GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 13, 2023

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

RE: License #: AS230010623
Investigation #: 2023A1029037
Thomas L Parkway Home

Dear Ms. Miller:

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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS230010623 |
| | |
| **Investigation #:** | 2023A1029037 |
| | |
| **Complaint Receipt Date:** | 04/25/2023 |
| | |
| **Investigation Initiation Date:** | 04/26/2023 |
| | |
| **Report Due Date:** | 06/24/2023 |
| | |
| **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:** | Thomas L Parkway Home |
| | |
| **Facility Address:** | 841 W Thomas L Parkway, Lansing, MI 48917 |
| | |
| **Facility Telephone #:** | (517) 323-4758 |
| | |
| **Original Issuance Date:** | 10/16/1985 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 05/01/2022 |
| | |
| **Expiration Date:** | 04/30/2024 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Direct care staff member Dominic Muigai restrained Resident A by placing him face down on the couch, twisting Resident A's arm behind his own back, and putting his knee on Resident A's lower back to hold him down. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 04/25/2023 | Special Investigation Intake 2023A1029037 |
| 04/26/2023 | Special Investigation Initiated – Letter - Email to complainant. |
| 04/26/2023 | Inspection Completed On-site – face to face with Resident A, Resident B, Dominic Muigai, direct care staff member Thomas Senzoga |
| 04/26/2023 | Contact - Telephone call made to Nicole Richards CMH case manager. |
| 04/27/2023 | APS Referral sent to Centralized Intake |
| 04/28/2023 | Contact - Telephone call made to Eaton County adult protective services, Robert Joyner. |
| 05/04/2023 | Contact - Telephone call made to Guardian A1, Nicole Richards (CMH) |
| 05/18/2023 | Contact - Document Sent to Guardian A1 |
| 05/18/2023 | Contact - Telephone call made to Dominique Miller, Jacob Graham, Sharon Farris, Greg Fox, ORR |
| 05/23/2023 | Contact - Telephone call made to Guardian A1 |
| 05/26/2023 | Contact - Document Sent from Ms. Miller. |
| 06/08/2023 | Exit conference with licensee designee Ms. Miller, left a message and sent an email. |

## ALLEGATION:

**Direct care staff member Dominic Muigai restrained Resident A by placing him face down on the couch, twisting Resident A's arm behind his own back, and putting his knee on Resident A's lower back to hold him down.**

### INVESTIGATION:

On April 25, 2023 a complaint was received via Bureau of Community and Health Systems online complaint system with concerns direct care staff member, whose current role is home manager, Dominic Muigai restrained Resident A by placing Resident A face down on the couch, twisting Resident A's arm behind his own back, and putting his knee on Resident A's lower back to hold him down. According to the complaint, Resident B took a video of the incident while Resident A yelled for help repeatedly and telling him to call 911. I was able to watch the approximately 30 second video and in the video, Resident A is on the couch with his hand behind his back while direct care staff member Mr. Muigai has it held there and Mr. Muigai does have his knee on Resident A's lower back. After a brief time, Mr. Muigai removed his knee off Resident A's back and steps onto the floor but remains standing over him with Resident A's arm twisted behind his back.

On April 26, 2023, I completed an unannounced on-site investigation at Thomas L. Parkway Home and interviewed Resident A. Resident A stated there was an incident because Resident B heard him yelling and came into the room. Resident A stated when he saw what was happening, Resident B started filming the incident on his cell phone. Resident A stated he was telling Mr. Muigai to get off of him or he was going to call the Sheriffs Department. Resident A stated, "I was upset and Dominic put me down on the couch to cool down." Resident A stated Resident B did not call the police during the incident because Resident B is afraid of the police and did not want to call them. Resident A stated Mr. Muigai has held him down two other times but he does not remember the details or times of the other incidents. Resident A stated he was held down during this incident for over ten minutes and his "back and arm hurt really bad." Resident A stated he and Mr. Muigai typically get along really well with each other and he feels safe living at Thomas L Parkway Home. Resident A stated if he did not feel safe, he would call Guardian A1 and tell her he was moving out of the home. Resident A stated he feels safe with Mr. Muigai because he is taking him to summer concerts and other social activities.

I interviewed Resident B at Thomas L Parkway Home. Resident B stated he recorded the incident between Mr. Muigai and Resident A. Resident B stated he heard Resident A screaming "let go of my arm" so came out to see Resident A on the couch which is when he started recording the incident. Resident B stated he does not know what occurred before Resident A was on the couch because he just walked out of his bedroom. Resident B stated Resident A was being held down for a half hour by Mr. Muigai and during this time he heard him saying "get off." Resident B stated he has

observed Mr. Muigai grab Resident A by his arm a couple times but he has never observed him holding him down outside of this incident. Resident B stated Mr. Muigai did not realize he was recording him until he stated this in the video. Resident B stated after the incident there was a rash on Resident A's arm which he tried to take a picture of it but Resident A would not allow him to do so. Resident B stated he does not believe Mr. Muigai should work at the facility any longer because he has anger issues and he does not like what he did to Resident A. Resident B stated he "does not feel safe living in the home and because of this incident, I lost trust in adult foster care homes."

On April 26, 2023, I interviewed direct care staff member Thomas Senzoga. Mr. Senzoga stated he has worked at the facility for five years with Mr. Muigai and has never had concerns regarding him being aggressive with the residents. Mr. Senzoga stated he has never observed the residents to be fearful of him. Mr. Senzoga stated in this home there are residents who have acting out behaviors and they have to protect themselves to make sure that they and other residents are safe. Mr. Senzoga stated typically Resident A does not have behaviors and he has never had to restrain a resident while he has been there. Mr. Senzoga stated they are trained in CPI training which moves towards redirection of a resident and not physical restraint. Mr. Senzoga stated he has never seen any direct care staff members be aggressive toward any of the residents.

On April 26, 2023, I interviewed direct care staff member whose current role is home manager, Mr. Muigai who stated Resident A was having a seizure and he was trying to keep him safe during the seizure. Mr. Muigai stated he did not feel there was an incident with Resident A because his seizures are typically caused by excitement and when he is upset. Mr. Muigai stated during this incident, Resident A was upset because another resident walked into the room and was telling him he was going to lose his outing for the week which upset Resident A. Mr. Muigai stated he knew that Resident A was going to have a seizure so he was going to direct him to the couch but before that Resident A fell onto the floor next to the couch. Mr. Muigai stated he stayed with Resident A and "he wanted him to stay down so he got him on the couch." Mr. Muigai stated Resident A sees a neurologist at MSU Neurology who oversees his epilepsy care however there is no seizure protocol for Resident A. Mr. Muigai stated he held him down on the couch because he is a "big guy and he's very unstable." Mr. Muigai stated he put his hand on his back holding his hands and asked Resident A if he could calm down. Mr. Muigai stated he believes Resident B recorded him because he was upset with him regarding a different issue. Mr. Muigai stated he did not put pressure on Resident A's hands when they were behind his back. Mr. Muigai stated he did not complete an *AFC Incident / Accident Report* after this incident or document this in a communication log, but he did contact his supervisor Ms. Miller to inform her of the incident. Mr. Muigai stated after the incident Resident A did not state he was hurt by any means or that he had any injuries on him. Mr. Muigai stated when the seizures occur he does swipe his VNS. Mr. Muigai stated he did not need to use his knee to hold Resident A down on the couch. During the interview, I showed Mr. Muigai the video of the incident and he denied that his knee was on Resident A and stated it was near him on the couch. Mr. Muigai stated he has completed Crisis Prevention Institute (CPI)

training and is his understanding a resident can be restrained if they are going to hurt themselves or someone else. Mr. Muigai stated he did not know if Resident A would hurt another resident but stated he wanted to make sure he was calm and he decided to manage the situation in the safest way possible. Mr. Muigai stated that Resident A was also trying to kick him during the incident, however, upon observing the video, there is no indication that Resident A was trying to kick him at any time. Muigai stated he did contact Resident A's guardian after the incident. Mr. Muigai again stated he would not do anything to harm any of the residents in the home.

On April 28, 2023, I interviewed Eaton County adult protective services specialist, Robert Joyner. Mr. Joyner stated he talked to Mr. Muigai about what they do when a seizure occurred. Mr. Muigai informed him during his interview he did not have a specific seizure protocol and they are going to follow up with the MSU neurologist. Mr. Joyner stated he did not know if Mr. Muigai's knee was on top of him or the hand was twisted behind him. Mr. Joyner stated when he mentioned having a seizure to Resident A, Resident A told him started and he said he was sitting on the loveseat watching television before it happened and all of a sudden he was on the couch. Mr. Joyner stated when Resident B informed him that he did not see how it began.

On May 18, 2023, I interviewed licensee designee, Nikki Miller. Ms. Miller stated Mr. Muigai has been there 8-10 years and she has never had any concerns regarding his treatment of the residents before this incident. Ms. Miller stated she did see the video because Guardian A1 showed it to her. Ms. Miller stated Mr. Muigai was calm in the video and it was not a violet episode but she did not agree with the position that he was in, kneeling on him, or holding his hand on the lower back. Ms. Miller stated as a result of this incident, Mr. Muigai is now being required to retake the trainings for Gentle Teaching and Recipient Rights. Ms. Miller stated Mr. Muigai described to her Resident A was agitated because he has been coming out of a seizure and because of his balance he put him on the couch. Ms. Miller stated Mr. Muigai informed her he was trying to encourage Resident A to stay seated but Ms. Miller stated it looks like a restraint in the video. Ms. Miller stated it did not look like it was punitive in nature but she does not know if Resident A had fallen that way on the couch or not. Ms. Miller stated she would have preferred if Mr. Muigai would have moved his hand into a more relaxed position. Ms. Miller stated in the past she would use Mr. Muigai as an example of a calm demeanor and the ability to de-escalate the instances. Ms. Miller stated he will follow her guidelines about how to manage situations in the future and she does not believe this is a normal occurrence for him. Ms. Miller stated she talked to Resident A after the incident and he said, "so Dominic needs to be disciplined" and he was asked if there were other times that he was not treated right and he said "No." Ms. Miller was asked if Resident A was aware of what was happening during the seizures and she did not know but when he is agitated he will often say "Call 911" or "I need to go to the ER." Ms. Miller stated the case manager has called MSU Neurology to ask for a seizure protocol. Mr. Muigai called Ms. Miller the day the incident occurred and told her that "there may be a complaint." Ms. Miller is going to reinforce concerns with the other direct care staff members understand what to do with seizures. Ms. Miller stated Resident A has fallen in the past hitting his head on the dresser and another time where

he bit a former direct care staff member so hard she needed reconstructive surgery so it would be likely that a direct care staff member would try to keep him still after a seizure.

On May 18, 2023, I interviewed Office of Recipient Rights (ORR) advisor, Greg Fox. He stated the video footage "told the story." Mr. Muigai told him his knee was on the couch not on the residents back. Mr. Fox stated the video file he saw was small but when the video was on the computer screen instead of the phone, when there were 12 seconds left it can be seen where Mr. Muigai pushed on Resident A's upper right shoulder blade and removed his knee. Mr. Fox stated that was not appropriate to do to any resident especially when a resident is having a seizure. Mr. Fox stated Mr. Muigai told him they both had a terrible week and that led to the seizure. Mr. Fox stated there was no appropriate context for prone positioning someone when using physical management. Mr. Fox stated it was unreasonable force by an unapproved techniques and ORR will not tell the licensee what action to take but Ms. Miller does have a corrective action plan for Mr. Muigai to retake Recipient Rights training on his own personal time, rather than work time. Mr. Fox stated it was also likely if Resident A were having a seizure during that time he would not be saying statements aloud. Mr. Fox sent his Report of Investigative Findings which confirmed there was a substantiated violation for "Right to be free from Abuse, Class II" for this incident.

On May 26, 2023, I received the seizure protocol from licensee designee, Ms. Miller. I reviewed the protocol which was completed on May 18, 2023 by MSU Neurology for Resident A prepared by Jennifer Edgar, NP. NP Edgar documented the following information regarding Resident A's seizures:

> *"[Resident A] has two types of seizures Tonic Seizures lasting 1-2 minutes where his arms or legs stiffen up and Atonic Seizures which are brief and he can fall on the ground if standing or slump forward if sitting.*
> *In order to respond to a seizure the following steps should be taken:*
>
> 1. *First aid*
> 2. *Give rescue therapy according to Seizure Action Plan*
> 3. *Notify Emergency Contact*
> 4. *Call 911 for Transport to Sparrow Hospital*
>
> *The rescue therapy Nayzilam 5 mg should be given if a seizure last more than five minute or there are back to back seizures without returning to baseline.*
> *Care after seizure: Can be agitated after seizure – may need redirection or to be led to a safe environment by staff.*
> *Special instructions: Swipe magnet for VNS with any seizure. Keep safe, redirect if able, encourage patient to sit after seizure, may need staff to lead to safe area post seizure."*

| APPLICABLE RULE | |
|---|---|
| **R 400.14308** | **Resident behavior interventions prohibitions.** |
| | **(2) A licensee, direct care staff, the members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:**<br>**(b) Use any form of physical force other than physical restraint as defined in these rules.** |
| **ANALYSIS:** | Based on the interviews with Mr. Muigai, Resident A, Resident B, licensee designee Ms. Miller, and ORR advisor Mr. Fox as well as my review of the recorded incident, Mr. Muigai restrained Resident A after he had a seizure with excessive force. Resident A did not state he had a seizure during his interview but instead he was upset and restrained by Mr. Muigai. During the video, I observed Resident A in a prone position on the couch with Mr. Muigai holding his arms behind his back while placing his knee on Resident A's lower back. According to the seizure protocol Resident A should be moved to safe location but there was no information regarding restraining him or using force in a prone position after having a seizure. Licensee designee Ms. Miller has started to address the situation with Mr. Muigai and is requiring him to repeat Gentle Teaching and Recipient Rights trainings. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

Jennifer Browning _____06/08/2023_____

Jennifer Browning
Licensing Consultant
Date

Approved By:

Dawn Timm 06/13/2023

_____

Dawn N. Timm
Area Manager
Date