



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 7, 2026

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

RE: License #: AS630418070
Investigation #: 2026A0991017
Indianwood

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 "Kristen Donnay". The signature is written in a dark ink and is positioned below the word "Sincerely,".

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

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

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| License #: | AS630418070 |
| Investigation #: | 2026A0991017 |
| Complaint Receipt Date: | 03/24/2026 |
| Investigation Initiation Date: | 03/25/2026 |
| Report Due Date: | 05/23/2026 |
| Licensee Name: | North-Oakland Residential Services Inc |
| Licensee Address: | 106 S. Washington Oxford, MI 48371 |
| Licensee Telephone #: | (248) 969-2392 |
| Licensee Designee/Administrator: | Roger Covill |
| Name of Facility: | Indianwood |
| Facility Address: | 5115 Indianwood Road Clarkston, MI 48348 |
| Facility Telephone #: | (248) 256-6043 |
| Original Issuance Date: | 02/13/2024 |
| License Status: | REGULAR |
| Effective Date: | 08/13/2024 |
| Expiration Date: | 08/12/2026 |
| Capacity: | 6 |
| Program Type: | PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED |

II. ALLEGATION(S)

| | Violation Established? |
|---|-----------------------------------|
| Direct care worker, DaSharae Bryant, left Resident A unattended in the shower and cursed at Resident A. | Yes |
| Additional Findings | Yes |

III. METHODOLOGY

| | |
|------------|---|
| 03/24/2026 | Special Investigation Intake 2026A0991017 |
| 03/24/2026 | Referral - Recipient Rights Received from Office of Recipient Rights (ORR) |
| 03/25/2026 | Special Investigation Initiated - Telephone Call to Office of Recipient Rights worker, Sarah Rupkuss |
| 03/25/2026 | APS Referral Referred to Adult Protective Services (APS) Centralized Intake |
| 03/30/2026 | Inspection Completed On-site Interviewed staff and residents |
| 03/30/2026 | Contact - Document Received Training verification |
| 03/31/2026 | Contact - Document Received Individual Plan of Service and Crisis Plan |
| 05/06/2026 | Contact - Telephone call made Left message for ORR worker, Sarah Rupkus |
| 05/06/2026 | Contact - Telephone call made Interviewed staff, Catrina Moore |
| 05/06/2026 | Exit Conference Via telephone with licensee designee, Roger Covill |

ALLEGATION:

Direct care worker, DaSharae Bryant, left Resident A unattended in the shower and cursed at Resident A.

INVESTIGATION:

On 03/24/26, I received a complaint alleging that direct care worker, DaSharae Bryant, left Resident A unattended in the shower. The complaint stated that Ms. Bryant walked out of the bathroom, got a plastic chair, and sat outside the bathroom so that Resident A could finish having a bowel movement while Resident A was in a shower chair under the running water. The complaint also alleged that Ms. Bryant used inappropriate language towards the residents in the home. Ms. Bryant told Resident A, "You have a shitty butt," and while cleaning up Resident A's bowel movement, she told Resident A, "...you are the most shitty person. I know you are fucking with my baby." I initiated my investigation on 03/25/26 by contacting the assigned Office of Recipient Rights (ORR) worker, Sarah Rupkus, and by referring the complaint to Adult Protective Services (APS). Ms. Rupkus stated that she spoke with the licensee designee, Roger Covill, who stated that DaSharae Bryant is a fairly new staff. He stated that Ms. Bryant has been counseled in the past for not being attentive while wearing headphones/earphones while on shift, and for cursing in the home around residents, but not specifically directed at anyone.

On 03/30/26, I conducted an onsite inspection with the assigned ORR worker, Sarah Rupkus. I interviewed the home manager, Glenda Simmons. Ms. Simmons stated that direct care worker, DaSharae Bryant, just started working in the home approximately one month ago. She stated that Ms. Bryant is fully trained, except she is finishing medication training. Ms. Simmons stated that when Ms. Bryant began working in the home, she was "a little rough" in how she spoke. She stated that Ms. Bryant recently moved from Philadelphia, so it may be cultural. She stated that Ms. Bryant's language was rough, and she would swear when she was talking, but it was not directed towards the residents. She stated that Ms. Bryant would say "shit" instead of "poop" or "bowel movement." Ms. Simmons stated that she told Ms. Bryant that she needed to use kinder language. She feels that Ms. Bryant's language has improved. She stated that Ms. Bryant interacts well with the residents and is kind to them.

On 03/30/26, I interviewed direct care worker, Sheena Vickery. Ms. Vickery stated that she has worked a few shifts with DaSharae Bryant. She stated that Ms. Bryant is "fine" and she has not had any problems with her. Ms. Vickery stated that Resident B brought up a concern that Ms. Bryant said to her, "Hey boo boo, come to the table." Resident B felt like Ms. Vickery was treating her like child and using babyish nicknames. Resident B told Ms. Bryant this and Ms. Bryant has changed her language. Ms. Vickery stated that

she believes Ms. Bryant has young children at home, so it might have been a habit to speak that way. She stated that she has not observed Ms. Bryant cursing or swearing at the residents. She has never seen her being malicious or mean. Ms. Vickery stated that Ms. Bryant interacts well with Resident A. Resident A does not appear to be fearful of Ms. Bryant. Ms. Vickery stated that Resident A requires assistance in the shower and must be supervised at all times. She cannot be left alone in the shower, as she might fall out of her shower chair. Ms. Bryant stated that all staff are trained to set up everything before bringing Resident A into the shower, so they do not need to leave the bathroom while Resident A is in the shower. New staff are required to read the residents' plans and observe other staff before they provide hands-on care.

On 03/30/26, I interviewed direct care worker, DaSharae Bryant. Ms. Bryant stated that she has worked in the home for about two months. She stated that she completed recipient rights training and is fully trained, other than being monitored for medication passing. She stated that she was trained on all the residents' individual plans of service (IPOS) and crisis plans. Ms. Bryant stated that Resident A is a two-person assist for transferring from her wheelchair to the shower chair. After she is in the shower chair, one staff takes over supervising Resident A in the shower. Staff provide hands on assistance to wash Resident A while she is in the shower. Staff stay in the bathroom at all times. Resident A cannot be left alone in the shower. Ms. Bryant stated that there was never a time when she left Resident A alone or unattended in the shower. She stated that Resident A does have bowel movements (bm) in the shower. She stated that Resident A does this regularly and she prefers it. She stated that the shower chair has an open bottom, so the bm goes onto the drain. Ms. Bryant stated that she immediately cleans it up. Ms. Bryant stated that they do not attempt to toilet Resident A before she showers. Resident A wears a brief throughout the day and does not go on the toilet. Ms. Bryant stated that she has stepped to the door to give Resident A privacy while she was having a bm. She stated that she still had eyes on her. She denied leaving the bathroom to get a chair to watch from the door. Ms. Bryant denied ever telling Resident A that she has a "shitty butt" or is a "shitty person." She could not recall ever swearing at Resident A or making comments like this in a joking way. She does not curse in front of the residents. She never heard any other staff making comments like this to Resident A. Ms. Bryant stated that she gets along well with the other staff in the home.

During the onsite inspection, Resident A was unable to participate in an interview due to limited verbal and cognitive abilities.

On 03/30/26, I interviewed Resident B. Resident B stated that she likes living in the home and things are great. She stated that if she has any problems with staff, they talk through it. Resident B stated that DaSharae Bryant is a new staff in the home. She stated that Ms. Bryant called her "honey bun" and she did not like it, because it was babyish. She stated that she talked to Ms. Bryant about this, and she stopped talking

like that. Everything is even-keel now and there are no problems. She never heard Ms. Bryant swearing at any of the residents in the home.

On 03/30/26, I interviewed Resident C. Resident C stated that she likes living in the home and the staff are okay. She stated that DaSharae Bryant is “fine” and is nice to her. She stated that she never heard any of the staff in the home swearing or using bad language.

On 05/06/26, I interviewed direct care worker, Catrina Moore. Ms. Moore stated that she was working the second shift with direct care worker, DaSharae Bryant. Ms. Moore stated that Ms. Bryant was assisting Resident A in the shower when she observed Ms. Bryant walk away to get a chair from the back bedroom. Ms. Bryant sat in the chair in the hallway while Resident A was sitting in the shower chair in the shower with water hitting her. Ms. Moore stated that Ms. Bryant sat in the chair outside of the bathroom for about ten minutes. She stated that Resident A requires supervision at all times when she is in the bathroom or shower. Staff are to remain in the bathroom with Resident A for her safety. Ms. Moore stated that she did not say anything to Ms. Bryant when she saw her sitting in the hallway. She stated that Ms. Moore can be very confrontational with staff, and she did not want to have a confrontation in front of the residents. Ms. Moore stated that she took a picture of the chair in the hallway, but Ms. Bryant was not sitting in the chair at the time. She provided a copy of this picture, which was taken from the kitchen, and shows through the doorway a plastic chair in the hall where the bathroom is located. Ms. Moore stated that this picture was taken on 03/17/26 at 7:50pm. Ms. Moore stated that she informed the home manager, Glenda Simmons, and Ms. Simmons notified the area manager and licensee designee. Ms. Moore stated that it is not uncommon for Resident A to have a bowel movement while she is in the shower, but staff are to remain in the bathroom with her when she is having a bm. Ms. Moore stated that Ms. Bryant sat outside the bathroom “quite often” until the home manager told her that she could not do this anymore. Ms. Bryant did not always get a chair, but she would sit on the floor or stand outside the bathroom. Ms. Moore stated that Ms. Bryant does not do this as often since the home manager spoke to her.

Ms. Moore stated that she also observed Ms. Bryant using bad language towards and around the residents. She stated that on one occasion, Resident A was being changed in bed and Ms. Bryant said to Resident A, “You’re the shittiest person I know. You’re messing with my baby.” She stated that it did not sound like Ms. Bryant was joking when she made this statement. Ms. Moore stated that Ms. Bryant frequently swears around the residents. The home manager has addressed this with Ms. Bryant on several occasions, even before the complaint was made. Ms. Moore stated that Ms. Bryant continues to swear around the residents and often uses bad language when she makes comments to the residents. She stated that staff in the home do not usually swear

around the residents. Ms. Moore stated that she is the staff person who typically works with Ms. Bryant, as they are scheduled on second shift together.

I received and reviewed Resident A's individual plan of service (IPOS) and crisis plan dated 03/01/26. With regards to bathing, the crisis plan notes that Resident A is dependent on others to set the water temperature and ensure that she is washed/dried thoroughly. Staff are to remain in the bathroom to assist Resident A as needed in all bathing tasks and for safety.

I received and reviewed an IPOS training record, which shows that direct care worker, DaSharae Bryant, was trained regarding Resident A's IPOS and crisis plan by the home manager, Glenda Simmons. I received and reviewed verification that Ms. Bryant completed new hire recipient rights training on 02/12/26.

| APPLICABLE RULE | |
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| 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 on the information gathered through my investigation, there is sufficient information to conclude that direct care worker, DaSharae Bryant, did not provide personal care and supervision as outlined in Resident A's plan of service. Resident A's crisis plan indicates that staff are to remain in the bathroom to assist Resident A as needed in all bathing tasks and for safety. Direct care worker, Catrina Moore, observed Ms. Bryant sitting in a chair in the hallway outside of the bathroom for ten minutes while Resident A was in her shower chair under the running water in the shower. Ms. Moore did not intervene or tell Ms. Bryant that she needed to be in the bathroom with Resident A. |
| CONCLUSION: | VIOLATION ESTABLISHED |

| APPLICABLE RULE | |
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| R 400.681 | Resident rights; licensee responsibilities. |
| | (1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe. |

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| ANALYSIS: | Based on the information gathered through my investigation, there is sufficient information to conclude that direct care worker, DaSharae Bryant, did not treat the residents with dignity and respect when she swore at and around the residents, and made comments such as, "You are the shittiest person I know," to Resident A. While Ms. Bryant denied using bad language, the home manager and direct care worker, Catrina Moore, stated that they observed Ms. Bryant swearing around the residents. The information provided by Ms. Moore is consistent with the information in the complaint, including having witnessed Ms. Bryant saying to Resident A, "You are the shittiest person I know." |
| CONCLUSION: | VIOLATION ESTABLISHED |

ADDITIONAL FINDINGS:

INVESTIGATION:

During my onsite inspection on 03/30/26, I observed that Resident B was in a wheelchair. A gait belt was around Resident A's waist and secured in the back of the wheelchair to keep Resident A in the wheelchair. Resident A was unable to remove the gait belt on her own, as it was tied around the back of the wheelchair. The home manager, Glenda Simmons, stated that Resident A needs a new wheelchair and an assessment was recently completed to replace the wheelchair.

On 05/06/26, I conducted an exit conference via telephone with the licensee designee, Roger Covill. Mr. Covill stated that they obtained a seatbelt for Resident B's wheelchair and are no longer using a gait belt. During the exit conference, Mr. Covill stated that he did not have any additional information to share regarding the investigation.

| APPLICABLE RULE | |
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| 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: (b) Use any form of restraint without an order from an appropriately licensed health care professional or physical force, other than physical restraint for crisis intervention. |

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| ANALYSIS: | Based on the information gathered through my investigation, there is sufficient information to conclude that staff were using a gait belt to restrain Resident A in her wheelchair. The gait belt was tied around Resident A's waist and the back of the wheelchair, preventing her from being able to untie it or get out of the wheelchair. |
| CONCLUSION: | VIOLATION ESTABLISHED |

IV. RECOMMENDATION

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



05/06/2026

Kristen Donnay
Licensing Consultant

Date

Approved By:



For

05/07/2026

Denise Y. Nunn
Area Manager

Date