GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 10, 2022

Dinah Owiti
Radiant Star LLC
203 Pepperidge Lane
Battle Creek, MI 49015

RE: License #: AS130393042
Investigation #: 2022A1024029
Radiant Star LLC

Dear Ms. Owiti:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS130393042
Investigation #:	2022A1024029
Complaint Receipt Date:	04/28/2022
Investigation Initiation Date:	04/28/2022
Report Due Date:	06/27/2022
Licensee Name:	Radiant Star LLC
Licensee Address:	203 Pepperidge Lane Battle Creek, MI 49015
Licensee Telephone #:	(269) 830-7252
Administrator:	Jasper Mukwada
Licensee Designee:	Dinah Owiti
Name of Facility:	Radiant Star LLC
Facility Address:	203 Pepperidge Lane Battle Creek, MI 49015
Facility Telephone #:	(269) 830-7252
Original Issuance Date:	10/16/2018
License Status:	REGULAR
Effective Date:	04/16/2021
Expiration Date:	04/15/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was discharged from the facility without proper notice.	No

III. METHODOLOGY

04/28/2022	Special Investigation Intake 2022A1024029
04/28/2022	Special Investigation Initiated – Telephone with Adult Protective Services (APS) Specialist Jennifer Stockford
04/28/2022	Contact - Document Received-*24-hour Discharge Notice* sent to Resident A, Guardian A1 and licensing consultant Ondrea Johnson on 4/13/2022
04/29/2022	Contact-Document Received-*AFC-Online Accident/Incident Report*
05/31/2022	Contact - Document Received-*Resident Register* and email correspondence with mental health provider Kaitlyn Knoppe.
06/01/2022	Inspection Completed On-site with administrator Jaser Mukwada and licensee designee Dinah Owiti
06/01/2022	Contact - Telephone call made with Guardian A1
06/01/2022	Exit Conference with licensee designee Dinah Owiti

ALLEGATION:

Resident A was discharged from the facility without proper discharge notice.

INVESTIGATION:

On 4/28/2022, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged Resident A was discharged from the facility without proper discharge notice.

On 4/28/2022, I conducted an interview with APS Specialist Jennifer Stockford who stated that she has completed her investigation of this allegation and found no evidence of neglect. Ms. Stockford stated licensee designee Ms. Dinah Owiti and administrator Jasper Mukwada gave appropriate discharge notice to Resident A and were willing to work with Resident A's mental health case manager and guardian to

find alternative placement for Resident A. However, when Resident A was discharged from the hospital back to the adult foster care home on 4/12/2022, Resident A refused to return to the home.

On 4/28/2022, I reviewed Resident A's *24-hour Discharge Notice* dated 4/13/2022. According to this notice, a 24-hour discharge notice was issued to Resident A due to issues with safety. The notice stated on 4/12/2022 Resident A walked away from the home twice, and then was subsequently taken to the hospital twice. The notice stated Resident A stated that he did not want to stay at the facility, and this was confirmed by Resident A's refusal to go inside the house when staff brought Resident A back from Bronson Hospital Battle Creek ER. The notice stated Resident A then stood in the middle of the road near the mailbox and cars had to go around Resident A to avoid hitting Resident A. Meanwhile Resident A also verbalized that he wanted to kill himself. The notice stated Resident A then walked towards the highway at which time the police were called. The notice stated, these behaviors were a safety issue, and since the home cannot restrain residents, a more secure place may be appropriate. It should be noted this notice was sent to Licensing and Regulatory Affairs (LARA) and Guardian A1 via email on 4/15/2022. I also received a phone call from the home on 4/13/2022 regarding this notice.

On 4/29/2022, I reviewed facility's *AFC-Online Incident/Accident Report* dated 4/12/2022. According to this report, when Resident A returned from Bronson ER, he refused to go inside the house and stated he did not want to stay at Radiant Star. Resident A stated he wanted to kill himself and proceeded to stand in the middle of the road near the facility and cars had to go around to avoid hitting him. The report stated staff tried to talk Resident A down to move out of the middle of the road however Resident A refused to listen.

On 5/31/2022, I reviewed the facility's *Resident Register* which provided an admission date for Resident A of 4/11/2022 and discharge date of 4/13/2022.

I also reviewed email correspondence with mental health provider Kaitlyn Knoppe from administrator Jasper Mukwada dated 4/13/2022. According to his email, Jasper stated Resident A did not want to come inside the home, and it is difficult to run after him and call the police numerous times therefore a discharge notice was sent to Resident A's guardian and Licensing and Regulatory Affairs.

On 6/1/2022, I conducted an onsite investigation at the facility with licensee designee Dinah Owiti and administrator Jasper Mukwada. Mr. Mukwada stated Resident A was admitted to the home on 4/11/2022 and went to the hospital twice on 4/12/2022. Mr. Mukwada stated Resident A was returned to the home by the hospital in a cab during both incidents and refused to go inside the home. Mr. Mukwada stated during the second attempt of returning Resident A to the home, Resident A stood in the middle of the road and walked down the highway wearing a hospital gown until he was picked up by the police. Mr. Mukwada stated after these two incidents Guardian A1 determined Radiant Star LLC was not a good placement

option for Resident A. Consequently, a 24-hour discharge notice to Resident A was issued. Mr. Mukwada further stated they were willing to accept Resident A back into the home until alternative placement was found however Resident A refused to stay in the home.

Ms. Owiti stated they were willing to accept Resident A back in the home after he was discharged from the hospital twice on 4/12/2022 however Resident A refused to go inside the home and stated he did not want to live in the home. Ms. Owiti stated she had to follow Resident A in the road and along the highway when he refused to go inside the home after being discharged from the hospital the second time which was a huge safety concern. Ms. Owiti stated Guardian A1 agreed Resident A needed a more secure housing placement to ensure his safety therefore a 24-hour discharge notice was issued to Resident A. Ms. Owiti stated Guardian A1 and Resident A's mental health worker were eventually able to find a safer housing option for Resident A and Resident A was discharged from the home on 4/13/2022.

On 6/1/2022, I conducted an interview with Guardian A1 who stated Resident A resided at Radiant Starr LLC for one day as Resident A refused to go inside the home after being discharged from the hospital on 4/12/2022. Guardian A1 stated the staff stayed in constant communication with her and provided appropriate discharge notice due to Resident A's safety concerns and refusing to go inside the home. Guardian A1 stated the staff contacted her via telephone and email regarding Resident A's concerns and she was in agreement with the discharge notice.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(4) A licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home.** **(b) Substantial risk, or an occurrence, of self-destructive behavior.** **(c) Substantial risk, or an occurrence, of serious physical assault.** **(d) Substantial risk, or an occurrence, of the destruction of property.** **(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident:**

	(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information: **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.** **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**
ANALYSIS:	Based on this investigation which included interviews with administrator Jaser Mukwada, licensee designee Dinah Owiti, APS Specialist Jennifer Stockford, Guardian A1, review of *Resident Register*, incident report and email correspondence with mental health provider Kaitlyn Knoppe, there is no evidence to support the allegation Resident A was discharged from the facility without proper notice. Licensee designee Dinah Owiti issued a written 24-hour discharge to all parties including myself and Guardian A1. Ms. Stockford investigated this allegation and found that Resident A refused to return to the home therefore, Resident A was provided with proper discharge notice. I also reviewed email correspondence dated 4/13/2022 with Resident A's mental health provider Ms. Knoppe from Mr. Mukwada stating his concerns of Resident A refusing to come inside the home and providing discharge notification. The licensee took appropriate steps prior to providing a discharge notice to

	Resident A and provided proper discharge notice to Resident A and his guardian.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 6/1/2022, I conducted an exit conference with licensee designee Dinah Owiti. I informed Ms. Owiti of my findings and allowed her an opportunity to ask questions or make comments.

IV. RECOMMENDATION

I recommend the current license status remain unchanged.

Ondrea Johnson

06/09/2022

Ondrea Johnson
Licensing Consultant

Date

Approved By:

Dawn Timm

06/10/2022

Dawn N. Timm
Area Manager

Date