GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 11, 2026

Christine Bertram
Keith Specialized Residential
3060 S Dye RD
Flint, MI 48507

RE: License #: AS250419065
Investigation #: 2026A0872027
Keith Specialized Residential

Dear Christine Bertram:

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) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

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 #:	AS250419065
Investigation #:	2026A0872027
Complaint Receipt Date:	03/17/2026
Investigation Initiation Date:	03/17/2026
Report Due Date:	05/16/2026
Licensee Name:	Keith Specialized Residential
Licensee Address:	3088 Keith Dr Flint, MI 48507
Licensee Telephone #:	(810) 337-9638
Administrator:	Katrina Bailey
Licensee Designee:	Christine Bertram
Name of Facility:	Keith Specialized Residential
Facility Address:	3088 KEITH Flint, MI 48507
Facility Telephone #:	(810) 337-9638
Original Issuance Date:	05/29/2025
License Status:	REGULAR
Effective Date:	11/29/2025
Expiration Date:	11/28/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 03/14/26, Resident A was having behaviors. Resident A alleges that staff Sebastian Pizano punched him in the nose. Resident A sustained a bloody nose but refused medical attention.	Yes
On 04/06/26, Resident A sustained a lacerated ear. It is alleged that Resident A urinated on his bedroom floor and in retaliation, staff Zykeius Williams threw him into his dresser, causing the injury.	No

III. METHODOLOGY

03/17/2026	Special Investigation Intake 2026A0872027
03/17/2026	Special Investigation Initiated - Telephone I spoke to Shiawassee County RRO, Ardis Bates about this complaint
03/19/2026	APS Referral This complaint was referred to APS. Daniel Spalthoff is the APS Worker
03/19/2026	Referral - Law Enforcement
03/24/2026	Contact - Face to Face I conducted staff interviews at SRS
04/07/2026	Inspection Completed On-site Unannounced
04/08/2026	Referral - Recipient Rights
04/30/2026	Contact - Telephone call made I spoke to RRO Ardis Bates
05/01/2026	Contact - Document Sent I emailed Flint Township PD requesting a copy of the police report
05/01/2026	Contact - Document Received I received a copy of the IR from Staff Hicks

05/04/2026	Contact - Document Sent I emailed the LD requesting additional documentation
05/05/2026	Contact - Document Received AFC documentation received
05/06/2026	Contact - Telephone call made I interviewed staff Don Lilly
05/06/2026	Contact - Document Received I received documentation from DO Hopper
05/06/2026	Contact - Telephone call made I interviewed Resident E's residential liaison, Rachel Lemiesz
05/06/2026	Contact - Telephone call made I spoke to RRO Bates
05/08/2026	Contact - Telephone call made I interviewed staff Stepheni Lazar
05/08/2026	Contact - Telephone call made I interviewed staff Sydney Hill
05/08/2026	Contact - Telephone call made I interviewed staff Zykeius Williams
05/08/2026	Exit Conference I conducted an exit conference with the licensee designee, Christine Bertram
05/08/2026	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 03/14/2026, Resident A was having behaviors. Resident A alleges that staff Sebastian Pizano punched him in the nose. Resident A sustained a bloody nose but refused medical attention.

INVESTIGATION: On 03/24/2026, I met with Shiawassee County Recipient Rights Officer (RRO), Ardis Bates at Specialized Residential Services (SRS), 3060 S. Dye Rd., Flint, MI. RRO Bates and I discussed information surrounding this investigation. RRO Bates said that she received a complaint alleging that on 03/14/2026, Resident A was having a behavior. Resident A's 1:1 staff, Sebastian Pizano dragged Resident A to his room and punched him in the nose. RRO Bates told me that EMS responded to the home and when they asked Resident A what happened, he said, "He (Staff Pizano) punched me in the nose." Resident A refused medical treatment. RRO Bates was told

that Resident A's nose bled heavily and there was blood all over his clothes and the floor of the facility.

RRO Bates showed me photographs of Resident A's face. I observed black and blue bruises on both Resident A's eyelids, a cut on the bridge of his nose, bruises on the inside of his right arm, and scrapes on the front and back of his right arm. RRO Bates said that when she interviewed Resident A on 03/18/2026, he reported that he received the marks and bruises from staff Sebastian Pizano. Resident A told RRO Bates that Staff Pizano, "punched me in the nose and it hurt." Resident A reported to RRO Bates that Staff Pizano was angry with him for spitting. Resident A said that Staff Pizano grabbed him by the shirt, dragged him to his room, and while in his room, Staff Pizano punched him in the nose.

While at SRS, RRO Bates and I conducted interviews with the following Keith SRS staff: Sydney Hill, Avian Hicks, Niyasia Burns, Sebastian Pizano, and Marshal Hyden.

Staff Hill confirmed that she worked 2nd shift on 03/14/2026. Staff Hill told us that she was in the living/dining room area, sitting at the computer, facing the living room. Resident A was having a behavior. Resident A threw a can of pop into the air and was spitting on staff and residents. Staff Pizano asked Resident A if he wanted to go to his room. Resident A slid off the couch and Staff Pizano grabbed his arm and guided him to his room. During this time, Staff Hill said that she heard the mop bucket knocking around in the hallway/ kitchen area. Shortly after, Staff Pizano came running out of Resident A's room saying that Resident A was bleeding. Staff Hill went down the hallway and saw a puddle of blood on the floor. She went into Resident A's room, and he was sitting on his bed with a gash on his nose. Staff Hill began attending to Resident A's injury and asked him what happened. Resident A responded, "He hit me!" referring to Staff Pizano. Staff Hill asked Staff Pizano what happened and he said that Resident A was trying to hit him, so he accidentally headbutted Resident A in the nose. Staff Hill stated that she observed blood on the front of Staff Pizano's hoodie and on his sleeves. Staff Hill told us that she completed a body check on Resident A. In addition to the gash on his nose and his bloody nose, Resident A also had bruises on the inside of his arm, scratches on the outside of his arm, and blood on his shirt and pants.

Staff Avian Hicks confirmed that she worked 2nd shift on 03/14/2026. Staff Hicks said that Resident A was having a behavior. Resident A was spitting on staff and residents, and he threw a full can of pop that exploded everywhere. Staff Pizano told Resident A that he needed to go to his room, so he took him by the arm, down the hallway to his room. Staff Hicks said that she walked into the kitchen and Staff Pizano came out of Resident A's room, stating "He (referring to Resident A) just spit in my fucking mouth." Staff Pizano then spit into the trash can. At that time, Resident A was coming out of his room. Staff Pizano turned around and pushed Resident A to the ground, telling him he could not come out of his room. Staff Hicks said that she left the area to tell the other staff what happened. Shortly after, Staff Pizano came running into the living room and said, "(Resident A's) nose is bleeding!" Staff Hicks said that she when she got to Resident A's room, he was sitting on his bed holding his bloody nose. She said that

there was blood all over Resident A, on the floor, and on Staff Pizano's hoodie. Staff Hicks asked Resident A what happened and he said, "I got punched!" Staff Hicks asked him who punched him and he pointed at Staff Pizano and said, "He did." Staff Hicks said that Staff Pizano told her that Resident A was hitting him with his hat, so he bent down to cover his head and when he stood up, he accidentally hit Resident A in the nose with his head.

Staff Niyasia Burns said that she worked at Keith SRS on 03/14/2026 from 9am-5pm. According to Staff Burns, that morning, Relative A1 came to visit and when she left, Resident A was upset. Resident A was spitting at everyone and peeing on the floor. That afternoon, Resident A was lying on the couch and was spitting, yelling, and throwing things. Resident A had a can of pop and he threw the can, spilling pop everywhere. Staff Pizano stood up, took Resident A by the arm and began walking him down the hallway to his room. Staff Burns said that she heard a lot of "booms and bangs" while Staff Pizano was taking Resident A to his room. Staff Burns said that she ran to see what was going on. When she got to Resident A's room, Resident A was standing in the corner, holding bloody napkins to his nose which was bleeding. There was a large puddle of blood on the floor under Resident A. Resident A had blood all over his face and clothing and Staff Burns observed blood on Staff Pizano's hoodie. Staff Burns said that she had Resident A sit on his bed so she and the other staff could assess his injuries. Staff Burns asked Resident A what happened and he told her that Staff Pizano "punched me and dragged me." Staff Burns asked Staff Pizano what happened and he told her that he headbutted Resident A "on accident." According to Staff Burns, Staff Pizano had blood all over the front of his hoodie and on both sleeves, but she did not observe any blood on his face or head. Staff Pizano took off his hoodie and began mopping up the blood.

Staff Burns said that Staff Pizano called the home manager (HM), Marshal Hyden and told him that Resident A's nose was bleeding but said that it was not bleeding "that bad" and said that he did not think 911 needed to be called. Staff Burns said that she and Staff Hicks felt the injury was serious enough, so they called 911. EMTs responded but Resident A refused to go to the hospital. Staff Burns said that the next day, she observed multiple marks and bruises on Resident A, which were not there prior to the incident involving Staff Pizano.

Staff Sebastian Pizano confirmed that he worked 2nd shift on 03/14/2026 and he was assigned to Resident A as his 1:1. Staff Pizano said when he got to work, Resident A was sitting on the couch, giggling, spitting, and throwing items. Resident A threw an empty Speedway cup and a hat at another resident and that resident got angry. Staff Pizano said that he asked Resident A if he wanted to go to his room to watch Cops on TV and Resident A agreed. Staff Pizano said he began guiding Resident A down the hallway to his room by putting one hand "lightly" on Resident A's shoulder and his other hand "lightly" on Resident A's arm. While in the hallway, Resident A started hitting Staff Pizano on the head with a hat, so Staff Pizano bent down to avoid being hit by the hat. Staff Pizano stated that when he stood up, the crown of his head accidentally hit Resident A in the face and Resident A's nose started bleeding.

Staff Pizano said that when he saw the blood, he grabbed paper towels and gave them to Resident A to hold to his nose. Staff Pizano then went and told the other staff that Resident A's nose was bleeding. I asked Staff Pizano if he and Resident A bumped into the walls or otherwise bumped into things while walking down the hallway and he said no. I asked Staff Pizano if he or Resident A made any noise on the way to Resident A's room and he said no. I asked Staff Pizano if Resident A spit in his mouth or if he told other staff that Resident A spit in his mouth and he said no. I asked Staff Pizano if he pushed Resident A to the ground and he said no.

Staff Pizano reported that he did get some blood on the cuffs of his hoodie when he was helping Resident A stop the bleeding but said that he did not have any blood on the front of his hoodie. He said that his head was sore from hitting Resident A's face but said that he was not bleeding, and he did not receive an injury. Staff Pizano told us that when EMTs arrived at the facility, they asked Resident A what happened and Resident A told them that Staff Pizano punched him. Staff Pizano said that he told the EMTs that he did not punch Resident A and he showed EMTs his hands to demonstrate that he did not have any injuries to his knuckles. Staff Pizano also showed RRO Bates and I his hands and said that he did not punch Resident A because he did not have any injuries to his hands/knuckles. Staff Pizano denied grabbing Resident A off the couch, denied pushing him to the ground, and denied punching him in the nose.

The home manager (HM), Marshal Hyden, said that he was not at the facility on 03/14/2026 at the time of the incident. According to HM Hyden, at approximately 3pm, he received a telephone call from Staff Pizano. Staff Pizano told HM Hyden that Resident A was hurt and there was blood everywhere. HM Hyden asked Staff Pizano what happened and he said that he dropped something and when he lifted his head up, he accidentally hit Resident A in the nose. HM Hyden said that Staff Hicks later told him about Staff Pizano pushing Resident A to the floor, but HM Hyden did not have that information when he spoke to Staff Pizano, so he did not ask him about it.

I reviewed two *Incident/Accident Reports* (IR) regarding this incident. Both IRs were written by the home manager (HM), Marshal Hyden. The first IR was dated 03/14/2026 and stated, "At approximately 3:13pm, (Resident A) became behaviorally escalated in the living room, spitting and throwing a can of Vernors soda which spilled on the couch and floor. Staff redirected (him) and attempted to guide him away from the area for safety as behaviors continued. During the redirection process in the hallway, (Resident A) fell to the floor. Staff responded immediately to help him up and to ensure (his) safety. Staff continued monitoring him." The corrective measures taken were, "The situation was brought under control and the environment was cleaned. Manager Marshal was notified of the incident. Staff continued to monitor the health and safety of the individual."

The second IR was dated 03/14/2026 at 3:30pm. According to this report, "(Resident A) began engaging in escalating behaviors that included spitting and throwing cups at his peers and staff. Staff provided verbal redirection; however, the behavior continued. In

effort to support de-escalation, staff encouraged him to move to a quieter and calmer area of the home. He initially agreed and began walking toward his bedroom. While in the hallway, he struck staff with his hat, continuing the previously observed behaviors. As (Resident A) moved toward staff and attempted to make physical contact, staff lowered their body position to protect themselves. (He) then began hitting staff in the back of his head with his fist. As staff raised their head from the lowered position, incidental contact occurred with (his) nose and causing it to bleed. Staff applied pressure to the area and contacted EMS. EMS arrived, assessed (Resident A) and advised stitches were not medically necessary. (Resident A) declined transport for further medical evaluation." The corrective measures taken by staff were, "Staff will continue to follow his behavior plan. Staff will continue to monitor him closely and maintain health and safety."

On 04/07/2026, I conducted an unannounced onsite inspection of Keith Specialized Residential Adult Foster Care facility. I interviewed Resident A, Resident C, Resident D, Resident E, and Resident F.

I met with Resident A in his bedroom. I observed a fading scar on Resident A's nose as well as gauze wound around his head and ears. I talked with Resident A about the scar on his nose and asked him questions about how he received the injury. Resident A was unable to tell me how he received the injury to his nose.

I met with Resident C and reviewed the allegations with him regarding Resident A receiving an injury to his nose. Resident C said that Resident A causes a lot of problems at this facility. He said that Resident A hits and spits at staff and the other residents and everyone gets angry with him. Resident C stated that usually, if Resident A hits or spits at people, staff will take him to his room as a "time out." I asked Resident C if he has ever seen any of the staff hurt Resident A. He said that staff will grab him by the arms to stop him from hitting or spitting but said that he has never seen any of the staff hit Resident A. I asked Resident C if he knows how Resident A received a bloody nose. Resident C said that on one occasion, he witnessed staff Sebastian Pizano grab Resident A by his arm and drag him to his room. Resident C said that Resident A was yelling during this incident, but he does not remember if Resident A received the bloody nose on that date.

I met with Resident D and reviewed the allegations with him regarding Resident A receiving an injury to his nose. Resident D said that Resident A "hits, spits, and pisses on everyone." Resident D said that staff will "get rough" with Resident A because of his behavior. I asked Resident D if he was present when Resident A received a bloody nose. Resident D stated, "I saw the blood but (Resident A) didn't say what happened." Resident D said, "I know that (Resident A's) nose got hit and (staff) Sebastian (Pizano) got fired." I asked him if he saw Staff Pizano hit Resident A and he said "no, but he (Staff Pizano) has a temper."

I met with Resident E and reviewed the allegations with him regarding Resident A receiving an injury to his nose. Resident E said that one day last month, Resident A was

in the living room, laying on the couch, spitting at people. Staff Sebastian Pizano grabbed Resident A and began pulling him off the couch, pulling/dragging him by his arm to his bedroom. Resident E said that he heard a loud noise and a “boom” and Staff Pizano came running out of Resident A’s room. Resident E said that he asked what happened and Resident A told him that Staff Pizano “punched me in the nose.” Resident E said that he asked Staff Pizano what happened and he said that Resident A headbutted him and said his head had a big bump on it. Resident E told me that he said to Staff Pizano, “Come on bro, you know you hit him! You need to be fired!” and Staff Pizano said, “I’m not gonna get fired because I know my family has my back. My family owns this company.”

I met with Resident F and reviewed the allegations with him regarding Resident A receiving an injury to his nose. Resident F told me that he usually stays in his room because “there’s a lot of drama that goes on around here.” I asked him if he was aware that Resident A received a bloody nose, and he said no. I asked him if he ever saw any of the staff hit or harm Resident A or any of the other residents and he said no.

On 05/01/2026, Staff Hicks provided me with a copy of the IR she completed on 03/14/2026. According to this report, “At approximately 3:13pm, during the start of second shift, (Resident A) was observed in a behavioral state while sitting on the couch in the living room. (He) began spitting and threw an entire can of Vernors soda, which spilled on the couch and floor. Staff member Sebastian Pizano physically removed (him) from the couch and guided him to his bedroom. At that time, staff Avian Hicks, Niyasia Burns and Sydney Hill remained in the living room and dining room area. While in the living/dining area, loud noises were heard coming from (Resident A’s) bedroom. Avian Hicks then went to the kitchen to prepare mop water in order to clean the spilled soda from the floor and couch. While at the kitchen sink, Sebastian Pizano entered the kitchen and spit into the trash, stating that (Resident A) had spit and that it went into his mouth. Sebastian was also emptying trash after sweeping up pieces of an apple (Resident A) had. Shortly after, (Resident A) came into the bedroom hallway attempting to leave his room. At that time, Avian Hicks witnessed Sebastian Pizano push (Resident A), causing (him) to fall to the floor. Both individuals then returned into (Resident A’s) bedroom. Avian Hicks then left the kitchen area to inform other staff members of what had been witnessed. While attempting to explain the situation, additional bumping noises were heard from (Resident A’s) bedroom. Shortly after, Sebastian Pizano ran into the living and dining room area stating that (Resident A’s) nose was ‘busted open’ and that there was blood everywhere. Staff members Avian Hicks, Niyasia Burns, and Sydney Hill immediately responded to the hallway area. Upon arrival a large amount of blood was observed on the hallway floor. (Resident A) was sitting on his bed with blood visible on his hands, arms, face, and clothing. Blood was also observed on Sebastian Pizano’s clothing. Staff immediately began assisting (Resident A) and attempted to control the bleeding while emergency medical services were contacted. While staff were cleaning blood from (Resident A), he stated that Sebastian broke his apple on the floor and punched him in the nose. Staff Avian Hicks did not witness the incident involving (Resident A’s) nose but did witness Sebastian Pizano push (Resident A) to the ground earlier in the hallway.”

On 05/01/2026, I exchanged emails with the Flint Township Police Department. I asked for a copy of the police report of the incident that occurred on 03/14/26. Lieutenant Matt VanLente responded and stated that the call came in as a “medical/nosebleed,” not as an assault. Lieutenant VanLente said that the police are not investigating this incident.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
ANALYSIS:	On 03/14/2026, Resident A sustained a bloody nose, black and blue bruises on both eyelids, a cut on the bridge of his nose, bruises on the inside of his right arm, and scrapes on the front and back of his right arm. Resident A told staff Sydney Hill, Avian Hicks and responding EMTs that staff Sebastian Pizano punched Resident A in the nose. Resident A told staff Niyasia Burns that Staff Pizano “punched me and dragged me.” Staff Pizano denied punching Resident A in the nose, grabbing Resident A by the arm, or pushing Resident A to the ground. He said that he was bending down and when he stood up, he accidentally headbutted Resident A in the nose. On 03/18/2026, RRO Bates observed several injuries to Resident A’s face and body. Resident A reported to her that Staff Pizano punched him in the nose, and it hurt. I asked Resident A how he received the injury to his nose, but he was unable to tell me. Resident C said that on one occasion, he witnessed staff Sebastian Pizanno grab Resident A by his arm and drag him to his room. Resident C said that Resident A was yelling during this incident, but he does not remember if Resident A received an injury on that date. Resident D stated, “I saw the blood but (Resident A) didn’t say what happened.” Resident D said, “I know that (Resident A’s) nose got hit and (staff) Sebastian (Pizano) got fired.” I asked him if he saw Staff Pizano hit Resident A and he said “no, but he (Staff Pizano) has a temper.”

ANALYSIS:	Resident E said that Resident A told him that Staff Pizano punched him in the nose which is how he obtained the bloody nose. Resident E said that Staff Pizano told him that Resident A headbutted him, resulting in a bloody nose. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(4) Direct care staff shall possess all of the following qualifications before working independently: **(a) Be capable of meeting the physical, emotional, intellectual, and social needs of each resident.** **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	During the course of my investigation, I determined that on 03/14/2026, Resident A sustained a bloody nose, black and blue bruises on both eyelids, a cut on the bridge of his nose, bruises on the inside of his right arm, and scrapes on the front and back of his right arm. Resident A told several individuals that staff Sebastian Pizano grabbed him, dragged him, and punched him in the nose. I conclude that there is sufficient evidence to substantiate this rule violation and staff Sebastian Pizano is incapable of ensuring the welfare of residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 04/06/2026, Resident A sustained a lacerated ear. It is alleged that Resident A urinated on his bedroom floor and in retaliation, staff Zykeius Williams threw him into his dresser, causing the injury.

INVESTIGATION: On 04/07/2026, I conducted an unannounced onsite inspection of Keith Specialized Residential Adult Foster Care facility. I interviewed Resident A, Resident C, Resident D, Resident E, and Resident F. Initially, I spoke to him while he was sitting in the living room. I observed a bandage encircling Resident A's head. I asked Resident A what happened and he said that he fell and hit his head. I then interviewed Resident A in his bedroom. I asked him about the bandage to his head, and he told me that one of the staff pushed him into his dresser and he hurt his head. I

asked Resident A who pushed him and he pointed outside his bedroom. I asked Resident A what the person looked like and he said it was a Black man with dark hair and he was tall.

I interviewed Resident E in his room. I began by talking with him about Resident A and he said, “Did you see his head?” I told him that I saw a bandage on Resident A’s head. Resident E told me that yesterday, Resident A “pissed all over the floor” in his bedroom. Resident E said that staff got angry with him and told him to mop it up, but Resident A refused. Resident E said that he witnessed staff grab Resident A out of bed and throw him into the wall where he hit his dresser. Resident A told me that Resident A “split his ear open” and there was blood all over the place.

I then asked Resident E who the staff was and he said, “It was ‘Ziggy.’ Me and him are cool now but it wasn’t cool what he did to (Resident A.)” Resident E said that when “Ziggy” saw Resident A’s injury, he kept saying, “You’re fine, you’re fine” and then he took Resident A to the hospital. Resident E stated that Resident A “disrupts everything and everyone always gets mad at him.”

While at the facility, I also interviewed Resident C, Resident D, and Resident F. All three residents said that they were aware that Resident A received an injury to his head on 04/06/2026 but they said they do not know what happened. Resident C said that he has never seen any of the staff hurt any of the residents. Resident D said that he has never seen any of the staff hit any of the residents but said that staff get angry with Resident A because he hits and spits on everyone. Resident F said that he has never witnessed any of the staff hurt any of the residents.

On 04/30/2026, I interviewed RRO Bates via telephone. RRO Bates said that she interviewed Resident A and he reported that he received an injury to his ear when staff threw him into his dresser. RRO Bates said that she showed Resident A a photograph of staff member Zykeius Williams and Resident A identified him as the staff who caused the injury.

RRO Bates said that she also interviewed Resident E. Resident E reported that on 04/06/2026, staff “Ziggy” was mad at Resident A “for pissing on his bedroom floor.” Resident E told RRO Bates that “Ziggy” told Resident A several times to mop it up, but he refused. “Ziggy” then grabbed Resident A off his bed and threw him into his dresser. Resident E told RRO Bates that Resident A hit his head, split his ear, and there was blood everywhere.

On 05/05/2026, I reviewed AFC paperwork related to this complaint. I reviewed an *Incident/Accident Report* dated 04/06/26 at 8am completed by Zykeius Williams. According to this report, “At approximately 8am staff prompted (Resident A) to take his scheduled morning medication. (Resident A) appeared to be in a negative mood and responded by telling staff to go home. Shortly after (Resident A) got out of bed and urinated on his bedroom floor. Staff immediately retrieved mop and began cleaning the area to maintain a safe and sanitary environment. While staff was mopping (Resident A)

got out of bed again and attempted to strike staff. During this time (Resident A) slipped on the urine that was on the floor and fell, hitting his head on the edge of the dresser. Staff immediately assisted (Resident A) following the fall and assessed him for injury. Staff observed that (his) ear was split open. Staff utilized a first aid kit to clean the wound, control bleeding and apply appropriate care. Due to the injury staff transported (Resident A) to urgent care for further medical evaluation. Home manager was notified of the incident. Staff will continue to monitor (Resident A) for any changes in condition or signs of further injury due to the head impact."

I reviewed the after-visit summary from Hurley Medical Center dated 04/06/2026. Resident A was diagnosed with a laceration of the left ear, initial encounter.

I reviewed the Internal Investigation Report completed by the director of operations (DO), Jordan Hopper. DO Hopper received information that Resident A had slipped in his bedroom, hit his dresser, and cut his ear. DO Hopper went to the facility on 04/06/2026 and began his investigation. He returned on 04/07/2026 to conclude his investigation. He interviewed staff Zykeius Williams, Don Lilly, Sydney Hill, and Stephani Lazar. DO Hopper determined that the incident was accidental in nature and there was no evidence to suspect staff misconduct, inappropriate force, or neglect/failure to respond properly. DO Hopper reported that Staff Williams has not had any performance complaints regarding misconduct or inappropriate use of force.

On 05/06/2026, I interviewed staff Don Lilly via telephone. Staff Lilly confirmed that he worked on 04/06/2026 along with Staff Hill, Staff Lazar, and Staff Williams. Staff Lilly said that he was assigned as Resident E's 1:1 on that date. According to Staff Lilly, earlier that morning, Resident A was having a behavior and he was yelling. Staff Zykeius Williams was Resident A's 1:1 on that date. Resident A began yelling that he wanted to get up so Staff Williams headed down the hallway to his room. In the meantime, Staff Lilly said that he and Resident E went outside for a walk in the front yard. When he and Resident E got back inside, Resident A was sitting at the table with a bloody ear and Staff Williams told them that Resident A had slipped on the floor in his bedroom and he hit his dresser, injuring his ear. Staff Williams told them that Resident A needed to go to the hospital for treatment.

I asked Staff Lilly if there was any way that Resident E could have witnessed the incident involving Resident A and Staff Williams and he said no. Staff Lilly said that he knows for sure that Resident E was with him at the time of the incident. I asked Staff Lilly why Resident E may have said that he saw Staff Williams throw Resident A into his dresser, and he said that Resident E was mad that day because they were supposed to go on an outing but since Resident A got injured, the outing was called off. Staff Lilly said that he did not suspect that Resident A received the injury deliberately and he has never had concerns about Staff Williams acting inappropriately with Resident A.

On 05/06/2026, I reviewed AFC paperwork related to this complaint. Resident E was admitted to this facility on 02/16/2026. Resident E is diagnosed with autism, attention deficit hyperactivity disorder, bipolar disorder, disruptive mood dysregulation disorder,

and oppositional defiant disorder. I reviewed his Individualized Plan of Service (IPOS) dated 05/13/2025. Resident E's IPOS does not address making false statements but does report his history of aggressive behavior. Behavior Treatment Plan (BTP) dated 02/19/2026. According to this document, Resident E has a history of physical aggression, verbal aggression, and threats of self-harm. He requires 1:1 staff supervision 16 hours per day.

On 05/06/2026, I interviewed Resident E's residential liaison (RL), Rachel Lemiesz. RL Lemiesz said that she has had Resident E on her caseload for a long time and she is very familiar with him. According to RL Lemiesz, Resident E has a history of making false allegations against staff and he can be very convincing. RL Lemiesz confirmed that Resident E has lived at Keith SRS since February and since that time, she has worked closely with the administrator (AD), Katrina Bailey to address his behaviors. RL Lemiesz said that Resident E has made several false allegations against staff at Keith SRS and at his previous AFC placement. RL Lemiesz said that Resident E will stick to his version of events until he is confronted with information that proves his history of events could not have happened and only then will he admit he had not told the truth.

On 05/08/2026, I interviewed staff Stepheni Lazar via telephone. Staff Lazar confirmed that she worked on 04/06/2026 along with staff Sydney Hill, Don Lilly, and Zykeius Williams. According to Staff Lazar, she was cleaning one of the residents' rooms and was not present for the incident. She said that when she walked into the dining room area, Resident A was sitting at the table and Staff Hill was attending to his injured ear. Staff Lazar asked what happened and Staff Williams said that Resident A fell into his dresser and cut his ear.

I asked Staff Lazar if any of the residents were present during the incident and she said she does not remember. Staff Lazar said that at no time did she suspect that Staff Williams had deliberately caused the injury to Resident A. Staff Lazar said that all the residents like Staff Williams and he interacts with all of them in a very positive way. Staff Lazar told me that she has never had concerns that Staff Williams was physically inappropriate with any of the residents.

On 05/08/2026, I interviewed staff Zykeius Williams via telephone. Staff Williams confirmed that he worked on 04/06/2026 and he was Resident A's 1:1 staff. Staff Williams told me that Resident A was having a lot of behaviors that morning, including urinating on his bedroom floor. Staff Williams said that he grabbed the mop and bucket and was standing in Resident A's doorway, getting ready to mop the floor. Resident A jumped up out of bed and charged Staff Williams, but he slipped on the urine and hit his ear on the corner of his dresser. Staff Williams said that Resident A's ear began bleeding so he took him to the hospital where he received stitches on his ear from the injury.

Staff Williams told me that he never grabbed Resident A, pushed him, or otherwise caused an injury to his ear. Staff Williams said, "Thank God he only hit his ear. He could have busted his head, and it could have been so much worse." Staff Williams said that

none of the other staff or residents were present during this incident. He said that Resident A's ear bled a lot, so he tended to it and then took him for medical attention. Staff Williams said that he has never been physically inappropriate with any of the residents.

On 05/08/2026, I interviewed staff Sydney Hill via telephone. Staff Hill confirmed that she worked on 04/06/2026 along with staff Zykeius Williams, Don Lilly, and Stephanie Lazar. Staff Hill said that earlier that morning, she attempted to pass medications to Resident A but he refused. Staff Hill said that she went to his room to attempt again and he was sitting on his bed with a bloody ear. Staff Hill said that she cannot remember if Staff Williams or Staff Lilly were with Resident A but said that one of them told her that Resident A had slipped when he got out of bed and he hit his head on his dresser. According to Staff Hill, there were no other residents present during the incident. Staff Hill said that she did not witness the incident, but she saw Resident A immediately afterwards and it was only him and staff in his bedroom.

Staff Hill confirmed that she and other staff tended to Resident A's ear and he was taken to the hospital for medical attention. I asked Staff Hill if Resident A said anything to her about how the incident occurred and she said no. I asked her if she had any reason to believe that Staff Williams deliberately caused the injury, and she said no. Staff Hill said that Staff Williams is very good with the residents and they all seem to like him. She said that she has never had any concerns about him being physically inappropriate with any of the residents.

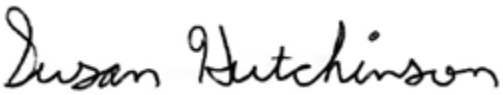
APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(a) Use any form of punishment.**
ANALYSIS:	On 04/06/2026, Resident A sustained an injury to his ear that required medical attention. Resident A told me that a tall Black man with dark hair pushed him into his dresser and he hurt his head. Resident E said that on 04/06/2026, Resident A "pissed all over the floor" in his bedroom. He said that staff "Ziggy" told Resident A to mop up the floor and Resident A refused. Resident E said that he saw "Ziggy" grab Resident A out of bed and throw him into the wall where he hit his dresser. Resident E told me that Resident A "split his ear open" and there was blood all over the place. Resident C, D, and F said that they know Resident A received an injury to his head, but they do not know how he received it. All three residents said that they have not seen any of the staff hurt any of the residents.

	Staff Don Lilly said that he worked on 04/06/2026 along with staff Zykeius Williams. Staff Lilly said that he and Resident E were outside when the incident happened with Resident A and there was no way that Resident E could have witnessed the incident. Resident E's residential liaison, Rachel Lemiesz said that Resident E has a history of making false allegations against staff and he can be very convincing. Staff Stepheni Lazar said that she worked on 04/06/2026 but was not present during the incident. Staff Lazar said that none of the residents told her that Resident A's injury was caused by staff and said that she has never had concerns that staff Zykeius Williams has ever been physically inappropriate with any of the residents. Staff Zykeius Williams said that Resident A slipped on the urine on his floor and fell into his dresser, injuring his ear. Staff Williams denied causing the injury and said that he never grabbed Resident A, threw him, or treated him physically inappropriately in any way. Staff Sydney Hill said that she walked into Resident A's room immediately after the incident occurred and there were no other residents present. She said that staff told her that Resident A got out of bed, slipped and hit his head on his dresser, causing his ear to split open. Staff Hill said that Resident A never told her that anyone deliberately caused the injury and she has no reason to believe that the incident was deliberately caused by staff. I conclude that there is insufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 05/08/2026, I conducted an exit conference with the licensee designee (LD), Christine Bertram. I discussed the results of my investigation and explained which rule violations I am substantiating. LD Bertram agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

IV. RECOMMENDATION

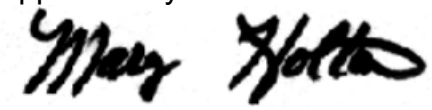
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



May 11, 2026

Susan Hutchinson Licensing Consultant	Date

Approved By:



May 11, 2026

Mary E. Holton Area Manager	Date