GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 23, 2025

Shawn Brown
Domel Inc
21005 Farmington Road
Farmington Hills, MI 48336

RE: License #: AS820414053
Investigation #: 2025A0116035
West Home

Dear Mr. Brown:

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 (313) 456-0439.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820414053
Investigation #:	2025A0116035
Complaint Receipt Date:	07/03/2025
Investigation Initiation Date:	07/03/2025
Report Due Date:	09/01/2025
Licensee Name:	Domel Inc
Licensee Address:	21005 Farmington Road Farmington Hills, MI 48336
Licensee Telephone #:	(734) 632-0125
Administrator:	Shawn Brown
Licensee Designee:	Shawn Brown
Name of Facility:	West Home
Facility Address:	23033 Arsenal Flat Rock, MI 48134
Facility Telephone #:	(734) 782-4013
Original Issuance Date:	01/19/2023
License Status:	REGULAR
Effective Date:	07/19/2025
Expiration Date:	07/18/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A is not allowed to return to his day program. He is currently able to ambulate and bear weight. He desires to return. Home manager Ann Cavins is refusing to ensure that he gets to day program.	No
Additional Findings **All allegations reported were not addressed as they are not rule related**	Yes

III. METHODOLOGY

07/03/2025	Special Investigation Intake 2025A0116035
07/03/2025	Special Investigation Initiated - Telephone Supports coordinator manager, Carolyn Kowalski.
07/03/2025	APS Referral Not required as there is no allegation of abuse or neglect.
07/08/2025	Inspection Completed-BCAL Sub. Compliance Home manager, Ann Cavins, Resident A, reviewed updated doctor orders for Resident A.
07/17/2025	Contact - Telephone call made Public Guardian, Amy Torony.
07/17/2025	Contact - Telephone call received Home manager, Ann Cavins.
07/23/2025	Exit Conference Licensee designee, Shawn Brown.

ALLEGATION:

Resident A is not allowed to return to his day program. He is currently able to ambulate and bear weight. He desires to return. Home manager Ann Cavins is refusing to ensure that he gets to day program.

INVESTIGATION:

On 07/03/25, I interviewed supports coordinator manager, Carolyn Kowalski, and she reported that Resident A is improving, is ambulating, can bear weight, and should be able to attend day program again. Ms. Kowalski believes that the staff/home manager are not doing their jobs and are refusing to get him to his day program and other community outings. Ms. Kowalski is aware that the visiting physician had ordered Resident A homebound, however, she believes that this was done at the request of Ms. Cavins.

On 07/08/25, I conducted an unscheduled onsite inspection and interviewed home manager, Ann Cavins, Resident A, and reviewed the orders from Resident A's visiting physician.

Ms. Cavins denied the allegations and was visibly frustrated with the matter. Ms. Cavins believes that Resident A's supports coordinator and manager have a personal issue with her and continues to make false allegations against her and the staff. Resident A has had issues ambulating, and some days would crawl around the house because he did not have the strength to walk. Resident A is also strong willed and most days refuses to get out of bed, and/or leave the house. Ms. Cavins reported that occupational and physical therapy has helped when Resident A is willing to participate/cooperate. She added that the physical therapist informed her during his last visit to the home, that he would be terminating his services if Resident A continues to refuse to participate. Resident A has made some strides, and they have been able to get him in the community a couple times. However, a couple of days ago they attempted to take him out and he refused, started throwing things and cursing at the staff. Ms. Cavins reported they have begun documenting his refusals to participate in community outings. Ms. Cavins has begun calling workshop programs to see if they can get Resident A back enrolled. As of 07/03/25, Resident A is no longer homebound and can go back to his workshop program, if he is willing.

Ms. Cavins reported that recipient rights have been to the home and is investigating. She reported that the assigned investigator is Ann Alexander.

I interviewed Resident A and he reported that he wants to return to his day program because he is tired of everyone asking and talking to him about it. Resident A then asked me to leave his bedroom.

I reviewed the notes and updated order from Resident A's visiting physician dated 07/03/25. The order states the following;

- Patient was previously ordered home bound due to safety concerns while taking blood thinners and his risk for falls, with impaired gait and not using his walker due to being uncooperative. There were also concerns for overall general health. Patient has remained stable and is working with physical

therapy. Patient is no longer required to be strictly homebound. Will continue to monitor safety.

On 07/17/25, I interviewed public guardian, Amy Torony, and she reported that Resident A is doing better and has regained some of his strength back. Home manager, Ann Cavins, and licensee designee, Shawn Brown are actively working to get Resident A back into a workshop program. There was a doctor's order in place keeping Resident A homebound for a period of time and the home was adhering to the order. Ms. Torony was in full agreement for Resident A to go back to a workshop program and believes it will be good for him. Ms. Torony reported that the staff still may face challenges as Resident A has the right to refuse, and there is a real likelihood that some days he will. I shared with Ms. Torony, that I too am aware of this and recommended to Ms. Cavins, that she and the staff document the refusals.

On 07/17/25, I spoke with home manager, Ann Cavins, and she reported that on 07/15/25, the supervisor from Resident A's previous workshop program came to the home to assess him. She is familiar with Resident A and is willing to allow his return. The plan is to slowly reintegrate him by starting him two half days per week and will see how that goes before increasing the number and length of days he attends. The anticipated start will be around the first week of August.

On 07/23/25, I conducted the exit conference with licensee designee, Shawn Brown, and informed him of the findings of the investigation. Mr. Brown agreed with the findings.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(5) A licensee shall provide both of the following when specified in the resident's written assessment plan: **(b) An opportunity for involvement in educational, employment, and day programs.**

ANALYSIS:	Based on the findings of the investigation, there is insufficient evidence to substantiate the allegations. Resident A was under a homebound order by his visiting physician due to his overall health, risk of falls, and noncompliance with use of his walker. This order was rescinded on 07/03/25. Since that time, Resident A has been accessed by his former workshop program and will return the first week of August, if he does not refuse to participate. This violation is not established as the licensee designee is providing Resident A an opportunity for involvement in a day program.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/08/25, I conducted an unscheduled onsite inspection. While interviewing Resident A in his bedroom, urine permeated the air.

I interviewed home manager, Ann Cavins, and she reported that Resident A has been urinating on the bedroom floor and down the floor vent. Resident A has decided that he does not want to use the bathroom, and so multiple times per day she and the staff are cleaning and disinfecting his bedroom. I observed the flooring near the vent to be softening, which I attributed to the moisture from the urine. Ms. Cavins reported that it's getting more difficult to cover the smell, because it is likely coming through the ventilation system due to his repeated urination in the vent. Ms. Cavins reported that she has informed licensee designee, Shawn Brown, of the matter and they are trying to determine how to resolve this matter.

On 07/23/25, I conducted the exit conference with licensee designee, Shawn Brown, and informed him of the findings of the investigation. Mr. Brown reported his knowledge of the matter and his intent to address it.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.

ANALYSIS:	Based on the findings of the investigation, there is a preponderance of evidence to establish the violation. Resident A's bedroom smelled of urine and the flooring near the floor vent is softening, likely due to the moisture caused by Resident A constantly urinating on his bedroom floor. This violation is established as housekeeping standards presently do not present as comfortable and clean.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

07/23/25

Pandrea Robinson
Licensing Consultant

Date

Approved By:

07/23/25

Ardra Hunter
Area Manager

Date