GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 11, 2025

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

RE: License #: AS630012339
Investigation #: 2025A0611025
Medow

Dear Ms. 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,

Sheena Worthy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012339
Investigation #:	2025A0611025
Complaint Receipt Date:	07/23/2025
Investigation Initiation Date:	07/24/2025
Report Due Date:	09/21/2025
Licensee Name:	JARC
Licensee Address:	Suite 100 6735 Telegraph Rd Bloomfield Hills, MI 48301
Licensee Telephone #:	(248) 940-9617
Administrator:	Jasmine Boss
Licensee Designee:	Jasmine Boss
Name of Facility:	Medow
Facility Address:	25020 Roycourt Huntington Woods, MI 48070
Facility Telephone #:	(248) 547-6029
Original Issuance Date:	06/01/1982
License Status:	REGULAR
Effective Date:	07/31/2025
Expiration Date:	07/30/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 7/4/25, staff found Resident C on the floor after an unwitnessed fall but failed to follow her crisis plan by not calling 911 or seeking medical care, reporting the incident the next day instead.	Yes

III. METHODOLOGY

07/23/2025	Special Investigation Intake 2025A0611025
07/23/2025	APS Referral The assigned Adult Protective Services (APS) worker is Brad Edwards.
07/24/2025	Special Investigation Initiated – Letter I emailed the Adult Protective Services Worker Brad Edwards regarding this investigation.
08/01/2025	Inspection Completed On-site I completed an unannounced onsite. I interviewed Resident R and Resident S. I also interviewed the CEO of the corporation Shaindle Braunestein. I received a copy of Resident C crisis plan, and incident report.
08/05/2025	Contact - Telephone call made I left a voice message for the licensee designee Jasmine Boss requesting a call back.
08/05/2025	Contact - Telephone call made I made a telephone call to Resident C's guardian. The allegations were discussed.
08/05/2025	Contact - Telephone call received I received a return phone call from the licensee designee Jasmine Boss. Ms. Boss agreed to send me the discharged paperwork from Resident C's urgent care visit.

08/05/2025	Contact - Telephone call made I made a telephone call to staff member Marketta Hillery. The allegations were discussed.
08/05/2025	Contact - Telephone call made I left a voice message for MORC Support Coordinator Ashley Perdue requesting a call back.
08/05/2025	Contact - Telephone call made I made a telephone call to the home manager Mariah Edwards. The allegations were discussed.
08/05/2025	Contact - Telephone call made I left a voice message for the district manager Marissa Mason requesting a call back.
08/05/2025	Contact – Document Received I received a copy of Resident C's discharge paperwork.
08/06/2025	Exit Conference I completed an exit conference with the licensee designee Jasmine Boss via telephone.
08/07/2025	Contact – Document Received I received an email from the Adult Protective Services worker Brad Edwards stating he will be substantiating his investigation.

ALLEGATION:

On 7/4/25, staff found Resident C on the floor after an unwitnessed fall but failed to follow her crisis plan by not calling 911 or seeking medical care, reporting the incident the next day instead.

INVESTIGATION:

On 07/23/25, complaint was received and assigned for investigation alleging that Resident C is bedbound. She has few verbalizations and is difficult to understand. Resident C has a crisis plan in place that states if she suffers any unwitnessed falls, staff are required to call 911 and seek medical attention. On 7/4/25, the staff member on shift, Marketta Hillery, went into Resident C room and found her lying on the floor. Resident C head was underneath the bed, and her body was on the floor. Resident C can move her body somewhat and it is believed she rolled out of bed. It is unknown how long Resident C was on the floor before being found. It is unknown what type of flooring Resident C landed on. Marketta looked Resident C over and did not see any visible injuries, so she put her back in bed and did not call 911 or seek any medical attention

for her. The next morning, Marketta reported the incident to her supervisor. The supervisor informed her manager. They questioned why Marketta did not call 911. Management was advised Marketta did not call 911 because she did not observe any injuries to Resident C. Resident C was never taken to the ER after this incident for any medical care. It is reported Resident C is doing fine and not presenting with any concerning symptoms following this fall or showing any sign of injury.

On 08/1/025, I completed an unannounced onsite. I interviewed Resident R and Resident S. I also interviewed the CEO of the corporation Shaindle Braunestein. I received a copy of Resident C crisis plan, and incident report.

On 08/01/25, I interviewed Resident R in her bedroom. Resident R does not know how long she has lived in the AFC group home. Resident R stated it is quiet in the AFC group home and she likes the staff as they treat her well. Regarding the allegations, Resident R stated she knows staff member Marketta. Marketta works the midnight shift. Resident R stated Marketta is a good staff member. Resident R stated if she needs help Marketta will help her. Resident R denies Marketta denying helping her or getting her anything she needs. Resident R has not been sick or needed any medical attention since residing at the AFC group home.

Resident R stated Resident C cannot walk. Resident R has never seen Resident C get hurt or fall down. Resident R denies ever seeing any marks or bruises on Resident C. The staff treat Resident C well.

On 08/01/25, I interviewed Resident S. Resident S stated she moved into the AFC group home recently. Resident S stated living in the AFC group home is perfect because she has her own computer. Resident S likes the staff and they treat her and all the residents well. Resident S stated she does not know staff member Marketta. Resident S denies seeing any staff member hurting Resident C. Resident S has never seen Resident C fall to the floor.

On 08/01/25, I interviewed the CEO of the corporation Shaindle Braunestein. Ms. Braunestein stated Resident C is currently at workshop. Resident C has Cerebral Palsey and she can stand with staff assistance. Resident C is either in her wheelchair or in bed. Ms. Braunestein was not present on the day in question but she was informed about what happened. It is Ms. Braunestein understanding that Resident C's parents were visiting her in her bedroom during bedtime. Ms. Braunestein stated she does not know what time Resident C's parents left and/or when Resident C fell out of bed thereafter. Ms. Braunestein stated Resident C's mother does not want Resident C to sleep in a hospital bed or have any bed rails. Resident C's mother did agree to put a foam mat on the floor next to Resident C's bed. Ms. Braunestein stated this is the first time Resident C has fallen out of bed.

Ms. Braunestein stated the staff are instructed to call 911 whenever any resident falls out of bed. The staff are also instructed to not move a resident after they fall. There is a sign posted in the staff office with these instructions. I observed this sign. Ms.

Braunestein stated staff member Marketta Hillery and the home manager Mariah Edwards were re-trained regarding emergency protocol as neither one of them called 911 when Resident C fell out of bed. Ms. Edwards did contact Resident C's mother when the incident happened. Ms. Braunestein stated Ms. Hillery did not call 911 when she found Resident C on the floor because she thought if there were no injuries and the resident appeared fine then there was no need to call 911. Ms. Hilery also thought it was ok that she didn't call 911 because when Resident C's mother was informed she was ok with not calling 911 as well. Ms. Braunestein stated Resident C went to workshop the following morning after the incident. Ms. Braunestein stated Resident C was seen by a doctor shortly after her fall as she went to an urgent care for pulling out her G-tube. I observed Resident C's bedroom and measured the distance between her bed and the floor which was 1' foot and 8'' inches.

On 08/01/25, I received a copy of Resident C's crisis plan dated 05/08/25 and incident report. According to the crisis plan, if there is a fall seek medical attention for the following:

- If a fall is unwitnessed (i.e. person is found on the floor)
- If there is bruising/pain/swelling/or bleeding that is not controlled with pressure
- If there is a suspected head injury
- If the person has a diagnosis of Osteoporosis or is elderly and high risk for injuries
- If they are on anticoagulant therapy (i.e. Coumadin)

According to the incident report dated 07/03/25, the incident report was completed by staff member Marketta Hillery. The incident report indicates that Resident C's mother put Resident C to bed during her visit. The staff completed a bed check and found Resident C on the floor. Resident C did not have any marks or bruises. The staff checked on Resident C frequently throughout the night. The incident report indicates that the incident happened at 2:18 am.

On 08/05/25, I made a telephone call to Resident C's guardian. Regarding the allegations, the guardian stated she visited Resident C the night before the incident happened. When the guardian left the AFC group home, Resident C was in bed properly, clean, and watching a movie. Resident C does not roll over in bed nor has she ever fallen out of bed. The guardian thinks the resident may have been trying to reach for the remote control which was on the table next to her bed. The guardian stated she was informed about the incident the next morning by the home manager Mariah Edwards. Ms. Edwards informed her that the staff member did not follow procedure by calling 911 therefore; she will have to write a report.

The guardian stated Resident C has lived at the AFC group home for two months and the staff have done a wonderful job taking care of her. The level of care is great and the guardian does not have any concerns pertaining to the staff or the home. The guardian stated she recently obtained a prescription to get an alarm pad to place on the floor near Resident C's bed as a safety precaution.

On 08/05/25, I made a telephone call to staff member Marketta Hillery. Regarding the allegations, Ms. Hillery started her shift on the day in question at 11:00pm. Ms. Hillery stated Resident C was asleep when she started working. Ms. Hillery completed bed checks every two hours with the exception of Resident R who she checked on every 30 minutes because she had a seizure earlier that day. Ms. Hillery stated around 3:00am she was in the living room when she heard a whimpering sound. Ms. Hillery went into Resident C's bedroom and found Resident C on the floor. Resident C's head and upper body were underneath the bed. Resident C was on her back. Ms. Hillery stated it was an instant reaction to pick Resident C up and place her back in bed. Ms. Hillery stated when she picked Resident C up, Resident C started smiling and appeared happy. Ms. Hillery stated she did not call 911 because Resident C appeared fine as she did not have any injuries, marks or bruises. Ms. Hillery is aware now that she should have called 911. Ms. Hillery stated there is an area rug on the floor next to Resident C's bed.

On 08/05/25, I made a telephone call to the home manager Mariah Edwards. Regarding the allegations, Ms. Edwards stated she arrived to the AFC group home around 7:00am on the day in question. Ms. Hillery debrief Ms. Edwards about her shift and informed her about Resident C falling out of bed. Ms. Hillery informed Ms. Edwards that she got Resident C off the floor and placed her back into bed. Ms. Hillery told Ms. Edwards that she did not call anyone about the fall. Ms. Edwards informed Ms. Hillery that she should not have moved Resident C and informed her about the sign posted with those instructions. Ms. Edwards checked Resident C and did not observe any marks or bruises. Ms. Edwards contacted the district manager and was advised to complete an incident report and notify the guardian. Ms. Edwards was not advised to call 911.

On 08/05/25, I received a copy of Resident C's discharge paperwork from Ascension Providence hospital in Southfield. Resident C was seen on 07/05/25. The discharge paperwork does not provide a summary as to why Resident C was seen by a doctor. However, the discharge paperwork did provide information about artificial feeding.

On 08/06/25, I completed an exit conference with the licensee designee Jasmine Boss via telephone. Ms. Boss was informed that the allegations will be substantiated and a corrective action plan will be required.

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 investigation and the information gathered, there is sufficient evidence to support the allegation. I reviewed Resident C's crisis plan and it clearly provides specific instructions on what to do in the event of a fall. Furthermore, the crisis plan indicates in the event of an unwitnessed fall, the staff are expected to seek medical attention. It is also the AFC group home's policy to contact 911 if any resident falls. Staff member Marketta Hillery admitted to not calling 911 when she found Resident C on the floor.
CONCLUSION:	**VIOLATION ESTABLISHED**

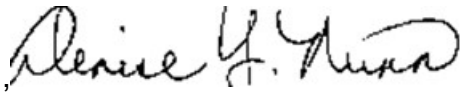
IV. RECOMMENDATION

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

08/07/25

Sheena Worthy
Licensing Consultant
Date

Approved By:



08/11/2025

Denise Y. Nunn
Area Manager
Date