

GRETCHEN WHITMER GOVERNOR STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

MARLON I. BROWN, DPA ACTING DIRECTOR

December 7, 2023

Rose Ogolla Precious Care Assisted Living, LLC 720 W. Walnut Street Kalamazoo, MI 49007

> RE: License #: AS390406106 Investigation #: 2024A1024004 Comstock Assisted Living

Dear Ms. Ogolla:

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,

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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 #:	AS390406106
License #:	AS390400100
laurationation #	202444024004
Investigation #:	2024A1024004
	40/40/0000
Complaint Receipt Date:	10/16/2023
Investigation Initiation Date:	10/17/2023
Report Due Date:	12/15/2023
Licensee Name:	Precious Care Assisted Living, LLC
Licensee Address:	720 W. Walnut Street
	Kalamazoo, MI 49007
Licensee Telephone #:	(269) 414-8013
Administrator:	Rose Ogolla
Licensee Designee:	Rose Ogolla
Name of Facility:	Comstock Assisted Living
Facility Address:	1155 N. 26th St.
racinty Address.	Kalamazoo, MI 49004
Facility Telephone #:	(269) 365-9698
	(209) 303-9090
Original Jacuanas Datas	04/01/2022
Original Issuance Date:	04/01/2022
Liconco Statuce	
License Status:	REGULAR
Effective Deter	10/01/2022
Effective Date:	10/01/2022
	00/00/0004
Expiration Date:	09/30/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED
	DEVELOPMENTALLY DISABLED
	MENTALLY ILL

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II. ALLEGATION(S)

	Violation Established?
Direct care staff member Elijah Mbwambr punched Resident A in	No
the arm and grabbed him by the neck.	

III. METHODOLOGY

10/16/2023	Special Investigation Intake 2024A1024004
10/17/2023	Special Investigation Initiated – Telephone w Adult Protective Service (APS) Specialist Melissa Pachota.
10/18/2023	APS Referral- APS already involved
11/02/2023	Inspection Completed On-site with direct care staff member Elijah Mbwambr
11/02/2023	Contact - Telephone call made with licensee designee Rose Ogolla
11/02/2023	Contact - Telephone call made with mental health case manager Rosa Brown
12/05/2023	Exit Conference with licensee designee Rose Ogolla

ALLEGATION:

Direct care staff member Elijah Mbwambr punched Resident A in the arm and grabbed him by the neck.

INVESTIGATION:

On 10/16/2023, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged direct care staff member Elijah Mbwambr punched Resident A in the arm and grabbed him by the neck.

On 10/17/2023, I conducted an interview with APS Specialist Melissa Pachota who stated that she was also investigating this allegation but found no substantial evidence to support Resident A's allegation. APS Specialist Melissa Pachota stated she is familiar with Resident A as he has a history of making false complaints against direct care staff members and has been discharged from previous adult foster care homes for

his aggressive behaviors towards others. APS Specialist Melissa Pachota stated she spoke with direct care staff member Elijah Mbwambr who denied this accusation and Resident A reported that he was hit by Elijah Mbwambr however his statements about the alleged incident were inconsistent therefore Melissa Pachota did not find Resident A to be truthful.

On 11/02/2023, I conducted an onsite investigation at the facility with direct care staff member Elijah Mbwambr who stated that Resident A is no longer a resident at the facility as he relocated to an independent setting. Elijah Mbwambr stated prior to Resident A leaving, he consistently made statements about direct care staff members that were untrue in attempts to convince his mental health case manager to relocate him to another placement. Elijah Mbwambr stated he has never hit Resident A nor has he ever mistreated Resident A in any way. Elijah Mbwambr stated Resident A fabricated a story about him to convince his case manager to discharge him. Elijah Mbwambr stated Resident A left the facility the following day after he reported this false claim to APS and informed his case manager that he was going to be living in an apartment with a woman that he met at a nearby grocery store. Elijah Mbwambr stated he has not talked to Resident A since he made this false claim about him and believe Resident A fabricated this allegation in order to move from the facility.

On 11/2/2023, I conducted an interview with licensee designee Rose Ogolla who stated Resident A reported to APS that direct care staff member Elijah Mbwambr hit him however Rose Ogolla found that this statement was untrue. Rose Ogolla stated Resident A has falsely accused direct care staff members of things in the past when he does not get what he wants. Rose Ogolla stated Resident A expressed that he wanted to move out of the facility to live with a woman that he met while he was out in the community at a grocery store and made this false complaint against Elijah Mbwambr to convince his case manager Rosa Brown to allow him to move from the facility to a setting of his choice. Rose Ogolla stated Resident A has no legal restrictions and his case manager eventually approved for Resident A to move out and live in an independent setting as she stated she could not prevent him from moving out of the facility.

On 11/2/2023, I conducted an interview with Resident A's case manager Rosa Brown who stated she has been working with Resident A to transition him to live in an independent setting however Resident A became impatient and voluntarily moved out of the facility to live with a friend as he is his own guardian. Rosa Brown stated prior to Resident A moving out, Resident A reported to her that direct care staff member Elijah Mbwambr hit him however she was not able to determine any truth behind this claim based on her investigation. Rosa Brown stated Resident A initially informed her that he was hit on the arm and then when she spoke to him on a second occurrence, Resident A changed his story and stated that he was pushed on the floor by Elijah Mbwambr. Rosa Brown stated Resident A provided her with several different versions of what he alleged happened involving Elijah Mbwambr therefore she did not believe his claim was truthful. In addition, Rosa Brown stated Resident A has a history of making false claims against direct care staff members in his previous placements where he has been

discharged from for demonstrating aggressive behaviors. Rosa Brown stated she does not believe Resident A was mistreated by any direct care staff members.

APPLICABLE RULE		
R 400.14308	Resident behavior interventions prohibitions.	
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.	
ANALYSIS:	Based on my investigation which included interviews with direct cares staff member Elijah Mbwambr, licensee designee Rose Ogolla, APS Specialist Melissa Pachota and mental health case manager Rosa Brown there was no evidence direct care staff member Elijah Mbwambr punched Resident A in the arm and grabbed him by his neck. Direct care staff member Elijah Mbwambr denied this allegation and stated that he has never hit or mistreated Resident A in any way and believes Resident A made this allegation to move out of the facility. Rosa Brown and Melissa Pachota both stated that Resident A reported that he was hit by Elijah Mbwambr however was inconsistent in his statements regarding the alleged incident therefore they were not able to find any evidence to support his claim. It should also be noted that Resident A has a history of making false claims against direct care staff members in his previous adult foster care settings.	
CONCLUSION:	VIOLATION NOT ESTABLISHED	

On 12/5/2023, I conducted an exit conference with licensee designee Rose Ogolla. I informed Rose Ogolla of my findings and allowed her an opportunity to ask questions or make comments.

IV. RECOMMENDATION

I recommend the current license status remain unchanged.

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Ondrea Johnson Licensing Consultant <u>12/05/2023</u> Date

Approved By:

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12/07/2023

Dawn N. Timm Area Manager Date