GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 7, 2024

Kodi Pierce
Miracle Care LLC
14005 East State Fair
Detroit, MI 48205

RE: License #: AS820290669
Investigation #: 2024A0992013
Glynn Court Residential Care

Dear Mr. Pierce:

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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820290669
Investigation #:	2024A0992013
Complaint Receipt Date:	12/18/2023
Investigation Initiation Date:	12/18/2023
Report Due Date:	02/16/2024
Licensee Name:	Miracle Care LLC
Licensee Address:	14005 East State Fair Detroit, MI 48205
Licensee Telephone #:	(586) 460-5900
Administrator:	Kodi Pierce
Licensee Designee:	Kodi Pierce
Name of Facility:	Glynn Court Residential Care
Facility Address:	602 Glynn Ct. Detroit, MI 48202
Facility Telephone #:	(313) 826-1140
Original Issuance Date:	08/16/2007
License Status:	REGULAR
Effective Date:	06/15/2023
Expiration Date:	06/14/2025
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Residents A and B got into a physical fight. Resident A went to get staff and there was no staff in the home.	Yes

III. METHODOLOGY

12/18/2023	Special Investigation Intake 2024A0992013
12/18/2023	Special Investigation Initiated - Telephone Sherry Underwood, Office of Recipient Rights Investigator
12/18/2023	Contact - Document Received Incident Report
12/18/2023	Contact - Telephone call made Dr. Judy Paull, Nurse Practitioner and Special Projects Department of Psychiatry and Behavioral Neurosciences with Wayne Health.
12/20/2023	Contact - Face to Face Denise Rush, direct care staff (DCS) and Resident A.
01/03/2024	Contact - Telephone call made Relative A
01/05/2024	Contact - Telephone call made Patrina Grayson, Resident A's supports coordinator with neighborhood services organization (NSO).
01/05/2024	Contact - Telephone call made Kodi Pierce, licensee designee
01/05/2024	Contact - Telephone call made Katrina Gouch, direct care staff was not available, call continuously failed.
01/08/2024	Contact - Telephone call made Karen Wolmack, Resident A's supports coordinator with NSO; was not available, message left.

01/10/2024	Contact - Telephone call made Ms. Wolmack was not available, message left.
01/11/2024	Contact - Telephone call made Ms. Wolmack was not available, message left.
01/11/2024	Contact - Telephone call made Ms. Gouch
01/12/2024	Contact - Telephone call received Ms. Wolmack
01/29/2024	Contact - Telephone call made Anissa Duren, adult protective services (APS).
01/31/2024	Contact - Telephone call made Tracy Spencer, Administrator, was not available. Message left.
01/31/2024	Contact - Telephone call made Ms. Spencer, Administrator, was not available. Message left.
02/06/2024	Contact - Telephone call made Ms. Underwood
02/06/2024	Exit Conference Mr. Pierce

ALLEGATION: On 12/3/2023, Residents A and B got into a physical fight. Resident A went to get staff and there was no staff in the home.

INVESTIGATION: On 12/18/2023, I contacted Sherry Underwood, Office of Recipient Rights Investigator (ORR) and interviewed her regarding the allegation. Ms. Underwood said she is currently investigating the allegation. She said she interviewed Kodi Pierce, licensee designee, and he denied the allegation. She further stated Mr. Pierce said Katrina Gouch, DCS was on shift on 12/3/2023 and had stepped outside. Ms. Underwood said Mr. Pierce stated he immediately arrived at the home and Resident B was in crisis. She said Mr. Pierce called 911 and Resident B was transported to the hospital and is currently at Pontiac General. Ms. Underwood said Mr. Pierce said Resident B will not be returning to the home.

On 12/18/2023, I contacted Dr. Judy Paull, Nurse Practitioner and Special Projects Department of Psychiatry and Behavioral Neurosciences with Wayne Health; I interviewed her regarding the allegation. Dr. Paull explained that she was made aware of the allegation during her weekly visit with Resident A. Dr. Paull said based

on the information she received, this is not the first incident between Residents A and B. However, this time Resident B was more aggressive and hypersexual. Dr. Paull said the DCS took the necessary action and Resident B was removed from the home and will not be returning. However, she said she is concerned because at the time of the incident, Resident A attempted to tell DCS and there was no staff in the home at the time. She said to her knowledge, the home should be staffed 24hrs; which I confirmed. Dr. Paull expressed concerns regarding adequate supervision in the home. Dr. Paull suggested I contact Resident A's guardian and provided her contact information.

On 12/20/2023, I completed an unannounced onsite inspection; I interviewed Denise Rush, direct care staff (DCS) and Resident A. Ms. Rush denied being on shift when the reported incident occurred. She said Resident B is no longer in the home and will not be returning.

Resident A confirmed the allegation. Resident A said she is not sure what time it was, but it was nighttime. She said she was getting ready for bed and Resident B took off all her clothes, started touching herself in the breast area and started calling out her name. Resident A said she told Resident B to stop and that she was scaring her. Resident A said Resident B continued calling out her name, propositioning herself around the room and in her space. Resident A said Resident B hit her twice and spit in her face. Resident A said she got out the bed and started grabbing her belongings out of the closet to leave the room and Resident B closed the closet door causing her to fall in the closet. Resident A said she got up, grabbed her purse, and went downstairs to tell DCS. Resident A said there was no DCS in the home, so she waited on the front porch until Ms. Gouch arrived. She said Ms. Gouch pulled up in a car. Resident A said Ms. Gouch separated Residents A and B, and the police were called. Resident A said Resident B was removed from the home and has not returned. Resident A said there is always one DCS in the home, and this is the first time there was none in the home. She said Resident B has never acted out sexually towards her, but it made her uncomfortable. She said she feels safe now that Resident B is no longer in the home. Resident A identified her guardian as Relative A and confirmed her contact information.

On 01/03/2024, I contacted Relative A and interviewed her regarding the allegation, which she confirmed. Relative A said to her knowledge the incident occurred on 12/03/2023, during the morning hours. She further explained that she was contacted by Tracy Spencer on 12/04/2023 stating that Resident B was standing over Resident A fondling herself. She said Ms. Spencer said appropriate action was taken by the DCS and Resident B was removed from the home. Relative A said Resident B was not stabilized on her medications and has been exhibiting behaviors. Relative A further stated that she visited with Resident A on 12/05/2023 and she sat in on her zoom meeting with Patrina Grayson, Resident A's supports coordinator with neighborhood services organization (NSO). Relative A said during the meeting Resident A explained the series of events that occurred between her and Resident B and that is when she learned that there was no DCS in the home when the incident

occurred. Relative A said the information Ms. Spencer reported was inaccurate. Relative A said the DCS that was on shift while she was visiting with Resident A was the same staff that pulled up while Resident A was standing on the porch the night of the incident. Relative A said when she addressed the issue with Ms. Gouch, she assured her that everything was taken care of. She said Ms. Gouch said she was only a couple blocks away and was pulling up as Resident A walked out of the house. Relative A said she further stated Mr. Pierce arrived onsite and called the police. Relative A said she feel as though the DCS is not being truthful.

On 01/05/2024, I contacted Ms. Grayson and interviewed her regarding the allegation. Ms. Grayson confirmed that during the zoom meeting with Resident A, she learned of the series of events that occurred between Residents A and B. Ms. Grayson said she asked Resident A if she notified the DCS and she said there was no DCS in the home at the time. Ms. Grayson said she notified ORR and then Resident A's case was transferred to Karen Wolmack, supports coordinator with NSO.

On 01/05/2024, I contacted Kodi Pierce, licensee designee, and discussed the allegation. Ms. Pierce said he was previously made aware of the allegation; Mr. Pierce said there was DCS on shift. He said Ms. Gouch was in the home and Ms. Spencer was in the basement. Mr. Pierce provided contact information for Ms. Spencer. I made Mr. Pierce aware that I will follow-up with him to complete an exit conference upon completion of the investigation.

On 01/11/2024, I contacted Ms. Gouch, and interviewed her regarding the allegation. Ms. Gouch confirmed she was on shift. She said Resident A stated that Resident B was nude, and she started calling out her name while fondling herself. She said Resident A tried to leave and Resident B pushed her down on her bed. Ms. Gouch said Resident A grabbed her belongings and went downstairs. I asked Ms. Gouch if Resident A is credible, and she said yes. She said Resident A is very detailed and descriptive. I asked if Resident A stated there was no DCS on shift when the incident occurred, would that be accurate, and she said no. Ms. Gouch said she was standing right outside the door smoking a cigarette. Ms. Gouch said if that is what Resident A reported, she believes Resident A was coached by Relative A to say there was no DCS on shift. Ms. Gouch reiterated that she was standing right outside the door. I asked Ms. Gouch if at anytime she stated she was only a couple blocks away when the incident occurred, and she said she never said that. In fact, Ms. Gouch said she has only spoken with Ms. Wolmack regarding the reported allegation. I asked Ms. Gouch if she was on shift by herself and she said yes. Ms. Gouch said she believes the allegation was reported as a method of retaliation due to some unresolved financial issues as it pertains to Resident A's cost of care.

On 01/12/2024, I received a call from Ms. Wolmack; I interviewed her regarding the allegation. Ms. Wolmack explained that at the time the incident occurred, Ms. Grayson was the assigned supports coordinator. However, she said once the case was transferred to her, she reviewed Ms. Grayson's case notes and visited with

Resident A. Ms. Wolmack said Resident A's explanation of what occurred has remained consistent. She said she spoke with Ms. Gouch, and she confirmed she was on shift, but was sitting in the car when the incident occurred. Ms. Wolmack said Ms. Gouch stated there are some financial issues as it pertains to Resident A's cost-of-care, and she believe that is why the allegation was reported.

On 01/29/2024, contacted Anissa Duren, adult protective services (APS). Ms. Duren said she investigated the allegation and substantiated due to inadequate supervision.

On 02/06/2024, I made follow-up contact with Ms. Underwood as it pertains to her investigation. Ms. Underwood said she is actively investigating the allegation, and it is not completed at this time.

On 02/06/2024, I competed an exit conference with Mr. Pierce. I made him aware that based on the investigative findings, there is sufficient evidence to support the allegation. I further stated that Resident A was very adamant that there was no staff on shift and Ms. Gouch arrived onsite while she was standing on the porch. Mr. Pierce stated Resident A's story changed as it pertains to DCS being on shift after visiting with Relative A. I made Mr. Pierce aware that although he previously stated Ms. Spencer was in the basement, Ms. Gouch stated she was the only DCS on shift. I stated only information that has remained consistent is Resident A's explanation of what occurred and that there was no DCS on shift. I made Mr. Pierce aware that he will be provided with a copy of the report and based on the findings, a corrective action plan is required. Mr. Pierce agreed to review the report and respond accordingly.

APPLICABLE 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:	During this investigation, I interviewed Kobi Pierce, licensee designee; Denise Rush and Katrina Gouch; DCS; Patrina Grayson, Resident A's (former) Supports Coordinator with NSO; Karen Wolmack, Resident A's Supports Coordinator with NSO; Sherry Underwood, ORR; Anissa Duren, APS; Relative A, Resident A's guardian and Resident A regarding the allegations. Although Mr. Pierce and Ms. Gouch denied the allegation, Resident A confirmed the allegation, and Ms. Duren stated based on her findings, there is evidence to support the allegation. During my interview with Resident A, she was very adamant and descriptive when discussing the allegations. Resident A presented as competent and credible. Based on the investigative findings, there is sufficient evidence to support the allegation that there was not sufficient direct care staff on duty for the supervision, personal care, and protection of residents. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend that the status of the license remains the same.

02/06/2024

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Denasha Walker Date
Licensing Consultant

Approved By:

02/07/2024

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Ardra Hunter Date
Area Manager