GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 31, 2019

Kimberly Nichols
Joyner Home LLC
PO Box 04030
Detroit, MI 48204

RE: License #: **AS820290866**
Investigation #: **2019A0989005**
Joyner Home II

Dear Ms. Nichols:

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) 975-5053.

Sincerely,

Theresa Cipponeri, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 285-8590

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820290866
Investigation #:	2019A0989005
Complaint Receipt Date:	10/10/2018
Investigation Initiation Date:	10/11/2018
Report Due Date:	12/09/2018
Licensee Name:	Joyner Home LLC
Licensee Address:	PO Box 04030 Detroit, MI 48204
Licensee Telephone #:	(313) 570-6006
Administrator:	Kimberly Nichols
Licensee Designee:	Kimberly Nichols
Name of Facility:	Joyner Home II
Facility Address:	7429 East Robinwood St. Detroit, MI 48234
Facility Telephone #:	(313) 891-6897
Original Issuance Date:	11/06/2007
License Status:	REGULAR
Effective Date:	06/02/2018
Expiration Date:	06/01/2020
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff, Shatonna Wade, took residents out with her to do her own personal errands instead of an approved, recreational outing.	Yes
Staff, Shatonna Wade, told Residents B and C to punch and hit Resident A.	Yes

III. METHODOLOGY

10/10/2018	Special Investigation Intake 2019A0989005
10/10/2018	APS Referral Received denied complaint from Adult Protective Services (APS) investigator.
10/11/2018	Special Investigation Initiated - Telephone Left voicemail message for the Licensee, Kimberly Nichols, requesting a return call.
10/17/2018	Contact - Telephone call made Called Ms. Nichols and scheduled an onsite inspection to the facility for 10/19/2018 at 10:00 a.m.
10/19/2018	Inspection Completed On-site Conducted scheduled onsite inspection to the facility. Interviewed Home Manager, Lakemia Jones, Residents A and B, and observed Residents C and D.
10/26/2018	Contact - Telephone call made Left a voicemail message for staff, Shatonna Wade, requesting a return call.
01/11/2019	Contact - Telephone call made Left a voicemail message for staff, Shatonna Wade, requesting a return call.
01/16/2019	Contact - Telephone call received Interviewed Ms. Wade via telephone.
01/16/2019	Contact - Telephone call made

	Interviewed Ms. Jones via telephone.
01/16/2019	Contact - Telephone call made Interviewed staff, Lakieta Spear via telephone.
01/16/2019	Exit Conference Left a detailed voicemail message for Ms. Nichols.
01/16/2019	Contact-Telephone call received Received a voicemail message from Ms. Nichols.
01/24/2019	Contact-Telephone call received Received a voicemail message from Ms. Nicholas.
01/24/2019	Exit Conference Held an exit conference with Ms. Nichols.

ALLEGATION:

Staff, Shatonna Wade, took residents out with her to do her own personal errands instead of an approved, recreational outing.

INVESTIGATION:

On 10/19/2018, I conducted a schedule onsite inspection to the facility. I interviewed the Home Manager, Lakemia Jones, Residents A and B, and observed Residents C and D. Ms. Jones stated that staff, Shatonna Wade, was supposed to be taking the residents to the Riverwalk in Detroit. Instead, she used the facility's van and took them on a personal errand to a car dealership so she could buy herself a car.

I interviewed Residents A and B, who stated that Ms. Jones was supposed to take them to the Riverwalk in Detroit for an outing, but instead she took them to a car dealership and made them sit by themselves while she talked to a car salesman in another part of the building. They did not see her for a while and did not know what they should do. They never went to the Riverwalk, and after they went to the car dealership, Ms. Wade took them back to the facility. Ms. Wade no longer works at the facility and they are happy about this.

I was unable to interview Residents C and D, as they are non-verbal.

On 1/16/2019, I interviewed staff, Shatonna Wade, via telephone. Ms. Wade stated that she did take Residents A-D to a car dealership, however, she took them there to try to teach them life skills. Ms. Wade denied that she was there buying herself a car and stated that she and the residents just walked around the dealership and she was teaching them about cars. Ms. Wade stated that she called a home manager

from another facility, Lakieta Spear, and asked her if she could take the residents to the Riverwalk in Detroit. Ms. Wade stated several times that she did take the residents to the Riverwalk and didn't stop anywhere else, then later in the conversation stated that on the way to the Riverwalk she had a personal emergency which required her to stop at a drugstore, CVS. Ms. Wade stated that after she stopped at CVS, she continued on the way to the Riverwalk, but then Resident D started to vomit. Ms. Wade called Ms. Spear again and Ms. Jones told her just to bring the residents home. Therefore, they never made it to the Riverwalk. Ms. Wade stated that she has since been fired.

On 1/16/2019, I interviewed Ms. Spear via telephone. Ms. Spear verified that on 9/21/2018, Ms. Wade asked her if she could take the residents to the Riverwalk in Detroit and Ms. Spear approved the outing. Ms. Spear stated that later that evening, Resident A spoke to her on the telephone and she was very upset and crying. Resident A told her that Ms. Wade took them to a car dealership to get herself a car and that she never took them to the Riverwalk. Ms. Spear stated that Ms. Wade did call her from the facility's van to tell her that Resident D was vomiting, so she told Ms. Wade to bring the residents home. They never made it to the Riverwalk. In addition, Ms. Wade told her that she had a personal emergency that required her to stop at CVS along the way with the residents.

On 1/16/2019, I interviewed Ms. Jones via telephone. Ms. Jones stated that she is the home manager that Ms. Wade was supposed to call, but she never called her and instead called Ms. Spear (home manager of another facility). The owner, Kimberly Nichols, called a mandatory meeting in which Ms. Wade, Ms. Nichols, and Ms. Spear attended. At that meeting, Ms. Wade admitted that she never took the residents to the Riverwalk and instead took them to CVS and the car dealership. However, Ms. Wade did not admit that she took them to the car dealership for her own personal reasons. Ms. Wade was subsequently fired.

APPLICABLE RULE	
R 400.14317	**Resident recreation.**
	(3) Equipment and materials shall encourage and reinforce all of the following: **(d) Productive utilization of leisure time.**

ANALYSIS:	Staff, Shatonna Wade, obtained permission from the Home Manager, Lakieta Spear, to take the residents on an outing to the Riverwalk. Ms. Wade did not take the residents to the Riverwalk; instead she ran personal errands to a car dealership and CVS. While at the car dealership, Ms. Wade left the residents alone and unsupervised while she spoke to a man in regards to purchasing a car for herself.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff, Shatonna Wade, told Residents B and C to punch and hit Resident A.

INVESTIGATION:

On 10/19/2018, I conducted a schedule onsite inspection to the facility. I interviewed the Home Manager, Lakemia Jones, Residents A and B, and observed Residents C and D. Ms. Jones stated that staff, Shatonna Wade, was in the facility's van with Residents A-D, and it was reported to another Home Manager, Lakieta Spear, that Ms. Wade told Residents C and D to punch and hit Resident A. Ms. Jones stated that Resident A had to be taken to Urgent Care later that evening because she had bruises on her face and she provided me with a copy of the discharge paperwork.

I interviewed Residents A and B, who stated that they were riding in the facility's van with Ms. Wade, along with Residents C and D. Ms. Wade told Residents B and C to start hitting and punching Resident A. Residents A and B stated that they do not know why Ms. Wade told them to do that except for the reason that she is very mean. Resident B stated that she and Resident C did punch Resident A because Ms. Wade told them to and not because they wanted to. Resident B stated that the residents were only hitting Resident A and no one else was hitting each other. Resident A denied hitting anyone and stated that the other residents were hitting her. Staff took Resident A to Urgent Care later that night because she had bruises on her face.

I could not interview Residents C and D, as they are non-verbal.

I interviewed the Home Manager, Lakemia Jones, who stated that Resident A told her that when she and Residents B-D were all riding in the van with Ms. Wade. Ms. Wade told Residents B and C to hit Resident A.

On 1/16/2019, I interviewed Ms. Wade via telephone. Ms. Wade denied that she told any of the residents to hit each other. Ms. Wade stated that she was driving in the car with Residents A-D, and all of a sudden Resident A started hitting Resident C. While this was happening, Resident B was trying to break up the fight so Resident A

then started hitting Resident C in the face. She attempted to contact Ms. Jones, but she didn't answer, so she called Ms. Spear and told her what was happening. Ms. Spear told Ms. Wade to bring the residents home. Ms. Wade stated that later that evening, Resident A called Ms. Spear and told her what happened. Ms. Wade stated that Ms. Spear only believed Resident A and would not listen to what Ms. Wade had to say. Ms. Wade stated that she was later fired by the Licensee Designee, Kimberly Nichols, and when Ms. Nichols asked her if she wanted to know the details of why she was fired, Ms. Wade stated that she declined because she already knew that Ms. Spear was setting her up to get fired.

On 1/16/2019, I interviewed Ms. Spear via telephone, and she stated that on 9/21/2018, Resident A called her and was crying, hysterical, and stuttering because she was so upset. Resident A told her that when she and Residents B-D were riding in the can with Ms. Wade, Ms. Wade told Residents B and C to start hitting her, so they did. Ms. Spear stated that Resident A was crying and very upset, so Ms. Spear tried to calm her down. Ms. Spear asked Resident A to go to in area in the facility where she could be alone out of earshot of Ms. Wade, however, Ms. Wade kept hovering and at one point Ms. Wade grabbed the phone away from Resident A and started screaming and was saying loud and extremely disrespectful words. She accused Ms. Spear of only listening to Resident A and would not calm down. Ms. Spear stated that Residents and B still speak about this and when something like this happens, they come forward and tell the truth. They will not hesitate to tell her if things are not right. A meeting was held on 9/23/2018 with Ms. Nichols, Ms. Wade, and Ms. Spear and Ms. Wade was fired. When Ms. Nichols asked her if she wanted to know why she was fired, she declined.

On 1/24/2019, I held an exit conference with Ms. Nichols via telephone. Ms. Nichols stated that Ms. Wade was terminated immediately, and she does not tolerate this sort of behavior from her staff. Ms. Nichols stated that Ms. Wade's behaviors were beyond inappropriate, and if any of her staff were to act like this again then they will also be terminated.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	I interviewed Residents A and B, who stated that staff, Shatonna Wade, told Residents B and C to hit Resident A when they were all driving in the van. Resident B stated that she and Resident C did hit Resident A in accordance with Ms. Wade's directives, not because she wanted to. I interviewed Ms. Wade, who denied that she told any of the residents to hit each other and that they started the fight themselves. I interviewed Ms. Spear, who stated that Resident A was crying and hysterical and told her that Ms. Wade told Residents B and C to hit her when she and Residents B-C were riding in the van. Resident A had bruises on her face and had to be taken to Urgent Care.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

1/16/2019

Theresa Cipponeri — Date
Licensing Consultant

Approved By:

1/31/2019

Ardra Hunter — Date
Area Manager