GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 7, 2022

Betty Mackie
Henrys Inc.
P.O. Box 81733
Rochester, MI 48308

RE: License #: AS820273992
Investigation #: 2022A0992043
Henry's Inc. Paradise Home

Dear Ms. Mackie:

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 (313) 456-0380.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

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 #:	AS820273992
Investigation #:	2022A0992043
Complaint Receipt Date:	09/20/2022
Investigation Initiation Date:	09/21/2022
Report Due Date:	11/19/2022
Licensee Name:	Henrys Inc.
Licensee Address:	P.O. Box 81733 Rochester, MI 48308
Licensee Telephone #:	(313) 910-2951
Administrator:	Betty Mackie
Licensee Designee:	Betty Mackie
Name of Facility:	Henry's Inc. Paradise Home
Facility Address:	30935 Pennsylvania Romulus, MI 48174
Facility Telephone #:	(313) 363-7018
Original Issuance Date:	06/07/2005
License Status:	REGULAR
Effective Date:	11/20/2021
Expiration Date:	11/19/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 9/20/2022, Wyandotte police transported Resident A back to Paradise group home after she was discharged from the hospital. Staff refused to allow her in the home due to violent with behaviors towards staff. Resident A was improperly discharged and has nowhere to go.	No
During the onsite review it was observed at least one bathroom did not have toilet paper, soap, or hand towels.	Yes

III. METHODOLOGY

09/20/2022	Special Investigation Intake 2022A0992043
09/21/2022	Special Investigation Initiated - Telephone Jawana Kelly, adult protective services (APS). She was not available, message left.
09/22/2022	Inspection Completed On-site Samantha Grace, direct care staff
09/22/2022	Contact - Telephone call made Latrice Edwards, home manager
09/23/2022	Contact - Telephone call received Ms. Edwards
09/23/2022	Contact - Telephone call made Sheila Hawkins, area manager/administrative assistant was not available. Message left
09/28/2022	Contact - Telephone call made Ms. Kelly
09/28/2022	Contact - Telephone call received Ms. Hawkins
09/28/2022	Contact - Face to Face Resident A
09/30/2022	Contact - Document Received

	Ms. Hawkins provided an outline of the reported incident
10/13/2022	Inspection Completed On-site Ms. Grace and Resident B
10/14/2022	Contact - Face to Face Betty Mackie, licensee designee
10/19/2022	Contact - Telephone call made Ms. Edwards
10/20/2022	Contact - Document Received Resident D's individual plan of services
10/24/2022	Contact - Document Received Resident D's adult foster care assessment plan
10/25/2022	Contact - Face to Face Ms. Grace, Residents B and C.
11/03/2022	Referral - Recipient Rights
11/03/2022	Contact - Telephone call made Ms. Hawkins
11/03/2022	Exit Conference Betty Mackie, licensee designee
11/04/2022	Contact - Telephone call Received Lynn Williams-Rogers, direct care staff

ALLEGATION: On 9/20/2022, Wyandotte police transported Resident A back to Paradise group home after she was discharged from the hospital. Staff refused to allow her in the home due to violent with behaviors towards staff. Resident A was improperly discharged and has nowhere to go.

INVESTIGATION: On 09/22/2022, I completed an unannounced onsite inspection and interviewed Samantha Grace, direct care staff (DCS), regarding the allegations. Ms. Grace said from her understanding Resident A attacked Latrice Edwards, home manager, and was transported to the hospital. However, Ms. Grace said she was not on shift and cannot provide any details. She said as it relates to Resident A being discharged, she is not sure what paperwork was completed and/or submitted. Ms. Grace suggested I contact Ms. Edwards or Sheila Hawkins, area manager/administrative assistant, for information pertaining to Resident A being

discharged. She said Resident A was picked up by a representative from Novus Living group home and she is currently in their care.

Ms. Grace called Ms. Edwards and I spoke with her briefly while onsite; she was at a medical appointment with another resident and unable to discuss the allegations but agreed to follow-up with me.

On 09/23/2022, I contacted Ms. Edwards and interviewed her regarding the allegations. Ms. Edwards said when she arrived on shift, Resident A was having behaviors including being verbally abusive and aggressive towards the staff and other residents. She said Lynn Williams-Rogers (DCS), from midnights was finishing up some tasks before her shift ended and she assisted with redirecting Resident A's behaviors. She said as soon as Ms. Williams-Rogers left, Resident A started exhibiting behaviors again including threatening Resident B and knocking things off the counter. Ms. Edwards said she proceeded to pick the items up off the floor and Resident A asked to call her mom. She said Resident A had the phone in her hand and she hit her in the jaw with the phone. Ms. Edwards said she immediately called the police because Resident A behaviors continued escalate. Ms. Edwards said Resident A was transported to Wyandotte hospital. Ms. Edwards said this is not the first instance of Resident A displaying aggression or threatening the staff and residents. She said she contacted Ms. Hawkins and she stated she was issuing an emergency discharge. Ms. Edwards said she is not familiar with the discharge process and suggested I contact Ms. Hawkins. I asked if Resident A has a guardian and she said no. She said she does communicate with her mother, but she is not her legal guardian.

On 09/28/2022, contacted Jawana Kelly, adult protective services (APS) regarding the allegations. Ms. Kelly said she interviewed Resident A and she said the staff would hit her. She said Resident A admitted to swearing at the staff but stated they would hit her. She said she was not treated well. Ms. Kelly said Resident A appeared to be knowledgeable and was very detailed when discussing the allegations. Ms. Kelly said Resident A said the staff swear at her. Ms. Kelly said she has not had an opportunity to speak with the staff or other residents at this time. However, she said she has spoken with the staff at her current location, and they identified Resident A as combative especially when she does not get her way.

On 09/28/2022, I received a telephone call from Ms. Hawkins; I interviewed her regarding the allegations. Ms. Hawkins said there has been nothing but chaos in the home since Resident A was admitted due to her behaviors. She said she is combative towards everyone, threatens the other residents and recently assaulted her staff. Ms. Hawkins said the most recent incident is when Resident A hit Ms. Edwards in the face with the phone. She said Ms. Edwards called the police and Resident A was transported to Wyandotte Hospital. Ms. Hawkins said at that point she initiated the emergency discharge process. She said she contacted Caitlyn, social worker at Wyandotte Hospital and made her aware that she was issuing an emergency discharge. She said she also contacted Detroit Wayne Integrated Health

Network (DWIHN) and made them aware of the situation. Ms. Hawkins said she drafted the emergency discharge and sent it to Caitlyn and DWIHN. She said while DWIHN was trying to secure placement, Resident A somehow managed to leave the hospital and go to a transportation company located in Wyandotte, next door to the police station. She said Wyandotte Police were contacted and they transported her back to the home. Ms. Hawkins said she had a three-way conversation with the officer onsite (name unknown), Diamond Snipes, manager with Community Living Services trying to inform the police of the process. However, she said during transport, Resident A soiled herself, so the staff returned to clean Resident A and she waited until a representative from Novus Living arrived. Ms. Hawkins said she did not improperly discharge Resident A. She said if Resident A was improperly discharged, the representative from the other home would not have known to pick her up. Ms. Hawkins agreed to provide me a copy of the discharge letter. Ms. Hawkins said Resident A does not have a guardian.

On 09/28/2022, I made face-to-face contact with Resident A and interviewed her regarding the allegations. Resident A said her previous home was not good. She said Ms. Edwards punched her in the face and on the side of her head twice, in August and September 2022. I asked her if she was injured or had any marks/bruises and she said yes. I asked if there were any witnesses such as other residents or staff present when Ms. Edwards hit her, and she said no. She said Ms. Edwards was the only staff on shift and the residents were in the other room. She said that “bitch” discharged her from the home and she had nowhere to go. I asked her who was she referring to and she said Ms. Edwards. She further stated that she pushed Ms. Grace and Ms. Grace twisted her arm and hurt her. She said Resident D twisted her arm too and hurt her. She said everybody hurt her. She later admitted to kicking Resident D for calling her a “white bitch,” “whore,” and saying, “fuck you.” I observed Resident A and at the time of this interview, she did not have any noticeable marks or bruises.

On 09/30/2022, I received an outline of events that occurred involving Resident A and a copy of the emergency discharge. According to the emergency discharge, Resident A has demonstrated bouts of aggression including slapping a staff, intentionally running into staff/residents with her wheelchair and hitting staff in the face with a telephone. Based on the above-mentioned, it is clear I can no longer assure the safety of Resident A, the other residents, or staff safety due to Resident A’s behaviors; authored by Betty Mackie, licensee designee.

On 10/14/2022, I made face-to-face contact with Ms. Mackie and interviewed her regarding the allegations. Ms. Mackie explained that she is aware of the allegations and that Ms. Hawkins can assist me with any information, I may need to complete the investigation.

On 10/25/2022, I made face-to-face with Ms. Grace, Residents B and C; I interviewed Residents B and C regarding the allegations. Resident B said Resident A did not get along with anybody. She said the home was horrible when she was in

the home, and she is happy she is gone. She said Resident A hit her, she has hit the staff and she was a bully. She denied witnessing the staff hit Resident A. She said Resident A would often call people names like “fatso” and other names. Resident B said she did not feel safe when Resident A was in the home, she said she often wanted to hide. Resident B said now that Resident A is gone the home is back to normal and she feels safe.

I attempted to interview Resident C. Resident C said Resident A did not get along with anybody. Resident C started having difficulty expressing herself and I was unable to understand her. I discontinued the interview.

Ms. Grace explained that Resident C has good and bad days as it pertains to her verbal skills and today, she was having extreme difficulty.

On 11/03/2022, I completed an exit conference with Ms. Mackie. I explained that based on the investigative findings, there is insufficient evidence to support the allegations. Ms. Mackie denied having any questions or concerns.

On 11/04/2022, I received a call from Lynn Williams-Rogers, direct care staff; I proceeded to interview her regarding the allegations. Ms. Williams-Rogers said she works midnights and she is familiar with Resident A. She said Resident A was very problematic and caused pure chaos in the home. She said she would taunt and bully the other residents in the home and staff. She said Resident A did not sleep through the night, so her behaviors would start as early as two o’clock in the morning. She said on the day in question, Resident A was having a bad day. She said she was on a rampage calling the staff and residents out their name, yelling, and trying to hit other residents/staff with her wheelchair. Ms. Williams-Rogers said she did not observe Resident A hit Ms. Edwards with the telephone but she later heard about it. Ms. Williams-Rogers said she is not familiar with the discharge process or how it goes but Resident A is no longer at the home.

On 11/04/2022, I contacted Elisa Jaboury, licensee designee with Novus Living. Ms. Jaboury explained that she was contacted by DWIHN regarding placement for Resident A. She said from her understanding an emergency discharge was issued to Resident A and she needed placement. She said her staff picked Resident A up from the home.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(4) A licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists:

	(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home. **(b) Substantial risk, or an occurrence, of self-destructive behavior.** **(c) Substantial risk, or an occurrence, of serious physical assault.** **(d) Substantial risk, or an occurrence, of the destruction of property.**
ANALYSIS:	During this investigation, I interviewed Betty Mackie, licensee designee; Sheila Hawkins, area manager/administrative assistant; Jawana Kelly, APS; Latrice Edwards, home manager; Samantha Grace, direct care staff; Residents A and B all of which denied the allegations except Resident A. I also reviewed the incident reports outlining Resident A's behaviors supporting the emergency discharge. The licensee determined substantial risk to the resident due to the inability of the home to meet Resident A's needs and to assure the safety and well-being of other residents of the home. Based on the investigative findings there is insufficient evidence to support the allegations. This allegation is unsubstantiated
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.**

	(ii) The alternatives to discharge that have been attempted by the licensee. **(iii) The location to which the resident will be discharged, if known.** **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**
ANALYSIS:	During this investigation, I interviewed Betty Mackie, licensee designee and Sheila Hawkins, area manager/administrative assistant and Elisa Jaboury, licensee designee with Novus Living regarding the allegations. Ms. Hawkins provided a copy of the emergency discharge and supporting documents. According to Ms. Jaboury she was contacted by DWIHN and Resident A was picked up from the home. Based on the investigative findings, I am unable to determine that Resident A was improperly discharged from the home. This allegation is unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: During the onsite review it was observed at least one bathroom did not have toilet paper, soap, or hand towels.

INVESTIGATION: On 10/13/2022, I completed an unannounced onsite inspection and interviewed Ms. Grace and Resident B regarding the allegations. Ms. Grace explained that Resident D's behaviors include putting an excessive amount of tissue in the toilet, stealing the other resident's belongings out their room and bathroom. She said there are two bathrooms on the same floor, one of which is kept locked and the other does not contain toiletries to prevent Resident D from stealing and overloading the toilet. Ms. Grace said Residents B and D are the only residents that can independently toilet themselves, she said the other residents require staff assistance and the staff will grab the essentials before going into the bathroom. She said there is toilet paper, soap, and paper towels available for the residents and a surplus is kept in the pantry, in which I observed. However, the bathroom located on the main hall did not contain toilet paper, soap, or paper towel. The second bathroom was observed to be locked. Ms. Grace unlocked the bathroom; I observed soap and toilet paper and no paper towel.

I interviewed Resident B. Resident B said she uses the bathroom located on the main hall and there is no soap, toilet paper or paper towel because Resident D will put it in the toilet. Resident B said she notifies staff when she needs toilet paper or paper towel. She said Resident D likes to steal items from the other residents.

I was unable to gain access to Resident D's adult foster care assessment and individual plan of services (IPOS) because the file was locked, Ms. Grace did not have a key and was only able to access the resident's medical file.

On 10/14/2022, I made face-to-face contact with Ms. Mackie and made her aware of the allegations. I explained that I visited the home and confirmed there was no toiletries in the bathroom and based on the staff disclosures, I need a copy of Resident D's adult foster care assessment and IPOS. Ms. Mackie said Ms. Hawkins can assist me with any information, I may need to complete the investigation.

On 10/19/2022, I contacted Ms. Edwards and interviewed her regarding the allegations. Ms. Edwards said the residents can use either bathroom in the home. However, she said the secondary bathroom is kept locked to prevent Resident D from putting items in the toilet and/or overloading it with tissue. She said the main bathroom is always open but there are no toiletries because of Resident D's behaviors. Ms. Edwards said staff mainly assist all the residents with toileting except for Residents B and D so they take tissue and paper towel with them when they assist. I requested a copy of adult foster care assessment and IPOS, in which Ms. Edwards agreed to provide.

On 10/25/2022, I reviewed Resident D's adult foster care assessment and IPOS. His assessment plan did not contain language outlining behaviors such as overloading

the toilet with toilet paper or other items. As for his IPOS it does include the following goal: Resident D will work on not bothering other people belongings. It further states, Resident D has a history of behaviors including arguing with housemates and staff, taking other's belongings, and hiding them in his room. The IPOS does not contain language outlining behaviors such as overloading the toilet with toilet paper or other items.

On 11/03/2022, I contacted Ms. Hawkins and explained that after reviewing Resident D's adult foster care assessment and IPOS, neither document contains language outlining behaviors such as overloading the toilet with toilet paper or other items. I made her aware that adult foster care assessment can be revised as often as necessary and if Resident D is exhibiting such behaviors, it should be included in his adult foster care assessment plan. I also advised her to notify Resident D's support coordinator, so that his IPOS can be revised as well. I made Ms. Hawkins aware that the other residents in the home have a right to toilet paper, paper towel and soap; and should not have to notify staff when they are going to the bathroom. I advised her to either speak with the residents and/or their guardian to obtain consent to not keep the bathrooms equipped with such items or explore the possibility of installing a dispenser so that the items can be kept in the bathroom.

On 11/03/2022, I completed an exit conference with Ms. Mackie. I explained that after reviewing Resident D's adult foster care assessment and IPOS, neither document contains language outlining Resident D's behaviors such as overloading the toilet with toilet paper/paper towel or other items. I suggested she revise his adult foster care assessment plan to include the above-mentioned behaviors and inform his support coordinator, so that his IPOS reflects the behaviors as well. I also made her aware that the other residents in the home have a right to toilet paper, paper towel and soap; and should not have to notify staff when they are going to the bathroom. I advised her to either speak with the residents and/or their guardian to obtain consent to not keep the bathrooms equipped with the items or explore the possibility of installing a dispenser so that the items can be kept in the bathroom. I made Ms. Mackie aware that as a result of the findings, the allegation is substantiated and requires a written corrective action plan, to which she agreed to provide.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(8) Hand-washing facilities that are provided in both the kitchen and bathroom areas shall include hot and cold water, soap, and individual towels, preferably paper towels.

ANALYSIS:	On 10/13/2022, I completed an unannounced onsite inspection and the bathroom identified for resident use was not equipped with soap, toilet paper or paper towels. The allegations is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend the status of the license remain unchanged.

11/04/2022

_____

Denasha Walker Date
Licensing Consultant

Approved By:

11/7/2022

_____

Ardra Hunter Date
Area Manager