



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 12, 2026

Joshua Kok
Davids House Inc
2390 Banner Drive SW
Wyoming, MI 49509

RE: License #: AM410008805
Investigation #: 2026A0357013
Davids House II

Dear Mr. Kok:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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.

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 (616) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM410008805
Investigation #:	2026A0357013
Complaint Receipt Date:	12/04/2025
Investigation Initiation Date:	12/04/2025
Report Due Date:	02/02/2026
Licensee Name:	Davids House Inc
Licensee Address:	2390 Banner Drive SW, Wyoming, MI 49509
Licensee Telephone #:	(616) 247-7861
Administrator:	Ruth Bonfiglio
Licensee Designee:	Joshua Kok
Name of Facility:	Davids House II
Facility Address:	2355 Banner Drive SW, Wyoming, MI 49509-1930
Facility Telephone #:	(616) 284-4388
Original Issuance Date:	02/07/1994
License Status:	REGULAR
Effective Date:	09/01/2024
Expiration Date:	08/31/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was hospitalized after swallowing a Tide Pod on 11/26/2025. He passed away in the hospital on 12/01/2025. Resident A was supposed to be receiving 1:1 supervision when he swallowed the Tide Pod.	Yes

III. METHODOLOGY

12/04/2025	Special Investigation Intake 2026A0357013
12/04/2025	Special Investigation Initiated - Telephone I left a message for Ashton Byrne, Recipient Rights officer network 180. A referral was not made to APS because the resident passed away on 12/01/2025.
12/10/2025	Contact - Telephone call made I telephoned Recipient Rights Officer, Ashton Byrne, at network 180, and left my name and phone number to call me back.
12/10/2025	Contact - Document Received Ashton Byrne, Recipient Rights Officer from network 180 sent me an email with attachments: Resident A's IPOS Addendum, IPOS Meeting 05/28/2025, and Certificate of Death.
12/30/2025	Contact - Document Received I received a copy of the Recipient Rights investigation report.
12/30/2025	Inspection Completed On-site
12/30/2025	Contact - Face to Face Face-to-Face interview with Madison Sova-Dombrowski, Home Supervisor, Arley Meza-Duran, Shift Supervisor, Andrew Onyaiti, Shift Supervisor, and Licensee Designee, Joshua Kok.
12/30/2025	Contact - Document Received I received and reviewed Incident/Accident Reports dated 11/26/2025, with an attached typed page of information. I also received a form "General Information," by Ms. Madison Sova-Dombrowaki, Home Supervisor and Resident A's, Health Care Appraisal and list of medications.
12/31/2025	Contact - Document Received

	From Ashton Byrnnne, Recipient Rights Officer, with the names and phone numbers of the staff she interviewed.
01/07/2026	Contact - Telephone call made Telephone interview with Direct Care Staff, Desiree Hazdian.
01/08/2025	Contact – Telephone call made to interview Direct Care Staff, Charkyne Niyibizi.
01/08/2025	Contact Telephone call made to interview Direct Care Staff, Eric Ruvuna.
01/08/2025	Contact – Document received via email Ms. Sova-Dombrowski sent me Resident A's assessment plan.
01/09/2026	Telephone exit conference with the Licensee Designee.

ALLEGATION: Resident A was hospitalized after swallowing a Tide Pod on 11/26/2025. He passed away in the hospital on 12/01/2025. Resident A was supposed to be receiving 1:1 supervision when he swallowed the Tide Pod.

INVESTIGATION: The complaint came to my attention on 12/03/2025, from a Recipient Rights Officer, from network 180 on 12/03/2025. She had received an adverse event report on 12/02/2025 documenting that on 11/26/2025 Resident A swallowed a Tide Pod and was hospitalized. Resident A reportedly passed away in the hospital on 12/01/2025. Resident A was reportedly on 1:1 supervision when he swallowed the Tide Pod. Our department received a second complaint on 12/16/2025, which reported the same events, including that Resident A required continuous monitoring and one-to-one care, to ensure his safety due to his severe cognitive impairments. This was the same complaint, so the second complaint was dismissed. This complaint was not referred to the Department of Health and Human Services, Adult Protective Services, because the resident was deceased on 12/01/2025.

On 12/10/2025, I received and reviewed Resident A's Individual Plan Of Service (IPOS), dated 05/28/2025, meeting with an effective date of 08/01/2025 from network 180. This document stated: *'(Resident A) needs AFC home for CLS/PC residential at the base behavioral medical LOC with 20 hours 1:1 staffing.'* This was to improve his skills with his community integration needs and feeding skills and he also needed assistance to learn to sleep in his Craig Bed. This document stated that Resident A was receiving behavioral services from Sparks Behavioral Services and they would provide a behavioral treatment plan. This document included that the home had door chimes on most exterior doors to protect other residents as well as Resident A. The pantry door was locked. This document stated: *'(Resident A) needs 1:1 staffing assistance for 12 hours everyday guidance and monitoring for his health*

and safety needs related to elopement and intrusiveness into others' personal space... (Resident A) has a seizure disorder. Because (Resident A) has a profound intellectual disability, he lacks awareness of danger and other people's personal boundaries.' The document stated that (Resident A) had difficulty with urination and bowel movements. He needed staff's assistance for health and safety with seizures, and he had a VNS magnet (Vagus Nerve Stimulator) to use as needed for major seizures. He needed monitoring when he had a seizure. *'(Resident A) requires a high level of personal care...and a daily medical/behavioral level of for CLS in a licensed specialized residential setting.'* This document stated that Resident A required full caregiver assistance with socialization/recreation opportunities, medical appointments, safety and supervision in the community, stranger safety, wandering/elopement, household safety skills, hands on assistance with all personal care including with daily dressing, bathing, grooming, teeth brushing, shaving, trim his nails, feeding at every meal, toileting, ambulation, medication administration, transferring to prevent falling, monitoring of fluid intake, bowel protocol, close monitoring for any seizure activity, for meal planning and food preparation, and fade out of Craig Bed. The document stated: *'(Resident A) would be susceptible to either hypothermia or hyperthymia due to any possible side effects on the medication he takes. He is regularly monitored by family and CLS staff who ensure that (Resident A) is dressed appropriately for the weather.'* This document stated Resident A has profound intellectual disability and lacks awareness of danger and other people's personal boundaries and therefore needs 1:1 staffing assistance for 12 hours every day. The IPOS read: *'(Resident A) needs supervision at all times.'* Resident A has a court appointed guardian, which is his father. The document also stated that due to his elopement risk the staff need to know where Resident A is at all times in order to ensure his safety and that he is not walking out the door when other people come in and out. In the community he required "eyes on" supervision and staff within "arm's length". Resident A also required "total assistance in any emergency or evacuate in case of fire or tornado and /or find a safe place to go." This document stated that the AFC home would provide 1:1 supervision 20 hours per day for health and safety for Resident A noting, *'(Resident A) requires assistance for 8 hours every night provided by the AFC home for implementing this fade plan.'* The fade plan was related to his use of a Craig Bed.

It was noted in this same document that Resident A has the diagnosis of "PICA." The document reported Resident A had 45 successful PICA episodes with none resulting in injury. The plan noted, *'Each episode requires verbal and hands-on guidance and 1-2 redirections each time. (Resident A) chews on his clothes, staff's clothes, his own clothes, bed liners, couch covers, remote controls, and one time he ate a tissue. Unsuccessful episodes 24 incidents. (Resident A) needs 1-4 attempts at verbal and physical redirection to avoid PICA incidents. Each episode requires verbal hands-on guidance and lasts 5-10 seconds.'*

On 12/10/2025, I received and reviewed network 180 IPOS Addendum, effective date 08/01/2025. This document read as follows: *'(Resident A) needs continued 1:1 enhanced staffing for an additional 30 days, for his health and safety needs in order*

to maintain his residential placement at the AFC home. (Resident A) will be provided 1:1 enhanced staffing for 16 hours per day where he lives, at the Davids House Ministries House #2 AFC Home, which was approved by SLT for the authorization period of 11/1/2025- 11/30/25. This document contained each of Resident A's goals with the objectives and the steps required along with the responsible person/role.

On 12/10/2025, I reviewed Resident A's Behavioral Treatment Plan from Sparks Behavioral Serves, LLC, Behavioral Assessment March 17, 2025, Date of Behavioral Plan Apr 11, 2025; updated May 7th, 2025, Plan Developer: Conny Raaymakers PhD, BCBA-D, LBA. Six References were recorded on pages 11 and 12. Resident A's Behavioral Treatment Plan stated that Resident A was non-verbal. The documentation recorded the goals, prior objectives, current objectives, preference assessment information, medications, medical rule-out, preventions strategies, with strategy #1 and # 2. I reviewed Strategy #2, which documented: *'Access to alternatives to pica. (Resident A) should have access to alternative items that he can mouth or chew on at all times; these items in a bowl that (Resident A) can easily get to, or staff should have them on hand so as to provide (Resident A) with these alternatives as quickly as possible before he engages in pica. This way staff can easily redirect (Resident A) to use these items instead of eating non-edible items.'* Resident A's plan included some alternatives that staff could consider based on Resident A's preferences. The list included the "Texture and Alternatives," and recorded 14 different Textures and their Alternatives. For example: Paper was listed under Texture, and the Alternative was rice paper, wafer crushers, and Oblea. This document noted, *'Strategy # 3: Visuals: (Resident A) will often wander into areas that should be off-limits (ex: other people's bedrooms). While (Resident A) has 1:1 staffing, it would be helpful to work on teaching (Resident A) to respond to safety visuals, such as "stop" signs. Staff should put these signs out in areas that would be unsafe for (Resident A) to wander into without supervision, such as a peer's bedroom doors, doors that lead to outside, kitchen door etc., When (Resident A) begins to wander towards those areas, staff should point to the visual and using a calm kind voice, tell (Resident A) "stop" while verbally redirecting and monitoring him away from the area. This can also be used to redirect boundary interfering behavior as well (using a stop visual and kind/gently telling (Resident A) to stop).'* The Behavioral Treatment Plan read, *'unless (Resident A) is safely in his room, he should have staff supervision at all times. Staff should be within line of sight when (Resident A) is outside of his room and staff should be able to reach (Resident A) without a barrier within 30 seconds.'*

On 12/10/2025, I received and reviewed two Critical Incident/Risk Event/SUD Sentinel Event Report Form, network 180. Madison Sova-Dombrowski signed and dated the form on 11/28/2025. This form indicated Resident A (DOB 11/17/1995) was injured requiring Emergency Medical Treatment and hospitalization on 11/28/2025. I reviewed the second Critical Incident /Risk Event/SUD Sentinel Event Report Form, Network 180. This report read: *'After being in the hospital starting 11/26/2025, (Resident A) developed aspiration pneumonia and passed away at*

5:45pm on 12/01/25. Cause of death: Aspiration Pneumonia.' This document was signed by Madison Sova Dombrowski, House Supervisor on 12/02/25.

On 12/10/2025, I received and reviewed a copy of State of Michigan Department of Health and Services Certificate of Death for Resident A. The form indicated the location of Resident A's death was Corwell Health Grand Rapids Hospitals – Meijer Heart Center, Grand Rapids, Kent County. It noted that Resident A was "Inpatient" on the date and time of his death. The form further indicated that the Medical Examiner was called. The Certifying Physician was Stephen D. Cohle, MD and he signed the death certificate on 12/04/2025. The actual time of death was listed as 6:10 PM, on December 01, 2025, and the document noted the cause of death was "Aspiration Pneumonia and Ingested of detergent pod(s)" and the manner of death was "Accident." The document noted that the date of injury 11/26/2025, at 1:30 on or about PM when the decedent ingested detergent pods causing vomiting at his Adult Foster Home. It also noted that an autopsy was not performed.

On 12/30/2025, I received a form entitled General Information, Incident Report on Resident A, dated 11/26/2025, 1:30 PM, First Shift, Safety Concern, Laundry room. The following was written: *'While walking towards the laundry room, (Resident A's) staff member stopped to grab the phone to call the pharmacy and reorder medication. During this time, (Resident A) continued walking and grabbed a laundry pod off the laundry room counter that a staff member had forgotten to put away in the cupboard. (Resident A's) assigned staff member noticed right away and washed out his mouth with a wet washcloth. The house supervisor contracted poison control about the incident. They stated that the only major concern would be if he had choked on the pod but it is not believed that he swallowed it. They recommend that staff monitor him for 6 hours and bring him into emergency room if he has signs of excessive drooling. They warned that he may have minor diarrhea, but it will not be a cause for concern. Staff were instructed to give him milk and water throughout the day to dilute any of the soap that may have gotten down his throat.'* Listed on this form were employees Andrew Onyaiti, Arely Meza-Duran, and Desiree Hardiman. The form noted staff: *'Washed out his mouth with a wet washcloth. Called poison control.'* (Resident A's) physician was not notified. (Resident A's) guardian/father notified. His father was informed of the incident and was told that he would be notified if any changes occur in his condition.' The form also indicated the home's supervisor Ruth Bonfiglio was notified on 11/26/2025, at 01:57 PM. Poison Control was notified at the same time. This document was created by Madison Sovs-Dombrowski, House Supervisor on 11/26/1:57 PM. The form documented that, *'No injuries to resident, Range of motion not performed, and the situation did not require outside medical care. No medications were passed during this time period.'*

On 12/30/2025, I made an announced inspection of the home. I received and reviewed Incident/Accident reports. The first was dated 11/26/2025 at 1:30 PM and listed Andrew Onyaiti, Shift Supervisor, Arely Neza-Duran, Shift Supervisor and Madison Sova-Dombrowski, House Supervisor. The report documented, *'(Resident A), walked into the laundry room and placed an UltraClean laundry pod in this*

mouth. Madison attempted to open his mouth and pull it out, but he had already broken the casing. Arely grabbed a wet washcloth and washed his mouth out while Madison called poison control and notified his guardian/father. The Poison Control representative took down (Resident A's) information and asked about the laundry pod that was in his mouth. They stated that the biggest concern with the type of pod is choking. Since he was not choking, they did not recommend sending him to the emergency room. The representative stated that if (Resident A) starts to drool excessively, then he would need emergency medical treatment. They stated that diarrhea would be normal and not cause for concern. Staff were instructed to monitor him for 6 hours. Around 3pm, (Resident A) began having diarrhea. Staff cleaned him up and he was acting normal. Around 4:30pm, he began vomiting blood. Staff immediately called 911 and notified (Resident A's) guardian/father. He was taken to Butterworth emergency room via ambulance. Zoey followed the ambulance and met (Resident A's) father at the hospital. The emergency room decided to admit (Resident A) for low oxygen levels and a high heart rate. Since his breathing was not getting better, they placed a breathing tube on the morning of 11/27/25. They took a fluid sample, echocardiogram, and CT of the abdomen and found no issues, or concerns caused by the laundry pod. The breathing issues were being caused by aspiration from his vomiting. The doctor believes that the aspiration caused him to get pneumonia which he is not being treated for. They are going to attempt to remove the breathing tube on 11-29-25 if (Resident A) continues to have positive results." This document was signed by Madison Sova-Dombrowski, House Supervisor, Josh Kok, Licensee Designee, on 11/28/2025. Ruth A. Bonfiglio, Administrator, signed on 11/29/2025.

On 12/30/2025, I reviewed an Incident / Accident Report dated 12/01/2025 at 05:45 PM, location ICU. The report documented the following: *'After being in the hospital from this incident on 11/26/25, (Resident A) developed aspiration pneumonia. The doctors informed his father that he would need significant medical intervention for the rest of his life and they decided to place him on comfort care. He passed away on 5:45pm on 12/01/25.'*

On 12/30/2025, I conducted a face-to-face with Direct Care Staff, Andrew Onyaiti at the home. He confirmed that he was Shift Supervisor. I asked him to walk me through the incident with Resident A on 11/26/2025. He stated it was the day before Thanksgiving and he was assigned to be Resident A's "one on one." He said a staff member is assigned to Resident A from 6:30am to 11:00am and then another staff takes over from 11:00am to 2:30pm. He confirmed that he was assigned as a staff member to be with Resident A from 11:00am to 2:30pm. He explained that he and Resident A were in the main living room of the home and he was sitting on the couch when another Shift Supervisor, Arely Meza-Duran, came and spoke to him that a medication for a resident needed to be ordered. He explained that he just jumped up and thought "I can just order that medication right now, because his shift ended at 2:30pm." He stated that he was responsible for ordering medication for the month of December. He said he grabbed the phone and did not even dial the pharmacy number and this took less than one minute, and he saw Resident A was rushing into

the laundry room. He said he thought another staff member would go and be with Resident A while he ordered the medication. He acknowledged that he did not ask any other staff to be with Resident A while he called the pharmacy. He stated Resident A was coming out of the laundry room when he heard someone say that it looked like Resident A had something in his mouth and he thought staff Desire Hazdinan had said that. He said they saw that Resident A had something in his mouth and they immediately tried to wash it out and clean out his mouth. He said it happened so fast. He explained that Resident A has PICA and puts everything in his mouth all the time. He said it appeared to be soap. He stated that Madison Sova-Dombrowski, House Supervisor immediately telephoned Poison Control. He reported that Ms. Sova-Dombrowski informed staff that Poison Control told her to have Resident A drink glasses of milk and water. He explained that each staff does laundry for each individual resident, so staff are in and out of the laundry room constantly. I asked him who the last staff member in the laundry room was and he did not know. I asked him what was in Resident A's mouth and he said a "laundry pod." He said it looked like Resident A had bit into it because he had blue coloring coming out of his mouth and down his shirt and the laundry pod was blue in color.

On 12/30/2025, I conducted an interview with Arely Meza-Duran, Shift Supervisor. She stated that she has worked in the home for two years. I asked her to walk me through what happened on 11/26/2025. She stated that she had walked into Ms. Sova-Drombrowaki's office, and she saw a piece of paper on her desk that said the pharmacy would be closed on Thanksgiving. She said the Shift Supervisor orders the refills on resident's medication for a month at a time. She stated that Mr. Onyaiti was the Shift Supervisor for the month. She knew that a resident needed a refill on their medication so she was concerned that if it was not called into the pharmacy today, they were closed on Thanksgiving, and it could not be ordered. She left the office and saw Mr. Onyaiti and reminded him he had to order the medication because the pharmacy would be closed on Thursday and they did not want the resident to run out of his medication. She reported that Mr. Onyaiti jumped up and grabbed the telephone she assumed to call the pharmacy. She then heard Ms. Hazdian yell that Resident A had something in his mouth. She said she could see the color blue coming out of his mouth. She said the laundry pods are blue and she thought that someone left them out on the counter and Resident A must have put one in his mouth. She said she grabbed a cloth to take it out of his mouth, but he would not open his mouth. She said she was able to secure a piece of the laundry pod. She reported that Ms. Sova-Dombrowski immediately called Poison Control and she reported to all the staff that they had been advised to give Resident A two glasses of milk and two glasses of water. She also stated that they needed to keep an eye on Resident A. She said someone did not put the jar of the laundry pods back on the shelf or left the pods out on the laundry counter. I asked if we could go to the laundry room together, so we did. She explained that someone had recently filled in the jar that holds the laundry pods. The laundry room has a large countertop for folding laundry. She showed me the shelves that are under the countertop and explained that is where they keep the jar of laundry pods way in the back. You can't even see the jar. She said when she has been with Resident A, she has never seen

him seek something that is put away, so she believed that he would not have found the laundry pod jar. It was her opinion that someone must have left the laundry pods out on the counter, loose. She showed me that now they lock them in a cabinet. She unlocked the cabinet to show me where the jar of laundry pods now sits. She said there were five staff working that day and the incident happened so fast. She said she understood that Resident A had vomited and aspirated his vomit into his lungs resulting in pneumonia and then he died.

On 12/30/2005 I conducted a face-to-face interview with Madison Sova-Dombrowski the House Supervisor. She explained that staff change off with being a one-on-one with Resident A. She confirmed that one staff member is with him 6:30am to 11:00am and then another staff member is assigned from 11:00am to 2:30pm. She confirmed that Mr. Onwait was the staff who was assigned 11:00am to 2:30pm to provide one-on-one care with Resident A. She confirmed the date of the incident as 11/26/2025. She also confirmed that Ms. Meza-Durdan had told Mr. Onyaiti that he needed to order another resident's medication. She stated Mr. Onyaiti got up to make the call to the pharmacy and must have assumed that Ms. Meza-Duran, who knew he was one-on-one with Resident A, would assume the role of one-on-one with Resident A. She said staff have to change off with other staff to go to the restroom or another need and the other staff will take over until the first staff gets back.

Ms. Sova-Dombrowski said she was in her office when she heard some commotion and she immediately got up to see what was going on. She said she could see that Resident A had something blue in his mouth and it was running down his shirt, and he was spitting the soap out of his mouth. She said Ms. Meza-Duran had secured a washcloth and was cleaning out Resident A's mouth. Ms. Sova-Dombrowski was certain that blue was from a laundry pod. She reported the pods are called UltraClean – Kirkland brand. (They were not Tide Pods as in the complaint.) She said she immediately called Poison Control and they told her to administer milk and water and rotate them. She said they told her this would help to get the detergent out of his system. They also told her not to take him to the Emergency Room. She said that they also said he would probably have diarrhea and that is good because it's working its way through his system. She also stated that they cautioned her that if he started drooling that he would need to go to the Emergency Room. She stated that Resident A took the milk and water. She said Resident A started to have diarrhea and it was all over. She reported that the staff provided Resident A with a shower and Resident A was happy and was running around as usual. Ms. Sova-Dombrowski reported that within approximately 45 minutes he started throwing up and there was red in it, probably blood, so she immediately called 911. She said he also was having a hard time breathing. She reported she had called Resident A's guardian/father immediately after the incident to let him know what had happened. He told her to give Resident A some applesauce, but she said no because Poison Control had not said that to her. Then when she called 911, she called him back. He said he would go to the hospital. She said she went to the laundry room and saw one laundry pod on the countertop. She was convinced that Resident A had picked

one up one and put it in his mouth because it looked like candy and he had PICA and he placed everything in his mouth. She said each staff member is responsible for doing resident laundry each day. She said the washers are running all the time and staff are in and out of the laundry room constantly. I asked her if she knew who had possibly left the pods on the counter. She said she interviewed each member of the staff that had worked that shift and they all denied that they had left the laundry pods out on the counter. She said that when Resident A was vomiting, he aspirated into his lungs, and he was diagnosed with pneumonia and the family decided to not put him through anymore and died on 12/01/2025.

I asked Ms. Sova-Dombrowski about Resident A's care needs. She explained that network 180 had been paying them for 1:1 care around the clock but then network 180 said they were not going to pay for that and cut their paid hours. She stated that they decided that they had to provide 1:1 care for Resident A around the clock to keep him safe, even though they were not provided with the funding to do so. She was unable to provide any dates for these changes. I asked Ms. Sova-Dombrowski the admission date of Resident A to the home and she reported, 06/12/2024. She reported that they kept Resident A safe for over a year and a half and he did not have one seizure in their care.

On 12/30/2025, I conducted an interview with the new Licensee Designee Joshua Kok. He reported that Recipient Rights wrote in their report that Mr. Adnrew Onyaiti was cited for a substantiated violation of Neglect Class 1 and this has been addressed as a personnel matter.

On 01/07/2025, I conducted a telephone interview with Direct Care Staff Desiree Hazdinan. She confirmed that she worked first shift on 11/26/2025. She reported that on 11/26/2025, Mr. Onyaiti was working with Resident A from 11:00 am to 2:30pm. She said she was sitting with the residents in the living room and she saw Resident A coming out of the laundry room. She said she saw his facial expression and he looked like he was disgusted from putting this pod in his mouth and not knowing what to do with it, when he probably thought it was candy. She said she could tell he had something in his mouth, and he did not like what was there, and he seemed not to know how to get it out of his mouth. She said she immediately said: "What is in his mouth?" She said the staff came immediately with a cloth to try to absorb what was in his mouth. She said Ms. Sova-Dombrowski immediately called Poison Control and told the staff to give him milk and water. She stated that there is no reason to not be right next to Resident A. I asked her if she had left any laundry pods on the counter in the laundry room and she denied that she had. She stated she had no idea who had left the laundry pods out.

On 01/08/2025, I requested from Ms. Sova-Dombrowski the names and telephone numbers of the staff who worked on 11/26/2025. She sent them to me via email.

On 01/08/2025, I conducted a telephone interview with Direct Care Staff, Charlyne

Niyibizi. She confirmed that she worked 1st shift on 11/26/2025. She said she worked with the residents and she did not see anything happening with Resident A. She denied doing laundry and denied leaving any laundry pods on the counter in the laundry room. She said she was helping a resident in the bathroom.

On 01/08/2025, I conducted a telephone interview with Direct Care Staff, Eric Ruvuana. He confirmed he worked 1st shift on 11/26/2025. He said he worked with the residents assigned to him. He denied leaving any laundry pods on the counter in the laundry room and stated he had no idea who would leave pods out. He had no direct knowledge about what had happened with Resident A.

On 01/09/2026 I conducted a telephone exit conference with the Licensee Designee, Joshua Kok. He agreed with my findings. He stated that he will provide an acceptable plan of correction and he will accept the provision.

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:	<p>It was reported that Resident A swallowed a Tide Pod on 11/26/2025, was hospitalized, and passed away in the hospital on 12/01/2025. Resident A was reportedly supposed to be receiving 1:1 supervision when he swallowed the Tide Pod.</p> <p>Ms. Madison Sova-Dombrowski (Home Supervisor) confirmed that resident A was able to access and ingest a detergent pod.</p> <p>Adnrew Onwaiti, Shift Supervisor, confirmed that he was assigned to provide 1:1 supervision for Resident A on 11/26/2025, from 11:00am to 2:30pm. He acknowledged that while supervising Resident A he went to get the phone to order medications. Mr. Onyaiti acknowledged that he did not ask any other staff to supervise Resident A while he was ordering the medication. He reported that during the time Resident A was left unsupervised, he went into the laundry room and ingested a laundry pod.</p> <p>Resident A's Behavior Treatment Plan indicated he required enhanced staffing for behaviors, including PICA. Staff were required to be within line-of-site when Resident A is outside of his bedroom. In addition, Resident A's IPOS stated Resident A required 1:1 supervision at all times.</p> <p>Resident A's Certificate of Death listed "Aspiration Pneumonia,</p>

	<p>Ingestion of detergent pod(s), Accident. Other significant conditions Autism, History Pica. Death on 12/01/2025 at 6:10 PM. Certifying Physician Stephen D Cohle. Decent ingested detergent pods causing vomiting.”</p> <p>Ms. Madison Sova-Dombrowski, the Home Supervisor, confirmed that Mr. Onyaiti was Resident A’s assigned 1:1 staff on first shift on 11/26/2025, from 11:00 am to 2:30pm. She expressed there was miscommunication between Mr. Onyaiti and Ms. Arely Neza-Duran because Ms. Sova-Domrworski thought that Mr. Onyaiti expected Ms. Neza-Duran would take over Resident’s A 1:1 supervision when he went to call the pharmacy to order another resident’s medication. But Mr. Onyaiti did not ask Ms. Neza-Duran to watch Resident A, and she did not assume Resident A’s 1:1 supervision.</p> <p>During this investigation I discovered that staff were required to provide Resident A with 1:1 supervision, be in line-of-sight and able to reach Resident A within 30 seconds. Mr. Onyaiti briefly left Resident A and failed to ask for help to take over his supervision. As a result, Resident A was able to enter the laundry room unsupervised and ingest a laundry pod resulting in vomiting which aspirated into his lungs which caused pneumonia which led to his death. Resident A’s protection and safety needs were therefore not met.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable correction action plan, I recommend issuance of a 1st Provisional License.

Arlene B. Smith 01/12/2026

Arlene B. Smith, Licensing Consultant Date

Approved By:
Jerry Hendrick 01/12/2026

Jerry Hendrick, Area Manager Date