GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 8, 2025

Najib Moalin
Ivy Lane Residence LLC
4897 Grenadier Dr SW
Wyoming, MI 49509

RE: License #: AS410417901
Investigation #: 2025A0357006
Ivy Lane Residence

Dear Mr. Moalin:

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 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 (616) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, MSW 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

I. IDENTIFYING INFORMATION

License #:	AS410417901
Investigation #:	2025A0357006
Complaint Receipt Date:	11/06/2024
Investigation Initiation Date:	11/06/2024
Report Due Date:	01/05/2025
Licensee Name:	Ivy Lane Residence LLC
Licensee Address:	4897 Grenadier Dr SW, Wyoming, MI 49509
Licensee Telephone #:	(612) 232-5643
Administrator:	Najib Moalin
Licensee Designee:	Najib Moalin
Name of Facility:	Ivy Lane Residence
Facility Address:	4897 Grenadier Dr SW, Wyoming, MI 49509
Facility Telephone #:	(616) 980-2145
Original Issuance Date:	02/13/2024
License Status:	REGULAR
Effective Date:	08/13/2024
Expiration Date:	08/12/2026
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 11/05/2024, Resident A was physically aggressive and hitting staff. The Licensee called 911 and Resident A was taken to the hospital. The Licensee issued a 24-hour discharge notice, and the home refused to take him back.	Yes
Staff did not follow Resident A's behavior treatment plan on 11/05/2024 when he was physically aggressive.	No
Staff did not administer Resident A's PRN medication on 11/05/2024 when he was physically aggressive.	No

III. METHODOLOGY

11/06/2024	Special Investigation Intake 2025A0357006 Department of Health and Human Services, Kent County, Adult Protective Services denied the compliant.
11/06/2024	Contact - Telephone call made Discussed the compliant with Saicia Jones, QUDP, Supports Coordinator Supervisor for network 180.
11/06/2024	Contact - Telephone call received From Licensee Designee, Najib Moalin,
11/07/2024	Contact - Telephone call made to Licensee Designee Najib Moalin.
11/20/2024	Contact - Telephone call received Licensee Najib Moalin
12/30/2024	Contact - Telephone call made To Licensee Designee, Najib Moalin,
01/02/2025	Inspection Completed On-site announced inspection, reviewed Resident A's file and medications along with Health Care Appraisal, Assessment plan, IPOS and the addendum to the IPOS.
01/02/2025	Contact - Face to Face With Direct Care Staff, Harun Husstain and Najib Moalin.
01/02/2025	Contact - Face to Face Zoom meeting with Licensee, Najib Moalin

01/03/2025	Contact - Telephone call made With Najib, the Licensee.
01/03/2025	Contact - Telephone call made To Saicia Jones, Supports Coordinator Supervisor, at network 180.
01/03/2025	Contact - Document Received Ms. Sacia Jones sent me an email with two attachments including: "Appointment Form, Hospital follow-up, and Resident A's Spark's Behavioral Service LLC, Behavioral Treatment Plan.
01/03/2025	Contact - Document Received The Licensee, Najib Moalin, sent me an email with three attachments including: Summary of Resident Rights and Discharge and Complaints, Ivy Lane Residence Discharge Policy, and Sparks Behavioral Services LLC Behavioral Treatment Plan In-Service attendance sheet with staff signatures.
01/08/2024	Telephone exit conference with Licensee Designee, Najib Moalin.

ALLEGATION: On 11/05/2024, Resident A was physically aggressive and hitting staff. The Licensee called 911 and Resident A was taken to the hospital. The Licensee issued a 24-hour discharge notice, and the home refused to take him back.

INVESTIGATION: On Wednesday November 06,2024, LARA-BCHS-Complaints@michgan.gov, received an anonymous complaint regarding Ivy Lane Residence. The Department of Health and Human Services, Kent County, Adult Protective Services denied the complaint for investigation. It was reported that Resident A was physically aggressive & hitting staff on 11/5/24 and was sent to the hospital. Staff did not follow Resident A's behavior plan & did not administer his PRN medication. The home is now refusing to allow him to return and has issued a 24 hour eviction notice.

On 11/06-07/2024, I received a telephone call from the Licensee Najib Moalin. He explained that on 11/05/2024, Resident A had exhibited extreme agitated behaviors, which they could not control. Resident A did not accept redirection, nor could they get him to focus on anything else. They encouraged him to go to his bedroom or the back yard, watch television or listen to his preferred music, but Resident A would not respond. He said he offered him water and a snack and calmy asked hit to sit at the table. Resident A had hurt one of the staff by pulling out a handful of his hair and then he bit the staff on his head. He stated they had been able to keep the other resident safe during the altercation. He reported that they had followed Resident A's Behavior Treatment Plan, but nothing was working. He explained Resident A had

refused his 8:00 PM seizure medication and did not have any PRN (as needed medications). He reported he had called 911 and Resident A had attacked the police officer when they arrived. He said the ambulance staff had to restrain him. He stated that Resident A was taken to the emergency room at Butterworth hospital, and they had great difficulty in containing him because he was head butting and hitting the hospital staff. He also stated that Resident A is a large male who is very strong. At this point he had made the decision to issue a 24-hour notice of discharge. I requested his discharge notice, which he had not yet sent to me. He reported that the hospital was contacting him and asking that Resident A be allowed to return to the home.

I explained to Mr. Moalin that he did not issue the discharge notice until Resident A was in the hospital, so it was less than 24-hours before the discharge because the discharge notice was on 11/05/2024 and he discharged Resident A on 11/05/2024. In addition, I explained that he had to take Resident A back because this was his home, and he cannot leave a resident in the hospital once he is ready for discharge.

On 11/06/2024, I telephoned network 180 to discuss the compliant with Saicia Jones, QUDP, Supports Coordinator Supervisor for network 180. She explained there was a “medication barrier” because Resident A's guardian would not allow Resident A to have the physician's recommended medications. Ms. Jones reported that Resident A requires a lot of care and structure, and he can be very aggressive. She reported that they had been paying for one-on-one care but recently lowered their rate and this had caused issues with Mr. Moalin the Licensee Designee.

On 01/03/2025, I received the documentation that Mr. Moalin gave to the guardian and to network 180. The document was his printed discharge policy which contained the rule and listed the substantial risks, or an occurrence of self-destructive behavior, serious physical assault and destruction of property. Typed in this document was the following: *“On the date 06/14/2024, the Licensee and Resident Designated Representative have reviewed and understand the detailed discharge policy provided at admission. In addition, all have agreed with the terms to be discharged from the facility if any occurrences have taken place while the Resident is living in the AFC.”* This original document was signed and dated by Resident A’s guardian. There was a handwritten message on this document that read: *“This serves as a 24-hour notice. Please see justification attached. Discharge date 11/05/2024.”* Mr. Moalin had told me that the justification was the Incident Report dated 11/05/2024.

On 01/03/2025, I reviewed the Incident/Accident Report. The date of the incident was 11/5/203 at 7:51PM. Direct Care Staff, Harun Hussein was listed as the staff. The report read as follows: *“The situation began when (Resident A) had difficulty with personal hygiene after a bowel movement. Staff attempted to assist him with wiping, but (Resident A), eager to return to his room, became agitated, and the wiping was incomplete. Later staff noticed residual feces on (Resident A’s) hands and in his room. Staff suggested a shower, which (Resident A) agreed to, but he*

exited prematurely. When staff informed him that they were cleaning his room. (Resident A) became increasingly agitated, pushing staff out and slamming his door repeatedly. Attempts to de-escalate by offering water and a snack did not calm him as (Resident A) continued expressing frustration by slamming his door. As evening approached, staff attempted to administer 8:00 pm medication, but he resisted and attempted to strike staff, indicating he did not want the medication. For safety, staff maintained a distance, observing as (Resident A's) behavior escalated to aggressive door-slamming. Concerned for everyone's safety, staff contacted police and emergency medical services. Upon arrival officers and paramedics attempted to assess the situation. (Resident A's) behavior remained escalated, and he continued slamming doors. When responders approached him, (Resident A) became physically aggressive, hitting and headbutting them. To prevent further harm, officers and paramedics retrained (Resident A) to manage his behavior safety."

In the same report the following was typed in; *"Staff initially assisted (Resident A) with hygiene, though he was only partially wiped due to his eagerness to return to his room. When signs of increased agitation appeared, staff provided him space and attempted to calm him by offering water and snack. After these efforts proved ineffective (Resident A's) behavior escalated, staff prioritized safety by contacting law enforcement and medical responders. Staff allowed officer and paramedics to take over, stepping back as needed for safety."* This IR was signed my Harun Hussein and Najib Moalin, on 11/05/2024.

The discharge notice provided to Resident A's guardian and network 180 was issued less than 24 hours before discharge. It was issued the day of the discharge on 11/05/2024. Other than referencing the IR the reason for the proposed discharge including the specific nature of the substantial risk was not in the 24-hour notice and there were no alternatives to discharge that had been attempted by the licensee.

During this investigation Mr. Moalin had explained that there were disagreements with network 180 for the payment of 24-hour one-on-one care for Resident A. He reported that he was to be paid at a rate of staff one-on-one but at the end of the month network 180 had cut the rate without letting him know when he had already paid the staff for their services. He also reported that he had met with staff at network 180 while Resident A was in the hospital, and they have worked out their differences and therefore he took Resident A back in the home on 11/20/2024 even though he had discharged him on 11/05/2024.

On 01/08/2024, I conducted a telephone exit conference with Najib Moalin, the Licensee Designee. He disagreed but acknowledged there is a rule that has to be followed.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting**

	resident's ability to make living arrangements prohibited; provision of resident records at time of discharge. **(5) A licensee who proposes to discharge for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident:** **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency and adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.**
ANALYSIS:	On 11/05/2024, Resident A was physically aggressive and hitting staff. The Licensee called 911 and Resident A was taken to the hospital. That same day the Licensee issued a 24-hour discharge notice for Resident A and refused to allow him to return to the home even though the hospital was discharging him. The discharge notice provided to Resident A's guardian and network 180 did not provide at least 24-hour notice. It was issued the same day of the discharge on 11/05/2024. Other than the IR the reason for the proposed discharge including the specific nature of the substantial risk was not in the discharge notice and there were no alternatives to discharge that had been attempted by the licensee. During this investigation evidence was found that the Licensee did not follow the rule related to the 24-hour discharge having been issued the same day of the discharge (11/05/2024) and not the required 24-hours before discharge. The Licensee failed to attempt to find alternatives to discharge. Therefore, there is a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff did not follow Resident A's behavior treatment plan on 11/05/2024 when he was physically aggressive.

INVESTIGATION: The complaint read in part that Resident A has a history of aggression behaviors which are his baseline. Resident A has severe IDD (Intellectual and Developmental Disabilities) and Autism, and he is non-verbal, and requires prompting and partial physical assistance with most of his ADL's. He needs full physical assistance with bathing and toileting. He ambulates independently. He needs medication assistance and partial physical assistance with eating.

On 01/02/2024, I was in the home and requested Resident A's Health Care Appraisal, which was provided. His Diagnosis's included "Complex partial epilepsy, Autism, and non-verbal." The staff also provide me with Resident A's Biopsychosocial Assessment dated 03/07/2024, and signed by Chad Drooger, QIDP and Sacia Jones, BS, QIDP. This document indicated that Resident A is diagnosed with Severe I/DD, Autism Spectrum Disorder and other pervasive developmental disability. This document stated that this disability results in the substantial limitations in the areas of self-care, receptive and expressive communication, learning, self-direction, economic self-sufficiency and capability for independent living. Without the current supports Resident A would be at risk of serious injury emotionally, physically and medically. This document also reported on the various homes that Resident A has lived in and have not worked out. The report stated that no new homes were found, and he moved back into his parents' home until moving into the Ivy Home on 06/14/2024. I reviewed Resident A's Assessment Plan, which stated that Resident A does not control his aggressive behaviors and that Resident A has a Behavioral Support Plan to work on decreasing aggressive behaviors. I also reviewed Resident A's IPOS Addendum dated 06/12/2024. This document indicated that Resident A needed a Behavioral Treatment Plan.

On 01/02/2024, I was in the home. I conducted an interview with Direct Care Staff Harun Hussein and Najib Moalin, the Licensee Designee. Mr. Moalin reported that Ms. Hussein was working with Resident A. They both reported that Resident A had a "happy evening". They offered him choices on what he wanted to do. Mr. Hussein stated that he was with Resident A in the back yard when Resident A was closing his eyes and biting his fingernails, which means he is becoming agitated. So, he started to talk to Resident A and to try to get his focus elsewhere. He asked Resident A if he wanted to go for a walk, but Resident A did not want to, so he went to his bedroom. Later on in the evening around 7:00 PM Resident A went to the bathroom and had a bowel movement. Mr. Hussein stated that Resident A cannot clean himself afterwards, so he was cleaning him up. He was not finished when Resident A ran to his bedroom. He reported that Resident A had fecal material under his fingernails. Ms. Hussein offered assistance to Resident A but he slammed his bedroom door. He then offered Resident A a shower. He was helping him in the shower to remove the fecal material when Resident A became agitated and tried to hit Mr. Hussein. He went on to explain that Resident A urinated all over the bathroom floor and slammed the door. Mr. Hussein reportedly cleaned up the bathroom floor. He explained that they administer Resident A's seizure medication around 7:50 to 8:00 PM. He said Resident A came in the living room, went back to his bedroom and then ran into the kitchen. He seemed to be a little calmer, so Mr.

Hussein tried to administer Resident A's medication to him, but then with no provocation he lunged at Mr. Hussein, and he moved to the hallway, and Resident A continued to come at him. He said Resident A slammed his bedroom door., which he took as a refusal for his medication administration. Mr. Hussein reported that Resident A pulled out a "chunk" of his hair, knocked him to the floor, and bit him on his head. He said he slapped at his door, and he kept slamming doors. Mr. Moalin said at this point he interceded with Resident A because Resident A's behaviors had become extreme. He reported that he calmly asked Resident A if he would like his water and a snack and to sit down at the table, but Resident A refused. He reported that he tried to refocus him on something different like watching television or listening to his music. All of this time they were protecting Resident B who is blind and unable to speak. Therefore, I could not interview Resident B for the investigation. In additional Resident A cannot speak so I could not interview him for the investigation. Mr. Moalin stated further that Resident A was slamming doors over and over again. He stated that he and his staff kept their distance from Resident A and they all remained calm, and did not talk about Resident A or what he was doing. Mr. Moalin stated that after Resident A had hit and bit staff and he was unable to redirect him or to calm him down was when he made the decision to call 911. He reported that the police arrived and approached Resident A, and he attached them and was head-butting and hitting them. After the paramedics arrived, they and the police restrained Resident A to manage his behaviors. Mr. Moalin stated that Resident A is 6' 1" and weighs 280 pounds.

On 01/03/2024, I received and reviewed Resident A's Behavior Treatment Plan (BTP) sent to me from Ms. Sacia Jones the supervisor of Supports Coordinator at network 180. She explained that the BTP was originally designed for Resident A living with his parents and siblings at their home. Then it was adapted to work in the AFC home that he was moving into. She confirmed that Resident A has many needs. She also explained that the BTP has Preventative Strategies, Proactive Strategies, Reactive Strategies, and Restrictive Strategies. It was developed by Sparks Behavioral Services LLC. Plan developed by Savannah Wirth, MA, QBHP and she signed the plan on 04/15/2024, and by Cora Santman MA, BCBA, LBA and she signed the plan on 04/17/2024.

The Complaint was anonymous so I could not interview or ask questions about the complaint but referenced the physical aggression of Resident A. The allegation is that staff did not follow the BTP and the behavior on the Incident/Accident Report was physical aggression. I will focus on physical aggression in the BTP although Resident A has many other target behaviors including: *"Inappropriate exposure, food stealing, fecal eating, fecal manipulation/inspecting, and inappropriate urination or bowel movement."*

The BTP listed for Resident A the: "Target Behaviors."

"*Behavior # 1 Physical Aggression is defined as the use of intentional physical force that can cause damage to others with or without the use of objects."*

Examples: (Resident A) forcefully pushes another individual. (Resident A) bites his roommate (Resident A does not have a roommate). *(Resident A) hits another person with an open hand. Non examples: (Resident A) accidentally runs into someone and knocks them over. (Resident A) gently guides someone out of his room. (Resident A) closes a door and it hits another individual. (Resident A) pits his mouth/teeth on another individuals head but when redirected stops. Reactive Strategies' Strategy # Responding to physical aggression. In the event that Resident A engages in physical aggression staff should: Refrain from reacting in a judgmental way, do not make frustrated noises. Do not make faces that show displeasure or indicate in any way that his behaviors are upsetting or getting your attention in any special way. Do not discuss that his behaviors are upsetting or getting your attention in any special way. Do not discuss what is happening with (Resident A) (i.e. Hey why are you hitting me? Stop that!) Instead staff should stay calm by using a quiet and neutral tone of voice, a non-threating physical stance and neutral nonemotional facial expression. (i.e. He should not be aware he is affecting you at all) Staff should put space between themselves and (Resident A) while ensuring that he is not a threat to himself. If staff "knows" what (Resident A) wants, attempt to prompt him to use his pictures exchange if possible and then reinforce this by immediately giving him what he wants. If (Resident A) continues to engage in physical aggression, attempt to redirect to a neutral response."*

In this BTP there was *"Identified Function, Physical aggression: Physical aggression hypothesized to be maintained by access to preferred items or activities and escape/avoidance. (Resident A) may engage in hitting or pushing if attempting to avoid a non-preferred activity or in order to gain access to a preferred item/activity. In the past (Resident A) has engaged in physical aggression if told "no" when attempting to take food from the kitchen that wasn't his. It is important to note that physical aggression has been shown to be likely to occur days leading up to a seizure and decrease after the seizure. Factors contributing are hypothesized to be heightened behaviors associated with stress/anxiety and discomfort."*

On 01/02/2024, during my interview with Direct Care Staff, Harun Hussein and the Licensee Designee, Najib Moalin they both stated that they were calm, and they did not talk about what was going on in front of Resident A. They did not make any faces or indicate in any way that they were upset. They both reported that they kept their distances to keep Resident A safe. They said it was not possible to use his picture exchange during this time because Resident A was not responding to any of their suggestions. They both reported that they did follow Resident A's BTP. Mr. Moalin expressed that he felt the safety of everyone involved was the most important decision, so he made the decision to call 911.

On 01/08/2024, I conducted a telephone exit conference with Najib Moalin, the Licensee Designee he agreed with my findings.

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:	It was alleged that Resident A has a behavior treatment plan, and staff did not follow that plan on 11/05/2024 when he was physically aggressive and hitting staff. Resident A's assessment plan stated Resident A has a Behavioral Support Plan to work on decreasing aggressive behaviors. Resident A's IPOS addendum recorded a need for a behavioral treatment plan. Resident A's Behavioral Treatment Plan indicated that the staff should refrain from reacting in a judgment way, not make frustrated noises or faces that show displeasure or indicate in any way his behavior is upsetting. In addition, staff are supposed to remain calm, use a quiet and neutral tone of voice, have a non-threatening stance, allow space between Resident A and not discuss his behaviors. Direct Care Staff, Hurun Hussein and the Licensee Designee, Najib Moalibn, both reported that they followed these directives on 11/05/2024, throughout the situation. Resident A and Resident B are non-verbal so they could not contribute to the investigation. During this investigation I did not find evidence that Mr. Hussein nor Mr. Moalin did not follow Resident A's Behavioral Treatment Plan. Therefore, there is not a violation to the rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff did not administer Resident A's PRN medication on 11/05/2024 when he was physically aggressive.

INVESTIGATION: On 11/07/2024, I conducted a telephone interview with the Licensee Designee, Najib Moalin. He reported that Resident A does not have any PRN medications because his guardian does not want Resident A to have any unnecessary medications.

On 01/02/2024, I made an announced inspection of the home. I reviewed Resident A's medication administration record, (MAR) from 11/2024, and he only received his prescribed seizure medications. There were no PRN medications on his MAR.

On 01/03/2024, I telephoned Saicia Jones, Supervisor of Supports Coordinators at network 180. She reported that Resident A has a **"**medication barrier**"** because his guardian does not allow Resident A to have medications. She also stated that physicians have recommended medications for Resident A, but his guardian will not let him have these medications and this includes PRN medications. She confirmed that at the time of the incident on 11/05/2024, Resident A did not have any prescribed PRN medications. Therefore, the staff could not have administered a PRN medication because he did not have any.

On 01/08/2025, I conducted a telephone exit conference with the Licensee Designee Najib Moalin and he agreed with my findings.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	It was alleged that on 11/05/2024, Resident A was physically aggressive, and he had a PRN medication which the staff did not administer. The Licensee Designee, Najib Moalin, stated that Resident A did not have any PRN medication to administer on 11/05/2024. On 01/03/2025, Saicia Jones, Supervisor of Supports Coordinators at network 180, reported that Resident A did not have any prescribed PRN medications on 11/05/2024. On 01/02/2024, I inspected Resident A's MAR for 11/2024 and there were no PRN medications recorded. During this investigation there was no evidence found that Resident A had PRN medication for staff to administer. Resident A did not have any PRN medications. Therefore, there is no violation to this rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend that Licensee provide an acceptable plan of correction, and the license remain the same.

Arlene B. Smith 01/08/2025

Arlene B. Smith Date
Licensing Consultant

Approved By:

01/08/2025

Jerry Hendrick Date
Area Manager