GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 15, 2024

Roger Covill
North-Oakland Residential Services Inc
P. O. Box 216
Oxford, MI 48371

RE: License #: AS630012358
Investigation #: 2024A0605013
Dartmouth Road Home

Dear Roger Covill:

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 (248) 975-5053.

Sincerely,

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012358
Investigation #:	2024A0605013
Complaint Receipt Date:	01/09/2024
Investigation Initiation Date:	01/09/2024
Report Due Date:	03/09/2024
Licensee Name:	North-Oakland Residential Services Inc
Licensee Address:	106 S. Washington Oxford, MI 48371
Licensee Telephone #:	(248) 969-2392
Administrator/Licensee Designee:	Roger Covill
Name of Facility:	Dartmouth Road Home
Facility Address:	3525 Dartmouth Oxford, MI 48371
Facility Telephone #:	(248) 628-6212
Original Issuance Date:	06/24/1983
License Status:	REGULAR
Effective Date:	03/02/2022
Expiration Date:	03/01/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 01/07/2024, Resident A was observed with a black eye. Resident A would not go to sleep, so staff Ron High used an end table as a barricade. Resident A tripped while trying to get out from the barricade, resulting in a black eye and bruised elbow.	Yes

III. METHODOLOGY

01/09/2024	Special Investigation Intake 2024A0605013
01/09/2024	Special Investigation Initiated – Letter Report made to Adult Protective Services (APS)
01/09/2024	APS Referral Referral made
01/09/2024	Referral - Recipient Rights Referral made to Oakland County Office of Recipient Rights (ORR) Rishon Kimble
01/10/2024	Contact - Telephone call made Contacted Lahser Prevocational Center located in Clarkston and was advised that Resident A has not attended workshop for the past two days. Discussed allegations with ORR Rishon Kimble.
01/10/2024	Contact - Telephone call made Left messages for Resident A's guardian and APS worker Bradley Edwards
01/10/2024	Contact - Telephone call received Discussed allegations with Resident A's guardian
01/10/2024	Inspection Completed On-site Conducted an unannounced on-site visit but there was no answer
01/10/2024	Contact - Document Received Email from APS Bradley Edwards with his face-to-face contact with Resident A

01/18/2024	Contact - Telephone call made Discussed allegations with home manager Rachel Love, direct care staff (DCS) Amy Prater, DCS Stephanie Petty, and Adrienne Doelle with corporate office and licensee designee Roger Covill. Left message for DCS Ron High
01/18/2024	Contact - Document Sent Email to ORR Rishon Kimble
01/18/2024	Contact - Document Received Email from ORR Rishon Kimble
01/22/2024	Contact - Telephone call received Discussed allegations with DCS Ron High
01/24/2024	Contact - Telephone call made Attempted to leave DCS Belinda Floor message but her mailbox is full. Texted the HM to have Ms. Floor call me.
01/25/2024	Contact - Telephone call received Message left by DCS Belinda Floor
01/29/2024	Contact - Telephone call made Left message for DCS Belinda Floor
01/30/2024	Contact - Telephone call made Left another message for DCS Belinda Floor
01/30/2024	Exit Conference Conducted exit conference with licensee designee Roger Covill with my findings

ALLEGATION:

On 01/07/2024, Resident A was observed with a black eye. Resident A would not go to sleep, so staff Ron High used an end table as a barricade. Resident A tripped while trying to get out from the barricade, resulting in a black eye and bruised elbow.

INVESTIGATION:

On 01/09/2024, intake #199129 was assigned for investigation regarding an incident report (RP) dated 01/07/2024 indicating that direct care staff (DCS) Ron High

barricaded Resident A in the front living room, Resident A tripped over the barricade, fell and has a black eye.

On 01/09/2024, I initiated the special investigation by making a referral to Adult Protective Services (APS). The case was assigned to APS worker Bradley Edwards.

On 01/10/2024, I attempted an on-site visit at the home, but there was no answer.

On 01/10/2024, I contacted Lahser Prevocational Center located in Clarkston and was advised that Resident A has not attended workshop for the past two days.

On 01/10/2024, I contacted Oakland County Office of Recipient Rights (ORR) worker, Rishon Kimble. Ms. Kimble will be investigating these allegations.

On 01/10/2024, I interviewed Resident A's sister/guardian via telephone regarding the allegations. The sister stated that she received a telephone call on 01/07/2024 at 11:45AM from the home manager (HM) Rachel Love stating that Resident A tripped and as a result got a black eye and bruised elbows. Resident A was being taken to McLaren Hospital for treatment. The sister did not think anything of this incident because Resident A's gait is unsteady, and he has a history of falls. However, today she received a telephone call from APS informing her that a DCS, Ron High barricaded Resident A in the front room with a nightstand and Resident A was trying to get out, tripped over the nightstand resulting in a black eye and both elbows bruised. The sister stated that Resident A's individual plan of service (IPOS) does not indicate any restraints for Resident A, so she does not understand why Mr. High barricaded Resident A. She has not met Mr. High and her last visit to the home was July 2023. Resident A has been living at this home for 40 years and she has never had any past concerns until now. Resident A has always been well taken care of so this was a surprise to her. She has a good relationship with the HM and staff at this home and reported no other concerns.

On 01/10/2024, APS worker Bradley Edwards emailed me his face-to-face contact with Resident A. Following is his contact: "APS arrived at the residence and met with home manager (HM) Rachel Love who allowed APS into the home. APS then discussed the allegations with the HM to which she stated that she was not working at the time of the incident. The HM stated that the incident occurred at 1:30am, however DCS Ron High did not contact her until 6:30am. The HM stated that she then came to the home to take Resident A to the hospital where he was examined and there was only bruising that was observed, and no other injuries were noted. APS then asked if she spoke with Mr. High concerning him using the nightstand as a barrier to which the HM stated he did tell her that, but she is unsure as to why he did that. The HM stated that Resident A does like to walk around, and she believes that he needed to go poop and that is why he was trying to get out of the room. APS then asked if a nightstand has been used as a barrier before and she stated no. APS then asked if any other object has been used as a barrier before and she stated no. APS then asked if this was the first time she has knowledge of anything like this occurring and the HM stated yes. APS then asked if

there have been any disciplinary actions taken regarding Mr. High and the HM stated that she has not at this time. APS asked how long the HM has been working with the home and she reported that she has been working in the home since January of 2016 and Mr. High was working in the home prior to her becoming the HM. APS asked if she has any concerns with Mr. High and she stated no. APS asked when the next time he works a shift and she stated that he works this Thursday from 11pm - 7am. APS asked if he normally works the night shifts and the HM stated that he is the night person. APS asked that she have him contact APS so that they could speak with him regarding the allegations to which she stated that she would do so.

APS then asked to speak with Resident A to which the HM informed APS that he is nonverbal and unable to be interviewed. APS requested to see Resident A to which the HM brought APS to the front room where Resident A was observed to be on his knees leaning on a chair. APS waved and attempted to speak with Resident A, but he did not respond. APS was able to observe some bruising around his eye. Resident A was dressed appropriately and there were no concerns at the time of the visit. APS then asked the HM if he has a guardian to which she stated that he does, and it is his Resident A's sister. APS asked if she has been notified of the incident and the HM stated that she has been.

APS then spoke with another worker who was present in the home named Stephanie (last name unknown). APS asked if she was present during the incident to which she stated no. APS asked if she has any issues when dealing with Resident A and she stated that she did not. APS asked if there was anything that she would like to inform APS about and she stated no. APS then informed the HM that they would be following up with her once they have completed their investigation."

On 01/18/2024, I contacted the HM Rachel Love via telephone and discussed the allegations. The HM has been working for this corporation since 2017. She usually works the first shift. On 01/07/2024, DCS Ron High contacted her, but she was sleeping when he called. That morning she saw a missed call from Mr. High. Mr. High left her a message stating, "Resident A fell and had a bruise on his eye." She called Mr. High back around 6:30AM, but he did not answer. He called her back saying, "I used an end table in the front room because Resident A did not want to go to bed so I barricaded him. Resident A tripped over the end table and fell." The HM arrived at work and saw Resident A's right eye, which looked like a black eye- purple in color. She took Resident A to the hospital and was informed that nothing was broken. The HM called Resident A's sister and then completed the IR based on what Mr. High reported to the HM. Mr. High told the HM he did not witness the fall, but then reported to other staff that he did witness the fall. It is unclear what happened, but the injuries to Resident A's face and elbows are consistent with Resident A falling. Resident A is non-verbal therefore, he was unable to report what happened.

On 01/18/2024, I interviewed via telephone DCS Amy Prater regarding the allegations. Ms. Prater has been with the corporation for 15 years, but only 2½ years at this home. On 01/07/2024 she arrived at her shift at 7AM and observed Resident A's right black

eye and a cut on his nose. DCS Ron High reported that “Resident A tripped over coffee table in the front room.” She observed both of Resident A’s elbows bruised up, so the HM took Resident A to the hospital. Ms. Prater was informed by Mr. High that Resident A was not sleeping so he kept Resident A in the front room all night. Mr. High told Ms. Prater, “he must have tripped,” implying that Mr. High did not witness the fall. Mr. High did not tell Ms. Prater that he barricaded Resident A in the front room, but Mr. High did report that to the HM as that is what the HM told Ms. Prater. Mr. High informed her that he did not observe the marks until that morning when he was giving Resident A shower because it was dark in the front room when Resident A fell. Resident A is non-verbal, so he was unable to state what happened. Mr. High did not complete an IR until the HM directed him to do so.

On 01/18/2024, I interviewed via telephone DCS Stephanie Petty regarding the allegations. Ms. Petty has been with this corporation since November 2022. She works first shift. She came in on 01/07/2024 at 7AM and DCS Ron High and DCS Belinda Floor were working the midnight shift. Ms. Floor whispered to Ms. Petty, “something happened to Resident A.” Mr. High told Ms. Petty that Resident A was in the red chair and that Mr. High did not realize the red chair was broken so when Resident A was sitting in the chair, he fell out of it.” Ms. Petty stated that then Mr. High said,” I barricaded him, and he tripped.” Then Mr. High said, “I put the chair in front of Resident A to barricade him and then Resident A stepped over it and tripped.” Mr. High’s story kept changing. Ms. Petty asked Ms. Floor if she saw or heard anything that night and Ms. Floor stated, “I didn’t hear a fall or anything.” The HM arrived at the home saw Resident A’s injuries and immediately took Resident A to the hospital. Mr. High never completed an IR until the HM directed him to do so. Ms. Petty observed that Resident A had a right black eye, bruising to both elbows and a linear mark on his right arm about one in a half inches long. She was unable to ask Resident A what happened as he is non-verbal.

On 01/18/2024, I contacted the area supervisor Adrienne Doelle regarding the allegations. Ms. Doelle was informed by the HM what happened on 01/07/2024 with Resident A. She was informed by the HM that DCS Ron High told the HM that Resident A was “up and down all day,” so Mr. High took Resident A to the front room. Mr. High told the HM, “I put a chair with the table to barricade Resident A and then Resident A tripped over the end table.” There was bruising to Resident A’s arms, elbow and face which is consistent with a fall. Ms. Doelle stated that the HM had a conversation with the licensee designee Roger Covill regarding Mr. High, but she is unsure what the outcome was.

On 01/18/2024, I reviewed the IR’s written by both the HM and DCS Ron High. The IRs do not match. The HM’s IR completed on 01/07/2024 at 6:30AM stated that Mr. High contacted the HM and informed the HM that he used an end table to barricade Resident A who then tried to climb the end table, fell, which resulted in the black eye and bruising to his elbows. However, Mr. High’s IR completed on 01/07/2024 at 1:30AM indicated that Resident A was sitting on a chair, stood up and slipped and fell, hit the side of the chair and end table. No signs of marks or cuts at that time. At 5:30AM, Mr. High was

getting Resident A ready for a shower and noticed a large dark purple bruise under his right eye, pin size red dot on corner of left eye and large purple bruise on right elbow and a scratch near left eye. There is no mention of Resident A being barricaded on Mr. High's IR.

On 01/18/2024, I contacted licensee designee Roger Covill via telephone regarding the allegations. Mr. Covill was informed by the HM that DCS Ron High told the HM that he barricaded Resident A with an end table in the front room to prevent Resident A from leaving. Resident A tried to go over the end table, fell and injured himself. Mr. Covill has left Mr. High on the schedule because he does not believe that Mr. High barricaded Resident A out of malice or wanted Resident A injured, but instead thought that was his way of keeping Resident A in the front room. Mr. Covill is also concerned why the HM's and Mr. High's IR's do not match.

On 01/18/2024, I received an email from ORR Rishon Kimble stating that she will be substantiating her case.

On 01/18/2024, I reviewed Resident A's IPOS completed on 12/14/2023 by Easterseals Macomb-Oakland Regional Center (MORC) and there are no statements regarding any restraints and/or restrictions for Resident A when he is awake at night.

On 01/22/2023 I interviewed DCS Ron High via telephone regarding the allegations. Mr. High has been working for this corporation for eight years. He works the midnight shift from 11PM-7AM. Mr. High stated that Resident A is non-verbal, but he makes noises, yells, and screams. Resident A shares a room with Resident B who has been aggressive in the past towards Resident A when Resident A makes noises while Resident B is sleeping. On 01/07/2024, Mr. High arrived at work and noticed that Resident A was in the front room, which Mr. High knew that was because Resident A could not sleep and was making noises, so he was brought to the front room. Mr. High went in the front room with Resident A. The room was lightly lit. He observed Resident A pacing back and forth and then Resident A "snatched the curtain off the window." Mr. High wanted to initially get the end table next to the chair to stand on it and fix the curtain, but instead, he got a step ladder. Mr. High climbed the step ladder and as he was trying to put the curtain back up, Mr. High saw Resident A making several attempts to get up off the chair where he was sitting, but then kept trying to get up and sit back down. Mr. High then said, "Resident A was trying to move to the side of the chair, crawling," then he said, "Resident A was trying to climb the chair. I didn't see him fall because I was too busy paying attention to the curtain." He believes the time was around 11:30PM when he saw "Resident A crawling on the floor." He did not see any bruising on his face because it was dark and then Resident A finally went to sleep.

Around 5:30AM, Resident A woke up and as Mr. High was getting Resident A ready for the shower, he noticed the right black eye and bruises on both elbows. He called DCS Belinda Foor who was working the shift with him over to see the bruising. He then called the home manager Rachel Love who initially did not answer, but then called him back. The HM told him she was coming to the home to check Resident A. He completed the

incident report and left when his shift ended at 7AM. He stated the HM took Resident A to the hospital. Mr. High was asked about him barricading Resident A in the front room with the end table and Resident A trying to get out of the barricade resulted in falling and sustaining these injuries. Mr. High stated, “that wasn’t a big deal. I barricaded him when he was standing up and then I moved the end table because I saw that he wasn’t trying to get out.” Then he said, “he fell, and I turned and saw him.” Mr. High’s explanation of how Resident A fell was inconsistent with the black eye because according to Mr. High, Resident A fell out of his chair onto the floor without hitting anything.

On 01/23/2024, I received an email from APS Bradley Edwards stating that he has been trying to get ahold of DCS Ron High but has been unsuccessful. Mr. Edwards received the incident reports (IR) completed by Mr. High and the HM and they are different. Mr. High’s does not mention barricading Resident A in the front room, but the HM’s IR reports that Mr. High told the HM that he barricaded Resident A. Mr. Edwards reported that the detective assigned to Resident A’s case will be going out to the home and conducting their own investigation.

On 01/30/2024, I received an email from APS Bradley Edwards stating that he is substantiating his case.

On 01/30/24, I interviewed DCS Belinda Floor regarding the allegations. She has worked with this facility since 02/2023. At 10:45PM and Ron arrived at 11PM. Resident A was awake in the front room with the lights on. She addressed him when she arrived at the home. She thought it was odd he was up at that time, because normally he’s asleep. She talked to the HM who was working the afternoon shift who told her he was having trouble sleeping and brought him out to the living room. Resident A was standing in the living room by the chair and yelling out. He is non-verbal but sometimes he yells when having a rough time. There were no barricades at that point, just standing there with the TV on. Mr. High arrived, and Resident A remained in the living room while we were cleaning. We did our checks, so Mr. High had Resident A and Resident B and she had the female residents. Mr. High checked on Resident A in the living room and she went to the other living room sat down and watching TV. Resident A was quiet, so Ms. Floor thought Resident A was asleep. She was in the front room from 1AM-5:30AM. She conducted her bed checks at 1AM-1:30AM and then again at 3PM-3:30PM. Mr. High was in the front room with Resident A the entire time. She did not hear anything the entire time.

That morning, Mr. High approached her and said, “I’m in trouble or Resident B is in trouble.” She is unsure why he said, “Resident B was in trouble.” She said, “I saw Resident A when I arrived last night and there was nothing wrong with him and the lights were on when I got here.” Mr. High said, “I’m not sure, but he possibly fell on the table.” Ms. Floor was not understanding what Mr. High was trying to say and why he said, “Resident B would be in trouble.” Mr. High then made a statement that “Resident A fell on the table.” Resident B was sleeping through the night and never came out of his bedroom. Ms. Floor observed Resident A’s face and saw a big purple/black eye. She

told Mr. High “you have to call Rachel and you need to do it now.” It was between 5:30AM and 6AM. The HM did not answer so Ms. Floor told Mr. High, “you need to text her now if she is not answering.” Ms. Floor walked to the front room and saw the table in the middle of the room and saw the chair facing the corner of the room. Mr. High told her something, “he fell and hit the table last night.” Ms. Floor said she would have heard the noise if Resident A had fallen but she was awake and did not hear anything. Ms. Floor stated, “I would hope not,” when asked if she believes Mr. High caused the injuries.

On 01/30/2024, I conducted the exit conference with licensee designee Roger Covill with my findings. Mr. Covill agreed to submit a corrective action plan and had no questions.

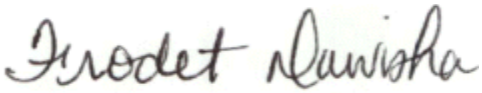
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on my investigation and information gathered, DCS Ron High did not attend to Resident A’s protection and safety at all times on the night of 01/07/2024. Mr. High barricaded Resident A in the front room with an end table, preventing Resident A from leaving. Resident A tried to climb over the end table to leave, tripped and fell. That fall resulted in a right black eye and bruising to his elbows and arms.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, 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: **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.**

ANALYSIS:	Based on my investigation and information gathered, DCS Ron High confined Resident A in the front room by using an end table as a barricade. On 01/07/2024, Resident A did not want to sleep and began pacing around. Mr. High had Resident A in the front room and to prevent Resident A from leaving the front room, Mr. High used an end table to restrict Resident A's movements, which then resulted in Resident A trying to climb over the end table to leave and then fell. The fall resulted in Resident A's black eye and bruising to both elbows and arms. According to Resident A's IPOS completed on 12/14/2023, there are no statements in the plan stating that Resident A should be confined or restricted in an area if he is awake at night.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

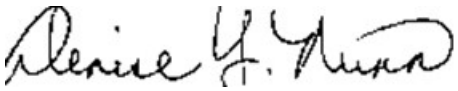
Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



02/15/2024

Frodet Dawisha Date
Licensing Consultant

Approved By:



02/15/2024

Denise Y. Nunn Date
Area Manager