



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 11, 2025

Rashalle Austin
Unity Group III LLC
440 S. Clay St
Coldwater, MI 49036

RE: License #: AS120416424
Investigation #: 2025A1032017
Unity Group III LLC

Dear Rashalle Austin:

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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

A handwritten signature in dark ink, appearing to read "Dwight Forde".

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS120416424
Investigation #:	2025A1032017
Complaint Receipt Date:	02/10/2025
Investigation Initiation Date:	02/11/2025
Report Due Date:	04/11/2025
Licensee Name:	Unity Group III LLC
Licensee Address:	75 N Michigan Ave, Coldwater, MI 49036
Licensee Telephone #:	(517) 617-9591
Administrator:	Rashalle Austin
Licensee Designee:	Rashalle Austin
Name of Facility:	Unity Group III LLC
Facility Address:	75 N Michigan Ave, Coldwater, MI 49036
Facility Telephone #:	(517) 617-9591
Original Issuance Date:	09/14/2023
License Status:	REGULAR
Effective Date:	03/14/2024
Expiration Date:	03/13/2026
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The facility allowed Resident B to assault Resident A.	No
The facility threatened to withhold Resident A's visits to a relative.	No
Additional Findings	No

III. METHODOLOGY

ALLEGATION:

The facility allowed Resident B to assault Resident A.

INVESTIGATION:

On 2/11/25, I made contact with Adult Services Specialist Richard Jacoby, who advised that there was inaccurate information regarding the background of the residents, who were purported to have lived together recently. He advised that statements from both residents denied any inappropriate touching.

On 3/4/25, I interviewed home manager Katherine Walker in the facility. Ms. Walker expressed an awareness of an argument between Resident A and Resident B during a community walk. She denied ever seeing Resident B strike Resident A. Ms. Walker stated that Resident A and Resident B will often be very friendly and cordial, but also argue, whereupon staff will redirect them. She stated that these arguments are verbal, not physical.

I attempted to interview Resident B, but he was sleeping, and did respond to requests to wake up.

I interviewed Resident C in the facility. Resident C denied witnessing any physical altercation between Resident A and Resident B. Resident C stated that staff usually redirect residents when they argue, and that any discord between them .

On 3/7/25, I interviewed Guardian A1 by telephone. Guardian A1 stated that she had recently met Resident A for a quarterly visit and he appeared healthy. She denied having any concerns about Resident A in the facility. Guardian A1 expressed the opinion that Residents A and B are like brothers who sometimes argue.

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.
ANALYSIS:	Based on my interview with the home manager, Resident C and other agency personnel, there is insufficient evidence to establish a violation. Information that was obtained suggests that there was no physical contact between Residents A and B.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The facility threatened to withhold Resident A's visits to a relative.

INVESTIGATION:

On 2/11/25, Adult Services Specialist Richard Jacoby reported that the allegation that staff had threatened to withhold visits to his mother was unfounded.

On 3/4/25, home manager Katherine Walker stated that Resident A was not at the facility but was visiting his mother. These visits typically occur on Tuesdays and Thursdays. Ms. Walker labelled as categorically false, the allegation that Resident A was coerced into not reporting abuse by having his visits withheld by the facility.

On 3/7/25, Guardian A1 denied receiving any reports from Resident A that he could not see his mother, and those visits occur on Tuesdays and Thursdays.

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: (f) Subject a resident to any of the following: (iv) Threats.
ANALYSIS:	While I was unable to interview Resident A during my onsite inspection, the fact that he was on a visit with his mother, as well as collateral contacts from other professionals not associated with the home denying reprisals, lend credence to the conclusion that the facility made no retaliatory threats to Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 3/11/25, I attempted to conduct an exit conference with licensee designee Rachelle Austin. I left a message regarding my findings, allowing Ms. Austin to respond if there were any concerns.

IV. RECOMMENDATION

I recommend no change to the status of this license.

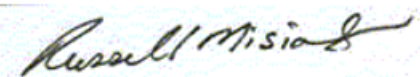


3/11/25

Dwight Forde
Licensing Consultant

Date

Approved By:



3/12/25

Russell B. Misiak
Area Manager

Date