GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 22, 2025

Jasmine Boss
JARC
Suite 100
6735 Telegraph Rd
Bloomfield Hills, MI 48301

RE: License #: AS630012603
Investigation #: 2025A0605011
Milan

Dear Jasmine Boss:

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) 972-9136.

Sincerely,

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd.
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012603
Investigation #:	2025A0605011
Complaint Receipt Date:	04/30/2025
Investigation Initiation Date:	04/30/2025
Report Due Date:	06/29/2025
Licensee Name:	JARC
Licensee Address:	Suite 100 6735 Telegraph Rd Bloomfield Hills, MI 48301
Licensee Telephone #:	(248) 940-9617
Administrator:	Sonia McKowen
Licensee Designee:	Jasmine Boss
Name of Facility:	Milan
Facility Address:	24245 Broadview Farmington Hills, MI 48336
Facility Telephone #:	(248) 477-7211
Original Issuance Date:	08/28/1990
License Status:	REGULAR
Effective Date:	07/07/2023
Expiration Date:	07/06/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Direct care staff (DCS) Mary Burns fell asleep when Resident A fell out of bed.	Yes

III. METHODOLOGY

04/30/2025	Special Investigation Intake 2025A0605011
04/30/2025	APS Referral Adult Protective Services (APS) made referral
04/30/2025	Special Investigation Initiated - Telephone Discussed allegations with Oakland County Office of Recipient Rights (ORR) Rachel Moore
05/01/2025	Contact - Telephone call made Discussed allegations with direct care staff (DCS)
05/01/2025	Contact - Document Received Email from ORR Rachel Moore
05/05/2025	Inspection Completed On-site Conducted announced on-site investigation
05/05/2025	Contact - Document Received Emails from Chief Administrator Officer Shula Kantrowitz
05/05/2025	Contact - Face to Face Interviewed Resident A at West Bloomfield SKLD
05/06/2025	Contact - Telephone call made Discussed allegations with APS
05/06/2025	Exit Conference Telephone call conducting exit conference with licensee designee Jasmine Boss

ALLEGATION:

Direct care staff (DCS) Mary Burns fell asleep when Resident A fell out of bed.

INVESTIGATION:

On 04/30/2025, intake #205375 was referred to by Adult Protective Services (APS) regarding DCS Mary Burns falling asleep during her shift and Resident A fell, resulting in a left hip fracture.

On 04/30/2025, I contacted via telephone Oakland County Office of Recipient Rights (ORR) Rachel Moore regarding the allegations. Ms. Moore is investigating these allegations. Resident A is a "sundowner," frequently awake and up out of bed at night. DCS Mary Burns was working the midnight shift with another staff on 04/26/2025 when Ms. Burns was sleeping during her shift and did not supervise Resident A, who fell, which resulted in a fractured hip. Resident A was hospitalized at Corewell Health and then discharged to West Bloomfield SKLD rehab facility. Ms. Burns completed an incident report (IR) however, Ms. Burns did not document on the IR that Resident A had fallen. The HM completed another IR for that incident indicating that Resident A fell. Ms. Burns' employment was terminated. According to Resident A's individual plan of service (IPOS)/crisis plan, Resident A requires a 30-minute well-being check during sleeping hours, which Ms. Burns did not conduct.

On 05/01/2025, I received an email from ORR worker Rachel Moore with the HM and DCS contact information.

On 05/01/2025, I contacted HM Michelle Smith via telephone regarding the allegations. Resident A moved in on 04/01/2025. She can ambulate but must use a walker and is a standby assist. Resident A is a sundowner; sleeps during the day and is up at night. On 04/26/2025, around 6AM, the HM received a telephone call from DCS Mary Burns. The HM was off on this day when she received a call from Ms. Burns. Ms. Burns told the HM that Resident A was in bed and could not get up out of bed. The HM directed Resident A to call Jasmine Boss who was the on-call supervisor that day. The HM then received a call from Ms. Boss advising her that Ms. Burns told Ms. Boss that Ms. Burns first said that Resident A had "trouble walking," but then reverted to saying, Resident A had "trouble standing." The HM called Ms. Burns who advised her that Resident A was still complaining of leg pain and that the morning shift staff, Amelia Garmon and Natasha Colbert had arrived. The HM spoke with Ms. Garmon advising her to call an ambulance as Resident A needed to go to the hospital. While at the hospital, Ms. Garmon called the HM, who was on the speaker phone and was informed by the emergency room (ER) doctor that Resident A appears to have had a recent fall resulting in a broken left hip. The HM heard the doctor asking Resident A what happened and Resident A stated, "I fell out of bed." The HM called Ms. Burns who confirmed what Resident A said and then Ms. Burns told the HM, "I was tired. I was asleep." Resident A is a fall risk; therefore,

staff are aware there is a 15-minute well-being check during sleep hours. Resident A has been transferred to West Bloomfield SKLD rehab facility.

On 05/01/2025, I interviewed DCS Amelia Garman via telephone regarding the allegations. Ms. Garman has worked for JARC since 08/2024. She works both morning and afternoon shifts. On 04/26/2025, she began her shift around 6:51AM to relieve the midnight shift. DCS Mary Burns and DCS Star Hogan were working the midnight shift. Ms. Burns was standing in the doorway on the phone with the HM when Ms. Burns told the HM, “Amelia just walked in.” Ms. Garman got on the phone with the HM who advised Ms. Garman that she needed to call an ambulance for Resident A as Resident A had been complaining about leg pain since 3:30AM. After Ms. Garman got off the phone, she went into Resident A’s bedroom and found Resident A sitting on her 4-wheeled seated walker. Resident A told Ms. Garman, “I think my leg is sprained. It hurts.” Ms. Burns was present and told Ms. Garman, “Yes, she was complaining of her leg hurting and couldn’t get up.” The ambulance arrived and Resident A told EMS, “my leg was hurting for a while.” Resident A was transported to Corwell Health Hospital and Ms. Garman followed. At the ER, an X-ray was taken of Resident A’s leg, and it was discovered that she had a broken left hip. The ER doctor spoke with Resident A about what happened. Resident A said, “I fell in my bedroom and staff helped me up.” Ms. Garman stated that Resident A has dementia and is not good with names, but she was clear when she said she had fallen, and staff helped her up. Ms. Garman stated that Ms. Burns never reported to Ms. Garman that Resident A had fallen.

There are two DCS during the midnight shift and Resident A’s IPOS says 30-minute well-being checks during sleeping hours but because of how frequently Resident A gets up at night, she is a 20-minute well-being check during sleeping hours. There is a safety assessment log that must be completed by staff every 20 minutes stating if Resident A was asleep or awake. Ms. Garman has worked with Ms. Burns and has never observed her sleeping during her shift. Ms. Garman stated she did not like that Ms. Burns waited until the morning shift arrived before getting medical treatment for Resident A.

On 05/01/2025, I interviewed DCS Natasha Colbert via telephone regarding the allegations. Ms. Colbert worked for JARC for five years. She too works the morning and afternoon shifts. On 04/26/2025, Ms. Colbert arrived at her shift at 7:01AM and was told by DCS Mary Burns that Resident A refused to get up to sit on the walker. The HM was on the phone and advised Ms. Colbert and DCS Amelia Garman to call an ambulance because Resident A was complaining of leg pain. Ms. Colbert went to see Resident A in her bedroom and Resident A stated, “I think I sprained my ankle.” Resident A said, “she fell, and staff got her up.” Ms. Colbert tried assisting Resident A out of the walker and into bed, but Resident A refused. Resident A kept saying “ouch.” The ambulance arrived and transported Resident A to the hospital. At the hospital, it was reported that Resident A had a broken hip. Ms. Burns never informed Ms. Colbert that Resident A fell. Resident A is a fall risk and staff must assist standby and check on Resident A every 15 minutes during sleeping hours and document on the safety assessment if Resident A is sleeping or awake. Ms. Colbert has worked with Ms. Burns and during their shifts, she has never observed Ms. Burns sleeping.

On 05/01/2025, I interviewed DCS Star Hogan via telephone regarding the allegations. Ms. Hogan has been working for JARC for one year. She works the midnight shift. On 04/26/2025, she worked with DCS Mary Burns. Resident A was awake and began walking back and forth around 1:30-2AM. Although Ms. Burns was responsible for Resident A, when Ms. Hogan observed Resident A walking back and forth, she helped Resident A to bed around 2AM. Ms. Burns was in the front room during this time according to Ms. Hogan. Ms. Hogan did not know what Ms. Burns was doing in the front room. She stated, “around a certain time, Mary and I don’t sit in the same room. I sit in the living room next to the kitchen and Mary sits in the from room around 12AM-1AM. I don’t know if she was sleeping or not.” Ms. Hogan denied that after she put Resident A to bed, that Resident A woke up again and began walking around. She did not hear Resident A again until around 4:50AM when Ms. Hogan was helping Residents D, E, and F to be ready for the morning. She heard Resident A speaking with Ms. Burns. She does not know what they were talking about. Resident A is a fall risk. She frequently gets up at night and requires staff to monitor her closely because sometimes she does not use her walker. She is a 15-minute well-being check during sleeping hours. Staff must document if Resident A is asleep or awake. She is unsure if Ms. Burns conducted these checks. Ms. Hogan stated, “I don’t know if Resident A fell. I never saw her on the floor, and I never helped Mary pick up Resident A off the floor. Ms. Burns never told Ms. Hogan that Resident A fell.

That morning, Resident A began complaining of leg pain and could not move. Ms. Burns called the HM who advised that Resident A needed to go to the hospital. The morning shift arrived, Amelia Garman and Natasha Colbert took over and both Ms. Hogan and Ms. Burns left the shift.

On 05/01/2025, I contacted via telephone direct care staff (DCS) Mary Burns regarding the allegations. Ms. Burns had been working for this corporation for three years before she was terminated on 04/28/2025. Ms. Burns was working the midnight shift on 04/25/2025-04/26/2025 from 11PM-7AM with DCS Star Hogan. Ms. Burns arrived at 11PM and stated she observed Mary Roy (Resident A) awake walking back and forth. Resident A was awake until Ms. Burns put her into bed around 3:30AM. On a normal day, Ms. Burns stated she would sit on Resident A’s seated 4-wheeled walker in the bedroom because Resident A gets up during the night, but on this night, Ms. Burns stated she was tired, so she went to the front room. She was in the front room until 5:45AM when she got up, went to check on Resident A and found Resident A on the floor. Ms. Burns stated she and Ms. Hogan picked Resident A up off the floor and put her on her walker seat and wheeled her into the bathroom. Resident A was unable to get up off the wheelchair to get onto the toilet and then began complaining of pain. Ms. Burns then called the home manager (HM) Michelle Smith at 6AM. The HM advised Ms. Burns to advise her that Resident A was complaining about pain and could not get up. Ms. Burns never informed the HM that Resident A fell. The morning shift staff, Amelia Garmen and Natasha Colbert arrived and called the ambulance as directed by the HM. The HM advised Ms. Burns to complete an incident report, which she did. Ms. Burns stated she waited for the ambulance and then once they arrived, she left.

Later, the HM called Ms. Burns and informed her that the emergency room doctor stated that Resident A's hip was broken. Ms. Burns denied being asleep in the front room and stated she was "just sitting," in the front room. There are six residents at this group home. Each member of staff is responsible for three residents. Ms. Burns was responsible for Resident A. Due to Resident A getting up frequently during the night, she had a 15-minute wellbeing check. Staff including Ms. Burns are responsible for completing a sleep assessment log indicating if Resident A is asleep or awake during the 15-minute checks. Ms. Burns stated on this night; she never conducted any 15-minute checks of Resident A between 3:30AM-5:45AM.

On 05/02/2025, I received via email from ORR worker Rachel Moore Resident A's IPOS/Crisis plan completed on 03/01/2025 by Easterseals/Macomb-Oakland Regional Center (MORC). According to the crisis plan regarding sleeping, "A caregiver is present while Mary is sleeping, and they check every 30 minutes."

Ms. Burns never informed the morning staff that arrived that Resident A had fallen. She stated, "she (Resident A) was assigned to me so I'm taking this, and I'm not changing the incident report like Michelle wanted me too." I asked Ms. Burns to elaborate. Ms. Burns stated that the HM asked her to change the time from 5:45AM to 3:45AM because Resident A may have fallen at 3:45 AM and not at 5:45AM. Ms. Burns does not know when Resident A fell but stated she believed she fell at 5:45AM. Ms. Burns then acknowledged that she does not know when Resident A fell because from 3:30AM-5:45AM she never conducted any well-being checks on Resident A.

On 05/05/2025, I conducted an on-site investigation at this group home. The HM, Michelle Smith, licensee designee Jasmine Boss, Chief Administrator Officer Shula Kantrowitz and DCS Amelia Garman were present. Also present were Residents B, D, and F. Residents C and E were at the workshop. Resident A was still at West Bloomfield SKLD rehab facility. On 04/26/2025, Ms. Boss received a telephone call at 6:34AM from DCS Mary Burns who informed Ms. Boss that "Resident A was having trouble walking." Then Ms. Burns reverted to say, "Resident A is having trouble standing." Ms. Boss stated, "I asked Ms. Burns if Resident A fell, and Ms. Burns said No. Ms. Boss was confused so Ms. Boss requested to speak with Resident A. Ms. Boss asked Resident A, "Are you in pain?" Resident A said, "Yes." Ms. Boss asked Resident A, "Where?" Resident A stated, "my leg." Ms. Boss then spoke to Ms. Burns and advised Ms. Burns to call 911 because Resident A was in pain and could not stand. Ms. Boss immediately contacted the HM and advised her of what Ms. Burns and Resident A reported. The HM called the group home and spoke with the morning shift Amelia Garman and Natasha Colbert advising them to call an ambulance as Resident A needed to go to the hospital.

The HM advised Ms. Burns to complete an IR which Ms. Burns did, but the IR did not state a time, nor did it state that Resident A had a fall. When Resident A was at the hospital and the HM learned that Resident A did have a fall that resulted in a broken left hip, the HM called Ms. Burns. The HM arrived the next day and reviewed the IR. The IR

did not state that Resident A had a fall, so the HM contacted Ms. Burns to inform her about Resident A's broken hip. The HM told Ms. Burns that according to Resident A, she fell. Ms. Burns confirmed that Resident A did fall and was found on the floor and both she and Ms. Hogan picked her up off the floor. Ms. Burns also stated, "I was tired and fell asleep." The HM completed another IR to reflect that on 04/26/2025, during the midnight shift, Resident A fell. Ms. Burns' employment was terminated on 04/28/2025.

Ms. Kantrowitz emailed me Resident A's safety assessment checks, April 2025 staff schedule, IR dated 04/26/2025, DCS Mary Burns' termination letter and employee conduct policy regarding. Ms. Boss will be conducting a staff meeting to discuss safety precautions for Resident A and all the residents regarding reporting, protocols that staff must follow pertaining to unwitnessed falls and when calling 911 prior to calling management. In addition, the HM will post these protocols in the home for staff to follow.

The HM is looking into getting a gait belt for Resident A when she is discharged from the rehab facility. Ms. Boss will be completing an in-service with all staff regarding employee conduct policy of no staff should be sleeping during their shift. In addition, DCS Star Hogan will be receiving an in-service regarding not reporting that DCS Mary Burns was sleeping, nor did she report that Resident A was on the floor and both she and Ms. Burns picked her up.

> **Note**: I reviewed the IR dated 04/26/2025, completed by Ms. Burns. The IR did not indicate that Resident A was found on the floor, nor did it state that Resident A had a fall. I reviewed the IR dated 04/26/2025, completed by the HM. The IR stated that Resident A stated she fell, and staff assisted her up into bed.
>
> I also reviewed Resident A's safety assessment. According to the safety assessment on 04/26/2025, DCS Mary Burns logged that Resident A was asleep from 3:00AM-4:45AM; however, Ms. Burns told me on 05/01/2025, that she never conducted her 15-minute well-being checks of Resident A from 3:00AM-5:45AM when she found Resident A on the floor.
>
> I reviewed DCS Mary Burns' termination letter dated 04/28/2025 due to "gross misconduct of falsifying the incident report submitted to ORR."
>
> I reviewed JARC's employee conduct policy that clearly states that "any employee who becomes aware of an incident of behavior towards another individual which may violate this policy, whether by witnessing the incident or being told of it, must report it to the human resource department immediately and that JARC encourages everyone to come forward to report a problem, policy violation, or unlawful activity without fear of any repercussions."

I was unable to interview Residents B, D, and F as they are non-verbal. I observed them in the home, and they appeared to be well with good hygiene. No concerns were noted.

On 05/05/2025, I conducted a face-to-face visit with Resident A at West Bloomfield SKLD rehab facility. Resident A was in her room sitting in the wheelchair. I interviewed Resident A who stated, “I fell,” but was unable to provide any further details due to her diagnosis of dementia. I concluded the interview.

On 05/06/2025, I contacted APS worker Carmen Smith. Ms. Smith is investigating these allegations. I advised Ms. Smith that based on my findings, I will be substantiating these allegations. She acknowledged.

On 05/06/2025, I conducted the exit conference with licensee designee Jasmine Boss with my findings. Ms. Boss acknowledged the findings, had no questions and will be submitting a corrective action plan to address these violations.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on my investigation, there was insufficient DCS on duty at all times on 04/26/2025 for the supervision and protection of Resident A. DCS Mary Burns and DCS Star Hogan were both working the midnight shift; 11PM-7AM. Ms. Burns was responsible for Resident A; however, after Ms. Burns put Resident A to bed at 3:00AM, Ms. Burns went to the front room because she was “tired,” and then “fell asleep.” Resident A fell, which resulted in a broken left hip. Ms. Burns’ employment was terminated on 04/28/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Based on my review of Resident A's IPOS/crisis plan completed on 03/01/2025 by Easterseals/Macomb-Oakland Regional Center (MORC), Resident A's plan was not followed by DCS Mary Burns. According to the crisis plan regarding sleeping, "A caregiver is present while Mary is sleeping, and they check every 30 minutes." However, due to Resident A being a fall risk, the HM implemented well-being checks every 15-minutes, but Ms. Burns never conducted these checks as she was sleeping from 3AM-5:45AM. This resulted in Resident A falling and breaking her left hip.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Based on my investigation and information gathered, Resident A protection and safety were not attended to at all times on 04/26/2025 by DCS Mary Burns. Resident A was assigned to Ms. Burns during the midnight shift. Resident A is a sundowner and frequently is awake during sleeping hours. Resident A was awake and walking back and forth as observed by Ms. Burns. Ms. Burns put Resident A into bed at 3:00AM and instead of conducting her 15-minute well-being checks throughout the night, Ms. Burns went to the front room and fell asleep. Ms. Burns slept until 5:45AM when she found Resident A on the floor. Resident A had fallen which resulted in a broken left hip.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference special investigation report (SIR) #2024A0612029 dated 06/24/2024, CAP dated 07/17/2024**

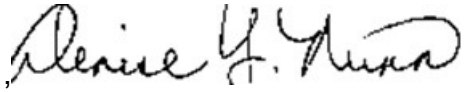
IV. RECOMMENDATION

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

05/08/2025

Frodet Dawisha — Date
Licensing Consultant

Approved By:



05/22/2025

Denise Y. Nunn — Date
Area Manager