GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 8, 2023

Javon Brown
38855 Plumbrook Dr.
Farmington Hills, MI 48331

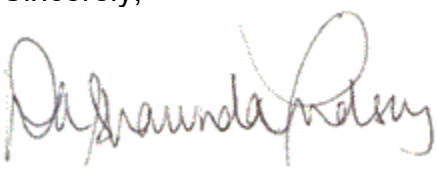
RE: License #: AS630404326
Investigation #: 2023A0993011
New Beginnings

Dear Ms. Brown:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is being recommended in the Licensing Study Report dated 02/07/2023, which remains in effect. You will be notified in writing of the department's action and your options for resolution of this matter.

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,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste. 9-100
Detroit, MI 48202
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630404326
Investigation #:	2023A0993011
Complaint Receipt Date:	12/12/2022
Investigation Initiation Date:	12/14/2022
Report Due Date:	02/10/2023
Licensee Name:	Javon Brown
Licensee Address:	32999 W. 14 Mile Farmington Hills, MI 48334
Licensee Telephone #:	(248) 506-5891
Administrator:	Yolanda Matthews
Licensee Designee:	Javon Brown
Name of Facility:	New Beginnings
Facility Address:	32999 W 14 Mile Rd. Farmington Hills, MI 48334
Facility Telephone #:	(248) 506-5891
Original Issuance Date:	01/13/2022
License Status:	1ST PROVISIONAL
Effective Date:	08/03/2022
Expiration Date:	02/02/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
• Resident A has gotten out of the facility on at least four occasions in the past six months with police involvement. Last night, around 4am, she left the facility and was found by police around 8am. She had been wandering barefoot with no coat and was found unresponsive. She has severe hypothermia and was taken to Henry Ford Hospital. • Staff at the facility stated they are allowed to sleep on shift.	Yes

III. METHODOLOGY

12/12/2022	Special Investigation Intake 2023A0993011
12/12/2022	APS Referral Allegations received from adult protective services (APS). The assigned APS specialist is Tiffany Pitts.
12/14/2022	Special Investigation Initiated - Telephone Telephone call made to Farmington Hills police officer Kean. Left a message.
12/14/2022	Inspection Completed On-site Conducted an unannounced onsite investigation
12/14/2022	Contact - Face to Face Interviews at Henry Ford West Bloomfield
01/11/2023	Contact - Telephone call made Telephone call made to staff Durale Williams
01/11/2023	Contact - Telephone call made Telephone call made to Farmington Hills police officer Kean. Left a message.
01/11/2023	Contact - Telephone call made Telephone call made to Resident A's guardian
01/26/2023	Contact - Document Sent Requested a copy of the police report from Farmington Hills Police Department

01/26/2023	Contact - Telephone call made Telephone call made to APS specialist Tiffany Pitts. Mailbox was full. Sent a text message.
01/26/2023	Contact - Telephone call received Telephone call received from APS specialist Tiffany Pitts
01/26/2023	Contact - Document Sent Requested a copy of Resident A's medical records from Henry Ford West Bloomfield
02/01/2023	Inspection Completed On-site Conducted an announced onsite investigation
02/03/2023	Contact - Document Received Received a copy of the police report from Farmington Hills Police Department
02/08/2023	Exit Conference Attempted to hold exit conference with licensee Javon Brown with no success. I was unable to leave a message as the mailbox was full. I sent an email.

ALLEGATION:

- **Resident A has gotten out of the facility on at least four occasions in the past six months with police involvement. Last night, around 4am, she left the facility and was found by police around 8am. She had been wandering barefoot with no coat and was found unresponsive. She has severe hypothermia and was taken to Henry Ford Hospital.**
- **Staff at the facility stated they are allowed to sleep on shift.**

INVESTIGATION:

On 12/12/2022, I received the allegations from adult protective services (APS). The assigned APS specialist is Tiffany Pitts.

On 12/14/2022, I conducted an unannounced onsite investigation. I interviewed administrator Yolanda Matthews. Ms. Matthews confirmed Resident A eloped from the facility, was found by police, and transported to the hospital. Per Ms. Matthews, Resident A does not have community access. She cannot move independently in the community. Staff Durale Williams was working at the time Resident A wandered away. Mr. Williams told Ms. Matthews that he checked on Resident A and she was fine. When he went to check on her later, he noticed the door was open and Resident A was gone. Resident A left out through the front door. Ms. Williams stated Resident A has a history of wandering away from the facility. This is the second time she wandered away from

the facility. The other time she wandered away occurred in August 2022. Ms. Matthews stated staff are supposed to be awake at night.

During the onsite investigation, I requested to review incident reports and the assessment plan for Resident A. Per the incident report (IR), Mr. Williams gave Resident A a snack around 1:30am on 12/10/2022. She went to lay down. While doing his rounds, Mr. Williams noticed Resident A was not in her room. He searched the facility for Resident A. He called police and notified the New Beginnings team. Ms. Matthews confirmed the incident report was not sent to the department.

Per Resident A's assessment plan, Resident A can move independently in the community. She may need help with grooming, dressing, and personal hygiene. The plan did not document that Resident A has a history of wandering away. The plan was not signed or dated by Resident A's guardian or licensee Javon Brown. Ms. Matthews acknowledged the error in the assessment plan and confirmed Resident A cannot move independently in the community.

On 12/14/2022, I interviewed hospital case manager Catherine Ditri at Henry Ford West Bloomfield. She verified Resident A was admitted to the hospital. She was assessed by social work and inpatient psychiatric treatment was recommended. Ms. Ditri did not have information about Resident A's physical state when she was transported to the hospital.

I also interviewed Resident A at Henry Ford West Bloomfield. Resident A stated she has lived in the facility since January 2022. She does not like living in the facility because there is nothing to do. In addition, she is not allowed to go outside. Resident A confirmed she left out of the facility without staff's knowledge as she was running away. She stated she has tried to run away from the facility three times.

On 01/11/2023, I conducted a telephone interview with staff Durale Williams. Mr. Williams stated he has worked the facility for approximately six months. He works on Saturdays and Sundays. He verified he was working alone in the facility on the day Resident A eloped in December 2022. Mr. Williams could not recall the exact date of the incident. He stated Resident A came out of her room around midnight and asked for a snack. He gave her a snack and some milk. Resident A returned to her room. Later, Mr. Williams went to the bathroom and then conducted rounds. While doing rounds, he noticed Resident A was not in her bedroom. Mr. Williams searched the facility and then called police. The police located Resident A and took her to the hospital. Mr. Williams denied he was sleeping when Resident A eloped from the facility.

On 01/11/2023, I conducted a telephone interview with Resident A'a guardian. Resident A's guardian stated Resident A moved into the facility about two years ago. Resident A has a history of eloping. Resident A's guardian informed staff of this history when she moved into the facility. Resident A's guardian stated Resident A cannot move independently in the community. Resident A was still hospitalized at a psychiatric hospital at the time of the interview. However, Resident A's guardian plans to send

Resident A back to the facility when she is ready to be discharged. Per Resident A's guardian, staff have placed alarms on the doors to prevent any future elopements.

On 01/26/2023, I conducted a telephone interview with APS specialist Tiffany Pitts. She stated her investigation was still pending. When Ms. Pitts interviewed Resident A and Resident A's guardian, she learned Resident A had wandered away from the facility a couple of times. Resident A has been discharged from the hospital and was transferred to a long-term care facility. Resident A is not returning to the adult foster care facility.

On 01/26/2023, I reviewed Resident A's medical records from Henry Ford Hospital. Per the records, Resident A was transported to the emergency room (ER) for hypothermia on 12/11/2022. Per the police and EMS report, Resident A went missing from the facility around 4:30am and was found shortly after. Resident A felt extremely cold. EMS was unable to get her temperature. Resident A's temperature at ER "was 26.4, lactate 6.8 and hypotensive". Resident A "was given 3L of warm fluids and [warmed] with warming blankets but remained hypotensive and placed on levo". Psychiatry was consulted and recommended admit to inpatient psych. Resident A was discharged from Henry Ford Hospital on 12/15/2022.

On 02/01/2023, I reviewed another IR for Resident A. Per the IR, staff Bryant Pugh was cleaning up around 4am on 08/07/2022. He conducted a bed check and noticed Resident A was missing. He checked the facility and called the police. Resident A was found in the backyard, naked in the yard. Resident A was transported to Beaumont Hospital. This incident report was not submitted to the department. I did not observe any other IRs in Resident A's folder.

On 02/03/2023, I reviewed a copy of the police report from Farmington Hills Police Department. The police department was dispatched to the facility on 12/11/2022 concerning a missing person. When police arrived at the facility, they interviewed Mr. Williams. He stated he last observed Resident A at 3am. He conducted checks at 4am and did not observe her. He observed the front door open. Mr. Williams informed police, Resident A had wandered away from the facility in the past but she either returned or was found in the backyard. Resident A was located by police lying on the ground between the median and a church. She was transported to the hospital.

On 02/08/2023, I attempted to conduct an exit conference with licensee Javon Brown with no success. I was unable to leave a message as the mailbox was full. I sent an email.

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:	Ms. Matthews and Resident A's guardian stated Resident A cannot move independently in the community. Per Resident A's assessment plan, Resident A can move independently in the community. Staff did not provide protection and supervision to Resident A when she wandered away from the facility. Ms. Matthews acknowledged the error in the assessment plan and confirmed Resident A cannot move independently in the community.
CONCLUSION:	**VIOLATION ESTABLISHED**

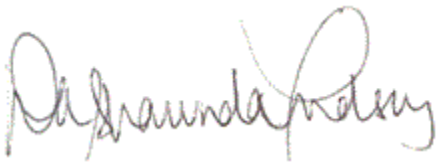
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A cannot move independently in the community. Resident A has a history of eloping from the facility. Resident A eloped from the facility in December 2022. She was found by the police the same day and transported to the hospital.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Resident A wandered away from the facility, was located by police, and transported to the hospital on 12/10/2022. Resident A wandered outside of the facility and was found in the backyard on 08/07/2022. She was transported to the hospital. Incident reports were completed but were not submitted to the department within 48 hours of the incidents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

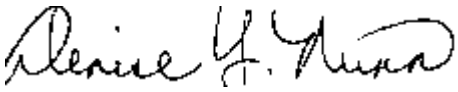
A temporary license was issued on 01/13/2022. The facility is currently on a provisional license effective 08/02/2022. Refusal to renew the license is being recommended in Licensing Study Report dated 02/07/2023, which remains in effect.



02/08/2023

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



02/08/2023

Denise Y. Nunn — Date
Area Manager