GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 18, 2024

Wycliffe Opiyo
Mercy Homes Assisted Living LLC
2901 Asbury St.
Kalamazoo, MI 49048

RE: License #: AS390380979
Investigation #: 2024A0581032
Mercy Homes Assisted Living

Dear Wycliffe Opiyo:

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 (517) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390380979
Investigation #:	2024A0581032
Complaint Receipt Date:	08/01/2024
Investigation Initiation Date:	08/06/2024
Report Due Date:	09/30/2024
Licensee Name:	Mercy Homes Assisted Living LLC
Licensee Address:	2901 Asbury St. Kalamazoo, MI 49048
Licensee Telephone #:	(817) 781-6512
Administrator:	Wycliffe Opiyo
Licensee Designee:	Wycliffe Opiyo
Name of Facility:	Mercy Homes Assisted Living
Facility Address:	2901 Asbury St. Kalamazoo, MI 49048
Facility Telephone #:	(817) 781-6512
Original Issuance Date:	09/26/2016
License Status:	REGULAR
Effective Date:	03/24/2023
Expiration Date:	03/23/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATIONS

	Violation Established?
The children of live in direct care staff run around the facility and disturb the residents.	No
The children of live in direct care staff go into resident bedrooms and take resident belongings.	No
Additional Findings	Yes

III. METHODOLOGY

08/01/2024	Special Investigation Intake 2024A0581032
08/01/2024	Referral - Recipient Rights - Summit Point is investigating allegations.
08/05/2024	APS Referral - via email
08/05/2024	PSOR – no hits
08/05/2024	Contact - Document Sent - Email to Kent Rehmann, Summit Point ORR
08/06/2024	Special Investigation Initiated - On Site - Interview with LD, staff and residents.
08/07/2024	Contact - Document Received - Email from licensee designee
08/20/2024	Contact - Document Received Email from ORR, Kent Rehmann
09/11/2024	Contact – Telephone call made – Licensee designee, Wycliffe Opiyo.
09/11/2024	Contact – Document Sent – Email to Summit Pointe RRO
09/11/2024	Contact – Telephone call made – Attempted to contact direct care staff, Debora Rashidi. Unable to leave a voicemail.
09/13/2024	Contact – Telephone call made – Interview with Ms. Rashidi.
09/18/2024	Exit conference with the licensee designee, Wycliffe Opiyo.

ALLEGATION:

- **The children of live in direct care staff run around the facility and disturb the residents.**

- **The children of live in direct care staff go into resident bedrooms and take resident belongings.**

INVESTIGATION:

On 08/01/2024, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged two direct care staff were living in the facility, along with their small child and/or infant. The complaint alleged the two staff, and their children were residing in the facility's garage, but were using the facility's kitchen and bathrooms. The complaint further alleged the children were brought to the facility while the staff were working and allowing the children to "run around and disturb the residents". The complaint alleged this behavior was not safe for the children or residents as neither the children nor the residents were getting needed attention. Additionally, the complaint alleged the residents were not getting their privacy as the children were running around naked, in the residents' bedrooms, and taking their belongings.

On 08/01/2024, I reviewed the facility's electronic file to determine if any staff were identified as "live-in" staff, which upon review of the facility's file, I determined Debora Rashidi and Ikulu Wakabumba, were both identified as live-in staff.

On 08/05/2024, I conducted a search of Michigan's Public Sex Offender Registry to determine if any sex offenders were registered for the facility's address; however, there were none associated.

On 08/06/2024, I conducted an unannounced investigation in conjunction with Summit Pointe Recipient Rights Officer (RRO), Kent Rehmann. Mr. Rehmann and I interviewed direct care staff, Ikulu Wakabumba, who also identified himself as Oredi Antoine. Mr. Wakabumba stated he also goes by the first name of "Antoine". The facility's licensee designee, Wycliffe Opiyo, came to the facility during the investigation. Mr. Wakabumba stated he and his wife, who he identified as Debora Rashidi, lived in the facility's renovated garage area with their three children, Child A, Child B, and Child C, who are 5, 3, and 1 years old, respectively; however, he stated they moved out of the facility on 08/04/2024 because they found another placed to live. Mr. Wakabumba stated both he and Ms. Rashidi lived and worked as direct care staff within the facility. He stated the renovated garage area in which they were living had two bedrooms, a common area, and one bathroom with a shower. Mr. Wakabumba stated his children stayed primarily in the garage area rather than in the resident areas of the facility.

Mr. Wakabumba stated when he and Ms. Rashidi resided in the facility, they were not scheduled to work for the same shifts. He stated whoever was not scheduled to work would be in the garage area with the three children. He denied the children running around the facility, disturbing residents, or going into resident bedrooms and taking their belongings. He also denied any resident's personal care, protection or supervision was compromised because the children resided in the facility.

Mr. Opiyo's statement to me was consistent with Mr. Wakabumba's statement.

I interviewed all five residents residing in the facility as they were all present during the inspection. Residents A, B, C, D, and E all stated Mr. Wakabumba's and Ms. Rashida's three children resided in the facility for an unknown length of time; however, they all confirmed Mr. Wakabumba, Ms. Rashidi, and their three children moved out on 08/04/2024. They all stated the children would spend time in the resident areas of the facility and several times per week would come into their bedrooms when their doors were open. Residents A, B, C, D, and E all stated the children were not in their rooms for more than a few minutes and either staff would retrieve the children from their rooms, or the residents were able to escort the children out of their rooms. None of the residents stated the children took their belongings; however, Resident A stated both the youngest and oldest child rifled through his VHS tapes and handled his toothbrush. Resident B also stated the children knocked over his pop and snacks. All resident statements were consistent that the children were observed in the resident's bathroom and in the common areas; however, they were unable to identify any instances where they were unable to go into a common area, use the bathroom or kitchen because the children were present. The residents all indicated having the children in the facility was more of an annoyance rather than their personal care, supervision or protection not being addressed because of the children's presence.

On 08/07/2024, Mr. Opiyo forwarded me the facility's July 2024 and August 2024 staff schedule. According to these schedules, Mr. Wakabumba and Ms. Rashidi were not scheduled for the same shifts on the same days.

On 08/07/2024, I reviewed Resident A's, B's, C's, D's, and E's current *Assessment Plans for AFC Residents* (assessment plans). None of the assessment plans documented any of the residents required increased or enhanced supervision from direct care staff. Additionally, none of the assessment plans documented any of the residents required more assistance for personal care other than reminders. Finally, none of the assessment plans documented any of the residents were sexually or physically aggressive except Resident A's assessment plan documented he self-reports "anger problems".

I also reviewed Resident A's, B's, C's, D's, and E's respective Summit Pointe Individual Plans of Service (IPOS) for additional information relating to the protection, supervision and personal care of all five residents; however, the

information documented in these IPOS' was consistent with the information provided in the assessment plans.

On 09/11/2024, I emailed Summit Pointe Recipient Rights Office requesting any Incident Reports (IRs) submitted by the licensee in July 2024 or August 2024 for any of the facility's five residents. Recipient Rights Officer, Jaimie Fedor, documented in her email to me that ORR received no IR's from the licensee in July 2024 or August 2024 for any of the residents.

On 09/13/2024, I interviewed direct care staff, Debora Rashidi, via telephone. Her statement to me was consistent with Mr. Wakabumba's and Mr. Opiyio's statement. Ms. Rashidi stated she and Mr. Wakabumba resided in the renovated part of the facility for approximately two months prior to moving out in August. She stated she and Mr. Wakabumba did not work the same shifts at the facility. She stated she worked the second shift while Mr. Wakabumba worked the overnight shift. Ms. Rashidi stated second shift was 4 pm until 11 pm while the overnight shift was 11 pm until 8 am. Ms. Rashidid stated she would sleep at night while her children slept and Mr. Wakabumba would sleep upon finishing his overnight shift. She stated Mr. Wakabumba would watch the children and then put them to bed so when she finished her shift at 11 pm she could immediately go to sleep. Ms. Rashidi stated this work, childcare and sleeping arrangement did not present any issues for them, their children, or the residents.

Ms. Rashidi denied the allegations of the children spending time on the resident's side of the facility. She stated there had been incidences while not working when she would go to the resident side of the facility to make food and the children would follow her. She stated the children were able to follow her because she didn't close the door between the renovated garage and the resident's side all the way. She stated if this occurred, she would gather and usher the children back into the renovated garage area. She denied the children going into resident bedrooms, taking resident belongings and/or disturbing the residents. She also denied her, Mr. Wakabumba, or the children utilizing the resident's bathroom. Ms. Rashidi stated the renovated garage area had a bathroom for her, Mr. Wakabumba and the children to use. She also denied eating on the resident's side or feeding her children on the resident's side. She stated when she wasn't working, she would make food in the resident's kitchen, but would take the food to the renovated garage area and feed the children in the common area.

Ms. Rashidi stated she has worked as a caregiver since 2020 and understands not allowing children in resident occupied areas as children can be triggering to some residents.

Additionally, Ms. Rashidi stated the facility's residents always had privacy within the facility, especially in their bedrooms. She stated all the residents can shut and lock their doors to prevent anyone from coming in unannounced.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on my investigation, which included interviewing direct care staff and former live in staff, Ikulu Wakabumba and Debora Rashidi, licensee designee, Wycliffe Opiyo, Residents A, B, C, D, and E, a review of each resident's *Assessment Plan for AFC Residents*, each resident's respective Summit Pointe Individual Plans of Service, a search of Michigan's Public Sex Offender Registry, and email documentation from Summit Pointe Office of Recipient Rights, there is no supporting evidence the presence of the facility's former live in staff, Ikulu Wakabumba's and Debora Rashidi's, children compromised the quality of care, protection, and supervision provided to the residents as specified in their assessment plans. Despite multiple residents stating the children went into their bedrooms and handled their belongings, there was no indication the children were being left unsupervised in resident bedrooms for extended periods of time, residents were having to provide supervision, personal care or protection to the children, or any notable or significant incidences occurred which put the children or resident's safety at risk. Rather, the residents expressed more annoyance and frustration with the children entering their rooms during brief interactions; however, the residents indicated each occurrence was brief and the children were able to be escorted out of their rooms.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or

	the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based on my investigation, the children of the facility's former live in staff, Ikulu Wakabumba and Debora Rashidi, would occasionally walk into resident bedrooms; however, the incidences reported by residents indicated their doors were open. The residents stated they were able to shut and lock their doors when they needed privacy, which was consistent with staff's statements, as well.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

The licensee designee, Wycliffe Opiyo, renovated the facility's garage into two bedrooms, a common area, and a bathroom, which has a shower, sink and toilet.

Upon review of the facility's file, there was no supporting documentation confirming Mr. Opiyo renovated the garage and submitted this documentation to the Department. Additionally, the facility's electronic file neither included a modification request to change the layout of the facility's garage or the use of space, nor an addendum to the facility's original license documenting any changes made to the original license.

During the inspection, Mr. Opiyo stated the individual, Annette Ondingo, was also a live in staff, and was residing in the facility's basement for approximately one month. Mr. Opiyo stated he neither submitted a BCHS 100 clearance form to the Department for Ms. Ondingo nor notified the Department of Ms. Ondingo's live in staff status. On 08/07/2024, Mr. Opiyo forwarded Ms. Ondingo's eligibility letter from the Workforce Background Check, dated 07/10/2024, confirming she was able to work in the facility.

APPLICABLE RULE	
R 400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(5) An applicant or licensee shall give written notice to the department of any changes in information that was previously submitted in or with an application for a license, including any changes in the household and in personnel-related information, within 5 business days after the change occurs.
ANALYSIS:	The licensee designee, Wycliffe Opiyo, did not notify the Department of changes in the facility's layout, use of space, and household members (live-in staff) within 5 days, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/18/2024, I conducted the exit conference with the licensee designee, Wycliffe Opiyo, via telephone. Mr. Opiyo acknowledged the findings and stated he would submit the appropriate documentation, as required.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

Cathy Cushman

09/17/2024

Cathy Cushman Date
Licensing Consultant

Approved By:

Dawn Timm

09/17/2024

Dawn N. Timm Date
Area Manager