GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 30, 2026

Erin Gust
Dignitas Inc
P.O. Box 3460
Farmington Hills, MI 48333-3460

RE: License #: AS630315897
Investigation #: 2026A0612021
Dignitas, Inc/Orchard Lake House 2

Dear Ms. Gust:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS630315897
Investigation #:	2026A0612021
Complaint Receipt Date:	03/31/2026
Investigation Initiation Date:	04/01/2026
Report Due Date:	05/30/2026
Licensee Name:	Dignitas Inc
Licensee Address:	Suite 112 24380 Orchard Lake Road Farmington Hills, MI 48336-3460
Licensee Telephone #:	(248) 442-1170
Administrator:	Erin Gust
Licensee Designee:	Erin Gust
Name of Facility:	Dignitas, Inc/Orchard Lake House 2
Facility Address:	24485 Orchard Lake Road Farmington Hills, MI 48336
Facility Telephone #:	(248) 442-1170
Original Issuance Date:	04/05/2012
License Status:	REGULAR
Effective Date:	10/05/2024
Expiration Date:	10/04/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Operations coordinator Mary Smith is rude. She refuses to talk to Resident A's family and hangs up on them.	No
Resident A does not have sufficient time to run personal errands. As such, he took an Uber to Best Buy to get his computer fixed. When he returned, operations coordinator Mary Smith grabbed the computer. They were snatching it back and forth.	No
The facility makes Resident A use a walker even though he does not feel that he needs it.	No
Resident A hit his face on the corner of his computer desk. Resident A did not receive medical attention.	No

III. METHODOLOGY

03/31/2026	Special Investigation Intake 2026A0612021
03/31/2026	APS Referral Referral received from Adult Protective Services (APS). APS denied the referral for investigation.
04/01/2026	Special Investigation Initiated - Telephone I initiated my investigation with a telephone call to operations coordinator Mary Smith. There was no answer, I left a voicemail requesting a return call.
04/13/2026	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed operations coordinator Mary Smith, Resident A, and direct care staff Ken Onyebinama. While onsite I obtained copies of relevant facility documentation.
04/14/2026	Contact - Document Received I received a copy of the prescription for Resident A's walker and rational for use sent via email from operations coordinator Mary Smith.

04/14/2026	Contact - Telephone call received Voicemail received from APS worker Carmen Smith.
04/30/2026	Contact – Telephone call made Telephone interview with Resident A's guardian.
04/30/2026	Exit Conference Telephone call to licensee designee Erin Gust to conduct an exit conference.

ALLEGATION:

Operations coordinator Mary Smith is rude. She refuses to talk to Resident A's family and hangs up on them.

INVESTIGATION:

On 03/31/26, I received an intake from Adult Protective Services (APS). APS denied the referral for investigation. In summary the referral indicates, Resident A is 66 years old; he resides at a traumatic brain injury facility. Resident A has a legal guardian. Resident A and his legal guardian argue all the time. Resident A is unhappy. He has run off multiple times. The last time he did this was within the last month. Resident A's guardian will not give Resident A his money. They also will not give him his mail. On Saturdays, Resident A is only given two hours to run his errands, which is not enough time. He needs a haircut. One time he did not have enough time to get his laptop fixed so he took an Uber to Best Buy. When he returned home, operations coordinator Mary Smith grabbed the computer. They were snatching it back and forth. The police were called. Ms. Smith said Resident A put his hands on her. He lost more privileges. They took his bird he had for 27 years and put it in foster care. When they moved him into this facility they left half of his belongings at his other place. Resident A's guardian and Ms. Smith are rude. They refuse to talk to Resident A's family and hang up on them. Resident A fell while at his family's home during Christmas. He did not tell anyone. Later, it was discovered that he had a broken bone. They will not allow him back to his family's home because they did not report the fall as they were unaware. Resident A is extremely depressed and angry. They make him use a walker even though he does not feel that he needs it. Within the last month he made a suicidal comment. When this was told to Resident A's guardian she said he made the comment to get family's attention he did not tell anyone at the facility. This intake includes several allegations that are not alleged AFC rule violations as such, not all the allegations are addressed in this report.

On 04/06/26, I received an additional intake from APS. The allegation was added to this investigation. In summary, the intake indicated that Resident A fell a couple days ago and had a lump on his head. Resident A hit the corner of a computer desk. Resident A reportedly had a massive headache. Resident A lied to staff about what happened. It is

believed that Resident A should have been taken to the hospital. On 04/05/26, Resident A was slurring his words, and the side of his face is drooping. There is a concern for the safety of Resident A.

On 04/01/26, I initiated my investigation with a telephone call to operations coordinator Mary Smith. There was no answer, I left a voicemail requesting a return call.

On 04/13/26, I completed an unscheduled onsite investigation. I interviewed operations coordinator Mary Smith, Resident A, and direct care staff Ken Onyebinama. While onsite I obtained copies of relevant facility documentation.

On 04/13/26, I interviewed Resident A. Resident A stated operations coordinator Mary Smith is rude to his mother and argues with her on the phone. Resident A was unable/unwilling to provide further explanation or examples.

On 04/13/26, I interviewed operations coordinator Mary Smith. Ms. Smith denied that she is rude to Resident A's family and/or hangs up on them. Ms. Smith stated on 03/25/26, Resident A's mother called and asked her to arrange for Resident A to come to her home. Ms. Smith explained to Resident A's mother that she needed to contact Resident A's guardian to make these arrangements. Ms. Smith said that Resident A's mother was argumentative. Ms. Smith again explained that Resident A's guardian needed to be contacted and advised Resident A's mother that she was going to end the call if she continued to be argumentative. Ms. Smith ended the call.

On 04/13/26, I interviewed direct care staff Ken Onyebinama. Mr. Onyebinama stated he has never witnessed Ms. Smith being rude to Resident A's family.

On 04/30/26, I interviewed Resident A's guardian. Resident A's guardian stated she regularly coordinates with Ms. Smith. Resident A's guardian has no concerns that Ms. Smith is rude to Resident A's family, refuses to talk to them, or hangs up on them.

APPLICABLE RULE	
R 400.623	**Applicant, licensee and administrator qualifications; licensee, administrator and staff requirements; parole or probation or convicted of felony.**
	(6) A licensee, administrator, and staff shall cooperate with a resident, resident's family as appropriate, designated representative of a resident, and the responsible agency.
ANALYSIS:	Based upon the information gathered during this investigation there is insufficient information to conclude the operations coordinator Marry Smith does not cooperate with Resident A's family. Ms. Smith denied the allegation and although Resident A said that Ms. Smith is rude to his mother and argues with her on the

	phone. Resident A was unable/unwilling to provide further explanation or examples. There were no other reports of Ms. Smith being rude to Resident A's family.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A does not have sufficient time to run personal errands. As such, he took an Uber to Best Buy to get his computer fixed. When he returned, operations coordinator Mary Smith grabbed the computer. They were snatching it back and forth.

INVESTIGATION:

On 03/31/26, I received an intake from APS that in summary indicates on Saturdays, Resident A is only given two hours to run his errands, which is not enough time. One time he did not have enough time to get his laptop fixed so he took an Uber to Best Buy. When he returned home, operations coordinator Mary Smith grabbed the computer. They were snatching it back and forth. The police were called. Ms. Smith said Resident A put his hands on her.

On 04/13/26, I completed an unscheduled onsite investigation. I interviewed operations coordinator Mary Smith, Resident A, and direct care staff Ken Onyebinama. While onsite I reviewed March 2026 and April 2026 Recreational Activities Calander which included several individual outings for residents and group activities.

On 04/13/26, I interviewed direct care staff Ken Onyebinama. Mr. Onyebinama stated he has taken Resident A to Best Buy several times on outings. If a resident has a specific request for an outings arrangements are always made.

On 04/13/26, I interviewed Resident A. Resident A stated he is supposed to put in a written request when he wants to go on an outing, however, he needed his computer repaired so he took an Uber to Best Buy. Resident A remarked, "I was not supposed to do that." Resident A was unwilling to discuss what occurred when he came back to the facility. Resident A avoided further interview questions and chose to discuss his dislike towards living in this home, his guardian, Ms. Smith, and his doctors. Resident A communicated that he does not believe he requires AFC care.

On 04/13/26, I interviewed operations coordinator Mary Smith. Ms. Smith stated residents are taken to complete personal errands on the weekends. They are asked to put in a written request if they have something special that they need to attend to. Ms. Smith stated on 03/16/26, without staff knowledge Resident A took an Uber to Best Buy

to get his computer fixed. He used his personal cell phone to arrange the transportation. No one knew that Resident A left the home. When Resident A returned to the home in an Uber he walked into the house using his walker. The Uber driver followed him holding his computer. Ms. Smith stated she called Resident A's guardian and asked if Resident A could have the computer, the guardian said no. Ms. Smith asked if the computer should be locked up and the guardian said yes. Ms. Smith stated she went to take the computer from the Uber driver, Resident A grabbed her shoulder and said, "give it to me Bitch." The police were called. Ms. Smith stated the police asked if she took the computer and she said yes, she took it from the Uber driver and locked it in her office per Resident A's guardian's request. Ms. Smith denied that she "snatched the computer back and forth" with Resident A reiterating that Resident A was never holding the computer, the Uber driver carried it inside. Ms. Smith stated following this incident Resident A refused to attend work for two weeks. He also refused to attend the following medical appointments: urologist 03/30/26, neurologist 03/24/26 and 04/01/26, podiatrist 03/30/26 and psychiatrist 03/16/26.

On 04/30/26, I interviewed Resident A's guardian. Resident A's guardian stated Resident A thought he was not going to go to Best Buy; however the outing was on the calendar for Saturday. As such, Resident A called an Uber and went to the store himself; he did not notify anyone that he was leaving the house. Resident A's guardian stated Ms. Smith called her and kept her up to date every step up the way. When Resident A returned to the home Resident A's guardian advised Ms. Smith to take the computer tower and lock it not to be used by Resident A. Resident A's guardian stated she does not believe that Ms. Smith physically took the computer tower away from Resident A because Resident A is unable to carry anything that heavy. Therefore, someone else had to have brought the computer tower into the house. Resident A's guardian stated that Ms. Smith said Resident A put his hand on her, and the police were contacted. Resident A's guardian stated Resident A must be taken to Best Buy with a staff he cannot go into the community alone. Resident A also cannot make unsupervised purchases as he forgets what he purchased and buys things again.

On 04/13/26, I reviewed a program note written on 03/16/26 at 5:15pm, by direct care staff Heather Wilson. In summary, the note indicates Resident A was last seen at 3:55 pm at the house. At 5:00 pm staff went into Resident A's bedroom and discovered that he was not in his room. Operations coordinator Mary Smith was contacted. Resident A was not at the home. At 5:30 pm Resident A arrived to the home in an Uber. Ms. Smith went to obtain a modem from the Uber driver. Resident A chased Ms. Smith down to the end of the ramp. Resident A was yelling and hit Ms. Smith. The police were called. The police arrived and spoke to Resident A and explained to him why the modem was taken.

On 04/13/26, I reviewed Resident A's AFC assessment plan. Resident A's assessment plan indicates Resident A does not have independent community access.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(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.
ANALYSIS:	Based upon the information gathered during this investigation there is insufficient information to determine that Resident A did not receive supervision, protection, and personal care as specified in his assessment plan. Resident A's assessment plan indicates Resident A does not have independent community access. It was consistently reported that on 03/16/26, Resident A took an Uber to Best Buy independently and without notifying staff. When he returned to the facility Ms. Smith locked up the computer tower/modem per Resident A's guardian's request. Per Ms. Smith Resident A grabbed her shoulder. The police were contacted.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The facility makes Resident A use a walker even though he does not feel that he needs it.

INVESTIGATION:

On 03/31/26, I received an intake from APS that in summary indicates the facility makes Resident A use a walker even though he does not feel that he needs it.

On 04/13/26, I completed an unscheduled onsite investigation. I interviewed operations coordinator Mary Smith, Resident A, and direct care staff Ken Onyebinama. While onsite I obtained a copy of Resident A's AFC assessment plan. Resident A's assessment plan indicates Resident A uses a walker for balance and pain issues; monitor usage and maintenance. The assessment plan is signed by Resident A's guardian and the licensee designee on 01/14/26.

On 04/13/26, I interviewed Resident A. Resident A stated he hates using a walker. He refuses to use it in the house, but he will use it in the community. Resident A stated he believes he has to use a walker because in the past he has gotten dizzy and fell. Resident A stated he would like to get a new guardian, a new doctor, and move out of this AFC home.

On 04/13/26, I interviewed operations coordinator Mary Smith. Ms. Smith stated Resident A was previously living independently in a condo. He started to experience health changes such as being unstable, forgetful, and having frequent falls. As such, he was moved into this AFC. Due to the frequent falls Resident A was prescribed a walker.

On 04/13/26, I interviewed direct care staff Ken Onyebinama. Mr. Onyebinama stated Resident A does not like to use his walker and he tried to demonstrate that he does not need to use it. However, Resident A has balance issues and benefits from the use of the walker.

On 04/14/26, operations coordinator Mary Smith emailed me a copy of a prescription for Resident A's walker. The prescription is dated 01/14/26 and indicates the use of a walker and gait belt is mandatory during waking hours to mitigate fall hazards.

On 04/14/26, Ms. Smith provided email documentation from Resident A's rehabilitation case manager, Tammoda Jolly. The email is dated 01/12/26, and in summary indicates Resident A experienced three falls while attempting to stand from his table and put on his jacket. During the first fall, Resident A fell backward onto his buttocks. He stood up quickly and continued trying to put on his jacket, which led to a second fall onto the lap of another participant. After standing again, Resident A fell a third time onto the table. Following the third fall, Resident A looked at staff and stated, "Document that shit," before walking away. Staff immediately assessed him for injuries; none were reported by Resident A or observed by staff.

On 04/30/26, I interviewed Resident A's guardian. Resident A's guardian stated Resident A's doctor and physical therapist assessed Resident A and determined that he would benefit from a walker due to frequent falls.

APPLICABLE RULE	
R 400.673	**Use of assistive devices, therapeutic support.**
	(1) An assistive device or therapeutic support intended to achieve or maintain a resident's proper position to enhance mobility, physical comfort, safety, and well-being must be specified in the resident's assessment plan and agreed on by the resident or resident's designated representative.
ANALYSIS:	Based upon the information gathered during this investigation there is insufficient information to conclude that the use of Resident A's walker is not specified in his AFC assessment plan and agreed on by Resident A's guardian. Resident A's assessment plan indicates Resident A uses a walker for balance and pain issues. The assessment plan is signed by Resident A's guardian and the licensee designee on

	01/14/26. The facility provided a prescription dated 01/14/26 for the use of a walker to mitigate falls.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A hit his face on the corner of his computer desk. Resident A did not receive medical attention.

INVESTIGATION:

On 03/31/26, I received an intake from APS that in summary indicates Resident A fell a couple days ago and had a lump on his head. Resident A hit the corner of a computer desk. Resident A reportedly had a massive headache. Resident A lied to staff about what happened. It is believed that Resident A should have been taken to the hospital. On 04/05/26, Resident A was slurring his words, and the side of his face is drooping. There is a concern for the safety of Resident A.

On 04/13/26, I completed an unscheduled onsite investigation. I interviewed operations coordinator Mary Smith, Resident A, and direct care staff Ken Onyebinama. While onsite I obtained copies of relevant facility documentation.

On 04/13/26, I interviewed Resident A. Resident A stated on an unknown date he went to sit down at his desk. His laptop was next to his desktop computer and when he sat down, he bumped his head on this computer. Resident A stated he did not tell staff that this happened. Resident A remarked "they think I fell." The next day Resident A had a black eye. Resident A stated he saw his primary care doctor the day after he hit his head and the doctor looked at his eye and said that he was okay.

On 04/13/26, I interviewed operations coordinator Mary Smith. Ms. Smith stated on Sunday, 04/05/26, Resident A was observed by staff with an abrasion on the left side of his forehead. When asked what happened he said that he had got into a fight with his computer and further remarked that it was none of our business what happened. On Monday, 04/06/26, Resident A's eye appeared black and blue. Ms. Smith stated Resident A had an appointment with his primary care doctor, Dr. Hollander, on 04/06/26 at 3:45 pm. Ms. Smith attended the appointment. Resident A's eye was examined during the appointment. There were no findings. Ms. Smith stated occupational therapy is going to assess if a rolling chair would be safer for Resident A to use while on his computer.

On 04/13/26, I interviewed direct care staff Ken Onyebinama. Mr. Onyebinama stated he worked on Sunday, 04/05/26, from 8:00 am – 4:00 pm. That morning, he noticed Resident A had a black eye. Mr. Onyebinama stated when he asked Resident A what happened, he said something with his computer, but he would not elaborate.

On 04/13/26, I reviewed a program note written on 04/04/26 at 6:00pm, by direct care staff Nicole Perkins. In summary, the note indicates Resident A came out of his bedroom and staff noticed a bruise on his forehead. Staff asked Resident A if he fell. Resident A said not he did not fall. Resident A said that he hit his head on the side of his computer. Resident A stated he was not in pain.

On 04/14/26, I received a voicemail from APS worker Carmen Smith. Ms. Smith stated when interviewed Resident A stated he hit his face on his computer monitor when he went to sit down. Resident A did not report the injury to staff as he did not think it was a big deal. The next day Resident A's eye was black and blue. Resident A had an appointment with his primary care doctor the next day, there were no findings. Ms. Smith stated she is not substantiating her investigation.

On 04/30/26, I interviewed Resident A's guardian. Resident A's guardian stated Resident A said he got into a fight with his computer resulting in a black eye. Resident A was seen by his primary care physician on Monday, 04/06/26, Resident A's guardian and Ms. Smith attended the appointment. The doctor said there were no broken orbitals, and it did not require an x ray.

On 04/30/26 I placed a telephone call to licensee designee Erin Gust to conduct an exit conference and review my findings. There was no answer. I left a voicemail informing Ms. Gust that no violations were established.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	Based upon the information gathered during this investigation there is insufficient information to conclude that Resident A did not receive health care immediately following an accident. On 04/04/26, Resident A stated he went to sit down at his desk. His laptop was next to his desktop computer and when he sat down, he bumped his head on this computer. Resident A stated he did not tell staff that this happened at the time of the incident. The next day Resident A was observed with a black eye. Operations coordinator Mary Smith, Resident A's guardian, and Resident A consistently stated Resident A was seen by his primary care doctor on 04/06/26, there were no significant findings.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend that this special investigation be closed with no change to the status of the license.

04/30/2026

Johnna Cade Date
Licensing Consultant

Approved By:

For 04/30/2026

Denise Y. Nunn Date
Area Manager