RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

August 17, 2018

Wycliffe Opiyo
Mercy Homes Assisted Living LLC
2901 Asbury St.
Kalamazoo, MI 49048

RE: License #: AS390380979
Mercy Homes Assisted Living
Investigation #: **2018A0462039**

Dear Mr. Opiyo:

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

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

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

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 251-9037

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390380979
Investigation #:	2018A0462039
Complaint Receipt Date:	06/18/2018
Investigation Initiation Date:	06/18/2018
Report Due Date:	08/17/2018
Licensee Name:	Mercy Homes Assisted Living LLC
Licensee Address:	2901 Asbury St. Kalamazoo, MI 49048
Licensee Telephone #:	(817) 781-6512
Administrator:	Wycliffe Opiyo
Licensee Designee:	Wycliffe Opiyo
Name of Facility:	Mercy Homes Assisted Living
Facility Address:	2901 Asbury St. Kalamazoo, MI 49048
Facility Telephone #:	(817) 781-6512
Original Issuance Date:	09/26/2016
License Status:	REGULAR
Effective Date:	03/24/2017
Expiration Date:	03/23/2019
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
A direct care worker utilized an inappropriate crisis intervention on Resident A, resulting in Resident A obtaining injuries.	Yes

III. METHODOLOGY

06/18/2018	Special Investigation Intake 2018A0462039
06/18/2018	Special Investigation Initiated – Telephone interview with case manager.
06/19/2018	Referral made to APS
06/19/2018	Unannounced investigation on-site. Interviews with Residents A, B and C. Interviews with licensee designee Wycliffe Opiyo and property owner Thomas Ongwela.
06/19/2018	Contact- Document received from APS specialist Mike Hartman.
06/20/2018	Contact- Document received from APS specialist Mike Hartman.
07/12/2018	Contact- Document received from licensee designee Wycliffe Opiyo.
08/17/2018	Exit conference with licensee designee Wycliffe Opiyo.

ALLEGATION:

A direct care worker utilized an inappropriate crisis intervention on Resident A, resulting in Resident A obtaining injuries.

INVESTIGATION:

On 06/18/2018 the Bureau of Community and Health Systems (BCHS) received this complaint through the BCHS on-line complaint system. The written complaint indicated that in the early morning hours of Sunday 06/17 Resident A was unable to sleep and made some noise inside his bedroom. A direct care worker (DCW) entered Resident A's bedroom without knocking and chocked Resident A for being

too loud. The written complaint indicated that Resident A filed a police report, and the DCW left the facility and would not be returning.

I conducted a telephone interview with Sam Page, Resident A's case manager with the community mental health agency InterAct of Michigan, Inc., who stated that Resident A reported this allegation to him. Mr. Page stated that he had spoken to licensee designee Wycliffe Opiyo, and according to Mr. Opiyo, this DCW was not allowed back to the AFC home until a full investigation was conducted. Mr. Page provided me with the name of the DCW who allegedly assaulted Resident A.

On 06/19 I made a referral to Kalamazoo County adult protective services (APS) and conducted an unannounced investigation at the facility. I interviewed Resident A who stated that in the early morning hours of 06/17 he couldn't sleep so he played music and talked on his cellular phone in his bedroom. Resident A stated that at approximately 1:45 AM DCW George Odhiambo entered his bedroom and told him to go to bed. Resident A stated that Mr. Odhiambo then put his hand around Resident A's neck and pushed him. Resident A showed me two scratch marks on his back and on the left side of his neck. Resident A stated that he asked Resident B, whose bedroom was located next to Resident A's bedroom, to call the police. Resident A stated that Mr. Odhiambo fled the facility shortly before an officer responded to the facility at approximately 2:15 AM. Resident A stated that this was the first time Mr. Odhiambo had ever acted inappropriately with him, and that he had never observed Mr. Odhiambo act inappropriately with other residents in the facility. Resident A stated that there were no witnesses to this assault.

I conducted an interview with licensee Wycliffe Opiyo and property owner Thomas Ongwela. Mr. Opiyo stated that he was out of town on 06/17, and at 1:45 AM on 06/17 Mr. Odhiambo was the only DCW on duty at the facility. Mr. Ongwela stated that on 06/17, at approximately 2:00 AM, he received a telephone call from Officer Crock with the Kalamazoo Township Police Department, who informed Mr. Ongwela that he was at the facility. Mr. Ongwela stated that he immediately responded to the facility and was informed that Mr. Odhiambo had physically assaulted Resident A before fleeing the facility. Mr. Ongwela stated that he and Officer Crock assessed Resident A's injuries and they all agreed that Resident A did not require medical treatment. Mr. Ongwela stated that he stayed at the facility and provided supervision to the residents until another DCW was able to relieve him later that morning.

Mr. Opiyo stated that on 06/18 he held a meeting with all the residents who confirmed not having witnessed the alleged assaulted. Mr. Opiyo stated that during the meeting he reassured the residents of their safety. Mr. Opiyo stated that they had experienced numerous issues with Resident A leaving the facility at all hours of the night, going out to the garage to smoke and leaving the garage door unlocked, putting the other residents at risk. Mr. Opiyo stated that Mr. Odhiambo had worked

at the facility for approximately five months and he had never received any previous reports regarding Mr. Odhiambo acting inappropriately towards residents.

Mr. Opiyo and Mr. Ongwela stated that they tried to contact Mr. Odhiambo. However, Mr. Odhiambo retained an attorney at law who instructed him not to speak to anyone regarding the allegation. Mr. Opiyo stated that he was able to speak briefly to Mr. Odhiambo's attorney who would not discuss specific details regarding the allegation, other than that Mr. Odhiambo denied the allegation and fled the facility because he was afraid of being arrested. Mr. Opiyo stated that if he was able to eventually contact Mr. Odhiambo, he would encourage him to reach out to me to conduct an interview.

Resident B was not home at the time of my investigation. I interviewed Residents C and D who both confirmed that they did not witness, nor hear, the alleged assault. They both stated that they had never witnessed neither Resident A, nor Mr. Odhiambo, display aggressive behavior and that they felt safe at the facility.

On 06/20 I spoke with APS specialist Mike Hartman who informed me that he was also conducting an investigation regarding this allegation. Mr. Hartman stated that he had been to the facility and interviewed Mr. Opiyo, Mr. Ongwela and Residents A and C. Mr. Hartman stated that he was also unable to interview Mr. Odhiambo due to an open criminal investigation and because Mr. Odhiambo had retained an attorney. However, Mr. Hartman stated that he had enough evidence to substantiate physical abuse on behave of Mr. Odhiambo.

On 07/12 Mr. Opiyo provided me with a copy of a document tiled *George Odhiambo Affidavit*. I reviewed the affidavit which outline Mr. Odhiambo's written version of events on the evening of 06/16 and on the morning of 06/17. According to documentation on the affidavit, on 06/16 Mr. Odhiambo asked Resident A to be quiet and to keep his music down once at 10:00 PM and again at 11:00 PM. According to documentation on the affidavit, Mr. Odhiambo reported that at 12:00 AM on 06/17 he heard noise coming from Resident A's bedroom. According to documentation on the affidavit, Mr. Odhiambo reported that he went to Resident A's bedroom and knocked on the door. When he opened the door, he noticed Resident A chatting on his computer with friends. According to documentation on the affidavit, Mr. Odhiambo reported that Resident A got upset and started to "charge" at Mr. Odhiambo. Resident A yelled "get out of my room" and "stop bothering me". According to documentation on the affidavit, Mr. Odhiambo reported that Resident A swung his hands wildly as he approached Mr. Odhiambo. According to documentation on the affidavit, Mr. Odhiambo reported that he thought Resident A may be under the influence of something, as he had previous drug and mental health issues, and that Mr. Odhiambo was "somewhat" afraid of what Resident A would do as he came towards him. According to documentation on the affidavit, Mr. Odhiambo reported that it was at that time that he "put his hands up and grabbed Resident A by the shoulders in order to somewhat try to restrain him." Mr. Odhiambo reported that he held Resident A by the shoulders until Resident A calmed down. According to

documentation on the affidavit, Mr. Odhiambo stated that once Resident A calmed down, he closed Resident A's bedroom door and went back to his bedroom.

According to documentation on the affidavit, Mr. Odhiambo reported that an unidentified resident, other than Resident A, approached Mr. Odhiambo and accused him of assaulting Resident A. According to documentation on the affidavit, Mr. Odhiambo reported that he observed the scratches on Resident A's neck and was "surprised" as he did not recall ever scratching Resident A's neck as he tried to restrain him. According to documentation on the affidavit, Mr. Odhiambo reported that he requested to call a manager to discuss what occurred. However, this resident called 911 anyway. According to documentation on the affidavit, Mr. Odhiambo reported that he could hear the resident report an assault that he had witnessed and that this statement was untrue. According to documentation on the affidavit, Mr. Odhiambo reported that due to having a heavy accent, he was scared that he would have a difficult time explaining himself to law enforcement without the assistance of an attorney.

Additional documentation on the affidavit read, it part;

"at no time did I (Mr. Odhiambo) ever assault [Resident A] or intend to scratch him. I don't remember even touching his neck. It happened very quickly, and I only remember grabbing him by the shoulders in order to restrain him and let him calm down. This only happened when he came at me quickly. I immediately went back to my room and went to sleep after this incident, not thinking there was any sort of problem".

APPLICABLE RULE	
R 400.14309	**Crisis intervention.**
	(3) Crisis intervention shall be used to the minimum extent and the minimum duration necessary and shall be used only after less restrictive means of protection have failed. **(4) Crisis intervention shall be employed to allow the resident the greatest possible comfort and to avoid physical injury and mental distress.**
ANALYSIS:	Resident A reported that on 06/17 DCW George Odhiambo physically assaulted him by putting his hand around his neck and pushing him. Via an affidavit, Mr. Odhiambo denied assaulting Resident A, but admitted to restraining him the morning of 06/17 by grabbing him by the shoulders. Mr. Odhiambo reported that he utilized this intervention procedure to provide for self defense after Resident A swung his hands wildly while "charging" at Mr. Odhiambo. Nowhere in Mr. Odhiambo's two and half page

	affidavit did Mr. Odhiambo report that Resident A physically touched him, nor did Mr. Odhiambo report the types of less restrictive alternatives he tried to calm Resident A down before resorted to restraining Resident A. According to both Resident A and Mr. Odhiambo, there were no other witnesses to this altercation. The intervention Mr. Odhiambo employed to calm Resident A down did not allow for the greatest possible comfort and resulted in physical injury, as evidenced by the scratch marks I observed on Resident A's back and on the left side of his neck. It has been established that Mr. Odhiambo utilized an inappropriate crisis intervention on Resident A, resulting in Resident A obtaining injuries.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 08/17 I conducted an exit conference with licensee designee Wycliffe Opiyo via telephone and shared with him the findings of this investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

Michele Streeter 08/15/2018

Michele Streeter Date
Licensing Consultant

Approved By:

Dawn Timm 08/16/2018

Dawn N. Timm Date
Area Manager