GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 17, 2026

Damaris Sima
37841 Hazel Street
Harrison Charter Twp, MI 48045

RE: License #: AF500405462
Investigation #: 2026A0990001
Hazel Home
AMENDED REPORT
Original Report date: December 23, 2025

Dear Ms. Sima:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF500405462
Investigation #:	2026A0990001
Complaint Receipt Date:	10/20/2025
Investigation Initiation Date:	10/22/2025
Report Due Date:	12/19/2025
Licensee Name:	Damaris Sima
Licensee Address:	37841 Hazel Street Harrison Charter Twp, MI 48045
Licensee Telephone #:	(586) 260-5121
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Hazel Home
Facility Address:	37841 Hazel Street Harrison Charter Tow, MI 48045
Facility Telephone #:	(586) 690-8868
Original Issuance Date:	01/21/2021
License Status:	REGULAR
Effective Date:	07/20/2025
Expiration Date:	07/19/2027
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
On 10/8/2025, Resident A suffered two suspected seizures and a fall at Hazel Home, breaking her arm, but staff failed to call 911, withheld the extent of her injury from family, and neglected to seek proper medical care.	Yes
Around the first or second week of September of 2025, Resident A was distraught and clinging to Relative A3 in the AFC home when he was attempting to leave. An unidentified AFC staff member grabbed Resident A by her ankles and dragged her off.	No

III. METHODOLOGY

10/20/2025	Special Investigation Intake 2026A0990001
10/20/2025	APS Referral Adult Protective Services (APS) referral – denied at intake
10/22/2025	Special Investigation Initiated - Letter I emailed Relative A.
10/27/2025	Contact - Document Received I received a new intake with the same allegations. The new intake was dismissed.
10/28/2025	Contact - Document Sent I emailed Emily Poley, APS.
10/28/2025	Contact - Face to Face I conducted an announced onsite special investigation. I interviewed Alex Dereciche, (Licensee's father). I interviewed Sherry Labanski, Hospice Visting Nurse. I attempted to interview Resident A. Mr. D. Called Relative A in which; I briefly spoke to.
12/05/2025	Contact - Telephone call made I conducted a phone interview with Relative A1.
12/05/2025	Contact - Document Received I reviewed Resident A's resident record.

12/05/2025	Contact - Telephone call made I left a detailed voice message for Ms. Sherry Labanski.
12/05/2025	Contact - Telephone call made I conducted a phone interview with Damaris Sima, licensee.
12/05/2025	Contact - Telephone call made I conducted a phone interview with Alexis Capus. direct care staff.
12/15/2025	Contact - Document Sent I emailed Emily Poley to request the status of the APS investigation. Ms. Poley forwarded email to the assigned specialist Latoyia Carter. Ms. Carter's investigation is incomplete.
12/22/2025	Exit Conference I conducted an exit conference with Ms. Sima.

ALLEGATION:

On 10/8/2025, Resident A suffered two suspected seizures and a fall at Hazel Home, breaking her arm. Staff failed to call 911, withheld the extent of her injury from family, and neglected to seek proper medical care.

INVESTIGATION:

On 10/20/2025, I received the complaint via email. In addition to the above allegations, it was reported that Resident A suffered two suspected seizures (resident does not have any seizure history or disorder) at Hazel Home, resulting in a fall where she broke her arm. Staff were present but did not call 911 when the incident occurred and did not seek medical attention afterwards for the resident's arm. Family members were not contacted immediately and were only told that she fell and "bruised her arm". When family members came to visit Resident A, it was obvious that her arm was more than just bruised. Family members took Resident A to the doctor, then found out that her arm was broken and needed surgery. Additional medical follow-up care was not taken by the staff at Hazel Home.

A second intake came in and it was reported that Resident A is 80 years old and her health has declined significantly over the past year and a half, with a lot of symptoms aligning with Alzheimer's disease. Resident A understands everything that is happening, but she has lost her ability to think and communicate effectively. Resident A gives one-to two-word responses and looks to others to finish her thoughts and sentences. Resident A began eloping from home and engaging in unsafe behavior, so she was placed in Hazel Home. On or about 10/07/2025, Resident A fell in the AFC home due to two suspected seizures; Resident A does not have a seizure condition. AFC home staff members did not call 911 and did not contact Resident A's family immediately; Resident

A's family was contacted five or six hours later and informed that she had a bruise on her arm. Resident A's family went to the AFC home and discovered her left arm was completely bruised - with black, blue, and green bruising - from her shoulder to her fingertips. Resident A's family transported her for medical care at an unidentified facility, where Resident A was found to have an obvious break in the bone that connects the arm and shoulder on her left side. Resident A was referred to have surgery on 10/14/2025 at an unidentified facility.

On 10/28/2025, I conducted an announced onsite special investigation. I interviewed Alex Dereciche, the licensee's father. Mr. Dereciche said that Demaria Sima, licensee, was on vacation, and he was covering for her. Mr. Dereciche lives across the street and is the owner of a family home, as well as Ms. Sima's father. Mr. Dereciche explained that Resident A has somewhat of a family split situation. Resident A and her spouse both have children from different marriages. Resident A's power of attorney (POA) is held by Relative A. Relative A makes all the decisions for Resident A. Resident A is currently in rehabilitation because he was hospitalized. Mr. Dereciche said that he became aware of Resident A's seizure because he received a phone call from his other daughter, Alexis Capus. Mr. Dereciche said Ms. Capus called him and said Resident A was having what appeared to her as a seizure at breakfast. Mr. Dereciche said Ms. Capus described that Resident A was having compulsive body movements. Mr. Dereciche said that Ms. Capus identified this immediately because they have a family member who suffers from grand mal seizures, and they have all witnessed them.

Mr. Dereciche said he immediately came to the home (he crossed the street) and at that time Ms. Capus had already taken Resident A to her bedroom. Mr. Dereciche believes Ms. Capus had already called Relative A to inform him of this. Mr. Dereciche called the nurse who provides nursing services to his home, Ms. Sherry Labanski. Mr. Dereciche said that Ms. Labanski called the doctor to inform the doctor that Resident A had a seizure and does not have a history of seizures. Mr. Dereciche was informed the doctor was sending over seizure medications. Mr. Dereciche said that after lunch, Resident A had another seizure. Mr. Dereciche called Ms. Labanski back to inform her that Resident A had another seizure. Later that day, they noticed that Resident A was holding her arm as if it was hurting. Mr. Dereciche said that he called Ms. Labanski again, informing her that her arm seemed to hurt. The doctor then ordered a mobile X-ray. Mr. Dereciche said that the mobile X-ray service did not come. The next morning, the family came to visit, and Relative A1 noticed Resident A's arm was bruised. They decided to take her to the urgent care. Mr. Dereciche was informed that her shoulder was dislocated and possibly fractured. Mr. Dereciche said that Resident A was taken to Henry Ford Urgent Care by Relative A. She was referred to a specialist and eventually had surgery on her left shoulder. Mr. Dereciche said that he was not present for the seizures, but Ms. Capus stated that Resident A never fell to the floor. There was no medical documentation provided from the family.

Mr. Dereciche called Relative A1 while I was present. Relative A1 was on speaker phone, and Mr. Dereciche informed him of my presence and the reason for the visit. Relative A1 said that Resident A had an X-ray done at urgent care and was sent to

three different specialists. Relative A1 said that this was the first time that Resident A had a seizure. Many years ago, she had a concussion from a car accident. She had surgery on her shoulder at Pioneer Surgical Center. Mr. Dereciche added that Resident A is now prescribed Depakote medication. I requested Resident A's records, and copies were received.

Mr. Dereciche called the nurse who was present across the street and Ms. Labanski arrived at the home. Ms. Labanski said that she received a phone call from Ms. Capus early in the morning, in which Ms. Capus described what had happened with Resident A, and it sounded like a grand mal seizure. Resident A's primary care physician is Dr. Datala. After she received the phone call, she sent a message to Dr. Datala, and he returned her call. Dr. Datala prescribed her Depakote. Ms. Labanski said she contacted Relative A right away to inform him of the seizure and to collect medical history.

Ms. Labanski said that she received another call after lunch that Resident A had another seizure. Ms. Labanski did not have her notes with the actual times of the calls. Ms. Labanski also said that an old head injury can show up later in life and cause seizures. Ms. Labanski could not confirm if she had seen Resident A face-to-face after the first or second seizure. Ms. Labanski said an X-ray was ordered, but for some reason, the order never went through. Ms. Labanski was informed that Resident A had a fracture of the left humerus. Ms. Labanksi had no medical documentation in the home regarding the calls or visits.

I attempted to interview Resident A, but due to her limited cognitive abilities, an interview could not be conducted. I observed her walking around the home. Resident A is a very petite lady. She appeared happy and content.

On 12/05/2025, I conducted a phone interview with Relative A1. Relative A1 said that on the day of the seizure, they received a phone call from Relative A. The seizure had allegedly occurred several hours before Relative A1 received a phone call about it. Relative A1 said that Resident A had never had a seizure. Relative A1 said that although they may have suspected that it was a seizure, they should have called 911. As a result, Resident A had fractures on the shoulder and arm (the joint joining the two bones. Resident A had outpatient surgery and healed well. Relative A3 is now living with Resident A at home. Relative A had taken Resident A to urgent care.

On 12/05/2025, I reviewed Resident A's resident record. I reviewed Resident A's *Health Care Appraisal*, *Assessment Plan*, two incident reports and POA paperwork. Resident A's diagnosis is as follows: Alzheimer's. seizure disorder, hypertension, left humoral fracture, and expressive aphasia. The *Health Care Appraisal* was dated 10/14/2025. Resident A is fully ambulatory and is at risk. Resident A requires assistance with ADLs, wears hearing aids and does not have a special diet. Relative A1 is the POA that was granted on 03/11/2025. I reviewed the incident report dated 10/06/2025 at 08:16AM written by Alexis Capus. The incident report documented that Resident A was eating breakfast at the dining room table. Having given her a sip to drink, she started having a seizure for less than one minute with chaotic movements in her arms. Once she gained

control of her body, it was noticed that her left arm was affected. Ms. Capus called Mr. Dereciche, nurse, doctor, and POA. Resident A was rolled to her bedroom and lay down with the help of Mr. Dereciche. Provided seizure medications, Depakote, and placed an order for X-ray. I reviewed the second incident report dated 10/06/2025. The incident report documented that Resident A was eating lunch at the dining room table. While sitting, she began to have another seizure for less than one minute with chaotic movements of her arms. Resident A was taken to the recliner seat, and the nurse, doctor, and POA were called. Resident A administered Acetaminophen after noticing signs of pain in her left arm. The incident report documented that Resident A was already prescribed Depakote and a mobile X-ray.

On 12/05/2025, I conducted a phone interview with Damaris Sima, licensee. Ms. Sima was not present the day Resident A had a seizure. She was made aware that Resident A's POA/Relative A1 was contacted the same day. There were quite a few family members with whom they had contact. Ms. Sima said that Resident A's *Health Care Appraisal* was completed after the seizure because it had not been completed upon admission. Ms. Sima said that Dr. Datala sees patients every two months. When Resident A moved into the home in September 2025: the doctor had not come out to the home. Resident A had been seen by the nurse prior to the doctor and health care appraisal. Resident A did not have a history of seizures; she has completely recovered from her shoulder injury. Resident A is doing much better in the home now that her husband/Relative A3 is living there.

On 12/05/2025, I conducted a phone interview with Alexis Capus, direct care staff. Ms. Capus said that on the day of the seizure, she was the only employee working in the home. She contacted her dad (Mr. Dereciche), who came over right away to assess the seizure. The seizure lasted 30 seconds. Ms. Capus said she called the nurse, Ms. Labanski, who described what had occurred. The second seizure happened during lunchtime. She started convulsing for about 30 seconds. Her eyes were blinking fast. Ms. Capus said that Ms. Labanski came to the home after the second seizure to assess her. Ms. Capus contacted Relative A, but was unsure what time, shortly after the first seizure.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	Based on the investigation, there is sufficient evidence to support that immediate medical treatment should have been sought for Resident A on 10/06/2025. Resident A had two seizures, which contributed to her receiving a fractured shoulder that required surgery. According to the first incident report, direct care staff Alexis Capus observed that Resident A's arm was

	affected, although nothing was described. Although Ms. Capus contacted the in-home nurse, Resident A was not seen by a medical doctor until the next day, which was completed by her family. Resident A did not have a history of seizures; therefore, her having one should have escalated to emergency room treatment.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Around the first or second week of September of 2025, Resident A was distraught and clinging to Relative A3 in the AFC home when he was attempting to leave. An unidentified AFC staff member grabbed Resident A by her ankles and dragged her off.

INVESTIGATION:

On 10/20/2025. A second intake was received. In addition to the above allegations, it was reported that one or two months ago, by Relative A3, visited Resident A the week of September 2025. It is not known if Resident A was dragged across the floor. Resident A was not injured. The staff did not use proper de-escalation techniques in handling the situation.

On 10/28/2025, I conducted an on-site special investigation. I interviewed Mr. Dereciche and he said that the incident never happened.

On 12/05/2025, I conducted a phone interview with Relative A1. Relative A1 said that they did not witness the incident but were informed by Relative A1 about what had happened. Relative A1 said that Resident A had recently moved into the home and was being visited by Relative A3. Relative A3 was attempting to leave the visit. Resident A was clinging to him and begging him to take her with him. She became combative and distressed and also began hitting. The staff could de-escalate her, but instead, she dragged her by her ankles to release her from Relative A3.

On 12/05/2025, I conducted a phone interview with Alexis Capus, direct care staff. Ms. Capus said that she recalls the incident as she was the only staff member working on this day. This was her second day at home, and Relative A and Relative A3 came to visit. They were all sitting outside on the deck, and the weather was warm. As Relative A3 was getting ready to leave, Resident A began hugging him tightly as he sat in his wheelchair. Relative A 3 kept telling her it was time for him to go, but Resident A would not release him. Relative A told her a couple of times to keep Relative A3 go, but she refused. Relative A3 began telling ‘Resident A that she was hurting him and letting go. Ms. Capus said that she, along with Relative A, gently pulled her back to release her from Relative A3. There was nothing hurtful done, and she was denied pulling her by

her ankles. Resident A was standing over Relative A3 as he sat in his wheelchair. Resident A was gently guided away.

On 12/22/2025, I conducted an exit conference with Ms. Sima. Ms. Sima was informed of the findings. The family had also relayed that the hospital visits triggered and made her disoriented; therefore, a mobile X-ray was ordered. Relative A also wanted her to see a specific specialist for the surgery. Typically, they send residents out to emergencies. They didn't know she had a fracture until later in the day. Resident A is in physical therapy and the swelling has decreased. Ms. Sima agreed to submit a corrective action plan when the report is finalized.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(c) Restrain a resident's movement for the purpose of immobilizing the resident.**
ANALYSIS:	Based on the investigation, there is insufficient evidence to support that Resident A was dragged by her ankles when embracing her spouse, Relative A3, during a visit. According to Ms. Capus, Relative A3 was visiting on resident A's second day living at home. She began hugging him tightly as he was leaving the visit. Ms. Capus and Relative A1 had to gently remove her from Relative A3 because she was hurting him.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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

L. Reed 12/22/2025

LaShonda Reed Date
Licensing Consultant

Approved By:

Denise Y. Nunn 12/23/2025

Denise Y. Nunn Date
Area Manager

Amended Report
SIR# 2026A0990001

PURPOSE:

The purpose of the amended report is to change the rule violation to no violation established based on additional information received for rule R 400.689 (3).

METHODOLOGY:

01/06/2026	I received an email from Damaris Sima, licensee.
01/07/2026	I received an email from Ms. Sima requesting a phone conference to further discuss the findings in the report as she believed that there was information that needed to be clarified.
01/08/2026	I received a call from Ms. Sima, Cornelia Derecichei, responsible person, and Alexandru Derecichei, father of licensee.
01/13/2026	I received from Ms. Sima the nurses' notes dated 10/06/206 and the mobile x-ray order dated 10/06/2025.

DESCRIPTION OF FINDINGS AND CONCLUSION:

On 01/06/2026, I received an email from Damaris Sima, licensee. Ms. Sima said that she did not have the corrective action plan completed due to the holidays and would get it back to me no later than Friday, 01/09/2026.

On 01/07/2026, I received an email from Ms. Sima requesting a phone conference to further discuss the findings in the report as she believed that there was information that needed to be clarified.

On 01/08/2026, I received a call from Ms. Sima, Cornelia Derecichei, responsible person, and Alexandru Derecichei, father of licensee. Ms. Sima said that medical care was sought for Resident A. Mr. and Mrs. Derecichei added comments regarding the rule stating medical attention was sought because Resident A was seen by the nurse and the nurse received guidance from the doctor. I questioned whether the doctor had Resident A as an established patient and they informed me that Resident A had one prior visit with the doctor. Ms. Sima said that she originally misspoke, stating that Resident A had never seen Dr. Datla and would send documentation to support this. We discussed in detail the events that occurred and I expressed that I believed that emergency medical treatment should have been sought being that Resident A was a new resident and did not have history of seizures. Ms. Sima said that they followed the

doctors' orders and they could not control that the mobile x-ray company did not show up as it was ordered the day of the seizure for the shoulder injury. Ms. Sima agreed to send the nurses notes for review.

On 01/13/2026, I received from Ms. Sima the nurses' notes dated 10/06/206 and the mobile x-ray order dated 10/06/2025. I also observed that there was a face-to-face visit note from Dr. Datla dated 09/04/2025 with Resident A prior to the seizure. The nurses' notes documented that Sherry Labanski, RN seen Resident A on 10/06/2025 at the home. The notes documented that Dr. Datla was called in which, they called in a prescription. Mr. Derecichei said that Resident A's seizure lasted about 30 seconds each. The note documented that the home should call 911 if another seizure occurs that lasts over five minutes.

CONCLUSION:

Based on the nurses note dated 10/06/2025, it has been determined that the home sought medical attention for Resident A after her first seizure. Resident A had two seizures on this day. Sherry Labanski consulted with Dr. Datla who also had an x-ray to be done at home, however, the company did not show up at the home. The home was advised to seek emergency care only if Resident A seizures lasted over five minutes.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	Based on the investigation, there is insufficient evidence to support that immediate medical treatment was not sought for Resident A on 10/06/2025. Resident A had two seizures, which contributed to her receiving a fractured shoulder that required surgery. According to the nurse's note dated 10/06/2025, Sherry Labanki, RN observed Resident A in the home and consulted with Dr. Datla. Medication was ordered and a mobile x-ray as well. The x-ray company did not show up. Therefore, Resident A received additional medical treatment the next day.
CONCLUSION:	VIOLATION NOT ESTABLISHED

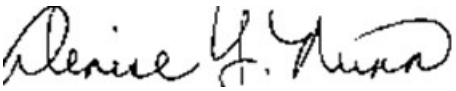
RECOMMENDATION:

I recommend that the special investigation be closed with no change to the status of the license.

01/27/2026

LaShonda Reed — Date
Licensing Consultant

Approved By:



02/17/2026

Denise Y. Nunn — Date
Area Manager