GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 14, 2026

Dominique Miller
Residential Options Inc.
2400 Science Parkway
Okemos, MI 48864

RE: License #: AM190015000
Investigation #: 2026A1033009
Dewitt Road Home

Dear Ms. Miller:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care violation identified in the report, a written corrective action plan is required and a six-month provisional license is recommended. The corrective action plan is due 15 days from the date of this letter and must include the following:

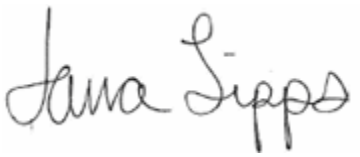
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (517) 335-5985.

Sincerely,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM190015000
Investigation #:	2026A1033009
Complaint Receipt Date:	12/01/2025
Investigation Initiation Date:	12/02/2025
Report Due Date:	01/30/2026
Licensee Name:	Residential Options Inc.
Licensee Address:	2400 Science Parkway Okemos, MI 48864
Licensee Telephone #:	(517) 374-8066
Administrator:	Dominique Miller
Licensee Designee:	Dominique Miller
Name of Facility:	Dewitt Road Home
Facility Address:	11262 N Dewitt Road Dewitt, MI 48820
Facility Telephone #:	(517) 669-3382
Original Issuance Date:	06/22/1993
License Status:	REGULAR
Effective Date:	02/28/2024
Expiration Date:	02/27/2026
Capacity:	8
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided adequate protection and supervision by direct care staff, resulting in significant injuries and her eventual death.	Yes

III. METHODOLOGY

12/01/2025	Special Investigation Intake 2026A1033009
12/01/2025	APS Referral- Denied APS referral. Resident A is deceased.
12/02/2025	Special Investigation Initiated - On Site- Interviews conducted with licensee designee, Dominique Miller, direct care staff/home manager, Lillian Sidelinker, direct care staff, Laura McNamara & Madison Carey. Review of Resident A's resident record was initiated.
12/02/2025	Contact - Document Sent- Email correspondence sent to licensee designee, Dominque Miller, requesting additional documentation for this investigation.
12/03/2025	Contact - Document Received- Telephone communication with Detective Derreck Shaberg, Dewitt Twp. Police.
12/03/2025	Contact - Telephone call made- Attempt to interview Complainant. Voicemail message left, awaiting response.
12/03/2025	Contact - Telephone call made- Attempt to interview Guardian A1, via telephone. Voicemail message left, awaiting response.
12/03/2025	Contact – Telephone call received- Interview conducted with Guardian A1, via telephone.
12/04/2025	Contact – Document Received- Email correspondence received from licensee designee, Dominique Miller.
12/04/2025	Contact – Telephone call received- Interview conducted with Complainant, via telephone.
12/04/2025	Inspection Completed On-site- Follow-up on-site inspection completed.

12/04/2025	Contact – Telephone call made- Interview conducted with Guardian B1, via telephone.
12/08/2025	Contact – Telephone call received- Telephone conversation with Guardian A1.
12/09/2025	Contact – Document received- Email correspondence received from licensee designee, Dominque Miller.
12/10/2025	Contact – Document received- Email correspondence received from licensee designee, Dominique Miller.
12/12/2025	Contact – Document received- Email correspondence received from licensee designee, Dominique Miller.
12/15/2025	Contact – Document sent- Email correspondence sent to Guardian A1.
12/15/2025	Contact – Document sent- Email correspondence sent to Clinton Eaton Ingham Community Mental Health compliance team requesting Resident A CEI-CMH records.
12/17/2025	Contact – Document received Email correspondence received from Emily Ryan at CEI-CMH Compliance office. Requested documents were attached to this email.
12/22/2025	Contact – Telephone call made Interview conducted via telephone with CEI-CMH, case manager, Jenee Wilson.
12/22/2025	Contact – Document Received Email correspondence received from licensee designee, Dominique Miller.
12/22/2025	Contact – Telephone call made Interview conducted with CEI-CMH, Occupational Therapist, Krista Winkler, via telephone.
12/22/2025	Contact – Telephone call made Attempt to interview CEI-CMH, Psychologist, Warner Myntti. Voicemail message left, awaiting response.
12/23/2025	Contact – Telephone call received

	Returned telephone call received from Warner Myntti with CEI-CMH. Attempt to call him back and received voicemail. Voicemail message left.
12/23/2025	Contact – Document Sent Email correspondence sent to Warner Myntti with CEI-CMH. Awaiting response.
12/23/2025	Contact – Telephone call received Interview conducted with Warner Myntti, Psychologist with CEI-CMH.
01/06/2026	Contact – Document Sent Email correspondence sent to Ms. Miller.
01/07/2026	Contact – Document Received Email correspondence received from Ms. Miller.
01/08/2026	Contact – Telephone call made Interview conducted with Guardian A1.
01/14/2026	Exit Conference with Dominique “Nicky” Miller and Kelly Bailey. Completed by Area Manager Dawn Timm

ALLEGATION: Resident A was not provided adequate protection and supervision by direct care staff, resulting in significant injuries and her eventual death.

INVESTIGATION:

On 12/1/25 I received an online complaint regarding the Dewitt Road Home, adult foster care facility (the facility). The complaint alleged that Resident A experienced multiple falls at the facility resulting in serious injury, and her eventual death. She died on 11/23/25. The complaint reported that prior to Resident A’s admission to the facility she was hospitalized for a period of eight months at University of Michigan Health Sparrow Hospital in Lansing, MI. The complaint noted that while at the hospital it was identified that Resident A was a fall risk and had a one-to-one sitter with her to ensure her safety. The complaint alleged that Resident A was a significant fall risk due to her decline in physical health, and limited vision. The complaint stated that Resident A continued to be a fall risk once admitted to the facility but was not provided with one-to-one direct care staff support to monitor for falls. The complaint reported that direct care staff were aware of Resident A’s fall potential and did not provide one-to-one staffing and chose to transport Resident A in the facility vehicle with only one direct care staff, who was the driver of the vehicle. The complaint reported that Resident A has a shunt in her neck and this shunt was damaged due to multiple falls Resident A sustained while under the

care of direct care staff at the facility. The complaint alleged that Resident A's death is related to the damage to Resident A's shunt caused by the multiple falls she sustained at the facility due to a lack of supervision provided by direct care staff.

On 12/2/25 I conducted an unannounced, on-site investigation at the facility. I interviewed licensee designee, Dominque Miller via telephone regarding the allegation. Ms. Miller reported that she had a prior connection with Resident A as Resident A had been a client in the Residential Options Inc. (ROI) independent living program years prior. Ms. Miller reported that she was aware of Resident A's shunt prior to her being referred to the facility due to this previous relationship. Ms. Miller reported that the licensee, ROI, received a referral for Resident A from University of Michigan Health Sparrow Hospital. She reported that they were told Resident A had stage three kidney disease, her mental health was not stable, and she had impaired vision. She reported that she was informed Resident A had been hospitalized for a period of seven months waiting for a proper placement and was not able to be placed due to behaviors she had been experiencing, including falls and having an unsteady gait. Ms. Miller reported that she had been aware that Resident A was treated for a urinary tract infection (UTI) prior to her discharge from the hospital, and admission to the facility on 8/5/25. She reported that once admitted to the facility, direct care staff were providing one-on-one care for Resident A during the evening hours due to increased confusion and falls Resident A was experiencing. She reported that a chair was placed in Resident A's bedroom, near her bed, to assist with preventing these falls. Ms. Miller reported it was discovered that the UTI Resident A was treated for at the hospital did not fully resolve. Resident A was treated for the UTI again, after admission to the facility. Ms. Miller reported that Resident A was frequently confused and could be combative with direct care staff when they attempted to provide physical help to her. She reported that Resident A had "zero balance" and wanted to "get up and go". She reported that this led to many of Resident A's falls. Ms. Miller reported that Resident A's UTI appeared to be resolving and she was having less confusion and episodes of falls about two to three weeks post admission. She reported direct care staff stopped sitting by her bedside at night but were providing regular checks on her throughout the night.

Ms. Miller also reported direct care staff had difficulty transporting Resident A in a vehicle due to her impulsive behavior to unfasten her seatbelt while the vehicle was moving. She reported that direct care staff/home manager, Lillian Sidelinker, transported Resident A to a medical appointment in Chelsea, MI, in September (date not recalled) and had to stop the van and call for additional direct care staff to meet her at an exit off the highway to assist with providing supervision to Resident A for the remainder of the drive. Ms. Miller reported that the direct care staff asked Clinton Eaton Ingham Community Mental Health (CEI-CMH) staff for assistance with ordering a "buckle buddy", bed alarms, and door alarms for Resident A and were repeatedly told by CEI-CMH psychologist Warner Mynttie that direct care staff just needed to continue to document episodes of Resident A's behaviors to prove she required these types of restrictive devices. Ms. Miller reported that a "buckle buddy" is a device that would lock Resident A's seatbelt so that she could not unfasten it on her own. The device would require that a direct care staff member have a mechanism to unlock the device which

would then allow the seatbelt to be released. Ms. Miller reported that a buckle buddy was never approved for Resident A's use, by CEI-CMH staff.

Ms. Miller further reported that Resident A had four major falls during her stay at the facility from 8/5/25 through 10/31/25. Ms. Miller reported that Resident A had an unwitnessed fall in her bedroom on 10/1/25 (transported to the emergency department), an unwitnessed fall down the basement staircase (date not provided, transported to emergency department), another unwitnessed fall in her bedroom the morning of 10/31/25 (transported to urgent care), and a fourth fall during transportation to the urgent care on 10/31/25. The last fall was a result of Resident A unfastening her seatbelt and falling in the van, hitting her head on the floor of the van. Ms. Miller reported that Resident A was being transported on this date by Ms. Sidelinker, who was the driver of the van. There were no other direct care staff members in the van with Ms. Sidelinker on this date. Ms. Miller reported that the staffing levels at the facility while Resident A was a resident were two direct care staff consistently 24 hours per day, seven days per week, and there were days when they added a third direct care staff between the hours of 10am to 6pm. Ms. Miller reported that line of sight or one-on-one staffing was never ordered for Resident A by CEI-CMH. Ms. Miller stated she did not order direct care staff to provide one-on-one, or line of sight supervision either for Resident A. Ms. Miller reported that after Resident A returned to the facility on 10/31/25, after experiencing two falls and two separate head injuries that day, she became very lethargic and difficult to arouse. She reported that Guardian A1 was contacted and the decision was made to send Resident A to the emergency department. Ms. Miller reported that her understanding is that Resident A was diagnosed with complications related to her shunt and noted that the shunt, located in her neck had been leaking fluid due to the shunt being damaged. She reported that her understanding is Guardian A1 was advised that the only correction for this complication would be surgery and Guardian A1 chose the less invasive process which was hospice care for Resident A. Resident A died under hospice care and did not return to the facility.

During the unannounced on-site investigation on 12/2/25, I interviewed Ms. Sidelinker regarding the allegation. Ms. Sidelinker reported that she has worked at the facility for about 21 years. She reported that her current title is home manager. Ms. Sidelinker reported that Resident A was admitted to the facility on either, 8/5/25 or 8/8/25, she could not recall on this date. She reported that prior to Resident A's admission she and Ms. Miller made an on-site visit to Resident A at University of Michigan Health Sparrow Hospital. Ms. Sidelinker reported that Ms. Miller had prior knowledge of Resident A's history, including her shunt placement. She reported that Ms. Miller shared this information with her. She reported that during the visit at the hospital Ms. Miller and Ms. Sidelinker were informed that Resident A had a history of unsteady gait, falls, did not like to be touched by others, had diabetes, and information about her shunt was "glazed" over. Ms. Sidelinker reported that she has a history of providing care to residents with a shunt as Resident B also has a shunt. She reported that it was discussed that if Resident A were to fall and hit her head, direct care staff would need to seek medical care due to the shunt. Ms. Sidelinker reported that the shunt placement was on the right side of Resident A's head extending down her neck. She reported that

she could feel the shunt when she washed Resident A's hair. Ms. Sidelinker reported that Resident A had been hospitalized for seven months prior to her admission to the facility as the hospital could not find a placement that would accept her due to her behaviors and falls. She reported that the hospital had been using a one-on-one sitter for Resident A to monitor her behavior and prevent falls. Ms. Sidelinker reported that when Resident A was admitted to the facility she presented as restless and confused. She reported that Resident A was sent back to the hospital, and it was discovered that her UTI had not fully resolved and she needed additional antibiotics. Ms. Sidelinker reported that Resident A required one-on-one direct care staffing at night when she first admitted due to her UTI, restlessness and falls. She reported that they had a chair next to her bed and direct care staff sat by her and monitored Resident A for safety purposes to prevent falls. She reported that Resident A's UTI began to resolve, and she no longer required someone sitting next to her throughout the evening. Ms. Sidelinker reported that Resident A's UTI resolved but she was still experiencing unsteady gait and some confusion. She reported that they took safety measures and put Resident A's dresser in her closet, to prevent her from hitting this when she fell, and they took foam "pool noodles" and lined her bedroom door frame with these to prevent her from injury if she fell and hit her head on the door frame. She also reported that a bedside commode was ordered for safety purposes. Ms. Sidelinker reported that Resident A was connected with CEI-CMH for services at the facility and they were working with Mr. Mynttie, the psychologist, on documenting Resident A's behaviors. She reported that they asked Mr. Mynttie multiple times for devices to increase Resident A's safety at the facility including bed alarms, door alarms, a buckle buddy for her seatbelt in the van, and these requests were declined by Mr. Mynttie. She reported that they were told that CEI-CMH required more documentation and behavior tracking to pursue these devices for Resident A. Ms. Sidelinker reported that Resident A had behaviors and would spit, hit, bite, and scratch direct care staff members. Ms. Sidelinker reported that Resident A had consistent issues with falling. She reported that she transported Resident A to a medical appointment in September 2025 and during this transport, Resident A repeatedly unfastened her seatbelt and tried to stand up in the van. She reported that this transport became unsafe so she stopped at an exit off the highway and called the facility for assistance. She reported that direct care staff, Laura McNamara and Claria Kigeme, drove to the exit and Ms. Kigeme assisted Ms. Sidelinker in providing safety to Resident A in the van for the remainder of the trip back to the facility. Ms. Sidelinker reported that it was known from this point forward that Resident A should not be transported with one direct care staff member due to her potential for falls and unfastening her seatbelt. Ms. Sidelinker reported that Resident A experienced multiple minor falls at the facility and four major falls under the care of the direct care staff. She reported that Resident A experienced a major fall on 10/1/25. She reported that this fall was unwitnessed and occurred in Resident A's bedroom. She reported that Resident A fell and hit the left side of her head on her closet door and was found lying on the floor in her room, non-responsive and bleeding from her head. She reported that Resident A was sent to the emergency department and returned to the facility after she was evaluated at the emergency department at University of Michigan Health Sparrow Hospital. Ms. Sidelinker reported that on another, unidentified date, Resident A had opened the basement door at the facility and fell down the staircase. She reported that on this date,

there were two direct care staff members on the schedule. One of the direct care staff had been providing personal care to a resident and the other was in the restroom. Ms. Sidelinker reported that she took Resident A to the emergency department on this date due to the significance of Resident A falling down the staircase. She reported that Resident A received a full medical evaluation and returned to the facility. Ms. Sidelinker reported that Resident A experienced a third major fall on 10/31/25. She reported that this fall was unwitnessed and occurred in Resident A's bedroom. She reported that Resident A had fallen and hit the left side of her head above her eyebrow. She reported that Resident A had "split her eye open." Ms. Sidelinker reported that she observed that this injury was going to require stitches so she called Guardian A1 and requested to transport Resident A to the urgent care for evaluation. Ms. Sidelinker reported that she transported Resident A on this date (10/31/25) by herself as there were no other direct care staff members who could ride in the van with her and provide supervision to Resident A. She reported that on the way to the urgent care, Resident A unfastened her seatbelt, stood up in the van, fell forward, hitting the top of her head on the floor of the van. She reported that this caused another head injury on the top of Resident A's head and that she was bleeding from both wounds. Ms. Sidelinker reported that the staff at the urgent care, glued both wounds closed and sent Resident A back to the facility. She reported that the staff at the urgent care did not recommend any further medical evaluation for Resident A. Ms. Sidelinker reported that within about one hour of Resident A returning to the facility, she was slumped over in her chair and not acting like herself. She reported that Resident A's eye was swelling. She reported that she contacted Guardian A1, who agreed to have Resident A sent to the emergency department for evaluation and treatment. Ms. Sidelinker stated the reason she chose to transport Resident A to urgent care on 10/31/25, alone, despite knowing that Resident A had a history of unfastening her seatbelt and being unsafe during transports and having this behavior previously identified as a safety concern, was because there was not adequate direct care staff available to assist with this transportation. Ms. Sidelinker confirmed she was aware that Resident A required a direct care staff member to sit next to her during transports to ensure her seatbelt did not become unfastened. She reported that she did not think Resident A required emergency department care on this date rather she thought Resident A just required stitches for the wound above her eye so this was why she did not call 911 for evaluation and treatment. Ms. Sidelinker reported that the facility is generally staffed with two direct care staff members on each shift and have a third direct care staff member scheduled from 11am to 7pm, but this is not an everyday occurrence. She reported that the 11am to 7pm shift would be staffed when there was adequate staffing to accommodate this need. Ms. Sidelinker reported that it was communicated to the ROI office that one-on-one staffing for Resident A was advisable due to the multiple falls she was experiencing at the facility. She reported that this was when the third staff member started being added to the schedule from 11am to 7pm.

During the on-site investigation on 12/2/25 I interviewed Ms. McNamara regarding the allegation. Ms. McNamara reported that she has worked at the facility for about 1.5 years. She reported that she primarily works the 7am to 3pm shift but does fill in on midnights from 11pm to 7am, when needed. Ms. McNamara reported that when

Resident A was admitted to the facility, she required full direct care staff assistance with all aspects of her care, from personal care/hygiene, to toileting, to feeding. She reported that Resident A became stronger after the first couple of weeks and was able to start feeding herself. She reported that as Resident A became stronger, she became more vocal and aggressive with direct care staff. Ms. McNamara reported, "[Resident A] fell all the time." She reported that Resident A had a walker to assist with mobility and unsteady gait, but she would not use the walker. Ms. McNamara reported that she was uncertain whether she did not use the walker because she did not want to or because she would forget to use the device. Ms. McNamara reported that when Resident A first was admitted to the facility, direct care staff sat in her bedroom all night due to risk of falls. She reported that this level of supervision was provided for about two to three weeks and then it was stopped due to Resident A no longer getting out of bed as much during the night. She reported that Resident A was a fall risk the entire time she resided at the facility. She reported Resident A would just get up and go. She reported that direct care staff would hear Resident A hit the floor and check on her after the fall had occurred. She reported that sometimes the direct care staff tried to catch Resident A if they were close enough to her when she was falling. She reported that the major falls with injury that were reported for Resident A generally occurred during the 11pm to 7am shift. She reported that Resident A would fall multiple times per shift on every shift. Ms. McNamara reported that Resident A "probably needed a one-to-one" regarding direct care staff supervision. She reported that there was not a good solution to keep her from falling without always having a direct care staff member right near her. Ms. McNamara reported that the facility management and direct care staff had meetings with CEI-CMH staff members (names she did not know) in efforts to gain permission to use devices such as a buckle buddy, bed alarms, or door alarms for Resident A to increase her safety and alert direct care staff that Resident A was moving. She reported that to her knowledge these devices were not approved. Ms. McNamara reported that while Resident A resided at the facility the staffing level was consistently two direct care staff per shift. She reported that a third direct care staff member was added to the direct care staff schedule from 11am to 7pm, but this was not always available each day. Ms. McNamara reported that during Resident A's transport to Chelsea, MI for a medical appointment, it was discovered that she would unfasten her seatbelt and try to stand in the moving vehicle. She reported that Ms. Sidelinker was transporting Resident A on this date and contacted the facility to request that direct care staff drive to meet her at an exit off the highway to assist with transporting Resident A back to the facility. Ms. McNamara reported that she was one of the two direct care staff who drove to this exit and assisted Ms. Sidelinker on this date. Ms. McNamara reported that after this incident it was determined that Resident A should not be transported with one direct care staff member and required a driver and someone to sit next to her to keep her seatbelt fastened. Ms. McNamara reported that two weeks prior to Resident A experiencing the fall in her bedroom on 10/31/25, Resident A had been struggling with not sleeping well and stated she was hearing loud voices in her head. She reported that Resident A was struggling to sleep and would only get five-to-ten-minute naps at a time. She reported that Resident A was found in her bedroom on 10/31/25 with a cut above her left eye and was transported to urgent care by Ms. Sidelinker. She reported that Resident A then

returned to the facility after her visit to urgent care, but continued to decline and was sent to the emergency department for further evaluation.

On 12/2/25 during the on-site investigation at the facility I interviewed direct care staff, Madison Carey. Ms. Carey reported that she has worked at the facility for a period of six months. She reported that she works the 11am to 7pm shift, primarily. Ms. Carey reported that Resident A required assistance with walking. She reported that she had an unsteady gait and "would fall a lot." She reported that it did not matter if she was using her walker, she stated that Resident A would fall backwards or to the side even when holding her walker. She reported that Resident A was admitted to the facility with this balance issue and it did not improve during her stay. Ms. Carey reported that there was a period when direct care staff attempted to provide one-to-one care for Resident A, but this was not always feasible based upon the needs of the other residents and the staffing level at the facility. She reported direct care staff spent any down time they had sitting with Resident A. Ms. Carey reported that one-on-one direct care staff supervision for Resident A would have been beneficial. She reported that to her knowledge this was not put in place because CEI-CMH was asking for further data to be collected regarding Resident A's behaviors to determine further interventions.

During the on-site investigation on 12/2/25 I reviewed the following documents:

- *Assessment Plan for AFC Residents* document for Resident A dated 8/5/25. On page one, under section, *I. Social/Behavioral Assessment*, subsection, *A. Moves Independently in Community*, the document is not marked with a "yes" or a "no". The written narrative reads, "Uses walker/wheelchair while in community unaware of surroundings at this time." Subsection, *D. Alert to Surroundings*, is marked "yes" with the narrative, "Sometimes confused with people and sounds." Subsection, *H. Follows Instructions*, is marked "yes" with the written narrative, "sometimes gets confused when trying to explain what is needed." Page two, section, *II. Self Care Skill Assessment*, subsection, *G. Walking/Mobility*, the document indicates that Resident A "yes" does need help with walking/mobility with the written narrative, "With one/one or two on one assistance". Under section, *III. Health Care Assessment*, subsection, *C. Physical Limitations*, the document is marked "Yes" with the written narrative, "Unable to walk on her own but still tries". Subsection, *E. Other Difficulties (Vision, Weight, Allergies, etc)*, the document is marked, "yes", with the narrative, "Glasses poor eyesight".
- *PCP/IPOS Inservice Sign in Sheet,* for Resident A. The only direct care staff signature on this document is Ms. Sidelinker, which is dated 8/5/25.
- Resident A's resident record contained a letter dated 8/5/25, which was addressed to Ms. Sidelinker, regarding Resident A's admission to the facility. This document states, "I have reviewed the documents stated above and have had the opportunity to discuss this case and have my questions answered." The document is signed and dated 8/5/25, but the signature is not legible. This document was an acknowledgment that Ms. Sidelinker had received the following documents regarding Resident A's care:
    - Annual Support Coordinator Assessment dated 7/7/25
    - Psychiatric Progress Notes Dated 8/5/25

    - Physical Examination dated 7/30/25
    - Person Centered Plan dated 8/5/25
- *AFC – Resident Care Agreement* document for Resident A, dated 8/5/25.
- *Treatment Plan Annual/Initial* completed by Jenee Wilson, CEI-CMH, for Resident A, dated 8/5/25. The following information was reviewed in this document:
    - On page one, under section, *Areas of Need*, it reads, "The clinician has recommended the following areas be addressed in the treatment plan: Thought/Content/Perceptions, Community Inclusion, Challenging Behaviors, Current Abilities, Health and Healthcare, Abuse/Trauma, Physical Aggression and/or Other Risk Factors, Speech."
    - On page two, section, *Goal #1*, discusses Resident A's desire to have choices and control how others interact with her. This goal specifically notes that Resident A would like people to ask her before they touch her whenever possible. Subsection, *Barriers to this goal*, reads, "[Resident A's] health is declining and she sometimes gets confused. If she starts to fall and someone reaches out to catch her she becomes upset. She wants to walk and have freedom to roam, however, she is not strong enough to stand or use her walker. In addition, she will get out of her wheelchair, chair, bed, or other furniture, falling in the process."
    - On page 3, section, *Goal #2*, this goal states, "To maintain independence and healthy hygiene, [Resident A] will shower every other day with assistance from Staff." Subsection, *Barriers pertinent to this goal*, reads, "[Resident A's] understanding of her environment is unclear. She attempts to move without having the physical capacity. [Resident A] has had past behavioral aggressions of biting, hitting, and throwing when she does not like a situation and when she is confused."
    - On page four, under section, *Deferred Treatment Issues*, the document reads, "Behavioral assistance – [Resident A] has had past behavioral needs at other residence. However, she has been in the hospital from December 2024 to August 2025, and has moved to higher level of care. Behavioral needs will be monitored and addressed as [Resident A] gets acclimated to her surroundings."
    - On page five, under section, *Criteria for Discharge*, the document reads, "Discharge or transition to a different level of service will be considered when one or more of the following are met:
        - A satisfactory or unsatisfactory level of progress toward goals is attained
        - A reduction or increase in symptoms is evident
        - Significant improvement or decline in outcome scores has occurred
        - A plan is identified to maintain improvements or address setbacks and manage crises"

On 12/3/25 I interviewed Guardian A1, via telephone, regarding the allegation. Guardian A1 reported that Resident A had a brain tumor around the age of twelve. She reported that this brain tumor was removed and Resident A had a shunt placed on the right side

of her head extending down her neck since this surgery. She reported that at the age of fifteen Resident A became mentally ill and required services through Community Mental Health. She reported that she and Resident A's father provided for her care until her father died in November 2022. Guardian A1 reported that Resident A was placed at another licensed adult foster care facility in the area and did well at this home for a period of about nine months. She reported that there was a behavioral issue at this facility and Resident A was requested to be discharged. She reported that Resident A then was admitted to another licensed adult foster care facility where her medications were changed, resulting in a hospitalization at University of Michigan Hospital in Ann Arbor, MI. Guardian A1 reported that from this hospitalization Resident A was then placed in a nursing home in Livingston County, MI, where her psychiatrist had been changed. She reported that this change also resulted in behavioral changes and Resident A was sent to the emergency department 13 times. She reported that Resident A needed inpatient psychiatric care and was denied admission by every inpatient psychiatric unit in Michigan. She reported that Resident A then was admitted to University of Michigan Health Sparrow Hospital Lansing in December 2024. She reported that the nursing home she had previously been residing in refused to take her back as a resident. Guardian A1 reported that Resident A remained at University of Michigan Health Sparrow hospital for a period of seven months. She reported that the admission was this long as Resident A was waiting for the case managers at the hospital to locate a proper discharge placement for Resident A. Guardian A1 reported that they attempted placement with multiple facilities and were denied admission due to Resident A demonstrating aggressive behaviors and being assessed as a serious fall risk. Guardian A1 reported that Resident A was assigned a safety sitter at the hospital 24 hours per day, seven days per week. Guardian A1 reported that ROI was contacted about accepting Resident A as a resident in July 2025. She reported that Ms. Miller and Ms. Sidelinker from ROI came to the hospital and met with Guardian A1 and Resident A. She reported that they conducted an assessment and agreed to accept Resident A as a resident. Guardian A1 reported that she wanted to take Resident A home to her home and provide care but this was discouraged by CEI-CMH. She reported that she requested from CEI-CMH assistance with providing Resident A care at night and a couple of afternoons per week but CEI-CMH told her "no" this was not possible. Guardian A1 reported that she was told the facility was a "level 4" care home and that there would always be 4-5 direct care staff on shift. She reported that she learned, after Resident A was admitted to the facility, that there were two direct care staff scheduled per shift and sometimes three, but this was not always the case. Guardian A1 reported that she had a meeting, after Resident A's admission to the facility, with Mr. Myntti and Ms. Sidelinker to discuss Resident A's safety and care needs. She reported that Resident A's behaviors of exit seeking and unsteady gait were discussed. She reported that Mr. Myntti stated Medicaid would not cover the cost of Resident A's care at the facility if there were restrictive devices in place, such as door alarms or bed alarms. Guardian A1 reported that CEI-CMH "blamed Medicaid for everything." Guardian A1 reported that during this meeting Ms. Sidelinker appeared to be blaming Resident A for her undesirable behaviors by making statements that Resident A "knew what she was doing" and implying that she could control these behaviors. Guardian A1 reported that Resident A had poor memory recall, unsteady gait, and visual impairment. She reported

that Ms. Sidelinker made statements about Resident A not being able to find her own bedroom and noting that she believed Resident A could find her own bedroom. Guardian A1 reported direct care staff were providing one-on-one supervision for Resident A when she was first admitted to the facility. She reported that they had a chair in her bedroom and would sit with her while she slept to ensure she did not fall. Guardian A1 reported that this level of supervision was only provided for a week or two and then it was stopped. She reported that she is not certain why it stopped but she felt it was related to staffing issues. Guardian A1 reported that Resident A never ceased to be a fall risk, despite some minor improvements in her cognition after her UTI was treated. Guardian A1 reported that she is aware of four major falls Resident A experienced while under the care of direct care staff. She reported that there were minor falls discussed on a routine basis but four falls resulting in injury. Guardian A1 reported Resident A experienced a fall down the basement staircase while at the facility. She reported that she asked Ms. Sidelinker why the basement door had not been locked for resident safety and Ms. Sidelinker reported that she had worked at the facility for over 20 years and never had this be an issue with any other residents. She reported Resident A was sent to the emergency department after this fall. Guardian A1 reported that on 10/1/25 Resident A experienced a fall in her bedroom where she ran into her closet door and hit her head. Guardian A1 reported that Resident A is legally blind in her right eye and has poor vision in her left eye. Guardian A1 reported that she was informed that Resident A lost consciousness on 10/1/25 for an unknown amount of time, after this fall. She reported that Resident A was treated at the emergency department and sent back to the facility after this fall. She reported that on 10/31/25 she received a telephone call from Ms. Sidelinker who reported that Resident A had a fall in her bedroom and hit her left eyebrow. She reported that Ms. Sidelinker requested to transport Resident A to the urgent care on this date and noted she thought Resident A just needed some stitches. Guardian A1 reported that she approved Resident A going to the urgent care. Guardian A1 reported that later this day she received a call from Ms. Sidelinker reporting that Resident A had returned to the facility from urgent care but she was less responsive and they could not get her to sit up. She reported that it was discussed to call emergency medical services and Resident A was transported to the hospital via ambulance. Guardian A1 reported that while she was sitting with Resident A in the emergency department, she touched Resident A's head and felt a sticky substance on her scalp. She reported that she asked the emergency department staff about this and they did not have any information as to why Resident A's scalp was sticky. Guardian A1 reported that she asked Ms. Sidelinker about this on 11/2/25 and Ms. Sidelinker reported to Guardian A1 that while she was transporting Resident A to the urgent care on 10/31/25, Resident A unfastened her seatbelt, stood up in the van, fell forward, and hit her head on the floor of the van. She reported that Resident A then rolled around the floor of the van. Guardian A1 reported that this was the first time Ms. Sidelinker had reported this incident to her. She reported to Guardian A1 that while at the urgent care the staff used glue to glue the injury above her left eyebrow and the new injury to the top of her head. Guardian A1 reported that she asked Ms. Sidelinker why she was transporting Resident A alone on 10/31/25 and Ms. Sidelinker reported that there was not another available direct care staff to ride with her to urgent care. Guardian A1 reported that if she had known this information she would have instructed Ms.

Sidelinker to call emergency medical services for an ambulance transport as Resident A was not supposed to be transported without an additional direct care staff. Guardian A1 reported that Ms. Sidelinker stated that she had communicated the second head injury, which occurred in the facility van, on 10/31/25 to Mr. Myntti, via email on 10/31/25. Guardian A1 reported that there had been multiple incidents with Resident A unfastening her seatbelt in a moving vehicle and direct care staff were aware this was a safety concern for Resident A to be transported without a safety sitter present. Guardian A1 further reported that she had a conversation with a neurosurgeon at University of Michigan Health Sparrow Hospital on 10/31/25 regarding the results of Resident A's recent CAT Scan. She reported that she was told that this scan revealed evidence that Resident A's shunt had been severed at her neck and had been leaking spinal fluid into her brain cavity. Guardian A1 reported that the neurosurgeon had compared the scan that was performed on 10/1/25 with the one performed on 10/31/25 and there was a noticeable change in condition of the shunt. She reported that the neurosurgeon was concerned as he noted the scan on 10/1/25 showed evidence of a concussion suffered by Resident A, explaining her non-responsive state for a period after the fall she experienced on 10/1/25. Guardian A1 reported that the neurosurgeon stated that he feels the shunt might have been impacted during the fall on 10/1/25 and the condition worsened by the falls experienced on 10/31/25. Guardian A1 reported that the neurosurgeon advised that the spinal fluid that was leaking into Resident A's brain cavity was "shrinking" her brain. She reported that she was offered surgery to repair the shunt, with no promise of this returning Resident A to her baseline state. Guardian A1 reported that she opted for hospice care for Resident A and declined any surgical intervention. Guardian A1 reported that the neurosurgeon stated that the symptoms Resident A was experiencing during October 2025, restlessness, sleeplessness and so forth were most likely related to the concussion suffered on 10/1/25.

On 12/3/25 I received email correspondence from Ms. Miller. Ms. Miller provided copies of requested documentation for my review. I reviewed the following documents:

- Email correspondence from Ms. Sidelinker to Mr. Myntti, dated 10/31/25. The email correspondence read, "[Ms. Sidelinker] was wondering if there was anything we could do to expedite the buckle buddy. All 3 times we have taken [Resident A] into the van she has tried to unbuckle. Today I did not have the extra staff to go to Urgent care with us due to a fall in her room, (I was thinking she needed stiches) She unbuckled and before I could get pulled over safely she unbuckled and stood up and fell hitting her head on the tiedown splitting her head open again. They ended up just being able to glue both her eye which she hit in her room and the side of her head that she hit on the van floor. She had a med change on Wednesday increasing her Seroquel to 400 at bedtime to help sleep which it is not. It's just making her very unsteady and more confused. She fell 10+ time in her room ending with her splitting her eye open. I know this is a lot and you couldn't come out this week due to the Flu being in the house. Today is the first day no one woke up sick, so fingers crossed we are done with it. If you have any questions, please let me know." This document is signed, Lillian Sidelinker, House Manager of Dewitt Road AFC.

- Email correspondence from Mr. Myntti to Ms. Sidelinker dated 10/31/25, in response to the prior document reviewed. This document read, “Thanks for reaching out about this, and I can definitely understand the concern with her falling and hitting her head in the van, especially with extra staff not being available. Thanks, too, for keeping me updated regarding her med changes and how those might be impacting her behavior. Given the concern surrounding her safety in the van, I think scheduling a visit for early next week would be helpful to go over next steps. I will consult here on what might be most important to pay attention to moving forward. My impression is that the behavior treatment committee would be unlikely to approve a plan right now as there are likely more questions (i.e., surrounding why she is unbuckling, what else should be tried first, etc.) they will want answers to first. I will consult and try and figure out what questions and what types of information they are most likely to require.” The document then lists times Mr. Myntti is available to make a visit to the facility and ends with the following statement, “I think it could also be helpful for me to take a closer look at the van and to potentially go on a ride with you all and [Resident A] to more directly observe her behavior when in the van. Let me know your thoughts here, too.”
- Email correspondence from Guardian A1, dated 9/14/25, sent to Ms. Miller, CEI-CMH, case manager, Jenee Wilson, Citizen 1, & Citizen 2. The email is titled, “Urgent Safety Concern Regarding [Resident A] – Incident on September 11 at Dewitt Home”. The content of this email correspondence is as follows: “I’m writing to express our deep concern regarding the incident that occurred on September 11 involving [Resident A] at the Dewitt home. We were informed that [Resident A] fell down the entire flight of stairs to the concrete basement floor—a situation that could have resulted in serious injury or even been fatal. It’s our understanding that CMH removed the locks from internal doors, which has created a significant safety hazard that must be addressed immediately. Given [Resident A’s] mobility, we are especially concerned about the risk of her exiting the home unsupervised or experiencing another fall. To ensure [Resident A’s] safety and prevent future incidents, we would appreciate clarification on the following: What immediate actions have been taken to address the safety issue following this incident? What long-term measures are being implemented to prevent similar occurrences? How will [Resident A’s] safety be monitored and ensured moving forward at this location? What does Level 4 care entail, specifically regarding resident safety protocols and supervision at the Dewitt home? And how does this align with her diagnosis of a traumatic brain injury and mental illness. [Resident A’s] well-being is our top priority. We strongly believe that the home should be equipped with appropriate locks, alarms, and cameras to enhance safety and security for all residents. Thank you for your attention to this serious matter. We look forward to your prompt response and a clear outline of the corrective actions being taken. Sincerely [Guardian A1] mother and guardian”
- Email correspondence from Citizen 2, dated 9/22/25, sent to Guardian A1, Ms. Miller, Ms. Wilson, and Citizen 1. This is a follow-up email intended for Ms. Miller and Ms. Wilson regarding the email Guardian A1 sent on 9/14/25. This email

stated, “We are following up on the email sent on September 14 regarding the urgent safety concerns for [Resident A] at the Dewitt home. We have not yet received a response to the questions outlined in that email.

Could you please provide clarification on the following points:
* What immediate actions have been taken to address the safety issue following the incident on September 11?
* What long-term measures are being implemented to prevent similar occurrences?
* How will [Resident A’s] safety be monitored and ensured moving forward at this location?
* What does Level 4 care entail, specifically regarding resident safety protocols and supervision at the Dewitt home, and how does this align with her diagnosis of a traumatic brain injury and mental illness?

Thank you for your prompt attention to this matter.

Sincerely,
[Citizen 2]”

- Email correspondence from Ms. Miller addressed to, Citizen 1, Citizen 2, Guardian A1, Shane Simon (CEI-CMH), Ms. Wilson, dated 9/23/25. This communication contained the following dialogue: “I apologize if you didn't get my original reply to this email. I didn't respond to every single bullet point thinking that others on this email may want to contribute to responding to some of these. FYI, I have also added Shane Simon, who is a coordinator and our liaison from CEI CMH. I want to share from ROI's perspective our typical processes and in particular what we did in response to the serious incident with [Resident A’s] fall down the basement stairs. Following the evening of [Resident A’s] fall down the basement stairs, [Ms. Sidelinker] took [Resident A] to the emergency room as no one saw that fall and we couldn't be certain that she didn't experience a head injury during the fall. Fortunately, through all the testing, it was determined that [Resident A] suffered no serious injury due to this fall. The next day, I delved into why there couldn't be a locking doorknob on the basement stairs with Brianne Hanner, Quality Assurance agent through CMH; she directed me to check our licensing documents. After this pursuit we found no reason why it couldn't be locked and [Ms. Sidelinker] made arrangements to have the new doorknob put on. Within our services we always have to follow processes in place to ensure we are not violating one's right to freedom of movement, etc. I can appreciate to the outside observer some of the things you may feel need to be in place i.e. video cameras, door alarms etc., those all fall under restrictions and in order to have such things in place there are steps the provider and assigned clinician need to go through. In general, I would like to describe what is typical when getting to know the individual moving into one of our homes. Our staff learn and gain information from the individual through conversations, direct observations, and through information provided by loved ones and clinical staff involved with her

care. There is a lot of brainstorming and information gathering that continues but certainly in the first few months this can be intensive. When there are challenges that seem outside of the typical care provided by our direct care workers we bring other supports as needed (Primary physician, Psychiatrist, PT, OT, Behavior supports etc.). [Resident A] was discharged from the hospital and was in need of a primary physician, a psychiatrist, etc. There also appeared to be some errors made with medicine administration as [Resident A] was discharged without the benefit of two medications that helped her sleep as well as one supporting her challenges associated with her mental illness. We also made a recommendation to change the administration time of one of her medications from evening to the morning time and this seemed to aid in reducing some of the nighttime agitation. Additionally, when [Resident A] first moved in she was also not clear of her UTI and this with all of the beforementioned challenges combined led to great challenges. As we sorted through all of this and found a physician, [Ms. Wilson] supported us in getting a psychiatrist, etc. we continue to try to develop a positive relationship with [Resident A]. As her health improved and started to get better sleep, we saw some decreases in some of her physical aggression and greater balance and mobility (although still hoping for continued improvement here). [Resident A] is not a line of site level of care but I am working with the staff on improving how to organize their supports so that when they are otherwise busy with other folks they attempt to see that [Resident A] has what she needs until they are able to finish up with the other person's supports. Our typical staffing is scheduled so that two staff are on each shift with a third staff overlapping the first and second shift during typical awake time ours. We are currently working with the therapist assigned to [Resident A] gathering baseline data to help with the development of a behavior support plan. Additionally, I was filling in for our QC who was on maternity leave and worked alongside staff on several days or responded to situations when staff were struggling to support [Resident A] during escalated situations. I was also able to provide some positive behavior supports and supported [Ms. Sidelinker] with two staff meetings since [Resident A's] arrival. We are going to follow our process and continue to build positive working relationships between [Resident A] and the staff currently supporting her; allow [Resident A] her right to access her house and space while also attempting to keep her safe; we're currently attempting to get a better understanding of the layout of the home to reduce challenges and improve safety. Currently under consideration, working the CMH maintenance to see if fencing a portion of the back yard is a possibility so [Resident A] can safely initiate being outdoors safely. [Ms. Sidelinker] and I also discussed purchasing some thin strip of LED lights to help [Resident A] have a visual cue in finding her way to her bedroom. I invite others to add their understanding of level 4 supports or their understanding of what ROI might consider in the future, etc. I truly enjoy supporting [Resident A] and hope this and other relationships she has started will continue to grow in a positive direction." This document is signed by Ms. Miller.

- Email correspondence from Mr. Simon, dated 9/23/25, and sent to Ms. Miller, Guardian A1, Citizen 1, Citizen 2, Ms. Wilson. The contents of this email are as follows: "Thank you for keeping me in the loop. [Ms. Miller], I appreciate your

transparency and ROI's response into this incident. I appreciate how timely you looked into securing the door knob to prevent this from occurring again. There are always challenges and learning curves that come with the transitions of any new residential placement, however, it is evident that your team is meeting [Resident A] where she is at, while doing your best to honor [Resident A's] civil liberties and rights. That is a hard balance to achieve, especially when trying to keep everyone safe and I appreciate your teams creativity and flexibility in that pursuit. [Ms. Miller], as evidenced by the overall reduction in falls and physical aggression, it appears the Dewitt team efforts are already making a difference for [Resident A]. In terms of explaining level 4 support, we would characterize the medical necessity for level 4 to be warranted by needing skilled staffing (Medical / behavioral), with frequent interventions. I think it is important to also consider that the type of work we do is based in the community and looks a lot different from typical inpatient settings like hospitals or long-term nursing care. We are bound by Medicaid requirements with home community based services and have to adhere to the state and local guidelines for what those services can look like. It is my rationale that based on the information that has been reported both by [Resident A's] interdisciplinary team and the information [Ms. Miller] provided, [Resident A] is receiving the appropriate amount of care. As [Ms. Miller] mentioned previously, unless its determined there is medical necessity for a restrictive behavioral plan, [Resident A] has the right to make her own choices that are within her civil liberties. Even if those choices bring about dignity of risk. However, I do not have any concerns that the Dewitt team will continue to work alongside the behavioral specialist, interdisciplinary team, to fulfill [Resident A's] IPOS in a way that not only meets but exceeds state and federal guidelines. My vote of confidence comes from both the historical context of the work ROI does in the Tri-County and also is currently evidenced in the clinical training that is being provided to the Dewitt team by ROI leadership, staffing tables, and the person centered approaches currently under way. Please feel free to ask any more questions and if it is more helpful to meet I am always open to that as well."

- I reviewed email correspondence between Mr. Myntti, Ms. Brennan, and Ms. Sidelinker spanning from 9/23/25 through 10/16/25. I observed the following information from these emails:
    - 9/23/25: Ms. Brennan reported to Mr. Myntti that the direct care staff were going to start "30 minutes of "[Resident A] time" today and will continue to do it at 11am each day." The stated goal was to see if behaviors arose between 12pm -3pm each day.
    - 10/2/25: Mr. Myntti responded to Ms. Brennan confirming the direct care staff intervention with Resident A would be to spend provide more "attention/activity time" to her and track the impact on her behavior. He inquired whether there were any additional interventions in place.
    - 10/2/25: Ms. Brennan responded to Mr. Myntti's inquiry about additional interventions and noted she would be making a weekly visit to the facility to model best approaches for interacting with Resident A to direct care staff members. She then inquired about a bed alarm and noted Resident A

had an “incident” the previous night where she “fell in her bedroom at night, cut her eye, and was unresponsive/taken to the emergency room.”

- 10/3/25: Mr. Myntti responded to Ms. Brennan and reported he was going to speak with Ms. Sidelinker and schedule a visit to the facility for the following week. He reported the purpose of this visit to be to “start determining what approaches to safety might be most helpful to [Resident A].” He also asked follow-up questions about the fall reported on 10/1/25. He did not address the request for a bed alarm directly in this email correspondence.
- 10/6/25: Ms. Brennan responded to Mr. Myntti and noted she had passed along his questions related to the fall on 10/1/25 to Ms. Sidelinker for response. She also tried to confirm Mr. Myntti would be visiting the facility on 10/7/25.
- 10/6/25: Mr. Myntti responded to Ms. Brennan and reported his visit to the facility was scheduled for 10/14/25 at 10am. He reported that Guardian A1 had contacted him on 10/3/25 and noted she wanted to be invited to the meeting on 10/14/25. Mr. Myntti noted in this email that he would like to meet with Ms. Sidelinker prior to the meeting on 10/14/25 to “discuss some of the questions we had on Medicaid rules/restrictive methods to plan moving forward…”
- 10/7/25: Ms. Sidelinker responded to Mr. Myntti’s email correspondence reporting she could meet with him prior to the meeting with Guardian A1 on 10/14/25 and answered his questions pertaining to Resident A’s fall on 10/1/25. The email correspondence ends with Ms. Sidelinker writing, “Let me know if this answers your questions. I don’t know if you were aware but [Resident A] fell again on Saturday morning and hit her head again on the corner of her dresser and cut her head again.” The Saturday referred to in this email is10/4/25.
- 10/8/25: Mr. Myntti responded to Ms. Sidelinker and Ms. Brennan that he was confirming the meeting on 10/14/25 and would be able to share information he had gathered about restrictions moving forward.
- 10/16/25: Mr. Myntti sent email correspondence to Ms. Sidelinker and Ms. Brennan with four attachments. The attached documents were a Behavior Tracking form, Eloping Tracking form, Travel Safety tracking form, and a Fall Tracking form. The content of this email was to provide information on how to use these documents to track Resident A’s behaviors and gather data on these behaviors. No interventions were discussed on how to provide for Resident A’s safety.

- *Basic Incident Information*, for Resident A, dated 9/11/25, at 8:30pm. Under the section, *Description of this Incident*, it reads, “While the staff were in the other room [Resident A] went to the basement door opened and fell down the stairs. Staff heard the fall came out of the bathroom and the other end of the house to find her climbing up the basement stairs. Staff checked her over and called supervisor.” Under the section, *On-site responsible staff comments*, it reads, “Manager took [Resident A] to the ER where they did blood work, CT and X-rays to make sure [Resident A] was ok. Manager reached out to get lock put on

basement door." This document was electronically completed by Lillian Sidelinker on 9/12/25.

- *Basic Incident Information,* for Resident A, dated 9/22/25, at 5pm. Under the section, *Description of this Incident*, it reads, "[Resident A] was in the van leaving her eye appointment in Chelsea MI. After pulling out and driving down the road 2 blocks [Resident A] unbuckled her seatbelt on her wheelchair and tried to stand up. Staff pulled over and rebuckled her seatbelt talking to her about leaving it on for safety. After driving about 10 more minutes [Resident A] unbuckled again and staff had to merge onto the shoulder of the highway to rebuckle and talk with her again. This happened 2 more times in the span of 15 minutes, [Resident A] getting more aggressive each time staff tried talking to her explaining the safety of using the seatbelt. Staff had to finally pull over and wait at an exit for staff to arrive as [Resident A] unbuckled and stood up trying to climb over the wheelchair, it was unsafe to continue driving alone with [Resident A]." Under the section*, On-site responsible staff comments*, it reads, "Staff waiting for staff to arrive and one staff sat in the back of the van with [Resident A] encouraging her to leave seatbelt on while van was moving. [Resident A] tried taking the belt off 2 more times but staff redirected her before she could take it completely off."
- *Basic Incident Information,* for Resident A, dated 10/1/25, at 8:30pm. Under the section, *Description of this Incident*, it reads, "Staff put [Resident A] to bed, leaving her closet door open with the light on as requested, and continued on putting others to bed. Staff heard a noise from [Resident A's] room and went to check on her and found her laying in front of closet door, staff called for her c-worker when she seen blood on the floor by [Resident A]. They both looked [Resident A] over trying to see where the blood was coming from, talking to [Resident A] while doing this and she was not responding, staff called manager and 911." Under the section, *On-site responsible staff comments*, it reads, "Staff called manager back after calling 911 to explain what they thought happened since they were not in the room. Manager went to meet [Resident A] in the ER and Guardian was called. Will talk with her team to see what we can do to keep [Resident A] safe in her room when moving around."
- *Basic Incident Information,* for Resident A, dated 10/31/25, 3pm. Under the section, *Description of this Incident*, it reads, "[Resident A] had fallen earlier in the morning, staff took her into urgent care to assess the situation. On the way there [Resident A] unbuckled and fell as she was standing up in the van before staff could get pulled over, hitting her head again. Once at the Urgent care the doctors assessed that they could apply glue to both spots as they were not to deep. Once back at home [Resident A] still was not acting herself and very confused as she had been since the increase in medication. After observing her for the morning and part of the afternoon staff call her supervisor and [Resident A's] guardian letting them know that something was not right and felt like she should been seen. Due to the incident in the van earlier staff decided to call 911. [Resident A] was admitted into the hospital for multiple tests." Under the section, *On-site responsible staff comments*, it reads, "Staff followed procedures and contacted the behavioral specialist due to the fall in the van."

- *Community Mental Health Authority Clinton – Eaton- Ingham Counties, Community Services for the Developmentally Disabled, Medical Visit Form,* for Resident A, dated 8/8/25. The reason for the visit is noted as “UTI”. This document is accompanied by an *After Visit Summary*, dated 8/8/25, from the University of Michigan Health Sparrow Hospital. The *After Visit Summary* notes the reason for the visit to the hospital is “Altered Mental Status.” The document states, “Go to MSU Family Medicine in 1 week (around 8/15/25)”. Imaging Tests completed on this date were, CT Scan, EKG, XR Shunt Series. On page four of the *After Visit Summary*, under section, *XR Shunt Series*, subsection, *Findings*, it reads, “Two-view skull with single view chest and abdomen. Right frontal ventricular catheter with tubing extending down the right neck chest and the tip of the tube in themed lower pelvis. Tubing appears intact.” Under section, *Impression*, it reads, “No evidence of shunt disconnection or breakage.” On page four and five, under the section, *CT Brain/Head wo Contrast*, subsection, *Findings*, it reads, “Craniotomy defect in the posterior fossa. Right frontal ventricular catheter tip at the frontal horn of the right lateral ventricle. The Ventricles, sulci and cisterns are unremarkable. There is no mass effect or midline shift. No extra-axial fluid collections are seen. There is not evidence of intracranial hemorrhage, There is no evidence of skill fracture Paranasal sinuses: clear where seen.” Under subsection, *Impression*, it reads, “No acute intracranial abnormality.” Resident A was diagnosed with a UTI on this date.
- *Community Mental Health Authority Clinton – Eaton- Ingham Counties, Community Services for the Developmentally Disabled, Medical Visit Form,*for Resident A, dated 8/25/25. The reason for visit was noted as, “First Visit/Release from Hospital.” Under the section, *Doctor’s Orders*, it reads, “1. Labs + Meds in, 2. OT ordered.” This document is accompanied by an *After Visit Summary*, dated 8/25/25, from the University of Michigan Health Sparrow Lansing Internal Med. Under the section, *Today’s Visit*, it reads, “You saw Mary Boudreau on Monday August 25, 2025. The following issues were addressed: Major neurocognitive disorder due to multiple etiologies with behavioral disturbance, Intractable epileptic spasms without status epilepticus, Brainstem tumor, elevated glucose, medication monitoring encounter, dysuria, Anemia, unspecified type, Vitamin D deficiency, Acquired hypothyroidism, Mixed Hyperlipidemia.”
- *Community Mental Health Authority Clinton – Eaton- Ingham Counties, Community Services for the Developmentally Disabled, Medical Visit Form,*for Resident A, dated 9/11/25. The reason for this visit was documented as “Fell down stairs.” This document is accompanied by an *After Visit Summary*, dated 9/11/25, from the University of Michigan Health Sparrow Clinton Hospital Emergency Room. The Reason for Visit was documented as, “Trauma”. Under the section, *Diagnoses*, it reads, “Fall down stairs, initial encounter, contusion of multiple sites of lower extremity, unspecified laterality, initial encounter, multiple abrasions.” The following Imaging Tests are noted as being performed during this encounter, CT Cervical Spine wo Contrast, CT Scan, CT Scan, EKG, XR knee left min 4 views, XR knee right min 4 views, XR Tibia Fibula left AP and lateral. On page four the document identifies that Resident A had a urinalysis performed

and the results of this test were “Abnormal”. The results noted for the imaging performed documented no abnormal findings.

- *Community Mental Health Authority Clinton – Eaton- Ingham Counties, Community Services for the Developmentally Disabled, Medical Visit Form,*for Resident A, dated 10/11/25. Under the section, *Doctor’s Orders*, it reads, “Stitches removed. Tolerated well. No bleeding.” That is the only thing documented on this form.
- *Community Mental Health Authority Clinton – Eaton- Ingham Counties, Community Services for the Developmentally Disabled, Medical Visit Form,*for Resident A, dated 10/31/25. The reason for visit is noted as, “Stitches above left eye.”
- Copies of the direct care staff schedule were provided for my review. I reviewed the schedule on the dates, 9/11/25, 10/1/25, 10/4/25, & 10/31/25. I observed the following information:
    - 9/11/25: Resident A experienced a fall on this date, documented as 8:30pm on the *Basic Incident Information* document. There were three direct care staff scheduled between 11am and 7:15pm. The staffing level then went to two direct care staff from 7:15pm to 9pm. Resident A has a documented fall around 8:30pm on this date.
    - 10/1/25: Resident A experienced a fall on this date, documented as 8:30pm on the *Basic Incident Information* document. There were at least three direct care staff scheduled between 11am and 7pm. The staffing level then went to two direct care staff from 7pm to 9pm. Resident A has a documented fall around 8:30pm on this date.
    - 10/4/25: Ms. Sidelinker’s email correspondence to Mr. Myntti on 10/7/25 noted Resident A experiencing a fall on 10/4/25 in the morning hours. There were two direct care staff members scheduled between 12am -8am, three direct care staff members scheduled between 8am and 4pm. Ms. Miller sent email correspondence on 12/12/25 with additional documentation regarding this fall. The email correspondence was from Ms. Sidelinker to Ms. Miller and Ms. Brennan and reported that the fall occurred on the midnight shift, between 12am – 7am. There were two direct care staff scheduled during this period.
    - 10/31/25: Resident A experience a fall on this date. According to the *Basic Incident Information* document reviewed for this date it indicated that the fall occurred, “earlier this morning”. There were two direct care staff members scheduled between the hours of 12am – 11am on this date.

On 12/4/25 I received further email correspondence from Ms. Miller. Ms. Miller reported that Resident A had been working with an Occupational Therapist (OT) regarding her balance and falls but a plan had not been put into action yet by the OT as to how to address this issue. She reported that an OT had also evaluated Resident B, due to her unsteady gait and her understanding of this assessment was that a walker would make Resident B more unstable. Ms. Miller reported that she did not have copies of the documentation from the OT for the assessment for Resident A or Resident B. She provided additional documentation for my review. I reviewed the following documents:

- *PCP/IPOS Inservice Sign In Sheet*, for Resident A, dated 8/5/25. This document is signed by the following staff:
    - Lillian Sidelinker, 8/5/25
    - Laura Beaudrie, 8/5/25
    - Claria Filgeme, 8/5/25
    - Florence Mwangaza, 8/7/25
    - Jacinta Lino, 8/7/25
    - Camille Owens, 8/12/25
    - Madison Carey, 8/5/25
    - Valerie Britten, 9/22/25
- *Resident Register*. This document notes that Resident A was admitted to the facility on 8/5/25 and was discharged on 10/31/25.
- *State of Michigan Probate Court Ingham County, Letters of Guardianship of Individual with Developmental Disability,* For Resident A, dated 8/22/25. This document appoints Guardian A1 as the "plenary guardian" for Resident A.
- *University of Michigan Health-Sparrow, Vituity Hospitalist Service, Progress Note,* dated 7/30/25, for Resident A. This document was completed by Papia Kar, MD. This document was made available to Ms. Miller in preparing Resident A for admission to the facility. I observed the following information in this document:
    - Under the section, *Chief Complaint*, the document reads, "[Resident A] presents with Mental Health Problem, Aggressive with other residents and staff at nursing home."
    - Under the section, *Interval History*, the first two paragraphs read, "[Resident A] is a 47 y.o. female with h/o schizoaffective disorder developmental delay who presented to U of M Health – Sparrow ED with aggressive behavior and attacking staff and other residents 12/29/2024. Patient was reportedly attacking other staff members and residents at her facility, [Previous facility] Meadow Lodge. Patient reportedly as biting at staff and other residents which prompted ED visit. Psychiatry was consulted and evaluated patient 12/30 and adjusted patient's medications. Patient was intermittently aggressive with ED staff and required restraints at times. Hyperammonemia resolved while in the ED. CPK was elevated in the ED, likely 2/2 restraints but improved post fluids. Psychiatry originally recommended inpatient psychiatric placement, but there were concerns that facilities would not be able to meet her needs so CM/SW working towards placement at a structured living facility. Several requests sent with bedside evals so far not accepting patient. Patient continues to require 1:1 sitter."
    - Under the section, *CM update 7.11*, the document notes:
        - 7/11: telephone call to Elizabeth Parker, CMH supervisor for update on home care approval.
        - 7/15: meeting scheduled with CMH at 11am on 7/15.
        - 7/18: "UA shows mild pyuria but given symptoms will treat with Vantin. Urine cultures are pending BMP pending from today to

assess patient's kidney function." Guardian A1 requested to address medication concerns with psychiatry.
        - 7/21: Guardian A1 met with psychiatry team. Prolixin dose decreased from 3.5mg to 2.5mg.
        - 7/22: Case management working with Guardian A1 and CMH on safe discharge planning.
        - 7/27: Resident A noted to have more gait instability today.
        - 7/28: Labs reviewed. Resident A noted to have hyponatremia and AKI on CKD. Patient refuses to be compliant with IV. Will need to push oral fluids and recheck labs in the morning.
        - 7/29: Resident A continues to have hypernatremia, renal fn is likely her new baseline. Li level is wnl.
        - 7/30: Resident A pulled out her IV. Will encourage oral intake instead of replacing the IV.
    - Under the section, *Assessment/Plan*, it reads, "Schizoaffective disorder, Bipolar type, Developmental delay and Neurocognitive disorder to multiple etiologies (brainstem astrocytoma s/p resection and VP shunt, multiple head injuries per report), anxiety. Previous psychiatric hospitalizations in 2016 and 2019, continue sitter at bedside."
    - Under the section, *Falls while Inpatient*, the document reads, "Fall precautions, Patient strongly advised to keep the bathroom door open using the restroom and sitter should be with the patient at all times. Continue safety precautions, Mother would like to avoid repeated CT brains for minor falls as much as possible (per discussion on 5/18/2025)."
    - Under the section, *Medical Decision Making*, subsection, *I reviewed current inpatient medications*, the following medications are listed as being current medications for Resident A:
        - Fluphenazine 2.5 mg, oral, QPM
        - Cholecalciferol 5000 Units, Oral, Daily
        - Levothyroxine 25 mcg, oral, once daily
        - Hydroxyzine, 25 mg, oral, nightly
        - Divalproex sodium, 125 mg, oral , daily
        - Divalproex, 500 mg, oral, BID
        - Lithium, 300 mg, oral, BID
        - Polyethylene glycol, 17 g, oral, QAM AC
        - Quetiapine (Seroquel), 300 mg, oral, BID
        - Hydroxyzine, 25 mg, oral, daily
        - Melatonin, 5 mg, oral, nightly

On 12/4/25 I interviewed Complainant via telephone regarding the allegation. Complainant reported that they had access to Resident A's documentation and reported that when reviewing the documentation they were alarmed by the lack of appropriate interventions put in place to ensure Resident A's safety at the facility. Complainant reported that it was well documented that Resident A was receiving one-on-one safety sitter supervision at the hospital for a period of seven months. Complainant reported that it was also documented that Resident A has a shunt on the right side of her head

extending down her neck, had an unsteady gait, was legally blind in her right eye, and experienced frequent falls. Complainant reported that they reviewed at least four incident reports identifying four major falls with injury that Resident A experienced while under the care and supervision of direct care staff. They reported these incident reports dated, 9/11/25 (fall down the basement staircase), 9/22/25 (fall in facility van when being transported with one direct care staff member), 10/1/25 (fall occurred in Resident A's bedroom, she was found unresponsive and bleeding), 10/31/25 (fall occurred in Resident A's bedroom and then again in transport on the way to the urgent care). Complainant reported that further documentation reviewed revealed that CEI-CMH, Occupational Therapist, Krista Winkler, reported that "[Resident A] falls multiple times per week." Complainant reported that Resident A's documentation reviewed did not include any concrete interventions in place at the facility to provide for Resident A's safety and protection, including but not limited to the use of a helmet, increased staffing for supervision, bed alarms, and so forth. Complainant reported that there was no indication of interventions that were being suggested or provided for Resident A's supervision and safety at the facility despite both minor and major falls resulting in injury occurring. Complainant reported that they are aware Guardian A1 did not wish for Resident A to return to the facility after her fall on 10/1/25 as she did not feel the direct care staff were able to keep Resident A safe. Complainant reported that Guardian A1 did reach out to the CEI-CMH case worker, Jenee Wilson, and expressed this concern on 10/2/25 and was told to address her concern with Mr. Myntti.

On 12/4/25 I conducted an unannounced, on-site investigation at the facility. I returned to the facility on this date to interview direct care staff regarding Resident B's required care needs. I interviewed Ms. McNamara on this date who reported that Resident B does have a shunt. She reported that her shunt is on the right side of her head. She reported that to her knowledge there were no protocols in place regarding the care required for the shunt. Ms. McNamara reported direct care staff have been advised that if Resident B hits her head, she should be sent to the emergency department for evaluation due to the shunt. Ms. McNamara reported that Resident B is a fall risk and falls at the facility about once per week. She reported that Resident B gets up on her own and walks very quickly with her head down. She reported that sometimes she walks too quickly and stumbles, falls forward and hits her chin on the ground. She reported that this has occurred frequently for Resident B to the point that Resident B has scar tissue on her chin from injuring this area and breaking the skin open. Ms. McNamara reported that Resident B also has a brace on her leg to assist with mobility. She reported that Resident B does not require line of sight or one-on-one supervision from direct care staff.

On 12/4/25, during the unannounced on-site investigation, I interviewed Ms. Carey. Ms. Carey reported that Resident B has a shunt on the right side of her head. She reported that Resident B is a fall risk and does fall at least once per week. She reported that Resident B has not experienced any recent falls where she has hit her head. She reported that the direct care staff are aware of Resident B's shunt and know that she should be sent for emergency medical evaluation if she falls and hits her head. Ms. Carey reported that Resident B will get up and walk quickly through the facility. She

reported that there are times when she is moving too quickly and loses her balance and does fall. She reported that she has fallen forward and injured her chin on multiple occasions.

During the on-site investigation on 12/4/25 I reviewed the following documents:

- *Assessment Plan for AFC Residents* document for Resident B, dated 4/21/25. On page two, under section, *II. Self Care Skill Assessment*, subsection, *G. Walking/Mobility*, it reads, "Ankle/foot orthotic, needs help getting on, only has peripheral vision. Under section, *III. Health Care Assessment*, subsection, *Physical Limitations*, it reads, "Cerebral palsy, vision and hearing impaired."
- *PCP/IPOS Inservice Sign in Sheet* for Resident B, dated 4/21/25. This document contains two signatures, Ms. Sidelinker and Elena Brennan, both dated 4/21/25.

On 12/4/25 I interviewed Guardian B1, via telephone, regarding Resident B's care needs. Guardian B1 reported that Resident B had a shunt placed on the right side of her head as an infant due to contracting Meningitis. He reported that Resident B had a revision of the shunt about 20 years ago. He reported that there are standard risks for Resident B regarding her shunt, and he noted direct care staff are aware of these risks. Guardian B1 reported the warning signs of a malfunction with the shunt could be increased irritability, loss of balance, and nausea. He reported that there is risk of damage occurring to the shunt if Resident B were to fall and hit her head where the shunt is located. He reported that this risk is minimal for Resident B as she has had the shunt for so long the bone and tissue have grown over it, providing added protection. Guardian B1 reported that Resident B does experience frequent falls as she has an unsteady gait related to her cerebral palsy diagnosis. He reported that Resident B wears an ankle foot orthodox (AFO) device to assist with her ambulation and gait. He reported that he feels direct care staff at the facility are always working to keep Resident B safe and obtained a wheelchair for her to use on outings to prevent her from exhaustion having to be up so long. He reported that this decreases her falls. Guardian B1 reported direct care staff have been trained in how to manage Resident B's care needs and he has no knowledge of any recent falls where Resident B would have hit her head causing any potential damage to her shunt.

On 12/8/25 I received a telephone call from Guardian A1. She reported that she had obtained documentation from the urgent care where Resident A had been taken on 10/31/25. She also reported that she had a copy of email correspondence Ms. Sidelinker forwarded to her regarding Ms. Sidelinker's communication to CEI-CMH on 10/31/25 regarding Resident A's fall. She provided this documentation for my review.

- *St. Johns Ouch Urgent Care*, document for Resident A, dated 10/31/25. Under the section, *History of Present Illness*, it reads, "The patient is a 48 year old female who presents with a laceration. The injury occurred on – Date: (10/31/2025). The occurrence was sudden following an incident at home (pt fell and hit head her head/face on her dresser at her AFC home). It is located on the scalp 9Right). There is also bleeding. The injury is covered by medical insurance. Note for "Laceration": Per caregiver patient has had Seroquel increased recently to help with sleep and she has been more unstable with multiple falls." Under the

section, *Review of Systems*, subsection, *General*, reads, “Not Present – Excessive Crying and Fever”, subsection, *Skin*, reads, “Present – New Lesions”, subsection, *HEENT*, reads, “Present – Head Injury, Not Present – Headache”, Subsection, *Neurological*, reads, “Not Present – Loss of Consciousness.” Under the section, Vitals, subsection, Weight, it reads, “108 lb (Patient reported)”. Under the section, *General,* subsection, *General Appearance*, it reads, “Not in acute distress, Well groomed, Consistent with stated age, Not lethargic/Slow.” Under section, *Integumentary*, subsection, *Problem #1 Description*, the document notes that Resident A had two lacerations, one at the hair & Scalp and one to the head/face, left temple with bruising and swelling noted. Under the section, *Neuropsychiatric*, the document reads, “The patient’s mood and affect are described as – agitated (mild). Subsection, *Speech – Note:* “non-verbal.” Subsection, *Thought Processes/Cognitive Function*, “no impairment of concentration.” The document notes that both wounds were 2.5cm or less in size. At the bottom of page two the document reads, “Caregiver states pt falls frequently and they are changing her meds. Avoid touching face and keep area clean and dry. Watch for signs of infection: redness, swelling, warm to touch or drainage. If any of these occur, it is recommended to be reevaluated for further treatment. Tetanus up to date accordingly to care worker based on recent injury and having updated. Discussed to monitor cognitive changes and when to go to ER. If symptoms acutely worsen or change, it is recommend to be reevaluated. Follow up with PCP in 48-72 hours or sooner if needed.”

- Email correspondence from Ms. Sidelinker, forwarded to Guardian A1, on 11/2/25. The original email was dated 10/31/25 and addressed to Mr. Myntti and Elena Brennan with ROI, from Ms. Sidelinker, and titled, “Fall in Van”. This email correspondence was previously provided by Ms. Miller on 12/3/25.

On 12/12/25 I had email correspondence with Ms. Miller regarding clarifying information discovered during this investigation. I inquired about the fall Ms. Sidelinker had referenced in her email correspondence to Mr. Myntti on 10/7/25. I inquired whether this fall had occurred on 10/4/25 and whether there was any further documentation regarding this fall such as an incident report or medical visit note. Ms. Sidelinker had reported in her email correspondence to Mr. Myntti that Resident A had hit her head on a dresser causing a cut to her head. Ms. Miller reported that she could not locate an incident report for this occurrence and noted that this incident occurred while Ms. Sidelinker was on vacation. She reported that Resident A was not sent for medical treatment after this fall. She reported that Resident A was seen by a medical provider on 10/11/25 to have stitches removed that were placed due to the fall she experienced on 10/1/25. Ms. Miller provided additional documentation for my review in this email correspondence. I reviewed the following documents:

- Email correspondence from Ms. Sidelinker to Ms. Miller and Ms. Brennan. This correspondence was pertaining to the fall Resident A experienced on 10/4/25. The email reads, “The fall that happened on 10-4-25. [Jacinta Lino] texted me that [Resident A] fell and the wound was not deep. We were guessing where she could have hit her head as no one seen her fall. That’s why we moved the dresser into the closet. I was out of town on LOA that weekend and asked [Ms.

Brennan] to check it out as she had plans on going out that weekend. I did not do an IR for it. [Ms. Brennan] do you remember if one was done? I do have a picture of the area in question. It is not by the shunt. It happened before 7am as [Jacinta Lino] was the midnight staff that night."

- *Health Care Appraisal,* for Resident B, dated 7/8/25. This document is signed by a nurse practitioner with the notation, "See office visit summary note from 7/8/25." The office visit summary from MSU Health Care, dated 7/8/25, was attached to this document. Under the section, *Reason for Visit*, it noted "Annual Exam". There was no information noted about Resident B's shunt on this document other than noting the history of brain surgery on 1/1/94.
- *Health Care Appraisal,* for Resident A, dated 7/30/25. Under section, *7. Diagnoses*, it reads, "Schizoaffective Disorder, Neurocognitive Disorder". There was not any specific information pertaining to Resident A's shunt on this document.

On 12/16/25 I received a telephone call from Guardian A1. Guardian A1 reported that she had additional documentation to provide regarding the care provided to Resident A. I reviewed the following documents that Guardian A1 sent via email:

- Guardian A1 sent photographs of Resident A that were taken on 11/2/25. Guardian A1 reported that these photographs represent injuries Resident A sustained due to falling at the facility and in the facility van on 10/31/25.
    - The first photograph is of Resident A's face. Resident A has a deep purple bruise that covers her entire left eye, with steri strips along the far left corner of her eyebrow. The bridge of her nose is bruised. She has a scrap at the top of her forehead just below her hairline. There is light red discoloring of her skin above her top lip on the right side. Her left cheek bone also has a bruise.
    - The second photograph is of Resident A's lower extremities. The photograph does not show Resident A's face. Bruising can be seen all along both of Resident A's shins and her knees. There are multiple bruises seen in this photograph.
    - The third photograph is of Resident A's right lower extremity. A reddened area is seen all along the exterior calf and shin in this photograph.
    - The fourth photograph is of Resident A's left foot. Bruising and small scraps can been seen on Resident A's foot in this photograph.
- *State of Michigan, Department of Health and Human Services, Certificate of Death*, for Resident A, dated 11/23/25.
    - Under section*, 27a. Certifier,* the box for "Medical Examiner" is checked with the name, Michael Markey, MD, noted.
    - Under the section, *36. Part I. Enter the chain of events – diseases, injuries or complications that directly caused the death*. Subsection, *a*., reads, "Major Neurocognitive Disorder, subsection, *b.*, reads, "Combined effects of brainstem astrocytoma and sequelae, Head Injury (Subdural Hygromas), and Schizoaffective Disorder."
    - Under section, *39. Manner of Death*, the report reads, "Accident".

- Under section, *40a. Was an Autopsy Performed*, the report reads, “No”. Guardian A1 reported that she had an independent autopsy performed at Western Michigan University Homer Stryker M.D. School of Medicine, in Kalamazoo, Michigan. Results from this autopsy are still pending.
- Under section, *41a. Date of Injury*, it reads, “10/1/2025”.
- Under section, *41b. Time of Injury*, it reads, “Unknown”.
- Under section, *41c. Describe How Injury Occurred*, it reads, “Multiple recent falls with head trauma including falls on September 11, October 1, and October 31, 2025 with subsequent development of subdural hematomas/hygromas.”
- Under section, *41e. Place of Injury*, it reads, “Adult Care Facility”.
- Under section, *41g. Location*, it reads, “11262 Dewitt Road, Dewitt Twp, Michigan 48820”.

- *XR Shunt Series*, for Resident A, collected on 10/31/25. Under the section, *Impression*, it reads, “Disruption of the external tubing posteriorly with discontinuity at the C1-C2 level.” Under the section, *Narrative*, subsection, *History*, it reads, “Suspect shunt malfunction.” Under subsection, *Findings*, it reads, “Right posterior parietal ventricular shunt catheter in place. Disruption of the external tubing posteriorly with discontinuity at the C1-C2 level. External shunt tubing otherwise intact. Distal tip overlies the left mid abdomen. No intracranial abnormality. Lungs clear. Heart and mediastinal structures within normal limits. Intestinal gas pattern nonspecific.”
- *MRI Brain W WO Contrast,* for Resident A, dated 11/3/25. Under the section, Impression, subsection, *4.*, reads, “Multiple foci of susceptibility, greatest in the bilateral cerebellar hemispheres, but also present in the cerebral hemispheres to a lesser degree. These are significantly increased since the prior MRI. These may be secondary to chronic microhemorrhages. Differential includes amyloid angiopathy.” Under the section, *Narrative*, subsection, *History*, reads, “Head trauma, abnormal mental status (Age 18-64y).” Under subsection, *Comparison*, it reads, “CT brain November 3, 2025. MRI brain December 1,2022.”
- *Progress Notes by Nasser Yaghi, MD at 11/05/25 1500.* Guardian A1 reported that this progress note was extracted from Resident A’s *MySparrow* through University of Michigan Health Sparrow Hospital’s online patient medical record. I observed the following information in this document:
  - Dr. Yaghi reported that he had completed a personal evaluation of Resident A’s condition.
  - Dr. Yaghi reported that he personally reviewed all imaging reports available for Resident A.
  - Dr. Yaghi documented Resident A as a 48 year old female with medical history including shunt placement in 1991, Diabetes insipidus, thrombocytopenia, Blind R eye/decreased vision, hypertension, thyroid nodule, and schizoaffective disorder, with history of electroconvulsive therapy for three years. He reported that neurosurgery had been consulted for evaluation of abnormal CT findings.
  - Dr. Yaghi noted Resident A presented at the hospital on 10/31/25 due to altered mental status.

- Paragraph five reads, “CT head shows bilateral convexity subdural hygromas and tentorial subdural hygromas not present on CT head from early October. Ventricles mildly reduced in size, subtle. XR shunt series with distal catheter break at level of C1-C2 however with calcified tract.”
- Dr. Yaghi reported, Resident A was also diagnosed with a UTI and elevated Depakote levels.
- Paragraph seven reads, “Repeat CT head stable. MRI brain shows stable bilateral convexity subdural hygromas and tentorial subdural hygromas. Of note, on my review of prior Ct head from last hospitalization (neurosurgery not consulted), CT head 10/1/2025 shows left convexity acute subacute with mild mass effect.”
- Dr. Yaghi noted, “Unclear etiology for this presentation of AMS: 1. Possible shunt failure with shunt overdrainage (valve may have been damaged in falls), 2. Traumatic brain injury/concussion in setting of prior neurocognitive deficits, 3. Depakote overdose, 4. Urinary tract infection, 5. Exacerbation of metal health schizoaffective disorder, bipolar type.”
- Dr. Yaghi noted that goals of care were discussed with Guardian A1 and noted a surgical intervention was presented but noted to be high risk with no guarantee of providing Resident A with mental status improvement. It was noted that after this discussion, Guardian A1 chose hospice care for Resident A.

On 12/15/25 I received email correspondence from Ms. Miller. I reviewed the following documents provided as an attachment in this email:

- *Treatment Plan Annual/Initial*, for Resident B, dated 4/21/25. This document was created by Mindy Farison with CEI-CMH. At the bottom of page eight, the document reads, “[Resident B] has an unsteady, unusual gait, and balance issues due to her limited depth perception and CP. The staff monitor her when she’s walking around to make sure she’s safe and doesn’t fall. The AFC staff will let the DD CM know if [Resident B] has any falls or stumbles, and if there are other needs related to this issue.” There are no mentions of Resident B’s shunt in this document.
- *Assessment,* for Resident B, completed by Ms. Farison with CEI-CMH. On page one, under section, New and Ongoing Presenting Problems since Last Annual Assessment, the fifth sentence of this paragraph reads, “[Resident B’s] independently mobile, but her CP has significantly impacted her gait, and she can be quite unsteady. She has a serious risk of falling, and typically falls at least 1-2x/week. She wears an AFO on her right foot/ankle/lower calf every day. She often walks too fast, and doesn’t watch the environment around her, resulting in her falling. Her caregivers often provide stand-by assistance to help prevent falls.”

On 12/17/25 I received email correspondence from Emily Ryan, Corporate Compliance and HIPAA Privacy Officer, with CEI-CMH. Ms. Ryan provided requested documentation for Resident A. I reviewed the following documentation:

- *Assessment*, for Resident A, dated 3/4/25, completed by Jamie Waltz, LMSW, with CEI-CMH.
    - On page one, section, *New and Ongoing Presenting Problems since Last Annual Assessment*, the document details Resident A's history going from an AFC placement in Haslett, MI, to placement at an AFC in Grand Ledge, MI, to hospitalization at University of Michigan Ann Arbor hospital, to placement at a nursing home in Howell, MI. The document notes that Resident A was hospitalized eight times from July 2024 – December 2024 and is now hospitalized, awaiting a "Specialized Residential placement."
    - On page two, section, *Serious Risk of Harm*, reads, "Clear compromise of ability to care adequately for oneself or to be adequately aware of environment."
    - On page two, section, *Serious Impairment*, reads, "Serious decrease in the quality of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may include impulsive, aggressive or abusive behaviors."
- *Treatment Plan Annual/Initial*, for Resident A, dated 3/13/25, completed by Ms. Waltz.
    - On page two, section, *Needs/Strengths/Barriers*, subsection, *Associated Needs for Goal 1*, it reads, "Medication Management, Socialization, Physical Health Coordination of Care." Subsection, *Barriers pertinent to this goal*, identified "Client has poor balance and requires support from staff, family and requires a wheelchair when in the community", as one of the barriers.
- *Case Management Service Note*, for Resident A, dated 3/13/25, completed by Ms. Waltz. Under section, *Today's Presenting Issues*, the document reads, "Clinician visited [Resident A] at U of M Sparrow to complete assessment and treatment plan. [Resident A] was lying in bed, hospital gown, not hooked up to any type of monitors, with a 1:1 sitter (reported to keep watch so [Resident A] does not leave her room). [Resident A] was able to communicate some of her needs and desires and [Guardian A1] was able to communicate some as well…"
- *LOC Full Life, CMHA-CEI,* for Resident A, dated 7/7/25. This document was signed by Barbara Reyna, LLMSW, from CEI-CMH, on 7/14/25.
    - Under the section, *Are there any other clinical circumstances/considerations of note?*, the first two paragraphs read, "[Resident A] has received supports with various departments within CEI-CMH, surrounding CMHs, and TCOA. [Resident A] has lived in a variety of specialized residential AFCs and nursing home settings that have struggled to support her needs. She is currently enrolled in the Mason Rural Outreach Program and was referred to CSDD to determine eligibility for program supports. In 1991, at the age of 13, [Resident A] was diagnosed with Astrocytoma, a type of brain tumor that required intensive medical treatment which has impacted [Resident A's] overall functioning. She had surgery to address the tumor and a shunt/catheter was implanted. She is blind in her right eye, has diminished sight in her left eye, he wears glasses, left side weakness, uses a walker, wheelchair, and

a shower chair. She has an ataxic gait and most often leans back when standing requiring assistance for stability. She is a significant fall risk and would benefit from a barrier free environment. She has a seizure history and [Guardian A1] reports that due to long term use of medication, [Resident A] has stage 3 kidney disease. [Resident A] has a history of frequent UTI's and chronic constipation. [Resident A] has hypothyroidism and has a mass in her neck; that is suspected to be related to her thyroid, and requires a biopsy. She will inconsistently inform others when she is not feeling well. Family and staff note that they will have to monitor for behavioral changes as it relates to physical or mental well-being. There is a history of hallucinations, bipolar disorder and schizophrenic symptoms. [Resident A] is said to state that the Devil is stealing her clothes. According to DSM-5 criteria, [Resident A] appears to meet diagnostic criteria for Intellectual disability: Moderate based on available reports and observation at intake. However, this diagnosis may require reassessment as more information becomes available regarding potential impact of current medications and environmental factors."

    - Paragraph seven states, "Per family report and clinical review, [Resident A] will fixate on males, relationships, and has inappropriately interacted with male staff and male peers leading to program suspension. This should be considered for placement. While at the hospital, [Resident A] has required 24/7 patient sitters as she will attempt to get out of bed on her own. She and has fallen at the hospital causing bruises and the caps on teeth to become dislodged. [Resident A] will yell, scream, and become agitated if working with non preferred staff. She has a history of physical and verbal aggression."

- *Assessment*, for Resident A, dated 7/7/25, completed by Ms. Reyna with CEI-CMH.
    - Under the section, *Current Abilities Summary*, paragraph one, reads, "[Resident A] requires the use of a walker to navigate her surroundings and the use of a wheelchair for longer distances. [Resident A] has a well documented ataxic gait which results in frequent falls causing bruising and other injuries. She has general left side weakness. She requires assistance to safely stand from a seated position and reminders to use her walker. When standing, it is common that she will lean backwards and will fall if she does not have support."
    - Under the section, *Clinical Interpretive Summary*, Ms. Reyna details her observations of Resident A when she made a visit to her in the hospital on this date. In paragraph two she reports that there was a safety sitter present in the room with Resident A, and references Resident A's attempt to reach the bathroom noting, "Difficulties with walking was clearly observable."
- *Transfer/Referral Document, CMHA-CEI*, for Resident A, dated 8/11/25. This document is completed by Jenee Wilson, case manager, with CEI-CMH. Under section, *Reason/Assessed Need for Transfer/Referral*, the document reads, "Assessment of physical assistance for walking, getting out of bed, and

transferring. Home manager is concerned for fall risk." Under the section, *Services Recommended*, it reads, "Evaluation, OT".

- *Case Management Service Note,* for Resident A, dated 9/3/25, completed by Ms. Wilson.
    - Under the section, *Today's Presenting Issues*, the document reads, "the case manager was at the home for two hours meeting with multiple residents. During this time [Resident A] was redirected six times, yelled three times, pounded on the wall twice, grabbed someone in a wheelchair and moved them around the house without their permission, asked repeatedly for items not in the home, and hit the home manager with both hands in the breastbone because she would not make someone else get up from the couch. Over the past two weeks [Resident A's] aggressions have increased. Staff report that she cannot be left alone in the back seat of the car or ride in the front seat because she will unbuckle. She has gained interest in a 23-year-old housemate and yells through the night that she loves him and tries to get into his room. She slapped a housemate for sitting in a chair and not moving, and numerous other episodes were reported."
    - Under the section, *Follow-up/Plan*, the document reads, "Case manager will refer her to psychology and continue to monitor her acclimation to her new home."
- *Psychiatric Evaluation*, for Resident A, dated 9/3/25, completed by Andrea Landesman Jonsson, MD, with CEI-CMH. This document reports that Dr. Landesman Jonsson met with Resident A and Guardian A1 to conduct an assessment. It was discussed to make a medication change to see if this helps with Resident A's behaviors. Medication change for Resident A to take Prolixin 3.5mg in the morning and Trazadone 50mg at bedtime. Under the section, *Plan/Orders*, it identifies the plan to make this medication change, continue already prescribed medications, adhering to regular appointments with primary care provider, and mental health sessions. There were no interventions for the direct care staff to utilize in terms of assisting in decreasing Resident A's behaviors, except the recommended change in medication administration stated.
- *Transfer/Referral Document CMHA_CEI,* for Resident A, dated 9/4/25. This document was a referral for "MH Services NOS" and received by Mr. Myntti at CEI-CMH.
- *Treatment Plan Addendum-Review,* for Resident A, dated 9/15/25.
    - Under the section, *Purpose of Addendum*, it reads, "Addition of OT goals". The document had the addition of "Goal #4 Occupational therapy evaluation as requested". This goal was created on 8/11/25 with a *Target Date* of 10/10/25. There are no specific interventions identified with this goal other than, "Occupational therapy evaluation and consultation as needed." Under the section, *Barriers pertinent to this goal*, the section reads, "[Resident A] will attempt to move whenever she wants without having the strength of her body to support her decisions."
- *OT Evaluation CMHA-CEI*, for Resident A, dated 9/15/25, completed by Ms. Winkler, MS,OTRL.

    - Under the section*, Client Factors and Performance Skills,* subsection, *Assessment Tool*, it reads, “Tinetti Performance Oriented Mobility Assessment (POMA). The Tinetti assessment tool is an easily administered task-oriented test that measures an older adult’s gait and balance abilities.” Subsection, *Results*, reads, “[Resident A] scored a 7/16 on balance portion and 8/12 on gait portion, indicating high fall risk. [Resident A] especially struggles on safe descent, and maintaining balance without assist (from vision or walker) along with difficulty with LLE.” Under subsection, *Movement Functions*, section, *Motor reflexes and involuntary movement reactions*, it reads, “Poor righting reactions causes frequent falls, although mom reports falls are “graceful” and she usually never is hurt.” Under the section, *Interventions methods*, the following are noted, “Therapeutic use of occupations and activities, Preparatory methods (e.g. splinting, assistive technology, wheeled mobility) and tasks, education and training.” Under the section, *Recommendations*, it reads, “Treat 1x/week to reach goals.”
- *Case Management Service Note*, for Resident A, dated 9/15/25, completed by Ms. Wilson with CEI-CMH.
    - Under the section, *Today’s Presenting Issues*, it reads, “The case manager received an email on Sunday from the client’s guardian expressing high regard for her safety because she fell down the basement stairs on Thursday night at 8pm. The case manager visited the home today and they stated that [Resident A] repeatedly tries to leave the house without having much balance and does not use her walker. One worker was using the restroom and the other was helping another client and [Resident A] opened the basement door and fell down. A hospital visit revealed no broken bones or bruises, but some scrapes. After falling down the stairs and returning from the hospital the client made two more attempts to access the basement door but was redirected.”
    - Under the section, *Follow-up Plan*, it reads, “The house manager received permission to put a lock on the basement door because residents do not access that area. Previously, CMH removed the lock from the door, per house manager. The client’s CMH psychologist will visit tomorrow to assess her safety.”
- *General Service Note*, for Resident A, dated 9/16/25, completed by Warner Myntti, TLLP, MS, with CEI-CMH.
    - Under the section, *Today’s Presenting Issues*, reads, “Psychologist met [Resident A], [Guardian A1], and [Ms. Sidelinker], for the first time at her group home. [Resident A] recently moved into the home about a month prior, and has been struggling with challenging behavior since her move. [Resident A] was described to engage in aggressive behavior with staff and with fellow residents, including kicking, hitting, spitting, and destroying furniture. These behaviors occurred several times per day, most times staff would approach [Resident A] to redirect her, upon her introduction to the home. Recently, one of [Resident A’s] medications was changed to be administered in the morning, and this change has coincided with a

decrease in these behaviors to where she is most often engaging in them once or twice per day at present. Staff describe that [Resident A] often becomes verbally or physically combative when some type of limit is set. During this visit, [Resident A] was observed asking for more juice, to which staff said, “I will get it for you in a minute, right now I’m busy,” to which [Resident A] responded by yelling “No!” repeatedly. To avoid escalation, staff strategically ignored [Resident A’s] yelling so as to not reinforce the behavior. Psychologist noted how well staff handled this interaction to both [Ms. Sidelinker] and [Guardian A1]. In addition to her aggressive behavior, [Resident A] has been engaging in some other behavior of concern. Specifically, [Resident A] is often wandering around the house and was described as “always on the move.” She will go outside without staff assistance and stand in the middle of the yard or sidewalk, and upon meeting her out there will tell staff that she does not know where she is. Staff sometimes have difficulty redirecting [Resident A] back in the home. Recently, [Resident A] opened a door to the basement of the home and fell down the stairs, where the basement floor is unfinished and made of concrete. While there was serious risk involved in this incident, [Resident A] was evaluated and did not sustain any injury. [Guardian A1] expressed serious concern over there not being a lock on the door. After this incident, home staff reached out to Quality Assurance at CMH-CEI to inquire if the basement of the home is defined as a shared living space. As the space is unfinished, unfurnished, and houses the water heater and other home appliances, this inquiry led to the determination it is not a shared living space. As such, the home is in the process of putting a lock on this door to prevent similar incidents in the future. As of the morning of our appointment, [Resident A] had also gone to the bathroom in one of the other residents’ trash cans in their bedroom. This was only just discovered the morning of the appointment, and is a new behavior. It is uncertain what led to this behavior, but [Resident A] was described as frequently walking up and down the halls of the home and checking if residents’ bedroom doors are locked as she will often want to enter other bedrooms later in the evening. Staff shared that redirecting [Resident A] from these other rooms is also often a case in which she will become aggressive or agitated. Psychologist gave home staff a tracking form to begin monitoring the contextual factors at play in [Resident A’s] behavior, and walked them through steps to complete it.”

- *CMHA-CEI Miscellaneous Note*, for Resident A, dated 10/7/25, completed by Ms. Winkler with CEI-CMH.
    - Under the section, *Narrative*, the document reads, “[Resident A] was seen at her AFC with home manager, staff and house mates present. HM reports [Resident A] had two falls in the past week, one resulting in hospitalization with stitches above eye and other cutting her head. Both happened alone in her room at different times of night, did not use walker and [Resident A] unable to recall what she was doing. [Resident A] had proper lighting and walker within reach. Educated on the importance of

calling out to ask for assistance, and demonstrated how [Resident A] can be heard from her room in various parts of the house. [Resident A] verbalized understanding and stated she would try to remember to ask for assist. [Resident A] was in her bed in pajamas upon arrival. Agreeable to sit edge of bed but required encouragement and completed supine <> sit multiple times with no loss of balance or assist required. When walker placed in front of her [Resident A] utilized for mobility but required mod asst for obstacle negotiation, did not bring walker with her prior to sitting in each trial despite verbal and visual cues. [Resident A] completed toilet transfers with CGA and able to maintain unsupported balance to assist with dressing and toileting tasks. Unable to maintain unsupported standing balance for pant management after voiding, educated on one handed dressing techniques but was not able to complete. Continued to require mod asst for walker management to avoid obstacles and CGA to stand upright with walker close by when ambulating around the home. [Resident A] walks very quickly and requires frequent cues for safety with walker for fall prevention. Will continue to work with HM on ideas for fall prevention at night. Continue treating as outlined in PCP."

- *CMHA-CEI Miscellaneous Note*, for Resident A, dated 10/13/25, completed by Ms. Winkler, with CEI-CMH.
    - Under the section, *Narrative*, it states, "[Resident A] was seen at her group home with HM and housemates present. HM reports [Resident A] has had multiple falls in the last week. All when self transferring, at different times of day and different places in the house. Asked about implementation of call light which HM reports they are able to install near [Resident A's] bed and they may try this. [Resident A] was lying on couch, dressed with only regular socks on upon therapist arrival. Agreeable to ambulate to her room to don shoes. [Resident A] required mod asst for obstacle negotiation, attempting to push her walker far in front and push objects out of the way, encouraged to stop and ask for assistance. Therapist provided cues throughout to assist with balance including shifting weight forward and slowing down with fair return demonstration and quickly requiring cues again. [Resident A] able to be redirected to bring walker with her when sitting down on bed. Attempts to engage [Resident A] in activities mom stated she enjoys such as spelling or math problems with [Resident A] showing little interest and wanting to lay down under blankets. Required max asst to don shoes and educated on importance of proper footwear for fall prevention to [Resident A] and HM. [Resident A] ambulated to kitchen table with max asst for obstacle negotiation and frequent cues for balance, pushed walker out of her way when near table and did not respond to cues to bring it with her for transfer. On next ambulation attempt, [Resident A] required same amount of cues and assistance and did not bring walker with her on descent. [Resident A] had difficulty recalling previously learned techniques for balance and safe transfers with walker. If walker was in her line of sight,

she initiated use of it for ambulation. Continue treating as outlined in PCP."

- *General Service Note*, for Resident A, dated 10/14/25, completed by Mr. Myntti, with CEI-CMH.
    - Under the section, *Treatment Plan Objectives Addressed by this Service*, two objectives are listed:
        - "[Resident A] will decrease her engagement in aggressive behavior."
        - "[Resident A] will feel more comfortable receiving care in her home."
    - Under the section, *Progress Towards Goals/Objectives*, it reads, "[Resident A] has decreased her engagement in aggressive behavior from 1-2x per day to 1-2x per week."
    - Under the section, *Today's Presenting Issues*, the document reads, "Psychologist met [Resident A], [Guardian A1], [Ms. Sidelinker], and ROI quality service team member [Ms. Brennan] at her group home. Psychologist provided follow up information regarding intrusive/restrictive techniques that were discussed at our last meeting. Psychologist provided the information that for a buckle buddy, bed alarms, and door alarms/locks, other interventions would need to be attempted prior to initiating a behavior treatment plan. Data will also need to be gathered on the efficacy of these interventions and the frequency/context surrounding [Resident A's] behavior prior to initiating a plan. Psychologist provided three new data tracking sheets that can be used to monitor [Resident A's] behavior and the efficacy of these interventions. [Ms. Sidelinker] and [Ms. Brennan] endorsed planning to train the rest of [Resident A's] staff on these forms on Thursday, 10/16 during a team meeting. Psychologist provided some ideas to home staff regarding [Resident A's] unbuckling in the van, suggested a sensory/engaging activity she can complete, engaging her more in conversation or in other stimuli while in the care (e.g., altering the radio station or volume), and reducing sensory information that may be distressing for [Resident A] by putting shades up in the windows surrounding [Resident A] when she is in the car. Psychologist encouraged staff, for all behaviors, to keep track if there is any particular strategy that appears to be working well for [Resident A] so we can build on this moving forward. Psychologist inquired about the frequency of [Resident A's] behaviors of concern over the past few weeks. Staff report that, with increased attention being paid toward [Resident A], that aggressive behaviors are down to 1-2x per week, which is a substantial improvement. They also report that other behaviors (e.g., "eloping" outside, attempting to access other residents' rooms and belongings, walking without her walker) are still consistent, but that home staff as a whole feel more confident in their ability to care for [Resident A] at this time."
- *CMHA-CEI Miscellaneous Note*, for Resident A, dated 10/21/25, completed by Ms. Winkler with CEI-CMH.

    - Under the section, *Narrative*, it reads, “[Resident A] was seen at her group home with house mates, home manager and staff present. Home manager reports [Resident A] has had a difficult week and her sleep schedule had been off. She had switched nights/days for a few days and last night slept for approx. 1 hour and it was very broken. [Resident A] had been yelling at staff upon therapist arrival and they stated this has been happening. Was in a wc to try to keep her awake and engaged and fall prevention. Did not ambulate as she was too fatigued and unsteady this date. Attempts to find activities to engage [Resident A] while sitting to improve endurance and decrease falls and yelling behaviors. With mod prompts, [Resident A] was able to count objects on a puzzle piece and find correct number that corresponded. Able to bring piece on top of one another, did not attempt to fit together. When given in small batches and cues throughout, able to match 1-9. Able to complete pop it with finger isolation intermittently throughout tx. When given 1 on 1 attention and attempts to engage [Resident A] in various activities, no yelling or attempts to self transfer noted, she appeared content and calm. Able to readjust in wc and propel as needed. By end of session, [Resident A] too fatigued to continue but remained calm. Too fatigued to attempt math problem version or matching game, but remained at table with small matching game and pop it in front of her upon therapist departure to encourage further engagement. Continue treating 1x/week to reach goals outlined in PCP.”
- *Nursing Note*, for Resident A, dated 10/31/25, completed by Nicole Stephens, CEI-CMH.
    - Under the section, *Narration*, it reads, “[Ms. Sidelinker] from the AFC called with concerns about [Resident A] and her lack of sleep, sleep was worse with the med changes and [Resident A] is hurting herself. Message to Dr. Landesman and was ok with client going back to old regimen. Per VO ok to send in Seroquel 300 mg BID and D/C Seroquel 400 mg. Awaiting response about increasing Trazadone. 2:14pm: Received ok from Dr. Landesman to d/c Trazadone 150mg. and increase to 200 mg, RX sent to pharmacy. [Ms. Sidelinker] notified.”
- *Discharge Summary CMHA-CEI*, for Resident A, dated 11/23/25, completed by Ms. Wilson, with CEI-CMH.
    - Under the section, *Summary of Progress*, subsection, *Strengths and abilities related to services*, it reads, [Guardian A1] and her home sought support to help keep [Resident A] physically safe and were still trying to obtain those services. [Resident A’s] physical aggression showed improvement with services.”
    - Under the section, *Reason for Discharge/Transition*, it reads, “Client deceased”. Subsection, *Additional Information*, reads, “[Resident A] passed away in hospice prior to her 14 day wait from her guardian’s request to cancel services.”
    - Under section, *Natural Supports*, it reads, “[Resident A] went to the emergency room and was transferred to hospice and did not return to her

AFC home. On November 11th the client's guardian requested all services end."
    - Under the section, *Client Feedback/Satisfaction*, the document reads, "Discharge was planned for 11/26/25. [Resident A] passed away on 11/23/25. Client's guardian was unsatisfied with the amount protection placed for falls and safety in the car."
- *Occupational Therapy Discharge Summary*, for Resident A, dated 11/24/25, completed by Ms. Winkler with CEI-CMH.
    - All goals listed on this document are marked as "Not Met".
    - Under the section, *Summary*, it reads, "Treatment focused on safety during ambulation, balance and core stability needed for self-care tasks. [Resident A] was participating well in therapy and making some improvements. Progress varied and was limited due to medical condition impacting physical performance and limited sessions. [Resident A] was admitted to the hospital and transitioned to hospice so dc initiate and not all units utilized. Unable to reassess formal assessments."

On 12/22/25 I interviewed CEI-CMH, case manager, Jenee Wilson, via telephone regarding the allegation. Ms. Wilson reported that she began working with Resident A in late July/early August of 2025. She reported that she was not part of the team who worked on her discharge from Sparrow Hospital to the facility. Ms. Wilson reported that she does not have any information on how the licensee designee felt she may be able to provide for Resident A's care needs at the facility. Ms. Wilson reported that she did make two visits to Resident A, at University of Michigan Health Sparrow Hospital on 7/17/25 and 8/1/25, prior to Resident A's admission to the facility. Ms. Wilson reported that it was known Resident A had some aggressive behaviors and was a fall risk. She reported that she directly observed a fall risk sign on Resident A's hospital room door and a safety sitter in the hospital room with Resident A on each of these visits. Ms. Wilson reported that Guardian A1 stated that Resident A required a safety sitter due to her aggressive behaviors and being a fall risk. She reported that there was an email communication which included multiple individuals involved in Resident A's care. She reported that on 8/4/25 Laren Hansen (Ms. Wilson was not certain of Ms. Hansen's title at the hospital) from University of Michigan Health Sparrow Hospital, had sent communication noting that they were preparing for Resident A's discharge and she would need to have physical therapy services ordered for Resident A to receive this treatment at the facility. She reported that she is unsure whether Resident A received any physical therapy services post discharge from the hospital. Ms. Wilson reported that it was also notable that Ms. Hansen had emailed on 8/1/25 and noted that Resident A was not medically stable to be discharged, was very weak and required two-person assistance with her care. She reported that by 8/4/25 this status changed and the hospital was pushing to have Resident A discharged to the facility on this date. Ms. Wilson reported that she is required to be present when Resident A was admitted to the facility and she was not working on 8/4/25, so the admission was planned for 8/5/25. Ms. Wilson reported that Guardian A1 made a statement that she wanted Resident A admitted to a nursing home and this was not possible as multiple nursing homes were consulted for potential admission and all declined to admit Resident A. She was not

certain why these nursing homes declined admission but noted she felt it was due to Resident A's aggressive behaviors. Ms. Wilson reported that she met with Resident A monthly at the facility and those dates included, 8/5/25, 9/15/25, 9/30/25, & 10/16/25. Ms. Wilson reported that she would usually visit the home between the hours of 11am and 1pm and she noted that there were usually three to four direct care staff members at the facility during these visits. Ms. Wilson reported that Guardian A1 had requested on multiple occasions to have cameras installed at the facility to provide for Resident A's safety and these requests were denied due to Medicaid not allowing this type of device. Ms. Wilson reported that after Resident A was admitted to the facility on 8/5/25, she worked to set up psychiatry services immediately for Resident A. She reported that post admission, Resident A was frequently in and out of medical appointments. She reported that she is not certain how often Resident A was falling in the early days of her admission to the facility. She reported that Resident A did not like using her walker and she noted "She did what she wanted to do" in terms of Resident A refusing her walker. Ms. Wilson reported that when she made visits to the facility the staff would have Resident A in the common area and would be watching her for safety. She reported if Resident A tried to get up, they would run to assist her. When asked about the level of supervision Resident A required, Ms. Wilson reported that she felt Resident A needed one-to-one staff supervision during the evening hours. She reported that she was told this was not possible as there was not adequate direct care staff to provide a one-to-one for Resident A. Ms. Wilson reported that Mr. Myntti was sent a referral to work with Resident A on a behavioral plan after Resident A assaulted a direct care staff member causing a workmen's compensation claim for that direct care staff. She reported that she thinks Mr. Myntti's services were requested on 9/29/25. She reported that she was not a part of Mr. Myntti's data collection process for Resident A. She reported that she would inform Mr. Myntti of observations made during her meetings with Resident A, but was not involved in his process for identifying goals to proceed with based on the data collected. Ms. Wilson reported that the direct care staff did ask for items such as a bed alarm and buckle buddy for Resident A. Ms. Wilson reported that she took these requests to Mr. Myntti and it was noted that these types of restrictive devices require a lot of documentation to enact them in the plan of care. Ms. Wilson reported that an example of this was when Resident A fell down the basement staircase. She reported that previously there had not been any issues with the basement door being unlocked, but due to Resident A's fall, they were able to approve locking the door in a timely manner to provide for her safety. She reported that the door had not been previously locked because a resident cannot be restricted from accessing any area of the facility they wish to access. Ms. Wilson reported, "[Residents] cannot be told where they can and cannot go]". When asked why CEI-CMH staff could not utilize information gathered on Resident A and her behaviors at the hospital during her seven-month hospital stay, Ms. Wilson reported that this was due to the hospital playing a "medical" role in Resident A's care planning. She reported that since a medical doctor ordered a safety sitter for Resident A, this was allowed in a hospital setting. Ms. Wilson reported that once Resident A was discharged to the facility, CEI-CMH staff were treating her behavioral health needs and not her medical needs. She reported that if Resident A's medical provider had ordered one-to-one supervision this would be viewed differently. She then clarified that she has only been in her current role at CEI-CMH for about

seven months and is still learning these processes. Ms. Wilson did agree that Resident A appeared to be falling due to medical reasons and not mental health related impairments. When asked if there were any interventions put into place by direct care staff to reduce the number of falls or provide additional safety measures for Resident A, Ms. Wilson reported there were a couple of items discussed. She noted that a floor mat was discussed for Resident A's bedroom so that if she fell the fall would be less serious due to padding on the floor. She reported that she is not certain this was ever initiated. She reported that the direct care staff were responding to Resident A yelling from her bedroom and by the time they had reached her, she had already fallen. She also reported that direct care staffing was increased but acknowledged that Resident A did not receive one-to-one direct supervision. Finally, Ms. Wilson noted that occupational therapy services had been started for Resident A, but she was not familiar with the plan of care enacted by occupational therapy to be able to speak to this plan today.

On 12/22/25 I interviewed Krista Winkler, Occupational Therapist (OT), with CEI-CMH, via telephone regarding the allegation. Ms. Winkler reported that she has been employed in her current role as an OT at CEI-CMH for about seven months. Ms. Winkler reported that she could not recall the start of service date for OT services for Resident A. She felt it was either late August or early September 2025. Ms. Winkler reported that she received the OT referral because Resident A was new to the facility and was experiencing some issues with falls. She reported that when she first assessed Resident A for OT services Resident A was using a four wheeled walker for ambulatory assistance. Ms. Winkler reported that she developed a plan of care to work with Resident A on her balance and ambulating without falling. She reported that she did not provide any interventions for the direct care staff to be working with Resident A on, in between her sessions. Ms. Winkler reported that she did not expect the direct care staff to be completing daily OT exercises with Resident A. She reported that the direct care staff were encouraged to keep Resident A's walker close by and within her visual line of sight. She also reported direct care staff were instructed to remind Resident A to ask for assistance before trying to walk unassisted. Ms. Winkler reported that her weekly visits would usually occur around 845am on Tuesdays. She reported that each time she saw Resident A at the facility there were two direct care staff members on duty. Ms. Winkler reported that she assessed Resident A to have poor balance and visual impairments which made safe ambulation a challenge. She reported that Resident A would push her walker out of the way and seemed to forget to use the device. She reported that she did not feel Resident A was averse to using the device, because when she provided verbal cues to Resident A, she would look for the walker and use the device. Ms. Winkler reported that each time she visited Resident A the direct care staff had her seated in the common area of the home to have a better eye on her. She noted that the direct care staff would participate in OT visits and let her know what issues they were experiencing with Resident A's falls. She reported that she was informed by direct care staff that they had put Resident A's dresser into her closet and placed foam "pool noodles" around the door frame of the bedroom closet to protect Resident A in the event she fell in her bedroom. Ms. Winkler reported that Resident A's falls seemed to occur in her bedroom after she was in bed for the evening. She reported that Resident A would get out of bed and then fall in her bedroom. She reported that there did not seem to be a direct care

staff member available to sit in Resident A's bedroom and monitor her activities during sleeping hours. Ms. Winkler reported that the direct care staff suggested a bed alarm for Resident A so that they would know that she was trying to get out of bed at night. Ms. Winkler reported that she discouraged this intervention as she thought the noise of the alarm would aggravate Resident A and had the potential to cause further behavioral issues. Ms. Winkler reported that she suggested getting Resident A a call light so that she could let the direct care staff know when she required assistance. I inquired whether Resident A was capable of properly using and understanding a call light. Ms. Winkler reported that this is something that would have needed to be trialed, but she thought it was a potential that Resident A could not understand this type of device. She also reported that she suggested socks with rubber grippers on the bottom of the feet for Resident A's safety. She reported that she did not ever observe Resident A wearing these types of socks when she visited her at the facility. She reported that Resident A could have removed the socks as she was capable of this, but she is uncertain. Ms. Winkler reported direct care staff mentioned that Resident A would unfasten her seatbelt in a moving vehicle, making it unsafe for one direct care staff member to transport her. She reported that she was made aware of an instance when direct care staff were required to pull over, call for assistance, and wait for additional direct care staff to come to assist with Resident A's transport home from a medical appointment due to her unfastening her seatbelt. Ms. Winkler reported that she is uncertain whether Resident A was referred for physical therapy services as CEI-CMH does not have physical therapy services available. She reported that she did not provide the OT plan of care to the direct care staff at the facility.

On 12/22/25 I received email correspondence from Ms. Miller in response to an email I had sent to Ms. Miller on 12/16/25. I had asked Ms. Miller to answer the following questions:

- Having prior knowledge of [Resident A's] behaviors at the hospital and fall occurrences. How did ROI anticipate they were going to keep her safe in the facility?
- Did you have any conversations with your licensing consultant about the issues you were experiencing trying to keep [Resident A] safe at the facility?

Ms. Miller responded with an attached document to this email highlighting her response to these questions. I observed the following information in this document:

- Ms. Miller noted that Resident A was an emergency discharge from the hospital due to pressure put on CEI-CMH by the hospital to secure a placement.
- Ms. Miller noted that the original admission date was postponed due to Resident A having a decline in her physical health, believed to be related to a UTI. She noted that ROI could not complete muti pre-admission visits prior to accepting Resident A for placement at the facility.
- Ms. Miller reported that based on Resident A's presentation in the hospital, known history of fall risk and behavioral challenges, she anticipated the need for direct care staff to provide close supervision during transfers, encourage consistent use of her walker, and utilize a gait belt while walking alongside her to ensure safety.

- Ms. Miller reported that there were critical factors that were not anticipated and/or not communicated prior to hospital discharge:
    - Resident A did not consistently inform direct care staff when she intended to stand or move to another location. A call button was attempted, and Resident A did not utilize this device. Direct care staff initiated one-to-one supervision by positioning a direct care staff near her recliner and in her bedroom during the initial weeks following admission.
    - Resident A demonstrated combative behaviors during personal care and transfers, despite staff announcing their presence and requesting permission prior to assisting. Ms. Miller reported that she worked with the direct care staff on refining their approach with Resident A.
    - Resident A was discharged from the hospital without two of her critical medications listed on her medication administration record, which had been prescribed to support restful sleep and manage symptoms related to her psychiatric diagnoses. One of the medications was Seroquel, which Ms. Miller noted can cause confusion, agitation, and discomfort when abruptly discontinued.
- Ms. Miller reported, “In [Resident A’s] case this involved extensive brainstorming, assessment, and information gathering to address her evolving needs.”
- Ms. Miller documented steps taken to support Resident A as follows:
    - Securing a primary care physician. First appointment with PCP scheduled for 8/25/25.
    - Working with Ms. Wilson to obtain psychiatric services through CEI-CMH.
    - Medication review following reports from Ms. Sidelinker that Resident A was not sleeping during the initial days and nights post-admission. Ms. Miller noted that she visited the facility on 8/8/25 and identified that Resident A’s Prolixin medication could be contributing to agitation and insomnia and coordinated with the psychiatrist to adjust the administration time. She also reported that Guardian A1 identified that the Seroquel and Melatonin that had been prescribed in the hospital had been omitted from the hospital medication administration records they had received. Ms. Miller reported that these medications were then reordered and added back into the scheduled administration for Resident A.
    - Ms. Wilson reaching out to Sparrow for occupational therapy and physical therapy referrals.
    - Education to direct care staff on possible signs of UTI’s, other medical concerns, and possible sensory processing issues.
    - Coordination with ROI’s human resources director and Ms. Wilson to increase staffing during typical awake hours.
    - Environmental modifications such as locking the basement door, adding LED light strips in the hallway to offer visual cues and reduce nighttime disorientation, purchasing a new sofa for the front room for Resident A’s comfort during the day.
    - Multiple on-site visits to coach direct care staff on proactive engagement strategies, safe transitions, and techniques to reduce behavioral challenges, including positive interactions with housemates, improving

staff organization, and reinforcing the importance of meeting Resident A's needs prior to direct care staff assisting other residents. Ms. Miller noted that Resident A did not have a "line-of-sight restriction".
    - Ms. Brennan conducted multiple visits to the facility in September and October 2025 collaborating with Resident A's "behavior therapist" to review observations and behavior tracking data. Devices such as bed alarms and buckle buddy were discussed.
    - Ms. Brennan also attended medication clinic appointments with Resident A's psychiatrist.
- Ms. Miller reported that she did not contact the adult foster care licensing consultant assigned to the facility for additional supports or feedback regarding the challenges the direct care staff were experiencing with Resident A. She reported, "We did not contact the licensing agent because we believed we were operating within established protocols and appropriately following clinical recommendations. At the time, there was no indication that involving Licensing would result in guidance different from that provided by the clinical professionals supporting [Resident A's] care."
- Ms. Miller attached a document written by Bisma Anwar, MA, MSC LMHC, published on 2/21/25 identifying side effects associated with abruptly stopping the use of Seroquel medication. This document highlighted the previous information Ms. Miller reported about abrupt discontinuation of Seroquel.

On 12/23/25 I interviewed Warner Myntti, Psychologist with CEI-CMH for Resident A. Mr. Myntti reported that he began working with Resident A on 9/16/25. He reported that initially his goals were related to the aggressive behaviors that Resident A had been exhibiting at the facility. He reported that Resident A was noted to be hitting and shoving other residents and direct care staff members. He reported that, initially, Resident A's poor balance and falls were not the presenting issue. He noted direct care staff had verbalized that they were concerned about a potential for elopement with Resident A because they had found her out in the backyard unsupervised and found it difficult to redirect her back into the facility. Mr. Myntti reported that it was not until about 10/14/25 when he learned more about Resident A's risk of falls and increased confusion. He reported that interventions were discussed to monitor falls and what may be causing these episodes. He reported that he provided behavior tracking sheets to the direct care staff to monitor falls and aggressive behaviors for Resident A. He reported that interventions were discussed in terms of direct care staff making efforts to change the stimuli in Resident A's environment to reduce her agitation and feeling the need to get up unassisted. He reported that specifically while transporting Resident A it was identified that she would unfasten her seatbelt while the vehicle was moving and attempt to stand up. He reported direct care staff were aware of this potential and it was discussed to have another direct care staff ride along in the van and provide stimulation to Resident A to decrease this behavior, as well as efforts to control the environment inside the van by changing music, controlling volume of music and type of music, using shades to block sunlight that may be disturbing Resident A, and engaging in activities to distract her from unfastening her seatbelt. Mr. Myntti reported that he is not certain which of these interventions were utilized by the direct care staff. He reported that many

of the reports he received from the direct care staff were verbal or email communication. He noted that he did not ever feel as though he received adequate information in the behavior tracking logs to be able to justify a meeting with the CEI-CMH Behavior Tracking Committee (BTC) to discuss further restrictive measures being put in place for Resident A's plan of care. Mr. Myntti reported that he needed to obtain information about how Resident A was responding to stimuli and interventions in her current environment and could not utilize information from her prior hospital stay which documented the need for a one-to-one safety sitter for Resident A. He noted that this information was helpful but did not give him proper information to move forward on with a behavior plan for Resident A since they needed to acquire information from how she is managing her new environment and surroundings. Mr. Myntti reported direct care staff did request bed alarms and a buckle buddy for the van to transport Resident A safely, but these devices were not yet approved by the BTC. I asked Mr. Myntti if direct care staff could have sought approval of a bed alarm or buckle buddy through Resident A's medical provider as her falls were related to her medical condition and not her behavioral health condition. Mr. Myntti was hesitant to answer this question as he noted he could not be certain that Resident A's falls were not in part related to her behavioral health needs. When asked whether Mr. Myntti observed direct care staff to be skilled in the act of critical thinking regarding developing interventions to provide for Resident A's increased safety, he reported he felt, due to Resident A's rapid decline, it was difficult to engage in active critical thinking strategies. He reported direct care staff followed guidance provided to place Resident A's dresser in her closet, add foam "pool noodles" to the door frame on her closet door and to the sharp edges of her dresser. He further noted that OT services started to begin working on Resident A's balance and gait. The direct care staff were also advised to make sure Resident A's walker was within reach and in her line of sight. Mr. Myntti reported that he is not certain why direct care staff discontinued Resident A's one-to-one sitter during the evening hours. I inquired of Mr. Myntti whether a helmet was recommended for Resident A to increase her safety due to the falls she was experiencing. Mr. Myntti reported that a helmet was not advised. Mr. Myntti reported that when he made visits to the facility he observed two to three direct care staff working on any given date and that they had Resident A in the common area where direct care staff were most frequently working. When asked about the duration of time to gather data for the behavior tracking logs, Mr. Myntti reported that there is not duration of time, specifically looked at in this process. He reported that he looks for adequate information on what interventions have and have not worked, the risk associated with the behaviors, and any change in behaviors related to the interventions attempted. Mr. Myntti reported that he did not feel that he had adequate information from Resident A's behavior tracking logs to bring her case to the BTC for review prior to 10/31/25 when Resident A was readmitted to the hospital.

On 1/7/26 I received email correspondence from Ms. Miller. Ms. Miller was responding to an inquiry I had sent to her via email on 1/6/26. I had asked, "Were [Resident A's] falls discussed with her medical provider? If so, were there any solutions offered to provide for her safety?" Ms. Miller reported that Ms. Sidelinker had conversations with Resident A's physician and Guardian A1 attended most of these appointments. She reported that the physician had made some recommendations for lab work and other

tests but noted that Guardian A1 declined these recommendations. Ms. Miller reported that she could not be certain what labs or tests were discussed and whether they were all relevant to the falls as she recalled one of the tests being offered was a mammogram. She reported she is attempting to contact a representative from CEI-CMH who may have more information regarding this matter.

On 1/8/26 I interviewed Guardian A1. Guardian A1 reported that Resident A was established with the medical provider, Mary Boudreau, a Nurse Practitioner with Sparrow Health System, for her primary care needs post discharge from the hospital. She reported that she was told by the administration at the facility that Ms. Boudreau made visits to the facility to provide care for other residents. Guardian A1 reported that Ms. Boudreau only saw Resident A on two occasions. The first was the new patient visit at Ms. Boudreau's office and the second visit was at the facility following Resident A's fall on 10/1/25. She reported that the second visit was for Ms. Boudreau to remove Resident A's stitches. Guardian A1 reported that during both visits Ms. Sidelinker and Guardian A1 were both present. She reported that Resident A's falls were addressed during these visits but noted that no interventions were discussed or addressed to keep Resident A safe related to the falls. Guardian A1 reported that no assistive devices such as buckle buddy, bed alarms, and such were discussed during either of these visits with Ms. Boudreau. Guardian A1 denies that she refused any testing that would have been related to assessing Resident A's safety related to her falls. She reported that she declined vaccinations for Resident A. Guardian A1 reported that as Resident A continued to struggle at the facility she requested another visit with Ms. Boudreau and was told by Ms. Sidelinker that Ms. Boudreau only visits the facility on a quarterly basis.

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 upon interviews conducted with the Complainant, Guardian A1, Guardian B1, Ms. Miller, Ms. Sidelinker, Ms. McNamara, Ms. Carey, Ms. Wilson, Ms. Winkler, & Mr. Myntti, as well as extensive documentation reviewed, it can be determined that the direct care staff did not adequately provide for Resident A's protection and safety while she was a resident at the facility. It was noted in the documentation reviewed from University of Michigan Health Sparrow Hospital that Resident A had a one-to-one sitter assigned to her 24 hours per day, seven days per week due to her behavior and assessed fall risk. Ms. Miller and Ms. Sidelinker were aware at the time of Resident A's admission of Resident A's behaviors, unsteady gait, fall risk, shunt placement, and poor vision along with the fact that the hospital utilized a safety sitter 24 hours per day, seven days per week during the seven month period Resident A was hospitalized to keep Resident A safe and monitored. Even though Resident A's *Assessment Plan for AFC Residents* dated 8/5/25 indicated Resident A required one-to-one or two-to-one assistance from direct care staff with mobility, this level of supervision was only provided to Resident A for roughly one to three weeks after admission during sleeping hours only. Multiple direct care staff interviewed reported that Resident A experienced daily falls at the facility, many of which occurred in her bedroom after she was assisted to bed for the evening and only two direct care staff members were working. There were four documented falls resulting in head injury, with three being unwitnessed (two in her bedroom, one down the basement staircase) and one of the four documented falls occurred in the van on the way to urgent care to be treated for another fall. There was a fifth fall resulting in head injury which occurred on 10/4/25, which was not documented (other than via email communication to Mr. Myntti by Ms. Sidelinker on 10/7/25). The fall which occurred on 10/4/25 was noted to have caused a cut to Resident A's head, although she was not sent to be evaluated by medical staff on this date. No action was taken by the licensee to continue one-to-one supervision for any length of time or implement other safety measures like bed alarms, a buckle buddy, or door alarms, even though Resident A's experienced numerous minor and major falls resulting in injuries including stitches, unconsciousness, and damage to Resident A's shunt. On 9/22/25 Ms. Sidelinker assessed that Resident A could not ride safely in a vehicle without a direct care staff providing direct supervision as she demonstrated behaviors of unfastening her

	seatbelt during transport and standing up in the vehicle. However, case manager documentation from Ms. Wilson, dated 9/3/25, noted that the direct care staff made reference to Resident A having the behavior of unfastening her seatbelt during transport. Despite having this prior knowledge, Ms. Sidelinker made the decision to transport Resident A to urgent care, unassisted by another direct care staff, on 10/31/25 because she reported she did not have another direct care staff who could accompany her on this transport. This decision resulted in Resident A unfastening her seatbelt, because she was not properly supervised, standing up and falling in the vehicle and hitting her head on the floor of the vehicle, causing an additional head injury on this date. Ms. Sidelinker chose not to contact emergency medical services on 10/31/25 to provide transportation for Resident A to urgent care when it was assessed that she did not have adequate staffing to provide for Resident A's safety in the vehicle. When asked whether direct care staff was increased to accommodate the intense supervision needs of Resident A, due to frequent falls with the possibility of head injury/damage caused to Resident A's existing shunt, the response was that a third direct care staff member had been added to the schedule between the hours of 11am to 7pm, on most days but was not guaranteed. However, I reviewed the direct care staff schedules and the *Basic Incident Information* documents provided for Resident A's falls and observed that on 9/11/25, 10/1/25, 10/4/25, & 10/31/25 when Resident A fell at the facility there were only two direct care staff members on duty to provide care. It was reported that conversations were held with Mr. Myntti regarding the use of restrictive devices for Resident A, such as bed alarms, door alarms, and a buckle buddy for the vehicle. These devices were being evaluated by Mr. Myntti but not yet approved for Resident A's use. Despite knowing Resident A previously had ordered 24/7 supervision at the hospital for a seven month period, was diagnosed with ataxic gait, was described by direct care staff as unsteady, experienced repeated falls with head injury, had impulsive behavior, required direct supervision while riding in the facility vehicle, the licensee did not increase staffing levels to provide for additional safety and supervision of Resident A. Nor did the licensee take action to explore with Resident A's physician if any assistive devices like a bed alarm, door alarm, and/or buckle buddy could be utilized to protect Resident A's from falls as documentation clearly stated Resident A's unsteady gait was attributed to medical conditions and not simply a behavioral response as

	indicated by Resident A's case manager and psychologist. Ms. Sidelinker's decision to transport Resident A in a vehicle on 10/31/25, alone, without a direct care staff to provide direct supervision, led to additional injury to Resident A. The *Certificate of Death* for Resident A notes the manner of death being "accident" and further states the accident was related to multiple falls causing head trauma and identifies the location of these falls as the address for the facility. Based upon this information, a violation is being established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Based upon the severity of the quality of care violations established, a six month provisional license is recommended at this time.

1/7/26

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Jana Lipps Date
Licensing Consultant

Approved By:

01/07/2026

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Dawn N. Timm Date
Area Manager