GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 26, 2025

Dinah Mukwada
6423 S47th Street
CLIMAX, MI 49034

RE: License #: AS130418635
Investigation #: 2025A1034036
JD Cares LLC

Dear Ms. Mukwada:

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 (616) 356-0100.

Sincerely,

Kevin L. Sellers

Kevin Sellers, Licensing Consultant
Department of Licensing and Regulatory Affairs
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(517) 230-3704
SellersK1@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS130418635
Investigation #:	2025A1034036
Complaint Receipt Date:	07/16/2025
Investigation Initiation Date:	07/18/2025
Report Due Date:	09/14/2025
Licensee Name:	Dinah Mukwada
Licensee Address:	6423 S47th Street CLIMAX, MI 49034
Licensee Telephone #:	(269) 830-7252
Administrator:	Jasper Mukwada
Licensee Designee:	Dinah Mukwada
Name of Facility:	JD Cares LLC
Facility Address:	452 W. Jackson Street Battle Creek, MI 49037
Facility Telephone #:	(269) 267-9739
Original Issuance Date:	02/25/2025
License Status:	TEMPORARY
Effective Date:	02/25/2025
Expiration Date:	08/24/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Darcus Ondungah caused injury to Resident A.	Yes

III. METHODOLOGY

07/16/2025	Special Investigation Intake 2025A1034036
07/16/2025	APS Referral-Not made already involved
07/16/2025	Contact - Telephone Contact Made
07/18/2025	Special Investigation Initiated – Telephone Contact
07/29/2025	Contact - Telephone Contact Received
08/19/2025	Inspection Completed On-site
08/19/2025	Contact - Telephone Contact Made
08/19/2025	Contact – Telephone Contact Received
08/19/2025	Contact - Telephone Contact Made
08/19/2025	Contact - Telephone Contact Received
08/22/2025	Contact - Document Sent
08/22/2025	Contact - Document Received
08/22/2025	Contact - Telephone Contact Made
08/22/2025	Contact - Telephone Contact Made
08/25/2025	Contact - Telephone Contact Made
08/26/2025	Contact - Telephone Contact Received
08/26/2025	Exit Conference

ALLEGATION:

Darcus Ondungah caused injury to Resident A.

INVESTIGATION:

On 7/16/25, I received a complaint through LARA-BCHS complaint alleging on 06/22/25 Resident A went to the refrigerator removing a container of milk and proceeded to empty it into the sink. The complaint alleged direct care worker (DCW) Dorcas Ondungah attempted to stop Resident A slapping Resident A on the back causing an injury. The complaint then alleged on 06/29/25 Resident A attempted to remove something else from the refrigerator DCW Ondungah held the refrigerator door close. The complaint alleged Resident A held the refrigerator door DCW Ondungah slapped Resident A's hand and pushed Resident A causing no injury. The complaint alleged on 06/29/25 management was notified of the incidents taking no action continuing to let DCW Ondungah provide care for residents. The complaint alleged management informed Adult Protective Services (APS) DCW Ondungah's employment was terminated. Finally, the complaint alleged bruises were observed on Resident A's body along with other residents verifying they observed the abuse.

On 7/18/25, I interviewed Calhoun County Department of Health and Human Services Adult Protective Services (APS) Specialist Anika Settler via telephone. Ms. Settler reported investigating concerns Resident A was physically abused by DCW Dorcas Ondungah.

On 8/19/25, I conducted an unannounced onsite investigation and interviewed with licensee designee Dinah Mukwada at the facility. Mrs. Mukwada reported learning of the concerns involving Resident A after having a meeting with DCW Patience Tekyi-Arhin on 7/2/25. Mrs. Mukwada reported DCW Tekyi-Arhin disclosed witnessing DCW Darcas Ondungah utilize physical force with Resident A on 6/22/25 and again 6/29/25. Mrs. Mukwada reported DCW Tekyi-Arhin denied observing Resident A with bruises on either date. Mrs. Mukwada reported questioning DCW Tekyi-Arhin why the delay of reporting the abuse and the importance of reporting these incidents immediately. Mrs. Mukwada reported following protocol filing a complaint with Office of Recipient Rights (ORR) and APS. Mrs. Mukwada reported interviewing DCWs Darcus Ondungah and Constant Segbefia along with Resident A. Mrs. Mukwada denied observing any new bruising on Resident A's body. Mrs. Mukwada reported due to the severity of the complaint DCW Ondungah's employment was terminated early morning of 7/3/25. Mrs. Mukwada reported later in the day on this date APS arrived with law enforcement at the facility. Mrs. Mukwada denied being at the facility when they arrived but arrived after being contacted. Mrs. Mukwada reported APS interviewed DCW Segbefia, Resident B along with herself. Mrs. Mukwada reported APS was very rude and disrespectful towards her and kept emphasizing Resident A was abused. Mrs. Mukwada reported informing APS DCW Ondungah's employment was terminated earlier in the day. Mrs. Mukwada reported both APS specialist continued being rude and disrespectful and contacted Guardian A1 for consent to

transport Resident A to the hospital for further medical attention. Mrs. Mukwada shared about other times Resident A sustained scratches or cuts as each incident was documented in Resident A's progress notes. Mrs. Mukwada reported Resident A's Onpointe case manager and Guardian A1 were informed and incident reports were filed. Mrs. Mukwada reported after Resident A was transported to the hospital on 7/3/25 she remained there for thirty days. Mrs. Mukwada denied any knowledge of Resident A's whereabout now due to no information from APS or Resident A's case manager. Mrs. Mukwada shared about other employee terminations of DCWs Tekyi-Arhin and Segbefia on 7/4/25 due to DCWs violating repeated rules in the employee handbook. Mrs. Mukwada reported hiring three new DCWs on 7/4/25 due to the termination of these employees.

On 8/19/25, I interviewed administrator Jasper Mukwada at the facility. Mr. Mukwada's statements coincided with those of Mrs. Mukwada.

On 8/19/25, I interviewed Resident B at the facility. Resident B denied any concerns for his safety or witnessing DCW Ondungah abuse Resident A.

On 8/19/25, I reviewed JD Cares LLC Incident Reports (IR), dated 6/9/25, 6/13/25, 6/16/25 and 6/29/25 determined what was written in the IRs was consistent with what was reported by licensee Mukwada and administrator Mukwada. The IRs indicated on these dates [Resident A] was observed with older bruising, sustained a cut and scratch to her toe and knee. The actions taken by management and staff members was "document bruising or injuries in [Resident A] progress notes, inform [Resident A's] case manager and Guardian A1, file IRs and remain compliant with APS and LARA continue to investigate."

On 8/19/25, I reviewed Resident A's progress notes dated 6/9/25, 6/13/25 and 6/16/25. The Progress notes indicated on 6/9/25 during Resident A's admissions older bruising was observed on the right and left triceps of Resident A's arms. It was documented on 6/13/25 and 6/16/25 Resident A sustained a cut to her right toe, scratched to her right knee while walking with staff near the river adjacenced to the facility.

On 8/20/25, I interviewed Resident A's Onpoint case manager, Amber Johnson via telephone. Ms. Johnson reported she was informed by APS specialist Anika Settler and Guardian A1 that Resident A was assaulted by DCW Darcus Ondungah. Ms. Johnson reported her last visit with Resident A was sometime around 6/18/25. Ms. Johnson denied observing the recent bruises on Resident A. Ms. Johnson denied Resident A ever disclosed any issues or concerns at the facility during the times they met. Ms. Johnson reported for the last several weeks being off work. Ms. Johnson reported after returning to work receiving several voice mail message from Ms. Settler. Ms. Johnson reported one of the message from Ms. Settler indicated on 7/3/25 APS with assistance from law enforcement had Resident A transported to the hospital for further medical treatment. Ms. Johnson reported contacting Guardian A1 who informed her Resident A would remain at the hospital until APS was able to

locate new placement. Ms. Johnson shared Resident A remained at the hospital for thirty days until being placed at her new placement. Ms. Johnson denied any concerns for Resident A prior to this incident.

On 8/20/25, I interviewed Guardian A1 via telephone. Guardian A1 reported being aware of concerns Resident A was physically abused by DCW Ondungah. Guardian A1 denied knowing the actual date this occurred but received a call from APS specialist Anika Settler on 7/3/25 about unexplained bruising on Resident A. Guardian A1 reported Ms. Settler requested permission to transport Resident A to the hospital for further medical treatment. Guardian A1 reported giving permission to have Resident A transported to the hospital. Guardian A1 shared she was aware law enforcement was involved investigating the matter. Guardian A1 reported on 6/28/25 she picked up Resident A from the facility for a day trip that way Resident A could attend a family gathering. Guardian A1 reported while at the gathering other family members swam in the swimming pool. Guardian A1 reported Resident A wanted to swim so she assisted Resident A in the bathroom with her bathing suit. Guardian A1 reported while assisting Resident A she observed a small old darkened bruise on Resident A's left thigh. Guardian A1 shared questioning Resident A how she sustained the bruise. Guardian A1 denied Resident A provided any disclosures how she sustained the bruise or if someone caused the bruise. Guardian A1 reported Resident A was not residing at the facility very long. Guardian A1 reported Resident A's admissions was on 6/9/25 and final discharge on 8/6/25. Guardian A1 denied any concerns with Resident A's safety and care during the short period at the facility. Guardian A1 reported she was aware of prior injuries Resident A sustained at the facility that included scratches to her knee and a cut on her toe. Guardian A1 shared she was aware of two older bruises to Resident A's triceps prior to admissions. Guardian A1 then shared every time Resident A sustained an injury licensee Mukwada contacted her and provided a written IR. Guardian A1 reported Resident A was transported to the hospital on 7/3/25 and remained there for thirty days until Ms. Settler located another placement. Guardian A1 reported when she visited Resident A was when Ms. Settler pointed out the bruising on Resident A. Guardian A1 reported visiting Resident A more often at the new placement.

On 8/22/25, I followed up with APS specialist Anika Settler who reported substantiating her investigation against the facility due to evidence Resident A was assaulted by DCW Ondungah. Ms. Settler reported Detective Joshua Chapman from Battle Creek Police Department was continuing his investigation. Ms. Settler provided pictures taken of Resident A's injuries on 7/3/25.

On 8/19/25 and 8/22/25, I attempted to make contact with DCW Darcus Ondungah via telephone. The purpose was to interview DCW Ondungah about her involvement in the investigation but DCW Ondungah declined to return contact.

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 on interviews with Mr. and Mrs. Mukwada, Resident B, APS specialist Settler, Guardian A1, Ms. Johnson along with reviewing JD Cares IRs, Resident A's progress notes and photographs of Resident A's injuries. It was evident DCW Darcus Ondungah caused injuries with bruising to Resident A's right and left upper arms. Management took immediate action terminating DCW Ondungah's employment due to severity of the incident. Resident A was removed from the facility on 7/3/25 and was relocated to another placement.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/26/25, I conducted an exit conference with licensee designee Teziah Manumbu who agreed with the findings of the special investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change in license is recommended.

Kevin L. Sellers 8/26/25

Kevin Sellers Date
Licensing Consultant

Approved By:

Russell Misiak 8/26/25

Russell B. Misiak Date
Area Manager