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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 23, 2025

Mary Fussman
Central Mich Non Profit Housing
P.O. Box 631
Mt. Pleasant, MI 488040631

RE: License #: AS370011310
Investigation #: 2025A0622026
Pickard St Home

Dear Mrs. Fussman:

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) 335-5985.

Sincerely,

Amanda Blasius, 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

I. IDENTIFYING INFORMATION

License #:	AS370011310
Investigation #:	2025A0622026
Complaint Receipt Date:	03/14/2025
Investigation Initiation Date:	03/14/2025
Report Due Date:	05/13/2025
Licensee Name:	Central Mich Non Profit Housing
Licensee Address:	PO Box 631 901 McVey St Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 772-0574
Administrator:	Mary Fussman
Licensee Designee:	Mary Fussman
Name of Facility:	Pickard St Home
Facility Address:	1831 Pickard Mt Pleasant, MI 48858
Facility Telephone #:	(989) 772-4901
Original Issuance Date:	02/01/1993
License Status:	REGULAR
Effective Date:	08/12/2023
Expiration Date:	08/11/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A is sexually assaulting other residents in the home and direct care staff are not addressing this behavior in an effective way.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/14/2025	Special Investigation Intake 2025A0622026
03/14/2025	Special Investigation Initiated – phone interview with adult protective services worker, Alison Witucki
03/21/2025	Inspection Completed-BCAL Sub. Compliance
03/25/2025	APS Referral- Referral came from APS. APS is already investigating
04/10/2025	Contact - Telephone call made to Resident C.
04/11/2025	Inspection Completed On-site
04/17/2025	Contact - Telephone call made to Resident A.
04/22/2025	Exit conference with licensee designee, Mary Fussman

ALLEGATION: Resident A is sexually assaulting other residents in the home and direct care staff are not addressing this behavior in an effective way.

INVESTIGATION:
On 03/14/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, Resident B has a guardian and recently came forward that Resident A was touching him inappropriately. The complaint stated Resident B reported that the first incident occurred in his bedroom, where Resident A reached down his pants and touched his genitalia and buttock even though Resident B told Resident A to stop. According to the complaint, Resident B reported feeling threatened by Resident A because he is bigger than him and has assaulted other residents and staff. The complaint also stated that Resident C reported being sexually assaulted by Resident A over a year

ago. According to the complaint, Resident B also stated that the inappropriately touching was occurring on bus rides also.

On 03/14/2025, I interviewed adult protective services worker, Alison Witucki via phone. She stated that she has yet to visit the home to interview residents, but she was aware that the adult foster home also made a police report.

On 03/21/2025, I completed an unannounced onsite investigation to Pickard St. Home. During the unannounced onsite investigation, Residents A, B and C were not home. Direct care worker (DCW), Rebecca Hodges stated that Resident A and Resident B were at Mid-Michigan Industries (MMI) and Resident C was at work. DCW Hodges stated that Resident B reported the sexual abuse to his case manager on 03/11/2025. DCW Hodges stated she and Resident A's case manager assisted Resident B with making a police report. DCW Hodges reported that Resident B stated that the first incident occurred in his bedroom upstairs and then started to occur on public transportation. DCW Hodges explained that all three residents have community access. DCW Hodges reported that prior to her being at the home, about a year ago, Resident C reported that Resident A was touching him inappropriately. With Resident A's community mental health case manager, a Behavior Treatment Plan was put into place for Resident A to address the inappropriately touching occurring to Resident C. The Behavior Treatment Plan was established on 10/11/2023 and was implemented within that week. DCW Hodges reported that a year ago, Resident C stated that the touching was occurring in his bedroom upstairs and one incident occurred at MMI. DCW Hodges reported that currently as of 3/11/2025, the home has put in a safety plan to protect all the residents. All three residents have bedrooms on the second level and during awake hours, a staff member will be sitting in the hallway. During sleeping hours, a staff member will be sitting at the bottom of the stairs. DCW Hodges reported that Resident A already had one alarm on his door frame and two additional alarms have been added. The door alarms are motion activated and will sound when exiting his bedroom. DCW Hodges reported that Resident A and Resident B will no longer be riding the bus together and staff transport Resident A to MMI and Resident B will continue to ride the bus. Resident C no longer attends MMI and works at Pizza Hut. DCW Hodges explained that Resident A and Resident B will have no groups together while at MMI, will not have lunch together at MMI and will be supervised during all meals at the home. She explained that all three residents can lock their bedroom doors. DCW Hodges stated that Resident A is reporting it was consensual, and he offered food to Resident B for sexual acts. DCW Hodges reported that Resident A's case manager is looking to move him to another home out of county. DCW Hodges explained that in the past Mid-Michigan Industries would have a staff member aide on the public transportation to work, but that is no longer available, and no approved supervision is available on the public transportation bus Resident A and Resident B take to Mid-Michigan Industries.

On 03/21/2025, during the unannounced onsite investigation, I viewed the locations of Resident A, Resident B and Resident C's bedrooms. All three bedrooms are

located on the second floor. Resident A's bedroom is located at the top of the stairs and can be seen from the bottom of the stairs. I confirmed that all three motion sensors were properly working on Resident A's bedroom door. I also confirmed that all three-bedroom doors have properly working locks from the inside of the bedroom. I also viewed a chair in the hallway, where staff sit when the residents are home.

On 3/21/2025, during the unannounced onsite investigation, I viewed resident records for Resident A, Resident B and Resident C. I viewed Resident A, Resident B and Resident C's *Assessment Plan for AFC Residents.*

Resident A's *Assessment Plan for AFC Residents* was dated 01/13/2024 and reported the following:

"Moves independently in the community: *No, [Resident A] does not currently move independently in the community, this will be a goal for in the future.*
Controls aggressive behavior: *Can be verbally aggressive and slams doors. He should be redirected and monitored.*
Controls Sexual Behavior: *Has an approved BTP to address sexual behavior.*
Workshop or Job: *Attends Mid-Michigan Industries."*

Resident B's *Assessment Plan for AFC Residents* was dated 01/07/2024 and reported the following:

"Moves independently in the community: *No, Due to Prader-Willi Syndrome (PWS), staff will supervise anytime [Resident B] is in the community.*
Controls aggressive behavior: *yes*
Gets along with others: *Needs to be monitored as to not take advantage of others to obtain food/money*
Participates in social activities*: Needs to be supervised to avoid access to food/money*
Eating/Feeding: *Due to PWS, [Resident A] needs constant supervision anytime he is near edible items.*
Workshop or Job: *Attends Mid-Michigan Industries."*

Resident C's *Assessment Plan for AFC Residents* was dated 01/05/2024 and reported the following:

"Moves independently in the community: *No, at [Resident C's] request, staff will supervise while in the community. [Resident C] can go into the community unsupervised if he chooses to do so.*
Controls Sexual behavior: *yes*
Workshop or Job: *Works at Pizza Hut and occasionally Mid-Michigan Industries."*

Resident A's *Behavior Treatment Plan* (BTP) was reviewed. It was dated 09/30/2024 and reported the following:

"On 10/13/2023, the BTP was revised to include staff supervision while he is using a multi-stall restroom due to an incident on 10/07/2023 while at MMI he was in a bathroom stall with a peer. On 10/27/2023, the BTP was revised to specify

supervision guidelines while at MMI and with MMI staff in the community. On 09/30/2024, an annual update of the BTP was conducted. [Resident A] requested to ride the bus to and from work independently and he was not reported to engage in target behaviors while being transported with staff."

"Enhanced Supervision: "*The use of additional staffing that is contingent on a target behavior: [Resident A] has a history of engaging in aggression and inappropriate acts towards others that poses a safety risk to him and others. Due to these behavioral needs, [Resident A] requires lines of sight supervision while in the community. At night if his door alarm goes off, staff will provide line of sight supervision until he returns to his bedroom. Staff are to be aware of [Resident A's] location while at home and while completing activities in the community."*
Home: "*Staff are to be aware of [Resident A's] location while at home. He does not need line of sight while in his bedroom or while in a single stall bathroom. At night when the alarm on the external door of his bedroom sounds, staff will provide line of sight supervision until he returns to his bedroom. If [Resident A] is invited in a housemate's bedroom, he will be encouraged to sit on a chair and maintain appropriate personal space. If he goes in a housemate's bedroom without being invited, he will be encouraged to leave the room.*
Bus: *[Resident A] has requested to ride the bus to and from MMI independently. In the past [Resident A] was reported to engage in inappropriate personal space violations without supervision, so home staff have been transporting him to and from MMI to maintain the health and safety of him and others. Based on his appropriate behavior, the number of days he rides the bus independently will increase. When riding the bus, he will be encouraged to sit in the front and respect personal boundaries."*

According to Resident A's BTP, Resident A reached his goal of riding the bus independently on 3/7/25 and rides the bus five days a week independently.

Resident B's *Person Centered Plan* was reviewed and dated 01/15/2025. The following was documented in Resident B's personal care plan.

"When in the community staff are to provide line of sight supervision. [Resident B] does not require supervision while riding the bus to and from work. Staff will provide supervision for [Resident B] while he is in the kitchen. The kitchen is locked all day, except during mealtimes including snacks times. When the kitchen is locked, [Resident B] can enter the kitchen with staff supervision."

On 04/10/2025, I interviewed Resident C via phone. Resident C reported that Resident A touched him inappropriately before the COVID-19 pandemic. Resident C explained that Resident A came into his room and put his hands down his pants. Resident C reported that Resident A would stop when he told him too, but the inappropriate touching was occurring daily. Resident C reported that he eventually told staff members, and they put a stop to it. Resident C stated that the inappropriate touch has not occurred to him since then. Resident C reported that he can shut his

door and lock it, does not ride the bus with Resident A and he feels safe in the house.

On 04/11/2025, I completed an unannounced onsite investigation to Pickard St. Home to attempt to interview Resident A and Resident B in person. Resident A was not at the home. I interviewed Resident B in person. Resident B reported that Resident A was touching him inappropriately. He explained that Resident A would touch his genital area under his pants. Resident B reported that it started with Resident A coming into his bedroom a few months ago. Resident B stated Resident A threatened that he would hurt him if he told anyone. Resident B reported that he told Resident A to stop, but he would not listen to him. Resident B reported that it then started to also happen on the bus ride to MMI. Resident B explained that he would try to move away from him on the bus, but Resident A would put his arm up to block him. He stated that no staff were present on the bus ride to MMI. Resident B reported that he told his case manager and talked to the police. Resident B explained that the sexual abuse has stopped since he told his case manager. Resident B reported that he did not inform direct care workers about the sexual abuse prior to telling his case manager. Resident B reported that DCW Hodges was present and supportive when he talked with law enforcement. Resident B stated that direct care workers have added additional alarms on Resident A's door and no longer allow Resident A to ride the bus with him, nor come into his bedroom. Resident B stated that Resident A is supposed to be moving to another home.

On 04/17/2025, I interviewed Resident A in person. Resident A reported that the first time it occurred was during the wintertime in Resident B's room. Resident A reported that Resident B touched his genital area first and then he touched Resident B's genital area under his pants. Resident A reported that it usually occurred on the weekends while direct care staff were downstairs. Resident A reported that Resident B did not tell him to stop. Resident A also reported that the touching also occurred on the bus to and from MMI. He stated that he would sit in the back by Resident B, where no one else was sitting. Resident A stated Resident B told him to not go inside his private area and dig. Resident A reported that he would stop touching Resident A, but the touching happened at least five times on the bus.

A copy of the police report was reviewed, and the case has been turned over to the prosecuting attorney's office for review.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	After interviewing all three residents, DCW Rebecca Hodges and reviewing documentation it was found that direct care workers were not providing supervision of Resident A and protection towards Resident B. Both Resident A and Resident B reported that the first sexual abuse incident occurred in Resident B's bedroom. According to Resident A's Behavior Treatment Plan dated 10/11/2023 staff are to be aware of Resident A's location while at home and an alarm was placed on Resident A's door to inform staff when he was leaving his bedroom due to a previous sexual assault towards Resident C. Resident A confirmed that he would enter Resident B bedroom on the weekends and when staff were downstairs. Direct care workers failed to provide line of sight for Resident A as he was exiting his bedroom and entering Resident B's bedroom without staff supervision or intervention.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:
On 03/21/2025, during an unannounced onsite investigation, I viewed Resident A, Resident B and Resident C's *Assessment Plans for AFC Residents.* All three *Assessment Plans for AFC Residents* had not been updated for the annual period and the information contained in the assessment plans did not match the information reviewed in the current behavior treatment plan for Resident A and the personal care plan for Resident B. Each *Assessment Plans for AFC Residents* reviewed was dated for January 2024.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.

ANALYSIS:	After reviewing Resident A, Resident B and Resident C's *Assessment Plans for AFC Residents* it was found that each had not been updated since January 2024. It was found that the information listed in Resident A's *Assessment Plan for AFC Residents* did not include information from Resident A's *Behavior Treatment Plan* nor was Resident B's Person Centered Care guidelines included in his Assessment Plan for AFC Residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains the same.

04/21/2025

Amanda Blasius Date
Licensing Consultant

Approved By:

04/23/2025

Dawn N. Timm Date
Area Manager