GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 18, 2025

Tamisha Kaplan
A Caring Home of Michigan, LLC
P.O. Box 81
Walled Lake, MI 48390

RE: License #: AS630418269
Investigation #: 2025A0605021
Chateau of Bloomfield-Lasher Home

Dear Tamisha Kaplan:

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
Cadillac Place
3026 W. Grand Blvd., 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
THIS REPORT CONTAINS PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS630418269
Investigation #:	2025A0605021
Complaint Receipt Date:	09/29/2025
Investigation Initiation Date:	09/29/2025
Report Due Date:	11/28/2025
Licensee Name:	A Caring Home of Michigan, LLC
LicenseeAddress:	45750 Eleven Mile Novi, MI 48374
Licensee Telephone #:	(248) 380-4663
Administrator/Licensee Designee:	Tamisha Kaplan
Name of Facility:	Chateau of Bloomfield-Lasher Home
Facility Address:	2563 Lasher Road Bloomfield Hills, MI 48304
Facility Telephone #:	(248) 380-4663
Original Issuance Date:	12/16/2024
License Status:	REGULAR
Effective Date:	06/16/2025
Expiration Date:	06/15/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED/MENTALLY ILL AGED/ ALZHEIMERS TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
• On September 20, 2025, Resident A was physically abused by direct care staff (DCS) Maurice McElway during transport from Southfield to Bloomfield Twp, while other staff at Chateau of Bloomfield-Lasher Home were also reported to be abusive toward residents. • Resident B stated that DCS Ashley Wilkins grabbed him by his neck.	No
• Resident A stated that DCS Maurice Elway verbally abused him. • Resident B stated that staff are mean to him.	Yes
On 10/05/2025, Resident B left the home while staff Ronald Lamar Jr., was sleeping.	Yes

III. METHODOLOGY

09/29/2025	Special Investigation Intake 2025A0605021
09/29/2025	APS Referral Adult Protective Services (APS) made referral
09/29/2025	Special Investigation Initiated - Letter Email sent to APS worker Carmen Smith
09/29/2025	Contact - Telephone call made Email to Oakland Office of Recipient Rights (ORR) Alanna Honkanen
09/29/2025	Contact - Document Received Email from ORR Alanna Honkanen. Assigned ORR worker is Greg Szopo
09/29/2025	Contact - Document Sent Email to ORR worker Greg Szopo
09/30/2025	Contact - Telephone call received Message from Greg Szopo

10/01/2025	Contact - Face to Face Attempted to conduct an unannounced on-site visit, but no one was home. Interviewed Resident A and the social worker (SW) at Henry Ford Behavioral Health Hospital regarding allegations.
10/01/2025	Contact - Telephone call made Discussed allegations with APS Carmen Smith, ORR Greg Szopo and licensee designee Tamesha Kaplan
10/01/2025	Contact - Face to Face Interviewed Resident A and the social worker Joe Dueweke at Henry Ford Behavioral Health Hospital regarding the allegations
10/06/2025	Inspection Completed On-site Conducted scheduled on-site investigation. Interviewed Resident B and direct care staff (DCS) regarding the allegations.
10/06/2025	Contact - Face to Face Interviewed the manager at Middle Eats regarding Resident B
10/13/2025	Contact - Telephone call made Followed up with ORR Greg Szopo and left message for the licensee designee Tamesha Kaplan
10/28/2025	Contact - Telephone call made Left another message for licensee designee Tamesha Kaplan
11/06/2025	Exit Conference Conducted exit conference with licensee designee Tamisha Kaplan with my findings

ALLEGATIONS:

- **On September 20, 2025, Resident A was physically abused by direct care staff (DCS) Maurice McElway during transport from Southfield to Bloomfield Twp, while other staff at Chateau of Bloomfield-Lasher Home were also reported to be abusive toward residents.**
- **Resident B stated that DCS Ashley Wilkins grabbed him by his neck.**

INVESTIGATION:

On 09/29/2025, intake #207541 was referred by Adult Protective Services (APS) who is also investigating these allegations. I referred this complaint to Oakland County Office of Recipient Rights (ORR).

On 09/30/2025, I received a message from ORR worker Greg Szopo stating that he has been assigned this investigation.

On 10/01/2025, I attempted an unannounced on-site visit at Chateau of Bloomfield-Lasher, but no one was home.

On 10/01/2025, I contacted Resident A's legal public guardian Kijuana Evans via telephone. Ms. Evans stated that Resident A was currently at Henry Ford Behavioral Health Hospital in West Bloomfield. Resident A reported to Ms. Evans that direct care staff (DCS) Maurice McElway "slapped his head into the window," and that "police were called, but police did not do anything." Resident A was adamant, that is what happened. Ms. Evans provided me with the licensee designee Tamisha Kaplan's contact information.

On 10/01/2025, I received a telephone call from licensee designee Tamisha Kaplan. Ms. Kaplan denied the allegations. She stated that Resident A was upset that another resident that was residing at this group home moved into a semi-independent apartment and Resident A did not. Ms. Kaplan does not believe Resident A is ready to live independently; therefore, she believes he made up these allegations. Ms. Kaplan agreed to let me come back to Chateau of Bloomfield-Lasher on 10/06/2025 to interview all DCS regarding these allegations and she stated that Resident B will also be present.

On 10/01/2025, I interviewed Resident A at Henry Ford Behavioral Health Hospital regarding the allegations. Resident A stated on 09/20/2025, he and DCS Maurice McElway were in the car when "Maurice put his hands on me. He yelled at me and told me to shut the fuck up." Maurice was driving while Resident A was sitting in the passenger seat. Resident A stated, "Maurice punched me in my mouth and slapped me in my mouth too." I did not observe any injuries on Resident A's mouth or face. When Resident A was asked why Maurice punched and slapped his mouth, Resident A stated, "I don't get along with Resident B." He was unable to provide any further details. Resident A told Ms. Kaplan what happened but Ms. Kaplan "didn't believe me." He stated, "I don't know why she didn't believe me." Maurice also threatened Resident A. Maurice told Resident A "when we get to the house, I'm going to fuck you up." When they arrived at the group home, Maurice opened the passenger door for Resident A and then said, "I'm going to smack your bitch ass." Maurice was not the only one who threatened Resident A. DCS Ronald Lamar Jr., who goes by RJ told Resident A "I'm going to fuck you up," when Resident A "poured milk on the ground." Resident A stated, "I would feel better if I moved into the apartment program." The apartment program is a semi-independent apartment where individuals can reside alone. Resident A stated he was told that he was not ready to live alone by Ms. Kaplan, but he wants to live alone. Resident A called the police on 09/20/2025, but they too did not believe him, so they let. Resident A stated, "I couldn't let it go so I called the police on 09/22/2025 saying I felt suicidal, so they brought me here." Resident A then began saying that he believes there is something going on between Maurice and DCS Patrice Vinson. Resident A likes

Patrice. He said, “Maurice tried to grab Patrice’s behind. I felt jealous because everybody likes Patrice.”

On 10/01/2025, I interviewed the social worker Joe Dueweke regarding the allegations. Resident A told Mr. Dueweke that “Maurice punched him on the head and slapped him on his lip when they were in the car driving.” There is friction between Resident A and his roommate Resident B. They do not get along. Resident A also reported that Maurice “put his hands on Resident B months ago.” When Mr. Dueweke talked to licensee designee Tamisha Kaplan, she told Mr. Dueweke that “Resident A tried to get out of the car while Maurice was driving, and Maurice grabbed him to prevent him from jumping out.” Ms. Kaplan also told Mr. Dueweke that this complaint was “suspicious,” because it came around the same time that Resident A wanted to live independently. In the past, when Resident A lived independently Resident A “beat up his roommate,” at the room and board he was living at. Also, Resident A has been charged with kidnapping a little girl; was court ordered to complete anger management and then Resident A assaulted the behavioralist at the group home. Currently, Resident A has not had any behaviors because he is compliant with his medications even though he needed some convincing to take them. Mr. Dueweke is unsure if Resident A will be discharged home as he is waiting to hear back from the APS worker.

On 10/01/2025, I contacted ORR worker Greg Szopo. Mr. Szopo stated that he has not interviewed Resident A yet but agreed to meet with me at the group home on 10/06/2025 to conduct a collaborative investigation.

On 10/06/2025, I, along with ORR worker Greg Szopo, conducted an on-site investigation regarding the allegations. The following individuals were present: Resident B, DCS Maurice McElway, Patrice Vinson, Ashley Wilkins, and the home manager (HM) Thomas Bates.

Resident B was interviewed regarding the allegations. Resident B has a legal public guardian. Resident B stated, “I used to have a roommate, Resident A, but he’s not here.” They got along and he enjoyed playing cards with Resident A. He has observed Resident A “punching things,” and whenever Resident A punches things, “the staff tell Resident B to go into his bedroom,” which he does.

I interviewed DCS Patrice Vinson regarding the allegations. Patrice has been employed with this corporation for about three months. She works first shift 7AM-7PM. There are three DCS per shift when both Resident A and Resident B are home. Patrice did not work on 09/20/2025 as she was out of town. When she returned, she did not hear anything about what happened between Maurice and Resident A. She did not read any incident reports (IR) nor any documentation about what happened. Patrice only heard that Resident A “had a behavior.” A behavior for Resident A means, “cursing,” from Resident A. Maurice gets along well with Resident A and Resident B. She has observed Resident A get upset when things do not go his way and when he is upset, Resident A “takes it out on Resident B.” She has never observed Resident A hit Resident B, but she has observed Resident A “verbally abuse Resident B.” Patrice gets along well with

Resident A and has never physically abused him, or Resident B. Resident A says, Patrice and Ashley are my favorite. Patrice reported that one time “Resident A tried to barricade me in the office and kiss me.” She immediately redirected him and told him he was confused. Resident A mentioned to her that he (Resident A) thought that she and Maurice had something going on. Patrice denied it. Patrice denied any staff physically abusing Resident A or Resident B.

I interviewed DCS Maurice McElway regarding the allegations. He has worked for this corporation since 01/2025. He too works first shift 7AM-7PM. When both Residents A and B were home, there is supposed to be three staff as Resident B requires two DCS per shift. Maurice and Resident A were got along great and Maurice stated, “it took a long time for Resident A’s attitude to show.” Resident A did not like his roommate Resident B. Whenever Resident A wanted something and did not get what he wanted, or did not want to be around Resident B, Resident A would get into it with staff. Resident A was verbally aggressive towards staff. On 09/20/2025, Maurice and Resident A were assisting another resident who was moving from this group home to one of the licensee designee Tamisha Kaplan’s independent apartments. As a thank you to Resident A for assisting, Resident A was going to get food and cigarettes. Maurice and Resident A began heading towards the group home when Maurice mentioned Resident B and DCS Ashley Wilkins being home. Resident A “flipped out,” on Maurice for mentioning Resident B. Resident A said, “I don’t want him (Resident B) to get rewarded for doing nothing.” Burger King was on the same route as this group home and that was where Maurice was taking Resident A, but Resident A thought that they were heading back to the group home to pick up Resident B. As Maurice was driving down Maple and Telegraph Road, Resident A unlocked the doors and pulled on the door handle. Maurice immediately reacted by grabbing Resident A’s arm and pulling him back, preventing Resident A from jumping out of the moving car. Maurice denied punching or slapping Resident A in the face or mouth. Maurice drove back to the group home and did not stop at Burger King after the incident. Maurice stated he stopped communicating with Resident A, they arrived at home and Resident A got out of the car. Maurice denied threatening Resident A and denied saying anything derogatory to him. Resident A called the police. Police came and then left. Resident A went to the hospital because he was threatening to harm himself.

I interviewed DCS Ashley Wilkins regarding the allegations. Ashley has worked for this corporation since 01/2025. Ashley works first shift from 7AM-7PM. On 09/20/2025, she was responsible for Resident B. She and Resident B were home when Maurice and Resident A returned to the group home in the afternoon. Resident A called the licensee designee Tamisha Kaplan and told Ms. Kaplan what happened. Ashley stated, “Resident A said I don’t feel safe around staff.” Resident A hung up the phone and told Ashley that Maurice “pushed and punched him.” Resident A also said, “he grabbed me.” Resident A did not tell Ashley how Maurice punched him, but Resident A did say, “he punched my face.” Ashley looked at Resident A’s face and did not see any marks. Resident A did not inform Ashley how Maurice grabbed him. Maurice told Ashley, “I didn’t do it.” Maurice informed Ashley that Resident A tried to jump out of the van when they were returning to the group home and that Maurice grabbed Resident A’s arm to

prevent him from jumping out. Ashley took Resident A to get food and then they returned home. Resident A was walking around the house and then Resident A called the police. The police arrived at the home and talked to both Maurice and Resident A. Ashley heard Resident A tell police that “Maurice punched him.” The police did not see any visible marks on Resident A. They took a report of what happened, and they left. On 09/21/2025, Resident A called police again but this time he told police “I’m feeling suicidal.” The police came to the home and transported Resident A to Common Ground. Resident A is still in the hospital. Ashley has never observed Maurice putting his hands on Resident A or Resident B. Maurice has never threatened Resident A nor has he made any derogatory statements towards Resident A or Resident B.

I interviewed HM Thomas Bates regarding the allegations. Thomas has been working on/off for this corporation since 2018. He is responsible for multiple group homes including this one. On 09/20/2025. Thomas received a telephone call from Maurice informing him that “Resident A was having a behavior during their outing when Maurice mentioned picking up Resident B.” Resident A became upset and according to Maurice, “Resident A tried jumping out of the van while Maurice was driving.” Maurice told Thomas, “I grabbed Resident A’s arm to try to prevent him from jumping out.” When Resident A has “behaviors,” Resident A “curses at staff,” and depending on how upset Resident A is now, “Resident A can get in staff’s face or destroy the house.” Resident A called the police on Maurice but there were no marks observed on Resident A, so the police took a report and left. The next day, Resident A called the police again and told police he “felt suicidal.” Resident A was transported to Common Ground. He has not returned home. Thomas stated Maurice and Resident A always go along. To Thomas’ knowledge, Maurice is Resident A’s favorite staff. Thomas has never observed Maurice put his hands on Resident A nor Resident B.

I reviewed the incident report (IR) dated 09/20/2025 at 2PM written by DCS Maurice McElway. “Resident A had gone into behavior today because he did not want to go anywhere with this roommate. Resident A immediately got upset and said that his roommate did not work for anything so he should not be able to go out. Staff tried to redirect his behavior, became elevated while I was driving. I pulled up to the intersection and Resident A took off his seatbelt and tried to jump out of the car. Staff tried grabbing him to prevent injury. Staff tried to redirect him.”

On 10/07/2025, I followed up with licensee designee Tamisha Kaplan. She stated that Resident A will not be returning to this group home. She is locating another placement for him.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions**
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident

	to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
ANALYSIS:	Based on my investigation and information gathered, DCS Maurice Elmay did not mistreat Resident A and DCS Ashley Wilkins did not grab Resident B by the neck. On 09/20/2025, Resident A reported that Maurice punched him and slapped him on the mouth. He was observed without injuries. Maurice denied punching or slapping Resident A and stated that Resident A attempted to jump out of the van and Maurice grabbed Resident A's arm to prevent him from jumping out. The police were called and due to Resident A having no injuries, they only took a report. Resident A will not be returning to this group home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATIONS:

- **Resident A stated that DCS Maurice Elway verbally abused him.**
- **Resident B stated that staff are mean to him.**

INVESTIGATION:

On 10/06/2025, Resident B was interviewed regarding these allegations. Resident B stated that the HM and Ashley were nice, but then said, “Ashley called me a “bitch and to sit down, when I told her I wanted to go for a walk.” They were in the front room when this happened.

On 10/06/2025, Patrice Vinson was interviewed regarding these allegations. She has never said anything derogatory to either Resident A or Resident B. Patrice has not heard any other DCS say anything derogatory to any of the residents. Resident B gets along with Ashley and Patrice has never heard Ashley call Resident B a “bitch.” Resident B calls Ashley, “his sister.”

On 10/06/2025, I interviewed Maurice McElway regarding these allegations. Maruice denied any verbal abuse towards Resident A. He has never said anything derogatory towards him. Maurice stated that “Resident B has a mouth on him.” Resident B plays around with staff and says “jackass,” and “gives the middle finger to staff all day long.” Staff including Maurice would redirect him and ask Resident B “to please stop.” Maurice stated, “I would joke with Resident B and say fat ass right back to him when he calls me fat ass.” Maurice has not heard other staff members joke with Resident B nor has he heard other staff use any derogatory words towards him. He has never put his hands on Resident B, nor has he witnessed any other staff including Ashley Wilkins grab Resident B by the neck.

On 10/06/2025, Ashley Wilkins was interviewed regarding these allegations. Ashley gets along with both Resident A and Resident B. She denied making any threats or derogatory remarks towards both residents. She stated, “I’m cool with Resident B. I’ve never called him a Bitch.”

On 10/06/2025, Thomas Bates was interviewed regarding these allegations. He has never heard or observed Maurice threatening Resident A or used any derogatory statements towards Resident A or Resident B. Resident A does not like nor does he get along with Resident B. Thomas has observed Resident A “hit,” Resident B, call Resident B names and antagonize him too. Resident A never left any marks on Resident B. Thomas stated that Resident B “uses colorful words,” when Resident B speaks with staff. He has never heard Maurice or any other staff member call Resident B a “fat ass,” or use any other derogatory words. He has never heard Ashley call Resident B a “Bitch.”

On 10/06/2025, I interviewed the manager at Middle Eats Restaurant who is very familiar with Resident B. The manager has observed staff from this group home speak “mean,” with Resident B. The tone staff use with Resident B is “demeaning,” and one-time Resident B came into Middle Eats without staff and lay on the floor. A female staff with tattoos arrived at the restaurant and instead of helping Resident B off the floor, just stood there saying, “get up, you can get up by yourself.”

On 10/13/2025, I followed up with ORR Greg Szopo who stated he will be substantiating his case regarding dignity and respect as it relates to Maurice using the derogatory word “fat ass,” when Resident B called Maurice a “fat ass.”

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based on my investigation and information gathered, DCS Maurice Elmay did not treat Resident B with dignity and respect. Resident B has a developmental disability and uses “colorful words,” when he speaks with staff. One-time Resident B called Maurice a “fat ass,” and Maurice stated he also called Resident B a “fat ass.”
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

On 10/05/2025, Resident B left the home while staff Ronald Lamar Jr., was sleeping.

INVESTIGATION:

On 10/06/2025, Resident B stated he had scratches on his stomach that occurred yesterday when he fell outside. He pulled up his shirt and there were multiple red scratches on his stomach. He stated he was home with DCS RJ who is Ronald Lamar Jr. Resident B wanted to go for a walk but stated that “RJ was sleeping.” Resident B tried to wake RJ up by “tapping him, but he would not wake up.” Resident B went outside by himself and fell. He stated, “I went to the store, and the police brought me back because I got hurt at Jimmy Johns.” RJ was the only staff on shift. He then stated, “Ashley grabbed me by the neck, when I was sitting back there chillin. Ashley said, you can’t sit by there.” Resident B was unable to provide details regarding where he fell as his story changed to the side of the house, on the grass, and then said when he was walking. Resident B said that Ashley grabs his collar. He was unable to provide additional details. Resident B had a bruise on his left arm. He did not know how he got the bruise.

On 10/06/2025, I interviewed Patrice Vinson regarding the allegations. There should be two DCS working when Resident B is home. Patrice arrived at 7PM on 10/05/2025 and was informed by Resident B what happened. Resident B told Patrice, “I was running in the driveway, and I fell.” He had scraped his stomach, arm, and shoulder. He tripped over his own feet. RJ was the DCS that worked with Resident B yesterday. Resident B did not report anything to Patrice about Ashley grabbing his neck and/or collar. Patrice has never observed Resident B’s neck to be red. Patrice noticed the bruise on his arm and does not know how he got it. She stated sometimes he falls asleep on the couch watching TV and may have slept on the remote or something. HM asked Resident B what happened when he too saw the bruise, but Resident B was unable to give him any information.

On 10/06/2025, I interviewed Maurice McElmay regarding these allegations. There should be two DCS working when Resident B is home. He was not working yesterday 10/05/2025; however, he received a telephone call from the police around 11AM saying that “Resident B escaped from the group home and was at Middle Eats Restaurant.” Maurice called HM Thomas informing him that Resident B was found by police at the restaurant. Thomas said, thank you and hung up the phone. He is not sure what happened afterwards. Resident B has eloped several times and when he has tried to elope when Maurice is working, Maurice will redirect him to prevent him from leaving, but Resident B will be “overdramatic,” and say, “staff pushed me,” or say, “staff pulled my shirt.” Maurice stated, “Resident B likes to bully them,” referring to the female staff. Maurice has never observed Ashley grabbing Resident B by the collar and has never observed Resident B’s neck red.

On 10/06/2025, Ashley Wilkins was interviewed regarding the allegations. There should be two DCS per shift for Resident B, but as of last month, there is only one DCS per shift. Since there have been only one DCS per shift for Resident B, Resident B has been eloping frequently. He tries to “run off,” so when redirecting does not work, Ashley

stated, “I grab his hoodie and pull him back into the house.” She stated, “I don’t pull him forcefully to leave marks, just to prevent him from leaving.” Ashley was not working yesterday as she had been off all weekend, so she did not know he eloped. Resident B likes going for walks, but when staff are doing something and tell him he must wait, he will try to leave the home. He has left multiple times.

On 10/06/2025, Thomas Bates was interviewed regarding the allegations. Resident B’s individual plan of service (IPOS) was updated by Easterseals sometime in either 08/2025 or 09/2025 to reflect the approval of 16 hours of two-to-one enhanced staffing and eight hours of one-to-one staffing for Resident B. There are two DCS from 4PM-12PM. In addition, alarms were added to all the doors to alert staff when Resident B tries to elope. Thomas stated that Resident B is easily redirected when he is offered to watch a movie or is made a smoothie, but nine out of 10 times, he wants a pop from the store. Since Thomas has been at this home for a couple of months, Resident B has successfully eloped about five times and yesterday 10/05/2025 was one of those times. Thomas received a telephone call yesterday from Maurice telling him that the police called Maurice because Resident B was found at Middle Eats Restaurant. Maurice called Ronald Lamar Jr., RJ who was working the shift by himself. RJ told Maurice he was in the bathroom and when he came out, Resident B had nowhere to be found. The police brought Resident B back to the home. Thomas stated during their all-staff meetings, Resident B’s elopes are discussed. He was informed that Ashley stated she grabs Resident B by his collar to prevent him from leaving home. Thomas stated that pulling Resident B by the collar is not appropriate and should have never been utilized by Ashley. All staff, including Ashley, have been informed during these staff meetings that no staff member can grab Resident B by his clothes to prevent him from leaving the home. He has never witnessed Ashley grab Resident B by the collar, nor has he observed any red marks on Resident B’s neck.

On 10/06/2025, I interviewed the manager at Middle Eats Restaurant regarding yesterday's incident pertaining to Resident B. The manager was present yesterday when Resident B arrived around 2:30PM. Resident B likes to come to the restaurant “by himself.” He came in and began talking to the employees. One of the employees gave him a drink and then Resident B told the manager he fell and then he lifted his shirt. The manager saw scratches on his stomach. Resident B then began complaining about his chest hurting so the manager called the ambulance. The ambulance arrived shortly after and then transported him to the hospital. About 45 minutes later, a staff member from the group home stopped by asking if Resident B was there. They told him he had been taken to the hospital. The manager stated that Resident B has escaped from the group home several times. The time before yesterday was last month. It was raining heavily outside when Resident B came into the restaurant drenched and his knees covered in mud. It looked like he had fallen. Resident B lay on the floor of the restaurant in front of the counter. Soon after, a black female with tattoos arrived at the restaurant. The female staff told Resident B to get up off the floor, but she would not assist him. Finally, she helped him up and then they left. The manager stated every time Resident B comes to their restaurant, he is by himself. The manager is concerned that Resident B is not being cared for properly given that the manager was informed by one of the staff that

Resident B was “mentally disabled.” The manager stated, “If he is mentally disabled, then why does he keep coming here by himself.”

On 10/06/2025, I reviewed the IR completed by Ronald Lamar Jr., on 10/05/2025 at 2:40PM regarding Resident B eloping from this home. Resident B left out of the back door while staff was in the restroom. Staff looked around the house for Resident B. Resident B was later returned to the house by local law enforcement. The box “No,” was checked off next to “Physical Injury,” even though Resident B had multiple scratches on his stomach due to falling when he eloped from the home.

On 10/13/2025, I received an email from ORR Greg Szopo. He forwarded an email that was sent to him by Resident A’s support specialist Christopher Sas that stated Resident B received 16 hours of enhanced staffing of two-to-one and 8 hours of staff of one-to-one. In addition, alarms on exit doors and windows to prevent elopement. I also received staff schedules for 09/2025 and 10/2025 that clearly shows that licensee designee Tamisha Kaplan is not staffing accordingly. The schedules show that Resident B is not receiving 16 hours of enhanced staff of two-to-one daily.

On 10/13/2025, I followed up via telephone with ORR Greg Szopo. Mr. Szopo stated that he is substantiating these allegations on abuse 2 on reasonable force due to Ashley pulling Resident B’s collar to prevent him from eloping and is also going to substantiate neglect, failure to provide adequate staffing as according to Resident B, Ronald Lamar Jr., (RJ) was asleep and licensee designee Tamisha Kaplan is only staffing appropriately two-to-one between 4PM-12AM.

On 10/13/2025, I made several attempts to reach Ronald Lamar Jr., to discuss these allegations but all attempts were unsuccessful.

On 10/13/2025, I reviewed Resident B’s individual plan of service (IPOS) amended on 09/11/2025. The IPOS stated that Resident B will receive 16-hour, two-to-one and eight-hour one-to-one enhanced staffing. “Fading of enhanced staffing will occur upon safe and healthy adjustment to his new home as evident by three or less acts of aggression, elopement, and psychosomatic complaints and zero 911 interventions or hospitalization attempts that are not medically necessary for three consecutive months.”

On 11/06/2025, I conducted the exit conference with licensee designee Tamisha Kaplan with my findings. Ms. Kaplan advised that she is staffing accordingly for Resident B and that the two-to-one staff is in the home during waking hours. She understands that on 10/05/2025, there was only one DCS, RJ working when Resident B eloped from the home and that according to Resident B, RJ was sleeping during the shift. Ms. Kaplan has been trying to reach RJ, but he has not returned any of her phone calls either. RJ is no longer employed for this corporation. Ms. Kaplan was not aware that Ashley grabbed Resident B’s hoodie to prevent him from eloping because if she was, she would have addressed this inappropriate behavior. Ms. Kaplan stated she is very hands-on at this group home and when she is made aware of any issue, she immediately investigates

and addresses those concerns. She will be addressing these issues with staff and has agreed to submit a corrective action plan.

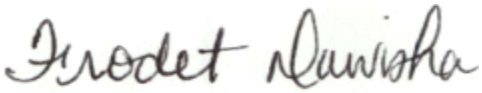
APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(b) 12 residents for small group and family homes.**
ANALYSIS:	Based on my investigation and information gathered, there was insufficient DCS on duty for the supervision and protection or Resident B. On 10/05/2025, Resident B eloped from the group home while DCS Ronald Lamar, Jr., (RJ) was working alone and according to Resident B asleep. Resident B attempted to wake RJ up but was unsuccessful. Resident B then left the home, fell outside, resulting in multiple scratches on his stomach and walked to Middle Eats Restaurant. The manager at Middle Eats stated that the staff (RJ) showed up 45 minutes after Resident B was at the restaurant. The manager also stated that there have been multiple times that Resident B has come to their restaurant by himself without staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(2) Interventions must be specified in the resident's assessment plan and performed in accordance with that plan. Interventions must ensure that the safety, welfare, and rights of the resident are adequately protected. If an intervention is needed to address the unique programmatic needs of a resident, the intervention must be developed in consultation with, or obtained from, a professional or professionals licensed, certified, or registered in that scope of practice.

ANALYSIS:	Based on my investigation and information gathered, DCS Ashley Wilkins utilized an intervention to prevent Resident B from eloping that was not approved or appropriate. Resident B stated that Ashley grabbed him by his shirts collar. Ashley confirmed that she had pulled on Resident B's hoodie to prevent him from eloping. This intervention was not approved by Easterseals nor was it in Resident B's IPOS amended on 09/11/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

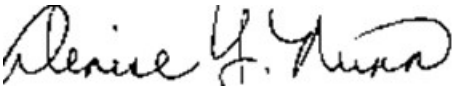
Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



11/10/2025

Frodet Dawisha Date
Licensing Consultant

Approved By:



11/18/2025

Denise Y. Nunn Date
Area Manager