



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 3, 2025

Timothy Van Dyk
Residential Opportunities, Inc.
1100 South Rose Street
Kalamazoo, MI 49001

RE: License #: AM390382663
Investigation #: 2025A0581026
Hoard Manor

Dear Timothy Van Dyk:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

A handwritten signature in black ink that reads "Cathy Cushman". The script is fluid and cursive, with the first letters of each name being capitalized and prominent.

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM390382663
Investigation #:	2025A0581026
Complaint Receipt Date:	04/10/2025
Investigation Initiation Date:	04/11/2025
Report Due Date:	06/09/2025
Licensee Name:	Residential Opportunities, Inc.
Licensee Address:	1100 South Rose Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-3731
Administrator:	Allen Giese
Licensee Designee:	Timothy Van Dyk
Name of Facility:	Hoard Manor
Facility Address:	305 West Cork Street Kalamazoo, MI 49001
Facility Telephone #:	(269) 343-9726
Original Issuance Date:	01/25/2018
License Status:	REGULAR
Effective Date:	07/25/2024
Expiration Date:	07/24/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION

	Violation Established?
Direct care staff, Aalyiah Stokes, is not treating residents with dignity and respect.	Yes

*** To maintain the coding consistency of residents across special investigations the residents in this special investigation report are not identified in sequential order.

III. METHODOLOGY

04/10/2025	Special Investigation Intake - 2025A0581026
04/10/2025	Referral - Recipient Rights - ISK involved.
04/11/2025	Special Investigation Initiated – Letter - Email with ISK rights
04/11/2025	Contact - Face to Face - MiTeams interview with Aliyah Stokes in conjunction with ISK RRO.
05/05/2025	Inspection Completed On-site - Interview with staff and residents
06/02/2025	APS Referral - No referral necessary. Staff no longer working in facility.
06/02/2025	Inspection Completed-BCAL Sub. Compliance
06/02/2025	Contact - Document Sent - Email to licensee's program director.
06/03/2025	Contact – Document Received – Fax from facility.
06/03/2025	Exit conference with the licensee designee, Timothy Van Dyk.

ALLEGATION: Direct care staff, Aalyiah Stokes, is not treating residents with dignity and respect.

INVESTIGATION: On 04/10/2025, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged direct care staff, Aaliyah Stokes, sent photos of Resident F to a friend while she was working in the facility. The complaint alleged Aaliyah Stokes mistreated Resident F in the photos because she showed herself holding a water bottle over him when he's afraid of water. Additionally, the complaint alleged Aaliyah Stokes antagonizes other residents by making things up, so they become angry and hit Resident A.

On 04/11/2025, I interviewed Integrated Services of Kalamazoo (ISK) Recipient Rights Officer (RRO), Kate Koyak, whose statement to me was consistent with the allegations. She stated she contacted Resident F's ISK case manager, Jackie Corbitt, who reported to her she was not aware of Resident F having any abnormal fears of water. Kate Koyak forwarded what she reported were screenshots of text messages between Aaliyah Stokes and an unidentified individual; however, only one screen shot contained a picture of Resident F and Aaliyah Stokes' identified phone number. This picture showed Resident F clapping his hands in front of his face while sitting on a chair in the facility. Upon further review of this screenshot, I could not determine what date it was taken or when it was sent although the time documented it was 9:34 pm.

I also reviewed an additional three screenshots of Resident F, which appeared to be taken on 11/04/2024 at approximately 4:06 pm. All three of these screenshots contained only photos of Resident F. They were all similar photos to one another consisting of Resident F putting his shoes on while sitting on a couch in the facility.

The final screenshot I reviewed of Resident F was dated 10/22/2024 at approximately 11:36 pm. It showed a picture of Resident F sleeping and lying on top of a bed and what appeared to be wrapped in a blanket and sheet with a CPAP machine on his face.

There were no additional pictures of Resident F, including no additional pictures documenting Aaliyah Stokes pouring water on Resident F. The additional screenshots forwarded by Kate Koyak contained irrelevant text messages between Aaliyah Stokes and an unidentified individual.

On 04/11/2025, Kate Koyak and I interviewed Aaliyah Stokes via MiTeams. Aaliyah Stokes' statement was contradicting throughout her interview. Initially, she stated she did not call or video call (e.g. Facetime) friends or family while working, but further along in the interview she acknowledged she did accept video calls while working; however, she denied residents being in the background of these video calls. Additionally, Aaliyah Stokes initially denied taking any photos of Resident F and sending them to anyone, but further along in the interview she stated she may have taken photos of Resident F's belongings and sent the photos via text to a group of her fellow employees. Aaliyah Stokes stated staff are not allowed to send photos of residents "due to HIPPA"; however, she could not provide an explanation for why she took photos of Resident F and sent them to friends or acquaintances.

Aaliyah Stokes stated Resident F can be difficult to shower because he does not like water on his head. She denied mistreating him by pouring or dripping water on him. She also stated Resident F prefers to sleep on top of his bedding with only a Detroit Tigers throw over him. Aaliyah Stokes initially denied swaddling or wrapping Resident F too tightly with a blanket, but later stated there had been a time where she "tucked" Resident F into bed, took a picture of him and sent it to a friend. She stated she did not wrap Resident F tightly with the blankets as a way to restrain him,

but described how she tucked a sheet and blankets under and around him for comfort. She stated after she took a photo of him she immediately untucked the sheet and blanket. Aaliyah Stokes stated she sent the picture of Resident F tucked in bed because she wanted to show a friend a picture of Resident F sleeping. Aaliyah Stokes was unable to provide any further explanation for her actions. She also denied antagonizing any of the residents so they would hit Resident A.

On 05/05/2025, I conducted an unannounced investigation at the facility. I interviewed Resident A's and Resident F's ISK case manager, Jackie Corbitt and the facility's two identified Assistant Program Coordinators, Gillian Thommes and Brittany Coggins de Pablo. All their statements were consistent with one another. Neither Jackie Corbitt, Gillian Thommes nor Brittany Coggins de Pablo had any knowledge of Aaliyah Stokes taking pictures of residents, specifically Resident F, and sending these pictures to friends, acquaintances, or coworkers. Additionally, none of them had any concerns Aaliyah Stokes was acting inappropriate with Resident A by antagonizing other residents so residents would hit Resident A or with her being inappropriate with Resident F. Their statements regarding Resident F's preference for sleeping was consistent with Aaliyah Stokes' statement to me. Both Gillian Thommes and Brittany Coggins de Pablo stated staff receive HIPPA training, including Aaliyah Stokes.

I interviewed Resident A who did not identify any concerns with Aaliyah Stokes antagonizing other residents to hit her. Resident A stated she did not observe Aaliyah Stokes take any pictures of Resident F.

I was unable to interview Resident F because he was difficult to understand and had difficulty communicating; however, I observed him during the inspection, and I had no concerns.

On 06/02/2025, I reviewed documentation from the licensee confirming Aaliyah Stokes' employment was terminated on 04/15/2025 because she photographed residents and shared these photographs, which resulted in a HIPAA violation and citation from ISK.

I also reviewed HIPPA training verification for Aaliyah Stokes confirming she completed this training through ISK in 2023.

On 06/03/2025, I reviewed Resident F's ROI assessment plan and his ISK assessment plan, both dated 06/17/2024. According to these assessment plans, Resident F can be difficult to understand. Though Resident F's assessment plans documented he does not like showering they did not identify any specific fears or aversion to water. Additionally, his assessment plans did not identify a preference for sleeping on top of his bedding with only one blanket draped over him or any difficulties or inabilities in removing bedding if placed on him. The assessment plan documented Resident F is ambulatory and capable of dressing himself.

APPLICABLE RULE	
R 400.14304	Resident rights; licensee responsibilities.
	<p>(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:</p> <p style="padding-left: 40px;">(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.</p> <p>(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.</p>
ANALYSIS:	<p>There is no supporting evidence Aaliyah Stokes poured water over Resident F's head, as alleged.</p> <p>However, based on my investigation, which included reviewing screenshots of text messages between direct care staff, Aaliyah Stokes, and an unknown individual, and Aaliyah Stokes' own admission, there is supporting evidence Aaliyah Stokes violated Resident F's need for privacy when she took pictures of him and forwarded these pictures to acquaintances via text.</p> <p>Additionally, multiple staff, including Aaliyah Stokes, stated Resident F prefers to sleep on top of his bedding with just a blanket covering him; however, Aaliyah Stokes admitted she "tucked" Resident F in to bed by securing the edges of his blanket under and around his body despite this not being Resident F's preference. Consequently, Aaliyah Stokes did not treat Resident F with consideration and respect when she secured him into bed using his own bedding and blankets.</p>
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14308	Resident behavior interventions prohibitions.
	<p>(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:</p> <p style="padding-left: 40px;">(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia,</p>

	contraptions, material, or equipment for the purpose of immobilizing a resident.
ANALYSIS:	Though I reviewed a photo of Resident F secured in his bed with his own bedding and Aaliyah Stokes own admission of securing the edges of Resident F's bedding under and around him, I do not have supporting evidence Resident F was incapable of removing the bedding. Subsequently, there is insufficient evidence supporting Aaliyah Stokes restrained or mistreated Resident F when she tucked him in to bed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 06/03/2025, I conducted the exit conference with the licensee designee, Timothy Van Dyk, via email, informing him of my findings.

IV. RECOMMENDATION

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

Cathy Cushman

06/03/2025

Cathy Cushman
Licensing Consultant

Date

Approved By:

Dawn Timm

06/03/2025

Dawn N. Timm
Area Manager

Date