GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 12, 2021

Angela Joquico
Resilire Neurorehabilitation, LLC
Suite 2
16880 Middlebelt Road
Livonia, MI 48154

RE: License #: AS630407488
Investigation #: 2021A0993033
Royal Oak

Dear Ms. Joquico:

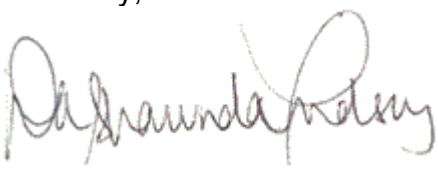
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
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51111 Woodward Avenue
Pontiac, MI 48342
(248) 505-8036

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 #:	AS630407488
Investigation #:	2021A0993033
Complaint Receipt Date:	08/16/2021
Investigation Initiation Date:	08/16/2021
Report Due Date:	10/15/2021
Licensee Name:	Resilire Neurorehabilitation, LLC
Licensee Address:	7200 Challis Rd. Brighton, MI 48116
Licensee Telephone #:	(734) 239-1937
Administrator:	Geoffrey Rantala
Licensee Designee:	Angela Joquico
Name of Facility:	Royal Oak
Facility Address:	2017 Rochester Rd. Royal Oak, MI 48073
Facility Telephone #:	(248) 546-4810
Original Issuance Date:	06/01/2021
License Status:	TEMPORARY
Effective Date:	06/01/2021
Expiration Date:	11/30/2021
Capacity:	6
Program Type:	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 8/10/2021, Resident A left the home without permission. Resident A was taken to the hospital. The group home is refusing to take the resident back.	Yes

III. METHODOLOGY

08/16/2021	Special Investigation Intake 2021A0993033
08/16/2021	APS Referral Received allegations from adult protective services (APS)
08/16/2021	Special Investigation Initiated - Telephone Telephone call made to Beaumont social worker Jan Kilpatrick
08/16/2021	Contact - Telephone call made Telephone call made to M. Johnson Associates case manager Renee Barum. Left a message.
08/16/2021	Contact - Telephone call made Telephone call made to APS specialist Donna Dennis. Left a message.
08/16/2021	Contact - Telephone call received Telephone call received from M. Johnson Associates case manager Renee Barum
08/16/2021	Contact - Telephone call made Telephone call made to Resident A's guardian (and mother). Left a message.
08/16/2021	Contact - Telephone call received Telephone call received from Resident A's guardian
08/16/2021	Contact - Telephone call received Telephone call received from APS specialist Donna Dennis
08/16/2021	Contact - Face to Face APS specialist Donna Dennis and I interviewed Resident A at Beaumont hospital

08/16/2021	Inspection Completed On-site Conducted an unannounced onsite inspection
08/16/2021	Contact - Telephone call made Telephone call made to licensee designee Angela Joquico
08/16/2021	Contact - Document Received Received an email from licensee designee Angela Joquico
08/26/2021	Contact - Telephone call made Telephone made to staff Cierra Buckner
08/26/2021	Contact - Telephone call made Telephone call made to staff Nykiya Johnson. Mailbox was full. Sent a text message.
08/26/2021	Contact - Telephone call made Telephone call made to APS specialist Donna Dennis. Left a message.
08/26/2021	Contact - Telephone call made Telephone call made to M. Johnson Associates case manager Renee Barum
08/26/2021	Contact - Telephone call received Telephone call received from staff Nykiya Johnson
10/12/2021	Exit Conference Held with licensee designee Angela Joquico and administrator Geoffrey Rantala

ALLEGATION:

On 8/10/2021, Resident A left the home without permission. Resident A was taken to the hospital. The group home is refusing to take the resident back.

INVESTIGATION:

On 08/16/2021, I received the allegations from adult protective services (APS). The assigned APS specialist is Donna Dennis.

On 08/16/2021, I conducted a telephone interview with Beaumont social worker Jan Kilpatrick. Ms. Kilpatrick stated Resident A was brought to the hospital on or around 08/12/2021. He was assessed, medically cleared, and ready to be discharged the same day. However, staff at the group home refused to pick him up. Per staff, the group home is not a safe placement for Resident A. Ms. Kilpatrick did not identify the names of any

staff at the group home. Ms. Kilpatrick stated M. Johnson Associates case manager Renee Barum is currently looking for another placement for Resident A.

On 08/16/2021, I conducted a telephone interview with M. Johnson Associates case manager Renee Barum. Ms. Barum verified Resident A was transported to the hospital after eloping from the group home. Resident A was assessed at the hospital and is now ready to be discharged. The group home is refusing to pick him up. Per Ms. Barum, Resident A was not issued a discharged notice. Ms. Barum stated Resident A was admitted to the group home two to two- and one-half years ago. His guardian is his mother. Resident A requires 1:1 supervision 16 hours per day.

On 08/16/2021, I conducted a telephone interview with Resident A's guardian (and mother). Resident A's guardian confirmed Resident A eloped from the group home on 08/10/2021 and was taken to the hospital. Resident A's guardian did not know what had happened prior to Resident A eloping from the group home. Per Resident A's guardian, Resident A requires 1:1 supervision. When he eloped from the group home, his 1:1 staff followed him. The police were called, and an ambulance transported him to the hospital. Resident A's guardian confirmed Resident A is ready to be discharged from the hospital, and staff from the group home is refusing to pick Resident A up. Resident A's guardian also confirmed Resident A was not issued a discharged notice.

On 08/16/2021, APS specialist Donna Dennis and I interviewed Resident A at Beaumont Hospital. Resident A stated he believed he had been at the hospital since yesterday. He did not know if he lived at the group home. He did not know how many staff were on shift the day he eloped from the group home. Per Resident A, he is not supposed to be in that group home or at the hospital. Resident A was unable to provide any details about the incident.

On 08/16/2021, I conducted a follow up telephone interview with Resident A's guardian. Resident A's guardian confirmed Resident A lived at the group home. She stated Resident A has a traumatic brain injury (TBI) and it affects his understanding and memory.

On 08/16/2021, I conducted an unannounced onsite investigation. I interviewed home manager Sandy Hamelink. Ms. Hamelink stated Resident A was transported to the hospital on 08/10/2021. She confirmed the group home was notified that Resident A was ready to be discharged on either 08/12/2021 or 08/13/2021. Ms. Hamelink was not certain about the exact date staff was notified Resident A was ready to be picked up. Ms. Hamelink confirmed that the group home is refusing to pick him up. Ms. Hamelink stated Resident A has exhibited severe behaviors in the community on a regular basis and it is not safe for him to return to the group home. When I inquired about incident reports, Ms. Hamelink stated staff do not always write incident reports and submit them to licensing. Ms. Hamelink confirmed Resident A requires 1:1 supervision. On the day of the incident, staff Cierra Buckner and staff Nykiya Johnson were working.

During the onsite investigation, I reviewed the group home team notes for Resident A. The following incidents occurred:

- On 07/19/2021, Resident A punched the brick wall outside by the smoking area. He came in and asked to go for a walk. Staff told him to give them a second. Resident A stated “fuck it. I’m out”. Resident A also threatened to beat staff ass and shoot staff. Resident A also was making gun finger and stated it was “a real gun it shoots when I tell it to”. This incident was not documented on a state licensing incident report form and reported to licensing.
- On 07/23/2021, Resident A attempted to elope from the group home to go get cigarettes. This incident was not documented on a state licensing incident report form and reported to licensing.
- On 07/25/2021, Resident A attempted to elope form the group home. This incident was not documented on a state licensing incident report form and reported to licensing.
- On 07/28/2021, Resident A left the group home to go get cigarettes. He stated, “he didn’t give a fuck about leaving to call the police”. He walked to Walgreens. Staff asked the Walgreen employee not to sell cigarettes to Resident A. Resident A stated, “fuck that bitch she don’t know me I’ll beat her ass”. Resident A then tried to swing on staff. The police were called. Resident A tried to swing on staff again as well as police. This incident was not documented on a state licensing incident report form and reported to licensing.
- On 08/10/2021, Resident A asked for a cigarette. He was denied due to the time. He walked out of the group home. Staff followed him. He shot his hand like a gun in the air. Earlier that day, Resident A had threatened another resident. Police was called. He was transported to Beaumont Hospital. This was documented on a state licensing form and reported to licensing.

On 08/16/2021, I conducted a telephone interviewed with licensee designee Angela Joquico. Ms. Joquico confirmed Resident A was transported to the hospital, and the group home is refusing to pick him up. Per Ms. Joquico, it is not safe for Resident A to return to the group home. Ms. Joquico stated Resident A has exhibited a lot of unsafe behaviors. Ms. Joquico acknowledged that these behaviors were not documented on the state licensing incident report form and submitted to licensing as required. Ms. Joquico also acknowledged that a discharged notice was not completed for Resident A until today. Ms. Joquico adamantly stated it is not safe for Resident A to return to the group home, and staff will not pick him up from the hospital. Ms. Joquico denied that the group home is abandoning Resident A at the hospital and stated Resident A’s case manager is actively looking for a more suitable placement for Resident A.

On 08/16/2021, I reviewed a 30-day discharge notice for Resident A dated 08/16/2021. Per the discharge notice, Resident A poses an imminent threat to himself and others. Over the past month he has had “an increase in aggressive behaviors and elopements that could cause substantial harm”. Resident A eloped five times since 07/17/2021. He walked into oncoming traffic, used aggressive derogatory statements towards staff with threatening homicidal ideations, has been impulsive without trigger or warning, and threatened to beat another resident and staff as well as to bust out all the windows.

On 08/26/2021, I conducted a telephone interview with staff Cierra Buckner. Ms. Buckner stated she has worked in the group home for a littler under one year. She works the afternoon shift from 2:30pm to 10:30pm. There are two to three staff per shift. Ms. Buckner verified she worked in the group home with staff Nykia Johnson the day Resident A eloped from the group home. Ms. Buckner could not recall the exact date of the incident. Per Ms. Buckner, Resident A asked for a cigarette. He was informed it was the cut off time for cigarettes. Resident A got mad. Resident A was gesturing like he had a gun and threatening another resident. Resident A walked to Speedway. Ms. Buckner stated she followed him. Resident A returned to the group home. The police were called. Ms. Buckner stated Resident A eloped from the group home a few days prior as well. The police came to the group home, talked to Resident A, and convinced him to go to the hospital. Ms. Buckner confirmed staff do not always complete incident reports when Resident A has behaviors. Instead, the behaviors are documented in the group home's team notes. These behaviors are not reported to licensing. Ms. Buckner confirmed staff initially refused to pick Resident A up from the hospital. However, she stated Resident A returned to the group home a few days ago. Ms. Buckner did not know the exact date Resident A returned to the group home.

On 08/26/2021, I conducted a telephone interview with Ms. Barum. She confirmed Resident A returned to the group home on 08/17/2021. She stated another placement was located for Resident A. He is scheduled to relocate to another group home on 09/13/2021.

On 08/26/2021, I conducted a telephone interview with staff Nykia Johnson. Ms. Johnson stated she has worked in the group home for about three years. She works the afternoon shift from 2:30pm to 10:30pm. There are two to three staff per shift. Ms. Johnson verified she worked in the group home with Ms. Buckner the day Resident A eloped from the group home. Ms. Johnson could not recall the exact date of the incident. Per Ms. Johnson, Resident A asked for a cigarette. He was informed the cut off time for cigarettes is 9pm. Resident A stated he was going to the store. He went into his bedroom. He came out of his bedroom, and he was dressed. Resident A stated, "I'm not being an asshole, but can I walk to the store?" Ms. Johnson stated staff reminded him it was not safe, it was dark, and he could not do it. Resident A stated, "I don't give a fuck. I'll bust the windows out this bitch". Then he walked out of the group home. Ms. Johnson stated Ms. Buckner followed Resident A to Speedway. Resident A kept turning around, making eye contact with Ms. Buckner, and making gestures like he was shooting a gun in the air. They returned to the group home. Ms. Johnson stated the police were called because this was the second time Resident A did this in a short period of time. The police came and Resident A eventually agreed to go to the hospital. Ms. Johnson confirmed staff do not always complete incident reports when Resident A has behaviors. She stated Resident A returned to the group home from the hospital about three to four days. She confirmed staff, initially, refused to pick him up when he was ready to be discharged. Ms. Johnson stated since Resident A returned to the group home, staff now gives him a cigarette whenever he asks for one, despite the time. Staff must go outside with him to make sure he is safe. This is to prevent behaviors.

On 10/12/2021, I conducted an exit conference with licensee designee Angela Joquico and administrator Geoffrey Rantala. I informed of them of the findings. Mr. Rantala agreed with violation concerning staff not writing the incident reports, but he disagreed with being cited for not picking up the resident. Per Mr. Rantala, the resident was not safe in the group home. Resident A was safer at the hospital. It was decided that Ms. Joquico will review the report and decide if a corrective action plan will be written or a compliance conference will be requested.

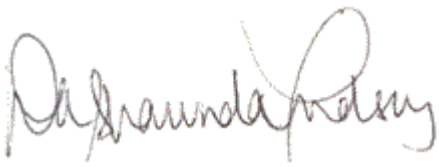
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A was brought to the hospital on or around 08/10/2021. He was assessed, medically cleared, and ready to be discharged the same day. Initially, staff at the group home refused to pick him up. Per staff, the group home was not a safe placement for Resident A. Resident A was left in the hospital for approximately six days due to the group home's refusal to pick him up. Resident A was eventually allowed to return to the group home on 08/17/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility** **(iii) Attempts to self-inflicted harm or harm to others.** **(iv) Instances of destruction of property.**

ANALYSIS:	I reviewed the group home team notes for Resident A. In addition, per the discharge notice, Resident A poses an imminent threat to himself and others. Over the past month he has had “an increase in aggressive behaviors and elopements that could cause substantial harm”. Resident A eloped five times since 07/17/2021. He walked into oncoming traffic, used aggressive derogatory statements towards staff with threatening homicidal ideations, has been impulsive without trigger or warning, and threatened to beat another resident and staff as well as to bust out all the windows. Most of these incidents were documented on a state licensing form and submitted to the department as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

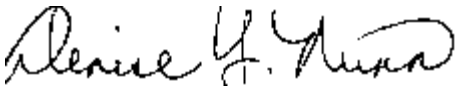
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



10/12/2021

DaShawnda Lindsey Date
Licensing Consultant

Approved By:



10/12/2021

Denise Y. Nunn Date
Area Manager