GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 22, 2024

Calvin Matheka
Amani LLC
1946 Andrew St SE
Kentwood, MI 49508

RE: License #: AS410406351
Investigation #: 2024A0357041
Amani AFC

Dear Calvin Matheka:

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) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
This report contains quoted profanity.

I. IDENTIFYING INFORMATION

License #:	AS410406351
Investigation #:	2024A0357041
Complaint Receipt Date:	06/26/2024
Investigation Initiation Date:	06/26/2024
Report Due Date:	08/25/2024
Licensee Name:	Amani LLC
Licensee Address:	1946 Andrew St Se Kentwood, MI 49508
Licensee Telephone #:	(616) 594-6924
Administrator:	Calvin Matheka
Licensee Designee:	Calvin Matheka, Designee
Name of Facility:	Amani AFC
Facility Address:	4797 Millhaven Dr. SE Kentwood, MI 49548
Facility Telephone #:	(616) 594-6924
Original Issuance Date:	02/11/2021
License **Status:**	REGULAR
Effective Date:	08/11/2023
Expiration Date:	08/10/2025
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was restrained by staff until he escaped to a neighbor’s house and called law enforcement.	No

III. METHODOLOGY

06/26/2024	Special Investigation Intake – SIR 2024A0357041 Department of Health and Human Services, Kent County, Adult Protective Services denied this complaint.
06/26/2024	APS Referral Referral from APS.
06/26/2024	Special Investigation Initiated – Telephone
08/13/2024	Contact - Telephone call made To Licensee Designee, Calvin Matheka.
08/13/2024	Contact - Telephone call made To Julie Rasmussen M.A. Limited License Psychologist. She confirmed that she works at Montcalm Care Network (CMH) and she wrote Resident A's Behavior Treatment Program, dated 08/21/2023.
08/16/2024	Inspection Completed On-site I made an announced inspection at the AFC home. I reviewed Resident A's file.
08/16/2024	Contact - Document Received Received and reviewed copies of the AFC Division - Incident / Accident Report dated 06/24/2024 for Resident A, Resident A's Shift Notes, and Resident A's Behavioral Treatment Program and his IPOS (Individual Plan of Service).2
08/16/2024	Contact - Face to Face Conducted interview with Sylvester Ngonga, Direct Care Staff, the Licensee Designee, Calvin Matheka and Daniel Kioko, Director.
08/16/2024	Contact – Face-to Face with Resident B.
08/16/2024	Telephone – Call – Received

	From Montcalm Care Network, Case Manager, Glory Strey, for Resident A.
08/20/2024	Telephone -Call-received from Direct Care Staff, Benaiah Nyanjui.
08/21/2024	Exit Conference- Telephone exit conference with Licensee Designee, Calvin Matheka.

ALLEGATION: Resident A was restrained by staff until he escaped to a neighbor's house and called law enforcement.

INVESTIGATION: On 06/26/2024, BCAL Online Complaints received a complaint. The complaint had come to us from APS, Kent County, and APS had denied the complaint. The date of the incident was 06/24/2024. The complaint read in part: .(Resident A) resides within Amani AFC home and is currently not his own person. Resident A's guardians are his parents…. Resident A is diagnosed with ADHD, Anxiety, Autism, and a history of intellectual disability. Today, Resident A was restrained by several staff members until he escaped to a neighbor's home and contacted law enforcement. Resident A did not sustain any injuries as a result. Resident A is restrained by adult foster care staff for an unknown reason every day. It is unknown what form of restraint is being used or when. Resident A did not disclose any other forms of abuse practiced by the adult foster care staff at this time. Resident A does not feel safe at the adult foster care home due to being placed in these unknown restraints every day and desires to be home with him parents.

The complaint also indicated Resident A reported that it was unknown why the AFC restraints him, however upon further discussion Resident A explained that they restrain him because Resident A has auditory hallucinations and states that he going to "Kick their ass." Resident A informed that they (the staff) think he's talking to them, but he is not. The guardians are aware of the incident and mother was called at the time of the incident was occurring and requested that Resident A not be brought to the emergency room because this is his typical behavior for him. The AFC staff explained that they had to bring Resident A to the emergency room due to Resident A expressing suicidal ideation to law enforcement. Resident A is not currently suicidal.

On 08/13/2024, I telephoned the Licensee Designee (LD) Calvin Matheka to explained that a complaint had been made on his home, which I explained to him. LD Matheka reported that Resident A was admitted to the home on 03/29/2024 and he came from jail to his home. LD Matheka also stated that Resident A was from Montcalm County, and they have a contract with Montcalm Care Network (CMH). He added that Resident A had been in three or four other homes before he came to Amani AFC. LD Matheka said Resident A has a Case Manager along with a Behavioral Specialist and he provided their names and telephone numbers. LD Matheka continued to report that Resident A has a Behavioral Treatment Program.

LD Matheka said his parents are divorced and he has scheduled visits with each parent once a month. LD Matheka recalled that Resident A's father had called and set up his time to visit with Resident A in June and he could not wait and talked about it continually. When the day came for his scheduled visit, his father did not show up. LD Matheka said this really upset Resident A, who took it out on the staff working in the home and with the other male residents living in the home. LD Matheka reported that Resident A has been showing signs of aggression and by name calling and saying: "I will get you.' LD Matheka thought that the trigger for his extreme behavior's was his father not showing up after the arrangements had been secured. He stated that they tried to have him talk about it along with his feelings, but Resident A was uncooperative. He explained that Resident A lies often. LD Matheka told me that the day of his admission to the home he beat his mother up and assaulted his father. Then on the day of the incident Resident A slept late into the morning and then he got up and came to the living room and kept asking why he was in this place and said he did not belong there. LD Matheka said he had been abducted. LD Matheka suddenly attacked staff and kicked Direct Care Staff, Sylvester Ngonga in his knee and he said he was going to kill them, and he used racial slurs. LD Matheka ran out of the house and picked up rocks and threw them into the picture window and broke them and he ran down the street. A staff went after him, and he was throwing rocks at him. LD Matheka said Resident A found a phone (unknown who had the phone) and he called 911 and the police found him and brought him back to the AFC home. LD Matheka said the police are very familiar with Resident A because he calls them frequently. LD Matheka reported that Resident A said to the police he was suicidal and so they called for an ambulance and that means they have to take him to the hospital. The staff had called Resident A's mother and she spoke to the police officer, and she explained this is what he does and please not take him to the hospital, but they had to because of his threat of suicide. LD Matheka said the neighbors were very upset by Resident A throwing rocks and yelling. I asked Mr. Matheka if they used any restraints on Resident A and he said "no". His plan does not allow that unless he is a danger to himself or others, but they can come along side of his arm on either side of him (side body hug) and they talk to him to calm him down and remind him of his coping skills and this was used only to keep him and others safe. LD Matheka reported they have not used any other interventions or physical restrains with Resident A.

On 08/13/2024, I telephoned the case manager and left her a message to return my call.

On 08/13/2024, I telephoned the Behavioral Specialist, Julie Rasmussen M.A. Limited License Psychologist. Julie Rasmussen confirmed that she had written Resident A's, Behavioral Treatment Program and she has worked with him for a long time she reported that he has had four to five other homes. Julie Rasmussen said she is not allowed to put any physical restraints in her behavioral treatment plans. Julie Rasmussen said Resident A has high levels of agitation, and he came from a home with poor parenting skills because they are afraid of him. Julie Rasmussen said the whole interdisciplinary team works with Resident A. Julie Rasmussen said

Resident A runs and elopes into the community often. Julie Rasmussen said Resident A throws rocks at other residential windows. Julie Rasmussen reported that he does not tell the truth. I asked her for Resident A's diagnoses, and she reported he has Moderate Intellectual Disability, Posttraumatic Stress Disorder, Unspecified Schizophrenia Spectrum and other Psychotic Disorder and Rule /Out Attention-Deficit/Hyperactivity Disorder. Julie Rasmussen explained that he is prescribed psychotropic medications for mood issues, psychosis, and sleep problems. Julie Rasmussen reported that Resident A has verbal outbursts including yelling, swearing, verbal threats, use of middle finger gestures, flipping furniture and throwing things. Resident A has conflicts with peers that can include angry language, arguing, disagreeing or otherwise developing conflicts with a peer. Resident A has had property destruction of AFC possessions or AFC property. Resident A has physical aggression where he hits others with his fist or objects and throws objects at others or otherwise becomes aggressive. Julie Rasmussen reported that this last incident required emergency intervention and he exhibited Imminent Risk. Julie Rasmussen stated that when they confronted Resident A, Resident A denied all of the things and said he didn't hurt anyone, and he did not throw any rocks. Julie Rasmussen said Resident A has no insight. Julie Rasmussen said they will be working to have Resident A admitted to Kalamazoo Regional Psychiatric Hospital. Julie Rasmussen said this is the only facility that will be able to handle his mental illness. Julie Rasmussen said the staff of Amani have worked very hard in following the plan she had developed, and they used the proactive strategies in a warm and positive environment. Julie Rasmussen said they could not have done any more for him. Julie Rasmussen denied that the Amani staff used any restraints on Resident A.

I further asked why her Behavioral Treatment Program did not include any physical intervention for Resident A especially with his history. Julie Rasmussen explained the CMH does not allow any physical interventions to be in their plans. Julie Rasmussen stated that the staff cannot put any hands on the resident. She explained that she would have to present hands on physical intervention to the Recipient Rights committee with all the reasons why and they would approve or disapprove of it. Therefore, Julie Rasmussen does not include any hands-on intervention with Resident A. I explained that licensed AFC homes who have Special Certification have to prove to us that all of their staff are required to have a three-day class in interventions that is called MANDT and the last day of training with this required class does allow for limited physical intervention in eminent danger to prevent injury to the residents or to the staff. Julie Rasmussen was aware of this information but said she was not allowed to put any physical intervention into her Behavior Treatment Program.

On 08/16/224, I made an announced inspection of the home. I reviewed Resident A's file. I requested a copy of the Incident/Accident Report, (IR) and his Behavior Treatment Program**.** The IR indicated Resident A was asleep and woke up and came to the living room asking why he was here. Resident A told staff that he did not want to be here. Resident A slammed doors, called staff names and eloped. Staff

encouraged him to come back, and he took rocks and threw them to hit staff then left. Staff followed Resident A at a safe distance after notifying the supervisor. Resident A managed to call the police using a stranger's phone. Police brought Resident A back and paramedics were called who then took him to Butterworth hospital for evaluation. Corrective Measures reported that staff will continue to encourage (Resident A) to make informed decisions and to work on his goals which will help him live independently in the community setting.

Resident A's Behavioral Treatment Program (BTP) was reviewed. The program addressed "Proactive Strategies with creating a warm and positive environment", which included five defined ways to show him an overall accepting and non-judgmental manner. The Plan addressed that he needed a structured and predicable daily routine which included ways to keep him busy and involved. The BTP include a section of "Reinforcement/Encouraging Appropriate Alternative Behaviors" with positive reinforcement and systematic Attention. There were four ways provided on how to do this. The Program addressed how the staff should help him with social skills training by staff being directly involved to help him and to provide him with positive feedback for specific and appropriate use of interpersonal skills. The Program addressed "Interventions for Targeted Behaviors, to address precursor behavior. The Behavioral Specialists included three defined ways to help Resident A so he would make wise choices. In this same section there were instructions how staff were to address conflicts with peers with three explained progress steps. Next was how staff were to address Resident A's verbal outbursts/property destruction/physical aggression which included six steps which addressed his escalation. There was a section on how to address eloping with three steps and the first was to go after Resident A on foot or by vehicle all the while encouraging him to return home and praise him if he does. Attached to this BTP was the training on 04/19/2024, of 12 staff with all of their signed initials. There was a documentation of the managers being trained by the Behavioral Specialists on 04/11/2024.

On 08/16/2024, I reviewed his IPOS (Individual Plan of Service) which said Resident A required continuous supervision by AFC staff. It also read that Resident A was a danger to himself and to others.

On 08/16/2024, I interviewed a Resident B. Resident B reported that he has lived in the home for six years. I asked Resident B how he got along with Resident A and he stated that he could be difficult and hard to get along with. I asked Resident B about the staff using restraints on him or any resident in the home. He said "No, they had not." Resident B was happy to be in the home and he expressed relief that Resident A was no longer living with him.

On 08/16/2024, I met the Program Director, Daniel Kioko. Daniel Kioko reported that Resident A had broken his wrist. Daniel Kioko said Resident A is very strong, and he said he followed the Behavioral Treatment Program by using Positive Reinforcement and Systematic Attention. Daniel Kioko said he gave verbal praise and attention

along with reinforcers. Daniel Kioko said he reminded Resident A of his goals and what Resident A had to do to reach them. Daniel Kioko said he had to stand in between him and another resident to provide protection. Resident A was hurt by Resident A. Mr. Kioko provided me with examples of how he used Resident A's BTP to address what was occurring with Resident A at the time. He even used the same language that was in the plan. Daniel Kioko denied that they had used any restraints on Resident A.

On 08/16/2024, LD Matheka said that he went to the hospital and Resident A refused to come back to the AFC home. LD Matheka said the hospital staff were working on placing Resident A into a psychiatric hospital. LD Matheka reported that Resident A told the staff he was abducted and taken to the AFC home. LD Matheka said Resident A refused to come back so he left and when home and called Montcalm staff and told then of the events and said he discharged Resident A from the Amani AFC home.

On 08/16/2024, I conducted an interview with Direct Care Staff, Sylvester Ngonga. Staff Ngonga said Resident A got up late that morning on 06/24/2024 and then Resident A came into the living room and said to staff, he did not want to be there. Resident A slammed doors, called staff names and he kicked Mr. Ngonga in his knee and then Resident A ran out of the house. Resident A was encouraged to come back but he picked up rocks and threw them at staff and at the window and Resident A broke the window. They called LD Matheka who came immediately. Also, another staff, (Beniah Nyanjui) followed Resident A down the street while Resident A threw rocks at him. Staff Ngonga said Resident A managed to find a phone to call the police, who called an ambulance after Resident A threatened suicide. Staff Ngonga provided me with statements that he had made to Resident A when Resident A had difficulty with other residents or with staff. Staff Ngonga stated that he always spoke in a calm tone and offered support and encouragement with Resident A. The statements he used were directly from Resident A's BTP. Staff Ngonga stated that they never used any restraints on Resident A.

On 08/16/2024, I received a return phone from Resident A's, Case Manager, Glory Strey. I explained that we had a complaint on Resident A telling individuals that he was put into restraints every day, Resident A did not feel safe in the home, and Resident A wanted to go home his parents. Resident A also said he was hearing voices. Glory Strey reported that Resident A was not truthful, and Resident A knows what to say to have a reaction. Glory Strey said he can manipulate any situation for what he wants. Glory Strey said he cannot go back to his parents, because they are divorced. Glory Strey said he has had a severe decline in his mental health. Resident A has been in three or four other homes. Resident A can't sleep at night. Glory Strey reported that they have a really good team at Montcalm Care, and they have worked together, and they all want success for Resident A, but he has been able to sabotage every placement. Glory Strey said Resident A has made some progress, but Resident A cannot establish trust. Glory Strey said she has been in the AFC home many times and she has observed how the staff have interacted with

Resident A. Glory Strey said they all had compassion, patience and kindness towards Resident A, and they followed the Behavioral Treatment Program. Glory Strey reported that he has lasted in this home longer than any of the other homes. Glory Strey said they are not offering Resident A anymore placements but are working towards a State Hospital placement. Glory Strey said the home did not use restraints with Resident A.

On 08/20/2024, I conducted a telephone interview with Direct Care Staff, Benaiah Nyanjui. Staff Nyanjui reported that Resident A got up late and came to the living room and he was acting a little weird. Resident A asked him why he was there, and he just escalated, and he reminded him of using his coping skills and what his goals where. Staff Nyanjui said Resident A hit the wall, was loud and made racial comments. Staff Nyanjui said he assaulted Mr. Ngonga by kicking him in his knee who was hurt. Resident A ran out of the home and started picking up rocks and throwing them. Resident A said that he was kidnapped and didn't belong there. Staff Nyanjui reported that Resident A started walking away and he followed him, but Resident A kept throwing rocks at him. Staff Nyanjui decided to go back to the home so he would not be injured. Staff Nyanjui said Resident A called the police and they came and picked him up and brought him back to the home. Staff Nyanjui reported that Resident A said he was going to commit suicide, so the police called for the ambulance, and they took him to the hospital. I asked Staff Nyanjui if he had followed Resident A's BTP and he said he had. Staff Nyanjui encouraged Resident A to think about his choices and his goals when he came out of the house and picked up rocks to throw. Staff Nyanjui also followed the BTP as he followed Resident A down the street when Resident A was eloping. Staff Nyanjui followed the program/plan. I asked him if they used restraints on Resident A and he denied that they used restraints on Resident A.

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.** **(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:**

	(b) Use any form of physical force other than physical restraint as defined in these rules. **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.** **(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:	Resident A was restrained by staff until he escaped to a neighbor's house and called law enforcement. The Licensee Designee Calvin Matheka denied the use of any restraints on Resident A. The Program Director, Daniel Kioko denied the use of restraints. Two Direct Care Staff, Sylvester Ngonga and Benaiah Nyanjui, both denied that they used restraints on Resident A. Resident B was interviewed, and he denied that the staff had not used any restraints on Resident A. Julie Rasmussen M.A. Limited License Psychologist from Montcalm Care Network, wrote Resident A's Behavior Treatment Program, and she denied that the home staff used any restraints on Resident A. Glory Strey, Resident A's Case Manager from Montcalm Care Network denied that the staff of the home used restraints on Resident A. During this investigation I did not find any evidence that the staff of the facility used any restraints on Resident A. Therefore, there is not a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 08/21/2024, I conducted a telephone exit conference with Licensee Designee, Calvin Matheka. Calvin Matheka agreed with my findings.

IV. RECOMMENDATION

I recommend that the complaint be closed, and the license status remain the same.

08/20/2024

Arlene B. Smith Date
Licensing Consultant

Approved By:

08/22/2024

Mary E. Holton Date
Area Manager