



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 18, 2025

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

RE: License #: AS630012358
Investigation #: 2025A0602023
Dartmouth Road 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) 972-9136.

Sincerely,

A handwritten signature in cursive script that reads "Cindy Berry". The signature is written in black ink and is positioned below the word "Sincerely,".

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012358
Investigation #:	2025A0602023
Complaint Receipt Date:	08/13/2025
Investigation Initiation Date:	08/14/2025
Report Due Date:	10/12/2025
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:	Dartmouth Road Home
Facility Address:	3525 Dartmouth Oxford, MI 48371
Facility Telephone #:	(248) 628-6212
Original Issuance Date:	06/24/1983
License Status:	REGULAR
Effective Date:	03/02/2024
Expiration Date:	03/01/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A sustained burns from scalding bath water due to a plumbing issue and is now hospitalized.	Yes
Resident B is possibly being overmedicated and has lost 10-15 pounds within the last year.	No

III. METHODOLOGY

08/13/2025	Special Investigation Intake 2025A0602023
08/13/2025	APS Referral Adult Protective Services (APS) referral received.
08/14/2025	Special Investigation Initiated - Telephone Call made to APS. Assigned worker is Donna Dennis.
08/19/2025	Inspection Completed On-site I interviewed staff member and observed Resident A.
09/12/2025	Contact – Telephone call made Spoke with staff member Danielle Hurt.
10/08/2025	Contact – Telephone call received Spoke with assigned APS worker, Ms. Dennis.
10/08/2025	Contact – Telephone call made Message left for the home manager Rachel Love.
10/08/2025	Contact – Telephone call made Spoke with Resident A's guardian.
10/21/2025	Exit Conference Message left for the licensee designee Roger Covill.
10/28/2025	Contact – Telephone call made Message left for the home manager, Rachel Love.

10/29/2025	Contact – Facetime telephone call made Spoke with Ms. Love.
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ALLEGATION:

Resident A sustained burns from scalding bath water due to a plumbing issue and is now hospitalized.

INVESTIGATION:

On 8/13/2025, a complaint was received and assigned for investigation alleging that Resident A sustained burns from scalding bath water due to a plumbing issue and is now hospitalized.

On 8/19/2025, I conducted an unannounced on-site investigation at which time I interviewed staff member Amy Prater. I was unable to interview/observe Resident A as he was still hospitalized with an unknown discharge date. Ms. Prater stated she could not recall exact dates but there were some issues with the hot water heater at the end of July 2025. The pilot light went out leaving the home without hot water for a couple of days. The home manager reported the issue to Community Housing and was informed that the homeowner would be notified. The homeowner made a visit to the home and said he had to relight the pilot light, but this did not correct the issue. Someone from All About Plumbing came out to the home and said the thermostat on the hot water heater needed to be replaced and made the repair. Apparently when the thermostat was replaced, the hot water was not adjusted to a safe temperature. The incident with Resident A occurred on the morning of 8/11/2025. On 8/15/2025, Resident A had skin graph surgery but they will not know if it was a success until 8/20/2025. Ms. Prater went on to state that the hot water heater has since been repaired and they have not had any further issues with the hot water.

On 8/19/2025, I received and reviewed notes documented in the staff log dated 7/25/2025 through 8/15/2025. According to the notes:

- No hot water on 7/25/2025 and 7/27/2025.
- On 7/28/2025 - someone was supposed to come out and access the hot water heater.
- On 8/07/2025 - the home manager was asked if there was a specific way to turn down the hot water heater. It was noted to monitor the water temperature when residents used it.
- On 8/11/2025 – until further notice - no one is to be showered. Sponge bath only until water temperature has been corrected (directive given by the licensee designee).
- Please check water temperature twice daily (am and pm shifts) and document in staff log after it has been fixed.

- On 8/12/2025 – Resident A in the hospital for burns.
- The water has been fixed; continue to check the temperature and document in staff log.
- On 8/13/2025 – It could be three days before the full burn develops. Resident A ate dinner on 8/12/2025 and drank quite a bit but is not urinating like he should (area possibly swollen).
- On 8/15/2025 – Resident A had skin graft surgery that went well. The burns were not as deep as initially thought to be and he may only need one more surgery.

The water temperature was also documented in the staff log on 8/12/2025 through 8/18/2025. The temperature readings were between 106 and 110 degrees Fahrenheit.

On 8/19/2025, I received and reviewed an incident report written by Danielle Hurt and dated 8/11/2025 at 6:00 am. According to the incident report, on 8/11/2025 around 6:00 am Ms. Hurt put Resident A in the shower and placed the removeable shower head between the wall and the safety bar. The shower head was pointed towards Resident A's lower body (abdomen and groin area). Ms. Hurt turned around to get shower items ready to wash Resident A up. When she turned back to Resident A, she noticed the water was extremely hot. She immediately turned the water off, checked Resident A and noticed that his skin was very red, peeling and a blister was forming. Resident A was dressed and immediately transported to the Clarkston McClaren Emergency Department.

On 09/12/2025, I spoke with staff member Danielle Hurt by telephone. Ms. Hurt stated on 8/11/2025 around 6 am she was getting Resident A ready for the day. She put Resident A in the shower, turned the water on midway between the hot and cold temperatures, tested it with her hand to make sure it was not too hot, put the removeable shower head between the wall and the safety bar so that the water was hitting Resident A's lower body then turned away to put soap on the towel. When she turned around she could see steam coming from the water and Resident A's abdomen had turned red. Resident A is non-verbal and was unable to state if the water was too hot or not. Ms. Hurt immediately removed Resident A from the shower, put ice on his stomach, informed the manager what had happened, got Resident A dressed and transported him to McClaren emergency department in Clarkston. The burns were dressed at McClaren and he was transported to the burn unit at Hurley Hospital in Flint where he remained for a couple of weeks. Ms. Hurt stated this was a horrible accident and she feels absolutely terrible that it happened. She went on to state that there had been an issue with the hot water heater not working properly as there were notes documented in the staff log. However, she thought the issue had been fixed as she tested the water with her hand prior to showering Resident A and it felt fine. The hot water heater has since been repaired and staff are now required to test the water daily.

On 10/08/2025, I spoke with Resident A's guardian by telephone. Resident A's guardian stated she was out of town the day the incident occurred but was immediately notified by staff. She was told that staff turned the shower on to the usual temperature but there was an issue with the hot water heater that caused the water to become too hot. Resident A was initially transported to McClaren Hospital and later transferred to Hurley Hospital in Flint to the burn unit. The burns were on his lower abdomen and on the side of his genitals. He only needed one skin graft surgery as the burns were not as deep as they initially thought. The doctor was able to remove skin from Resident A's thigh and attached it to his burns. She was told by hospital staff that the water temperature had to be at least 170 degrees Fahrenheit in order for Resident A to sustain the burns that he did. He spent two weeks in the hospital and was discharged back to the home with a home care nurse to treat his burns. The home care nurse has been in constant contact with her and reported that the home is doing an excellent job of taking care of his burns. Resident A's guardian stated Resident A has resided in the home for 30 years and the staff has been wonderful with him. She said she believes it was an awful accident that occurred but hopes the home does something to monitor the water temperature so this does not happen again.

On 10/29/2025 I conducted a Facetime call with the home manager, Rachel Love. I asked Ms. Love to test the water temperature to ensure it was at a safe temperature. The water temperature had a reading of 109 degrees Fahrenheit.

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:	<p>Based on the information obtained during the investigation, there is sufficient information to determine that Resident A's protection and safety were not attended to at all times.</p> <p>Ms. Prater, Ms. Hurt and Resident A's guardian stated there was an issue with the hot water heater that led to Resident A's injury.</p> <p>On 8/11/2025, Resident A sustained burns to his lower abdomen and the side of his genitals as a result of the water temperature being too high during a shower. As a result, Resident A spent two weeks in the hospital and underwent skin graft surgery.</p>
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14401	Environmental health.
	(2) Hot and cold running water that is under pressure shall be provided. A licensee shall maintain the hot water temperature for a resident's use at a range of 105 degrees Fahrenheit to 120 degrees Fahrenheit at the faucet.
ANALYSIS:	<p>Based on the information obtained during the investigation, there is sufficient information to determine that on 8/11/2025 the hot water in the shower had a temperature reaching higher than 120 degrees Fahrenheit.</p> <p>On 8/11/2025, Resident A was burned on his lower abdomen and the side of his genitals as a result of the water temperature being too high in the shower.</p> <p>According to staff member Amy Prater, Danielle Hurt and Resident A's guardian, there had been an issue with the hot water heater prior to Resident A being burned. Resident A's guardian stated the hospital informed her that the water temperature had to be at least 170 degrees Fahrenheit in order for Resident A to sustain the burns that he did.</p> <p>On 8/19/2025, I reviewed documentation in the staff log indicating that the hot water heater was not working properly and staff were to test the water prior to residents using it.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident B is possibly being over medicated and has lost 10-15 pounds within the last year.

INVESTIGATION:

On 8/14/2025, another complaint was received and included in this investigation alleging that Resident B is possibly being over medicated and has lost 10-15 pounds within the last year.

On 8/19/2025, I conducted an unannounced on-site investigation at which time I interviewed staff member Amy Prater. I was unable to interview/observe Resident B as she was at the Dutton Farms workshop. Ms. Prater stated she had no knowledge of Resident B being overmedicated or losing 10-15 pounds over the last year.

On 8/19/2025, I received and reviewed copies of Resident B's weight records dated 11/05/2022 through 8/14/2025 and her medication log for the month of August 2025. According to the weight records, Resident B weighed 174 pounds on 11/05/2022 and 149 pounds on 8/15/2025. On 8/15/2024, she weighed 136 pounds and on 8/14/2025, she weighed 149 pounds. It appears that Resident B gained 13 pounds within the last year. According to the medication log, Resident B is prescribed the following medication:

- Vitamin D2, 1.25 mg 1tab twice a month on Wednesdays
- Oyster Shell 500-VIT D3 1tab daily
- Aripiprazole 5 mg 1tab daily for 30 days
- Adult vitamin gummies 1tab daily
- Sertraline Hcl 100 mg 1tab daily for 30 days
- Oxcarbazepine 600 mg 1tab twice daily for 30 days
- Clonidine Hcl 0.1 mg 1tab three times daily for 30 days
- Clonazepam 1 mg 1tab twice daily and 1tab at bedtime
- Atorvastatin 20 mg 1tab daily
- Tylenol cold 2tabs every 4 hours for 3 days (administered 8/7, 8/8, 8/9)
- Mupirocin 2% ointment apply to affected area by topical route 2 times daily
- Albuterol Sul 2.5 mg/3ml inhale 1 unit by nebulizer every 4 hours as needed for wheezing (administered 8/7, 8/9, 8/14)

I did not observe anything unusual with the medication log and it appeared as if all prescribed medication was administered.

On 09/12/2025, I spoke with staff member Danielle Hurt by telephone. Ms. Hurt went on to state that Resident B has not lost any weight since she began working for the company in September 2024. She said there were some recent concerns about her appearing to still be hungry after eating her lunch at the workshop so additional fruits and vegetables are now being added to her lunch. Ms. Hurt said Resident A likes to eat and as long as you keep giving her food, she will continue to eat. Ms. Hurt stated she had no knowledge of Resident B being overmedicated. This is all the information Ms. Hurt had regarding Resident B.

On 10/21/2025, I spoke with the licensee designee, Roger Covill by phone for the exit conference. I informed him of the allegations and investigative findings documented in this report. Mr. Covill stated the home is owned by a private owner and any issues with the property must be addressed by the owner. The owner was notified of the issue with the hot water heater and had a plumber come out to make the necessary repairs. On 8/11/2025, Mr. Covill was notified that Resident A suffered from burns as a result of high water temperature while showering. Mr. Covill made a visit to the home on this same date to test the hot water and inspect the hot water heater. At 11:30 am the hot water was turned down. At 12:30 pm the water temperature was 141.6 degrees Fahrenheit. At

1:30 pm the water temperature was 95 degrees Fahrenheit. Upon review of the hot water heater, the mixing valve had been bypassed which caused the cold water to be shut off. Mr. Covill turned the mixing valve back on and tested the water temperature again. At that point the water temperature had a reading of 95 degrees Fahrenheit and would not rise any higher than that. Mr. Covill determined that the mixing valve was the issue and needed to be replaced. As of this date, the water heater is working properly and staff are required to test the water temperature daily.

APPLICABLE RULE	
R 400.14312	Resident medication.
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information obtained during the investigation, there is insufficient information to determine that Resident B was being overmedicated. On 8/19/2025 I received and reviewed copies of Resident B's medication log for the month of August 2025. According to the log, Resident B received all of her medication as prescribed. Resident B was prescribed Tylenol Cold every 4 hours for 3 days (8/7, 8/8, 8/9) which could have caused her to be drowsy.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14310	Resident health care.
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	Based on the information obtained during the investigation, there is insufficient information to determine that Resident B lost 10-15 pounds within the last year. On 8/19/2025 I received and reviewed Resident B's weight records dated 11/05/2022 through 8/14/2025. According to the weight records, Resident B weighed 136 pounds on 8/15/2024 and on 8/14/2025 she weighed 149 pounds. It appears that Resident B gained 13 pounds within the last year.
CONCLUSION:	VIOLATION NOT ESTABLISHED.

IV. RECOMMENDATION

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

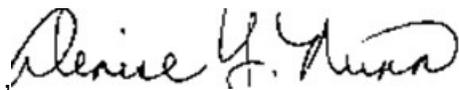


10/29/2025

Cindy Berry
Licensing Consultant

Date

Approved By:



11/18/2025

Denise Y. Nunn
Area Manager

Date