Gomez found out what happened, he called APS, LARA and Law Enforcement.

On 12/23/2024, I reviewed Resident A’s Assessment Plan which does not detail any history of making up accusations or having a delusional type of diagnosis. Resident A has anxiety whenever he hears on the news that bad weather is approaching.

On 12/23/2024, I interviewed Resident A regarding the allegation. Resident A was pacing back and forth throughout the interview. I allowed for Licensee Designee, Victor Gomez to remain in the office to assure that Resident A would be comfortable speaking with me. Resident A remember ear being bruised and stated, “I was just trying to mind my own business by falling asleep. I don’t know why Andrew (Ritter) did that.” I asked what Andrew Ritter do and Resident A stated, “He hit me on my ear. It was more than

once.” When asked if Andrew Ritter had been physical before, Resident A informed that Andrew Ritter punched him in the stomach and made him throw up, but Andrew Ritter apologized for it.

On 02/06/2025, I interviewed former staff, Andrew Ritter regarding the allegation. Andrew Ritter denied the allegation. Andrew Ritter informed that Resident A tried to accuse him of hitting him once before while he was on vacation. Andrew Ritter did not interact with Resident A much because he worked 3rd shift. Andrew Ritter does not know if Resident A has a history of making things up but made allegations against him twice. Andrew Ritter does not know if Resident A just doesn’t like him or if there’s something else. When he last worked with Resident A, he did not observe a bruise on Resident A’s ear. Andrew Ritter denied ever being upset with Resident A or making threatening statements about Resident A.

On 02/06/2025, I interviewed Staff, Chase Alexander regarding the allegation. Chase Alexander worked with former staff, Andrew Ritter on 2nd shift, which would have been the shift before the incident would have occurred. Nothing was unusual about Chase Alexander or Resident A’s behaviors or demeanor. When Chase Alexander returned to work the next day at 3pm, he was informed by 1st shift that Resident A had a bruise on ear. Chase Alexander described Andrew Ritter as being a nice guy who worked for the company for a long time and was a fire fighter. According to Chase Alexander, there were a couple of times that Resident A made a complaint about Andrew Ritter. Nobody really took it too seriously at the time and assumed it was just two guys messing around. Chase Alexander indicated that a lot of the workers are males, and they are caring for male residents, so it was also assumed that they were really close and just kidding around. Chase Alexander indicated that if Andrew Ritter was having a bad night, then Resident A was probably just an easy target for him. Chase Alexander informed that he worked with Andrew Ritter on 2nd shift and Resident A went to bed at 9pm. Andrew Ritter worked a double shift by also working the 3rd shift that night, so the incident had to occur on 3rd shift. Chase Alexander describes Resident A as a person who will say mean things, although its true, its mean, but it comes out that way because Resident A is autistic. Because of this, Chase Alexander believes that Resident A normally tells the truth.

On 02/05/2025, I interviewed Staff, Leticia Ybarra regarding the allegation. Leticia Ybarra worked 3rd shift with Andrew Ritter and never knew anything happened. It was quiet and nothing out of the ordinary happened that night. Residents are usually in bed and asleep all shift and they don’t normally interact with any of the residents until morning when they are getting out of bed. There was no change in behaviors or demeanor in Andrew Ritter. It was quiet all night and the only noises came from the furnace and the water softener. Letrica Ybarra indicated that Resident A is a very light sleeper and Resident A’s bedroom is way in the back near the employee’s bathroom. Staff Ybarra used the bathroom a few times during shift and Resident A’s bedroom door was always closed. Staff try to be very quiet going to the bathroom because Resident A is such a light sleeper and if woken, Resident A will get up and start pacing all night. From what little interaction she has observed, Andrew Ritter and Resident A got along

just fine. Staff Ybarra was the one who Resident A didn't really deal with much and would appear to avoid her. Resident A has told a fib before, but Resident A is pretty honest. Sometimes Resident A can be found sleeping in several different positions. Against the headboard, against the wall, Resident A will take the mattress and place it on the floor and sleep in even more unusual positions. The only thing she can think of is that Resident A could have injured self while sleeping

On 02/06/2025, I contacted Resident A's Case Manager, Mindy Novak regarding the allegation. Mindy Novak informed that this incident was said to have occurred on 3rd shift while Resident A was asleep. Resident A is very honest and does not even know if Resident A is capable of telling stories. Resident A had mentioned to her that Resident A was slammed on the bed before, which broke the boxspring. Mindy Novak saw bruise on Resident A's ear and described it as looking very bad. She is not aware of Resident A having any allergies or a rash on the ear. The bruise appeared to be from a hit. Resident A does not present with any self-injurious behaviors. Resident A is autistic and pretty much just does a lot of pacing because of anxiety.

On 02/07/2025, I held an exit conference with Licensee Designee, Victor Gomez regarding the findings of the investigation. Victor Gomez was satisfied with the results and will submit the corrective action plan as soon as possible.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on the interview of Resident A, Staff, Licensee Designee and Case Manager, there is enough to establish a rules violation. Resident A has been consistent with what happened and does not have a history of making false allegations. Ex-Staff, Andrew Ritter denied the allegation, but was terminated from employment due to physical abuse of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

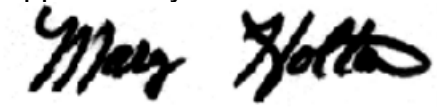
IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this small adult foster care group home, pending the receipt of an acceptable corrective action plan (capacity 3-6).

02/07/2025

Anthony Humphrey — Date
Licensing Consultant

Approved By:



02/10/2025

Mary E. Holton — Date
Area Manager