



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 16, 2026

Heather Iuni
GESHER HUMAN SERVICES, LLC
15999 W Twelve Mile Rd
Southfield, MI 48076

RE: License #: AS630383361
Investigation #: 2026A0626032
Charach 1

Dear Ms. Iuni:

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

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

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

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 972-9136.

Sincerely,

A handwritten signature in cursive script, reading "Sara E. Shaughnessy". The signature is written in a dark ink and is positioned below the word "Sincerely,".

Sara Shaughnessy, Licensing Consultant
Bureau of Community and Health Systems
3044 West Grand Boulevard
2nd Floor Annex, Suite 2-730
Detroit, MI 48202
(248) 320-3721

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630383361
Investigation #:	2026A0626032
Complaint Receipt Date:	08/11/2026
Investigation Initiation Date:	08/11/2026
Report Due Date:	10/10/2026
LicenseeName:	GESHER HUMAN SERVICES, LLC
LicenseeAddress:	15999 W Twelve Mile Rd Southfield, MI 48076
LicenseeTelephone #:	(248) 559-8235
Administrator:	Heather luni
Licensee Designee:	Heather luni
Name of Facility:	Charach 1
Facility Address:	33884 Yorkridge Street Farmington Hills, MI 48331
Facility Telephone #:	(248) 559-5000
Original Issuance Date:	04/26/2018
License Status:	REGULAR
Effective Date:	10/26/2024
Expiration Date:	10/25/2026
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was forced to complete five laps around the home as punishment for using profanity.	Yes
Additional Findings	No

II. METHODOLOGY

08/11/2026	Special Investigation Intake 2026A0626032
08/11/2026	APS Referral A referral was not made to APS due to them rejecting the original complaint.
08/11/2026	Special Investigation Initiated - Telephone I initiated the special investigation by completing a telephone interview with recipient rights specialist, Rachel Moore.
08/11/2026	Contact - Document Received I received, via email, the incident report and IPOS of Resident A, from ORR specialist, Rachel Moore.
08/13/2026	Contact - Face to Face I completed an unannounced onsite investigation at Charach 1. I completed an interview with direct care staff member, Vorica Porter, and a private interview with Resident A.
08/20/2026	Contact - Telephone call made I completed a telephone interview with home manager, Aaliyah Black. I attempted telephone interviews with direct care staff members, Tanisha Williams and Roslyn Howard.
08/20/2026	Contact - Telephone call made I completed a telephone interview with Relative A1.
09/09/2026	Contact - Telephone call made I completed telephone interviews with direct care staff members, Tanisha Williams and Roslyn Howard.

09/09/2026	Exit Conference I completed an exit conference, via telephone, with licensee designee, Heather Iuni. The findings were discussed.
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ALLEGATION:

Resident A was forced to complete five laps around the home as punishment for using profanity.

INVESTIGATION:

On 08/11/2026, I received a complaint, via email, indicating a direct care staff member at Charach 1 Home had punished Resident A for swearing, by making him walk laps around the home.

On 08/11/2026, I initiated the special investigation by completing a telephone interview with office of recipient rights specialist, Rachel Moore. Ms. Moore informed me that she had the incident report and the individual plan of service (IPOS) for Resident A and she agreed to send them to me. She informed me that she had received the incident report and was told that the staff member, Roslyn Howard, had been taken off the work schedule. Ms. Moore stated she already had enough evidence to support her substantiation.

On 08/11/2026, I received the incident report, crisis plan, and IPOS for Resident A. I reviewed Resident A's crisis prevention plan dated 08/14/2025. The crisis prevention plan indicates that Resident A has a traumatic brain injury (TBI) and it affects his medical health and memory. He has a hard time retaining new information. He often becomes depressed and will stop participating in activities and caring for his hygiene. He can become angry if he does not see his family enough. It does indicate that his coping skills include watching television, taking a walk with home staff, and taking a nap. If he experiences a mental health crisis, 911 then Easter Seals MORC should be contacted to arrange a medication review.

On 08/11/2026, I reviewed Resident A's IPOS dated 04/28/2026. The IPOS does not contain any behavior plan regarding use of profanity.

On 08/11/2026, I reviewed the incident report dated 08/03/2026. The incident report was completed by , Aaliyah Black and it reads:

"On Monday, 08/03/2026, I received a phone call from home manager, Dallas Sweeney, stating staff member, Tanisha Williams, was working with another staff member, Roslyn Howard, during the afternoon shift and observed her make Resident A do 6 laps around the house due to using profanity."

The incident report indicates that the incident was reported to another home manager, James Crawford, on 08/06/2026. The corrective measures indicate that Ms. Howard was placed on administrative leave and a meeting will be scheduled with all the staff to go over the expectations regarding the welfare of residents. In another section labeled "Reviewer comments", it indicates that Ms. Howard has been terminated.

On 08/13/2026, I completed an unannounced onsite investigation at Charach Home. I first completed an in-person interview with direct care staff member, Vorica Porter. Ms. Porter has been with the company for approximately 19 years. She was not working when the incident took place but was told that Resident A was made to do laps due to him cussing. Ms. Porter shared that Resident A will cuss frequently and she will usually just tell him to calm down and redirect him, which works. She did not work frequently with Ms. Howard, but when she did, she did not have any concerns with how she cared for or interacted with the residents. She stated Resident A's worse behavior is cussing, and while he will often threaten people, he has no history of being violent and described him as a "model consumer". Resident A's memory is not great due to his TBI, but he can access long term memories.

On 08/13/2026, I completed a private, in-person interview with Resident A. He stated he feels safe in the home and is well taken care of. The staff is "ok" most of the time. He used to call them names and threaten them but was kidding. He does not like Ms. Howard and stated that she is not nice to anyone and raises her voice at them for no reason. Ms. Howard woke him up by putting her cold hand on his ankle. She was mad at him for swearing and would act like she was writing it down to tell his mother. He threatened her and she laughed. She punished him one time by taking his lunch away and wrote a note to his mother to tell on him. Resident A shared that Ms. Howard made him do laps a couple of times and the last time was a long time ago. Ms. Howard was "uncool" with everyone who would swear in the home, she also threw water at him and squeezed his toe.

On 08/20/2026, I completed a telephone interview with home manager, Aaliyah Black. Ms. Black was not working the day of the incident. She received a phone call from another home manager, informing her of being told about what happened by direct care staff member, Tanisha Williams. She was told that Resident A said some cuss words and Ms. Howard made him do laps. She stated Resident A does cuss quite often, but it is just something he does, and they just don't give it any attention, as he has a brain injury. She denied that they have considered coming up with a behavior plan regarding Resident A's language, stating, "It is just what he does" and is not a big deal. She did not speak to Ms. Howard regarding the incident and shared that she had been terminated.

On 08/20/2026, I completed a telephone interview with Relative A1. She denied knowing about the incident regarding Resident A. She denied having had any previous concerns regarding the care of Resident A. She sees him often, and so does his father, and just saw him last weekend at the Dream Cruise. Resident A did not tell her about anything happening. She stated bad language is not usual for him and she does not

know about it being an issue at the home. She mentioned that when he has low blood sugar, he gets irritable and that could be why. She likes and trusts, Ms. Porter and shared that Ms. Porter helps her out due to her being disabled. She stated Resident A can usually be calmed down easily, but she has concerns due to him showing signs of dementia.

On 09/09/2026, I completed a telephone interview with direct care staff member, Tanisha Williams. Ms. Williams started working at Charach 1 in July of 2026. She worked with Roslyn Howard on Mondays and Tuesdays. She was working with Ms. Howard on 08/03/2026, just the two of them. Ms. Williams was washing dishes and could hear Resident A telling a story to another resident and Ms. Howard told her that she could not wait for Resident A to cuss. Ms. Williams stated she thought it was weird but listened further. Ms. Williams heard Resident A cuss and then she heard Ms. Howard say, "Give me five", and Resident A started walking. She stated he knew exactly what Ms. Howard meant, which led her to believe that this was not the first time this had happened. Ms. Williams spoke with a friend of hers who also works for the company and got her the job, about what had happened. Ms. Williams had not yet taken her Recipient Rights training, and her friend informed her that it was a serious violation and went to their superior. She knew it was not right but did not think it was as serious as the company was taking it. She did not hear the cuss words Resident A used but stated he uses them all the time when telling a story; he cusses to them, not at them. She denied seeing any other instances of residents being disrespected or treated poorly. She added that Ms. Howard would cuss too and treat the residents like children. She confirmed that Ms. Howard is no longer working in the home.

On 09/09/2026, I completed a telephone interview with direct care staff member, Roslyn Howard. Ms. Howard stated she heard Resident A talking to another resident and he was using profanity. Ms. Howard was asking him not to use it and he would apologize to her, then continue doing it. She admitted that she looked at Resident A and stated, "Give me five", and he started walking up and down the hallway five times. She stated he uses profanity quite a bit and has repeatedly asked him why he was cussing. Ms. Howard stated she made Resident A do it one other time and that is why he knew what it meant when she told him to give her five.

On 09/09/2026, I completed an exit conference, via telephone, with licensee designee, Heather Iuni. We discussed the findings. Ms. Iuni indicated she knew about the incident and the incident report, she is the one who sent it to recipient rights. She confirmed that Ms. Howard is no longer employed at Charach 1. Ms. Iuni stated that all staff have been retrained on how residents are to be treated, as she understands the seriousness of the situation.

APPLICABLE RULE	
R 400.641	Resident behavior interventions.
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: (a) Use any form of punishment.
ANALYSIS:	Based on the information obtained during the special investigation, it has been determined that there is sufficient evidence to support that direct care staff member, Roslyn Howard, used a form of punishment on Resident A. Resident A stated he was made to do laps for using foul language. Direct care staff member, Tanisha Williams, witnessed the incident and confirmed that Ms. Howard told Resident A, "Give me five". Ms. Howard admitted to making Resident A do laps up and down the hall in the home for using foul language, and that it was the second time she did.
CONCLUSION:	VIOLATION ESTABLISHED

III. RECOMMENDATION

Contingent on receipt of an approved corrective action plan, I recommend no changes to the status of the license.

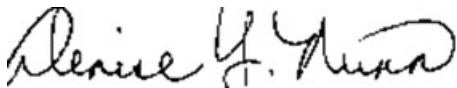


09/09/2026

Sara Shaughnessy
Licensing Consultant

Date

Approved By:



09/16/2026

Denise Y. Nunn
Area Manager

Date