GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 26, 2022

Jean Nyambio
Detroit Family Home, INC.
Suite 202
17356 W. 12 Mile Road
Southfield, MI 48076

RE: License #: AS630384634
Investigation #: 2022A0465049
Detroit Family Home 2

Dear Mr. Nyambio:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found. ***A previous recommendation of revocation of the license was made in special investigation report #2022A0465034, dated 8/19/2022, which remains in effect.***

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,

Stephanie Gonzalez

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-514-9391
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630384634
Investigation #:	2022A0465049
Complaint Receipt Date:	09/06/2022
Investigation Initiation Date:	09/09/2022
Report Due Date:	11/05/2022
Licensee Name:	Detroit Family Home, INC.
Licensee Address:	Suite 202 - 17356 W. 12 Mile Road Southfield, MI 48076
Licensee Telephone #:	(313) 270-7751
Administrator:	Jean Nyambio
Licensee Designee:	Jean Nyambio
Name of Facility:	Detroit Family Home 2
Facility Address:	21778 Frazer Avenue Southfield, MI 48075
Facility Telephone #:	(313) 270-7751
Original Issuance Date:	11/07/2017
License Status:	1ST PROVISIONAL
Effective Date:	06/16/2022
Expiration Date:	12/15/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED ALZHEIMERS; AGED

II. ALLEGATION(S)

	Violation Established?
On 9/5/2022, direct care staff, David (last name unknown) hit Resident A in the face with a glass bottle.	No

III. METHODOLOGY

09/06/2022	Special Investigation Intake 2022A0465049
09/06/2022	APS Referral Adult Protective Services (APS) referral, assigned to Staysha Ellison for investigation
09/09/2022	Special Investigation Initiated - Letter I spoke to Complainant via email exchange
09/12/2022	Inspection Completed On-site I conducted a walkthrough of the facility, reviewed Resident A's record and the *Employee Phone List*, interviewed Resident B and direct care staff, Lamar Bothwell, and Zhane Thrasher
09/13/2022	Contact - Telephone call made Facility documents received
09/13/2022	Contact - Document Received Email exchange with APS Worker, Staysha Ellison, who stated she will not be substantiating
09/15/2022	Contact - Telephone call made I attempted to contact Resident A via his cell phone. Requested a return call
09/21/2022	Contact - Telephone call made I contacted Relative A1 and requested a return call
09/28/2022	Contact - Telephone call made I attempted to speak to Resident A by calling his cell phone. No answer. Requested a return call.
10/20/2022	Contact - Telephone call made I contacted Relative A1. Left a voice message and requested a return call.

10/21/2022	Contact - Document Received Facility documents received
10/21/2022	Contact - Telephone call made I spoke to MORC Case Manager, Sarah Nabhan, via telephone
10/21/2022	Contact - Telephone call made I attempted to speak to Resident A by calling his cell phone. No answer. Unable to leave a voice message.
10/24/2022	Contact – Telephone call made I interviewed Resident C and Resident D via telephone
10/24/2022	Contact - Telephone call made I spoke to direct care staff, Thrushania Anderson, via telephone
10/24/2022	Contact - Telephone call made I spoke to direct care staff, Peace Okba, via telephone
10/24/2022	Contact - Telephone call made I spoke to direct care staff, Zhane Thrasher, via telephone
10/24/2022	Exit Conference I conducted an Exit Conference with Mr. Jean Nyambio via telephone

ALLEGATION:

On 9/5/2022, direct care staff, David (last name unknown) hit Resident A in the face with a glass bottle.

INVESTIGATION:

On 9/6/2022, a complaint was received, alleging that on 9/5/2022, direct care staff, David/Daniel (last name unknown) hit Resident A in the face with a glass bottle. The complaint stated that Resident A sustained a cut and refused medical treatment.

On 9/9/2022, I spoke to Complainant via email exchange. Complainant confirmed that the information contained in the complaint is accurate.

On 9/13/2022, I spoke to Adult Protective Services (APS) worker, Staysha Ellison, who stated that she has completed an investigation of this complaint and determined that there is not sufficient information to confirm the allegation is true. Ms. Ellison stated that she will not be substantiating for physical abuse and her investigation will be closed.

On 9/12/2022, I conducted an onsite investigation at the facility. At the time of my onsite visit, Resident A was no longer residing at the facility. I conducted a walkthrough of the facility, reviewed Resident A's record and the *Employee Phone List*, interviewed Resident B, and direct care staff, Lamar Bothwell, and Zhane Thrasher.

I reviewed the *Employee Phone List* and was unable to confirm that a staff by the name of David or Daniel worked at the facility.

The *Face Sheet* stated that Resident A resided at the facility from 8/12/2022 – 10/5/2022 and does not have a legal guardian. The *Health Care Appraisal* listed Resident A's medical diagnosis as Schizophrenia. The *Assessment Plan for AFC Residents* stated that Resident A requires supervision in the community, has a history of aggressive behavior towards staff and others, refusal to participate in services, independently completes self-care tasks and does not require use of assistive devices for mobility assistance. The *Incident/Accident Report*, dated 9/5/2022, indicated the following:

> 9/5/2022; Completed by Zhane Thrasher: Resident A was upset because he couldn't get an iced coffee, so he threw his fan into the wall and broke it. He began threatening to kill himself. He kept calling his mom, cussing her out. Then Resident A broke the picture on his wall, then he picked up the glass and cut his hand then he began to throw chairs across the lawn. Staff had to call the police. Resident A was transported to the hospital.

I interviewed Resident B, who stated she does not have any concerns related to staff care. Resident B stated, "I haven't had any issues. Staff take care of us. I never seen staff be mean to a resident or hit any of us either." Resident B denied any concerns related to this allegation.

I interviewed direct care staff, Lamar Bothwell, who stated that he has no knowledge of this allegation being true. Mr. Bothwell stated, "I have never seen any staff mistreat a resident or hurt a resident. The other day, Resident A broke a mirror and cut his hand. But it was something he did to himself. No one hit him with a glass bottle. And we do not have any staff here by the name of David or Daniel." Mr. Bothwell denied this allegation is true.

On 9/12/2022 and 10/24/2022, I interviewed direct care staff, Zhane Thrasher, who stated that she was working on 9/5/2022, the date of the incident. Ms. Thrasher stated, "Resident A has a history of aggression. He will throw things, scream, and hit people when he is mad. And he gets mad when he doesn't get what he wants. The smallest things can set him off. On 9/5/2022, I was working at the facility. We do not have a staff named David or Daniel that works at the facility, so I don't know anyone by that name. While I was working, Resident A became upset because Relative A1 had promised to bring Resident A an iced coffee. Resident A became upset when Relative A1 did not come, and also wasn't answering his calls. Resident A began throwing things and screaming. He went in his room and pulled a picture off the wall and threw it on the

ground and broke it. He then picked up a piece of the glass off the ground and put it in his hand. When he did that, he cut his hand. I called 911 right away and the police and ambulance came. Resident A was transported to the hospital. I never hit Resident A with a glass bottle. That never happened." Ms. Thrasher denied this complaint is true.

On 10/21/2022, I spoke to Macomb-Oakland Regional Center Case Manager, Sarah Nabhan, via telephone. Ms. Nabhan stated that she has been Resident A's case manager for one year. Ms. Nabhan stated, "Resident A is his own guardian, but I oversee his placement and case management services. Resident A has a history of constant verbal and physical aggression. Resident A has a hard time controlling his anger and is often discharged from facilities due to his volatile behavior. I am aware of the incident when Resident A broke items at the facility, cut his arm and was sent to the hospital. I do not believe that staff caused any harm to Resident A or mistreated him. During the time that Resident A resided at the facility, I had no concerns regarding the staff's treatment of Resident A." Ms. Nabhan denied any concerns related to staff's treatment of Resident A.

On 10/24/2022, I spoke to Resident C, via telephone. Resident C stated, "The staff are nice here. Staff are not mean to me. I never seen staff be mean to anyone else here either. I have never seen staff hit anyone." Resident C denied knowledge of this complaint being true.

On 10/24/2022, I spoke to Resident D, via telephone. Resident D stated, "Staff have never yelled at me or hit me. And I never saw them do anything like that to anyone else that lives here." Resident D denied any concerns related to staff treatment of residents.

On 10/24/2022, I spoke to direct care staff, Thrushania Anderson, via telephone. Ms. Anderson stated that she has worked at the facility since 2015. Ms. Anderson stated, "I am familiar with Resident A and provided care to him while he lived here. Resident A had aggressive behavior and would become easily upset. When he was upset, he would scream, yell, hit and throw things. But I never mistreated Resident A and I never cause him any harm. I never saw any other staff to anything harmful to Resident A either. And we have never had a staff work here by the name of David or Daniel." Ms. Anderson denied knowledge of this complaint being true.

On 10/24/2022, I spoke to direct care staff, Peace Okba, via telephone. Ms. Okba stated that she has worked at the facility for four months. Ms. Okba stated, "I do not know any staff or resident by the name of David or Daniel that works or lives at the facility. Resident A was very aggressive and would be verbally and physically harmful to others. He would easily get angry and would break things and yell and attempt to hurt staff. He often screamed at staff when he did not get his way. I never mistreated Resident A and I never physically harmed him. I am not aware of any other staff mistreating or harming Resident A nor any other resident." Ms. Okba denied knowledge of this complaint being true.

On 9/15/2022, 9/28/2022, and 10/21/2022, I attempted to speak to Resident A via telephone. Resident A has not returned my phone calls as of the date of this report.

On 10/24/2022, I conducted an exit conference with licensee designee and administrator, Jean Nymabio, via telephone. Mr. Nyambio is in agreement with the findings of this report.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	On 9/12/2022, I reviewed the *Employee Phone List* and was unable to confirm that a staff by the name of David or Daniel worked at the facility. According to the *Incident/Accident Report*, dated 9/5/2022, Resident A sustained a cut on his hand related to self-harm behavior. I was unable to locate any documents confirming that a direct care staff hit Resident A with a glass bottle. According to Resident B, Resident C and Resident D, they have not been mistreated, nor observed direct care staff, mistreat other residents. According to Mr. Bothwell, Ms. Thrasher, Ms. Anderson, and Ms. Okba, they have never mistreated Resident A and I never physically harmed him. I am not aware of any other staff mistreating or harming Resident A nor any other resident." Ms. Okba denied knowledge of this complaint being true. Based on the information above, there is not sufficient information to confirm that a direct care staff by the name of Daniel or David, nor any other direct care staff, mistreated Resident A by hitting him with a glass bottle.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

A previous recommendation of revocation of the license was made in special investigation report #2022A0465034, dated 8/19/2022, which remains in effect. However, since there are no violations cited in this report, I recommend that this special investigation is closed.

10/25/2022

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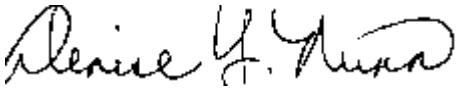
Stephanie Gonzalez Date
Licensing Consultant

Approved By:



10/26/2022

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Denise Y. Nunn Date
Area Manager