GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 8, 2022

Sonia McKeown
JARC
6735 Telegraph Rd
Suite 100
Bloomfield Hills, MI 48301

RE: License #: AS630085648
Investigation #: 2023A0991002
Greenberg Shiffman Stein

Dear Ms. McKeown:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630085648
Investigation #:	2023A0991002
Complaint Receipt Date:	10/14/2022
Investigation Initiation Date:	10/14/2022
Report Due Date:	12/13/2022
Licensee Name:	JARC
Licensee Address:	6735 Telegraph Rd. Suite 100 Bloomfield Hills, MI 48301
Licensee Telephone #:	(248) 403-6013
Licensee Designee:	Sonia McKeown
Name of Facility:	Greenberg Shiffman Stein
Facility Address:	28773 Village Lane Farmington Hills, MI 48334
Facility Telephone #:	(248) 539-1762
Original Issuance Date:	07/02/1999
License Status:	REGULAR
Effective Date:	09/18/2022
Expiration Date:	09/17/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 10/13/22, direct care worker, Marcus Lucas, choked Resident A.	Yes

III. METHODOLOGY

10/14/2022	Special Investigation Intake 2023A0991002
10/14/2022	Referral - Recipient Rights Received from Office of Recipient Rights (ORR)
10/14/2022	APS Referral Received referral from Adult Protective Services (APS)
10/14/2022	Special Investigation Initiated - Telephone Call to assigned ORR worker, Alanna Honkanen
10/14/2022	Contact - Telephone call made Call to assigned APS worker, Candid Jamerson
10/17/2022	Contact - Telephone call received From ORR worker, Alanna Honkanen
10/17/2022	Contact - Telephone call made To home manager, Kim Fulks
10/17/2022	Contact - Telephone call made Interviewed direct care worker, Marcus Lucas
10/17/2022	Contact - Document Received Received plan of service, crisis plan, incident reports, and pictures
10/18/2022	Contact - Telephone call received From APS worker, Candid Jamerson
10/18/2022	Inspection Completed On-site Unannounced onsite inspection- interviewed Resident A

12/06/2022	Exit Conference Via telephone with licensee designee

ALLEGATION:

On 10/13/22, direct care worker, Marcus Lucas, choked Resident A.

INVESTIGATION:

On 10/14/22, I received a complaint from Adult Protective Services (APS). The complaint alleged that on 10/13/2022, Resident A was upset and was in his bedroom stomping around. Resident A was saying that he was going to kill a staff member, Marcus, and that he hates black people. The home manager, Kim, calmed down Resident A. Resident A then walked out of his bedroom and Marcus began choking Resident A. Marcus stated that he was tired of Resident A threatening him. Resident A sustained red vertical marks on both sides of his neck. I initiated my investigation on 10/14/22, by contacting the assigned APS worker, Candid Jamerson, and the assigned Office of Recipient Rights (ORR) worker, Alanna Honkanen.

On 10/17/22, I interviewed Ms. Honkanen via telephone. Ms. Honkanen stated that she received additional allegations that on 09/30/22, Resident A told his psychologist during a Zoom (video conference) appointment that staff, Marcus, slapped him. Ms. Honkanen stated that neither the psychologist nor staff reported this to recipient rights at the time it was alleged. Ms. Honkanen stated that she interviewed the accused staff, Marcus Lucas, via telephone. Mr. Lucas admitted that he grabbed Resident A by the shirt and pinned him against the wall after Resident A came out of his room in an aggressive manner and walked up on him. Ms. Honkanen stated that she did a video conference with Resident A at his workshop and observed that he had red marks that were linear and vertical on the sides of his neck. Ms. Honkanen provided photographs that show red marks on the right and left sides of Resident A's neck. The marks appear to be a couple of inches in length, with the mark on the right side being slightly smaller.

On 10/17/22, I interviewed the home manager, Kim Fulks, via telephone. Ms. Fulks stated that she has worked at Greenberg, Shiffman, Stein since January 2022. On Thursday, 10/13/22, Ms. Fulks arrived for her shift early at 6:45am. She was sitting in her car on the driveway when staff, Bersheena Jenkins, came out to get her. Ms. Jenkins told her that Resident A was yelling. When Ms. Fulks went into the home, she heard Resident A in his bedroom yelling, "I'm going to kill him. I hate black people." Ms. Fulks stated that Resident A was upset because he wanted to wear shorts and staff would not let him. She went into Resident A's bedroom and talked to him. Resident A calmed down. A few minutes later, Resident A came out of his bedroom and was walking down the hall. Ms. Fulks saw direct care worker, Marcus Lucas, jump up out of his chair, run towards Resident A, and start to choke him. They were in the hallway near

the front foyer when this happened. Ms. Fulks stated that she witnessed the incident and saw that Mr. Lucas's hands were directly on Resident A's neck. Resident A was not being aggressive and did not touch Mr. Lucas prior to Mr. Lucas choking him. Ms. Fulks stated that she immediately intervened and told Mr. Lucas to leave the home. Mr. Lucas stated, "I'm tired of him threatening me." None of the other residents witnessed this incident. The other staff on shift, Bresheena, was getting ready to leave and did not see what happened. Resident A did not want to go to urgent care. Ms. Fulks stated that there were red marks on each side of his neck. Mr. Lucas was removed from the schedule pending the investigation and has not returned to the home since the incident occurred.

Ms. Fulks stated that she was not aware of Mr. Lucas being aggressive towards Resident A prior to this incident. She stated that Resident A told his psychologist that Mr. Lucas slapped him on 09/30/22 during a Zoom (video conference) appointment. The psychologist did not report this information to Ms. Fulks until Wednesday, 10/12/22. Ms. Fulks stated that Resident A would have reported this to his stepmom or to staff when it happened, so she did not believe it was true.

On 10/17/22, I interviewed direct care worker, Marcus Lucas, via telephone. Mr. Lucas stated that he has worked at Greenberg, Shiffman, Stein since May 2022. Mr. Lucas stated that Resident A typically gets dressed on his own and then staff give him feedback afterwards to let him know if he is dressed appropriately. On 10/13/22, Resident A got dressed and was asking staff to look at him while they were trying to assist another resident. Mr. Lucas told Resident A that he looked good and asked him to go up front. He told Resident A that staff would check him over later. Resident A went to the front of the house and sat down. He ate his breakfast and took his medications. While Mr. Lucas was passing medication to another resident, Resident A went to his room and came out wearing summer clothing. He had changed into shorts, a t-shirt, and flip flops. Mr. Lucas stated that he laughed a little and told Resident A that he needed to change because it was cold outside. Resident A replied, "I can wear what I want to wear." Mr. Lucas continued trying to redirect Resident A. Resident A stormed into his room and changed his pants. He ran out of his bedroom in pants, socks, and a t-shirt. Mr. Lucas brought Resident A's shoes to him in the living room. Resident A threw one of the shoes at Mr. Lucas. He threw the other shoe towards the front door.

Mr. Lucas stated that he tried to redirect Resident A, but Resident A refused to move. The other staff on shift, Bresheena, stated that she would get Resident A to put his shoes on. Mr. Lucas went to the computer to work on documentation and Resident A went back to his room. A few minutes later, the home manager, Kim Fulks, came in and Resident A started crying. Mr. Lucas stated that Resident A frequently tries to get the home manager to turn against staff. Resident A was "making a scene" and Ms. Fulks was trying to calm him down. Mr. Lucas went into Resident A's room and Resident A stated that he had a knife in his room. Ms. Fulks told Mr. Lucas that Resident A did not

have a knife and asked staff to give Resident A some space. Mr. Lucas sat back down at the computer desk. He could hear Resident A hitting something against the wall and then Resident A started running down the hall towards Mr. Lucas. Mr. Lucas stated that he grabbed Resident A by his shirt collar and held him towards the wall. His hands were on Resident A's shirt, but they were going up towards Resident A's chin, because Mr. Lucas is shorter than Resident A. Mr. Lucas stated that Resident A did not put his hands on him. He grabbed Resident A as Resident A was running towards him, because "the way he was coming towards me, he looked like he was going to do something." Resident A was wearing a collared shirt with buttons, and Mr. Lucas grabbed him right at the collar. His hands never touched Resident A's skin. He stated that it was a quick grab and he held onto him for a few seconds. Resident A stated, "you're choking me." The other staff came and told Resident A that Mr. Lucas was not choking him. The home manager then came and told Mr. Lucas to let go of Resident A. Mr. Lucas stated that he did not see any marks on Resident A, but his shift was ending so he left the home. Mr. Lucas stated that as he was leaving the home, he told the home manager that he needed to get out of there, because he was tired of Resident A threatening to kill him. This was the second time Resident A threatened to get a knife and stab him.

Mr. Lucas stated that he has never put his hands on Resident A or slapped him. Resident A will say staff slapped him if he does not get his way. Mr. Lucas stated that staff are not trained on what to do for physical aggression. He was not sure if they were allowed to physically restrain the residents. Resident A is the only resident in the home who has aggressive behaviors. Staff are usually able to redirect him.

On 10/18/22, I conducted an unannounced onsite inspection at Greenberg, Shiffman, Stein. I interviewed Resident A. Resident A stated that staff, Marcus Lucas, choked him. Resident A was coming out of his room and going to watch TV when Mr. Lucas got out of his chair and choked him. Mr. Lucas's hands were crossed on Resident A's neck. He was pinned up against the wall and could not move or breath. Mr. Lucas's hands were touching his skin, not his clothes. The home manager, Kim Fulks, told Mr. Lucas to stop choking Resident A and he stopped. Resident A stated that he did not remember what was happening before Mr. Lucas choked him. He was just walking down the hall. He did not put his hands on Mr. Lucas. Mr. Lucas did not say anything when he was choking Resident A. It happened at the end of the hallway and nobody else saw what was happening. Resident A stated that he feels scared of Mr. Lucas and does not want him to come back to the home. Resident A stated that Mr. Lucas never slapped him. The only time Mr. Lucas put his hands on Resident A was when he choked him in the hallway.

I reviewed copies of incident reports completed by the home manager, Kim Fulks, and staff, Marcus Lucas, on 10/13/22. The information in the incident reports is consistent with the information that they provided during their interviews.

I reviewed a copy of Resident A's MORC (Macomb Oakland Regional Center) individual plan of service (IPOS) and crisis plan dated 03/01/22. The crisis plan indicates that staff should be mindful of Resident A's body language. If he appears restless, tense, pacing or is staring at another person this can be a sign of impending aggression. Signs of escalating aggression include a raised voice, physical tension, verbal threats, hitting walls, throwing objects, etc. Staff should provide prompt redirection to a preferred activity or ask Resident A to help with something to prevent the behavior from further escalating. If Resident A does not respond to redirection multiple times and appears to be fixated upon an emotion, aggressive act, threat, sexual fantasy, urge, or desire, then it may be necessary to contact JARC management, Resident A's psychologist, guardians, or the MORC emergency (after hours) number. If physical aggression and/or sexual advances escalate beyond staff's ability to maintain the safety of Resident A or his housemates, then it may be necessary to engage police intervention by calling 911. If this occurs, staff should notify Resident A's parents, MORC professionals, and other persons of interest. The crisis plan also notes that physical contact beyond high fives and fist bumps is not recommended.

On 12/06/22, I conducted an exit conference via telephone with the licensee designee, Sonia McKeown, regarding my findings. I informed Ms. McKeown that a provisional license is being recommended due to repeat violations. Ms. McKeown stated that she would review the report and submit a corrective action plan and a written statement as to whether or not JARC contests the provisional license.

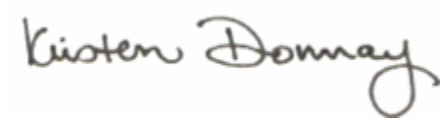
APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that direct care worker, Marcus Lucas, did not employ behavior interventions in accordance with Resident A's written assessment and crisis plan. Resident A's MORC crisis plan dated 03/01/22 indicates that staff should try to redirect Resident A and should contact JARC management, Resident A's psychologist, guardians, or

	the MORC emergency number if he does not respond to redirection. If physical aggression escalates beyond staff's ability to maintain safety, then staff should contact 911. The plan notes that physical contact beyond high fives and fist bumps is not recommended. Mr. Lucas did not follow these steps on 10/13/22 when he pinned Resident A against the wall and choked him, because he felt Resident A was moving towards him in an aggressive manner. Mr. Lucas stated that he was not aware of whether or not staff were allowed to physically restrain Resident A.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation #: 2021A0605048 dated: 10/21/2021; CAP dated: 10/25/2021.**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff, Marcus Lucas, used physical force towards Resident A on 10/13/22 when he pinned him against the wall and choked him. Mr. Lucas admitted that he grabbed Resident A by the shirt collar and pinned him against the wall. The home manager and Resident A both stated that Mr. Lucas choked Resident A by placing his hands directly on Resident A's neck and not his clothing. Resident A had red marks on both sides of his neck following this incident.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation #: 2021A0605048 dated: 10/21/2021; CAP dated: 10/25/2021.**

IV. RECOMMENDATION

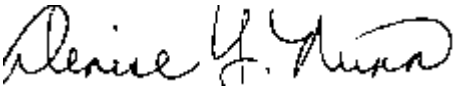
Contingent upon receipt of an acceptable corrective action plan, issuance of a provisional license is recommended.



12/06/2022

Kristen Donnay Date
Licensing Consultant

Approved By:



12/08/2022

Denise Y. Nunn Date
Area Manager