GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 14, 2023

Roger Covill
North-Oakland Residential Services Inc
P. O. Box 216
Oxford, MI 48371

RE: License #: AS630339744
Investigation #: 2024A0993002
Edgar Home

Dear Mr. Covill:

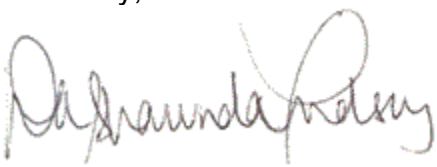
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste. 9-100
Detroit, MI 48202
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630339744
Investigation #:	2024A0993002
Complaint Receipt Date:	10/30/2023
Investigation Initiation Date:	10/31/2023
Report Due Date:	12/29/2023
Licensee Name:	North-Oakland Residential Services Inc
Licensee Address:	106 S. Washington Oxford, MI 48371
Licensee Telephone #:	(248) 969-2392
Administrator:	Roger Covill
Licensee Designee:	Roger Covill
Name of Facility:	Edgar Home
Facility Address:	8740 Andersonville Road Clarkston, MI 48347
Facility Telephone #:	(248) 625-4273
Original Issuance Date:	06/13/2013
License Status:	REGULAR
Effective Date:	03/13/2022
Expiration Date:	03/12/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was dropped off at the wrong building by staff Demechia Sanders.	Yes

III. METHODOLOGY

10/30/2023	Special Investigation Intake 2024A0993002
10/30/2023	Referral - Recipient Rights Received allegations from recipient rights advocate Sarah Rupkus
10/31/2023	Special Investigation Initiated - Telephone Telephone call made to recipient rights advocate Sarah Rupkus. Left a message.
10/31/2023	Contact - Telephone call made Telephone call made to home manager Tiffany Cooper
10/31/2023	Contact - Telephone call made Telephone call made to Life Focus Center staff Taevin Johnson
11/01/2023	Contact - Telephone call made Telephone call made to recipient rights advocate Sarah Rupkus. Left a message.
11/01/2023	Contact - Face to Face Interviewed Life Focus Center program manager Sarah Lueck
11/01/2023	Inspection Completed On-site Conducted an unannounced onsite investigation
11/01/2023	Contact - Telephone call made Telephone call made to staff Demechia Sanders
11/01/2023	Contact - Telephone call made Telephone call made to EasterSeals receptionist Denise Kaminiski. Left a message.
11/01/2023	Contact - Telephone call made Telephone call made to EasterSeals medical assistant Estefani Ovall

11/01/2023	Contact - Telephone call made Telephone call made to EasterSeals manager Imelda Ransby
11/06/2023	Contact - Telephone call made Telephone call made to recipient rights advocate Sarah Rupkus
11/07/2023	Contact - Telephone call made Telephone call made to EasterSeals receptionist Denise Kaminiski
11/07/2023	Contact - Telephone call made Telephone call made to EasterSeals manager Imelda Ransby
11/07/2023	APS Referral Forwarded allegations to adult protective services (APS)
11/07/2023	Exit Conference I held an exit conference with license designee Roger Covill

ALLEGATION:

Resident A was dropped off at the wrong building by staff Demechia Sanders.

INVESTIGATION:

On 10/30/2023, I received allegations from recipient rights advocate Sarah Rupkus.

On 10/31/2023, I conducted a telephone interview with home manager Tiffany Cooper. Ms. Cooper confirmed staff Demechia Sanders dropped Resident A off at EasterSeals as opposed to the Life Focus Center. Ms. Cooper stated she did not have additional details about the incident as she was not working that day.

On 10/31/2023, I conducted a telephone interview with Life Focus Center staff Taevin Johnosn. Mr. Johnson confirmed Resident A was left outside of EasterSeals. EasterSeals is in the same parking lot as the Life Focus Center. Mr. Johnson went over to get Resident A and transport him to the program. Mr. Johnson did not know how long Resident A was outside.

On 11/01/2023, I conducted an unannounced visit to the Life Focus Center. I interviewed Life Focus Center program manager Sarah Lueck. Ms. Lueck confirmed Resident A was left outside of EasterSeals as opposed to being transported to the Life

Focus Center. Ms. Lueck stated she received a telephone call at 10:52am on 10/17/2023 from staff at EasterSeals. They informed her Resident A was in a motorized wheelchair, and he was left outside of their door. Ms. Lueck sent Life Focus Center staff Taevin Johnson over to get Resident A and transport him to the program. Ms. Lueck did not know how long Resident A was outside.

At the time of my visit to the Life Focus Center, I was unable to interview Resident A. He was not in attendance that day.

On 11/01/2023, I conducted an unannounced onsite investigation. I interviewed staff Roshawnda Williams. Ms. Williams confirmed Ms. Sanders dropped Resident A off at EasterSeals as opposed to the Life Focus Center. The incident occurred on 10/17/2023. Ms. Williams suggested I talk with Ms. Sanders for additional information.

During the onsite investigation, I attempted to interview Resident A with no success. Resident A has limited cognitive abilities.

On 11/01/2023, I conducted a telephone interview with staff Demechia Sanders. Ms. Sanders could not recall the date of the incident. The manager left instructions in the communications book regarding transport for Resident A. She grabbed the highway instructions but left the other instructions. The building number where she was supposed to drop off Resident A, was not on the instructions that she had in her possession. The GPS led her to the middle of a street. She contacted staff Tina McFadden to ask her to look in the book for the building number. Ms. Fadden informed her she did not see it. Ms. Sanders contacted staff Roshawnda Williams and asked for directions as Ms. Williams had transported Resident A to his program before. Ms. Williams provided her directions, but Ms. Sanders somehow went to the wrong building. Ms. Sanders stated she walked Resident A into the building, and there was a lady in the building who let him in. Ms. Sanders did not know she took him to the wrong building. That was her first day doing transport.

On 11/01/2023, I conducted a telephone interview with EasterSeals medical assistant Estefani Ovall. She a client came in the building and stated there was a patient dropped off outside. The patient’s communication was limited. When asked if he had an appointment, he stated “workshop”. Another client stated they observed someone on the side of the building who dropped the patient off and then drove off. Staff at EasterSeals went through Resident A’s belongings and observed his name. They contacted the Life Focus Cetner and learned he was supposed to be there. Someone from the Life Focus Center came to EasterSeals and took him to the program. Ms. Ovall did not know how long Resident A was outside.

On 11/07/2023, I conducted a telephone interview with EasterSeals receptionist Denise Kaminiski. Ms. Kaminiski stated she was at the front desk. A client came in and stated

there was a gentleman outside in a wheelchair. Ms. Kaminiski informed Ms. Ovall and Ms. Ransby about what she was told. They went through Resident A's belongings and observed his name. They contacted the Life Focus Cetner and learned he was supposed to be there. Someone from the Life Focus Center came to EasterSeals and took him to the program. Ms. Ovall did not know how long Resident A was outside.

On 11/07/2023, I conducted a telephone interview with EasterSeals manager Imelda Ransby. Ms. Ransby stated she was informed there was an elderly male in a wheelchair left outside, and he was nonverbal. They went through Resident A's belongings and observed his name. They contacted the Life Focus Center and learned he was supposed to be there. Someone from the Life Focus Center came to EasterSeals and took him to the program. Ms. Ransby did not know how long Resident A was outside.

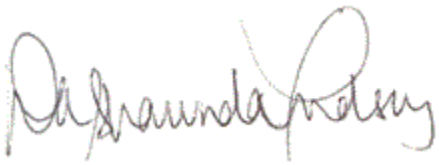
On 11/06/2023, I conducted a telephone interview with recipient rights advocate Sarah Rupkus. Ms. Rupkus stated her investigation was still pending.

On 11/07/2023, I conducted an exit conference with licensee designee Roger Covill. I informed him of the findings. He agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(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.
ANALYSIS:	Ms. Sanders transported Resident A to EasterSeals as opposed to the Life Focus Center. Staff at EasterSeals had to go through Resident A's belongings to find out his name. They contacted the Life Focus Cetner and learned he was supposed to be there. Someone from the Life Focus Center came to EasterSeals and took him to the program. It is unknown how long Resident A was outside.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED.** **Reference SIR 2023A0605027 date 05/11/2023.** **CAP date 05/25/2023.**

IV. RECOMMENDATION

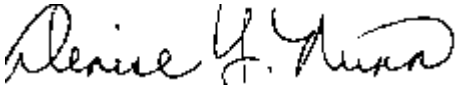
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



11/14/2023

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



11/14/2023

Denise Y. Nunn — Date
Area Manager