GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 14, 2025

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

RE: License #: AS390401226
Investigation #: 2025A1024008
RoseDiri Care Facility

Dear Rose Ogolla:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390401226
Investigation #:	2025A1024008
Complaint Receipt Date:	11/25/2024
Investigation Initiation Date:	11/27/2024
Report Due Date:	01/24/2025
Licensee Name:	Precious Care Assisted Living, LLC
Licensee Address:	720 W. Walnut Street Kalamazoo, MI 49007
Licensee Telephone #:	(269) 414-8013
Administrator:	Rose Ogolla
Licensee Designee:	Rose Ogolla
Name of Facility:	RoseDiri Care Facility
Facility Address:	1223 Cobblestone Ln Portage, MI 49024
Facility Telephone #:	(269) 414-8013
Original Issuance Date:	12/16/2019
License Status:	REGULAR
Effective Date:	06/15/2024
Expiration Date:	06/14/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A has been harassed by a female resident who makes sexually inappropriate comments to him and has been seen with a black eye.	No
Resident A is isolated in his bedroom and handcuffed to his bed.	No

III. METHODOLOGY

11/25/2024	Special Investigation Intake 2025A1024008
11/27/2024	Special Investigation Initiated – Telephone call with licensee designee Rose Ogolla.
11/27/2024	APS Referral completed.
12/12/2024	Contact - Telephone call made with Guardian A1.
12/17/2024	Contact - Telephone call made with Resident A's mental health provider Haleigh Hardy.
12/23/2024	Inspection Completed On-site with direct care staff members Naza Reuben, Kenneth Waltham, Resident A, Resident B, and Resident C.
01/11/2025	Exit Conference with licensee designee Rose Ogolla.

ALLEGATION: Resident A has been harassed by a female resident who makes sexually inappropriate comments to him and has been seen with a black eye.

INVESTIGATION:

On 11/25/2024, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged Resident A has been harassed by a female resident who makes sexually inappropriate comments to him. Resident A has also been observed with a black eye.

On 11/27/24, I conducted an interview with administrator and licensee designee Rose Ogolla who stated that she has not seen or heard of any complaints regarding Resident A being sexually harassed by a female resident nor has she seen Resident A with any bruises. Rose Ogolla stated the female resident in the home is an elderly woman with dementia who is nonverbal and does not like to be around the other residents. Rose Ogolla stated she has had other complaints of this nature in the past from Resident A's previous guardian who had their guardianship revoked due to neglect and Rose Ogolla

believes this complaint is in retaliation because of the court action. Rose Ogolla stated there is a lot of family issues regarding guardianship that she does not want to take part of however the previous guardian continues to target Resident A's adult foster care home and make false complaints. Rose Ogolla stated Resident A's case manager visits the AFC home regularly and is also aware that this family dynamic has been counterproductive to Resident A. Rose Ogolla stated there has been no other issues involving Resident A and he is safe at the facility.

On 12/17/2024, I conducted an interview with Relative A1 who stated that she recently was appointed guardianship for Resident A, and she has not seen any bruises on Resident A however she lives out of state and does not see Resident A often. Relative A1 also stated she has not heard any complaints regarding Resident A being sexually harassed by any residents.

On 12/17/2024, I conducted an interview with Resident A's mental health provider Haleigh Hardy who stated she visits Resident A often at the facility and has not seen any bruises on him nor has she seen or heard of Resident A being sexually harassed by any residents. Haleigh Hardy stated there has been a lot of family issues with court involvement which includes a relative being recently removed as Resident A's guardian. Haliegh Hardy stated this relative also has a history of making complaints against the facility that have not been substantiated. Haleigh Hardy stated she believes direct care staff members are adequately trained and appropriately tends to Resident A's needs.

On 12/23/2024, I conducted an onsite investigation at the facility with direct care staff members Naza Reuben, Kenneth Waltham, Resident A, Resident B, and Resident C. Naza Reuben and Kenneth Waltham both stated they have not seen any bruises on Resident A, nor have they seen or heard of any complaints regarding Resident A being sexually harassed or mistreated by anyone. Naza Reuben and Kenneth Waltham also both stated Resident B is the only female resident in the facility and she is nonverbal and sits to herself often staring at the walls.

I observed Resident A sitting at the dining room table who was not able to be interviewed due to his cognitive ability. I also observed Resident B sitting in the living room who was not able to be interviewed due to her cognitive ability.

I conducted an interview with Resident C who stated that he is roommates with Resident A and has not seen any bruises on him nor has he heard, or seen Resident B make any sexually inappropriate comments towards Resident A. Resident C further stated both Resident A and Resident B are nonverbal and "they stick to themselves" without bothering anyone.

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 which included interviews with direct care staff members Naza Reuben, Kenneth Waltham, administrator/licensee designee Rose Ogolla, Relative A1, Resident C and Resident A's mental health provider Haleigh Hardy, there is no evidence Resident A has been sexually harassed by a female resident or that Resident A had a black eye. Naza Reuben, Kenneth Waltham and Rose Ogolla all stated they have not seen Resident A with any bruises, nor have they seen or heard of any complaints involving Resident A being sexually harassed by Resident B who is the only female resident in the facility. Resident C, who is Resident A's roommate, also stated he has not seen any bruises on him, nor has he seen or heard of Resident A being sexually harassed by any residents. Haleigh Hardy stated she visits Resident A often and has not seen any bruises on Resident A, nor has she seen or heard of Resident A being sexually harassed by any residents. Therefore, Resident A has been provided protection and safety.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A is isolated in his bedroom and handcuffed to his bed.

INVESTIGATION:

This complaint also alleged Resident A is isolated in his bedroom and handcuffed to his bed.

On 11/27/24, I conducted an interview with administrator and licensee designee Rose Ogolla who stated that she has not seen or heard any complaints of Resident A being isolated in his bedroom and handcuffed to his bed. Rose Ogolla stated Resident A is nonverbal and spends most of his time in the common areas of the facility. Rose Ogolla stated Resident A also has a roommate and the roommate have never reported to her that he has seen Resident A handcuffed to his bed. Rose Ogolla stated she believes this is another false complaint made by his previous guardian who has a history of making false complaints against the facility.

On 12/17/2024, I conducted an interview with Relative A1 who stated that she has not seen or heard of any complaints regarding Resident A being isolated in his bedroom and handcuffed to his bed. Relative A1 stated she talks to Resident A's mental health provider regarding his progress and there has been no mention of this to her.

On 12/17/2024, I conducted an interview with Resident A's mental health provider Haleigh Hardy who stated that she visits Resident A regularly and she has always seen

Resident A have freedom of movement while in the facility and has not received any complaints regarding Resident A being isolated in his bedroom and handcuffed to his bed. Haleigh Hardy stated she has no concerns about the care provided at this AFC facility and has no reason to believe that he is isolated in his bedroom.

On 12/23/2024, I conducted an onsite investigation at the facility with direct care staff members Naza Reuben and Kenneth Waltham who both stated that they have no knowledge of Resident A ever being isolated in his bedroom and handcuffed to bed. Naza Reuben and Kenneth Waltham also both stated that Resident A tends to stay out in the common areas.

Resident C stated he is Resident A's roommate and has never seen Resident A isolated in his bedroom and handcuffed to his bed. Resident C stated he hasn't seen any issues involving Resident A.

I observed Resident A without any restrictions sitting in the dining room. I also observed no handcuffs or devices to indicate that Resident A is isolated and restrained to his bed.

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: **(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:	Based on my investigation which included interviews with direct care staff members Naza Reuben, Kenneth Waltham, administrator/licensee designee Rose Ogolla, Relative A1, Resident A, Resident C and Resident A's mental health provider Haleigh Hardy there is no evidence Resident A is isolated in his bedroom and handcuffed to his bed. Naza Reuben, Kenneth Waltham, and Rose Ogolla all stated that they have no knowledge of Resident A being isolated to his bedroom and handcuffed to his bed. They also stated Resident A spends most of his time in the common areas of the facility. Haleigh Hardy stated she visits Resident A regularly and she has always seen Resident A have freedom of movement while in the facility and has no reason to believe that Resident A is isolated in his bedroom and handcuffed to his bed. Resident C, who is Resident A's roommate, also stated he has never seen Resident A isolated to his bedroom and handcuffed to his bed. Resident A's freedom of movement has not been restrained or restricted.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 1/11/2025, I conducted an exit conference with licensee designee Rose Ogolla. I informed Rose Ogolla of my findings and allowed her an opportunity to ask questions or make comments.

IV. RECOMMENDATION

I recommend the current license status remain unchanged.

Ondrea Johnson
Licensing Consultant

1/11/2025
Date

Approved By:

01/14/2025

Dawn N. Timm
Area Manager

Date