GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 17, 2025

Roger Covill
North-Oakland Residential Services Inc
P. O. Box 216
Oxford, MI 48371

RE: License #: AS630402011
Investigation #: 2025A0612021
Dunwoodie

Dear Mr. Covill:

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 #:	AS630402011
Investigation #:	2025A0612021
Complaint Receipt Date:	06/23/2025
Investigation Initiation Date:	06/23/2025
Report Due Date:	07/23/2025
Licensee Name:	North-Oakland Residential Services Inc
Licensee Address:	106 S. Washington Oxford, MI 48371
Licensee Telephone #:	(248) 969-2392
Administrator:	Roger Covill
Licensee Designee:	Roger Covill
Name of Facility:	Dunwoodie
Facility Address:	1781 Dunwoodie Ortonville, MI 48462
Facility Telephone #:	(248) 793-3066
Original Issuance Date:	03/27/2020
License Status:	REGULAR
Effective Date:	01/25/2024
Expiration Date:	01/24/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 06/05/25, a bruise was found on Resident A's penis.	Yes
Resident A alleged that direct care staff Demechia caused the bruise by pushing him.	No

III. METHODOLOGY

06/23/2025	Special Investigation Intake 2025A0612021
06/23/2025	APS Referral Referral received from Adult Protective Services (APS). Assigned APS worker Angelique Evans.
06/23/2025	Special Investigation Initiated - Letter Email sent to assigned Recipient Rights Specialist Sarah Rupkus.
06/23/2025	Contact - Document Received Resident A's Individual Plan of Service and Crisis Plan received via email.
06/24/2025	Contact - Telephone call made Telephone interview completed with Resident A's Family Member.
06/24/2025	Contact - Telephone call made Telephone call to Resident A's guardian. There was no answer. I left a voicemail requesting a return call.
06/25/2025	Contact - Document Received Email correspondence (pictures) received from Resident A's Family Member.
06/26/2025	Inspection Completed On-site I completed an unscheduled onsite inspection. I interviewed direct care staff Shania Robinson.
07/03/2025	Contact - Document Received Resident A's Personal Care Logs dated 06/02/25 - 06/04/25 and Resident A's Health Care Chronological (HCC) received via email.

07/03/2025	Contact - Telephone call made Telephone interview completed with direct care staff DelRico Washington.
07/03/2025	Contact - Telephone call made Telephone interview completed with Recipient Rights Specialist Sarah Rupkus.
07/07/2025	Contact - Telephone call made Telephone interviews completed with direct care staff Demechia Sanders and Greg Williams.
07/09/2025	Contact - Telephone call made Telephone call to Dr. Montrose. There was no answer. I left a voicemail requesting a return call.
07/10/2025	Contact - Telephone call received Telephone interview completed with Dr. Montrose.
07/16/2025	Exit Conference I placed a telephone call to the licensee designee Roger Covill to conduct an exit conference. There was no answer. I left a detailed voicemail regarding my findings.

ALLEGATION:

- **On 06/05/25, a bruise was found on Resident A's penis.**
- **Resident A alleged that direct care staff Demechia caused the bruise by pushing him.**

INVESTIGATION:

On 06/23/25, I received a referral from Oakland Community Health Network (OCHN) – Office of Recipient Rights (ORR) and Adult Protective Services (APS).

The referral from OCHN – ORR indicates on 06/05/25, Resident A went to workshop at New Gateways where a bruise on his penis was discovered by New Gateways staff. On or around 06/09/25, Resident A's Family Member stated that she asked Resident A a series of yes or no questions to determine how the injury occurred. When Resident A's Family Member asked Resident A, "Did Demechia do this [cause the bruise]?", Resident A shook his head yes. Resident A's Family Member then asked Resident A, "Did she [Demechia] push you?", which Resident A's Family Member demonstrated to Resident A by pushing him on his back, Resident A shook his head yes. Resident A's Family Member stated that this was reported to home manager Vanessa Jones, who stated that Demechia would no longer be assigned to work with Resident A alone. On

06/23/25, I initiated my investigation by contacting the assigned Recipient Rights Specialist Sarah Rupkus via email. Ms. Rupkus and I scheduled a time to interview Resident A together.

The referral from APS indicates Resident A is severely cognitively impaired. Resident A resides in a group home, and he has been residing there for one year. Resident A can ambulate independently. Resident A has a legal guardian. On 06/02/25, Resident A was returned to the group home by his guardian. On 06/03/25, the group home informed Resident A's guardian that Resident A would not be going to New Gateways on Tuesday and Wednesday because he was ill. On 06/05/25, at 10:00 am, Resident A's guardian was told to pick Resident A up from the day program due to his penis being black. Resident A was seen by a doctor and the doctor determined that his penis was bruised, and he did not receive the bruise from falling. On 06/06/25 and 06/07/25, other bruises developed on Resident A's body. The bruises were located on his left hip, up to his belly button, and there were some bruises near his groin. The bruises were yellow and purple color. Resident A reported direct care staff Demechia Sanders, caused the bruises by pushing him from behind.

On 06/23/25, I emailed the assigned APS worker Angelique Evans to coordinate. Ms. Evans indicated that she spoke with home manager Vanessa Jones. Ms. Jones denied physically abusing Resident A. Ms. Jones stated Resident A has a tendency or a habit of fondling himself in front of other residents and staff have to redirect him to go to his room. One day he even took off his brief in the common area. Ms. Jones stated Monday through Friday from 7:30 am to 3:30 pm, Resident A goes to New Gateways and on the weekends his mother picks him up on Saturday evening and he returns on Sunday evening. As such, he is away from the home a lot. Ms. Jones indicated that she always observes Resident A when she bathes him after he spends the night away. She did not observe a change in Resident A's behavior when direct care staff Demechia is working with him further indicating Resident A loves her. Ms. Evans also indicated that she interviewed direct care staff Shania Robinson. Ms. Robinson denied physically abusing Resident A. Ms. Robinson confirmed that Resident A has a tendency to rub his genitals constantly.

On 06/24/25, I interviewed Resident A's Family Member via telephone. Resident A's Family Member is his standby guardian. Resident A's Family member confirmed the information reported in the referral. Resident A's Family Member stated Resident A cannot answer open ended questions. By asking him a series of yes or no questions Resident A confirmed by shaking his head that direct care staff Demechia caused the bruises on his body by pushing him. Resident A's Family Member concluded that Resident A sustained the injures sometime between 7:00 pm Monday, 06/02/25 – Thursday, 06/05/25, in the morning when Resident A arrived at workshop. Resident A's Family Member stated in February 2025 Resident A broke his left hip. The bruises that Resident A has currently are on his left side. Resident A was taken to his doctor, and they determined that there are no internal issues causing the bruises. Resident A's Family Member stated Resident A requires full assistance with completing his activities of daily living (ADL). Resident A's Family Member indicated that because the bruises on

Resident A's body are even with the bathroom counter she suspects that while a staff was assisting him in the bathroom they pushed him into the bathroom counter from behind causing the bruises.

On 06/26/25, I completed an unscheduled onsite inspection. I interviewed direct care staff Shania Robinson. During the onsite inspection I observed Resident B. Due to his cognitive delays Resident B was unable to be interviewed.

On 06/26/25, I interviewed direct care staff Shania Robinson. Ms. Robinson stated she has been working for this company since 2019. Ms. Robinson stated she was made aware of the allegation when Resident A's guardian showed her pictures of the bruising on Resident A's penis. Ms. Robinson stated Resident A's guardian alleged that direct care staff Demechia Sanders caused the injury. Ms. Robinson stated she works with Ms. Sanders often, she is kind and caring and she does not suspect that she caused the bruises on Resident A. Ms. Robinson stated Resident A walks independently, often moving fast he could have unintentionally caused the bruises to himself. He also goes to New Gateways daily, and to his guardian's house where he spends the night regularly. Ms. Robinson remarked that Resident A could have injured himself anywhere at any time. Ms. Robinson stated Resident A uses his hands and frequently rubs his penis over his clothing and brief. She has never seen him expose himself. Additionally, she has observed Resident A slam his tablet on his lap which could have caused the bruising. Ms. Robinson stated when Resident A experiences pain, he will usually notify staff by pointing to the area. Resident A did not express that he was in pain or discomfort. Ms. Robinson stated Resident A requires assistance with ADLs. Staff change his brief in the bathroom or his bedroom. Resident A stands and the staff stand behind him while completing the brief change. Resident A will usually hold on to the dresser or the counter for stability. Resident A does not resist brief changes. Ms. Robinson denied that she caused the bruising to Resident A.

On 06/26/25, in collaboration with Recipient Rights Specialist Sarah Rupkus, I conducted interviews at New Gateways. I interviewed Resident A, New Gateways team lead Kadijah Ford, New Gateways staff Adrew Forge, and New Gateways staff Connie Birchett.

On 06/26/25, I interviewed Resident A. Resident A greeted me, gave eye contact, and answered yes or no to casual questions/pleasantries by shaking his head. Resident A declined to respond to yes or no questions related to this allegation. It should be noted that when questioned, Resident A's head nodes were not consistent and did not appear to be a reliable form of communication.

On 06/26/25, I interviewed New Gateways team lead Kadijah Ford. Ms. Ford stated she has worked with Resident A for four years. Resident A wears a brief, and he requires assistance with ADL's. When staff change his brief Resident A stands up and staff stand behind him. Resident A holds on to the counter in front of him and staff change the brief. Resident A does not resist or refuse brief changes. Ms. Ford stated on 06/05/25, New Gateways staff Andrew Forge was changing Resident A's brief when he

observed a bruise on his penis. Mr. Forge called her over to observe the injury. Ms. Ford asked Resident A if someone hit him, and he shook his head yes. Ms. Ford stated Resident A does not like his current group home and she knows this because Resident A shakes his head “no” when asked if he likes living there.

On 06/26/25, I interviewed New Gateways staff Andrew Forge. Mr. Forge stated during the afternoon on 06/05/25, he was changing Resident A’s brief, and he observed bruising on his penis. He notified Ms. Ford of the injury and completed an incident report. Mr. Forge stated he has never observed bruising on Resident A before. He is not someone who is easily or commonly bruised. Mr. Forge stated he did not ask Resident A what caused the bruise as to not interfere with any investigation that may be conducted. Mr. Forge explained when changing Resident A’s brief Resident A stands and he stands in front of Resident A as he finds it easier to assist him this way. However, most staff stand behind Resident A to change his brief. It is not common for Resident A to resist having his brief changed.

On 06/26/25, I interviewed New Gateways staff Connie Birchett. Ms. Birchett stated she transports Resident A to and from New Gateways and his AFC home. Ms. Birchett does not provide Resident A with personal care, and she did not see the bruising to his penis. Ms. Birchett stated Resident A hates his AFC home and when she drops him off at the house he does not want to get out of the van. Ms. Birchett remarked that she has to verbally encourage Resident A to get out of the van and go home when she drops him off. Ms. Birchett stated in the mornings Resident A is happy to see her and excited to get on the van and come into New Gateways. Ms. Birchett stated she mostly interacts with the home manager Vanassa Jones who is friendly, however, the other staff who work at the home are not friendly. Ms. Birchett does not have any information regarding how Resident A sustained the bruises on his body.

On 07/03/25, in collaboration with Recipient Rights Specialist Sarah Rupkus, I interviewed direct care staff DelRico Washington via telephone. Mr. Washington stated he has worked at this company for one to two years. He works on all shifts. Mr. Washington stated when he arrived for his shift on an unknown date he was informed by home manger Vanessa Jones that Resident A had a bruise on his penis. Ms. Jones informed him that Resident A’s guardian was aware, and an incident report was written. Mr. Washington stated he observed bruising on the shaft of Resident A’s penis, it was fading. There was also bruising on Resident A’s leg where his brief cups his leg. Mr. Washington stated he has no idea what caused the bruises. Mr. Washington remarked, Resident A wears briefs that have tabs that must be tightened so that the brief stays up, he does not wear pull ups. Typically, this style of brief is used on someone who is not as active as Resident A. Mr. Washington stated if the brief was put on too tight that could have caused the bruising. Mr. Washington does not suspect that any staff caused the bruising to Resident A. Mr. Washington stated Dunwoodie is the best home that he has ever worked at. Mr. Washington works with direct care staff Demechia Sanders, he remarked that Ms. Sanders has been working there longer than him, she is the best worker there. Mr. Washington does not suspect that she caused the bruises on Resident A. Mr. Washington stated Resident A uses both hands and frequently rubs his

penis over his clothing and brief. He does this constantly and when redirected he will stop for a short time then continue. Mr. Washington has never seen Resident A expose himself in a common area. Mr. Washington further states Resident A drops his tablet on his lap which could have caused the injury. Mr. Washington stated Resident A requires assistance with ADL's. Staff change his brief in the bathroom and in his bedroom. Resident A stands up and the staff stand behind him while completing the brief change. Resident A does not resist brief changes, but he does move around a lot. Mr. Washington denied that he caused the bruises on Resident A.

On 07/03/25, Recipient Rights Specialist Sarah Rupkus stated that she interviewed home manager Vanessa Jones. Ms. Jones stated that she showered Resident A on Wednesday 06/04/25, at night she did not observe any bruises on Resident A. Ms. Jones explained that when staff shower Resident A the staff stand behind him and/or to the side of him while he is sitting on a shower chair. Staff stand behind him as he may urinate or self-pleasure. Ms. Jones stated staff give him a chance to wash his body himself and then they go back over him. Staff wash his private parts. Ms. Jones stated that no falls were reported to her by staff from 06/02/25 - 06/04/25. Ms. Jones stated that even if Resident A fell while staff were changing his brief, he would not have fallen on his penis, but on hands and knees. Ms. Jones stated that she does not suspect that any staff caused bruises on Resident A. Resident A's brief is changed in his bedroom or the bathroom. Staff are trained to change Resident A's brief standing behind him. There were no reported issues from staff while changing Resident A's brief.

On 07/07/25, in collaboration with Recipient Rights Specialist Sarah Rupkus, I interviewed direct care staff Demechia Sanders via telephone. Ms. Sanders has worked for this company for two years. Ms. Sanders stated she worked on 06/02/25, then she was off for two days. When she returned to work, she was informed by home manager Vanessa Jones that Resident A had a bruise on his penis, and it was alleged that she caused it. Ms. Sanders denied causing the bruise on Resident A's penis. Ms. Sanders stated the last time she worked with Resident A she did not assist him with the ADL's she only passed his medications. Ms. Sanders stated she does not know what caused the bruise to Resident A's penis. Ms. Sanders denied witnessing Resident A injury himself or fall. Ms. Sanders stated Resident A does have a habit of repeatedly rubbing his genitals using both of his hands over top of his clothing and brief. He does this often and he must be redirected.

On 07/07/25, in collaboration with Recipient Rights Specialist Sarah Rupkus, I interviewed direct care staff Greg Williams via telephone. Mr. Williams stated he has been working for this company for one month. He was informed that Resident A had a bruise on his penis from the home manager Vanessa Jones and Resident A's guardian. It was alleged that direct care staff Demecia Sanders caused the bruising. Mr. Williams stated Ms. Sanders is a good person and a good employee. He has no concerns about how she interacts with Resident A; he does not suspect that she caused the bruising. Mr. Williams stated he does not know how Resident A bruised his penis he did not witness Resident A fall or injure himself. Mr. Williams denied that he caused the bruise.

Mr. Williams stated he assists Resident A with bathing and brief changes he has not had any injuries or issues while providing him with ADL care.

On 07/10/25, I interviewed Resident A's doctor, Dr. Montrose, via telephone. Dr. Montrose stated the bruise on Resident A's penis is an odd location to have a bruise. She further remarked that it is a "stranger pattern for bruising." Dr. Montrose completed an ultrasound on Resident A and found no medical issues causing the bruise. Dr. Montrose stated she does not have contact with staff from the group home as they do not bring Resident A to his medical appointments. Dr. Montrose further remarked that she does not typically work with patients who live in a group home setting. Dr. Montrose stated the bruise to Resident A's penis could possibly have been caused by someone pushing him while changing his brief. Dr. Montrose stated Resident A is nonverbal and was unable to report what caused the bruising at the time of his appointment.

On 06/23/25, I reviewed Resident A's Easter Seals MORC Individual Plan of Service (IPOS) and Crisis Plan. In summary, the IPOS and Crisis Plan indicate Resident A is totally dependent on others to ensure his safety. Resident A requires visual checks every 15 mins, when in his room 30 min visual checks. Resident A requires full assistance with personal care and activities of daily living. Resident A has a tendency to drop to his knees quickly while standing. Staff should monitor his legs for signs of injury. He will do this when he does not want to do something. Resident A has a history of self-injurious behaviors: Biting own hand; slapping own face as well as potentially not eating.

On 07/03/25, I reviewed Personal Care Logs dated 06/02/25 – 06/04/25 and Resident A's Health Care Chronological (HCC). Staff who worked with Resident A from 06/02/25 – 06/04/25 were interviewed. On 06/03/25, Resident A was showered during the 3:00 pm – 11:00 pm shift. Direct care staff DelRico Washington and Shania Robinson worked. On all shift Resident A was toileted and received assistance with grooming and dressing. Resident A's HCC indicates on 06/02/25 and 06/04/25 he was "gratifying himself" in the living room and was redirected to his bedroom.

On 06/25/25, I received three photos and a note from Resident A's My Chart Record sent via email from Resident A's Family Member.

- Photo # 1 is a picture of Resident A's penis taken on 06/05/25 when the injury was reported by New Gateways to Resident A's guardian at 10:00 am. Resident A's penis is bruised (black). There is also bruising under his testicles.
- Photo # 2 was taken on 06/08/25 and shows Resident A with yellow bruising on his belly button down across his groin to the hip and into leg.
- Photo # 3 was taken on 06/08/25 and shows Resident A's hip and leg area. Note: On 06/11/25, Resident A's hip surgeon completed an x ray of both hips and pelvis. They are bruised, not damaged.
- I reviewed correspondence between Resident A's Family Member and Resident A's doctor that was noted in Resident A's My Cart Record dated June 8, 2025. Resident A's Family Member inquired what could have caused the bruising.

Resident A's doctor stated, "I am not certain my only guess is he was fighting someone when they were changing him and they had to push him hard to get him to cooperate because it is not like a fall could do that, I really don't know how he could have sustained it."

On 07/16/24, I placed a telephone call to the licensee designee Roger Covill to conduct an exit conference. There was no answer. I left a detailed voicemail regarding my findings and informed Mr. Covill that a corrective action plan is required.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on the information gathered during this investigation there is sufficient information to conclude that on 06/05/25, Resident A had a bruise on his penis. On 06/06/25 – 06/07/25 additional bruising on his belly button down across his groin onto his hip and into his leg developed. Per Resident A's IPOS and Crisis Plan he is totally dependent on others to ensure his safety. Resident A requires visual checks every 15 mins. Resident A is nonverbal, he has a history of self-injurious behavior, he requires full assistance with personal care and activities of daily living. Per the Personal Care Logs dated 06/02/25 – 06/04/25 Resident A was showered, toileted, and he received assistance with grooming and dressing. However, all staff interviewed denied observing any bruises on Resident A while assisting him with ADL's including showering and/or toileting. Although, the cause for the bruising on Resident A's penis is unknown Resident A is nonverbal and completely dependent on staff for personal care. Direct care staff failed to perform ongoing monitoring for sudden adverse changes or adjustments to his physical condition and therefore were unable to obtain care immediately.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based on the information gathered during this investigation there is insufficient information to conclude that direct care staff Demechia Sanders used any form of physical force against Resident A resulting in the bruise on his penis. Although Resident A does have a bruise on his penis the cause of the bruise in undetermined. Resident A is fully ambulatory. Resident A leaves the home Monday – Friday to go to New Gateways from 7:30 am – 3:30 pm. He is transported to and from New gateways on a van with other individuals. Resident A regularly spends extended periods of time out of the home with his family. It was consistently reported that Resident A constantly rubs his genitals, he has been known to drop his iPad in his lap, and per his IPOS he has a history of self-injurious behavior and a tendency to drop to his knees quickly while standing. All staff interviewed denied concerns about the way that Ms. Sanders interacts with residents and further remarked that they do not suspect that she caused or contributed to the bruise on Resident A's penis. Resident A was interviewed however he declined to respond to yes or no questions related to this allegation. It should be noted that when questioned, Resident A's head nods were not consistent and did not appear to be a reliable form of communication. Moreover, Ms. Sanders denied the allegation. Ms. Sanders worked on 06/02/25 from 3pm – 11pm, then she was off for two days. Resident A returned home on 06/02/25 around 7:00 pm. During this shift Ms. Sanders did not provide personal care to Resident A. Ms. Sanders was on shift with home manager Vanessa Jones. Ms. Jones corroborated Ms. Sanders testimony as she denied that she and/or Ms. Sanders caused or contributed to the bruises on Resident A's penis.
CONCLUSION:	VIOLATION NOT ESTABLISHED

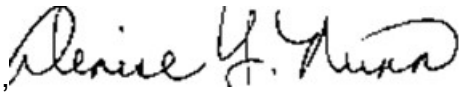
IV. RECOMMENDATION

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

07/16/2025

Johnna Cade — Date
Licensing Consultant

Approved By:



07/17/2025

Denise Y. Nunn — Date
Area Manager