GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 14, 2025

Wycliffe Opiyo
Mercy Homes Assisted Living LLC
2901 Asbury St.
Kalamazoo, MI 49048

RE: License #: AS390380979
Investigation #: 2025A0581045
Mercy Homes Assisted Living

Dear Wycliffe Opiyo:

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 (517) 335-5985.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390380979
Investigation #:	2025A0581045
Complaint Receipt Date:	09/05/2025
Investigation Initiation Date:	09/05/2025
Report Due Date:	11/04/2025
Licensee Name:	Mercy Homes Assisted Living LLC
Licensee Address:	2901 Asbury St. Kalamazoo, MI 49048
Licensee Telephone #:	(817) 781-6512
Administrator:	Wycliffe Opiyo
Licensee Designee:	Wycliffe Opiyo
Name of Facility:	Mercy Homes Assisted Living
Facility Address:	2901 Asbury St. Kalamazoo, MI 49048
Facility Telephone #:	(817) 781-6512
Original Issuance Date:	09/26/2016
License Status:	REGULAR
Effective Date:	03/24/2025
Expiration Date:	03/23/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION

	Violation Established?
Resident A eloped from the facility on or around 08/31/2025 because direct care staff were not providing adequate supervision.	Yes

III. METHODOLOGY

09/05/2025	Special Investigation Intake - 2025A0581045
09/05/2025	Special Investigation Initiated – Telephone - Interview with APS specialist, Amber Price Johnson
09/05/2025	APS Referral - APS received the allegations; no referral necessary. APS substantiated.
09/09/2025	Inspection Completed On-site - Interview with staff and resident.
09/09/2025	Contact - Face to Face - Interview with licensee designee, Wycliffe Opiyo.
09/09/2025	Exit conference with the licensee designee, Wycliffe Opiyo.
09/26/2025	Inspection Completed-BCAL Sub. Compliance
10/03/2025	Contact – Telephone call made – Interview with Woodland's Behavioral Health case manager, Michelle Nicely.
10/06/2025	Contact – Document Received – Kalamazoo Township Police report # 2025-00003070.

ALLEGATION: Resident A eloped from the facility on or around 08/31/2025 because direct care staff were not providing adequate supervision.

INVESTIGATION: On 09/05/2025, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged Resident A requires increased supervision by having a one on one direct care staff with her; however, on or around 08/31/2025 at approximately 7 pm, the complaint alleged Resident A walked away from the facility and was missing from the facility until she returned to the facility on 09/02/2025.

The complaint alleged staff initially followed Resident A when she walked away from the facility, but the assigned one to one direct care staff stopped providing Resident

A with supervision in order to return to the facility and obtain a vehicle and cellphone. The complaint alleged the staff returned to the area where Resident A was last seen, but Resident A could not be located. When Resident A returned to the facility she did not disclose where she had been for three days.

On 09/05/2025, I interviewed Kalamazoo County Adult Protective Services (APS) specialist, Amber Price-Johnson, whose statement was consistent with the allegations. Amber Price-Johnson stated licensee designee, Wycliffe Opiyo, and Resident A's guardian both reported to her that Resident A had enhanced supervision while out in the community. Amber Price-Johnson described this enhanced supervision as an assigned one to one staff with Resident A while she was out in the community. Amber Price-Johnson stated she interviewed Resident A on 09/02 at the facility who would not elaborate or provide additional details as to what she was doing while she eloped for several days from the facility. Amber Price-Johnson stated she substantiated her complaint for neglect because the facility's staff did not stay with Resident A on 08/31 and did not provide Resident A's enhanced supervision as required. She stated rather than continue to supervise Resident A, staff turned around, went to the facility, and retrieved a phone and the facility vehicle and then returned to look for Resident A.

On 09/09/2025, I conducted an unannounced inspection and interviewed Resident A. Resident A provided me with minimal information as she did not want to answer my questions. Resident A stated she walked away from the facility on or around 08/31 because she was following Resident B. She stated Resident B also left the facility to go out in the community. Resident A stated staff are required to be with her while out in the community, but she does not want this level of supervision. Resident A was unable to provide any information as to the level of supervision staff are required to provide her while out in the community or what happened to staff when she left the facility. Resident A stated she "lost" Resident B while attempting to follow him. Subsequently, she stated "a friend" picked her up and took her to his house. Resident A refused to identify the friend's name, where he lived, or what she did for approximately three days.

I interviewed direct care staff, Asende Ecasa, who was identified as the staff assigned to Resident A as her one to one staff when Resident A eloped from the facility on 08/31. It was challenging to interview Asende Ecasa due to English not being her first language. Asende Ecasa stated Resident A left the facility on 08/31, but she stated she followed her as required. She stated Resident A stopped at another facility, owned and operated by the licensee, a few houses down the street. Asende Ecasa stated when Resident A left the neighboring facility she could not redirect her back to Mercy Assisted Living Homes despite her attempts. She stated she and Resident A were getting further away from the facility, so she decided to return to the facility, obtain a facility vehicle and her cell phone. Asende Ecasa could not state why she did not have her cell phone when she initially left the facility or why she did not request assistance at the neighboring facility. She stated she was unable to locate Resident A despite driving up and down the road and around the area

where she last observed her. Asende Ecasa stated Resident A requires staff supervision while out in the community.

I interviewed the licensee designee, Wycliffe Opiyo, during the investigation. His statement was consistent with Ascende Ecasa's statement to me. He stated Asende Ecasa initially followed Resident A; however, upon getting to a major roadway, she turned around to retrieve her phone and a facility vehicle. Wycliffe Opiyo stated Asende Ecasa searched the area in the facility's van to no avail. He stated after approximately 30 minutes of searching the police were contacted. He stated staff often use the facility van to follow Resident A because Resident A does not respond to redirection.

I interviewed direct care staff, Ikulu Oredei, who stated he was also working in the facility with Asende Ecasa when Resident A eloped from the facility on 08/31. His statement was consistent with Asende Ecasa's and Wycliffe Opiyo's statements. He did not provide any additional information as to the expectations of staff if they leave the facility with Resident A without a cell phone or vehicle.

I reviewed Resident A's Woodland's Behavioral Health *Behavior Support Plan* (BSP)*,* dated 05/06/2025. According to Resident A's BSP, she is diagnosed with a mild intellectual disability, posttraumatic stress disorder, disruptive mood dysregulation disorder, attention deficit/hyperactivity disorder (combined presentation) and fetal alcohol syndrome. The BSP documented Resident A has a restriction on her freedom of movement. It documented she has "1:1 Supervision when in the Community". The BSP documented "While [Resident A] in the community[*sic*], staff will accompany her and should be within arms reach at all times". It was documented Resident A requires this level of supervision because she has a "…documented history of unsafe behaviors in the community, including elopement, arranging meetings with unknown individuals, and engaging in risky online and sexual behaviors". It further documented the following:

> "She has also demonstrated impulsivity and poor judgement that place her at increased risk for exploitation and harm. 1:1 supervision is essential to ensure [Resident A's] safety, provide in-the-moment support with problem-solving and emotional regulation, and prevent potential incidents that could result in legal or medical risk."

The BSP identified reactive strategies to be used by staff when Resident A engages in elopement. The BSP documented the following:

> "If [Resident A] begins to walk away from the home or staff, follow her (as staffing ratios allow) and verbally redirect her back to the home (or to the van if on an outing). As needed, remind

[Resident A] she is to stay with staff now, so that she can work toward her goal of more independence in the future."

It also documented, "If [Resident A] continues to elope and staff are unable to follow, or if staff cannot locate her, staff will follow the agency policy for a missing resident".

I confirmed Asende Ecasa was trained on Resident A's BSP.

On 10/03/2025, I Interviewed Resident A's Woodland's Behavioral Health case manager, Michelle Nicely. Her statement regarding Resident A's level of supervision was consistent with statements from staff and the licensee designee. She stated staff are expected to follow Resident A and attempt to redirect her back to the facility, but otherwise, they should monitor Resident A for safety while she is out in the community. She stated Resident A has a history of flagging down vehicles and leaving with random strangers. Michelle Nicely stated police were contacted and the facility's staff followed the missing person protocol. She stated from a Community Mental Health(CMH) perspective, staff would be allowed to have a cell phone on their person when Resident A elopes from the facility.

On 10/06/2025, I received Kalamazoo Township Police Department police report #2025-00003070. The contents of the report were consistent with the information gathered from interviews with staff and Resident A including police documenting a difficult time interviewing staff and obtaining clear information due to a language barrier. According to the report, police interviewed staff, Bulla Mumbo, who reported to police Resident A left the facility on foot at approximately 7 pm. He reported to police after 10-15 minutes he also got into a vehicle and searched the area for Resident A, but was unable to locate her. Bulla Mumbo reported to police he reported Resident A missing at approximately 9:32 pm.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.

AN/ALYSIS:	Based on my investigation, which included interviews with APS specialist, Amber Price-Johnson, Resident A, Woodland's Behavioral Health case manager, Michelle Nicely, direct care staff, Asende Ecasa and Ikulu Oredei, and the licensee designee, Wycliffe Opiyo, and my review of Resident A's Woodland's Behavioral Health *Behavior Support Plan* (BSP), dated 05/06/2025, and Kalamazoo Township Police Department police report #2025-00003070, there is supporting evidence Resident A requires enhanced supervision, which is defined as a one to one direct care staff with her while in the community; however, this level of supervision was not provided to Resident A on 08/31/2025. On 08/31/2025, Resident A left the facility on foot with direct care staff, Asende Ecasa, who initially provided Resident A with enhanced supervision; however, Asende Ecasa was unable to redirect Resident A back to the facility. Subsequently, Asende Ecasa stopped providing Resident A with enhanced supervision and returned to the facility to retrieve a cell phone and vehicle. Consequently, while staff Asende Ecasa returned to the facility, Resident A got into a vehicle with an individual and was unaccounted through 09/02/2025 until she returned to the facility on her own volition.
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.

AN/ALYSIS:	On 08/31/2025, Resident A abruptly left the facility and walked down the road. Resident A's BSP documents her need for enhanced supervision while in the community, which is defined as a one to one direct care staff. Despite direct care staff, Asende Ecasa initially following her on foot, she stopped providing Resident A with her required enhanced supervision when she was unable to redirect her back to the facility. Asende Ecasa returned to the facility to retrieve a cell phone and facility vehicle; however, while Resident A was left unsupervised she got into a vehicle with an individual and did not return to the facility until 09/02/2025. Consequently, Resident A was not provided with adequate protection and supervision in the community, as required.
	VIOLATION ESTABLISHED

On 09/09/2025, I conducted my exit conference with the licensee designee, Wycliffe Opiyo, in person at the facility and in a follow up phone call. He acknowledged my findings; however, he expressed concern with staff being out in the community far from the facility with no cell phone or vehicle. I processed with Wycliffe Opiyo the importance of developing a plan for staff to have their personal cell phone or making a house cell phone readily available in the event Resident A abruptly leaves the facility and encouraged he process and problem solve with Resident A's case manager.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

Cathy Cushman

10/14/2025

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Cathy Cushman Date
Licensing Consultant

Approved By:

Dawn Timm 10/14/2025

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Dawn N. Timm Date
Area Manager