



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

May 6, 2026

Simbarashe Chiduma  
Open Arms Link  
Suite 130  
8161 Executive Court  
Lansing, MI 48917

RE: License #: AM190396226  
Investigation #: 2026A0577036  
Boichot

Dear Mr. Chiduma:

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 (517) 335-5985.

Sincerely,

*Bridget Vermeesch*

Bridget Vermeesch, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AM190396226
<b>Investigation #:</b>	2026A0577036
<b>Complaint Receipt Date:</b>	04/17/2026
<b>Investigation Initiation Date:</b>	04/17/2026
<b>Report Due Date:</b>	06/16/2026
<b>Licensee Name:</b>	Open Arms Link
<b>Licensee Address:</b>	Suite 130 8161 Executive Court Lansing, MI 48917
<b>Licensee Telephone #:</b>	(517) 253-8894
<b>Administrator:</b>	Masculine Chiduma
<b>Licensee Designee:</b>	Simbarashe Chiduma & Masculine Chiduma
<b>Name of Facility:</b>	Boichot
<b>Facility Address:</b>	14120 Boichot Road Lansing, MI 48906
<b>Facility Telephone #:</b>	(517) 455-8300
<b>Original Issuance Date:</b>	11/20/2018
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	05/20/2025
<b>Expiration Date:</b>	05/19/2027
<b>Capacity:</b>	8
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A eloped, unsupervised from the facility on April 14, 2026.	Yes

**III. METHODOLOGY**

04/17/2026	Special Investigation Intake-2026A0577036
04/17/2026	APS Referral-Denied for investigation.
04/17/2026	Special Investigation Initiated – Telephone call made to Tom Hilla, Clinton County APS.
04/17/2026	Contact - Telephone call made to Officer Sherman, Dewitt Township Police- left message.
04/28/2026	Inspection Completed On-site
04/28/2026	Contact - Face to Face- Interviews with Concerned Citizens.
04/30/2026	Referral - Recipient Rights- CEI-ORR.
04/30/2026	Contact - Telephone call made to Michelle Robingson, CMH Case Manager.
05/04/2026	Contact - Telephone call made- Interview with DCS.
05/04/2026	Exit Conference with licensee designee Simba Chiduma and administrator Mascline Chiduma.
05/04/2026	Inspection Completed-BCAL Sub. Compliance

**ALLEGATION: Resident A eloped, unsupervised from the facility on April 14, 2026.**

**INVESTIGATION:**

On April 17, 2026, a complaint was received alleging that Resident A had left the facility without supervision and entered neighboring yards, causing property damage by destroying a mailbox and taking mail. The complaint also stated that Resident A had entered neighbors' vehicles and taken items. Additionally, it was reported that Resident A was found in the middle of the road with his pants down.

On April 17, 2026, I interviewed Tom Hilla, Clinton County Adult Protective Service Specialist, who reported he was not familiar with Resident A and has no additional information regarding the denied Adult Protective Service Referral.

On April 17, 2026, I interviewed Officer Sherman with the DeWitt Township Police Department. He reported that on April 14, 2026, at approximately 9:00 p.m., he was dispatched to a neighbor's residence after Resident A destroyed their mailbox and took their mail. Officer Sherman stated that neighbors reported previous incidents in which Resident A was seen standing in the middle of the road with his pants down, though still wearing underwear. Neighbors also reported that Resident A frequently enters their yards, attempts to access their homes, and has taken items from their vehicles. Officer Sherman further reported that when he spoke with direct care staff, they told him, "we cannot lock the doors to keep him inside," and staff were unaware that Resident A had been outside unsupervised on April 14, 2026.

On April 28, 2026, I completed an unannounced onsite investigation and interviewed Anastatia Ngugi, Home Manager, who reported she was not working when Resident A eloped on April 14, 2026. Ms. Ngugi provided me with a copy of an *AFC Licensing, Division-Incident/Accident Report* (IR), a copy of Resident A's *Assessment Plan for AFC Residents, Initial Positive Support Plan* (IPSP), *Person Centered Plan* (PCP), and *Behavior Treatment Plan* (BTP) which documented the following:

- IR: Completed on April 14, 2026, documented an incident which involved Resident A, direct care staff (DCS) Chisomo Mazhangara and Nicole Uwicyeza. The IR reported at 9:00pm "Nicole Uwicyeza, DCS staff member was passing medications and while Chisomo Mazhangara, DCC was cleaning the kitchen, after a few minutes realized [Resident A] was not present in the home. Staff went out to look in backyard, neighbor came and notified staff of [Resident A] being in road, staff was able to bring [Resident A] back to the facility, neighbor called the police, [Resident A] attempted to elope a second time and was redirected by police and direct care staff. Will reach out to CMH to set up a meeting to discuss additional support for [Resident A]."
- IPSP: Completed on November 14, 2025, listed the following for Resident A:
  - Goal: "[Resident A] would benefit from working to improve his relationships with housemates and direct care staff at the facility."
  - Objective: "[Resident A] will work twice a month and develop skills and identify support strategies to use with the direct care staff to increase his ability to respect other belongings, engage with others in an appropriate manner, and accept redirection from staff to stay safe and health."
  - Physical, Medical, and Health Issues: "[Resident A] is fully ambulatory and able to navigate his home independently."
  - Environmental variables that may impact behavior: "[Resident A] requires a significant level of engagement and activity to avoid some of the target behaviors, including eloping, stealing, and property destruction. Without readily available options for sensory engagement, he is more likely to engage in challenging behaviors."

- If there are environmental variables that impact the behavior how are they being addressed? “Boichot AFC group home staff have created sensory activities in his environment that he can easily access, these include sand box, ergonomic swing chair, bench swing sensory bins with rice, beans, sand, and shred box.”
- Target Behaviors: 1: Elopement- “[Resident A’s] eloping behaviors were significant for several months after moving into Boichot AFC. He would elope to the road and walk down the street or go to the neighbor’s house, resulting in police being called by some neighbors. [Resident A] would typically elope when not engaged with staff or in an activity. Having consistent positive interactions with staff and a routine of activities for [Resident A] to engage in during times when he is more likely to elope have helped to reduce this behavior. Staffing changes, inconsistency with positive engagement, and other stressors may trigger a recurrence.” 2. Physical Aggression- “[Resident A] has a history of hitting and throwing objects at others when distressed, this is typically in response when being told ‘no’ or when scolded. Finding ways to redirect [Resident A] and prompting without saying ‘no’ reacting strongly has helped reduce these behaviors. Potential Triggers: Boredom, Uncertainty in routine, changes lack skills, being disciplined-such as saying his name in harsh, loud, or startled tone.
- PCP: Completed on September 26, 2025, documented the following for Resident A: “[Resident A’s] mood has been calm/relaxed during the day but seems to ‘flip’ a switch in the evening with increased energy and anxiety. [Resident A] has been taking food out of residents hands, pacing, restlessness and has at times eloped to the neighbor’s yard and down the street. [Resident A] has been more communicative with staff when waiting to sit on porch will say ‘go outside’ or ‘inside’. At a previous Open Arms Link facility, in September 2024, [Resident A] left his AFC home and went across the road to someone’s home, the police were called and brought [Resident A] back to the facility. [Resident A] displays anxiety/restlessness after dinner but calm throughout the day. PCP documents under section titled RAP Community, #8, “I can keep myself safe in my neighborhood and I can avoid being exploited, taken advantage of and dangerous situations and people-Level 4, if the person requires supervision or personal assistance in order to stay safe. This could include a requirement that supervision is required to cross a street or an escort is required for community outings, need for supervision or personal assistance is needed.”
- BTP: Completed on October 15, 2025, documented that “[Resident A] has made great improvements since being at facility, has not eloped in many weeks, and is making connections with staff and other residents. [Resident A] requires a high level of care and staff oversight due to his disability and current behaviors.”
- *Assessment Plan for AFC Residents*: Completed on January 21, 2026 and under the section titled, “*Social/Behavioral Assessment Plan of Action-Moves Independently in Community*”, was marked “no” and documented that direct care staff, Resident A’s guardian, case manager or peer support personnel must be with Resident A when in the community. Under the section titled, *Requires*

*Routine Supervision Checks*, this was marked “yes” and documented that direct care staff must monitor for Resident A’s safety and wellness. Under the section titled, *Requires Routine Overnight Supervision Checks*, this was also marked “yes” and documented that direct care staff must monitor Resident A for safety and wellness.

On April 28, 2026, I interviewed Concerned Citizen 1 who reported over the past six months, she has had to take Resident A back to the facility at least four times due to Resident A coming to their house unsupervised, going in their camper and garage, and getting into their cars. Concerned Citizen 1 reported receiving a telephone call on April 14, 2026, around 9:00pm from Concerned Citizen 2 asking Concerned Citizen 1 to notify facility direct care staff that a resident was in the middle of the road by Clark Road. Concerned Citizen 1 confirmed notifying direct care staff that Resident A was in the street. Concerned Citizen 1 reported direct care staff did not realize Resident A had eloped from the facility. Concerned Citizen 1 reported a direct care staff brought Resident A back to the facility.

On April 28, 2026, interviewed Concerned Citizen 3 who reported on April 14, 2026, around 9:00pm she noticed a vehicle in the middle of the road with hazard lights on and a person standing in front of the truck. Concerned Citizen 3 determining if any help was needed but Concerned Citizen 2, who was on scene, stated, “no, I called the police and contacted [Concerned Citizen 1] to go and get a staff member from the facility because their resident is walking down the road.” Concerned Citizen 3 reported Resident A had a bunch of mail in his hands and it was assumed Resident A gathered this mail from various neighbors’ mailboxes while walking down the street. Concerned Citizen 3 reported this is the third time, since last spring, she has witnessed Resident A walking down the street by himself with no direct care staff. Concerned Citizen 3 stated each time Resident A has been observed walking down the street by himself has been during the evening. Concerned Citizen 3 voiced great concern about this because the road on which the facility is located is “dark, hilly and busy” with cars driving too fast.

On April 30, 2026, I interviewed Michelle Robinson with Clinton-Eaton-Ingham County Community Mental Health (CEI-CMH) who reported being aware of Resident A eloping April 14, 2026. Ms. Robinson reported Resident A also eloped from the facility in March 2026, but the exact date and time were unknown. Ms. Robinson reported Resident A eloped by exiting through the laundry room, into the garage and through the side garage door. Ms. Robinson reported her agency has received three IRs dated September 02, 2025, September 03, 2026, and April 14, 2026, which documented Resident A eloping from the facility. Ms. Robinson reported Resident A’s CEI-CMH team met during the week of April 23, 2026, and reviewed Resident A’s current behavior plans to determine if additional safety measures need to be put into Resident A’s plan to address this elopement behavior. Ms. Robinson reported Resident A’s plans are very specific with suggestions to assist direct care staff in keeping Resident A busy and distracted from exit seeking. Ms. Robinson reported that she has been told by direct care staff that the evenings are busy with direct care staff making supper, passing nighttime medications, giving residents showers, and cleaning the facility. Ms. Robinson stated, “maybe [Resident A] is exit seeking due to lack of attention from direct care staff because they

are busy assisting other residents. But I think it is more of [Resident A] being impulsive instead of attention seeking.”

Concerned Citizen 2 contacted the police. Concerned Citizen 2 reported that Concerned Citizen 3 came out of their house to offer assistance. Concerned Citizen 2 provided me with two photos of Resident A standing in the middle of the road at 9:01pm on April 14, 2026, with mail in his hands. Concerned Citizen 2 reported a staff member came and took Resident A back to the facility. Concerned Citizen 2 reported they had video from their Ring Camera of Resident A getting into his truck and into their daughters car taking items from the vehicles. Concerned Citizen 2 reported both times Concerned Citizen 1 was able to get Resident A to give the items to her and return Resident A to the facility.

On May 1, 2026, I interviewed Concerned Citizen 2. He reported that on April 14, 2026, at approximately 9:00 p.m., he turned from Clark Road onto Boichot Road and observed Resident A standing alone in the middle of the roadway. Concerned Citizen 2 stopped his vehicle and activated his hazard lights for safety due to the darkness. He stated that Resident A was approximately a quarter mile from the facility and was holding a large amount of mail while walking. Concerned Citizen 2 reported that he contacted Concerned Citizen 1 and asked them to get a staff member because Resident A was unwilling to return to the facility with him. He then contacted the police. Concerned Citizen 2 stated that Concerned Citizen 3 came out of their home to help. He provided me with two photographs taken at 9:01 p.m. on April 14, 2026, showing Resident A standing in the roadway holding mail. A staff member later arrived and escorted Resident A back to the facility. Concerned Citizen 2 also reported that his Ring camera captured video of Resident A getting into his truck and into his daughter’s car and taking items from both vehicles. He stated that on both occasions, Concerned Citizen 1 was able to retrieve the items and return Resident A to the facility.

DCS Mazhangara reported that suddenly DCS Uwicyeza noticed Resident A was missing, and they both started looking for Resident A. DCS Mazhangara stated, “DCS Uwicyeza went to the backyard looking and I noticed the garage door was opened and went into the garage and noticed the side garage door opened that led outdoors.” DCS Mazhangara reported that a neighbor found Resident A down in the road toward Clark Rd. DCS Mazhangara reported that DCS Uwicyeza went to get Resident A from the road to bring him home and that is when then the police arrived at the facility. DCS Mazhangara stated, “when [Resident A] goes outside he walks very fast, especially if he does not see a staff member with him.” DCS Mazhangara reported that she believes Resident A was outside for about 3-5 minutes until the neighbor came and alerted the direct care staff of Resident A being in the road. DCS Mazhangara reported Resident A has not eloped in months from the facility, stating, “he has been really good with staying inside unless a staff member is with him.”

On May 4, 2026, I interviewed DCS Chisomo Mazhangara regarding the incident that occurred on April 14, 2026, when Resident A eloped from the facility. DCS Mazhangara reported that she was working with DCS Nicole Uwicyeza at the time. According to her

statement, DCS Uwicyeza was passing medications to residents while DCS Mazhangara was in the kitchen cleaning. She stated that Resident A had been quiet throughout the day and was not very active, generally keeping to himself. DCS Mazhangara reported that, unexpectedly, DCS Uwicyeza noticed that Resident A was missing, and both staff began searching for him. She stated, “[DCS Uwicyeza] went to the backyard looking, and I noticed the garage door was open. I went into the garage and saw that the side garage door leading outside was also open.” According to DCS Mazhangara, a neighbor located Resident A in the road toward Clark Road. She reported that DCS Uwicyeza went to bring Resident A back to the facility, and the police arrived shortly thereafter. DCS Mazhangara stated, “When [Resident A] goes outside, he walks very fast, especially if he does not see a staff member with him.” She estimated that Resident A was outside for approximately three to five minutes before the neighbor alerted staff.

On May 04, 2026, I interviewed DCS Nicole Uwicyeza who reported she was passing 8:00pm medications and initially thought Resident A was in the bathroom. DCS Uwicyeza reported upon Resident A coming out of the bathroom, DCS Uwicyeza passed Resident A his medications and continued passing medications to other residents. DCS Uwicyeza reported DCS Chisomo Mazhangara was in the kitchen cleaning during this time. DCS Uwicyeza reported suddenly she did not see Resident A in the facility and asked DCS Mazhangara where Resident A was but Resident A could not be found. DCS Uwicyeza reported DCS Mazhangara stated, “I heard a door close.” DCS Uwicyeza reported they were both looking for Resident A when Concerned Citizen 1 knocked at the facility door and reported Resident A was down the road with Concerned 2. DCS Uwicyeza reported they went to get Resident A and bring Resident A back to the facility. DCS Uwicyeza reported that the police arrived and interviewed DCS Uwicyeza and DCS Mazhangara. DCS Uwicyeza reported Resident A used to elope quite frequently last summer but has not eloped since it turned cold.

<b>APPLICABLE RULE</b>	
<b>R 400.671</b>	<b>Resident care.</b>
	<b>(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.</b>

