RICK SNYDER
GOVERNOR

State of Michigan
DEPARTMENT OF HUMAN SERVICES
BUREAU OF CHILDREN AND ADULT LICENSING

MAURA D. CORRIGAN
DIRECTOR

November 26, 2014

Mr. Bartholomew Ajulufoh
Strathmoor Manor, LLC
23580 Oneida
Oak Park, MI 48237

Re: **MAHS Docket No. 14-011529-DHS**
License AS820284341

Dear Mr. Ajulufoh:

On or about November 17, 2014 you were mailed a copy of the Final Decision and Order upholding the agency's revocation of your license to operate an adult foster care small group home. In accordance with that Decision and Order, your license has been revoked effective November 25, 2014. It is further understood that you will not receive adults for care now, or in the future, without being properly licensed.

Sincerely,

Jerry Hendrick, Acting Director
Adult Foster Care/Homes for the Aged Licensing Division
Bureau of Children and Adult Licensing

JH:kam

cc: Ardra Hunter, Area Manager
Regina Buchanan, Licensing Consultant

Certified Mail- Return Receipt Requested

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STATE OF MICHIGAN
DEPARTMENT OF HUMAN SERVICES

In the matter of	Docket No. 14-011529-DHS
Strathmoor Manor, LLC,	Case No. AS 820284341
Petitioner,	Agency: DHS
v	Case Type: DHS BCAL
Bureau of Children and Adult Licensing,	Filing Type: Sanction
Respondent.	

RECEIVED
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BUREAU OF CHILDREN AND ADULT LICENSING

Issued and entered
this 17th day of November, 2014
by
Maura D. Corrigan, Director
Department of Human Services

FINAL DECISION AND ORDER

This matter began with Respondent's June 2, 2014 Order of Summary Suspension and Notice of Intent to Revoke License (notice of intent), regarding Petitioner's license to operate an adult foster care small group home under the Adult Foster Care Facility Act (Act), 1979 PA 218, as amended, MCL 400.701 *et seq.* A properly noticed hearing regarding the matter at issue was held by Administrative Law Judge David M. Cohen (ALJ) on August 12, 2014. Licensee Designee Bartholomew Ajulufoh appeared as representative on behalf of Petitioner. Assistant Attorney General Kelley McLean appeared on behalf of Respondent.

Respondent seeks to revoke Petitioner's license based on allegations in the notice of intent that Petitioner violated the Act and administrative rules promulgated under the Act. Respondent alleged in Count I of the notice of intent that Petitioner's conduct violated R 400.734b which states in pertinent part as follows:

* * *

> Except as otherwise provided in subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to resident's after April 1, 2006 until the adult foster care facility conducts a criminal history check in compliance with subsections (4) and (5) . . . . [Rule 400.734b(2)]

* * *

The record established Petitioner employed individuals at its adult foster care facility without conducting the required criminal history checks (Respondent's Exhibit B, page 9). Therefore, the ALJ determined that Respondent demonstrated Petitioner's willful and substantial violation of Rule 400.734b (2).

Respondent further alleged in Count II of the notice of intent that Petitioner violated R 400.14201, which states in pertinent part as follows:

* * *

> A licensee shall have the financial and administrative capability to operate a home to provide the level of care and program stipulated in the application. [Rule 400.14201 (2)]

* * *

Petitioner failed to demonstrate its administrative capability to operate the facility when it failed to maintain the required employee records and obtain the required criminal history checks for its staff. In addition, Petitioner lacked the general capability

to operate the home at a level of care that provides for the protection and safety of its residents that ensures they are treated with dignity. The record indicated Licensee Designee failed to ensure a safe environment for residents as evidenced by the credible testimony provided by a former employee Dominique Blade that described residents eating food that had been thrown on the floor. Pursuant to an investigation residents had been removed from Petitioner's facility and information provided by residents indicated Petitioner's staff treated residents with cruelty by physically hitting them with their hands or other objects. Therefore, the ALJ determined Respondent demonstrated Petitioner's willful and substantial violation of Rule 400.14201 (2).

Respondent also alleged in Counts III of the notice of intent that Petitioner violated R 400.14204, which states in pertinent part as follows:

* * *

> A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas:
>
> (a) Reporting requirements.
> (b) First aid.
> (c) Cardiopulmonary resuscitation.
> (d) Personal care, supervision, and protection.
> (e) Resident rights.
> (f) Safety and fire prevention.
> (g) Prevention and containment of communicable diseases. [Rule 400.14204 (3)(a)-(g)]

* * *

Petitioner failed to provide the required training and to assure that the direct care staff was competent to perform their assigned tasks. Specifically, former employee,

Dominique Blade, who sat back and recorded the physical abuse of Resident A, credibly testified that Petitioner did not provide any training prior to the commencement of her employment. The 2011 Special Investigation Report indicated Petitioner had not trained staff on how to meet the needs of residents prior to allowing staff to care for them (Respondent's Exhibit H). Therefore, the ALJ concluded that Respondent demonstrated Petitioner's willful and substantial violation of Rule 400.14204 (3) (a)-(g).

In Count IV of the Notice, Respondent alleged that Petitioner violated R 400.14208, which states in pertinent part:

> A licensee shall maintain a record for each employee. The record shall contain all of the following employee information:
>
> (a) Name, address, telephone number, and social security number.
> (b) The professional or vocational license, certification, or registration number, if applicable.
> (c) A copy of the employee's driver license if a direct care staff member or employee provides transportation to residents.
> (d) Verification of the age requirement.
> (e) Verification of experience, education, and training.
> (f) Verification of reference checks.
> (g) Beginning and ending dates of employment.
> (h) Medical information, as required.
> (i) Required verification of the receipt of personnel policies and job descriptions. [Rule 400.14208 (1) (a)-(i)]

The record indicated Petitioner failed to maintain a record for each employee as evidenced by Petitioner producing two of the seven personnel files. Furthermore, employee files failed to contain the required information as described by Rule 400.14208 (1)(a)-(i). Therefore, the ALJ properly determined that Respondent demonstrated that Petitioner willfully and substantially violated R 400.14208 (1)(a)-(i).

In Count V of the Notice, Respondent alleged that Petitioner violated R 400.14208 which states in pertinent part:

> The records identified in subrule (1) of this rule shall be maintained for not less than 3 years after the direct care staff member's or employee's ending date of employment. [Rule 400.14208 (2)]

The evidence on the record established Petitioner failed to maintain employee records for a minimum of three years after the ending date of employment. Therefore, the ALJ properly concluded that Respondent demonstrated that Petitioner willfully and substantially violated R 400.14208 (2).

In Count VI of the Notice, Respondent alleged that Petitioner violated R 400.14305, which states in pertinent part:

* * *

> 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. [Rule 400.14305]

* * *

There was no dispute or evidence presented that negated the fact that Petitioner's employee, Kadia Konate, physically abused a resident by beating her with a mop handle and an extension cord, while another employee, Dominique Blade, watched and recorded the incident. Petitioner's staff failed to seek assistance or assist the resident, therefore failing to protect said resident and ensure her safety. Further testimony indicated Licensee Designee was aware of the staff's mistreatment of the residents residing in Petitioner's facility. Therefore, the ALJ properly concluded that

Respondent demonstrated that Petitioner willfully and substantially violated R 400.14305 (3).

In Count VII of the Notice, Respondent alleged that Petitioner violated R 400.14308, which states in pertinent part:

* * *

> A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:
>
> Use any form of physical force other than physical restraint as defined in these rules. [Rule 400.14308 (2)(b)]

The evidence on the record established that Petitioner's staff wrongfully used physical force on a resident. A resident was struck with an extension cord and a mop handle and suffered several injuries (Respondent's Exhibit C). Therefore, the ALJ properly concluded that Respondent demonstrated Petitioner willfully and substantially violated R 400.14308 (2) (b).

On August 21, 2014, the ALJ issued and entered a Proposal for Decision (PFD) concluding that Petitioner had willfully and substantially violated Rule 400.734b(2); Rule 400.14201(2); Rule 400.14204 (3)(a)-(g); Rule 400.14208 (1)(a)-(i); Rule 400.14208 (2); Rule 400.14305 (3); and Rule 400.14308(2)(b). The parties had 14 days to file exceptions and 14 days to file responses to any exceptions. Petitioner filed exceptions and no response or exceptions were filed by Respondent.

Upon review, to the extent not inconsistent with this Order, I agree with the ALJ's findings of fact and conclusions of law in this case.

ORDER

NOW THEREFORE, IT IS ORDERED that:

1. To the extent not inconsistent with this Order, the ALJ's Proposal for Decision (PFD) is adopted and is incorporated by reference, and made a part of this Final Decision and Order (see attached PFD).
2. The actions of the Bureau of Children and Adult Licensing in this matter are AFFIRMED.
3. Petitioner's license is REVOKED effective on the date this Final Decision and Order is issued and entered.

for **Maura D. Corrigan, Director**
Department of Human Services

PROOF OF SERVICE

I hereby state, to the best of my knowledge, information and belief, that a copy of the foregoing document was served upon all parties and/or attorneys of record in this matter by Inter-Departmental mail to those parties employed by the State of Michigan and by UPS/Next Day Air, facsimile, and/or by mailing same to them via first class mail and/or certified mail, return receipt requested, at their respective addresses as disclosed by the file on the 7th day of November, 2014.

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STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM

IN THE MATTER OF:

Strathmoor Manor, LLC,
Petitioner

v

Bureau of Children and Adult Licensing,
Respondent

/

Docket No.: 14-011529-DHS

Case No.: AS 820284341

Agency: Department of Human Services

Case Type: DHS BCAL

Filing Type: Sanction

Issued and entered
this 21st day of August, 2014
by: David M. Cohen
Administrative Law Judge

PROPOSAL FOR DECISION

PROCEDURAL HISTORY

This matter commenced on or about June 21, 2014, with the Bureau of Children and Adult Licensing (BCAL or Respondent) issuing an Order of Summary Suspension and Notice of Intent to Revoke License, regarding the license of Strathmoor Manor, LLC (Licensee or Petitioner) to operate an adult foster care small group home pursuant to the authority of the Adult Foster Care Facility Licensing Act, 1979 PA 218 (Act), as amended, MCL 400.701 *et seq.*

A hearing was held on August 12, 2014 at the Michigan Administrative Hearing System, Cadillac Place, 2nd Floor Annex 3026 West Grand Boulevard, Detroit, Michigan. Administrative Law Judge David M. Cohen presided. Petitioner was represented at the hearing by its Licensee Designee Bartholomew Ajulufoh. Assistant Attorney General Kelley McLean represented Respondent at the proceeding. Respondent solicited testimony from Resident A's Mother1, Licensee's Former Employee Dominique Blade, and BCAL Licensing Consultant Regina Buchanan. Licensee Designee Bartholomew Ajulufoh offered testimony on behalf of Petitioner. There were no additional witnesses. The record closed as the end of the proceeding.

SUMMARY OF EXHIBITS

Respondent Exhibits:

Exhibit A - A May 15, 2014 typed note to Dominique Blade from Bartholomew Ajulufoh, indicating a "need to create an employee file for you"

1 Name intentionally omitted to promote privacy of Resident A

Exhibit B - BCAL Special Investigation Report #20140901020

Exhibit C - A series of photographs depicting injury to Resident A

Exhibit D - An Adult Foster Care License Application (Renewal) completed by the Licensee Designee

Exhibit E - BCAL Special Investigation Letter #2009A0778038

Exhibit F - BCAL Special Investigation Report #2010A0778009

Exhibit G - A Corrective Action Plan completed by the Licensee Designee (2010)

Exhibit H - BCAL Special Investigation Report #2011A0780038

Exhibit I An April 20, 2012 correspondence from Licensee Designee Ajulufoh to BCAL Licensing Consultant Roeiah Epps with attachments related to a Corrective Action Plan

Exhibit J BCAL Special Investigation Report #2012A0780025

Exhibit K BCAL Special Investigation Report #2013A0122024

Exhibit L A Corrective Action Plan completed by the Licensee Designee (2013)

Exhibit M Proof of Service regarding the Order of Summary Suspension and Notice of Intent

Exhibit N Medical Record pertaining to Resident A (May 21, 2014)

Petitioner Exhibits:

Exhibit 1 - A seven page document prepared by Licensee Designee Ajulufoh entitled *{Child A's Mother} vs. Strathmoor Manor*

Exhibit 2 - A two page document prepared by Licensee Designee Ajulufoh entitled *Taking Care of {Resident A} (The Positives) at Strathmoor Manor*

Exhibit 3 - Resident A's Behavior Management Plan (May 2013)

Exhibit 4 - Outline of testimony prepared by Licensee Designee Ajulufoh

ISSUES AND APPLICABLE LAW

The general issue presented is whether the Licensee committed willful and substantial violations of the Act, or rules promulgated under the Act with respect to the maintenance and operation of an adult foster care small group home.

The specific issues are whether Licensee violated MCL 400.734b(2), R 400.14201(2), R 400.14204(3)(a)(b)(c)(d)(e)(f)&(g), R 400.14208(1)(a)(b)(c)(d)(e)(f)(g)(h)(i) & (2), R 400.14305(3), and R 14308(2)(b), which provide in pertinent part:

> **MCL 400.734b**
> (2) Except as otherwise provided in subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents after April 1, 2006 until the adult foster care facility conducts a criminal history check in compliance with subsections (4) and (5)...
>
> **R 400.14201**
> (2) A licensee shall have the financial and administrative capability to operate a home to provide the level of care and program stipulated in the application.
>
> **R 400.14204**
> (3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas:
> (a) Reporting requirements.
> (b) First aid.
> (c) Cardiopulmonary resuscitation.
> (d) Personal care, supervision, and protection.
> (e) Resident rights.
> (f) Safety and fire prevention.
> (g) Prevention and containment of communicable diseases.
>
> **R 400.14208**
> (1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information:
> (a) Name, address, telephone number, and social security number.
> (b) The professional or vocational license, certification, or registration number, if applicable.
> (c) A copy of the employee's driver license if a direct care staff member or employee provides transportation to residents.
> (d) Verification of the age requirement.
> (e) Verification of experience, education, and training.
> (f) Verification of reference checks.

(g) Beginning and ending dates of employment.
(h) Medical information, as required.
(i) Required verification of the receipt of personnel policies and job descriptions.

(2) The records identified in subrule (1) of this rule shall be maintained for not less than 3 years after the direct care staff member's or employee's ending date of employment.

R 400.14305
(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.

R 400.14308
(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:
(b) Use any form of physical force other than physical restraint as defined in these rules.

SUMMARY OF EVIDENCE

The following is intended as only a very brief summary of relevant evidence from the August 2014 proceeding. At the initiation of the hearing it was indicated that the Licensee wished to present arguments sounding in mitigation regarding penalty.

It was not disputed at the hearing that an incident occurred on May 12, 2014. The incident involved an employee of the Licensee, Ms. Kadia Konate, viciously beating Resident A, an adult female resident of the Licensee's facility. Resident A is autistic and non-verbal. Resident A was beaten with a mop handle as well as an extension cord.

This physical assault was videotaped by another employee of the facility, Ms. Dominique Blade, who was sitting passively in the living room of the residence waiting for a ride. Per the credible testimony of Ms. Blade, the beating went on for a period of hours and seventeen different videos were taken by Ms. Blade, who subsequently passed at least some of the footage to a local media outlet.

Ms. Blade indicated in her testimony that Resident A was struck on various parts of her body, including her head. The hearing record indicated that loop marks and linear marks were observed on Resident A's body by the investigating licensing consultant in the week after the incident.

Ms. Blade showed at least a portion of the footage she recorded to Licensee Designee Bartholomew Ajulufoh approximately two days after it was recorded. The Licensee Designee did terminate the employment of Kadia Konate on that date, and also transported Resident A for a medical examination. At that time Resident A was diagnosed as having a swollen and infected finger which was attributed to a bite mark. Approximately a week later, it was determined that Resident A had a fractured finger. The fracture was a week old when confirmed, which would date it back to the time of the assault (Testimony of Licensing Consultant Regina Buchanan and Exhibit N).

The matter became the subject of BCAL Special Investigation #2014A0901020 which was conducted by Licensing Consultant Regina Buchanan. The residents at the facility were immediately relocated to other facilities at the commencement of the investigation. During the course of the investigation conducted by Licensing Consultant Buchanan, several violations were found, and a licensing history replete with special investigations and rule violations was noted. On June 21, 2014, Respondent issued a Summary Suspension and Notice of Intent to Revoke License which contained seven counts drawn primarily from the findings asserted in the May/June 2014 special investigation, and this led to the present proceeding. The alleged rule violations at issue and an analysis of each are detailed below.

Resident A's mother was one of the witnesses at the proceeding. Resident A's mother detailed her concerns over her daughter's general treatment while at the licensee's facility. Of note, the witness indicated she once visited her daughter to find a large gash on her head and her hair shaved. The testimony suggested that there was no explanation put forward as to what had happened on that occasion. Resident A's mother acknowledged being engaged in civil litigation against the Licensee.

Dominique Blade, the employee of the licensee who witnessed the assault and sat passively recording the incident, testified that Resident A was not the only resident mistreated at the facility, noting to the effect that another female resident was also maltreated.

Of note, Dominique Blade testified that Resident A's food would be thrown on the floor and she would have to pick it off the floor and eat it. The witness clearly was averring that this was a practice of which the Licensee Designee had knowledge.

Dominique Blade also testified that she was never asked to provide any information prior to beginning employment at the residence, and that a request from the Licensee Designee to create an employment file was received in the days after the incident (Exhibit A).

Licensing Consultant Regina Buchanan testified that the personnel files of seven employees were requested during her special investigation, but only two were provided. Licensee Designee Ajulufoh offered varied explanations for the missing records, and this is detailed and discussed below.

Several arguments were advanced by Licensee Designee Ajulufoh during the course of the hearing. Mr. Ajulufoh indicated that he owns many other licensed facilities. Mr. Ajulufoh repeatedly cast aspersions on Resident A during the course of the proceeding, indicating to the effect that she was a very difficult resident. Mr. Ajulufoh indicated that the resident required one on one care, but that funding for that level of care was not granted, yet the Licensee took it upon itself to give the resident necessary heightened care.

At the summation of the proceeding, Mr. Ajulufoh requested an administrative closure of the license as opposed to revocation. Respondent maintained that the summary suspension was appropriate and urged revocation of the license.

FINDINGS OF FACT

Based on the entire record in this matter, the following findings of fact are established:

1. On or about October 5, 2006, Licensee was issued a license to operate an adult foster care small group home with a licensed capacity of 6 at 12866 Strathmoor Street, Detroit, MI 48227. The Licensee Designee indicated at the hearing that he owns numerous other licensed facilities.

2. In mid-to late-April 2014, Dominique Blade began working for Licensee. Licensee did not require Ms. Blade to submit her identification or social security card, an application, a health appraisal, or TB test results before she began working, nor did Licensee train Ms. Blade. This was established through the credible testimony of Dominique Blade.

3. On May 12, 2014, Kadia Konate, staff, beat Resident A with an extension cord and the metal part of a mop handle because Resident A would not listen to her. Resident A was struck on various parts of her body, including her head. Resident A suffered a broken left index finger and cuts to her left hand, and her left hand was swollen. Resident A also had scars and bruises on her back, arms, and legs. Bartholomew Ajulufoh, licensee designee, fired Ms. Konate on May 14, 2014 upon learning of the incident. The Notice of Intent avers that on May 19, 2014, Ms. Konate was arraigned on one count of Felony Vulnerable Adult Abuse-1st Degree, two counts of Felony Assault with Intent to do Great Bodily Harm less than Murder, and two counts of Felonious Assault. While the arraignment and criminal charges were not specifically addressed at the hearing, it was indicated through the testimony of Resident A's mother that she attended a criminal proceeding in 36th District Court regarding Ms. Konate.

4. Ms. Blade observed and recorded the May 12, 2014 incident between Ms. Konate and Resident A. Ms. Blade testified that she took seventeen videos of Ms. Konate abusing Resident A over a four hour period of time. Ms. Blade released the video to Fox 2 News, but she did not report the incident to anyone else before informing Mr. Ajulufoh on May 14, 2014. Fox 2 News aired the video

on the news on or about May 15, 2014, and posted the video on their website, thereby identifying Resident A (Exhibit B at Page 7).

5. On or about May 15, 2014, Residents A-E were removed from Licensee's facility. Regina Buchanan, licensing consultant, interviewed the residents on May 19, 2014. Residents A and B were nonverbal (Resident A was also autistic), and Resident E would not respond to questioning. Resident D repeatedly said that Licensee's staff were mean, but she would provide no further information. Resident C reported that Sandra Emoka or Miriama Cesay, staff, sometimes hit her with their hands, a cord, or a belt when she would not listen. Resident C stated that she suffered marks from these incidents, but no marks were presently observable. Resident C also stated that she informed Mr. Ajulufoh about the incidents (Exhibit B at Page 4).

6. On May 23, 2014, Mr. Ajulufoh met with Ms. Buchanan as scheduled. Ms. Buchanan noted the following problems with Licensee's staff files:

   a. Mr. Ajulufoh brought only two of the seven requested staff files (Exhibit B at Page 8 and testimony of Licensing Consultant Regina Buchanan).

   b. Mr. Ajulofoh claimed that Ms. Blade took her file (Exhibit B at Page 8 and testimony of Licensing Consultant Regina Buchanan), which she denied (Testimony of Dominique Blade).

   c. Mr. Ajulufoh claimed that law enforcement had taken Ms. Konate's file (Exhibit B at Page 8). On May 28, 2014, Detective Lovan, of the Detroit Police Department, told Ms. Buchanan that the police department had not taken any files from Licensee's facility (Exhibit B at Page 8 and testimony of Licensing Consultant Regina Buchanan).

   d. Mr. Ajulufoh did not maintain copies for two staff who stopped working for Licensee in 2014. He claimed that Jasmine Smith had taken her file, but he had no explanation for why there was not a file for Rhonda (he did not know her last name) (Exhibit B at Page 10 and testimony of Licensing Consultant Regina Buchanan).

   e. Licensee had not conducted criminal history fingerprint checks on Ms. Konate or Ms. Blade (Exhibit B at Page 9 and testimony of Licensing Consultant Regina Buchanan).

7. On May 12, 2009, LaKeitha (Grant) Stevens, licensing consultant, concluded Special Investigation #2009A0778038 and cited Licensee for a violation of R 400.14507(5). Licensee allowed three doors in the facility to have hardware that locked against egress (Exhibit E and testimony of Licensing Consultant Regina Buchanan). Licensee submitted a corrective action plan (CAP) to resolve the inspection.

8. On September 11, 2009, a renewal inspection cited Licensee for a violation of R 400.14507(5). Licensee allowed two doors in the facility to have hardware that locked against egress. Licensee submitted a CAP to resolve the inspection (Testimony of Licensing Consultant Regina Buchanan, who indicated that this data was retrieved from computer records during the course of her investigation).

9. On December 3, 2009, Ms. Stevens concluded Special Investigation #2010A0778009 and cited Licensee, in part, for a violation of R 400.14507(5). Licensee continued to allow two doors in the facility to have hardware that locked against egress. Licensee submitted a CAP to resolve the investigation and accepted the terms of a first provisional license, which was effective from March 4, 2010 until September 3, 2010 (Exhibit F and Testimony of Licensing Consultant Regina Buchanan).

10. On October 20, 2011, Roeiah Epps, licensing consultant, concluded Special Investigation #2011A0780038 and cited Licensee, in part, for the following violations:

    a. R 400.14305(3) -Several staff often yelled at the residents (Exhibit H, at Page 3).

    b. R 400.14204(3)(d)-Licensee had not trained a staff how to meet the needs of all residents prior to allowing the staff to care for residents (Exhibit H, at Page 5-6).

    c. R 400.14507(5) -The door to the living room was not equipped with positive-latching, non-locking-against-egress hardware. Licensee submitted a CAP to resolve the investigation, and specifically indicated that it would ensure all staff received the training necessary to meet all residents' needs prior to caring for residents (Exhibit H, at Page 6-7).

11. On December 11, 2012,Ms.Epps concluded Special Investigation 2012A0780025 and cited Licensee, in part, for the following violations:

    a. R 400.14305(3) -a resident repeatedly used her fingers to dig into her vagina and rectum. This was an on-going issue for the resident. On this occasion, Licensee did not seek medical treatment for the resident even though she bled for over an hour (Exhibit J, at Page 1-7).

    b. R 400.14204(3)(d) -Licensee still had not trained staff to handle all residents' needs before allowing the staff to care for residents. Licensee submitted a CAP to address the violations and accepted the terms of a first provisional license, which was effective from October 25, 2013 until April 24, 2014 (Exhibit J, at Page 9).

12. On September 5, 2013,Vanita Bouldin, licensing consultant, concluded Special Investigation #2013A0122024 and cited Licensee, in part, for a violation of R 400.14305(3) (Exhibit K). One staff cared for two residents while the other staff on duty was at the grocery store. The remaining staff allowed a resident to enter the dining room for an interview while naked, and did not place an adult diaper on the resident as required when she dressed the resident. When both residents continued to touch and grab at Ms. Bouldin, the staff took a resident to the resident's bedroom, and shut the door (Exhibit K at Page 6-7). Given the timing of this investigation, Licensee submitted one CAP to resolve this investigation and Special Investigation #2012A0780025.

CONCLUSIONS OF LAW

The principles that govern judicial proceedings also apply to administrative hearings. The burden of proof is upon BCAL to prove by a preponderance of the evidence that grounds exist for the imposition of sanctions upon the Licensee/Petitioner.

The Administrative Law Judge (ALJ) evaluates the testimony and evidence elicited at the hearing and renders a proposed decision setting forth an opinion as to whether the Licensee in fact committed a willful and substantial violation of the Act, rules or terms of the license. If a willful and substantial violation is determined, the Director of the Department is statutorily empowered to take appropriate adverse action against the license. Thus, the words "willful and substantial" must be evaluated.

The words "willful and substantial" as used in the Act are defined in the applicable Administrative Rule as follows:

> **R400.16001**
>
> (c) "Noncompliance" means a violation of the act or act 218, an administrative rule promulgated under the act or act 218, or the terms of a license or a certificate of registration.
>
> (d) "Substantial noncompliance" means repeated violations of the act or act 218 or an administrative rule promulgated under the act or act 218, or noncompliance with the act or act 218, or a rule promulgated under the act or act 218, or the terms of a license or a certificate of registration that jeopardizes the health, safety, care, treatment, maintenance, or supervision of individuals receiving services or, in the case of an applicant, individuals who may receive services.
>
> (e) "Willful noncompliance" means, after receiving a copy of the act or act 218, the rules promulgated under the act or act 218 and, for a license, a copy of the terms of a license or a certificate of registration, an applicant or licensee knew or

> had reason to know that his or her conduct was a violation of the act or act 218, rules promulgated under the act or act 218, or the terms of a license or a certificate of registration.

In the present case the Order of Summary Suspension and Notice of Intent to Revoke License sets forth seven counts asserting the allegations against the Licensee/Petitioner.

Count I – MCL 400.734b(2)

By this charge, Respondent asserts that the Licensee failed to conduct a criminal history check on employees of its facility. The hearing record in this matter supports a finding of a violation of MCL 400.734b(2).

Licensing Consultant Regina Buchanan presented throughout her lengthy testimony as a credible and straightforward witness. Ms. Buchanan's testimony clearly conveyed that she determined that criminal background checks had not been conducted for more than one of Licensee's employees.

Turning to the Special Investigation report authored by Ms. Buchanan, it is noted that a May 28, 2014 check of the Michigan Workforce Background Check system verified that criminal clearances were *not* completed by the Licensee regarding its employees Kadia Konate and Dominique Blade (Exhibit B at Page 9).

Accordingly, based upon the above, Respondent has established by, a preponderance of the evidence, a violation of MCL 400.734b(2).

The violation of the above-referenced rule was both legally "willful noncompliance" and "substantial noncompliance" as those terms are defined by 2000 AACS, R 400.16001, *supra*. The Licensee knew or should have known that a failure to conduct criminal background checks was in violation of the rules. Thus, the established violation was "willful noncompliance" as defined above.

Additionally, the failure to adequately screen employees entrusted with providing care to vulnerable adults is inherently of such a significant nature, that it does meet the criteria of "substantial noncompliance" as defined above.

Count II – R 400.14201(2)

By this charge, Respondent asserts that the Licensee failed to demonstrate the financial and administrative capability to operate a home to provide the level of care and program stipulated in the application. The hearing record in this matter supports a finding of a violation of R 400.14201(2). In fact, the hearing record presents numerous examples of conduct and actions/inactions which demonstrate a lack of administrative capability.

By way of one example, the evidence presented at the August 12, 2014 hearing demonstrates that the Licensee did not maintain adequate staff files as required by the rules, and this is noted below.

During a May 23, 2014 meeting, Licensee Designee Ajulufoh was unable to provide Licensing Consultant Buchanan with requested staff files, producing only two of the seven staff files that had been requested (Exhibit B at Page 8 and testimony of Licensing Consultant Regina Buchanan).

Moreover, rather than acknowledge the significant lapse in rule adherence and administrative responsibility, the Licensee Designee proceeded to offer various excuses for the lack of required records. Mr. Ajulufoh claimed that Dominique Blade took her file (Exhibit B at Page 8 and testimony of Licensing Consultant Regina Buchanan). Of note, the Licensee Designee wrote to Ms. Blade on May 15, 2014, after the assault on Resident A, indicating that "I need to create an employee file for you" (Exhibit A).

The assertion that a former employee left with her personnel records presented an interesting and unusual pattern. Mr. Ajulufoh also asserted that a former employee, Jasmine Smith, had taken her file when she left during 2014 (Exhibit B at Page 8 & Page 10).

As to another former employee known to the Licensee Designee only as "Rhonda", the Licensee was again without a staff file. There was no explanation for the lack of this file (Exhibit B at Page 10). The files of two other employees, Pheleshia Washington and Mariama Cesay, were also not located (Exhibit B at Page 8).

While the Licensee Designee indicated that law enforcement had taken Ms. Konate's file (Exhibit B at Page 8), the police department reported to BCAL that it had not taken any files from Licensee's facility (Exhibit B at Page 8 and testimony of Licensing Consultant Regina Buchanan). In short, the Licensee Designee's varied explanations for a lack of meaningful employee records was devoid of credibility.

Moreover, as noted above in the discussion of Count I, the Licensee had not conducted criminal history fingerprint checks on Ms. Konate or Ms. Blade (Exhibit B at Page 9 and testimony of Licensing Consultant Regina Buchanan).

Perhaps more concerning to this Administrative Law Judge were the varied arguments advanced, under a theory of mitigation, by the Licensee Designee. These arguments appeared to convey a lack of general capability to operate a licensed home. By way of example, the Licensee argued that Resident A was a very difficult person to care for, seemingly implying that this somehow ameliorated the atrocious physical abuse that Resident A suffered (Testimony of Licensee Designee Ajulufoh).

The Licensee Designee also appeared confused when Licensing Consultant Buchanan, responding to his cross-examination questioning, indicated that the facility had been on two prior provisional licenses.

The Licensee Designee indicated a belief that there had only been one past provisional license. This lack of knowledge regarding licensing history also goes to the issue of administrative capability.

Accordingly, based upon all of the above, Respondent has established by, a preponderance of the evidence, a violation of Rule 400.14201(2).

The violation of the above-referenced rule was both legally "willful noncompliance" and "substantial noncompliance" as those terms are defined by 2000 AACS, R 400.16001, *supra*. The Licensee knew or should have known that a profound and widespread failure to demonstrate administrative capability through various inactions such as the failure to maintain adequate records and conduct the required employee screenings was in violation of the rules. Thus, the established violation was "willful noncompliance" as defined above. Additionally, the severe and repeatedly exhibited failure to exhibit administrative capability in running a licensed home is inherently of such a significant nature, that it does meet the criteria of "substantial noncompliance" as defined above.

Count III – R 400.14204(3)(a)(b)(c)(d)(e)(f)&(g)

By this charge, Respondent asserts that the Licensee failed to provide in-service training or make training available through other sources to direct care staff. Respondent avers that the Licensee failed to ensure that direct care staff was competent before performing assigned tasks. This lack of training and competence was alleged to encompass areas such as reporting requirements, first aid, cardiopulmonary resuscitation, personal care-supervision-protection, resident rights, safety and fire prevention, and prevention and containment of communicable diseases. The hearing record in this matter does support a finding of a violation regarding R 400.14204(3)(a)(b)(c)(d)(e)(f)&(g).

Although Dominique Blade did not work for the Licensee for an extended period of time, the hearing record establishes that Ms. Blade was employed by the Licensee for a number of weeks during April/May 2014. Ms. Blade's hearing testimony credibly related that the Licensee did not provide any training to Ms. Blade before her employment commenced or during her period of employment.

Reviewing records submitted at the hearing, it is evident that the Licensee was the subject of Special Investigation #2011A0780038 conducted circa October 2011 (Exhibit H). Amongst other violations, the 2011 Special Investigation cited Licensee for a violation of R 400.14204(3)(d), as it was determined the Licensee had not trained staff on how to meet the needs of all residents prior to allowing the staff to care for residents (Exhibit H, at Page 5-6).

Also, the 2014 hearing established that the Licensee was the subject of Special Investigation #2012A0780025 conducted circa December 2012 (Exhibit J). Amongst other violations, the 2012 Special Investigation found a violation of R 400.14204(3)(d). The Special Investigation noted that the Licensee had not trained staff to handle all

residents' needs before allowing the staff to care for residents. Licensee submitted a CAP to resolve the investigation and accepted the terms of a first provisional license, which was effective from October 25, 2013 until April 24, 2014 (Exhibit J, at Page 9).

Based upon the above, Respondent has established by, a preponderance of the evidence, a violation of Rule 400.14204(3)(a)(b)(c)(d)(e)(f)&(g).

The violation of the above-referenced rule was both legally "willful noncompliance" and "substantial noncompliance" as those terms are defined by 2000 AACS, R 400.16001, *supra*. The Licensee knew or should have known that it had an obligation to provide training to staff and to ensure the competency of staff. Thus, the established violation was "willful noncompliance" as defined above.

Further, as indicated above, the hearing record indicates that the Licensee employed *at least* one staff member during April/May 2014 who had not received any training in the above-referenced areas. As also noted above, the Licensee had been cited twice previously for failure to adequately train staff. As such, the violation was one that was repetitive in nature. This Administrative Law Judge finds that this violation's consistent recurrence meets the criteria of "substantial noncompliance" as defined above.

Count IV – R 400.14208(1) (a)(b)(c)(d)(e)(f)(g)(h)&(i)

By this charge, Respondent asserts that the Licensee failed to maintain a record for each employee. R 400.14208(1) and its subparts provide that employee records should include the employee's name, address, telephone number, and social security number, Additionally, the employee file should indicate a license, certification or registration number if applicable for the employee. Employee files should also include a copy of the employee's driver license, verification of age requirement, experience, education, training and reference checks. The file should contain beginning and ending dates of employment, required medical information and verification that the employee has received personnel policies and the appropriate job description.

As noted in the analysis of Count II above, the Licensee was only able to produce two of the seven requested personnel files for review by Licensing Consultant Buchanan. There is strong indication that the Licensee Designee sought to retroactively cure some of the deficiencies (Exhibit A). Further, the hearing record relates that the Licensee Designee offered varied explanations for the missing records, and that these explanations lacked credibility.

Accordingly, based upon the above, Respondent has established by, a preponderance of the evidence, a violation of Rule 400.14208(1)(a)(b)(c)(d)(e)(f)(g)(h)&(i).

The violation of the above-referenced rule was both legally "willful noncompliance" and "substantial noncompliance" as those terms are defined by 2000 AACS, R 400.16001, *supra*. The Licensee knew or should have known of the need to maintain employee records. Thus, the established violation was "willful noncompliance" as defined above.

Additionally, the Licensee was not in minor violation of the rule due to a deficiency in a single employee's file. The hearing record establishes that five employees, current and former, were without **any** employee files. As previously noted, the Licensee Designee did not know the last name of one former employee (Rhonda) when asked by Licensing Consultant Buchanan during the course of the investigation. The repeated and complete violations of Rule 400.14208(1)(a)(b)(c)(d)(e)(f)(g)(h)&(i) meet the criteria of "substantial noncompliance" as defined above.

Count V – R 400.14208(2)

By this charge, Respondent asserts that the Licensee did not maintain employee records for a minimum of three years after a direct care staff member/employee's ending date of employment. The hearing record in this matter does support a finding of a violation regarding R 400.14208(2).

As already indicated in the above analysis, Licensing Consultant Buchanan stated that the Licensee could not provide employment records regarding at least two former employees of the Licensee, Jasmine Smith and "Rhonda" (Exhibit B at Page 10). Both employees were indicated to have worked during 2014 (Exhibit B at Page 10).

While the hearing record strongly suggests that it wasn't technically a matter of failing to maintain records, as the records probably were never properly assembled so as to exist and be maintained, the rule violation is clearly still present.

Accordingly, based upon the above, Respondent has established by, a preponderance of the evidence, a violation of Rule 400.14208(2).

The violation of the above-referenced rule was both legally "willful noncompliance" and "substantial noncompliance" as those terms are defined by 2000 AACS, R 400.16001, *supra*. The Licensee knew or should have known of the need to maintain employee records for a minimum of three years. Thus, the established violation was "willful noncompliance" as defined above. Further, the violation was noted regarding at least two former employees. These violations of the rule also meet the criteria of "substantial noncompliance" as defined above.

Count VI – R 400.14305(3)

By this charge, Respondent asserts that the Licensee failed to ensure that resident(s) were treated with dignity, with personal needs, including protection and safety being attended to at all times. The hearing record in this matter does support a finding of a violation regarding R 400.14305(3).

It was not disputed at the hearing that on May 12, 2014, Licensee's staff member, Kadia Konate, beat Resident A with a mop handle and an extension cord. Per the hearing testimony of Dominique Blade, another employee of the Licensee, the beating of

Resident A occurred over a period of hours. Ms. Blade passively made seventeen different videos of the abuse, and did not intercede to assist the Resident or seek help from law enforcement.

Resident A was struck on various parts of her body, including her head. Resident A suffered a broken left index finger, cuts to her left hand, and her left hand was swollen. Resident A also had scars and bruises on her back, arms, and legs.

The August 2014 hearing record indicates that Resident A had some scaring pre-dating the incident, and was described as someone who exhibited self-mutilation. However, Licensing Consultant Buchanan testified that she observed loop marks and linear marks on the back and on the arm of Resident A which were indicative of abuse. As astutely noted by the testimony of Licensing Consultant Buchanan, the loop marks present on Resident A's back could not rationally be understood to have come from self-mutilation (See Exhibit C).

Licensee Designee Ajulufoh did terminate Ms. Konate upon learning of the incident and viewing the videos. However, this ALJ finds that this remedial measure does not remove the severity of the R 400.14305(3) violation.

Additionally, the August 2014 hearing testimony of Licensee's former employee, Dominique Blade, indicates that Resident A was not the only one ill-treated, and that another female resident of the facility was also subject to inappropriate actions by staff. Ms. Blade also noted that she witnessed staff throw Resident A's food on the floor and watch Resident A pick it up and eat it. The witness clearly expressed a belief that the Licensee Designee was aware that this had occurred.

As a component of her investigation, Licensing Consultant Regina Buchanan interviewed the residents that were removed from the Licensee's facility during May 2014. One former resident stated that Licensee's staff was mean, but the resident would not or could not provide further information. Another resident identified two staff members that were averred to have sometimes hit her with their hands, a cord, or a belt when she would not listen. The resident stated that she suffered marks from these incidents, but no marks were observed (Exhibit B at Page 4).

The Licensee was cited on at least three prior occasions for violations of R 400.14305(3). Specifically, Special Investigation #2011A0780038 performed circa October 2011 noted a R 400.14305(3) violation as it was determined that multiple members of the Licensee's staff often yelled at the residents (Exhibit H, at Page 3).

Additionally, Special Investigation #2012A0780025, conducted circa December 2012, cited Licensee for a R 400.14305(3) violation as the Licensee did not seek medical treatment for a resident even though she was exhibiting bleeding from a self-inflicted injury for over an hour (Exhibit J, at Page 1-7).

As recently as September 2013, Special Investigation #2013A0122024 cited Licensee, in part, for a violation of R 400.14305(3) (Exhibit K). The Special investigation detailed that one of Licensee's staff members allowed a resident to enter the dining room for an interview while naked, and did not place an adult diaper on the resident as required when she dressed the resident. When residents continued to touch and grab at the staff member, the staff took a resident to the resident's bedroom, and shut the door (Exhibit K at Page 6-7).

Accordingly, based upon all of the above, Respondent has established by, a preponderance of the evidence, a violation of Rule 400.14305(3).

The violation of the above-referenced rule was both legally "willful noncompliance" and "substantial noncompliance" as those terms are defined by 2000 AACS, R 400.16001, *supra.* The Licensee knew of the obligation to respect the rights, dignity and physical safety of residents and the License is responsible for the actions of its employees/agents. Thus, the established violation was "willful noncompliance" as defined above.

Additionally, the Licensee was not in minor violation of the rule. A resident entrusted to the Licensee's care suffered profound physical abuse at the hand of one of Licensee's employees. As noted above, there were at least three prior violations of R 400.14305(3). The repeated, clear violations of R 400.14305(3) meet the criteria of "substantial noncompliance" as defined above.

Count VII - R 400.14308(2)(b)

By this charge, Respondent asserts that the Licensee and/or its staff failed to refrain from the use of any form of physical force other than physical restraint which is specifically defined in these rules.

Again, it was not disputed that on May 12, 2014, a staff member of Licensee's facility violently beat Resident A with a mop handle and extension cord. As such, it is readily evident that the Licensee is in willful and substantial violation of R 400.14308(2)(b).

The violation of the above-referenced rule was both legally "willful noncompliance" and "substantial noncompliance" as those terms are defined by 2000 AACS, R 400.16001, *supra.* The Licensee is responsible for the actions of its employees and it was undisputed at the hearing that an employee physically assaulted Resident A. Further, the hearing record establishes that the residence had a history of not respecting residents' rights. The established violation was "willful noncompliance" as defined above.

Additionally, the Licensee was not in minor violation of the rule. As noted with the analysis of Count VI, a resident entrusted to the Licensee's care suffered profound physical abuse at the hand of one of Licensee's employees. The violation does meet the criteria of "substantial noncompliance" as defined above.

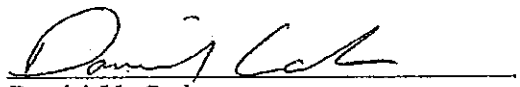
PROPOSED DECISION

The Administrative Law Judge proposes that the Director conclude that there were willful and substantial violations of MCL 400.734b(2), R 400.14201(2), R 400.14204(3)(a)(b)(c)(d)(e)(f)&(g), R 400.14208(1)(a)(b)(c)(d)(e)(f)(g)(h)(i) & (2), R 400.14305(3), and R 14308(2)(b).

EXCEPTIONS

If any party chooses to file Exceptions to this Proposal for Decision, the Exceptions must be filed within fourteen (14) days after the Proposal for Decision is issued and entered. If an opposing party chooses to file a Response to the Exceptions, it must be filed within fourteen (14) days after Exceptions are filed. All Exceptions and Responses to Exceptions must be served on all parties to the proceeding and filed with the:

Michigan Administrative Hearing System
Cadillac Place
3026 West Grand Blvd, Suite 2-700
Detroit, Michigan 48202



David M. Cohen
Administrative Law Judge

PROOF OF SERVICE

I hereby state, to the best of my knowledge, information and belief, that a copy of the foregoing document was served upon all parties and/or attorneys of record in this matter by Inter-Departmental mail to those parties employed by the State of Michigan and by UPS/Next Day Air, facsimile, and/or by mailing same to them via first class mail and/or certified mail, return receipt requested, at their respective addresses as disclosed below this 21st day of August, 2014.

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