GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 25, 2025

Adam Frazier
Docate Homes, LLC
5297 Clato St
Kalamazoo, MI 49004

RE: License #: AS390085644
Investigation #: 2025A1024045
Docate Manor

Dear Mr. Frazier:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On August 12, 2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390085644
Investigation #:	2025A1024045
Complaint Receipt Date:	07/08/2025
Investigation Initiation Date:	07/08/2025
Report Due Date:	09/06/2025
Licensee Name:	Docate Homes, LLC
Licensee Address:	5297 Clato St Kalamazoo, MI 49004
Licensee Telephone #:	(269) 359-1511
Administrator:	Adam Frazier
Licensee Designee:	Adam Frazier
Name of Facility:	Docate Manor
Facility Address:	5297 Clato Street Kalamazoo, MI 49004
Facility Telephone #:	(269) 381-7939
Original Issuance Date:	04/01/1999
License Status:	REGULAR
Effective Date:	07/02/2024
Expiration Date:	07/01/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff do not take care of Resident A's personal care needs as required and he is allowed to sit in urine and is not changed.	No
Staff did not provide Resident A with a clean, appropriate mattress.	Yes

III. METHODOLOGY

07/08/2025	Special Investigation Intake 2025A1024045
07/08/2025	Special Investigation Initiated – Telephone with Witness 1
07/11/2025	APS Referral denied investigating
07/11/2025	Inspection Completed On-site with Resident A, direct care staff members Larry Bolo and Brian Ogutu
07/17/2025	Contact - Document Received email correspondence with licensee designee Adam Frazier
07/17/2025	Contact-Document Received-Resident A's *Assessment Plan for AFC Residents*
08/04/2025	Exit Conference with licensee designee Adam Frazier
08/04/2025	Inspection Completed-BCAL Sub. Compliance
08/12/2025	Corrective Action Plan Requested and Due on 8/21/2025
08/12/2025	Corrective Action Plan Received
08/13/2205	Contact-Document Received-Intake #206875 with additional allegations
08/21/2025	Corrective Action Plan Approved

ALLEGATION: Staff do not take care of Resident A's personal care needs as required and he is allowed to sit in urine and is not changed.

INVESTIGATION:

On 7/8/2025,I received this complaint through the LARA-BCHS online complaint system. This complaint alleged staff do not take care of Resident A's personal care needs as required and he is allowed to sit in urine and is not changed.

On 7/8/2025, I conducted an interview with Witness 1 who stated that she visits Resident A often and does not believe staff members are attending to his personal care needs as he has been soaked in urine and staff members do not check on Resident A as required. Witness 1 stated that Resident A must wear adult incontinence briefs and the facility did not provide incontinence briefs to Resident A therefore Resident A urinated on himself and soaked his underwear during a recent visit with him. Witness 1 stated staff members eventually purchased the adult incontinence briefs for Resident A however he had to wait almost three hours to get them. Witness 1 stated she believes the staff members should be checking on him more often and assist him more with his personal care needs.

On 7/11/2025, I conducted an onsite investigation at the facility with direct care staff members Larry Bolo and Brian Ogutu who both stated that Resident A performs all his personal care needs on his own, including toileting, and does not require staff assistance. Larry Bolo and Brian Ogutu both stated that Resident A does not require enhanced supervision, and staff are not required to provide adult incontinence briefs for him, however, there are times staff have provided these items to Resident A when he has run out. Larry Bolo and Brian Ogutu also both stated that Resident A has issues with incontinence which could be caused by his health issues that are being managed by his primary care physician with assistance from Witness 1. Larry Bolo and Brian Ogutu also both stated that they have no knowledge of Resident A sitting in urine for long periods of time and he has been able to manage toileting on his own. Larry Bolo and Brian Ogutu stated Resident A's personal care are attended to at all times according to his assessment plan and care agreement.

While at the facility, I also conducted an interview with Resident A who stated that he completes all his personal care needs on his own including toileting and does not need staff assistance. Resident A stated that sometimes he has accidents and urinates on himself or while he is in bed, and he tries to take care of his accidents right away. Resident A stated that staff must clean his mattress if urine gets in his mattress which it often does due to Resident A's incontinence issues. Resident A stated he is independent and has help from Witness 1 if he needs to go out in the community or when he needs to go to his doctor's appointments.

On 7/17/2025, I reviewed Resident A's *Assessment Plan for AFC Residents* which stated that Resident A performs his own personal care needs and moves independently with a walker in the community. It should be noted that there is no mention of Resident A needing enhanced supervision.

I also reviewed Resident A's AFC *Resident Care Agreement* which stated that Resident A agrees to pay a basic fee for services specified in his assessment and care

agreement. It should be noted that there is no mention of additional services to be provided such as the licensee providing adult incontinence briefs.

On 8/13/2205, additional allegations were received regarding Witness 1 not being allowed to visit the facility which will be addressed in SIR # 2025A0581042.

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 which included interviews with direct care staff members Larry Bolo, Brian Ogutu, Resident A, Relative A1, review of Resident A's *Assessment Plan for AFC Residents* and *AFC Care Agreement* there is no evidence that direct care staff do not take care of Resident A's personal care needs as required. Larry Bolo and Brian Ogutu both stated that Resident A performs all his personal care needs on his own, including toileting, and does not require staff assistance nor does he require any additional supervision. Resident A also stated that he completes all his personal care needs independently including toileting and does not need staff assistance. According to Resident A's written assessment plan and written resident care agreement, Resident A does not require assistance with any of his personal care needs and there was no obligation documented that the licensee must purchase adult incontinence briefs for Resident A. Therefore, Resident A's personal care needs have been attended to at all times.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Staff did not provide Resident A with a clean, appropriate mattress.

INVESTIGATION:

On 7/8/2025,I received this complaint through the LARA-BCHS online complaint system. This complaint alleged staff did not provide Resident A with a clean, appropriate mattress.

On 7/8/2025, I conducted an interview with Witness 1 who stated that she and Resident A requested staff to replace Resident A's mattress for months due to the mattress being extremely worn out caused by Resident A urinating on the mattress however action to

purchase a new mattress by staff was never done. Witness 1 stated she purchased a new mattress for Resident A with her own money. Witness 1 stated she observed Resident A's previous mattress to have a hole in the mattress with the mattress spring exposed and that the mattress was soiled with urine. Witness 1 stated she was never reimbursed for the mattress and staff members never made any attempts to ensure Resident A had a mattress that was in good condition, which is very concerning to her.

On 7/11/2025, I conducted an onsite investigation at the facility with Larry Bolo who stated that Resident A damaged his mattress by repeatedly taking the mattress cover off his mattress and urinating on his mattress. Larry Bolo stated Witness 1 insisted that she pay for Resident A to have a new mattress and purchased Resident A's mattress before the licensee had a chance to purchase a new mattress for him. Larry Bolo stated that Witness 1 was not reimbursed for purchasing Resident A, a new mattress.

Brian Ogutu stated that Resident A caused excessive wear to his mattress because he constantly urinated on his mattress along with taking sharp objects to tear holes in the mattress. Brian Ogutu stated the licensee was more than willing to purchase a new mattress for Resident A due to the poor condition of his mattress, however, Witness 1 insisted that she purchased the new mattress herself.

While at the facility, I also interviewed Resident A who stated that Witness 1 purchased a new mattress for him because his mattress was worn from excessive urine. Resident A stated that staff often cleaned his mattress whenever he would urinate on the mattress, however, he believes this wore out the mattress overtime due to excessive cleaning and flipping the mattress over. Resident A stated that he requested staff to replace his mattress, however, it was never done.

While at the facility, I observed Resident A's old mattress which was stored in the garage waiting to be taken to a dumpster. I observed a hole in the center of the mattress and the mattress to be in poor condition. I also observed Resident A's newly purchased mattress in his bedroom with no concerns.

On 7/17/2025, I received email correspondence from Adam Frazier who confirmed that Resident A's mattress was purchased by Witness 1. It should be noted there was no other information provided on why staff did not purchase a new mattress for Resident A.

APPLICABLE RULE	
R 400.14410	**Bedroom furnishings.**
	(5) A licensee shall provide a resident with a bed that is not less than 36 inches wide and not less than 72 inches long. The foundation shall be clean, in good condition, and provide adequate support. The mattress shall be clean, comfortable, in good condition, well protected, and not less than 5 inches thick or 4 inches thick if made of synthetic

	materials. The use of a water bed is not prohibited by this rule.
ANALYSIS:	Based on my investigation which included interviews with direct care staff members Larry Bolo, Brian Ogutu, Resident A, Relative A1, email correspondence with Adam Frazier there is evidence that supports that Resident A was not provided with a clean mattress in good condition by the licensee. Witness 1 and Resident A both stated that Resident A's mattress was not in good repair and a request for a new mattress was made however the licensee never took any action to replace his mattress. Larry Bolo and Brian Ogutu both stated that Resident A's mattress was in poor condition and his mattress was replaced by Witness 1 who was not reimbursed. I also observed Resident A's previous mattress which was noted to be torn and in poor condition. Therefore, the licensee did not provide Resident A with a mattress that was clean, in good condition.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/4/2025, I conducted an exit conference with licensee designee Adam Frazier. I informed Adam Frazier of my findings and allowed him an opportunity to ask questions and make comments. On 8/12/2025, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action was received; therefore, I recommend the current license status remain unchanged.

08/21/2025

Ondrea Johnson
Licensing Consultant

Date

Approved By:

08/25/2025

Dawn N. Timm
Area Manager

Date