GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 19, 2025

Peggy Root
411 Silver Street
Reading, MI 49274

RE: License #: AM300008365
Investigation #: 2025A1032024
Heritage House AFC

Dear Peggy Root:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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) 356-0100.

Sincerely,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM300008365
Investigation #:	2025A1032024
Complaint Receipt Date:	04/02/2025
Investigation Initiation Date:	04/04/2025
Report Due Date:	06/01/2025
Licensee Name:	Peggy Root
Licensee Address:	411 Silver Street Reading, MI 49274
Licensee Telephone #:	(517) 283-1478
Administrator:	Peggy Root
Name of Facility:	Heritage House AFC
Facility Address:	121 West State Street Reading, MI 49274
Facility Telephone #:	(517) 283-3152
Original Issuance Date:	08/02/1993
License Status:	REGULAR
Effective Date:	04/23/2024
Expiration Date:	04/22/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
The licensee did nothing to address assaultive behavior.	No
Additional Findings	No

III. METHODOLOGY

04/02/2025	Special Investigation Intake 2025A1032024
04/04/2025	Special Investigation Initiated - On Site
05/19/2025	Exit Conference

ALLEGATION:

The licensee did nothing to address assaultive behavior.

INVESTIGATION:

On 4/4/25, I interviewed Resident A in the facility alongside Adult Protective Services Specialist Jessica Bradley. Resident A stated that Resident B approached her in her bedroom, lifted up her shirt and sucked on her breasts. She denied that the contact was consensual. She reported that this happened on 3/21/25. Resident A reported that Resident B is no longer allowed upstairs, where Resident A resides. Resident A advised that there were no witnesses to this event.

Resident B was interviewed in the facility. Resident B stated that Resident A had grabbed on to his penis through his pants while they were in the mudroom. He acknowledged that he did in fact enter Resident A's room to touch her breasts. He stated that when the incident was brought to the licensee's attention, he was told not to go upstairs.

Employee Alexis Oates was interviewed in the facility. Ms. Oates stated that this behavior was recently disclosed, specifically after March 21st. Ms. Oates stated that both residents were counseled on their inappropriate behavior. She reported that alarms had now been installed in the doors leading upstairs to alert employees of resident movement.

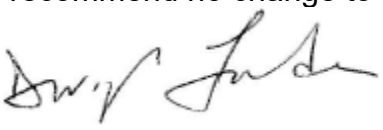
Ms. Bradley advised that a law enforcement notification had been sent but that at this time there was no follow up. It was noted that there were interventions in place to address what happened between Residents A and B, and that from the APS standpoint, there was insufficient evidence to establish a violation.

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:	It appears that Resident A and B engaged in unwanted contact with one another, but when the licensee discovered what happened, steps were taken to address the behavior and increase supervision, so as to remove exposure to harm and keep the residents safe.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 5/19/25, I shared my findings with Ms. Root through an exit conference.

IV. RECOMMENDATION

I recommend no change to the status of this license.



5/19/25

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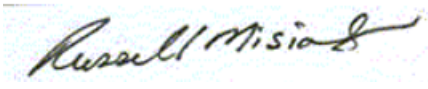
Dwight Forde Date
Licensing Consultant

Approved By:



5/23/25

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Russell B. Misiak Date
Area Manager