GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 24, 2026

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

RE: License #: AM190396226
Investigation #: 2026A0577048
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

License #:	AM190396226
Investigation #:	2026A0577048
Complaint Receipt Date:	06/16/2026
Investigation Initiation Date:	06/16/2026
Report Due Date:	08/15/2026
Licensee Name:	Open Arms Link
Licensee Address:	Suite 130 8161 Executive Court Lansing, MI 48917
Licensee Telephone #:	(517) 253-8894
Licensee Designee:	Simbarashe Chiduma
Administrator:	Simbarashe Chiduma
Name of Facility:	Boichot
Facility Address:	14120 Boichot Road Lansing, MI 48906
Facility Telephone #:	(517) 455-8300
Original Issuance Date:	11/20/2018
License Status:	REGULAR
Effective Date:	05/20/2025
Expiration Date:	05/19/2027
Capacity:	8
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A continues to elope from the facility unsupervised.	Yes

III. METHODOLOGY

06/16/2026	Special Investigation Intake, 2026A0577048
06/16/2026	Special Investigation Initiated – Telephone, Tom Hilla, Clinton Co APS.
06/16/2026	Contact - Document Received, Tom Hilla, APS Clinton Co.
06/16/2026	Contact - Document Received, Concerned Citizen 1.
06/16/2026	APS Referral- Tom Hilla, APS Clinton Co, denied APS received on 6/15/26.
06/18/2026	Contact - Document Received, Denied APS referral from 6/17/26.
06/18/2026	Contact-Document Received, IR from Tom Hilla, APS.
06/18/2026	Contact - Document Sent, Group email with Open Arms, LARA, and CMH.
06/18/2026	Contact - Telephone call made, Dewitt Township Police
06/22/2026	Contact - Document Received, Email with Open Arms
06/22/2026	Contact - Telephone call received, Interview with Concerned Citizen 2.
06/22/2026	Inspection Completed On-site, Jason Zilka, Operations Director.
06/22/2026	Contact - Document Received, Tom Hilla, APS.
06/23/2026	Contact - Telephone call made- Mtng. with Open Arms, CMH, APS, Dewitt Tsp Police, and LARA.
06/23/2026	Contact - Document Received, Tom Hilla, APS.
07/07/2026	Contact - Document Received, 30Day discharge notice for DH.
07/16/2026	Contact-Telephone call made, Interviews with DCS.

07/16/2026	Contact-Document Received, IR for 6/13/26.
07/20/2026	Contact-Telephone call made, Interview with DCS.
07/20/206	Exit Conference, Simba and Masculine Chiduma
07/23/2026	Contact-Telephone call made. Attempted interviews with DCS.
07/23/2026	Contact-Document Received

ALLEGATION: Resident A continues to elope from the facility unsupervised.

INVESTIGATION:
On June 16, 2026, a complaint was received alleging that Resident A had been eloping from the facility without direct care staff knowledge. During one episode of elopement, Resident A was caught by a neighbor looking in windows during the middle of the night.

On May 09, 2026, a special investigation was completed and during this investigation I reviewed Resident A's Assessment *Plan for AFC, Individual Service Plan, Person Centered Plan, and Behavior Treatment Plans.* All of which documented that Resident A has a history of elopement and property destruction requiring direct care staff supervision while in the community. These documents also noted Resident A requires routine supervision checks during daytime and sleeping hours, however, there was no enhanced or 1:1 supervision requirement noted in any of the service plans. I reviewed these plans again for this investigation and noted that no updates or changes in any of the plans had occurred since last reviewed.

On June 16, 2026, I interviewed Tom Hilla, Adult Protective Services Specialist (APS) with Clinton County Department of Health and Human Services (DHHS) who reported on June 14, 2026, that he received a denied APS referral reporting "an unknown male resides at Boichot Adult Foster Care home and is cognitively impaired. The unknown male escapes from the adult foster care home and the caregivers of unknown male do not realize he is missing. Unknown male lingers in neighbors' yards, porches, and looks through neighbors' windows. Unknown male is barely clothed. Unknown male has been observed in soiled pajama bottoms. On Saturday June 13, 2026, unknown male was observed with pajama bottoms and socks on, he looked uncleaned, and there are concerns that unknown male will get hit by a car on the busy street roads." Mr. Hilla reported that he has a current investigation open from a previous referral he received and will continue to monitor the concerns of Resident A eloping from the facility through his current investigation.

On June 16, 2026, I received a call from Concerned Citizen 1 who reported over the past week (June 9- June 16) Concerned Citizen 1 has observed Resident A wandering the street by himself in the middle of the night at least twice. Concerned Citizen 1 reported during the time frame of June 9 through June 16, 2026, Resident A was found in a neighbor's garage, entered a different neighbor's house and was seen peeking into a separate neighbor's windows. Concerned Citizen 1 reported neighbors are very upset and have called Dewitt Township Police Department on multiple occasions since the beginning of June 2026 regarding Resident A being unsupervised and entering property without permission. Concerned Citizen 1 reported that someone almost hit Resident A the other night while driving down the road and then another neighbor almost shot Resident A as he was attempting to break into this neighbor's home.

On June 18, 2026, via email from Tom Hilla, Clinton County APS Specialist forwarded a denied APS referral from June 17, 2026, reporting "the Dewitt Township Police Department have received several calls regarding [Resident A] walking in the middle of the road and into neighbor's yards without supervision." The denied APS referral reported that on June 13, 2026, Resident A was observed on camera walking up to a neighbor's house and looking into the windows and also opening a sliding door of another neighbor's home and walking into the residence. The APS referral reported that this is an ongoing issue with Resident A and the AFC home does not lock the doors which allows Resident A the opportunity to leave without direct care supervision.

On June 18, 2026, I contacted Dewitt Township Police and spoke with Rachel Perrine, Administrative Assistant, who reported an officer was dispatched to the facility on May 09, and June 13, 2026, due to Resident A eloping from the facility and being found by different neighbors at various addresses. Ms. Perrine reported that Dewitt Township Police were contacted on June 17, 2026, by Concerned Citizen 1 on behalf of the neighborhood, voicing concerns about Resident A's frequent elopements and that Resident A is now entering or attempting to enter neighbors' homes. Ms. Perrine via email sent me copies of Police Report 26-00717 reporting on June 17, 2026, at 10:55pm, Officer Sherman from the Dewitt Township Police Department received general noncriminal complaint via telephone from Concerned Citizen 1 voicing concerns of Resident A consistently leaving the facility and wandering into the neighbors' yards. Concerned Citizen 1 voiced concerns of Resident A becoming violent and harming others. Concerned Citizen 1 reported they have contacted an attorney who has advised Concerned Citizen 1 to contact Dewitt Township Police Department. Officer Shermain advised Concerned Citizen 1 to send a certified letter to the facility putting them on notice of the no trespassing order.

On June 18, 2026, Tom Hilla, Clinton County APS emailed me a copy of an AFC Licensing Division -Incident/Accident report dated May 09, 2026, completed by Direct Care Staff (DCS), Sharafey Mohamed documenting that at 7:40pm "[Resident A] went outside, left the house and property, and the neighbor called the police. By

the time the police came, [Resident A] was back on the property. Staff called the manager, kept an eye on [Resident A], and followed him around for the rest of the night."

On July 16, July 20, and July 23, 2026, I called to interview direct care staff members (DCS) Rachel Niyokwizera, and Sharafey Mohamed left messages requesting a return call but no return call has been received.

On June 22, 2026, I received a call from Concerned Citizen 2 who reported over the past several months Resident A has eloped consistently from the facility. Concerned Citizen 2 reported that on June 09, 2026, around 11:00pm their Ring Camera went off and Concerned Citizen 2 observed people with flashlights in their yard and then heard a knocking on their door. Concerned Citizen 2 stated it was police notifying that Resident A was missing. Concerned Citizen 2 reported on June 13, 2026, around 9:41pm, their Ring Camera went off and upon reviewing the footage, Concerned Citizen 2 observed Resident A looking in their windows while they were not home. Concerned Citizen 2 reported that Resident A continued to go from house to house that same evening (June 13, 2026) and was observed on multiple neighbors' Ring Camera footage. Concerned Citizen 2 reported that one neighbor called the police and had their gun out due to fear of an intruder trying to get into their home. Concerned Citizen 2 reported there are multiple times where a neighbor has walked Resident A back to the facility without contacting the police. Concerned Citizen 2 reported that Resident A elopes at least weekly from the facility.

On June 18, 2026, I received an email from licensee designee Simbarashe Chiduma. This email was sent to staff from Clinton, Eaton, Ingham County Community Mental Health (CEI-CMH) with the purpose of discussing if direct care staff can meet Resident A's current needs given his frequent elopements from the facility. The email stated that licensee designee Simbarashe Chiduma also wanted to discuss Resident A's demonstrated pattern of taking advantage of even brief lapses in supervision and noted Mr. Chiduma's concern that direct care staff are challenged to consistently know Resident A's whereabouts even when Resident A is inside the facility. Mr. Chiduma's email stated, "it is important to recognize the operational challenges our staff face. This home serves seven residents with varying levels of care needs. In addition, we have residents who require a two-person assist with transfer, and there are four separate exits or access points that must be monitored. [Resident A] has become increasingly skilled at identifying and exploiting moments when staff are attending to other residents' needs. While we remain committed to providing the highest level of supervision possible, there are practical limitations within the current staffing model. We have recently received information that several neighbors are seeking legal counsel because they are concerned about [Resident A] entering their properties and the potential risk this presents, particularly to families with teenage children in the neighborhood. These concerns have heightened tensions within the community and have increased the urgency of finding a sustainable solution." It should be noted that at the time of this email, Resident A

did not require 1:1 supervision or any other type of enhanced supervision like within eyesight or arm's length supervision.

Mr. Chiduma's email went on to state, "additionally, the local Police Chief has expressed serious concerns regarding the ongoing elopements and has indicated that they believe the home's license should be revoked if these incidents continue. This underscores the severity of the situation and the need for immediate intervention."

Mr. Chiduma reported to CEI-CMH that "given the repeated incidents and the increasing concerns from law enforcement, neighbors, and regulatory stakeholders, it has recommended that the following option be adhered to in order to keep [Resident A] safely in the home:

1. Approval for dedicated one-to-one staffing to provide continuous supervision,
2. Authorization to install additional security measures, including locking some of the gates where legally permissible and in compliance with resident rights and regulatory requirements, and
3. A comprehensive review of DH's placement to determine whether the current setting can safely meet his supervision needs."

On June 22, 2026, a second email was received from Mr. Chiduma, which stated that in response to the concerns regarding Resident A's safety, the facility has already implemented the following measures without waiting for additional recommendations from CEI-CMH:

- both side gates have been secured and locked to limit unauthorized exits,
- direct care staff have been clearly informed that failure to provide proper supervision resulting in Resident A eloping from the home will lead to immediate disciplinary action, up to and including termination of employment,
- an outdoor camera and monitoring system were installed. The camera and monitoring system provides a loud and clear alert to direct care staff whenever someone is outside, allowing for immediate awareness and response.

On June 22, 2026, I completed an unannounced onsite investigation regarding this complaint and to verify compliance with corrective action plan (CAP) submitted on June 08, 2026, referencing Special Investigation Report #2026A0577036. Per the CAP submitted by licensee designee Simbarashe Chiduma, the facility developed a structured schedule for Resident A which I observed a copy of on the pantry door. Various activities for Resident A to engage in included looking at multiple magazines, sensory toys, bubbles, playdough, and swing set in the backyard. Mr. Chiduma had also installed a camera monitoring system connected to cameras outside of the facility to alert direct care staff when someone is inside of the yard. Lastly, Mr. Chiduma installed safety latches on the two gates that exit the backyard. All direct care staff were provided with updated in-service training on Resident A's plans on May 22, 2026. During the onsite investigation, I interviewed Jason Zilka, Operations Manager, who reported that management is not being notified by direct

care staff of Resident A's continued elopements. He also stated the licensee developed a structured schedule for Resident A, but have noted that it is when other residents require care that Resident A takes the opportunity to elope. Mr. Zilka reported that the motion cameras outside of the building should alert direct care staff when someone is outside. Mr. Zilka reported that at this time, without CEI-CMH's approval, they cannot staff Resident A with supervision of a 1:1 direct care staff.

On June 23, 2026, a meeting was held with CEI-CMH staff, Open Arms Links Staff, Dewitt Township Police Department, Adult Protective Service and me to develop a safety plan for Resident A. Jason Zilka, Operations Directors for Open Arms Link recommended enhanced supervision of 1:1 for Resident A during the times of 8:00pm-12:00am. Andrew Armbruster, CEI-CMH reported that he does not believe that the Behavior Treatment Committee will approve enhanced supervision and stated, " we should educate the neighbors on the types of residents that are in care, that the residents are not harmful, and instead of calling the police, call the facility to notify them of [Resident A] eloping." Mr. Armbruster reported that he will be taking the concerns and suggestions back to the Behavior Treatment Committee for review and approval. This meeting ended with no safety plan in place or additional temporary enhanced supervision approved for Resident A.

On July 07, 2026, I received a copy of a 30-Day discharge notice for Resident A, documenting that the licensee cannot meet Resident A's needs or provide the specific supervision Resident A requires.

On July 16, 2026, Jason Zilka, Operations Manager with Open Arms Link, emailed me a copy of an IR dated June 13, 2026, completed by DCS Chisomo Mazhangara involving an incident with Resident A. The IR documented that at 10:20pm, Resident A went out of the house to the road, he was seen by a driver in the middle of the road and the driver called the police. The IR documented direct care staff tried to look for Resident A but could not find him. The IR documented police helped search for Resident A and observed Resident A trying to run into the woods to get away from the police. The IR documented police reported to direct care staff that Resident A had been attempting to get into the neighbors' homes and one neighbor had pulled a gun on Resident A thinking it was someone trying to break into their home. Once the police found Resident A they returned Resident A to the facility.

On July 16, 2026, I interviewed DCS Nissalo Mulandani who reported on June 13, 2026, DCS Mulandani was working with DCS Chisomo Mazhangara and around 10:30pm DCS Mulandani and DCS Mazhangara realized that Resident A was not inside the facility so they called the police to report Resident A missing. DCS Mulandani reported that Resident A left the facility around 10:30pm and was found by police and brought back to the facility around 11:00pm. DCS Mulandani reported that Resident A was initially sitting at the table looking at books when other residents needed assistance from DCS Mazhangara and DCS Mulandani so Resident A must have left the facility while they were assisting other residents. DCS Mulandani

reported that they were told by police that Resident A was found down the road trying to get into a neighbor's house.

On July 20, 2026, I interviewed Chisomo Mazhangara who reported that she was working on June 13, 2026, with DCS Nissalo Mulandani. DCS Mazhangara reported that she was assisting another resident with going to bed and DCS Nissalo Mulandani was passing medications. DCS Mazhangara reported that when she returned to the common area, DCS Nissalo Mulandani reported that Resident A was missing. DCS Mazhangara reported that she went into the backyard to look for Resident A and Resident A was not in the backyard. DCS Mazhangara reported that as she was walking down the driveway, she was met by police and the police reported that they were called to the area due to Resident A being seen in the middle of the road. DCS Mazhangara reported that she started walking down the road looking for Resident A with the assistance of the police when a neighbor reported that Resident A was seen walking through the neighbors' yards. DCS Mazhangara reported that another neighbor came out to the road to report that Resident A was in their yard, had tried to break into their house and that neighbor almost shot Resident A. DCS Mazhangara reported that Resident A refused to return to the facility with her so Resident A was brought back to the facility by the police. DCS Mazhangara reported that Resident A was provided his mediations and went to bed. DCS Mazhangara reported that she reported the incident to administrator Masculine Chiduma.

At the time of this report, no new incidents of Resident A eloping have been received from any citizen, neighbor or local police.

Special Investigation Report #2026A0577036, dated May 9, 2026, cited Rule 400.671(4) after Resident A was not provided with supervision and protection as specified in his plans of care leading to Resident A eloping from the facility without the knowledge of direct care staff. The *Corrective Action Plan* documented that direct care staff will be trained on Resident A's plans of service, an evening structured schedule for Resident A will be developed for direct care staff to follow and a communication log will be implemented to track when Resident A is exit-seeking to determine times when Resident A is at high risk of elopement.

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:	Since the last SIR, 2026A0577036, dated May 06, 2026, Resident A has eloped from the facility on May 09, June 13, and June 17, 2026, without direct care staff realizing Resident A had left the facility without permission. Resident A's *Assessment Plan for AFC Residents, ISP, PCP, and BTP* documented that Resident A has a history of elopement and property destruction requiring direct care staff supervision while in the community. These documents also noted Resident A requires routine supervision checks during daytime and sleeping hours. Although the licensee implemented multiple treatment actions and physical plant improvements to decrease Resident A's elopement behaviors since May 06, 2026, Resident A continues to elope during times when direct care staff are assisting other residents. Despite requesting enhanced supervision approval from Resident A's CMH authority no approval or funding was provided to meet this increase in Resident A's supervision needs. The licensee remains responsible for implementing Resident A's supervision and protection needs as outlined in Resident A's various plans of services and this has not been achieved.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR #2026A0577036, DATED 05/06/2026 AND CAP DATED 05/08/2026]**

On July 23, 2026, I interviewed and conducted an exit conference with administrator Mascline Chiduma who acknowledged licensing concerns regarding Resident A's supervision needs. Ms. Chiduma stated, "since the previous Special Investigation Report, the organization has continued to implement and maintain multiple interventions, environmental modifications, and individualized supervision strategies in an effort to prevent further elopement incidents. Despite these efforts, [Resident A] continues to demonstrate behaviors that exceed the level of supervision that can safely be provided within the current AFC setting. Open Arms Link has exhausted all reasonable measures available within the home's resources to maintain [Resident A's] safety while continuing to meet the needs of the other residents in the home. The resident's supervision needs now require a higher level of support than can be safely provided in the current placement. On July 7, 2026, Open Arms Link issued [Resident A] an official 30-day discharge notice after determining that the resident's needs could no longer be safely met within the AFC program. Following the notice, the Community Mental Health (CMH) authority-initiated discharge planning and has begun coordinating [Resident A's] transition to a more appropriate level of care which has been found, but a final move date has not yet been established. Until [Resident A] is transferred, Open Arms Link will continue to implement all feasible

supervision measures, document all interventions, maintain ongoing communication with CMH and make every reasonable effort to protect the health and safety of [Resident A] and the other residents within the home."

IV. RECOMMENDATION

Due to the quality of care violations cited in the report, an approved corrective action plan is required. Upon receipt of an acceptable corrective action plan, I recommend the current status of the license remains unchanged.

Bridget Vermeesch

07/24/2026

_____

Bridget Vermeesch Date
Licensing Consultant

Approved By:

07/24/2026

_____

Dawn N. Timm Date
Area Manager