



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 16, 2025

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

RE: License #: AS630384699
Investigation #: 2025A0605019
Westlyn Home

Dear Roger 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,

A handwritten signature in cursive script that reads "Frodet Dawisha". The signature is written in dark ink on a white background.

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630384699
Investigation #:	2025A0605019
Complaint Receipt Date:	08/28/2025
Investigation Initiation Date:	08/28/2025
Report Due Date:	10/27/2025
Licensee Name:	North-Oakland Residential Services Inc
LicenseeAddress:	106 S. Washington Oxford, MI 48371
Licensee Telephone #:	(248) 969-2392
Administrator/Licensee Designee:	Roger Covill
Name of Facility:	Westlyn Home
Facility Address:	3859 Westlyn Drive Lake Orion, MI 48359
Facility Telephone #:	(248) 391-0822
Original Issuance Date:	02/09/2018
License Status:	REGULAR
Effective Date:	08/09/2024
Expiration Date:	08/08/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A had bruises and scratches on both arms.	Yes
On 08/27/2025, Resident A arrived at Dutton Farm visibly cold and inappropriately dressed by group home staff.	No

III. METHODOLOGY

08/28/2025	Special Investigation Intake 2025A0605019
08/28/2025	Special Investigation Initiated - Letter Email to Oakland County Office of Recipient Rights (ORR)
08/28/2025	APS Referral Adult Protective Services (APS) made referral
08/29/2025	Contact - Document Received Email from APS worker Ra'Shawnda Robertson
09/04/2025	Inspection Completed On-site Conducted unannounced on-site investigation
09/04/2025	Contact - Telephone call made Discussed allegations with APS worker Ra'Shawnda Robertson and direct care staff (DCS)
09/04/2025	Contact - Telephone call received From ORR worker Rishon Kimble
09/29/2025	Contact – Telephone call made Let message for DCS
09/29/2025	Contact – Telephone call received Discussed allegations with DCS
10/07/2025	Contact - Telephone call made Discussed allegations with Adrienne Doelle
10/07/2025	Contact - Telephone call received Received call from DCS

10/07/2025	Exit Conference I conducted an exit conference with licensee designee Roger Covill with my findings
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ALLEGATION:

Resident A had bruises and scratches on both arms.

INVESTIGATION:

On 08/28/2025, intake #207171 was referred by Adult Protective Services (APS) regarding Resident A being sent to workshop with shorts and a t-shirt on 08/27/2025 and had scratches and bruises on the inside of his arms.

On 08/29/2025, I received an email from APS worker Ra'Shawnda Robertson with pictures of Resident A's marks/scratches. There were several prominent scratches on his right upper inside of his forearm. There were also faint bruises on both sides of his upper arms.

On 09/02/2025, I discussed the allegations with Office of Recipient Rights (ORR) worker Rishon Kimble. Ms. Kimble stated that Resident A's behavioral plan stated that Resident A has self-injurious behavior, including pinching himself. She does not believe that staff are abusing Resident A. Ms. Kimble may not be investigating these allegations.

On 09/04/2025, I received a telephone call from ORR worker Rishon Kimble. She will be speaking with the home manager (HM) Angela Woods regarding documentation pertaining to Resident A's scratches, bruises, and marks. She will also discuss the importance of completing incident reports (IR) whenever DCS observe any marks on Resident A.

On 09/04/2025, I followed up with APS worker Ra'Shawnda Robertson. Ms. Robertson went to Dutton Farms on 08/29/2025 and observed Resident A. Resident A is non-verbal therefore, he was not interviewed regarding these allegations. She observed the scratches on his arms and some bruises. She spoke with the HM Angela Woods who advised Ms. Robertson that Westlyn does not conduct skin assessment checks. Ms. Robertson spoke with Resident A's mother who expressed no concerns about the staff at Westlyn Home and does not believe that Resident A is being abused or neglected. Ms. Robertson expressed concerns of the lack of documentation by DCS at Westlyn Home regarding Resident A's marks.

On 09/04/2025, I conducted an unannounced on-site investigation at Westlyn Home regarding the allegations. Present at Westlyn Home as the home manager (HM) Angela Woods, direct care staff (DCS) Lucy Adomaa and Residents A, B, C, D, and E. All the

residents were non-verbal; therefore, I was unable to interview them regarding these allegations.

I interviewed the HM Angela Woods regarding these allegations. The HM has been working for this corporation since 2014 and has been the HM at Westlyn since 2016. She works first shift and there are always two DCS per shift. Resident A has self-injurious behaviors that include hitting and pinching himself. Resident A also jumps on couches and chairs. When Resident A exhibits self-injurious behaviors such as hitting or pinching himself, staff will grab his hands gently and if he's jumping on the couches or chairs, staff again will grab his hands gently and redirect him from self-harm. The HM has never grabbed Resident A's arms causing any scratches or bruises. She has never observed another DCS grab Resident A's arms leaving any scratches or bruises. Staff do not conduct skin assessments; however, when DCS are assisting Resident A with his showers, DCS will note in the health care chronological (HCC) or complete an incident report (IR) if a scratch, bruise, or mark is observed. The HM has observed a couple of bruises on Resident A's left arm, but these bruises were not noted in the HCC nor was there an IR completed. The HM denied observing scratches on both Resident A's arms and stated there have not been anything noted in the HCC nor IR's regarding scratches, bruises, or any other marks on Resident A. I showed the HM the pictures provided by APS worker Ra'Shawnda Robertson and the HM stated she has never observed any of these marks/scratches on Resident A. Nor is there anything noted regarding these marks in HCC, IR, or the staff log.

On 09/04/2025, I interviewed DCS Lucy Adomaa regarding the allegations. Ms. Adomaa has been working for this corporation since 2011. She helps at Westlyn and works all shifts. Ms. Adomaa denied observing any bruises, marks, or scratches on Resident A. The process is when she observes a mark, bruise, or scratch she must note it in his HCC, complete an IR and write it on the staff log. Ms. Adomaa reported that Resident A has self-injurious behaviors such as scratching and/or hitting himself. When she observes these behaviors, she gently redirects him by grabbing his hands and denied grabbing his arms and denied causing any scratches or marks on him. She also denied observing any other staff grabbing his arms or causing any injuries.

On 09/04/2025, I contacted DCS Hailey Helm via telephone regarding the allegations. Ms. Helm has worked for this corporation for about four years but then left and returned about a year ago. She works midnight shifts from 11PM-7AM and on weekends she works day shift from 7AM-3PM. Ms. Helm worked on 08/26/2025-08/27/2025 but is not sure if Resident A was assigned to her or not. During her shift, she did not observe any marks, scratches, or bruises on his arms. Resident A was already in bed when she arrived on her shift on 08/26/2025. The morning of 08/27/2025, she does recall getting him dressed and changing his brief, but stated she did not conduct a skin assessment, nor did she observe the scratches and bruises on his arms. The only time she conducts her skin assessments is when she showers Resident A. If she observes any marks on Resident A during the showers, she documents it in the HCC, staff log, and then completes an IR. She did not note anything about the marks/scratches because she did not see them prior to him leaving for Dutton Farms. However, she noticed the scratches

on the inside of his arm, she is unsure which arm after Resident A's mother contacted the home and informed her about them. She stated, "I may have missed it." Ms. Helm denied grabbing Resident A by his arm and denied causing the scratches. Resident A has self-injurious behaviors such as hitting the top of his head, jumping up and down or hitting the walls. When she observes these behaviors, she attempts to grab his hands and if that does not work, she administers his as needed medication. She has never observed another DCS grab Resident A's arms or inflict any marks/scratches.

On 09/04/2025, I contacted DCS Tiffany Cooper via telephone regarding these allegations. Ms. Cooper worked for this corporation for a while then left and returned last year. She works both second and third shifts. She worked 08/26/2025 and 08/27/2025, but she was not responsible for Resident A; DCS Hailey Helm was. She was assigned to Resident A the evening of 08/27/2025 and during her shift she denied seeing any scratches, marks, or bruises on his arms. She showered Resident A and again stated she did not observe any marks. If she had observed the marks/scratches, she would note them in the HCC, staff log, and then complete an IR. She has never grabbed his arms, nor has she observed any other DCS grab Resident A causing the marks/scratches. Resident A gets agitated and when that happens, he makes noises.

On 09/22/2025, I received an email from APS worker Ra'Shawnda Robertson. Ms. Robertson will substantiate these allegations due to all staff at Westlyn Home not providing any reason for how Resident A sustained these injuries. She does not believe Resident A was abused; however, she is substantiating for neglect due to no DCS documenting any of his injuries on his arms.

On 09/29/2025, I received a return call from DCS Georgia Taylor. She began working for this corporation the end of June 2025-August 20, 2025. She was not working 08/27/2025 and stated she never provided care to Resident A and has never observed any marks/scratches/bruises on his arms or body. No one has ever reported any marks/scratches to her. She had no other information.

On 10/07/2025, I received a return call from DCS Chanell Purdy. Ms. Purdy stated that she only worked for this corporation for one week and does not know anything about marks/bruises on Resident A.

On 10/07/2025, I left several messages for DCS Madison Tolen but received no return call.

On 10/07/2025, I interviewed Area Supervisor Adrienne Doelle via telephone regarding the allegations. Ms. Doelle was not aware of any marks/bruises/scratches on Resident A. She was never informed by the HM nor by anyone else that Resident A was observed with these marks. However, she will be meeting with all the managers tomorrow 10/08/2025 and will be discussing the importance of documentation and skin assessments for Resident A and all the residents.

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 my investigation and information gathered, DCS at Westlyn Home were not always attending to Resident A's needs. On 08/27/2025, Resident A was observed by Dutton Farms staff to have significant scratches and marks on his arms. I interviewed the HM Angela Woods and DCS Hailey Helm, Tiffany Cooper, and Georgia Taylor whom all denied observing these scratches and marks on both Resident A's arms. I observed the pictures of the marks/scratches provided by APS worker Ra'Shawnda Robertson and DCS should have noted these marks/scratches because they were prominent on his arms, especially his right upper arm. According to the HM and all the staff, there were no notes documented in HCC, staff log, or an IR completed regarding these injuries. Therefore, due to staff not providing a reasonable explanation as to these marks/scratches, Resident A's safety and protection were not attended to at all times.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

On 08/27/2025, Resident A arrived at Dutton Farm visibly cold and inappropriately dressed by group home staff.

INVESTIGATION:

On 09/02/2025, I received a telephone call from Oakland County Office of Recipient Rights (ORR) worker Rishon Kimble. The temperature on 08/27/2025 was around 70° Fahrenheit so shorts, and a T-shirt were appropriate for that day. Resident A's workshop, Dutton Farms, did not contact the home manager Angela Woods to advise her that Resident A appeared cold and to bring warmer clothing to the school. Instead, Dutton Farms contacted Resident A's mother and APS. Ms. Kimble will not be investigating the allegations regarding Resident A wearing shorts and a T-shirt to Dutton Farms.

On 09/04/2025, I interviewed the HM Angela Woods regarding the allegations. The HM received a telephone call on a different day from the alleged incident of 08/27/2025 from Resident A's mother. Resident A's mother told the HM that Dutton Farms called the mother to advise the mother to bring clothes to school because the group home sent Resident A with shorts and a T-shirt on and Resident A was cold. Dutton Farms never contacted the HM nor anyone at Westlyn Home advising them that Resident A was cold or to bring warmer clothing. The HM stated that she recalls the temperature to be warm on 08/27/2025, so shorts and a T-shirt would be appropriate for Resident A on that day.

On 09/04/2025, I interviewed DCS Lucy Adomaa regarding the allegations. Ms. Adomaa stated that it was not cold on 08/27/2025 when Resident A was dressed in shorts and a T-shirt. She stated, "if it was cold, then we would have dressed him in warmer clothing." Ms. Adomaa never received a call from anyone at Dutton Farms informing them that Resident A was cold. If they had, then staff would have taken clothes for them. Ms. Adomaa reported that staff are always checking the weather daily to ensure Resident A is dressed appropriately for the day.

On 09/04/2025, I interviewed DCS Hailey Helm regarding the allegations. Ms. Helm does not recall the weather on 08/27/2025 but stated that she and other staff are checking the weather daily to ensure all the residents, including Resident A, are dressed appropriately. She never received any phone calls from anyone from Dutton Farms advising them that Resident A was cold. If she had received the call, then she would have taken warmer clothing for them.

On 09/04/2025, I interviewed DCS Tiffany Cooper regarding the allegations. Ms. Cooper recalls that it was "warm," on 08/27/2025 and therefore, Resident A wore shorts and a T-Shirt. She and other staff are always checking the weather to ensure residents are dressed appropriately for the day. She did not receive any phone calls from anyone from Dutton Farms advising her that Resident A was cold. If that was the case, she would have taken clothes for them.

On 10/07/2025, I interviewed Area Supervisor Adrienne Doelle regarding the allegations. Ms. Doelle heard from the HM that Resident A's mother called the HM advising her that Dutton Farms called the mother advising her that Resident A was cold. Ms. Doelle stated that Dutton Farms does not call the HM but instead will call everyone else such as Resident A's mother, case manager, and APS instead of calling Westlyn Home to address something such as these allegations. The licensee designee Roger Covill has met with Dutton Farms to try to build communication between Dutton Farms and Westly Home, but there is still a disconnect between them as Dutton Farms continues to not call the HM to discuss any issues Dutton Farms has.

On 10/07/2025, I contacted Grace Pillars with Dutton Farms. Ms. Pillars stated that Dutton Farms has a policy to report any abuse and neglect to APS and stated, “historically, we have not had good communication with the group home, so we must follow our policies. Ms. Pillars could not provide me with a reason why staff from Dutton Farms did not reach out to the HM regarding Resident A being cold on 08/27/2025. She repeatedly stated that she must follow policy of reporting any abuse and/or neglect to APS.

On 10/07/2025, I conducted the exit conference with licensee designee Roger Covill via telephone with my findings. Ms. Covill was aware of the issue with Resident A being sent to Dutton Farms with only shorts and a T-shirt, but he was not aware of the scratches/marks on Resident A. He agreed and acknowledged that DCS should be doing a better job documenting marks/scratches regarding Resident A and will be discussing these issues during their meeting tomorrow. Mr. Covill met with Dutton Farms to try to get them to reach out to Westly Home regarding concerns that can be addressed such as Resident A being cold if he had on shorts and a T-Shirt. Mr. Covill understands that APS must be contacted regarding the marks/scratches if abuse and/or neglect is suspected, but he feels that Dutton Farms is not resolution focused therefore, there is a lack of communication between them. However, he will continue to rebuild the communication between Dutton Farms and his group homes. He agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.14314	Resident hygiene.
	(4) A licensee shall afford a resident opportunities, and instruction when necessary, to dress as fashion, fit, cleanliness, and season warrant.
ANALYSIS:	Based on my investigation and information gathered, DCS at Westlyn Home dressed Resident A accordingly based on the weather. On 08/27/2025, the temperature was mid 70’s; therefore, Resident A was dressed in shorts and a T-shirt. Dutton Farms staff never contacted Westlyn Home to advise them that Resident A was cold to have staff at Westlyn Home bring warm clothes to Dutton Farms. I interviewed all the staff at Westlyn Home who stated that they check the weather for the day before getting residents dressed to ensure the residents, including Resident A, were dressed appropriately. Therefore, staff felt that shorts and a T-shirt was appropriate for Resident A on 08/27/2025 because it was warm outside.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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

Frodet Dawisha

10/13/2025

Frodet Dawisha
Licensing Consultant

Date

Approved By:

Denise Y. Nunn

10/16/2026

Denise Y. Nunn
Area Manager

Date