STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

February 16, 2023

Virgil Yarbrough
Yarbrough Better Living Center Inc.
P O Box 19734
Detroit, MI 48229

RE: License #: AS820382718
Investigation #: 2023A0101012
Yarbrough Better Living Center

Dear Mr. Yarbrough:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On January 26, 2023, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820382718
Investigation #:	2023A0101012
Complaint Receipt Date:	01/25/2023
Investigation Initiation Date:	01/26/2023
Report Due Date:	03/26/2023
Licensee Name:	Yarbrough Better Living Center Inc.
Licensee Address:	3766 14 th Street Ecorse, MI 48229
Licensee Telephone #:	(313) 383-8365
Administrator:	Virgil Yarbrough
Licensee Designee:	Virgil Yarbrough
Name of Facility:	Yarbrough Better Living Center
Facility Address:	3766 14 th Street Ecorse, MI 48229
Facility Telephone #:	(313) 383-6385
Original Issuance Date:	01/12/2017
License Status:	REGULAR
Effective Date:	07/12/2021
Expiration Date:	07/11/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 01/23/2023, a Disability Rights Advisor conducted an onsite review and observed Residents' records which contain personal and confidential information were piled on top of a cabinet.	Yes
On 01/23/2023, a Disability Rights Advisor conducted an onsite review. She observed the following physical plant disrepairs: • A bedroom window was broken. • Several walls had been repaired however they have not been painted. • The wheelchair ramp in the front of the home was in disrepair.	Yes

III. METHODOLOGY

01/25/2023	Special Investigation Intake 2023A0101012
01/26/2023	Special Investigation Initiated - On Site
01/26/2023	Corrective Action Plan Requested and Due on 01/26/2023
01/26/2023	Corrective Action Plan Received
01/26/2023	Corrective Action Plan Approved
12/26/2023	Inspection Completed-BCAL Sub. Compliance
01/30/2023	Referral received from the Office of Recipient Rights APS referral not needed. No allegation of abuse or neglect.

ALLEGATION: On 01/23/2023, a Disability Rights Advisor conducted an onsite review and observed Residents' records which contain personal and confidential information were piled on top of a cabinet.

INVESTIGATION: This facility is a two-family dwelling. Virgil Yarbrough, the licensee designee, resides in the west side of the structure and the group home is on the east side of the structure. Several of the allegations reported were in the licensee designee's private residence. Residents are not allowed to enter Mr. Yarbrough's home. I observed the residents come to Mr. Yarbrough's door but, they did not enter his private residence.

Mr. Yarbrough had the residents' records which contain personal and confidential information, stacked on top of a cabinet in his private residence. Mr. Yarbrough stated he was cleaning up and promised to have the files back in the large filing cabinet that I observed in his living room.

APPLICABLE RULE	
MCL 400.712	**Keeping and maintaining records and reports; examination and copying of books, records, and reports; confidentiality; inspection of records by resident.**
	(3) The records of the residents of a facility which are required to be kept by the facility under this act or rules promulgated under this act shall be confidential and properly safeguarded. These materials shall be open only to the inspection of the direct or, an agent of the director, another executive department of the state pursuant to a contract between that department and the facility, a party to a contested case involving the facility, or on the order of a court or tribunal of competence jurisdiction. The records of a resident of a facility which a required to be kept by the facility under this act or rules promulgated under this act shall be open to inspection by the resident, unless medically contradicted, or the guardian of a resident.
ANALYSIS:	Mr. Yarbrough failed to safeguard residents' confidential information. Even though the residents' records were in Mr. Yarbrough's private residence, the residents' records are exposed to anyone who enters his home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 01/23/2023, a Disability Rights Advisor conducted an onsite review. She observed the following physical plant disrepairs:

- **A bedroom window was broken.**
- **Several walls had been repaired however they have not been painted.**
- **The wheelchair ramp in the front of the home was in disrepair.**

INVESTIGATION: On 01/26/2023, I conducted an onsite investigation and observed the following:

A bedroom window did not close. There was a ½ inch gap between the windowsill and the window frame.

Several walls had been repaired, however, they have not been painted.

The wheelchair ramp in the front of the home was in disrepair. Several wooden boards were loose. Even though this home is not wheelchair accessible and no one living in the home is using a wheelchair, the wheelchair ramp needs to be constructed, arranged and maintained is a safe condition.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	On 01/26/2023, I conducted an onsite investigation and observed the following: A bedroom window did not close. There was a ½ inch gap between the windowsill and the window frame. Several walls had been repaired however they have not been painted. The wheelchair ramp in the front of the home was in disrepair with several loose wooden boards. The ramp is not constructed, arranged and maintained to provide adequately for the health , safety and well-being of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

On 01/26/2023, Mr. Yarbrough submitted an acceptable corrective action plan. I recommend the status of the license remains unchanged.

02/15/2023

Edith Richardson
Licensing Consultant

Date

Approved By:

02/16/2023

Ardra Hunter
Area Manager

Date