GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 17, 2022

Tamikya Lewis
G.R.A.C.E. Family Services
1904 Miller Rd.
Flint, MI 48503

RE: License #: AS250321981
Investigation #: 2022A0871035
Beautiful Blades I

Dear Ms. Lewis:

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 (989) 732-8062.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250321981
Investigation #:	2022A0871035
Complaint Receipt Date:	04/25/2022
Investigation Initiation Date:	04/25/2022
Report Due Date:	06/24/2022
Licensee Name:	G.R.A.C.E. Family Services
Licensee Address:	1904 Miller Rd. Flint, MI 48503
Licensee Telephone #:	(810) 449-0519
Administrator:	Tamikya Lewis
Licensee Designee:	Tamikya Lewis
Name of Facility:	Beautiful Blades I
Facility Address:	1640 Euclid Avenue Flint, MI 48503
Facility Telephone #:	(810) 234-7404
Original Issuance Date:	10/07/2012
License **Status:**	REGULAR
Effective Date:	04/23/2021
Expiration Date:	04/22/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was taken to the emergency room by police after being found outside of the Genesee Health Systems building. Resident A is supposed to be living at 1640 Euclid, Flint, MI however has been coming to 210 W. Seventh Ave., Flint, MI.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/25/2022	Special Investigation Intake 2022A0871035
04/25/2022	Special Investigation Initiated - Telephone Telephone call to Resident A's Guardian A1
04/25/2022	APS Referral From Genesee County MDHHS
04/27/2022	Inspection Completed On-site Attempted onsite investigation, no one at facility
05/02/2022	Inspection Completed On-site Attempted onsite investigation, no one at facility
06/01/2022	Inspection Completed On-site Attempted onsite investigation, no one at facility
06/01/2022	Contact - Document Received Received Assessment Plan for AFC Residents for Resident A
06/09/2022	Contact - Face to Face Interviewed Resident A at her new placement
06/13/2022	Inspection Completed-BCAL Sub. Compliance
06/13/2022	Contact - Telephone call made Telephone call to Resident A's Guardian A1
06/13/2022	Exit Conference Telephone exit conference with Licensee Tamikya Lewis
06/17/2022	Contact – Telephone call made

	Interview with Mr. Lewis.
06/17/2022	Exit Conference Exit conference with Tamikya Lewis.

ALLEGATION:

Resident A was taken to the emergency room by police after being found outside of the Genesee Health Systems building. Resident A is supposed to be living at 1640 Euclid, Flint, MI however has been coming to 210 W. Seventh Ave., Flint, MI.

INVESTIGATION:

On April 25, I telephoned Guardian A1. Guardian A1 reported that Resident A left the 7th street address but lives on Euclid in Flint. Guardian A1 said Resident A left the facility on 7th Street about 4 pm on April 23, 2022, and was found by the police on April 24, 2022.

On May 10, 2022, I received a telephone call from Adult Protective Service Worker Samantha Belanger. Ms. Belanger stated that on April 23, 2022, Resident A was sitting outside of Beautiful Blades II and did not want to go back inside. Ms. Belanger indicated that this is the second time this has happened in the last week, and it has also happened on other occasions. Ms. Belanger reported that Resident A left the facility about 4 pm on April 23, 2022, and was found by the police at 4 am on April 24, 2022. The police transported Resident A to the hospital. Ms. Belanger indicated Resident A never returned to Beautiful Blades I and has been placed at another adult foster care facility.

On April 27, May 2, and June 1, 2022, I attempted onsite investigations to the facility at 1640 Euclid, Flint, but no one was there.

On June 7, 2022, Licensee Tamikya Lewis emailed me a copy of Resident A's *Assessment Plan for AFC Residents.* The assessment plan states, 'Moves Independently in Community,' it indicates 'no – with staff assistance.' The plan was signed and dated on January 27, 2022, by Guardian A1 and Licensee Tamikya Lewis.

On June 9, 2022, I interviewed Resident A at her new residence. When I asked Resident A about living at Beautiful Blades I, she replied "I don't want to go back there." Resident A could not provide any further information.

On June 13, 2022, I telephoned Resident A's Guardian A1. Guardian A 1 stated Resident A "walked away a couple of times from 7th Street (Beautiful Blades II)." Guardian A1 stated Staff Todd Lewis called him on April 23, 2022, and advised that Resident A walked away and told him the direction that she was going. Guardian A1

said he immediately went driving around looking for Resident A but could not find her. Guardian A1 said he came upon a state police officer and advised him that Resident A was missing. The police officer told Guardian A1 to call 911 and report her missing. Guardian A1 said Resident A was found the next day by a police officer at the mental health building and she was taken to the hospital. Guardian A1 picked Resident A up from the hospital and she spent a few weeks at his house and then moved her into the facility that she is presently in. Guardian A1 said Resident A never returned to Beautiful Blades I.

On June 13, 2022, I telephoned Licensee Lewis and asked if she could meet me at the facility. Licensee Lewis indicated it would be difficult to meet me as she is now a flight attendant, and her Mr. Lewis is her only staff. Mr. Lewis works at Beautiful Blades I and would be unable to leave the residents at that facility.

On June 13, 2022, I conducted a telephone exit conference with Licensee Tamikya Lewis. Licensee Lewis was advised that this is a rule violation as Resident A left the facility without a staff and was not supervised.

On June 17, 2022, I telephoned Staff Todd Lewis. Mr. Lewis indicated there are currently no residents residing in this facility. Mr. Lewis stated the plan is to close this license due to staffing difficulties.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A left the facility on April 23, 2022, and was found on April 24, 2022, by the police. Resident A cannot move independently in the community without supervision. Resident A left the facility and was not supervised by staff. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On June 13, 2022, I telephoned Resident A's Guardian A1. Guardian A 1 stated Resident A "walked away a couple of times from 7th Street (Beautiful Blades II)." Guardian A1 stated Staff Todd Lewis called him on April 23, 2022, and advised that

Resident A walked away and told him the direction that she was going. Guardian A1 said he immediately went driving around looking for Resident A but could not find her. Guardian A1 said he came upon a state police officer and advised him that Resident A was missing. The police officer told Guardian A1 to call 911 and report her missing. Guardian A1 said Resident A was found the next day by a police officer at the mental health building and she was taken to the hospital. Guardian A1 picked Resident A up from the hospital and she spent a few weeks at his house and then moved her into the facility that she is presently in. Guardian A1 said Resident A never returned to Beautiful Blades I.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(3) If a resident is absent without notice, the licensee or direct care staff shall do both of the following: **(b) Contact the local police authority.**
ANALYSIS:	Guardian A1 was notified of Resident A's absence and he was contacted the police about her absence. The facility did not contact the police. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On June 15, 2022, I looked in the adult foster care files of Beautiful Blades I and Beautiful Blades II. An *AFC Licensing Division – Incident/Accident Report* was not found regarding Resident A leaving the facility and going to the hospital.

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: **(b) Any accident or illness that requires hospitalization.**
ANALYSIS:	An *AFC Licensing Division – Incident/Accident Report* was not completed regarding Resident A going to the hospital. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On June 17, 2022, I informed Licensee Lewis that there were additional findings as there was not an *AFC Licensing Division – Incident/Accident Report* completed regarding Resident A leaving the facility and the police were not contacted.

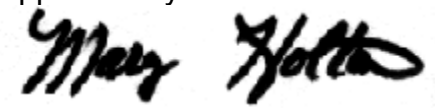
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care facility remain unchanged (capacity 1-6).

06/17/2022

Kathryn A. Huber Date
Licensing Consultant

Approved By:



06/17/2022

Mary E Holton Date
Area Manager