GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 13, 2023

Javon Brown
38855 Plumbrook Dr.
Farmington Hills, MI 48331

RE: License #: AS630404326
Investigation #: 2023A0993027
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 recommended. A previous recommendation for refusal to renew the license was made in the Renewal Licensing Study report dated 02/14/2023, 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 #:	2023A0993027
Complaint Receipt Date:	05/26/2023
Investigation Initiation Date:	05/30/2023
Report Due Date:	07/25/2023
Licensee Name:	Javon Brown
Licensee Address:	32999 W. 14 Mile Farmington Hills, MI 48334
Licensee Telephone #:	(248) 506-5891
Administrator:	Yolanda Matthews
Licensee Designee:	N/A
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?
• On 04/30/2023, a resident noticed an elderly resident on the floor and alerted staff William (last name unknown). William did not wake up for over an hour. • William did not serve lunch until 3:10pm. His speech was slurred, and he was passing out. At 5:30pm, William threw up and passed out from being intoxicated. At 7:30pm, William was still passed out. • At 8:10pm, the residents were looking for their medications but did not receive them. At 10:12pm, Resident H requested his medications again. • Between 8:10 and 10:12pm, a pizza was delivered. William could not find the door because he was intoxicated. • On 05/01/2023, at 1:00am, Williams went into Resident H's bedroom and got into his face stating, "what are you going to do". William hoovered over him and was telling him he wasn't "sh*t". William told Resident H to get up so he could see what he was going to do. The insults and verbal abuse continued. William destroyed Resident H's room and broke his television. Resident H retreated to the bathroom and locked the door where he stayed until 6:40 am. • On 05/01/2023 at 6:40 am, Resident H spoke with Mr. Matthews, and he was told not to say anything to anyone. Resident H told Mr. Matthews they had not had breakfast. Mr. Matthews never sent anyone to the home regarding the incidents that occurred beginning on 04/30/2023.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/26/2023	Special Investigation Intake 2023A0993027
05/26/2023	APS Referral Received allegations from adult protective services (APS). The assigned APS specialist is Heather Stickel.
05/30/2023	Special Investigation Initiated – Telephone Telephone call made to APS specialist Heather Stickel
05/30/2023	Contact - Telephone call made

	Telephone call made to Resident H's attorney. Left a message.
05/30/2023	Contact - Telephone call made Telephone call made to Resident H's guardian. Left a message.
06/05/2023	Inspection Completed On-site Conducted an unannounced onsite investigation. There was no answer at the door.
06/05/2023	Contact - Document Sent Emailed licensee Javon Brown and administrator Yolanda Matthews
06/06/2023	Contact - Telephone call made Telephone call made to administrator Yolanda Matthews. Left a message.
06/06/2023	Contact - Telephone call made Telephone call made to Resident H's guardian. Left a message.
06/06/2023	Contact - Telephone call made Telephone call made to administrator Yolanda Matthews
06/06/2023	Contact - Telephone call received Telephone call received from Resident H's guardian
06/06/2023	Contact - Document Sent Requested a copy of the Farmington Hills police report
06/06/2023	Contact - Telephone call made Telephone call made to staff Sofhia Steen
06/06/2023	Contact - Document Sent Requested documentation
06/06/2023	Contact - Telephone call made Telephone call made to staff Durale Williams
06/06/2023	Contact - Telephone call made Telephone call made to administrator's husband Emory Matthews. Mailbox full. Sent a text message.
06/08/2023	Contact - Telephone call made Telephone call made to licensee Javon Brown
06/13/2023	Contact - Telephone call made

	Received a copy of the Farmington Hills police report
06/15/2023	Contact - Telephone call made Telephone call made to APS specialist Heather Stickel. Left a message.
06/15/2023	Contact - Telephone call made Telephone call made to administrator Yolanda Matthews. Left a message.
06/15/2023	Contact - Document Sent Requested documents by 5pm on 06/19/2023
06/15/2023	Contact - Telephone call made Telephone call made to Resident H. Left a message.
06/15/2023	Contact - Telephone call made Telephone call made to staff Durale Williams. Left a message.
06/15/2023	Contact - Telephone call made Telephone call made to administrator's husband Emory Matthews. Mailbox full. Sent a text message.
06/21/2023	Contact - Telephone call made Telephone call made to Resident H's guardian. Left a message.
06/21/2023	Contact - Telephone call received Telephone call received from Resident H's guardian
06/21/2023	Contact - Telephone call made Telephone call made to APS specialist Heather Stickel. Left a message.
06/21/2023	Contact - Telephone call made Telephone call made to Resident H. Left a message. Sent a text message.
06/26/2023	Contact - Telephone call made Telephone call made to Resident H. Left a message.
06/26/2023	Contact - Telephone call received Telephone call received from Resident H
06/26/2023	Contact - Telephone call made Telephone call made to administrator Yolanda Matthews. Left a message. Sent a text message.

06/26/2023	Contact - Telephone call made Telephone call made to administrator's husband Emory Matthews. Mailbox full. Sent a text message.
06/26/2023	Contact - Telephone call made Telephone call made to staff Durale Williams. Mailbox not set up. Sent a text message.
07/05/2023	Contact - Telephone call made Spoke with administrator Yolanda Matthews
07/10/2023	Exit Conference Held with licensee Javon Brown

ALLEGATION:

- On 04/30/2023, a resident noticed an elderly resident on the floor and alerted staff William (last name unknown). William did not wake up for over an hour.
- William did not serve lunch until 3:10pm. His speech was slurred, and he was passing out. At 5:30pm, William threw up and passed out from being intoxicated. At 7:30pm, William was still passed out.
- At 8:10pm, the residents were looking for their medications but did not receive them. At 10:12pm, Resident H requested his medications again.
- Between 8:10 and 10:12pm, a pizza was delivered. William could not find the door because he was intoxicated.
- On 05/01/2023, at 1:00am, Williams went into Resident H’s bedroom and got into his face stating, "what are you going to do". William hoovered over him and was telling him he wasn't "sh*t". William told Resident H to get up so he could see what he was going to do. The insults and verbal abuse continued. William destroyed Resident H's room and broke his television. Resident H retreated to the bathroom and locked the door where he stayed until 6:40 am.
- On 05/01/2023 at 6:40 am, Resident H spoke with Mr. Matthews, and was told not to say anything to anyone. Resident H told Mr. Matthews they had not had breakfast. Mr. Matthews never sent anyone to the home regarding the incidents that occurred beginning on 04/30/2023.

INVESTIGATION:

On 05/26/2023, I received the allegations from adult protective services (APS). The assigned APS specialist is Heather Stickel.

On 05/30/2023, I conducted a telephone interview with APS specialist Heather Stickel. Ms. Stickel stated Resident H left the facility and went to Hope 360. Ms. Stickel did not know the resident’s current whereabouts.

On 06/06/2023, I conducted a telephone interview with administrator Yolanda Matthews. Ms. Matthews confirmed Resident H used to live in the facility. Initially, Ms. Matthews stated there was an incident between Resident H and another resident (Resident J). Resident H was not assaulted by Resident J. However, Resident J threw everything off the dresser in Resident H's bedroom. Later, Ms. Matthews stated she was made aware of the allegations concerning staff by Resident H and Resident H's guardian. Staff Durale Williams was scheduled to work on 04/30/2023, and he denied the allegations. Ms. Matthews stated she believed the allegations to be true as Resident H is not a person who would lie. Mr. Williams was terminated immediately. Ms. Matthews stated Resident H's guardian removed him from the facility on 05/01/2023.

Ms. Matthews stated she took a pizza to the facility on Sunday night. She could not recall the time she took it to the facility. She also took food to the facility on Monday morning (05/01/2023). Staff Sofhia Steen went to the facility that Monday morning as well to help clean Resident H's bedroom as well as everything else. Ms. Matthews denied that Resident H ever talked to her husband. She stated when Resident H contacted him, he gave her the phone. Ms. Williams stated Resident C, Resident E, Resident H, Resident I, and Resident J lived in the facility and were present during the incident. As a result of the incident as well as the pending court hearing for this facility, Ms. Matthews stated all the residents have been discharged from the facility. Ms. Matthews denied knowing any of the residents' current whereabouts.

On 06/06/2023, I conducted at telephone interview with Resident H's guardian. Resident H's guardian stated staff William (last name unknown) acted and spoke to Resident H in an intimidated manner. He did not physically hit Resident H. Resident H locked himself in the bathroom for safety. William was intoxicated. William destroyed Resident H's bedroom. He broke his TV and furniture and there was broken glass on his floor. William did not provide meals to the residents or administer medications. Resident H stated he called Mr. Matthews on Sunday to inform him about what was happening in the facility. Mr. Matthews arranged for food to be delivered to the facility via door dash. Mr. Matthews and Ms. Steen went to the facility on Monday morning. Resident H's guardian stated he only learned of the incident from Resident H on 05/01/2023. He confirmed he went to facility and observed Resident H's bedroom.

On 06/06/2023, I conducted a telephone interview with staff Sofhia Steen. Ms. Steen stated she arrived at the facility the Monday following the incident. Resident H was locked in the bathroom. The person who covered Mr. Williams' shift was still in the facility. He was intoxicated, belligerent, and trying to fight everyone. The police were called to the facility. Ms. Steen stated Resident H's bedroom was tore up, and she had to clean up broken glass.

On 06/06/2023, I conducted a telephone interview with staff Durale Williams. Mr. Williams stated he did not observe the incident on 04/30/2023 but was informed about it. Mr. Williams stated he was terminated on Monday (05/01/2023).

On 06/08/2023, I conducted a telephone interview with licensee Javon Brown. Ms. Brown stated she was not familiar with Resident H or the allegations. She requested that I contact Ms. Matthews for information.

On 06/13/2023, I reviewed a copy of a redacted police report from Farmington Hills Police Department. Per the report, the police were dispatched to the facility on 05/01/2023 for a welfare check. Officers spoke with Resident H. Resident H showed them a video. No physical assault occurred, and no direct threats were made. No other information was provided in the redacted report.

On 06/15/2023, I sent an email to Ms. Brown and Ms. Matthews to request a copy of the resident register, any incident reports from 04/27/2023 to 05/01/2023, the staff schedule from 04/27/2023 to 05/01/2023, and the medication administration records (MARs) for all residents.

On 06/26/2023, I conducted a telephone interview with Resident H. Resident H confirmed William worked in the facility the weekend of the incident and that was William's first time working in the facility. William was very drunk. His speech was slurred. At one point, he was passed out on the floor. Resident H took a video of him while he was passed out. One of the other residents told William that Resident H took a video of him. Resident H did not disclose the name of the resident who told William about the video. William got in Resident H's face and was verbally aggressive with him. Resident H went into the bathroom that was connected to his bedroom and locked the door. William tore up Resident H's bedroom. That weekend, William refused to administered medications to the residents or prepare meals. Resident H stated he informed Mr. Matthews about what was happening in the facility. Mr. Matthews told him not to tell anyone about the incident. Mr. Matthews had a pizza delivered to the facility. Resident H stated Mr. Matthews came to the facility with his wife around 7am on Sunday or Monday. William was still in the facility when they arrived.

On 06/26/2023 as well as on 06/06/2023 and 06/15/2023, I attempted to interview the administrator's husband Emory Matthews with no success. Mr. Matthews has failed to call me back to date.

On 07/05/2023, I spoke with Ms. Matthews. Ms. Matthews acknowledged that I requested documents from her, and she still had not submitted them to me. Ms. Matthews agreed to get the documents to me.

As of the date of this report, I have not received a copy of the resident register, any incident reports from 04/27/2023 to 05/01/2023, the staff schedule from 04/27/2023 to 05/01/2023, and the medication administration records (MARs) for all residents. In addition, I was unable find out the last name of William, obtain his contact information, or interview him.

APPLICABLE RULE	
R 400.14103	**Licensees; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(3) The failure of an applicant or licensee to cooperate with the department in connection with an inspection or investigation shall be grounds for denying, suspending, revoking, or refusing to renew a license.
ANALYSIS:	On 06/15/2023, I sent an email to Ms. Brown and Ms. Matthews to request a copy of the resident register, any incident reports from 04/27/2023 to 05/01/2023, the staff schedule from 04/27/2023 to 05/01/2023, and the medication administration records (MARs) for all residents. On 07/05/2023, I spoke with Ms. Matthews. Ms. Matthews acknowledged that I requested documents from her, and she still had not submitted them to me. Ms. Matthews agreed to get the documents to me. As of the date of this report, I have not received a copy of the resident register, any incident reports from 04/27/2023 to 05/01/2023, the staff schedule from 04/27/2023 to 05/01/2023, and the medication administration records (MARs) for all residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	On 06/15/2023, I requested a copy of the staff schedule from 04/27/2023 to 05/01/2023. Ms. Brown and Ms. Matthews failed to submit a copy of the staff schedule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14210	**Resident register.**
	A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident: **(a) Date of admission.** **(b) Date of discharge.** **(c) Place and address to which the resident moved, if known.**
ANALYSIS:	I requested a copy of the resident register. Ms. Brown and Ms. Matthews failed to submit a copy of the resident register.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report 06/21/2023.**

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:	On 04/30/2023, William (last name unknown) worked in the facility. He was intoxicated and his speech was slurred. He did not administer the residents' medications. He did not prepare meals for the residents. He was verbally aggressive towards Resident H. Resident H locked himself in a bathroom for safety. William destroyed Resident H's bedroom. Mr. Matthews was informed about what was happening in the facility, but he failed to go to the facility until Monday morning (05/01/2023). Ms. Matthews stated she believed the allegations to be true as Resident H is not a person who would not lie. Mr. Williams was terminated immediately. Mr. Williams stated Resident C, Resident E, Resident H, Resident I, and Resident J lived in the facility and were present during the incident. As a result of the incident as well as the pending court hearing for this facility, Ms. Matthews stated all the residents have been discharged from the facility. Ms. Matthews denied knowing any of the residents' current

	whereabouts. As of the date of this report, the whereabouts of Resident C, Resident E, Resident I, and Resident J is unknown.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report dated 02/08/2023.** **Reference Special Investigation Report dated 06/21/2023.**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(2) An immediate investigation of the cause of an accident or incident that involves a resident, employee, or visitor shall be initiated by a group home licensee or administrator and an appropriate accident record or incident report shall be completed and maintained.
ANALYSIS:	I requested a copy of any incident reports from 04/27/2023 to 05/01/2023. Ms. Brown and Ms. Matthews failed to submit a copy of the staff schedule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 04/30/2023, William did not administer the medications to the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.**

	(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	I requested the medication administration records (MARs) for all residents. Ms. Brown and Ms. Matthews failed to submit the MARs.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Renewal Licensing Study Report 02/14/2023.**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	On 04/30/2023, William did not prepare meals for the residents. A pizza was sent to the facility later that evening. Ms. Matthews stated she took food to the facility on Monday morning (05/01/2023) as well.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/06/2023, I conducted a telephone interview with Resident H's guardian. Resident H's guardian stated staff Durale Williams was scheduled to work the weekend of the incident. However, he asked another person named William (last name unknown) to cover his shifts.

On 06/06/2023, I conducted a telephone interview with staff Sofhia Steen. Ms. Steen stated Mr. Williams was scheduled to work the weekend of the incident. Instead, he had someone else cover his shifts. Per Ms. Steen, the person who worked that weekend was not staff. Ms. Steen stated, "I had never seen that man before." The man's name may have been William, but Ms. Steen was not sure.

On 06/06/2023, I conducted a telephone interview with staff Durale Williams. Mr. Williams verified he was scheduled to work the weekend of the incident. Mr. Williams stated he worked Saturday (04/29/2023), but left Sunday morning around 9-10am. William (last name unknown) replaced him. Mr. Williams confirmed William was not a staff in the facility. Licensee Javon Brown and administrator Yolanda Matthews did not

know that William was going to work in his place. Mr. Williams stated he did not think it would be an issue as William worked in another facility. Mr. Williams did not know the name of the facility.

On 07/05/2023, I spoke with Ms. Matthews. Ms. Matthews confirmed William worked in the facility the weekend of the incident. William is not staff. Ms. Matthews did not know William's last name or have contact information for him. Per Ms. Matthews, Mr. Williams asked William to cover his shifts for him.

On 07/10/2023, I conducted an exit conference with licensee Javon Brown. I informed her of the findings. Ms. Brown did not provide any feedback.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.** **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	On 04/30/2023, staff Mr. Williams asked William to work in the home to cover his shifts unbeknownst to Ms. Brown and Ms. Matthews. William worked alone in the facility on 04/30/2023. William was not trained to work in the facility. While William was working, he was intoxicated and his speech was slurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

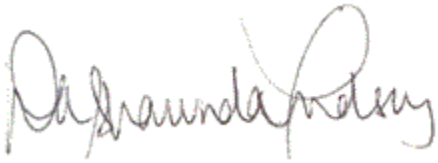
APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**

ANALYSIS:	William worked in the facility alone on 04/30/2023 and was not trained.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Renewal Licensing Study Report 02/14/2023.**

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	William worked alone in the facility on 04/30/2023. William was not trained to work in the facility. No other trained staff was in the facility with the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

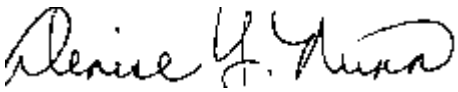
Due to the severity of the quality of care violations, I recommend revocation of the license and that the license be summarily suspended effective immediately.



07/11/2023

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



07/11/2023

Denise Y. Nunn — Date
Area Manager