GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 5, 2025

Roland Higgs
Family Living Center Inc.
Suite 220
2350 Franklin Rd.
Bloomfield Hills, MI 48302

RE: License #: AS630377628
Investigation #: 2025A0612016
Rainbow Group Home

Dear Mr. Higgs:

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 (248) 972-9136.

Sincerely,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(248) 302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630377628
Investigation #:	2025A0612016
Complaint Receipt Date:	04/14/2025
Investigation Initiation Date:	04/16/2025
Report Due Date:	06/13/2025
Licensee Name:	Family Living Center Inc.
Licensee Address:	Suite 220 2350 Franklin Rd. Bloomfield Hills, MI 48302
Licensee Telephone #:	(248) 334-5330
Administrator:	Roland Higgs
Licensee Designee:	Roland Higgs
Name of Facility:	Rainbow Group Home
Facility Address:	19331 Rainbow Drive Lathrup Village, MI 48076
Facility Telephone #:	(248) 569-8289
Original Issuance Date:	12/03/2015
License Status:	REGULAR
Effective Date:	05/31/2024
Expiration Date:	05/30/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 04/05/25, Resident A left the house and was found standing outside with his pants at his ankles. Staff did not know that he had left the house.	Yes

III. METHODOLOGY

04/14/2025	Special Investigation Intake 2025A0612016
04/15/2025	APS Referral Referral received from Adult Protective Services (APS). Assigned APS worker Gene Evans.
04/16/2025	Special Investigation Initiated - Letter Email sent to assigned APS worker Gene Evans to coordinate.
04/16/2025	Referral - Recipient Rights Referral made to Oakland Community Health Network - Office or Recipient Rights via email.
04/16/2025	Contact - Telephone call made Telephone call to reporting source. There was no answer. I left a voicemail requesting a return call.
04/16/2025	Contact - Telephone call received Telephone interview completed with reporting source.
04/16/2025	Contact - Document Received Copy of Resident A's Individual Plan of Service and Crisis Plan received via email.
04/16/2025	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed assistant home manager Felica Gross and direct care staff Jacob Neba.
04/16/2025	Contact - Telephone call made

	Telephone interview completed with home manager Oscar Duru and direct care staff Precious Tiobiog-Ayos.
04/16/2025	Contact - Document Received Two incident reports received via email from home manager Oscar Duru.
04/21/2025	Exit Conference I placed a telephone call to licensee designee Roland Michael Higgs to conduct an exit conference.

ALLEGATION:

On 04/05/25, Resident A left the house and was found standing outside with his pants at his ankles. Staff did not know that he had left the house.

INVESTIGATION:

On 04/15/25, I received a referral from Adult Protective Services (APS) that indicated Resident A lives at Rainbow group home. Resident A has an intellectual development delay, Autism, and impulse control issues. Resident A is not able to make decisions for himself. Resident A is one of six residents that reside in the group home. On Saturday, 04/05/25, Resident A got out of the group home and was standing in the street with his pants down at his ankles. The staff did not know he got out of the home. One of the neighbors alerted the staff that he was out in the street. The staff that was assigned to Resident A did not know he was out of the home. There are alarms on the doors that are supposed to alert staff when someone leaves but there is concern that these door alarms were turned off, so they are not aware when the resident left the home.

On 04/16/25, I initiated my investigation by emailing APS worker Gene Evans to coordinate. Mr. Evans stated he completed an onsite inspection on 04/15/25. Per report from staff at the group home there were two staff members working when this incident occurred, Precious Tiobiog-Ayos and Jacob Neba. It was reported that Jacob Neba had four residents with him in the basement and Precious Tiobiog-Ayos was one on one with Resident A. Mr. Neba reported that he is not sure what Ms. Tiobiog-Ayos was doing when Resident A went outside without supervision. Mr. Evans was informed that Ms. Tiobiog-Ayos has been taken off the schedule. On 04/15/25, I made a referral to Oakland Community Health Network (OCHN) - Office or Recipient Rights (ORR) via email. The investigation was assigned to Recipient Rights Specialist Heather Shepheard. OCHN – ORR provided a copy of Resident A's Easter Seals MORC Individual Plan of Service and Crisis Plan via email.

On 04/16/25, I interviewed the reporting source (RS) via telephone. RS stated she was informed that on 04/05/25, Resident A was found standing in the street with his pants down at his ankles. The staff did not know Resident A left the home. RS stated Resident A is nonverbal and he does not have adequate safety skills to be outside alone. It is unknown why Resident A's pants were down, removing his clothing is not a known behavior of Resident A's. RS stated the home has alarms on the egress doors that should alert staff if Resident A opens the door. If Resident A wants to go outside staff should go outside with him. RS stated on occasion the staff will turn off the door alarms as they are easily triggered if people are walking up and down the stairs to go in the basement.

On 04/16/25, I reviewed Resident A's Easter Seals MORC Individual Plan of Service (IPOS) and Crisis Plan. Resident A's Crisis Plan indicates on 03/20/23, the Behavior Treatment Plan Review Committee (BTPRC) approved door alarms to alert caregivers when Resident A exits the home without staff supervision. Staff will stay with Resident A outside or will escort him back into the home safely and provide him with an activity to engage him in to avoid him exiting the home again. Resident A's IPOS indicates Resident A is nonverbal. He has a diagnosis of Autism and may become agitated from sensory overload or chaotic environments. He may exhibit aggression or self-injurious behaviors.

On 04/16/25, I completed an unscheduled onsite investigation. I interviewed assistant home manager Felica Gross and direct care staff Jacob Neba. While onsite I observed Resident A, Resident B, Resident C, Resident D, and Resident E. Due to their respective intellectual disabilities the residents were unable to be interviewed. During the onsite inspection I observed the door alarms on the three egress doors in the home. The alarms on the front door and the back door that leads to the backyard were turned off and did not chime when the door was opened or closed. The alarm on the side door that opens to the driveway was on/ in working order.

On 04/16/25, I interviewed assistant home manager Felica Gross. Ms. Gross stated she was not present when the incident occurred however, when she came to work Sunday, 04/06/25, the day after the incident, she was informed that direct care staff Precious Tiobiog-Ayos was in the front room sleeping, wearing headphones, and not paying attention to Resident A. Direct care staff Jacob Neba was downstairs with three of the other residents and when he came back upstairs he noticed that Resident A was not in the home. Mr. Neba located Resident A outside in front of the house. Mr. Neba completed an Incident Report. Ms. Gross stated on Monday, 04/07/25, one of the neighbors stopped her while she was outside and told her that they observed Resident A alone outside, in the street, with his pants down. Ms. Gross wrote an Incident Report after talking to the neighbor. Ms. Gross stated Ms. Tiobiog-Ayos was suspended.

On 04/16/25, I interviewed direct care staff Jacob Neba. Mr. Neba stated on 04/05/25, he worked the day shift 7:00 am – 3:00 pm with Ms. Tiobiog-Ayos. Mr. Neba stated on Saturdays the staff are responsible for washing all the resident's bedding. Around 8:00 am he went into the basement with Resident B, Resident C, and Resident D. The residents have an area to hang out downstairs and Mr. Neba was going to do the laundry. Ms. Tiobiog-Ayos was upstairs in the front room, she was assigned to work with Resident A. Mr. Neba remarked Resident E was also home, however, he was spending time in his bedroom. Resident E is independent, he does not require direct supervision. Therefore, Ms. Tiobiog-Ayos was only responsible for directly supervising Resident A. Mr. Neba stated he came upstairs around 1:30 pm and he noticed that Resident A was not in the house. When he walked past the window in the front room, he saw Resident A standing outside, his pants were down around his ankles. Mr. Neba told Ms. Tiobiog-Ayos to go outside and get Resident A. When Resident A came inside, he was cold from being outside. His pants had fallen to his ankles because his brief was soiled and overweight. Mr. Neba quickly removed Resident A's brief, changed him into warm clothes, and stayed with him to monitor him. Mr. Neba stated he wrote and Incident Report and informed assistant home manager Ms. Gross about what occurred. Mr. Neba stated the door alarms were on and activated at the time of the incident however, Ms. Tiobiog-Ayos wears headphones while on shift and she cannot hear her surroundings and often does not respond to others.

On 04/16/25, I interviewed home manager Oscar Duru via telephone. Mr. Duru stated he was on vacation when the incident occurred. When he returned to work, he was informed about the incident from Ms. Gross and Mr. Neba. Mr. Duru stated he has worked with Resident A since 2018 and he has never walked away from the home. Mr. Duru explained that it is possible for Resident A to open the door and go outside, but he would not typically leave the yard. Mr. Duru stated Ms. Tiobiog-Ayos has been suspended.

On 04/16/25, I interviewed direct care staff Precious Tiobiog-Ayos via telephone. Ms. Tiobiog-Ayos stated she started her employment in December 2023. On 04/05/25, she worked the morning shift 8:00 am – 3:00 pm with Mr. Neba. Ms. Tiobiog-Ayos stated she was responsible for providing one on one supervision to Resident A as he is most likely to go outside without supervision. Ms. Tiobiog-Ayos stated sometime between 12:00 pm – 1:00 pm she was in the front room and Mr. Neba was in the kitchen. Resident B and Resident E were in their bedrooms, Resident C and Resident D were in the basement and she looked out of the front window and observed Resident A standing outside in the driveway. Ms. Tiobiog-Ayos estimated that Resident A was outside for 20 -30 seconds. Ms. Tiobiog-Ayos stated once she observed Resident A outside, she brought him back inside. Ms. Tiobiog-Ayos stated she did not see Resident A go outside however, she did hear the side door, that is closest to the kitchen open,

and slam close. Ms. Tiobiog-Ayos remarked that she thought Mr. Neba was watching Resident A since he was in the kitchen, so she did not respond to the door opening and closing. Ms. Tiobiog-Ayos stated she was wearing one Airpod in her ear during her shift because she listens to lectures while working. Ms. Tiobiog-Ayos remarked that the volume was low, and she could hear out of her other ear. Ms. Tiobiog-Ayos stated the doors have alarms however, they were turned off. Ms. Tiobiog-Ayos does not know why the door alarms were not being utilized. Ms. Tiobiog-Ayos stated Resident A's pants regularly fall down and staff have to constantly readjust them and pull them back up. Ms. Tiobiog-Ayos denied that Resident A's pants had fallen off when he was found outside. Ms. Tiobiog-Ayos further denied that Resident A's brief was soiled. Ms. Tiobiog-Ayos stated Resident A requires full assistance with toileting. However, during her shift on 04/05/25, she did not change Resident A's brief because it was not soiled. Ms. Tiobiog-Ayos stated when she was ending her shift at 3:00 pm, Resident A's brief was wet, Mr. Neba changed him. Ms. Tiobiog-Ayos denied sleeping on shift.

On 04/16/25, I reviewed two Incident Reports (IR's) sent via email from home manager Oscar Duru. IR # 497482 written by assistant home manager Felica Gross and IR # 497483 written by direct care staff Jacob Neba. The IR's are consistent with what Ms. Gross and Mr. Neba reported when interviewed.

On 04/21/25, I placed a telephone call to licensee designee Roland Michael Higgs to conduct an exit conference and review my findings. Mr. Higgs was advised that a corrective action plan is required, he acknowledged and agreed to provide one.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the information gathered during this investigation there is sufficient information to conclude that on 04/05/25, Resident A was not provided with supervision, protection, and personal care as specified in his Individual Plan of Service (IPOS) and Crisis Plan. Resident A's Easter Seals MORC IPOS and Crisis Plan indicate that the Behavior Treatment Plan Review Committee (BTPRC) approved door alarms to alert caregivers when Resident A exits the home without staff supervision. Resident A's IPOS indicates that he is nonverbal, he has a diagnosis of Autism, and he may become agitated from sensory overload or chaotic environments. Resident A may exhibit aggression or self-

	injurious behaviors. As such, Resident A does not have the safety skills to access the community independently. Direct care staff Precious Tiobiog-Ayos stated on 04/05/25, she was responsible for providing one on one supervision to Resident A as he is most likely to go outside without supervision. Direct care staff Jacob Neba was also on shift. Mr. Neba was responsible for supervising the other residents. Although Ms. Tiobiog-Ayos denied sleeping on shift she stated that she was wearing an Airpod in her ear and listening to a lecture. Ms. Tiobiog-Ayos said that she did not see Resident A go outside however, she heard the side door open and slam close. Ms. Tiobiog-Ayos remarked that she thought Mr. Neba was supervising Resident A because he was in the kitchen, so she did not respond to the door opening and closing. Resident A was found outside, in front of the house, with his pants down around his ankles. Mr. Neba stated Resident A's pants had fallen because his brief was soiled and overweight. Although Ms. Tiobiog-Ayos denied that Resident A's pants were down when he was found outside and further denied that his brief was soiled, she stated that Resident A requires full assistance with toileting and during her shift (8:00 am – 3:00 pm) she did not change his adult brief as she indicated that it was not soiled.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	Based on the information gathered during this investigation there is sufficient information to conclude that Resident A's Easter Seals MORC IPOS and Crisis Plan includes interventions to address unacceptable behavior however, these

	interventions are not being employed in accordance with the plan. Resident A's Easter Seals MORC Crisis Plan indicates that the Behavior Treatment Plan Review Committee (BTPRC) approved door alarms to alert caregivers when Resident A exits the home without staff supervision. On 04/16/25, I completed an unscheduled onsite investigation. Two of the three door alarms were turned off. The alarms on the front door and the back door that leads to the backyard were turned off and did not chime when the door was opened or closed. The alarm on the side door that opens to the driveway was on/ in working order. The reporting source stated on occasion staff will turn off the door alarms. Although direct care staff Jacob Neba stated the door alarms were on and activated at the time of the incident direct care staff Precious Tiobiog-Ayos stated the door alarms were turned off.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

04/28/2025

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Johnna Cade Date
Licensing Consultant

Approved By:

For 06/05/2025

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Denise Y. Nunn Date
Area Manager