GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 21, 2023

Jessica Lyons
11751 Nottingham
Detroit, MI 48224

RE: License #: AS820395579
Investigation #: 2023A0121027
New Beginning Care

Dear Ms. Lyons:

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 June 14, 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,

K. Robinson

K. Robinson, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820395579
Investigation #:	2023A0121027
Complaint Receipt Date:	05/02/2023
Investigation Initiation Date:	05/02/2023
Report Due Date:	07/01/2023
Licensee Name:	Jessica Lyons
Licensee Address:	11751 Nottingham Detroit, MI 48224
Licensee Telephone #:	(313) 208-3219
Administrator:	N/A
Licensee Designee:	
Name of Facility:	New Beginning Care
Facility Address:	11751 Nottingham Rd Detroit, MI 48224
Facility Telephone #:	(313) 208-3219
Original Issuance Date:	12/20/2019
License **Status:**	REGULAR
Effective Date:	06/20/2022
Expiration Date:	06/19/2024
Capacity:	3
Program Type:	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
There has not been any Staff in the home for over a year. Licensee may drop in once a day to drop off food to the residents. No one is present to monitor the residents throughout the day. Owner is living her life and collecting money for rent.	Yes

III. METHODOLOGY

05/02/2023	Special Investigation Intake 2023A0121027
05/02/2023	Special Investigation Initiated - Telephone Left message for Mye'Yonna Williams with APS; no response.
05/04/2023	Inspection Completed On-site Interviewed Resident A and B, DCW Tonya Evans
05/04/2023	Contact - Telephone call received Jessica Lyons
05/09/2023	Contact - Telephone call made Follow up call to Ms. Lyons
05/12/2023	Contact - Telephone call made Left message for APS; no response.
05/12/2023	Contact - Telephone call made Left message for Ms. Lyons; no response.
05/19/2023	Contact - Telephone call made Left message for Ms. Lyons
05/19/2023	Exit Conference Return call from Ms. Lyons
06/14/2023	Corrective Action Plan Received/Approved

ALLEGATION: There has not been any Staff in the home for over a year. Licensee may drop in once a day to drop off food to the residents. No one is present to monitor the residents throughout the day. Owner is living her life and collecting money for rent.

INVESTIGATION: On 5/4/23, I completed an unannounced onsite inspection at the facility. Upon my arrival, I found Resident A and B home alone. Resident A immediately contacted Ms. Lyons by phone. Ms. Lyons instructed Resident A to allow me entry into the home. Once, inside I observed Resident B laying in bed. Both Resident A and B reported they had not eaten since the night before. Yet, Resident A said they receive 3 meals per day. Resident B acknowledged residents are left home alone including overnights. According to Resident B, Staff usually leave the home at 9:00 p.m. Resident B insisted the home cares for independent persons. Both Resident A and B indicated they like the placement. Approximately 15 minutes later, direct care worker, Tonya Evans arrived at the facility. Ms. Evans is the mother of licensee, Jessica Lyons. Ms. Evans arrived using a cane to assist her with walking. Ms. Evans identified herself as “on-call” staff. Per Ms. Evans, she thought residents could be left unsupervised for up to 4 hours. Ms. Evans conveyed Ms. Lyons is experiencing car problems, so the licensee won’t be available onsite. I left my name and phone number for Ms. Lyons to reach me when available. Ms. Lyons contacted me shortly after I left the home. Ms. Lyons explained she was scheduled to work at the time of inspection. Ms. Lyons stated, “I don’t know what I was thinking” and that she “ran to the store” to buy the residents some cigarettes. Ms. Lyons further explained there are only 2 workers at the home that include herself and Tonya; she said they work 12-hour shifts. This information is contrary to what Tonya reported as an on-call worker. According to Ms. Lyons, she’s had a difficult time staffing the home without a placement contract with Detroit Wayne Integrated Health Network. Ms. Lyons reported Resident A and B are the only residents in care; they do not have guardians.

On 5/9/23, I made a follow-up call to Ms. Lyons who reported a woman named Deidre will be volunteering at the home. I explained volunteers cannot be considered in the staff-to-resident ratio, so Deidre cannot be left to supervise residents. Ms. Lyons also reported she has since enrolled Resident A and B in day programs to alleviate the need to Staff the home 24/7.

On 5/19/23, I completed an exit conference with Ms. Lyons. Ms. Lyons stated she would like to voluntarily terminate her license once this complaint is resolved. Ms. Lyons reported Resident A and B have Supports Coordinators with Team Wellness and Adult Well Being. According to Ms. Lyons, Resident A and B are like family to her. Ms. Lyons stated her previous work experience has been in unlicensed settings, so she is not as familiar with the licensing rules and statutes.

PPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	• On 5/4/23, I observed Resident A and B left unattended by Staff at approximately 12:45 p.m. • Resident A and B hadn't eaten breakfast or lunch, yet Ms. Lyons implied she was at the home earlier that day. • Ms. Lyons tried to downplay how long the residents were left unsupervised, so her credibility is questionable. In addition to the fact that Ms. Lyons said Staff work 12-hour shifts and Tonya said she works "on-call." • Resident B confirmed residents are left home alone after 9:00 p.m.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend the plan to voluntarily terminate the license be executed.

6/20/23

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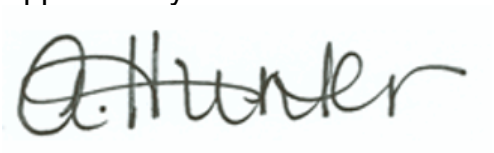
Kara Robinson Date
Licensing Consultant

Approved By:



6/21/23

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Ardra Hunter Date
Area Manager