GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 1, 2025

Hope Lovell
LoveJoy Special Needs Center Corporation
17101 Dolores St
Livonia, MI 48152

RE: License #: AS330297845
Investigation #: 2025A1033024
Michigan Ave. Residential Care

Dear Ms. Lovell:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the quality-of-care violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Jana Lipps

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330297845
Investigation #:	2025A1033024
Complaint Receipt Date:	03/28/2025
Investigation Initiation Date:	03/28/2025
Report Due Date:	05/27/2025
Licensee Name:	LoveJoy Special Needs Center Corporation
Licensee Address:	17101 Dolores St Livonia, MI 48152
Licensee Telephone #:	(517) 574-4693
Administrator:	Hope Lovell, Designee
Licensee Designee:	Hope Lovell, Designee
Name of Facility:	Michigan Ave. Residential Care
Facility Address:	1204 W. Michigan Ave. Lansing, MI 48915
Facility Telephone #:	(517) 367-8172
Original Issuance Date:	12/11/2009
License Status:	REGULAR
Effective Date:	02/23/2024
Expiration Date:	02/22/2026
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was physically assaulted at the facility because the direct care staff were not providing adequate supervision, protection, and safety for the current residents.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/28/2025	Special Investigation Intake 2025A1033024
03/28/2025	APS Referral- Assigned to adult services worker, Robert Joyner.
03/28/2025	Special Investigation Initiated - Telephone Interview conducted via telephone with Adult Protective Services, adult services worker, Robert Joyner.
03/31/2025	Inspection Completed On-site Interviews conducted with direct care staff, Jolie Porubsky, Christina Worthington, & Khai Baker. Review of Resident A & Resident B resident records initiated. Review of staff schedule and Resident Register initiated.
03/31/2025	Contact - Document Sent Email correspondence sent to licensee designee, Hope Lovell, requesting additional documentation.
04/02/2025	Contact - Telephone call made Telephone interview with Lansing Police Department, Detective Jacki Lindeman.
04/02/2025	Contact - Telephone call made Attempt to interview Lansing Police Department, social worker, Melissa Misner. Left voicemail message, awaiting response.
04/02/2025	Contact - Telephone call received Interview conducted with LPD social worker, Melissa Misner.
04/02/2025	Contact - Telephone call made Attempt to interview U of M Sparrow Forensic Nurse Examiner, Aimee Fitzpatrick. Voicemail message left, awaiting response.

04/02/2025	Contact - Document Sent FOIA request submitted to the Lansing Police Department for police report #2551902807 and police report #2551902768. Awaiting response.
04/02/2025	Contact - Telephone call made Interview conducted with direct care staff, Arica Williams, via telephone.
04/02/2025	Contact - Telephone call made Attempt to interview direct care staff, Breshay Wilder. Voicemail message left, awaiting response.
04/02/2025	Contact - Telephone call made Attempt to interview direct care staff, Keyonna Stewart. Voicemail message left, awaiting response.
04/02/2025	Contact - Telephone call received Interview conducted with direct care staff, Breshay Wilder, via telephone.
04/04/2025	Contact - Telephone call made Interview conducted with licensee designee, Hope Lovell, via telephone.
04/04/2025	Contact - Telephone call made Attempt to interview direct care staff, Keyonna Stewart, via telephone.
04/07/2025	Contact - Telephone call received Interview conducted with direct care staff, Keyonna Stewart, via telephone.
04/09/2025	Contact - Telephone call received Interview conducted with Aimee Fitzpatrick, U of M Sparrow, Sexual Assault Nurse Examiner.
04/09/2025	Contact - Telephone call made Interview conducted with Guardian A1, via telephone.
04/09/2025	Contact - Telephone call made Interview conducted with Community Mental Health, Case Manager, Rebecca Shebester.
04/09/2025	Contact - Telephone call made

	Attempt to interview Guardian B1. Voicemail message left and awaiting response.
04/09/2025	Contact - Telephone call made Interview conducted with direct care staff, Michelle Young, via telephone.
04/09/2025	Contact - Telephone call made Interview conducted with direct care staff, Chris Patino, via telephone.
04/09/2025	Contact - Telephone call made Interview conducted with Guardian B1, via telephone.
04/09/2025	Contact – Document Received Documentation received from Ms. Shebester, via email.
04/10/2025	Contact – Document Received Email correspondence received from Ms. Brown with FirstLight Home Care.
04/10/2025	Contact – Telephone call received Interview conducted with Operations Director, Kathleen Delmerico, via telephone.
04/10/2025	Contact – Telephone call made Interview conducted with Marci Brown, from FirstLight Home Care, via telephone.
04/11/2025	Contact – Document Received Email correspondence received from Ms. Shebester.
04/14/2025	Contact – Telephone call received Interview conducted with Community Mental Health Central Michigan, Recipient Rights Office, Angela Wend.
04/14/2025	Contact – Document Received Email correspondence received from Ms. Delmerico.
04/15/2025	Contact – Telephone call made Interview conducted with Ms. Delmerico, via telephone.
04/15/2025	Contact – Document Received Email correspondence received from Ms. Brown and Ms. Moerland with FirstLight Home Care.

04/16/2025	Contact – Document Received Fax transmittals received from Ms. Delmerico.
04/17/2025	Contact – Document Received Email correspondence with Ms. Moerland with FirstLight Home Care.
04/21/2025	Contact – Telephone call made Interview conducted with Ms. Worthington, via telephone.
04/22/2025	Contact – Face to Face Interview with Ms. Delmerico, at the facility, and review of direct care staff trainings.
05/01/2025	Exit Conference Conducted with licensee designee, Hope Lovell, via telephone.

ALLEGATION: Resident A was physically assaulted at the facility because the direct care staff were not providing adequate supervision, protection, and safety for the current residents.

INVESTIGATION:

On 3/28/25 I received an online complaint regarding the Michigan Avenue Residential Care, adult foster care facility (the facility). The complaint alleged that Resident A was observed to have 8-10 “savage” bite marks and bruises covering her arms, legs, upper thighs, buttocks, and back. The complaint alleged direct care staff at the facility observed initial injuries on 3/25/25 and responded by increasing direct care staffing from 11pm 3/25/25, through 7am 3/26/25. It was reported that despite the increase in direct care staffing, additional bites and bruises were found on Resident A on 3/26/25. This complaint further alleged that Resident B admitted to causing the injuries to Resident A.

On 3/28/25 I interviewed Adult Protective Services (APS), adult services worker, Robert Joyner, via telephone. He reported that the initial APS referral was denied for assignment and then a second referral was called in on 3/26/25 reporting additional findings of abuse toward Resident A. Mr. Joyner reported that Resident A was taken to the hospital for a Sexual Assault Nurse Examiner (SANE) exam, as it was believed she may have been sexually assaulted in addition to the physical injuries observed. Mr. Joyner reported that the SANE exam was completed at U of M Health Sparrow Hospital on 3/26/25. Mr. Joyner reported that he has spoken with direct care staff, Michelle Young, and direct care staff/Director of Operations, Kathleen Delmerico, regarding the allegations. Mr. Joyner reported that both Ms. Young and Ms. Delmerico indicated that Resident A had not expressed to them that she had been assaulted and that they found these injuries while providing for her daily care. Mr. Joyner reported that he was

informed by Ms. Delmerico that Resident B was issued a 24-Hour Emergency Discharge Notice and that the staffing level had been increased at the facility to two direct care staff at all times. Mr. Joyner reported he was also informed by Ms. Delmerico that the residents were placed on 15-minute safety checks by direct care staff members.

On 3/31/25 I conducted an unannounced, on-site investigation at the facility. At the time of my arrival at the facility, direct care staff, Breshay Wilder, Jolie Porubsky, & Christina Worthington (Human Resources Assistant) were present at the facility. Resident A was resting in her bedroom, with the door locked. Direct care staff were conducting 15-minute checks on Resident A throughout my time at the facility. Resident B was at his school program during this investigation. Direct care staff, Khai Baker, arrived for his scheduled shift during this investigation.

During the on-site investigation on 3/31/25 I interviewed Ms. Porubsky. She reported that she has worked “on and off” at the facility for about a year. She reported that the shifts she works vary, and she does provide direct care to residents. Ms. Porubsky reported that prior to Resident A’s injuries being identified by direct care staff, Resident B’s supervision requirements were line-of-sight, unless he was in the bathroom or his bedroom. Ms. Porubsky reported that Resident A’s supervision requirements were that she required one-to-one supervision in the community, but she did not know what her requirements were inside the facility. Ms. Porubsky reported that the current supervision for Resident A, since the injuries were identified, is that she requires line-of-sight supervision, unless she is in her bedroom, and 15-minute checks to be completed. Ms. Porubsky reported that she was called in to assist as a direct care staff at the facility due to staffing challenges on 3/27/25. She reported that prior to this date, she had not worked a shift at the facility in one to two months. Ms. Porubsky reported that on 3/27/25 she observed Resident A to have bite marks on her forearms. She reported that Resident A did not say how these bite marks happened. Ms. Porubsky reported that Resident B attends a school program Monday through Friday from about 7:30am to 3:30pm. She reported that she continues to conduct the 15-minute checks on Resident A while Resident B is at school, just to keep it routine. Ms. Porubsky reported that she has never observed Resident B to be physically aggressive with another individual and that this was a new behavior. Ms. Porubsky reported there was no eyewitness to the injuries occurring and that Resident B admitted causing Resident A’s injuries to other direct care staff members.

During the on-site investigation on 3/31/25 I interviewed Ms. Worthington regarding the allegation. Ms. Worthington reported that she has been called to the facility to assist with staffing as they needed additional direct care staff to provide supervision for the two residents. Ms. Worthington reported that she works in the capacity of a human resources assistant for the company, but does provide direct care on occasion, when needed. Ms. Worthington reported that on 3/27/25, Ms. Delmerico asked her to come and help with a staffing shortage. Ms. Worthington reported that when she arrived for her shift on 3/27/25 she observed Resident A having bruises on her lower back and both forearms. She reported that the bruising looked like bite marks. Ms. Worthington reported that the current supervision for Resident A is for direct care staff to conduct 15-

minute checks on her while she is upstairs in her bedroom. She reported the supervision for Resident B is that direct care staff will always have eyes on him while he is awake. Ms. Worthington reported Resident B attends school Monday through Friday from 7:30am until 3:30pm. She reported that the facility is currently staffed with two direct care staff members on all shifts. Ms. Worthington reported that she has never observed Resident B to exhibit these types of physically aggressive behaviors prior to this event and she has never heard of him having these types of behaviors. Ms. Worthington reported that she does not know what transpired when the injuries were identified on Resident A as she was not working at the facility on 3/25/25 or 3/26/25. Ms. Worthington reported that Ms. Young was working on the date the injuries were observed. Ms. Worthington reported that Resident B has not admitted guilt of these allegations to her and does not speak about Resident A's injuries.

During the on-site investigation on 3/31/25 I interviewed Mr. Baker regarding the allegations. Mr. Baker reported that he works 2nd, and 3rd shifts at the facility. He noted that 2nd shift is from 3pm – 11pm and 3rd shift is from 11pm – 7am. Mr. Baker reported that prior to Resident A's injuries being identified by direct care staff, the supervision requirements for Resident A had been that direct care staff provide a one-to-one supervision in the facility except for in the bedroom and bathroom. Mr. Baker reported that Resident B did not require one-to-one supervision in the facility prior to the incident. Mr. Baker reported that when he arrives for third shift, usually the residents are sleeping in their bedrooms. Mr. Baker reported that he worked on 3/23/25 and 3/24/25 and he did not hear any noise or commotion during his shift. He reported that he did go upstairs to do rounds during his shift, as both resident bedrooms are located upstairs, and he did not hear or see anything concerning. Mr. Baker reported Resident A had come down a couple of times during the night on 3/24/25. He reported she did not appear distressed and that this is normal behavior for her to wake up during the night, come downstairs, and then go back to bed. Mr. Baker reported that since the injuries were observed on Resident A's person, they now provide 15-minute checks on Resident A and direct care staff keep Resident A's door locked when she is in her bedroom. He reported that this lock is a positive latching, non-locking against egress hardware, so Resident A can open her door easily, but Resident B cannot enter her bedroom. Mr. Baker reported direct care staff are now scheduled for two people per shift whereas prior to the incident there had only been one direct care staff scheduled for third shift. Mr. Baker reported that Resident B has not stated to him that he caused the injuries to Resident A. Mr. Baker reported that he heard that Resident B admitted causing these injuries to Ms. Delmerico. Mr. Baker did not observe this admission from Resident B. Mr. Baker reported that he has not seen the full extent of Resident A's injuries as she does not require much personal care during 3rd shift. He reported that he has seen bruising on her backside, near her tailbone.

On 4/2/25 I interviewed the Lansing Police Department, Detective Jacki Lindeman, via telephone. Detective Lindeman reported that she had interviewed the provider, Aimee Fitzpatrick, from U of M Health Sparrow Hospital who conducted the SANE assessment on Resident A on 3/26/25. Detective Lindeman reported that Ms. Fitzpatrick made a statement that the injuries she observed on Resident A were some of the worst bite

marks she had seen on a person, and she does not know how Resident A did not scream out in pain. Detective Lindeman reported that the allegations of assault toward Resident A were reported to the Lansing Police Department on 3/25/25 and an officer arrived on scene to investigate the report. Detective Lindeman reported that the officer questioned Resident B on this date and that Resident B had stated to the officer that Resident A had been attacking a direct care staff and Resident B stepped in the way and hit Resident A to stop her. Detective Lindeman reported that another report was made to the Lansing Police Department on 3/26/25 reporting more bruising found on Resident A. She reported that Officer Carlson conducted that police visit and noted that Resident B stated that he punched Resident A two times. Detective Lindeman reported that at this time she is having difficulty obtaining interviews with direct care staff members as her telephone inquiries have not been returned. Detective Lindeman reported that Guardian B1 stated she was uncertain as to whether she could give consent for Detective Lindeman to interview Resident B at this time.

On 4/2/25 I interviewed the Lansing Police Department, social worker, Melissa Misner, via telephone. Ms. Misner reported that she has not met either Resident A or Resident B at this time. She reported that her colleague, Jason Morrisseau, went to the facility on 3/26/25 with Officer Carlson. Ms. Misner reported that she has been assisting Detective Lindeman on this case and that direct care staff have not been forthcoming with providing reliable information regarding the injuries Resident A has sustained. Ms. Misner reported that this is the second incident in the month of March 2025 where the Lansing Police Department has been called to this facility. She reported that she has serious concerns about the abilities of the direct care staff to provide adequate supervision and safety for the current residents. Ms. Misner reported direct care staff verbalized to Mr. Joyner that Resident B would be moved from the facility, and she knows as of 4/2/25, Resident B is still residing at the facility with Resident A.

On 4/2/25 I interviewed direct care staff, Arica Williams, via telephone. Ms. Williams reported that she worked 2nd shift (3pm to 11pm) on 3/25/25 at the facility. She reported that the 1st shift direct care staff had already observed the injuries to Resident A and had determined that the injuries must have been sustained between the hours of 11pm and 7am the previous evening/early morning hours. Ms. Williams reported that when she arrived for her shift at 3pm, direct care staff, Keyonna Stewart, Breshay Wilder, Michelle Young, and Operations Director, Kathleen Delmerico, were all present at the facility. Ms. Williams reported Ms. Stewart stated that Resident B admitted to causing the injuries observed on Resident A's body. Ms. Williams reported that the injuries were observed as bite marks, "mostly". She reported that some of the injuries looked like bruises from being punched. Ms. Williams reported that these bruises were found on Resident A's arms, legs, between her thighs. She reported that many of these injuries appeared to her to be bite marks. She further reported that Resident A's shoulders looked as though they had been punched. Ms. Williams reported that she accompanied Resident A to the hospital where she had the SANE exam performed. Ms. Williams reported that injuries were found on Resident A on two separate occasions, within a day of each other. She reported that the second set of bruising was observed when Resident A was sent to the hospital for evaluation. Ms. Williams reported that she has

never seen Resident B exhibit this type of behavior prior to this occurrence. She reported that no one directly observed Resident B assaulting Resident A. She reported that she wonders if the recent staffing changes at the facility have caused Resident B more stress and this to be the reasoning for his alleged actions. Ms. Williams reported that Resident A is non-verbal. She reported that she has a high pain tolerance and may not have yelled out during the assault. Ms. Williams reported Resident A is not sexually active to her knowledge. She reported that when Resident A is upset she will physically act out and attempt to hit staff or self-injure. Ms. Williams reported Resident A was experiencing these behaviors the day the injuries were found on her body. Ms. Williams reported that prior to Resident A's injuries being observed the supervision requirements for Resident A were 15–20-minute checks if she was awake and upstairs in her bedroom. She reported that neither Resident A nor Resident B required a line-of-sight supervision in the home, prior to the incident. Ms. Williams reported that now the requirements for supervision are to keep the two residents separated as much as possible and have line-of-sight on Resident A, as she is "basically a one to one now". She reported that there are now two direct care staff scheduled for the 3rd shift (11pm to 7am). Ms. Williams reported that she had heard there was a discussion about moving Resident B from the facility, but he is still at the facility on this date, and she does not know any further information about this plan.

On 4/2/25 I interviewed direct care staff, Breshay Wilder, via telephone. Ms. Wilder reported that she is relatively new to the facility as this is just her third or fourth week of employment at the facility. Ms. Wilder reported that she was working on the date that the Program Manager/direct care staff, Michelle Young, discovered the injuries to Resident A. Ms. Wilder reported that Resident A had been acting out this day and was hitting Ms. Wilder. She reported that Ms. Young stepped in to attempt to stop Resident A from this behavior and when she did, she noticed bruising on Resident A's arms. Ms. Wilder reported that bruises were observed on Resident A's legs the day prior. She could not recall the date of these occurrences. Ms. Wilder reported Ms. Stewart is the one who noticed the bruising the prior day. Ms. Wilder reported Ms. Delmerico came to the facility and did a skin assessment on Resident A in her bedroom. Ms. Wilder reported that she has not seen the extent of the injuries to Resident A. She reported that she rarely provides intimate personal care to Resident A as Ms. Stewart is the one who usually assists with Resident A's showers. Ms. Wilder reported that the week the injuries were discovered was not a typical week at the facility because Resident B was home on spring break. She reported that he usually attends school Monday through Friday from about 7:30am to 3:30pm. Ms. Wilder reported that she did not see any altercations between Resident A and Resident B the week of 3/23/25. She reported that she has never observed Resident A hit Resident B. Ms. Wilder reported that when the bruising was found on Resident A, that she turned to Resident B and stated to him, "Why would you do that to her?". She reported that Resident B stated, "I don't know." Ms. Wilder reported that prior to this incident she was not aware of any supervision requirement for Resident A to be a line-of-sight supervision in the facility. She reported that now Resident A is a line-of-sight supervision. Ms. Wilder reported that 15-minute checks are now being conducted when Resident A and Resident B are both in the facility at the same time. She reported that there are currently two direct care staff

scheduled per shift. Ms. Wilder reported that she has never observed aggressive behaviors between Resident A and Resident B prior to the injuries observed on Resident A's person. She reported that she did not observe Resident B harming Resident A. Ms. Wilder reported that she does not believe a direct care staff member assaulted Resident A, causing these injuries.

On 4/4/25 I interviewed licensee designee, Hope Lovell, regarding the allegations. Ms. Lovell reported that on either 3/26/25 or 3/27/25 she received a telephone call from Ms. Delmerico reporting the concerns about Resident A's injuries. Ms. Lovell reported that she was informed there were two separate incidents, and that Resident B admitted guilt for causing the injuries to Resident A. Ms. Lovell reported that she was told that the first incident, Resident A was found with a bite mark on her skin and the next day there was more biting observed and concerns about possible sexual intercourse. Ms. Lovell reported that Resident A was sent to the hospital for evaluation and the staffing levels at the facility were modified. She reported that prior to Resident A's injuries being discovered, the facility was staffed with two direct care staff members during the day and one direct care staff member on the overnight shift. She reported that this staffing has been modified to include two direct care staff members on all shifts. Ms. Lovell reported that there are currently only two residents residing at the facility. Ms. Lovell reported that she was on vacation when the allegations against Resident B were made. She reported she submitted an emergency discharge notice for Resident B due to the allegations, but "that fell through". She reported that the emergency discharge notice was given verbally, not in written form. Ms. Lovell reported that Resident B's CMH case manager completed a modified Individualized Plan of Service (IPOS) document which included for Resident B to receive one-to-one supervision and an additional direct care staff member during the overnight shift. Ms. Lovell reported that on 4/3/25 Guardian A1 requested that Resident A be moved from the facility. Ms. Lovell is not certain whether a new placement has been located for Resident A yet. Ms. Lovell reported that prior to the incident, the overnight staff (11pm to 7am) would complete bed checks every two to three hours on the two residents. She reported that Resident A required a line-of-sight supervision during waking hours. Ms. Lovell reported that she is not certain Resident A would have screamed or yelled out for help if she were physically assaulted. Ms. Lovell reported that Resident A has a high pain tolerance. She also reported that Resident A would masturbate at times and direct care staff would need to redirect this behavior. Ms. Lovell reported that she was told by direct care staff that Resident B confessed to causing the injuries to Resident A. Ms. Lovell did not have direct knowledge of this reported confession.

On 4/7/25 I interviewed direct care staff, Keyonna Stewart, regarding the allegations. Ms. Stewart reported that she has worked at the facility for about two years. She reported that she usually works first shift (7am to 3pm) at the facility. Ms. Stewart reported that Resident A does require assistance with her showers, but she only showers with direct care staff assistance twice per week. Ms. Stewart reported that Resident A will take "sensory showers" three to four times per day. Ms. Stewart reported that Resident A likes to feel the water flowing on her skin but does not use this time for hygiene purposes. She reported that Resident A can do her own sensory showers and

direct care staff do not need to assist her with cleansing during these showers. Ms. Stewart reported that she did not provide a shower for Resident A on the date the injuries were discovered. Ms. Stewart reported direct care staff observed the injuries and reported that they felt they must have happened during second shift (3pm to 11pm) the prior day. She reported that she thinks these injuries occurred during second shift as this is when Ms. Williams was working and Resident B stated he hit Resident A because Resident A was hitting Ms. Williams. Ms. Stewart reported the injuries were first discovered by Ms. Young and were located on Resident A's arms. I noted Ms. Stewart had difficulty recalling which dates the injuries were observed during this conversation. Ms. Stewart reported that Ms. Delmerico and Ms. Young completed a full body exam for Resident A and found bruising and bite marks on her arms, legs, back, inner thighs, and buttocks. She reported that "the managers" called the police and Resident A was sent to the hospital for further evaluation. Ms. Stewart reported she has no knowledge of how Resident A was injured. Ms. Stewart reported Resident A has behaviors where she self-harms, by hitting herself. Ms. Stewart reported she spoke with Resident B about the injuries to Resident A and he admitted to causing the injuries because he was upset with Resident A for hitting Ms. Williams and because his mom did not answer his telephone call that day. Ms. Stewart reported that she has never observed Resident B physically assault anyone at the facility. She reported that he has no prior history of biting or hitting. Ms. Stewart reported that prior to Resident A's injuries being identified, the supervision requirements for the two residents were, Resident A required line-of-sight supervision in the community, but neither required line-of-sight supervision in the facility. She reported that this supervision expectation has now changed to Resident A being a one-to-one in the facility, except in her bedroom. She reported that when Resident A is in her bedroom, the door is locked from the inside, with non-locking against egress hardware, so that the resident can let herself out, but Resident B cannot enter. She reported that the direct care staff are doing 15-minute checks on Resident A as well.

On 4/9/25 I interviewed U of M Health Sparrow, Forensic Nurse Examiner, Aimee Fitzpatrick, via telephone. Ms. Fitzpatrick reported that she completed a SANE exam on Resident A on 3/26/25. Ms. Fitzpatrick reported that she observed "savage bite marks" all over Resident A's body during this examination. She reported that there was also bruising on Resident A which was so extensive that it was too large to measure. She reported that the bruises ran into one another and overlapped. Ms. Fitzpatrick reported that she took 170 photographs as evidence during this examination. She reported that she observed at least 8 to 10 bite marks on Resident A covering her arms, legs, back, and more. She reported that these bite marks were so intense that you could fully visualize the upper and lower teeth of the perpetrator on Resident A's skin. Ms. Fitzpatrick reported that these are the worst bite marks she has ever seen in conducting SANE examinations and she cannot believe that Resident A would not have screamed out in pain. She reported, "I don't know how the neighbors didn't hear her scream?" Ms. Fitzpatrick reported that she was horrified by the condition of Resident A's body and noted, "Her whole body was a crime scene." She noted two "huge" black and blue marks on her calves that included the perpetrators full set of teeth. Ms. Fitzpatrick reported that Ms. Williams was present with Resident A during the examination. She

reported that Resident A did not appear to be in discomfort during the exam. She reported that Resident A would make noises but was non-verbal during the examination. Ms. Fitzpatrick reported that she swabbed the bite marks, her vulva, her anis, her vaginal wall, bite mark on her left and right shoulders, and the inside of her mouth for DNA evidence. She reported that she could not determine whether Resident A had been sexually assaulted via intercourse as Resident A is 26 years old and produces estrogen. She reported that women who produce estrogen have more pliable vaginal tissue and less than 5% of sexual assault cases involving intercourse can be determined through the SANE exam due to this factor. Ms. Fitzpatrick reported that the information she gathered during the SANE examination was sent to the crime lab and they process the results and deliver the results to law enforcement. She reported that these results could take up to three or four months before being issued. Ms. Fitzpatrick reported that she spoke with Ms. Delmerico who had informed her that they noticed the bite marks the day prior (3/25/25) and had increased their supervision at the facility. Ms. Fitzpatrick reported that Ms. Delmerico reported that additional bite marks and bruising were found the following day (3/26/25). Ms. Fitzpatrick reported that she could not comment on the staging of the bruises found on Resident A's body, as everyone clears bruises at a different rate and it's difficult to identify staging based on this factor. She reported that the bruises she observed were of various sizes, color, and shape.

On 4/9/25 I interviewed Guardian A1, via telephone. Guardian A1 reported that Resident A's guardianship had just been changed to her the week of 3/23/25. She reported that she has still not received the guardianship papers from the probate court but thinks the guardianship became effective sometime between 3/25/25 and 3/28/25. Guardian A1 reported that she has not met Resident A yet and has no knowledge of her history. She reported that she was asked to take on this resident as a ward and she has agreed to this assignment. Guardian A1 reported that there was confusion between herself, the previous guardian, and the direct care staff as to who to contact when the injuries were discovered. She reported direct care staff first reached out to the former guardian, Guardian A2, to update regarding the situation. She reported that on 3/28/25 she was notified by Community Mental Health (CMH) case manager, Rebecca Shebester, of the injuries found on Resident A. Guardian A1 reported that she did speak with Ms. Young, via telephone, who gave her an update on Resident A's status and the changes to resident supervision. She reported that Ms. Young advised that direct care staff were treating Resident A as a one-to-one supervision and were making sure her door was locked when she was in her bedroom. Guardian A1 reported that she has not received an incident report from the direct care staff or Ms. Lovell. She reported that she had not received any telephone communication from Ms. Lovell or Ms. Delmerico regarding the incident.

On 4/9/25 I interviewed CMH case manager, Rebecca Shebester, regarding the allegations. Ms. Shebester reported that she is currently the case manager for Resident A and Resident B. She reported she received a telephone call from Ms. Delmerico on 3/25/25 reporting direct care staff had found bruising on Resident A on 3/24/25. Ms. Shebester stated that Ms. Delmerico reported that Resident B confessed to hitting Resident A on 3/24/25. Ms. Shebester reported that her understanding is that the direct

care staff called Guardian A2 on 3/25/25 to report the injuries to Resident A. She reported that she was told by Ms. Delmerico that the direct care staff were implementing 15-minute safety checks for Resident A and that they had told Resident B not to enter Resident A's bedroom. Ms. Shebester reported that she received a telephone call from Ms. Delmerico on 3/26/25 reporting more bruising and bite marks being found on Resident A and that the direct care staff were going to be taking Resident A to the hospital. Ms. Shebester stated that it was reported to her that the bite marks were found on Resident A's, wrists, arms, breasts, shoulders, legs, and upper inner thighs. Ms. Shebester reported that she had requested approval for 15-minute safety checks for Resident A on 3/25/25 and that line-of-sight supervision was put in place for Resident B on 3/27/25. She reported that the line-of-sight supervision is in effect when Resident B is sleeping, but the staff must keep eyes on his bedroom door. They must be visualizing his bedroom door the entire time. Ms. Shebester reported that prior to this incident the expectation for supervision for these residents was that Resident A were to have one-on-one line-of-sight supervision 8 hours per day, while at the facility, with periodic monitoring in the bedroom every 60 minutes. Ms. Shebester reported that this supervision was put in place on 12/9/24. She reported that she has been Resident A's case manager since 9/5/23. She reported that she visits with Resident A at least once per month. Ms. Shebester reported that Resident A does exhibit self-injurious behaviors, and she is "pretty verbal" when she is experiencing these behaviors. She reported that Resident A will scream and yell out when she is engaging in self-harm. Ms. Shebester reported that she is not aware of Resident A having been diagnosed with any medical condition where she does not feel pain. Ms. Shebester reported that Resident A does have some extensive tooth decay, and this does not seem to bother her. She reported that when Resident A is upset, she tends to act out in an aggressive manner. Ms. Shebester reported that she did receive a prior incident report from the facility dated 8/17/24, which documented bruising found during her shower. Ms. Shebester reported that Resident A does not receive any visitors to the home and only leaves the home with direct care staff members. She reported that Resident A is always with a direct care staff member from the facility. Ms. Shebester reported that she has been Resident B's case manager for about 1.5 years. Ms. Shebester reported that supervision for Resident B, prior to these allegations, was just line-of-sight in the community. She reported Resident B has not displayed behaviors of hitting or biting in the past and these allegations are surprising to her. Ms. Shebester reported Resident B had a couple of recent incidents where he exposed himself to a neighbor and was acting "inappropriately" on the bus. She reported that it was not identified to her what "inappropriately" was referring to in this instance.

On 4/9/25 I interviewed direct care staff, Michelle Young, regarding the allegations. Ms. Young reported that she started as the Program Manager for the facility on 3/19/25 and has since been moved to another adult foster care facility, owned by the same licensee, LoveJoy Special Needs Center Corporation. Ms. Young reported the initial injuries to Resident A were noticed by direct care staff on 3/24/25. She reported that a direct care staff member had been adjusting Resident A's pants, visualized bruising on her back and followed the bruising down to a bite mark on Resident A's buttocks. Ms. Young reported that she informed Ms. Delmerico to contact recipient rights, APS, Guardian A1,

911, and Ms. Shebester. Ms. Young reported that two days later (3/26/25) Resident A was aggressively attacking direct care staff, Ms. Wilder, and Ms. Young had to step in between Resident A and Ms. Wilder to stop the assault. She reported that she put her forearm up to block Resident A's attack and that's when she noticed bite marks on Resident A's wrists. Ms. Young reported that she then rolled up Resident A's sleeves and found more injuries, which included numerous bite marks on her arms, buttocks, calves, ankles and more. Ms. Young reported, "She was bit and bruised from head to toe." She reported that some of the bruises appeared fresh and were blue in color whereas others were dark purple and yellowing. Ms. Young reported that Resident B was asked, "[Resident B] did you bite her? Did you do this to her?" To which Resident B replied, "Yeah". Ms. Young reported that Resident B did not admit to causing all the injuries to Resident A and he did not admit to biting her all over her body. Ms. Young reported direct care staff who were present, Ms. Stewart and Ms. Wilder then started shouting at Resident B, "Oh my God!", "Why did you do that?!", "You're going to go to jail!". Ms. Young reported that Ms. Stewart and Ms. Wilder also tried to get Ms. Young to make these similar statements, and she reported that she told them to stop making these statements. Ms. Young reported that the police were called and came to the facility to take statements. She reported that they interviewed all the direct care staff and Resident B. Ms. Young reported that Ms. Delmerico stated to institute 15-minute checks for the residents. Ms. Young reported that she drafted a document to keep track of the 15-minute safety checks. Ms. Young reported that there was confusion with who Resident A's guardian was and she initially called Guardian A2 on 3/26/25 to report the injuries to Resident A and she did not receive a call back. Ms. Young reported that she observed Resident A's injuries and due to the extent of the bruising on her body she reported, "There's no way she didn't make a noise" when this assault occurred. Ms. Young reported that she does not have proof, but she believes either the direct care staff on duty were not paying attention, sleeping, or outside of the home. Ms. Young reported that there were so many bite marks, and the skin had been broken on multiple of these bites. Ms. Young reported previous staffing levels at the facility were two direct care staff members on first and second shifts and one direct care staff on third shifts. She reported that the facility was understaffed, and they were utilizing a staffing agency, FirstLight Home Care to fill in for some shifts. She noted that these individuals were not trained to pass medications and could not pass resident medications. Ms. Young reported now Resident B requires one-to-one supervision. She reported that to her knowledge there is not a direct care staff member with eyes on Resident B's bedroom door while he is sleeping. She reported that the direct care staff have been instructed to ensure Resident A's bedroom door is locked while she is in her bedroom. She reported that this lock is a "pop lock" and Resident A can easily open the locked door when she wants to leave the bedroom.

On 4/9/25 I interviewed direct care staff, Chris Patino, via telephone, regarding the allegations. Mr. Patino reported that he works third shift (11pm to 7am) at the facility. Mr. Patino reported that he had been away for a four-day period and when he returned he was told about the assault against Resident A. He initially reported that he did not work on 3/25/25 and 3/26/25, but later recanted this statement and reported that he had worked on 3/25/25 and 3/26/25, as the staff schedule indicated. Mr. Patino reported no

knowledge of the injuries Resident A sustained while at the facility. He reported that he did not hear or observe any behaviors from either of the residents on those dates. Mr. Patino reported that prior to Resident A's injuries being identified the expectation for third shift was to check on the residents about every 30 – 60 minutes. He reported that now the expectation is to check on the residents every 15 minutes throughout the night. He reported that there are now two direct care staff on 3rd shift and they take turns going upstairs to check on the residents every 15 minutes. He reported that they do not need to have eyes on the residents' bedrooms, just to go upstairs once every fifteen minutes for checks. Mr. Patino reported that sometimes Resident A likes to get up during the night and come downstairs to check the mail or go to the bathroom. He reported that she usually returns to her bedroom without incident. Mr. Patino reported that since the incident they keep Resident A's bedroom door locked with non-locking against egress hardware, so that she can get out when needed, but Resident B cannot enter her bedroom. Mr. Patino reported that Resident A has a history of self-injurious behaviors, and she will go to her bedroom hit herself and roll around on the ground. He reported that when he hears these things he will go up to check on her, but he could see other direct care staff ignoring the noises because this is normal behavior for Resident A. Mr. Patino reported that he has never observed Resident B demonstrate physically aggressive behaviors. Mr. Patino reported that he feels Resident B has not been adjusting well since there have been recent staffing changes at the facility and two direct care staff members were "let go".

On 4/9/25 I interviewed Guardian B1, regarding the allegations, via telephone. Guardian B1 reported that she has been Resident B's guardian for the past two years. She reported that Resident B does not have any history of assault and these allegations of him assaulting Resident A are very surprising to her. Guardian B1 reported that one of the police officers from the Lansing Police Department did interview Resident B on 3/25/25, when they were on-site at the facility, and they had Guardian B1 on speaker phone for this interview. She reported during that interview, Resident B stated that he and Resident A had a physical altercation on an unidentified date because Resident A was physically assaulting a direct care staff member and Resident B tried to stop her. Guardian B1 reported that Resident B has a history of compulsive lying and that it is difficult to determine what statements he makes are true or false. Guardian B1 reported that Detective Lindeman had requested to interview Resident B regarding the allegations, but she does not feel he has the capacity to be interviewed. She reported that she sought the advice of the Isabella County Court system as to whether Resident B had capacity to be interviewed about the allegations and she was told that Resident B does not have capacity to make his own decisions or to be interviewed regarding legal matters. Guardian B1 reported she was first informed of the injuries to Resident A and allegations against Resident B on 3/25/25 by Ms. Shebester. Guardian B1 reported she does not believe the allegations against Resident B to be true as this would be totally out of character for him.

On 4/10/25 I interviewed Ms. Delmerico, regarding the allegations, via telephone. Ms. Delmerico reported that her current position at the facility is that of the Operations Director. She reported she does not provide direct care to residents, but instead her

duties include administrative details such as scheduling, hiring direct care staff, and overseeing day-to-day general operations. She reported she took this position in January 2025. Ms. Delmerico reported that she had no prior history working in an adult foster care setting prior to working at the facility. She reported that her background is in business, finance, and office management. Ms. Delmerico reported she first became aware of the injuries to Resident A on 3/25/25. She reported that Ms. Stewart called her and reported that Resident A had bruises all over her back and a bite mark on her buttocks. Ms. Stewart reported to Ms. Delmerico that Resident B had admitted to causing these injuries. Ms. Delmerico reported Ms. Stewart stated Resident B stated he caused these injuries to Resident A because he was mad at Resident A. She reported that she had no knowledge of how Ms. Stewart elicited this information from Resident B. Ms. Delmerico reported she and Ms. Young then went to the facility to assess Resident A. Ms. Delmerico reported that it was decided to implement 15-minute safety checks on the resident areas, especially at night, due to the concerns that Resident B could have been the perpetrator of the abuse toward Resident A. Ms. Delmerico reported she was told direct care staff did not have the capability of entering the resident bedrooms if their doors were closed as this was a recipient rights violation. She reported direct care staff would go upstairs and if resident bedroom doors were closed, they would listen for any activity. She reported if resident bedroom doors were open, then direct care staff would look inside to assess safety. Ms. Delmerico reported she was told that since neither of the residents had a behavior plan that instructed direct care staff to check on the residents in their bedrooms, she was under the impression direct care staff could not enter resident bedrooms without resident permission or power granted through a behavior treatment plan. Ms. Delmerico reported that this information was stated to her by Ms. Shebester on 3/26/25 or 3/27/25. Ms. Delmerico reported that prior to Resident A's injuries being found, Resident A's required supervision was line-of-sight 16 hours a day and then 8 hours a day she was not required to have line-of-sight, during sleeping hours. She reported this was accommodated with two direct care staff members being scheduled during 1st and 2nd shifts and one direct care staff member scheduled during third shift. Ms. Delmerico reported that on 3/25/25 the 15-minute "area" checks were put into place but the staffing patterns were not altered. She reported that there was still just one direct care staff member scheduled on 3rd shift. She reported that she updated the previous Operations Director, Heidi Morton, to the incident and possibility of Resident B causing the injuries to Resident A, on 3/25/25. Ms. Delmerico reported that Ms. Morton stated to have the direct care staff make sure Resident A's bedroom door was locked with non-locking against egress hardware, and to have Resident B sleep downstairs on the couch in the living room so that direct care staff could keep an eye on him. Ms. Delmerico reported direct care staff were told to follow the directive regarding the lock on Resident A's bedroom door, but she advised that she did not follow Ms. Morton's suggestion of having Resident B sleep on the couch. Ms. Delmerico reported Resident B slept in his bedroom on 3/25/25. Ms. Delmerico reported that on 3/26/25 she, Ms. Young, Ms. Wilder, and Ms. Stewart, were all at the facility and Resident A was experiencing a behavioral episode and hitting Ms. Wilder. Ms. Delmerico reported that Ms. Young stepped in to assist in deescalating the situation and noticed bite marks on Resident A's wrists. Ms. Delmerico reported, "There were bite marks everywhere", she stated, "It's really awful". Ms. Delmerico reported that she did a skin assessment on

Resident A and the direct care staff started to “freak out”. She reported that Ms. Wilder and Ms. Stewart were heard saying, “[Resident B] did you do this?!”. She reported Resident B stated he had not done it that night, but the night before. Ms. Delmerico reported that the bite marks appeared very fresh. She reported she made a telephone call to Ms. Morton for directions and Ms. Morton advised against calling law enforcement. Ms. Delmerico reported she felt Ms. Morton did not understand the full extent of the situation and she decided to call law enforcement on her own. She reported the police arrived and took statements from Resident B, Ms. Stewart, Ms. Young, and herself. Ms. Delmerico reported that an ambulance was called for Resident A, and Ms. Williams had arrived for her scheduled shift and rode with Resident A to the hospital for an evaluation. Ms. Delmerico reported that after the new injuries were observed on 3/26/25, Ms. Shebester changed the protocol for Resident B’s supervision to, line-of-sight at all times, even when he is sleeping. Ms. Delmerico reported Resident B must have a direct care staff sitting on a chair in the hallway outside his bedroom door so direct care staff can ensure he does not attempt to enter Resident A’s bedroom. Ms. Delmerico reported that a chair has been placed in the hallway on the second level of the facility, near the resident bedrooms and it is expected that one of the two direct care staff on third shift will always be in this chair, watching Resident B’s door, while he is in his bedroom. Ms. Delmerico reported she is familiar with Resident A’s mannerisms and feels that it is possible Resident A did not make much of a sound when she was assaulted. She reported Resident A self-injures and she doesn’t scream or yell during these episodes. Ms. Delmerico reported she sees Resident B try to manipulate Resident A. She reported Resident A will listen to Resident B, sometimes better than she will respond to direct care staff. Ms. Delmerico reported she does not think Resident A’s injuries were caused by anyone other than Resident B. She reported she took photographs of the bite marks on Resident A and the imprint of the teeth match the spacings that Resident B has in his bite. Ms. Delmerico reported she does not believe direct care staff were distracted or had abandoned their shift and left the residents unsupervised. She reported there has been some staffing challenges and the licensee has been using a staffing agency, FirstLight Home Care, to supplement their staff schedule. Ms. Delmerico was asked about this staffing agency and whether the management at the facility has direct care staff files for the agency staff. Ms. Delmerico reported that the staffing agency keeps files of training and background checks for the individuals they send to the facility. I referenced the direct care staff schedule to Ms. Delmerico as there are spaces on the schedule that just read, “Staffing Company” and have time slots filled with this title. Ms. Delmerico reported that she did not have a list of the individuals sent by the staffing agency and would need to gather this information from FirstLight Home Care. She reported she does not have training documentation on hand for these contracted employees and that they are trained to the resident IPOS documents when they arrive on-site. Ms. Delmerico provided the name of Marci Brown, as a contact with FirstLight Home Care for follow up regarding training documentation and background checks on these individuals.

On 4/10/25 I interviewed FirstLight Home Care, employee, Marci Brown. Ms. Brown reported that FirstLight Home Care has a contract with the licensee and they have been working together for a couple of years. She reported their services will be used from

time to time when the facility is short staffed. Ms. Brown reported that during March 2025, 12 of their employees provided direct care services at the facility for a total of approximately 192 hours. Ms. Brown reported that all employees, except for Danny Ndisanze, have been trained in cardiopulmonary resuscitation and first aid. Ms. Brown reported that none of their employees have been fingerprinted through the *Michigan Workforce Background Check* system. Ms. Brown reported that they no longer conduct fingerprinting of employees. Ms. Brown reported that none of their employees can administer medications to residents and have not been trained to complete this task. She reported that there have been shifts where her employees were scheduled to work at the facility where they were the only direct care staff member working and another direct care staff, trained in medication administration, was not paired with them to accommodate for this need. Ms. Brown reported that her employees are not trained in safety/fire prevention or resident rights. Ms. Brown reported that the contract FirstLight Home Care has with the licensee requires that the licensee provide resident rights training to the FirstLight Home Care staff and this has not happened in recent months.

On 4/14/25 I interviewed Central Michigan Community Mental Health, Recipient Rights Officer, Angela Wend, regarding the allegations. Ms. Wend reported that she is actively investigating these allegations to determine whether the direct care staff provided adequately for Resident A's safety and whether CMH had appropriate supervision outlined in the residents' IPOS documents. Ms. Wend reported that previously she had been Resident A's CMH case manager, from 7/28/16-11/10/20. She reported that Resident A has a history of self-harm, but she is also very vocal. She reported, "[Resident A] is a fighter". She noted, "She wouldn't just lay there and take it." Ms. Wend was referring to Resident A being physically assaulted by someone. She reported that she fully believes that Resident A would have fought back if someone had assaulted her to the degree she had been assaulted. Ms. Wend reported that Resident A does have a high pain tolerance and noted the example of her punching herself in the eye multiple times, causing blindness in this eye. Ms. Wend reported that even when Resident A self-harms to this extent, she makes noises and is vocal, she doesn't do this silently. Ms. Wend reported that she believes Resident A must have attempted to fight back or make noises of distress during the assault.

During the on-site investigation on 3/31/25, I reviewed the following documents:

- *Resident Register*. This document identifies Resident A's date of admission to the facility on 3/28/22 and Resident B's date of admission on 6/3/23. This document identifies that Resident A & Resident B were the only residents of the facility on the date of the alleged assault.
- Direct care staff schedule for the month of March 2025. I observed the following:
    - 3/2/25: 1 direct care staff scheduled per shift on all three shifts.
    - 3/3/25: No direct care staff scheduled from 7am to 3pm. 1 direct care staff scheduled on 2nd and 3rd shifts.
    - 3/4/25 – 3/9/25: 1 direct care staff scheduled per shift on all three shifts.
    - 3/10/25: 2 direct care staff scheduled 7am to 3pm, 1 direct care staff scheduled 2nd and 3rd shifts.

- 3/11/25 – 3/12/25: two direct care staff scheduled 7am to 3pm, 1 direct care staff scheduled 3pm to 11pm, 2 direct care staff scheduled 11pm to 7am.
- 3/13/25: two direct care staff scheduled 7am to 3pm, one direct care staff scheduled 3pm to 11pm and 11pm to 7am.
- 3/14/25: one direct care staff scheduled 7am to 11pm, two direct care staff 11pm to 7am.
- 3/15/25: two direct care staff scheduled 7am to 3pm, one direct care staff scheduled 3pm to 7am.
- 3/16/25: one direct care staff scheduled 7am to 11pm, two direct care staff scheduled 11pm to 7am.
- 3/17/25 – 3/18/25: two direct care staff scheduled 7am to 3pm, one direct care staff scheduled 3pm to 7am.
- 3/19/25: two direct care staff scheduled 7am to 10am, three direct care staff scheduled 10am to 3pm, two direct care staff scheduled 3pm to 6pm, one direct care staff scheduled 6pm to 11pm, one direct care staff scheduled 11pm to 7am.
- 3/20/25: one direct care staff scheduled all three shifts.
- 3/21/25: One direct care staff scheduled 7am to 10am, two direct care staff scheduled 10am to 6pm, one direct care staff scheduled 6pm to 7am.
- 3/22/25: Breshay Wilder (7am to 3pm), Arica Williams (3pm to 11pm), Khai Baker (11pm to 7am).
- 3/23/25: Breshay Wilder (7am to 3pm), Arica Williams (3pm to 11pm), Khai Baker (11pm to 7am).
- 3/24/25: Keyonna Stewart (7am to 3pm), Michelle Young (10am to 6pm), Arica Williams (3pm to 11pm), Khai Baker (11pm to 7am).
- 3/25/25: Breshay Wilder (7am to 3pm), Keyonna Stewart (7am to 3pm), Arica Williams (3pm to 11pm), Chris Patino (11pm to 7am).
- 3/26/25: Breshay Wilder (7am to 3pm), Keyonna Stewart (7am to 3pm), Michelle Young (10am to 6pm), Arica Williams (3pm to 11pm), Chris Patino (11pm to 7am), Staffing Company (11pm to 7am). There was not a direct care staff member listed in the space for Staffing Company.
- 3/27/25: Breshay Wilder (7am to 3pm), Keyonna Stewart (7am to 3pm), Christina Worthington (3pm to 11pm), Khai Baker (11pm to 7am), Staffing Company (11pm to 7am). There was not a direct care staff member listed in the space for Staffing Company.
- 3/28/25: Breshay Wilder (7am to 3pm), Michelle Young (10am to 6pm), Khai Baker (3pm to 11pm), Chris Patino (11pm to 7am), Staffing Company (11pm to 7am). There was not a direct care staff member listed in the space for Staffing Company.
- 3/29/25: Keyonna Stewart (7am to 3pm), Christina Worthington (7am to 3pm, next to this time frame is the name “Hayley”), Christina Worthington (3pm to 11pm, next to this time frame is the name “Adriana”, Staffing Company (3pm to 11pm). There was not a direct care staff member listed in the space for Staffing Company. Chris Patino & Khai Baker (11pm to 7am).

    - 3/30/25: Keyonna Stewart (7am to 3pm), Christina Worthington (7am to 11pm, next to this time frame is the name “Adriana”), Khai Baker (3pm to 11pm), Chris Patino & Michelle Young 11pm to 7am).
    - I observed Mr. Baker’s name to first appear on the direct care staff schedule on 3/11/25 with the notation “training”. He was paired with another direct care staff for multiple shifts. Mr. Baker began working independent shifts on 3/17/25. The word “training” no longer was next to his shift schedule and he was scheduled to work shifts alone on this date.
    - I observed Ms. Wilder’s name to first appear on the direct care staff schedule on 3/10/25 with the notation, “training”. Ms. Wilder was scheduled for her first independent shift on 3/21/25, according to the schedule reviewed.
- *Assessment Plan for AFC Residents*, document for Resident B, dated 4/4/24. Under section, *I. Social/Behavioral Assessment*, subsection, *J. Controls Sexual Behavior*, the document is marked “No”, and reads, “needs reminding of what is appropriate to watch in communal areas of…” (the remainder of this sentence is cut off from the form). Under subsection, *I. Controls Aggressive Behavior*, the document is marked, “Yes”. Under subsection, *M. Participates in Social Activities*, the document is marked, “Yes”, with the narrative, “Staff assistance needed for reminder of boundaries”. On page three, under the section, *IV. Social and Program Activities*, subsection, *F. School*, the document is marked, “Yes”, with the narrative, “Currently enrolled in Beekman Center 5 days a week”.
- *Health Care Appraisal,* for Resident B, dated 2/26/24. Under section, *7. Diagnoses*, it lists, Cognitive Delay and Foreign Body Left Ear. Under section, *Explanation of Abnormalities/Treatment Ordered*, it reads, “Needs Assistance with activity planning and with walking outside to avoid getting lost”.
- *PCP,* for Resident B, dated 8/24/23, completed by Community Mental Health for Central Michigan, Rebecca Pope. On page three, under the section, *Description of Safety Concerns*, it reads, “Mom has noted in the past that her primary issues related to impulsivity and judgement. Mom reported that she had to keep a close eye on him when out in the community “so he doesn’t dart out in front of a car”. She has also said that his behaviors is not consistent, he is very impulsive and he does not know what he will do. Staff indicate that he will get online and go to pornographic websites on the smart TV in the living room. He also will go down to the neighbor’s house and help with their animals’ however, other neighbors won’t let him come down because he prefers to play with the younger children and not those of his own age. He continues to pick at the drywall in his room and also the siding on the house. He also has been noted with stealing money from the staff and others. He will ask others to buy things for him. He has not stolen from a store but he has gone into the purses of the home staff. He has taken money from his housemates as well.” Under the section, *How Are Your Safety Needs Being Met*, it reads, “Staff provide for safety needs. Staff do 15-minute checks on him and make sure that he is not outside on his own. They will check his room to make sure that he is not picking at the walls/drywall. Staff have to make sure that they keep their purses out of the house so that he does not steal money from them.” Page four of this document identifies that Resident B requires

direct care staff to supervise him in the community. Under section *B.* on this page it discusses the reasoning for having direct care staff present in the community and states, “[Resident B] can be impulsive and not think through his actions prior to doing them. He needs prompting and reminders while in the community to remember safety skills.”

- *PCP Addendum,* for Resident B, dated 3/27/25, written by Community Mental Health for Central Michigan, Rebecca Shebester. This document notes the PCP effective date of 9/6/24 and the addendum effective date as 3/27/25. This document identifies on page one that Resident B requires support with aggressive behavior, behavioral safety, and other. The first paragraph on page three reads, “AFC staff will remain within line-of-sight of [Resident B] 24/7 except while he is in his bedroom or the bathroom. Staff must remain in line-of-sight of the door when [Resident B] is in his bedroom or the bathroom. This intervention is due to [Resident B] assaulting a housemate on multiple occasions. CMHCM’s Behavior Treatment Committee completed an urgent review of this intervention and approves of the intervention for a period of 30 days. BTC will review the intervention at a frequency determined by the Committee but no less than quarterly. [Resident B’s] guardian has reviewed the intervention and consents to the intervention at this time. Any other intrusive/restrictive interventions must be reviewed by the BTC prior to implementation. Case Manager will ensure a BTC Special Consent and staff training is completed prior to implementation of the intrusive interventions.” On the back of page 10 is a written statement that reads, “Trained Staff.” This notation has the names Michelle Young and Breshay Wilder, written below. A second copy of this document was found in Resident B’s resident record and contained the following signatures; Michelle Young, Breshay Wilder, Khai Baker, (Illegible name, with the notation “FirstLight Home Care” after the name). All these signatures were dated 3/28/25.
- *PCP Addendum,* for Resident A, dated 12/15/24, completed by Community Mental Health for Central Michigan, Rebecca Shebester. The document identifies the effective date for this PCP Addendum as 1/26/25, with a PCP effective date of 1/25/25. On page one, the following areas have been identified as areas Resident A requires support; aggressive behavior (“[Resident A] continues to be aggressive towards staff and other residents”), Risk of physical/sexual/emotional abuse, neglect, or exploitation (“[Resident A] has been sexually assaulted previously”), Self-Injurious behavior (“hitting herself, throwing herself on the ground”). On page two under section *1.*, it reads, “Staff will provide group level line of site staffing support for [Resident A] and will provide supervision for her health and safety, and physical guidance and verbal direction for [Resident A] to navigate her home due to her legal blindness – [Resident A] may choose to hold staff’s hand for physical guidance to walk and move around her home. CMHCM Behavior Treatment Committee has approved a Behavior Treatment Plan which includes restrictive/intrusive interventions. The BTC will review the plan at a frequency determined by the Committee, but no less than quarterly. Case Manager will ensure a BTC Special Consent and staff training is completed prior to any intrusive or restrictive intervention being implemented. Staff will provide group level line-of-sight staffing while out in the community. [Resident A] requires

staff monitor her whereabouts while she is at home to ensure the safety and wellbeing of herself and others. When [Resident A] is home, staff should be aware of and monitor her whereabouts in the home to assure her safety and wellbeing. When [Resident A] is in the community, she requires line-of-sight supervision at all times. [Resident A] should not be supervised while using the restroom in public, unless staff are required to be present to meet her personal care needs. When she is using a single-occupancy restroom, staff should remain outside the door. Staff should remain outside the stall when [Resident A] is using a bathroom with multiple stalls. When [Resident A] is sleeping, resting, or engaging in activities in her room, she does not require regular checks. [Resident A] no longer requires enhanced supervision while being transported in a vehicle. Staff are able to provide adequate support to maintain safety within the standard level of care". On page two, under section, *4.*, it reads, "Staff report that [Resident A] takes sensory showers daily or sometimes multiple times a day." On page two, under section, *9.*, it reads, "Staff verbally direct and guide [Resident A] with putting on her clothes/dressing herself and will provide physical assistance as needed." The last paragraph of page three reads, "[Resident A] requires line-of-sight supervision after self-harm (e.g., hitting self, dropping self, etc.). Staff should be able to see [Resident A] within their field of vision at all times except when she is using the restroom. This means that staff and [Resident A] should be in the same room or area. Enhanced supervision in the home should continue until [Resident A] has discontinued threatening or engaging in self-harm for 30 minutes and has resumed participation in other appropriate goal-directed behaviors."

- *AFC – Resident Care Agreement,* for Resident A, dated 6/4/24.
- *AFC – Resident Care Agreement,* for Resident B, dated 6/4/24.
- *Assessment Plan for AFC Residents,* document for Resident A, dated 4/3/24. On page one, under section, *I. Social/Behavioral Assessment*, subsection, *I. Controls Aggressive Behavior*, the document is marked, "No", with the narrative, "Requires staff assistance to monitor for Health and Safety". Under subsection, *J. Controls Sexual Behavior*, the document is marked, "Yes". On page two, under section, *II. Self Care Skill Assessment*, subsection, *C. Bathing*, it reads, "Requires staff assistance required to monitor for Health and Safety".
- *LoveJoy Community Service Training Log.* This document is dated, 3/12/25 and identifies Ms. Delmerico as the trainer of a Behavior Plan. It is not identified which Behavior Plan is being trained to on this document, but this document was located in Resident A's resident record. The staff identified as being trained are Ms. Williams, Mr. Baker, Ms. Stewart, Mr. Patino, Ms. Wilder, & Ms. Young.
- *Behavior Treatment Plan,* for Resident A, dated 12/9/24, created by Chelsey K. McGillis, Psychologist with Community Mental Health for Central Michigan. On page one, under the section, *Revision History*, it reads, "12/9/24 – Annual revision increasing designated staffing at home, during transportation, and after engaging in self-injurious behaviors." On page one, under section, *Reason for Referral*, it reads, "[Resident A] has had a Behavior Treatment Plan (BTP) with limiting and intrusive interventions since December of 2022. She has historically engaged in physical aggression toward herself and others. In the last year staff

have verbally noted increased in her agitation and engagement in unsafe behaviors. This revision increases staffing supports and outlines environmental limits to assist [Resident A] in remaining safe." Pages two and three of this document discuss Resident A's current behaviors, such as scratching, punching, kicking, throwing objects at others, hitting self, spanking self, banging head on wall, throwing self on ground. It is discussed in this document that the cause for such behaviors could be related to staffing instabilities in the home, increased pain due to dental decay, sudden unexpected death of Resident A's mother, and overall lack of ability to communicate needs effectively. The document reports that Resident A had experienced a decline in negative behaviors in 2023 and saw a spike in her negative behavior in 2024. On page four, under section, *Behavioral Interventions*, subsection, *Relationship*, the document identifies, "[Resident A] should receive positive attention and interactions from staff at least once every 15 minutes whenever possible." On page eight, under section, *Enhanced Supervision*, subsection, *Home*, it reads, "[Resident A] requires 1:1 line-of-sight supervision for 8 hours per day while at home to ensure the safety and wellbeing of herself and others. Suggested times for enhanced staffing include just after she wakes up in the morning and later at night when she is struggling to sleep. This aligns with the times of day [Resident A] is most likely to engage in target behaviors. Her 1:1 staff should be within eyesight of [Resident A] at all times and able to respond to her quickly if she engages in self-injurious or aggressive actions. Staff should monitor her level of agitation and position themselves accordingly (e.g., standing between her and the kitchen or stairs). At any given time, [Resident A] should have a designated staff member monitoring her throughout the home. This staff person can and should rotate with other staff on shift, as long as all staff in the home are aware of who is providing her with 1:1 support at any given moment. Her staff should be communicating with one another to coordinate supports, including expressing when they need to step away or take a break." Under subsection, *Bedroom*, it reads, "While in the bedroom, staff should complete periodic monitoring hourly (every 60 minutes). If [Resident A] is in her room and appears agitated or aggressive staff should continue to monitor her visually, but do not need to enter her room to intervene unless she engages in behaviors that place herself or others at serious risk of harm. Instead, staff should position themselves just outside of her bedroom so that they are able to react and move with her once she elects to leave her bedroom. Staff should return to 1:1 line-of-sight supervision when [Resident A] leaves her bedroom during scheduled staffing hours or if she has recently engaged in self-harm behaviors (as described below)." Under subsection, *Bathroom*, it reads, "Although [Resident A] will likely require personal care assistance, line-of-sight supervision is not required to maintain [Resident A] or others' safety when she is in the bathroom." On page 12, under section, *Training & Monitoring of Treatment Effectiveness/Fidelity*, it reads, "The Psychologist will provide initial training on how to implement the approved Behavior Treatment Plan and behavioral data collection. Ongoing training may be provided by the Case Manager, Home Manager/Lead Staff, or other individuals how have been trained by the Psychologist and will be documented in a PCP Training Record.

All staff members must be trained on the Behavior Treatment Plan prior to providing direct care services with the [Resident A]. Additional training may be provided by the Psychologist if requested. Case Manager will monitor progress on a regular basis. The Psychologist will monitor fidelity of the plan and data collection at least monthly. The Behavior Treatment Committee will review plan documents at least quarterly in accordance with the Michigan Department of Health and Human Services Standards for Behavior Treatment Plan Review Committees."

- *AFC Licensing Division – Incident/Accident Report (IR),* for Resident A, dated 3/25/25, and completed and signed by Kathleen Delmerico. This document lists the date of the incident as 3/25/25 at 12pm, and the direct care staff present, as Ms. Stewart and Ms. Wilder. Under section, *Explain What Happened/Describe Injury (if any)*, it reads, [Resident A] was sitting at the table for lunch. When she stood up, she walked past the staff who noticed the bruising. Staff further examined the bruising and noticed that there was additional bruising under the waistband. A bite mark was found at that time. Housemate was interviewed regarding the situation, and he admitted to being the one who caused the bruising. He stated that the incident occurred in the afternoon on 3/24/25 when [Resident A] was in her bedroom, and he entered her room. Housemate stated that he hit her because he was tired of [Resident A] hitting the staff." Under the section, *Action taken by Staff*, it reads, "Staff completed first aid and contacted all appropriate parties. Guardian denied seeking medical services." Under section, *Corrective Measures Taken to Remedy and/or prevent recurrence*, it reads, "Housemate has been informed that he is not to enter [Resident A's] room. Additionally, we will increase monitoring and perform employee coaching and counseling. Room check intervals were increased to 15-minute periods instead of 30-minute periods."
- *AFC Licensing Division – Incident/Accident Report,* for Resident B, dated 3/25/25, completed and signed by Kathleen Delmerico. This document contains the same information as Resident A's IR, dated for the same date.
- *AFC Licensing Division – Incident/Accident Report,* for Resident A, dated 3/27/25, and completed and signed by Kathleen Delmerico, Operations Director. This document lists the date of the incident as 3/26/25 at 2:30pm, and the direct care staff present, as Ms. Stewart. Under the section, *Explain What Happened/Describe Injury (If any)*, it reads, "While [Resident A] was reaching her arm out, staff noticed that she had severe bruising on her wrist. Upon further examination, bite marks and bruising were found on both wrists. At that time, a full head to toe skin check was completed by two staff members, [Ms. Delmerico] and [Ms. Stewart]. Numerous injuries were found including bite marks (with broken skin) and bruising which were found on her arms, shoulder, breast, lower legs, and upper/inner thighs. [Resident B] admitted to causing the bite marks and bruising." Under section, *Action Taken by Staff/Treatment Given*, it reads, "Emergency services were called immediately to report the incident and to have medical care preformed on the wounds. The residents were separated immediately and not left unattended at any time." Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, "An

emergency discharge of [Resident B] was filed. Additional staff have been placed on the schedule to ensure there are always 2 employees in the home. Also, 15-minute bed checks have been implemented."

- *[Resident A] 15 Minute Checks.* This document is a printout of times beginning at 7am and going through 6:45am the following morning for direct care staff to record that they have completed 15-minute safety checks on Resident A. There is a different page for each date completed. I reviewed the sheets for the dates, 3/26/25 through 3/30/25. I made the following observations:
    - 3/26/25: The 15-minute safety checks were not recorded as being completed by direct care staff between the hours of 3:15pm and 12:15am.
    - 3/27/25: All 15-minute safety checks were signed off on this document.
    - 3/28/25: All 15-minute safety checks were signed off on this document.
    - 3/29/25: The 15-minute safety checks were not recorded as being completed at 6:15am, 6:30am, and 6:45am.
    - 3/30/25: The 15-minute safety checks were not recorded as being completed between the hours of 3:15pm and 10:45pm.
- *Specialized Residential Progress Note for Resident A*, dated 3/26/25, and completed by Ms. Stewart. This document identifies that Ms. Stewart provided Resident A with physical assistance with personal hygiene and dressing on this date. Ms. Stewart did not document any incident of physical aggression from Resident A on this shift and wrote the narrative, "[Resident A] had a nice day. Not so much hitting. She ate breakfast and laid back down til lunch. Her meds was given on time."
- *Specialized Residential Progress Note* for Resident A*,* dated 3/27/25, 3/28/25, 3/29/25, all contained documentation from the first shift (7am to 3pm) direct care staff member, and no documentation from second (3pm to 11pm) or third (11pm to 7am) direct care staff members.
- *Specialized Residential Progress Note* for Resident A, dated 3/30/25, contained documentation from direct care staff on first and third shifts but no documentation recorded by second shift direct care staff.

On 4/1/25 I received email communication from Ms. Delmerico. Ms. Delmerico provided documentation from Resident A's medical visit to U of M Health Sparrow on 3/26/25. On page one of the document, the *Reason for Visit* was noted to be, "Other", with a *Diagnosis* of, "Assault".

On 4/2/25 I submitted a *Freedom of Information Act* (FOIA) request to the Lansing Police Department for police report numbers, 2551902807 and 2551902768. On 4/10/25 I received access to police report #2551902768 but was denied access to police report #2551902807. I observed the following information in police report #2551902768:

- *#2551902768*: completed on 3/25/25 by reporting officer, Brendan Erwin. The report names Resident A as the victim and Resident B as the identified suspect. On page three under the section, *Accused Statement*, it reads, "I made contact with the accused, [Resident B] inside the residence of 1204 W Michigan Ave. [Resident B] agreed to provide a statement regarding the

assault. [Resident B] stated on 3/24/25 at approximately 15:00 hours he was upstairs in his bedroom when he heard a lot of noise coming from the living room. [Resident B] went downstairs to the living room and observed a female assaulting the staff of the AFC home. [Resident B] provided the name of [Resident A] as the female resident that was assaulting staff. [Resident B] advised he approached [Resident A] and attempted to move her aside to get her to stop assaulting staff. [Resident B] stated at this time [Resident A] continued to assault staff, so he began to punch [Resident A]. [Resident B] advised he punched [Resident A] in the lower back approximately 7 times with his right hand with a closed fist. [Resident B] advised [Resident A] then went to her room, and he sat in a chair near the stairwell. [Resident B] stated he then observed [Resident A] come back out of her room and attempt to assault staff once more. [Resident B] advised he didn't assault [Resident A] other than the initial punches to the lower back." On page three, under section, *Property Manager Statement*, it reads, "I made contact with the property manager inside the residence. The property manager was identified as [Ms. Delmerico]. [Ms. Delmerico] advised she was informed by her staff there that the assault took place after the residence had all gone to bed for the evening. [Ms. Delmerico] stated at some point [Resident B] came out of his bedroom and went into [Resident A's] room. [Resident B] punched [Resident A] in the lower back and bit her on the right buttock. [Ms. Delmerico] advised [Resident A] had visible bruising to the lower back and a bite mark on her right buttock. [Ms. Delmerico] advised [Resident A] would be unable to provide a statement due to her being non-verbal. [Ms. Delmerico] stated she was mandated to report the assault and just wanted it documented." On page five, under the section, *Staff Statement*, it reads, [Ms. Williams] left 1204 W. Michigan Ave. on 3/24/25 at approximately 2300 hours. Staff arrived on 3/25/25 at approximately 0700 hours. [Ms. Williams] observed the bruising on [Resident A] but advised she would not be able to provide a statement due to her being verbal/non-verbal. [Ms. Williams] advised there was bruising on [Resident A's] back and a bite mark to her left butt cheek. [Ms. Williams] advised [Ms. Stewart] would be able to provide additional information."

On 4/9/25 I received email communication from Ms. Shebester. Ms. Shebester provided the Community Mental Health, clinical documentation for both Resident A and Resident B for my review. I reviewed the following documentation:

- *PCP*, for Resident B, dated 8/5/24, completed by Ms. Shebester. On page two it is noted that Resident B has a need for support in the following areas, aggressive behavior ("some verbal aggression, needs redirection, became upset with loud noises and he would yell "shut up"), behavioral safety ("[Resident B] exposed himself previously"), other ("would go out into traffic previously"). Near the bottom of page four, it reads, "[Resident B] assaulted a female housemate on 3/25 on 3/26. Behavior treatment has approved the following restriction after an urgent review: AFC staff will remain within line-of-sight of [Resident B] 24/7 except while he is in his bedroom or the bathroom. Staff must remain in line-of-sight of the door when [Resident B] is in his

bedroom or the bathroom. This intervention is due to [Resident B] assaulting a housemate on multiple occasions. CMHCM's Behavior Treatment Committee completed an urgent review of this intervention and approved of the intervention for a period of 30 days. BTC will review the intervention at a frequency determined by the committee but no less than quarterly. [Resident B's] guardian has reviewed the intervention and consents to the intervention at this time. Any other intrusive/restrictive interventions must be reviewed by the BTC prior to implementation. Case Manager will ensure a BTC Special Consent and staff training is completed prior to implementation of the intrusive interventions."

- *Psychosocial Assessment*, for Resident B, dated 8/5/24, completed by Ms. Shebester. On page four, under the section, *Brief Description of Consumer's Presenting Problem(s) and Symptomology*, it reads, "[Resident B] reports anxiety about loud noises. I'm always wrapped up in my blankets. Home manager disorganization is triggering, change is hard for him. [Resident B] often needs prompting to allow staff to do their jobs as he tries to dictate the choices that other residents make. He will at times whisper in the ear of the residents that they are not going to be able to leave the house or attend an outing that they are hoping to go to. He is typically redirectable. [Resident B] may need prompts for being safe in the community." On page nine it is identified that Resident B needs support in the following areas, aggressive behavior ("some verbal aggression, needs redirection, became upset with loud noises and he would yell "shut up" to other residents"), Inappropriate sexual behavior or history of criminal sexual conduct charge ("[Resident B] has exposed himself in his neighborhood twice in the past year"), Risk of physical/sexual/emotional abuse, neglect, or exploitation ("[Resident B] has been sexually abused previously by former schoolmate and biological parents"), other ("unsafe near roads and vehicles historically").
- *Psychosocial Assessment,* for Resident B, dated 8/24/23, completed by Ms. Shebester. The first paragraph on page 13 reads, "[Resident B] is a young man with a history of being mildly intellectual disabled. Mom has brought him in because of growing concerns about sleep, anxiety, some inappropriate sexual behaviors, some destructive behaviors, and some stealing. It seems he was admitted to U of M and they felt he suffered from FAS as it is reported mom used multiple substances while pregnant with him. It is also reported that a peer engaged in inappropriate sexual behaviors with him 4 times and since then his anxiety has been higher and he has started engaging in inappropriate sexual behaviors like trying to touch others in private areas when they walk by and emailing classmates to go have sex in the bathroom. Mom's other chief concerns are that he steals things frequently and destroys property at home frequently. We discuss that like his previous psychiatrist said, some of these issues sound behavioral and so behavioral counseling would be recommended. We tried Wellbutrin XL 150 and mom felt he was picking less and seemed calmer, but also noted him getting more physically aggressive with people so stopped it after a couple of months. Today, [Resident B] has been moved to a new AFC in Lansing as of about a month ago. He continues to have a public

guardian. There are no behavioral concerns in the AFC as of yet, but they do report him having very little sleep. They report not having a behavioral plan yet, so unclear that they are tracking date, but amount of sleep might be something worth watching. Behaviors associated with ASD are seemingly stable. Behaviors potentially related to trauma are reportedly stable. ADHD is unclear."

- *Medical Review,* for Resident B, completed 2/5/25 with CMH Psychiatrist, Timur Akinli, MD, former direct care staff, Camille Owens, and Resident B. On page one, under the section, *Interval History of Present Illness*, it reads, "[Resident B] continues to feel like things are going well. Staff says behaviorally he is doing well and follows rules well. She notes he is a picky eater. She says he was suspended from school last week. Staff says [Resident B] found a THC vape pen, took it to school, and shared it with another student." On page three, under the section, *Mental Status Exam*, it reads, "[Resident B] is casually dressed and in no apparent distress. [Resident B] appears the stated age. [Resident B] is cooperative with the exam. Behavior is appropriate. He participates well , as is typical. There are no abnormal movement or tics noted on exam. Speech is dysarthric, but understandable. Mood is described as "good". Affect is euthymic. Sensorium is clear. Attention and concentration are good. Thought process is linear, logical, and goal directed. There are no loose associations or evidence of delusions. There are no thoughts of suicide or homicide expressed. [Resident B] does not appear to respond to internal stimuli during the exam. [Resident B's] judgement and insight are good, for the most part. [Resident B's] estimated intelligence is below average (mildly intellectually disabled)."
- *Behavior Treatment Plan,* for Resident A, dated 12/9/24, created by Chelsey K. McGillis, Psychologist with Community Mental Health for Central Michigan. This is the same document reviewed during the on-site investigation on 3/31/25.
- *PCP Addendum,* for Resident A, dated 12/15/24, completed by Community Mental Health for Central Michigan, Rebecca Shebester. The document identifies the effective date for this PCP Addendum as 1/26/25, with a PCP effective date of 1/25/25. This is the same document reviewed during the on-site investigation on 3/31/25.
- *Psychiatric Evaluation,* for Resident A, dated 4/15/22, and completed by CMH, Psychiatrist, Lawrence Beek NP, PMHNP-BC. This document identifies that Resident A has a history of self-injurious behavior, resulting in retinal detachment, as well as a history of aggressive behaviors toward her caregivers and family members. It further identifies that she has "displayed sexual aggression towards a blanket" and that she becomes physically aggressive when others attempt to redirect her from this behavior.

On 4/10/25 I received email correspondence from Ms. Brown with FirstLight Home Care. Ms. Brown provided the names of the individuals she employs who were assigned to work as direct care staff at the facility during the month of March 2025. These individuals are as follows:

- Segbe Ahoueya
- Susan Dickey

- Latoya Campbell
- Valerie Parkey
- Barbara Wilbon
- Susan Sah
- Orlandeeya Fields Lee
- Brooklnn Hill
- Danny Ndisanze
- Selognon Ahoueya
- Danielle Smith
- Alicia Braxton
- Tracey Chambers
- Elizabeth Jones
- Nyonna Latham Brown
- Lacher Greenwood

Ms. Brown also included in her email correspondence a schedule of the individuals who were contracted to work at the facility during the month of March 2025. *MARC HOUSE LOVEJOY March 2025* is the title of the document. I reviewed this schedule and made the following observations:

- There were not any contracted direct care staff scheduled at the facility on 3/22/25 – 3/26/25.
- Contracted direct care staff members did work at the facility on the following days, 3/1/25 – 3/5/25, 3/7/25 – 3/11/25, 3/13/25 – 3/17/25, 3/27/25 – 3/31/25.
- On the following dates the contracted direct care staff were scheduled to be at the facility as the only direct care staff provider present in the facility to provide for medication administration, personal care, supervision, and protection, as cross referenced to the facility direct care staff calendar:
    - 3/2/25: 3pm to 11pm
    - 3/3/25: 3pm to 7am the following day
    - 3/4/25: 11pm to 7am the following day
    - 3/7/25: 11pm to 7am the following day
    - 3/8/25: 11pm to 7am the following day
    - 3/9/25: 7am to 3pm
    - 3/13/25: 3pm to 7am the following day
    - 3/14/25: 3pm to 11pm
    - 3/15/25: 3pm to 11pm
    - 3/16/25: 3pm to 11pm
    - 3/17/25: 3pm to 11pm

On 4/11/25 I received email correspondence from Ms. Shebester, reporting that Resident B is being moved to another facility some time the week of 4/13/25.

On 4/14/25 I received email correspondence from Ms. Delmerico. Ms. Delmerico provided the *Michigan Workforce Background Check* eligibility letters for my review for the following direct care staff members:

- Arica Williams (eligible)
- Breshay Wilder (eligible)
- Christopher Patino (eligible))
- Christina Worthington (eligible)
- Jolie Porubsky (eligible)
- Keyonna Stewart (eligible)
- Michelle Young (eligible)

On 4/14/25 I sent email correspondence to Ms. Delmerico inquiring whether there was documentation of a completed *Michigan Workforce background Check* for direct care staff, Khai Baker. She reported that there was an issue retrieving this document on this date.

On 4/15/25 I had a telephone conversation with Ms. Delmerico. Ms. Delmerico reported that Resident B is moving from the facility to another adult foster care home on 4/17/25. She reported that Mr. Baker's *Michigan Workforce Background Check* was completed on 3/5/25 but due to issues with the payment system at Idemia Public Security, the background check was not processed. She reported that she was told today, by Ms. Worthington, that Mr. Baker will need to have his fingerprints completed again and that he is going today to address this situation. Ms. Delmerico reported that the payment method used to pay the vendor had expired and they were required to submit a new form of payment prior to receiving Mr. Baker's fingerprints. I inquired of Ms. Delmerico to confirm the process in place for the contracted direct care staff records for the individuals from FirstLight Home Care. Ms. Delmerico reported that FirstLight Home Care keeps the direct care staff records for these individuals which include medical reviews, Tuberculosis testing, trainings, and *Michigan Workforce Background Checks*.

On 4/15/25 I received email communication from Ms. Brown with FirstLight Home Care. Ms. Brown provided a document titled, *On-site Non-Medical Care Service Agreement* for my review. The effective date of this document is 1/7/24. The Community listed is LoveJoy with the address as 1204 W. Michigan Ave. Lansing, MI 48912. On page four of this contract, section *12. Amended due to LoveJoy Request*, reads, "Training is paid at $32 an hour. Background checks through iChat will be sent. CPR/First Aid will be completed before caregiver is working. Recipient Rights will be completed." Page eight of this contract, is titled *Exhibit B.* Under section *3. Non-Medical Care*, it reads, "In all cases, Firstlight Home Care caregivers are not permitted to provide any medical or skilled care services. These include, but are not limited to, wound care, medicine dispensing, diagnostic interpretation, operation & Maintenance of any medical devices in use under the direction of attendant doctor orders or other skilled medical professional orders." Page nine is titled *Exhibit C*, *Background Check Policy*. Under the subsection, *Procedure*, the following information is listed:

1. FirstLight HomeCare does background checks on all prospective employees prior to hire.
2. The owner or principal of the business and all members of their staff have passed:
    a. Deep Criminal Background Check

    b. Civil Record Screening
    c. Terrorist Watch List
    d. Identity Verification
3. Detailed individual checks include:
    a. County criminal records court search
    b. Civil Record
    c. Social Security Verification/Trace
    d. National Criminal Scan
    e. NIPR (insurance providers)
    f. Professional License
    g. Address Check

In reviewing the *On-site Non-Medical Care Service Agreement* I did not observe any language regarding training requirements for direct care staff, except the notation on page four, section *12*, which indicated individuals must have current Cardiopulmonary Resuscitation training and Recipient Rights training prior to working.

On 4/15/25 I received an email correspondence from Deborah Moerland, owner of FirstLight Home Care. Ms. Moerland reported that the background check company they use on their employees is called *Checkr* and it performs a national check and county checks. She further reported that they do not conduct fingerprints on any of their employees.

On 4/16/25 I received fax transmittals from Ms. Delmerico containing requested documentation. The documents reviewed included:

- *Medication Administration Records* (MAR) for Resident A & Resident B for the month of March 2025.
- *Notice of Facility – Initiated Discharge* for Resident B, dated 3/26/25. The document identified that Resident B was recommended for a 24-hour emergency discharge notice. This document stated, "[Resident B] has committed sexual assault against another resident in the home. [Resident B] admitted to doing this on 3/25/25." This document was signed by Ms. Delmerico on 3/26/25. She signed under the section for "Operations Director Signature" and "Licensee Signature".
- Direct care staff training records. These records were found to be incomplete.
- *Patient Plan For 4/3/25* for Resident A. This document was from the Ingham Community Health Centers, Forest Community Health Center. The notation on this document under the section, *Reason for Visit*, was "Establish Care". A *Health Care Appraisal (HCA)* was not connected to this document. Ms. Delmerico reported that she has requested the HCA to be completed to coincide with this visit.
- *Patient Plan For 5/9/24,* for Resident A. This document was from the Ingham Community Health Centers, Willow Community Health Center. There was not a notation on this document for the reason for this visit. A completed HCA was not attached to coincide with this document.

On 4/21/25 I had a telephone conversation with Ms. Worthington. Ms. Worthington has been identified as a direct care staff who also works in the Human Resources department for the facility. I asked Ms. Worthington to provide information regarding staff training records for Mr. Patino, Ms. Williams, Mr. Baker, Ms. Wilder, Ms. Young, & Ms. Stewart. Ms. Worthington reported that she would send copies of the training records she currently has on hand, via email. She reported that the employee files were previously being housed at the facility and some of the information was not filed correctly and is missing from the files. She reported that it was the duty of the previous home manager to keep the files organized and this was not being attended to correctly. Ms. Worthington reported that they are in the process of moving all direct care staff files to an electronic system to improve accountability for these records. Ms. Worthington reported that files for the contracted direct care staff through FirstLight Home Care are kept by the FirstLight Home Care office. She reported she does not keep any information on the FirstLight Home Care individuals.

On 4/22/25 I conducted an on-site visit at the facility and met with Ms. Delmerico. I reviewed direct care staff training records on this date. Ms. Delmerico reported that she did not have current documentation of trainings provided to the contracted direct care staff through FirstLight Home Care regarding training received to Resident A and Resident B's IPOS documents and/or Behavior Treatment Plan. She reported direct care staff would go over the documents with these contracted direct care staff but it was not recorded that this was completed. I reviewed the following documents today:

- Direct care staff trainings for the following individuals:
    - Arica Williams (all trainings completed)
    - Christopher Patino (all trainings completed)
    - Khai Baker (Missing cardiopulmonary resuscitation training. All other trainings are completed on or after 4/7/25.)
    - Breshay Wilder (Missing cardiopulmonary resuscitation training, resident rights, crisis intervention, and reporting requirements. All other trainings completed on or after 4/7/25.)
    - Keyonna Stewart (all trainings completed)
    - Michelle Young (all trainings completed)
    - Jolie Porubsky (all trainings completed)
    - Christina Worthington (all trainings completed)
- I asked for the training record for Resident B's IPOS document, addendum date 3/27/25. I observed the following signatures on this document:
    - Michelle Young 3/28/25
    - Breshay Wilder 3/28/25
    - Khai Baker 3/28/25
    - Illegible name, notation FirstLight Home Care 3/28/25
    - Keyonna Stewart 4/1/25
    - Arica Williams 4/1/25
    - Christopher Patino 4/1/25
- I asked for the training record for Resident A's IPOS document, dated 12/9/24. I observed the following signatures on this document:
    - Michelle Young (no date)

- Keyonna Stewart (4/1/25)
- Breshay Wilder (4/1/25)
- Keyonna Stewart (4/1/25)
- Arica Williams (4/1/25)
- Khai Baker (4/1/25)

*Each of these signatures occurred after the reported assault of Resident A.

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 upon the numerous interviews conducted and extensive documentation reviewed during this investigation it can be determined that there is adequate evidence that direct care staff did not provide for the protection and safety of Resident A, resulting in a heinous physical assault of her person including multiple human bite marks and extensive bruising throughout her body. In reviewing the *Behavior Treatment Plan* for Resident A, dated 12/9/24, it highlights that Resident A requires line-of-sight supervision from direct care staff members for at least eight hours during the day, 60-minute checks on Resident A while she is in her bedroom, and visual supervision of Resident A while she is experiencing an episode of self-harm, until 30 minutes after she has ceased self-harm behavior. When interviewing multiple direct care staff regarding this investigation, none of the direct care staff could properly articulate this safety plan for Resident A. Some knew bits and pieces of the safety plan, but no individual was able to accurately articulate all the plan elements. In reviewing Resident B's PCP Addendum dated 3/27/25, it indicated that Resident B was required to have line-of-sight supervision at all times unless in his bedroom or the bathroom, and in such cases direct care staff were to keep eyes on the door he occupied. In interviewing multiple direct care staff, none of the direct care staff were able to articulate this safety plan correctly, except Ms. Delmerico. In reviewing the training records for these reviewed documents, there were missing direct care staff signatures to indicate training had been completed. There were also missing signatures from the contracted staff through FirstLight Home Care to indicate their employees had been properly trained to these documents. In reviewing the 15-minute checks log created to address safety concerns at the facility, there were dates and times when these logs were not completed by direct care staff members. The direct care staff were responsible for only two residents, and all claimed they did not hear any noise or commotion that would have indicated Resident A being assaulted. Ms. Fitzpatrick, Ms. Wend, Ms. Young, Ms. Shebester, all indicated that due to the extent of the injuries Resident A sustained, they have no idea how she would not have made noise of cries or screaming out during the assault. Resident A was found with injuries to her person on 3/25/25, direct care staff reported that they increased supervision at the facility to include two direct care staff per shift after the initial injuries were observed, and yet Resident A was found with even more extensive injuries on 3/26/25. As a result of the findings, it can be determined that there is substantial evidence to conclude a violation has been established.

CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site investigation on 3/31/25, I reviewed the following documents:

- Direct care staff schedule for the month of March 2025.
    - I observed that there were multiple dates where the schedule was marked with the title, “Staffing Company” and there were hours scheduled under this title. There was not any individual person listed, but there were hours assigned under this category, just as hours were assigned next to regular direct care staff members’ names.
    - I observed Mr. Baker’s name to first appear on the direct care staff schedule on 3/11/25 with the notation “training”. He was paired with another direct care staff for multiple shifts. Mr. Baker began working independent shifts on 3/17/25. The word “training” no longer was next to his shift schedule and he was scheduled to work shifts alone on this date.
    - I observed Ms. Wilder’s name to first appear on the direct care staff schedule on 3/10/25 with the notation, “training”. Ms. Wilder was scheduled for her first independent shift on 3/21/25, according to the schedule reviewed.

On 4/10/25 I interviewed Ms. Delmerico regarding the direct care staff schedule. She reported that they have had some staffing challenges and have been using a staffing agency, FirstLight Home Care, to supplement their staff schedule. Ms. Delmerico was asked about this staffing agency and whether the management at the facility has direct care staff files for the contracted direct care staff. Ms. Delmerico reported that the staffing agency keeps files of training and background checks for the individuals they send to the facility. I referenced the direct care staff schedule to Ms. Delmerico as there are spaces on the schedule that just read, “Staffing Company” and have time slots filled with this title. Ms. Delmerico reported she did not have a list of the individuals sent by the staffing agency and would need to gather this information from FirstLight Home Care. She reported that she does not have trainings on hand for these agency employees and that they are trained in the resident IPOS documents when they arrive on-site. Ms. Delmerico provided the name of Marci Brown, as a contact with FirstLight Home Care for follow up regarding training documentation and background checks on these individuals.

On 4/10/25 I interviewed FirstLight Home Care, employee, Marci Brown. Ms. Brown reported that FirstLight Home Care has a contract with the facility, and they have been working together for a couple of years. She reported that their services will be used from time to time when the facility is short staffed. Ms. Brown reported that during the month of March 2025 12 of their employees provided direct care services at the facility for a

total of approximately 192 hours. Ms. Brown reported that all employees, except for Danny Ndisanze, have been trained in cardiopulmonary resuscitation and first aid. She reported that Brooklnn Hill does not have current documentation of her completed CPR/First aid training as this information is with her former employer and she does not have access to the records. Ms. Brown reported that none of their employees have been fingerprinted through the *Michigan Workforce Background Check* system. Ms. Brown reported that they no longer conduct fingerprinting of employees. Ms. Brown reported that none of their employees can administer medications to residents and have not been trained to complete this task. She reported that there have been shifts where her employees were scheduled to work at the facility where they were the only direct care staff member working and another direct care staff, trained in medication administration, was not paired with them to accommodate for this need. Ms. Brown reported that her employees are not trained in safety/fire prevention or resident rights. Ms. Brown reported that the contract FirstLight Home Care has with the facility requires that the facility provides resident rights trainings to the FirstLight Home Care staff, and this has not happened in recent months. Ms. Brown reported that FirstLight Home Care does provide training in bloodborne pathogens, CPR/First Aid, dementia, personal care, & Parkinsons.

On 4/10/25 I received email correspondence from Ms. Brown with FirstLight Home Care. Ms. Brown provided the names of the individuals she employs who were assigned to work as direct care staff at the facility during the month of March 2025. These individuals are as follows:

- Segbe Ahoueya
- Susan Dickey
- Latoya Campbell
- Valerie Parkey
- Barbara Wilbon
- Susan Sah
- Orlandeeya Fields Lee
- Brooklnn Hill
- Danny Ndisanze
- Selognon Ahoueya
- Danielle Smith
- Alicia Braxton
- Tracey Chambers
- Elizabeth Jones
- Nyonna Latham Brown
- Lacher Greenwood

Ms. Brown also included in her email correspondence a schedule of the individuals who were contracted to work at the facility during the month of March 2025. *MARC HOUSE LOVEJOY March 2025* is the title of the document. I reviewed this schedule and made the following observations:

- There was not any contracted direct care staff scheduled at the facility on 3/22/25 – 3/26/25.
- Contracted direct care staff members did work at the facility on the following days, 3/1/25 – 3/5/25, 3/7/25 – 3/11/25, 3/13/25 – 3/17/25, 3/27/25 – 3/31/25.
- On the following dates the contracted direct care staff were scheduled to be at the facility as the only direct care staff provider present in the facility to provide for medication administration, personal care, supervision, and protection, as cross referenced to the facility direct care staff calendar:
    - 3/2/25: 3pm to 11pm
    - 3/3/25: 3pm to 7am the following day
    - 3/4/25: 11pm to 7am the following day
    - 3/7/25: 11pm to 7am the following day
    - 3/8/25: 11pm to 7am the following day
    - 3/9/25: 7am to 3pm
    - 3/13/25: 3pm to 7am the following day
    - 3/14/25: 3pm to 11pm
    - 3/15/25: 3pm to 11pm
    - 3/16/25: 3pm to 11pm
    - 3/17/25: 3pm to 11pm

On 4/15/25 I conducted a telephone conversation with Ms. Delmerico. I inquired of Ms. Delmerico to confirm the process in place for the contracted direct care staff records for the individuals from FirstLight Home Care. Ms. Delmerico reported that FirstLight Home Care keeps the direct care staff records for these individuals which include medical reviews, Tuberculosis testing, training, and *Michigan Workforce Background Checks*.

On 4/15/25 I received email communication from Ms. Brown with FirstLight Home Care. Ms. Brown provided a document titled, *On-site Non-Medical Care Service Agreement* for my review. The effective date of this document is 1/7/24. The Community listed is LoveJoy with the address as 1204 W. Michigan Ave. Lansing, MI 48912. On page four of this contract, section *12*. *Amended due to LoveJoy Request*, reads, “Training is paid at $32 an hour. Background checks through iChat will be sent. CPR/First Aid will be completed before caregiver is working. Recipient Rights will be completed.” Page eight of this contract, is titled *Exhibit B*. Under section *3. Non-Medical Care*, it reads, “In all cases, Firstlight Home Care caregivers are not permitted to provide any medical or skilled care services. These include, but are not limited to, wound care, medicine dispensing, diagnostic interpretation, operation & Maintenance of any medical devices in use under the direction of attendant doctor orders or other skilled medical professional orders.” Page nine is titled *Exhibit C*, *Background Check Policy*. Under the subsection, *Procedure*, the following information is listed:

1. FirstLight HomeCare does background checks on all prospective employees prior to hire.
2. The owner or principal of the business and all members of their staff have passed:
    a. Deep Criminal Background Check
    b. Civil Record Screening

    c. Terrorist Watch List
    d. Identity Verification
3. Detailed individual checks include:
    a. County criminal records court search
    b. Civil Record
    c. Social Security Verification/Trace
    d. National Criminal Scan
    e. NIPR (insurance providers)
    f. Professional License
    g. Address Check

In reviewing the *On-site Non-Medical Care Service Agreement* I did not observe any language regarding training requirements for direct care staff, except the notation on page four, section *12*, which indicated individuals must have current Cardiopulmonary Resuscitation training and Recipient Rights training prior to working.

On 4/15/25 I received an email correspondence from Deborah Moerland, owner of FirstLight Home Care. Ms. Moerland reported that the background check company they use on their employees is called *Checkr* and it performs a national check and county checks. She further reported that they do not conduct fingerprints on any of their employees.

On 4/17/25 I had email correspondence with Ms. Moerland. I asked Ms. Moerland if the employees through FirstLight Home Care have completed medical clearances or tuberculosis testing. Ms. Moerland responded, “We require everyone to have a TB test.”

On 4/14/25 I received email correspondence from Ms. Delmerico. Ms. Delmerico provided the *Michigan Workforce Background Check* eligibility letters for my review for the following direct care staff members:

- Arica Williams (eligible)
- Breshay Wilder (eligible)
- Christopher Patino (eligible))
- Christina Worthington (eligible)
- Jolie Porubsky (eligible)
- Keyonna Stewart (eligible)
- Michelle Young (eligible)

On 4/14/25 I sent email correspondence to Ms. Delmerico inquiring whether there was documentation of a completed *Michigan Workforce background Check* for direct care staff, Khai Baker. She reported that there was an issue retrieving this document on this date.

On 4/15/25 I had a telephone conversation with Ms. Delmerico. Ms. Delmerico reported that Resident B is moving from the facility to another adult foster care home on 4/17/25. She reported that Mr. Baker’s *Michigan Workforce Background Check* was completed on 3/5/25 but due to issues with the payment system at Idemia Public Security, the

background check was not processed. She reported that she was told today, by Ms. Worthington, that Mr. Baker will need to have his fingerprints completed again and that he is going today to address this situation. Ms. Delmerico reported that the payment method used to pay the vendor had expired and they were required to submit a new form of payment prior to receiving Mr. Baker's fingerprints. I inquired of Ms. Delmerico to confirm the process in place for the contracted direct care staff records for the individuals from FirstLight Home Care. Ms. Delmerico reported that FirstLight Home Care keeps the direct care staff records for these individuals which include medical reviews, Tuberculosis testing, trainings, and *Michigan Workforce Background Checks*.

On 4/16/25 I received fax transmittals from Ms. Delmerico containing the *Medication Administration Records* for Resident A & Resident B for the month of March 2025. I made the following observations:

- Ms. Wilder & Mr. Baker, both initialed that they administered resident medications during the month of March 2025.

On 4/16/25 I received fax transmittals from Ms. Delmerico containing requested documentation for direct care staff trainings. These records were found to be incomplete.

On 4/17/25 I received email correspondence from Ms. Delmerico regarding Mr. Baker's *Michigan Workforce Background Check* eligibility letter. Ms. Delmerico provided a copy of Mr. Baker's eligibility letter, noting he is "eligible" for employment at an adult foster care facility. This letter was dated 4/16/25. Mr. Baker's name first appears on the direct care staff schedule on 3/11/25.

On 4/21/25 I had a telephone conversation with Ms. Worthington. Ms. Worthington has been identified as a direct care staff who also works in the Human Resources department for the facility. I asked Ms. Worthington to provide information regarding staff training records for Mr. Patino, Ms. Williams, Mr. Baker, Ms. Wilder, Ms. Young, & Ms. Stewart. Ms. Worthington reported that she would send copies of the training records she currently has on hand, via email. She reported that the employee files were previously being housed at the facility and some of the information was not filed correctly and is missing from the files. She reported that it was the duty of the previous home manager to keep the files organized and this was not being attended to correctly. Ms. Worthington reported that they are in the process of moving all direct care staff files to an electronic system to improve accountability for these records. Ms. Worthington reported that files for the contracted direct care staff through FirstLight Home Care and kept by the FirstLight Home Care office. She reported she does not keep any information on the FirstLight Home Care individuals.

On 4/21/25 I received email correspondence from Ms. Delmerico. She sent copies of training records for Mr. Baker. It was observed that Mr. Baker completed the following trainings:

- Resident Rights: completed on 4/18/25
- Safety & Fire Prevention: completed on 4/17/25

- Prevention & Containment of Communicable Diseases: completed on 4/16/25
- Medication Administration: Completed on 4/16/25
- Crisis Intervention: Completed on 4/17/25
- Person Centered Planning: Completed on 4/17/25

On 4/22/25 I conducted an on-site visit at the facility and met with Ms. Delmerico. I reviewed direct care staff training records on this date. Ms. Delmerico reported that she did not have current documentation of trainings provided to the contracted direct care staff through FirstLight Home Care regarding training received to Resident A and Resident B's IPOS documents and/or Behavior Treatment Plan. She reported that the direct care staff would go over the documents with these contracted direct care staff but it was not recorded that this was completed. I reviewed the following documents today:

- Direct care staff trainings for the following individuals:
    - Arica Williams (all trainings completed)
    - Christopher Patino (all trainings completed)
    - Khai Baker (Missing cardiopulmonary resuscitation training. All other trainings are completed on or after 4/7/25.)
    - Breshay Wilder (Missing cardiopulmonary resuscitation training, resident rights, crisis intervention, and reporting requirements. All other trainings completed on or after 4/7/25.)
    - Keyonna Stewart (all trainings completed)
    - Michelle Young (all trainings completed)
    - Jolie Porubsky (all trainings completed)
    - Christina Worthington (all trainings completed)
- I asked for the training record for Resident B's IPOS document, addendum date 3/27/25. I observed the following signatures on this document:
    - Michelle Young 3/28/25
    - Breshay Wilder 3/28/25
    - Khai Baker 3/28/25
    - Illegible name, notation FirstLight Home Care 3/28/25
    - Keyonna Stewart 4/1/25
    - Arica Williams 4/1/25
    - Christopher Patino 4/1/25
- I asked for the training record for Resident A's IPOS document, dated 12/9/24. I observed the following signatures on this document:
    - Michelle Young (no date)
    - Keyonna Stewart (4/1/25)
    - Breshay Wilder (4/1/25)
    - Keyonna Stewart (4/1/25)
    - Arica Williams (4/1/25)
    - Khai Baker (4/1/25)

  *Each of these signatures occurred after the reported assault of Resident A.

On 1/29/24, Renewal Licensing Study Report, cited a violation of Rule 400.734b, regarding missing documentation of completed *Michigan Workforce Background Checks* in employee files. The Corrective Action Plan submitted 2/14/24 stated that then

direct care staff/Program Manager, Jessica Cortez, would be responsible for ensuring employee fingerprints/*Michigan Workforce Background Checks*, were completed within 14 days of hiring.

APPLICABLE RULE	
400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(3) An individual who applies for employment either as an employee or as an independent contractor with an adult foster care facility or staffing agency and who has not been the subject of a criminal history check conducted in compliance with this section shall give written consent at the time of application for the department of state police to conduct a criminal history check under this section, along with identification acceptable to the department of state police. If the individual has been the subject of a criminal history check conducted in compliance with this section, the individual shall give written consent at the time of application for the adult foster care facility or staffing agency to obtain the criminal history record information as prescribed in subsection (4) or (5) from the relevant licensing or regulatory department and for the department of state police to conduct a criminal history check under this section if the requirements of subsection (11) are not met and a request to the Federal Bureau of Investigation to make a determination of the existence of any national criminal history pertaining to the individual is necessary, along with identification acceptable to the department of state police. Upon receipt of the written consent to obtain the criminal history record information and identification required under this subsection, the adult foster care facility or staffing agency that has made a good-faith offer of employment or an independent contract to the individual shall request the criminal history record information from the relevant licensing or regulatory department and shall make a request regarding that individual to the relevant licensing or regulatory department to conduct a check of all relevant registries in the manner required in subsection (4). If the requirements of subsection (11) are not met and a request to the Federal Bureau of Investigation to make a

	subsequent determination of the existence of any national criminal history pertaining to the individual is necessary, the adult foster care facility or staffing agency shall proceed in the manner required in subsection (5). A staffing agency that employs an individual who regularly has direct access to or provides direct services to residents under an independent contract with an adult foster care facility shall submit information regarding the criminal history check conducted by the staffing agency to the adult foster care facility that has made a good-faith offer of independent contract to that applicant.
ANALYSIS:	Based upon information obtained through interviews with Ms. Brown and Ms. Delmerico it can be determined that FirstLight Home Care provided sixteen private duty employees to work at the facility during the month of March 2025 and neither FirstLight Home Care, licensee designee, direct care staff, or Operations Manager, have proof of completed *Michigan Workforce Background Check* eligibility letters for any of these sixteen individuals. Therefore, a violation has been established.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE RENEWAL INSPECTION AS330297845_RNWL_20240129 AND CAP DATED 2/14/24].**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.**

ANALYSIS:	Based upon the interviews conducted with Ms. Brown and Ms. Delmerico it can be determined that the sixteen individuals assigned to work at the facility in the capacity of a direct care staff member, through FirstLight Home Care, did not receive training in the areas of resident rights, safety and fire prevention, reporting requirements. It was also reported by Ms. Brown that two of these individuals had not completed, or did not have adequate documentation of completing their cardiopulmonary resuscitation training and therefore were not competent in this area. Ms. Delmerico & Ms. Worthington reported that they did not have any documentation of trainings completed for any of these sixteen individuals and that Ms. Brown possessed all the training records. Ms. Brown reported that FirstLight Home Care provides training in CPR/First Aid, bloodborne pathogens, and personal care. She reported that the individuals are to be trained in the other areas as arranged by the licensee. Due to these findings, it can be determined that all sixteen of these individuals, who acted in the capacity of a direct care staff member, did not have documented training in resident rights, safety and fire prevention, and reporting requirements. Two of these individuals did not have documented completion of CPR/First Aid training. It was observed during the on-site investigation on 4/22/25 that Mr. Baker & Ms. Wilder did not have documentation of completed CPR/First Aid Training and Ms. Wilder did not have documentation of completed resident rights, crisis intervention, or reporting requirements trainings. Mr. Baker & Ms. Wilder had documentation of completing their required trainings, after they had already been assigned to work shifts, independently, at the facility. This did not demonstrate competence in required training areas prior to performing assigned tasks. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/29/24, Renewal Licensing Study Report, cited a violation of Rule 400.14205, regarding missing documentation of signed statement by a licensed physician attesting to the health of direct care staff members. The *Corrective Action Plan* submitted 2/14/24 stated that then direct care staff/Program Manager, Jessica Cortez, would be responsible for ensuring employee physicals were completed within 14 days of hire.

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the physician's knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.
ANALYSIS:	Based upon the interviews with Ms. Brown and Ms. Delmerico it can be determined that Ms. Delmerico reported she does not keep any direct care staff files for any of the sixteen individuals through FirstLight Home Care who provided personal care, supervision and protections services to residents during March 2025. As a result, documentation of a statement signed by a licensed physician attesting to the health of any of these individuals is not available for review. In addition, Ms. Moerland did not report having proof of any medical evaluations for the contracted direct care staff members. Therefore, a violation has been established.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE RENEWAL INSPECTION AS330297845_RNWL_20240129 AND CAP DATED 2/14/24].**

On 1/29/24, Renewal Licensing Study Report, cited a violation of Rule 400.14205, regarding missing documentation negative tuberculosis testing within the past three years for a direct care staff member. The *Corrective Action Plan* submitted 2/14/24 stated that then direct care staff/Program Manager, Jessica Cortez, would be responsible for ensuring employee negative tuberculosis tests were completed and documented within 14 days of hire.

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken

	as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.
ANALYSIS:	Based upon the interviews with Ms. Brown and Ms. Delmerico it can be determined that Ms. Delmerico reported she does not keep any direct care staff files for any of the sixteen individuals through FirstLight Home Care who provided personal care, supervision and protection services to residents during March 2025. As a result, documentation of a negative tuberculosis test within the last three years was not readily available for my review in the facility employee files. Therefore, a violation has been established.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE RENEWAL INSPECTION AS330297845_RNWL_20240129 AND CAP DATED 2/14/24].**

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(a) Name, address, telephone number, and social security number.** **(b) The professional or vocational license, certification, or registration number, if applicable.** **(c) A copy of the employee's driver license if a direct care staff member or employee provides transportation to residents.** **(d) Verification of the age requirement.** **(e) Verification of experience, education, and training.** **(f) Verification of reference checks.** **(g) Beginning and ending dates of employment.** **(h) Medical information, as required.** **(i) Required verification of the receipt of personnel policies and job descriptions.**

ANALYSIS:	Based upon the interview conducted with Ms. Delmerico it can be determined that there were not available employee files that were accessible for my review for the sixteen individuals who were contracted through FirstLight Home Care to provide personal care, supervision and protection services as direct care staff members during March 2025. Ms. Delmerico reported that FirstLight Home Care maintains these employee files. There was not documentation available for review of these individuals' experience, education, signed job description, signed personnel policy, age verification, reference checks, medical information, or drivers license. Ms. Brown keeps her own employee files on these individuals but Ms. Delmerico did not have immediate access to these files. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: (a) Names of all staff on duty and those volunteers who are under the direction of the licensee.
ANALYSIS:	Based upon my observations made in reviewing the direct care staff schedule for the facility, it can be determined that the names of the contracted direct care staff through FirstLight Home Care, do not appear on the direct care staff schedule for the month of March 2025. I inquired of Ms. Delmerico about the names of these individuals and she reported that she would have to look back at other paperwork to determine which individual worked on each date as their names do not appear on the direct care staff schedule. Due to this, a violation has been established as all direct care staff names shall appear on the direct care staff schedule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:

	(a) Be trained in the proper handling and administration of medication.
ANALYSIS:	Based upon interviews conducted with Ms. Brown and Ms. Delmerico it can be determined that the sixteen direct care staff who were contracted through FirstLight Home Care did not have proper medication administration training. Further review of the direct care staff schedule outlined that there were multiple occasions when these individuals were documented as the only direct care staff providing care at the facility. These direct care staff members were not trained in medication administration and providing care without the assistance of a direct care staff member trained in medication administration. It is noted through Resident A and Resident B's *Medication Administration Records* that they both were prescribed medications to be administered at different times throughout the day and as needed medications being prescribed. Ms. Brown reported that there were issues with her employees being scheduled as the only direct care staff in the facility and not being able to properly administer resident medications. Furthermore, Mr. Baker and Ms. Wilder both initialed the MARs for the month of March 2025 that they had administered resident medications, and their medication administration training records indicate that neither were trained in medication administration until April 2025. Therefore, a violation has been established due to the fact that the residents were left in the care of untrained direct care staff members who did not have the capability of properly administering medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(2) All staff who work independently and staff who function as lead workers with clients shall have successfully completed a course of training which imparts basic concepts required in providing specialized dependent care and which measures staff comprehension and competencies to deliver each client's individual plan of service as written. Basic training shall address all the following areas: **(b) An introduction to the special needs of clients who have developmental disabilities or have been diagnosed as having a mental illness. Training shall be specific to the needs of clients to be served by the home.** **(d) Basic first aid and cardiopulmonary resuscitation.**

	(e) Proper precautions and procedures for administering prescriptive and nonprescriptive medications. **(f) Preventing, preparing for, and responding to, environmental emergencies, for example, power failures, fires, and tornados.** **(g) Protecting and respecting the rights of clients, including providing client orientation with respect to the written policies and procedures of the licensed facility.** **(h) Nonaversive techniques for the prevention and treatment of challenging behavior of clients.**
ANALYSIS:	Based upon interviews conducted with Ms. Brown, Ms. Delmerico, & Ms. Worthington, as well as review of direct care staff training records, it can be concluded that the contracted direct care staff through FirstLight Home Care did not receive proper training to Resident A and Resident B's IPOS documents, medication administration, environmental emergencies, resident rights, or nonaversive techniques for the prevention and treatment of challenging behavior, prior to providing care to these residents. It was also discovered that two of the contracted direct care staff and two of the direct care staff employed through the licensee designee, did not have documentation of current cardiopulmonary resuscitation trainings. Due to these findings, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the on-site investigation on 3/31/25, I reviewed the following documents:

- Direct care staff schedule for the month of March 2025. I observed that there were multiple dates where the schedule was marked with the title, "Staffing Company" and there were hours scheduled under this name. There was not any individual person listed, but there were hours assigned under this category, just as hours were assigned next to regular direct care staff members names.

On 4/10/25 I interviewed Ms. Delmerico regarding the direct care staff schedule. She reported that they have had some staffing challenges and have been using a staffing agency, FirstLight Home Care, to supplement their staff schedule. Ms. Delmerico was asked about this staffing agency and whether the management at the facility has direct care staff files for the agency staff. Ms. Delmerico reported that the staffing agency keeps files of trainings and background checks for the individuals they send to the facility. I referenced the direct care staff schedule to Ms. Delmerico as there are spaces on the schedule that just read, "Staffing Company" and have time slots filled with this title. Ms. Delmerico reported that she did not have a list of the individuals sent by the staffing agency and would need to gather this information from FirstLight Home Care. She reported that she does not have trainings on hand for these agency employees and

that they are trained to the resident IPOS documents when they arrive on-site. Ms. Delmerico provided the name of Marci Brown, as a contact with FirstLight Home Care for follow up regarding training documentation and background checks on these individuals.

On 4/10/25 I interviewed FirstLight Home Care, employee, Marci Brown. Ms. Brown reported that FirstLight Home Care has a contract with the facility and they have been working together for a couple of years. She reported that their services will be used from time to time when the facility is short staffed. Ms. Brown reported that during the month of March 2025 12 of their employees provided direct care services at the facility for a total of approximately 192 hours. Ms. Brown reported that her employees cannot administer medications as they are not trained and competent in this area. She reported that there have been shifts where her employees were scheduled to work at the facility where they were the only direct care staff member working and another direct care staff, trained in medication administration was not paired with them to accommodate for this issue.

Ms. Brown also included in her email correspondence a schedule of the individuals who were contracted to work at the facility during the month of March 2025. *MARC HOUSE LOVEJOY March 2025* is the title of the document. I reviewed this schedule and made the following observations:

- There were not any contracted direct care staff scheduled at the facility on 3/22/25 – 3/26/25.
- Contracted direct care staff members did work at the facility on the following days, 3/1/25 – 3/5/25, 3/7/25 – 3/11/25, 3/13/25 – 3/17/25, 3/27/25 – 3/31/25.
- On the following dates the contracted direct care staff were scheduled to be at the facility as the only direct care staff provider present in the facility to provide for medication administration, personal care, supervision, and protection, as cross referenced to the facility direct care staff calendar:
    - 3/2/25: 3pm to 11pm
    - 3/3/25: 3pm to 7am the following day
    - 3/4/25: 11pm to 7am the following day
    - 3/7/25: 11pm to 7am the following day
    - 3/8/25: 11pm to 7am the following day
    - 3/9/25: 7am to 3pm
    - 3/13/25: 3pm to 7am the following day
    - 3/14/25: 3pm to 11pm
    - 3/15/25: 3pm to 11pm
    - 3/16/25: 3pm to 11pm
    - 3/17/25: 3pm to 11pm

During the on-site investigation on 3/31/25, I reviewed the following documents:

- Direct care staff schedule for the month of March 2025. I observed the following: On the following dates the contracted direct care staff were scheduled to be at the facility as the only direct care staff provider present in the facility to provide for medication administration, personal care, supervision, and protection.

    - 3/2/25: 3pm to 11pm
    - 3/3/25: 3pm to 7am the following day
    - 3/4/25: 11pm to 7am the following day
    - 3/7/25: 11pm to 7am the following day
    - 3/8/25: 11pm to 7am the following day
    - 3/9/25: 7am to 3pm
    - 3/13/25: 3pm to 7am the following day
    - 3/14/25: 3pm to 11pm
    - 3/15/25: 3pm to 11pm
    - 3/16/25: 3pm to 11pm
    - 3/17/25: 3pm to 11pm
- *Assessment Plan for AFC Residents*, document for Resident B, dated 4/4/24. On page two under section, III. Health Care Assessment, subsection, A. Taking Medication, the box for "No" is checked, indicating Resident B does not require assistance in this area. On page three, under section. V. Medications Taken At Time of Assessment, it reads, "See Attached". There was not an attachment included with this document at the time of the on-site investigation.
- *Health Care Appraisal* for Resident B, dated 2/26/24. Under section, 8. Current Medications and Instructions, it reads, "No Active Meds".
- *AFC – Resident Care Agreement,* for Resident B, dated 6/4/24. On page three, under section, 17, it reads, "I agree to supervise this resident's taking of his or her prescription medication unless otherwise indicated by a written statement from the resident's physician."
- *AFC – Resident Care Agreement,* for Resident A, dated 6/4/24. On page three, under section, 17, it reads, "I agree to supervise this resident's taking of his or her prescription medication unless otherwise indicated by a written statement from the resident's physician."
- *Assessment Plan for AFC Residents,* document for Resident A, dated 4/3/24. On page two under section, III. Health Care Assessment, subsection, A. Taking Medication, the box for "No" is checked, indicating Resident A does not require assistance in this area. On page three, under section. V. Medications Taken At Time of Assessment, it reads, "See Attached". There was not an attachment included with this document at the time of the on-site investigation.

On 4/16/25 I received fax transmittals from Ms. Delmerico containing the *Medication Administration Records* for Resident A & Resident B for the month of March 2025. I made the following observations:

- Resident A's March 2025 MAR:
    - Clonazepam Tab 2mg, Take 1 tablet by mouth twice daily. This medication was not initialed as being administered on the following dates and times; 3/4/25 & 3/5/25 at 8pm, 3/7/25 8am & 8pm, 3/9/25 – 3/12/25 8pm, 3/18/25 – 3/26/25 8pm, 3/29/25 & 3/30/25 at 8am.
    - Clonidine Tab 0.1mg, Take 1 tablet by mouth twice daily. This medication was not initialed as being administered on the following dates and times; 3/4/25 & 3/5/25 at 8pm, 3/7/25 8am & 8pm, 3/9/25 – 3/12/25 8pm, 3/18/25 – 3/26/25 8pm, 3/30/25 at 8am.

    - Fluoxetine Cap 20mg, Take 1 capsule by mouth daily. This medication is not initialed as being administered on 3/7/25 & 3/30/25.
    - Melatonin Sub 3mg, Take 1 tablet by mouth at bedtime. This medication was not initialed as being administered on the following dates, 3/4/25, 3/5/25, 3/7/25, 3/9/25 - 3/12/25, 3/18/25 - 3/26/25.
    - Olanzapine Tab 15mg, Take 1 tablet by mouth twice daily. This medication is not initialed as being administered on the following dates and times; 3/4/25 & 3/5/25 at 8pm, 3/7/25 8am & 8pm, 3/9/25 – 3/12/25 8pm, 3/18/25 – 3/26/25 8pm, 3/30/25 at 8am.
    - Topiramate Cap 25 mg, Take 1 capsule by mouth daily. This medication is not initialed as being administered on 3/7/25 and 3/30/25.
    - Trazadone Tab 50mg, Take 1 tablet by mouth at bedtime. This medication is not initialed as being administered on 3/4/25, 3/5/25, 3/7/25, 3/9/25 - 3/12/25, 3/18/25 - 3/26/25.
    - Vitamin D3 Tab 400Unit, Take 1 tablet by mouth daily. This medication is not initialed as being administered on 3/7/25 & 3/30/25.
    - Fleet Enema, Insert rectally as needed for constipation lasting longer than 3 to 4 days. There are no documented administrations of this medication during the month of March 2025.
    - Ibuprofen Tab 600mg, May also take 1 tablet by mouth every 6-8 Horus as needed for pain or discomfort. There are no documented administrations of this medication during the month of March 2025.
    - Loperamide Cap 2mg, Take 2 capsules by mouth after fist loose stool then 1 cap after each subsequent loose stool. There are no documented administrations of this medication during the month of March 2025.
    - Quetiapine Tab 25mg, Take 1 tablet by mouth twice daily as needed. This medication is recorded as being administered on 3/21/25 & 3/22/25.
    - Robitussin SF, Take 10ML by mouth every 4 hours as needed for cough. There are no documented administrations of this medication during the month of March 2025.
    - Stomach Relf Sus 525/30ML, Take 30ML by mouth every 30 to 60 minutes as needed for gas, upset stomach, indigestion, heartburn, nausea. There are no documented administrations of this medication during the month of March 2025.
    - Triple ANTIB OIN, Apply small amount on area 1 to 3 times daily as needed for minor cuts, scrape, and burns. There are no documented administrations of this medication during the month of March 2025.
    - Tums 500mg, Chew 2 to 3 tablets by mouth as needed or heartburn, acid indigestion, sour stomach, upset stomach. There are no documented administrations of this medication during the month of March 2025.
    - There were not any notations on the MAR accounting for the medications that were not signed for as being administered.
- Resident B’s MAR March 2025:
    - Clonidine Tab 0.1mg, Take 1 tablet by mouth at bedtime. This medication is not initialed as being administered on the following dates, 3/4/25, 3/5/25, 3/7/25, 3/9/25 - 3/12/25, 3/18/25 - 3/25/25.

- Concerta Tab 54mg, Take 1 tablet by mouth daily every morning. This medication has a Stop Date of 3/6/25 and was marked as being administered 3/1/25 – 3/6/25.
- Lamotrigine Tab 100mg, Take 1 tablet by mouth twice daily. This medication is not initialed as being administered on the following dates and times, 3/4/25 & 3/5/25 at 8pm, 3/7/25 8am & 8pm, 3/9/25 – 3/12/25 8pm, 3/18/25 – 3/25/25 8pm, 3/30/25 at 8am.
- Methylphenid Tab 54mg ER, take 1 tablet by mouth daily every morning. This medication is not initialed as being administered on the following dates, 3/1/25 – 3/7/25, & 3/30/25.
- Sertraline Tab 100mg, Take 1 tablet by mouth every morning. This medication is not initialed as being administered on 3/7/25 & 3/30/25.
- Sertraline Tab 50mg, Take 1 tablet by mouth every morning. This medication is not initialed as being administered on 3/7/25 & 3/30/25.
- Trazadone Tab 100mg, Take 1 tablet by mouth at bedtime. This medication is not initialed as being administered on 3/4/25, 3/5/25, 3/7/25, 3/9/25 - 3/12/25, 3/18/25 - 3/25/25.
- Tylenol ER 650mg GEQ, Take 1 tablet by mouth every 8 hours as needed *Do not crush, swallow whole*. There are no documented administrations of this medication during the month of March 2025.
- There were not any notations on the MAR accounting for the medications that were not signed for as being administered.

- Ms. Wilder & Mr. Baker, both initialed that they administered resident medications during the month of March 2025.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based upon interviews conducted with Ms. Delmerico and Ms. Brown as well as review of documentation gathered during this investigation it can be determined that the facility has not been staffed appropriately to provide for the services specified in the resident care agreements for both Resident A & Resident B. During this investigation, it was discovered that employees through the FirstLight Home Care agency were being utilized to supplement direct care staffing at the facility. There were multiple occasions when these contracted direct care staff were the only direct care staff scheduled to be providing care to Resident A & Resident B. After reviewing Resident A & Resident B's *Resident Care Agreements* and *Medication Administration Records*, it can be determined that both Resident A & Resident B require the administration of both routine and as needed medications. It was identified that these contracted employees through FirstLight Home Care are not trained to administer medications yet were scheduled as the only direct care staff in the facility on multiple occasions during the month of March 2025. Furthermore, Mr. Baker and Ms. Wilder both initialed the MARs for the month of March 2025 that they had administered resident medications, and their medication administration training records indicate that neither were trained in medication administration until April 2025. As a result, these individuals were not capable of properly administering resident medications on these dates and therefore the facility was not adequately staffed to provide for the care specified on the *Resident Care Agreements* and the resident MARs.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based upon review of Resident A & Resident B's Medication Administration Records for the month of March 2025 and the discovery that direct care staff who were untrained in medication administration were being scheduled to work alone at the facility on multiple occasions, it can be determined that there is adequate evidence to suggest that resident medications have not been administered as ordered during the month of March 2025. I reviewed both Resident A and Resident B's MARs and discovered multiple dates and times where resident medications were not initialed as being administered and there were no available notations to identify why these medications were not signed for as being administered. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	During the review of Resident A & Resident B's *Medication Administration Records* for the month of March 2025, it was observed that there were multiple dates and times where direct care staff did not initial that medications had been administered to these residents. There were no available notations to identify why these medication administrations were not recorded on the MARs. Therefore, a violation has been established as all resident medication administrations are to be documented on the MAR once completed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Based upon the number and severity of quality care violations cited in this investigation, a recommendation for revocation of the license is recommended at this time.


4/30/25

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Jana Lipps Date
Licensing Consultant

Approved By:


04/30/2025

_____

Dawn N. Timm Date
Area Manager