GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 31, 2024

Rebirth Community Inclusion Program, LLC
16951 Maryland
Southfield, MI 48075

RE: License #: AS820396286
Investigation #: 2024A0116037
Rebirth Community Inclusion Program

Dear Ms. Jefferson:

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,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820396286
Investigation #:	2024A0116037
Complaint Receipt Date:	07/08/2024
Investigation Initiation Date:	07/11/2024
Report Due Date:	09/06/2024
Licensee Name:	Rebirth Community Inclusion Program, LLC
Licensee Address:	16951 Maryland Southfield, MI 48075
Licensee Telephone #:	(313) 778-3194
Administrator:	Linda Jefferson
Licensee Designee:	Linda Jefferson
Name of Facility:	Rebirth Community Inclusion Program
Facility Address:	811 Superior St Wyandotte, MI 48192
Facility Telephone #:	(734) 407-7390
Original Issuance Date:	07/22/2021
License Status:	REGULAR
Effective Date:	01/22/2024
Expiration Date:	01/21/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff sleep while on shift.	No
Resident A previously lived at the home and reported verbal abuse and neglect by staff toward residents. Resident A reported an unknown staff pushed an unknown resident on the couch.	No
Resident A was given another residents medication.	No
Residents do not eat breakfast or lunch.	No
Additional Findings	Yes

III. METHODOLOGY

07/08/2024	Special Investigation Intake 2024A0116037
07/08/2024	Adult Protective Services (APS) Referral Received.
07/11/2024	Special Investigation Initiated - On Site Interviewed staff, Jennifer Jones, Residents B-D and reviewed medications and medication administration records.
07/11/2024	Inspection Completed-BCAL Sub. Compliance
07/12/2024	Contact - Telephone call made Interviewed licensee designee, Linda Jefferson.
07/22/2024	Contact - Telephone call made Interviewed assigned APS investigator, Laura DeCarlo.
07/22/2024	Exit Conference With licensee designee, Linda Jefferson.
07/30/2024	Contact-Telephone call made. Interviewed Guardian C1.

ALLEGATION:

Staff sleep while on shift.

INVESTIGATION:

On 07/11/24, I conducted an unscheduled on-site inspection and interviewed staff, Jennifer Jones, and Residents B-D. Ms. Jones denied the allegations and reported that she does not sleep during her shifts. Ms. Jones reported that there is only one staff per shift so she is unable to speak to what other staff may or may not do on their shift.

I interviewed Residents B-D separately and they all were alert and oriented to person, place and time. Resident B and D reported that they are their own guardians and handle their own affairs. Resident C has a guardian. Residents B-D a denied the allegations and reported that they have never observed any of the staff sleeping on shift.

On 07/12/24, I interviewed licensee designee, Linda Jefferson, and she denied the allegations. Ms. Jefferson reported that the allegations are coming from Resident A's mother, who has been harassing her since she took her from the facility on 01/12/24. Ms. Jefferson reported that Resident A lived in the facility for about two weeks and ever since her departure her, Resident A's mother has been making up false accusations and threatening her.

On 07/30/24, I interviewed Guardian C1, and she reported that she has no concerns regarding the care provided in the home. Guardian C1 reported that she often makes unscheduled visits to the facility and has never observed any of the staff asleep. Guardian C1 also reported that Resident C is high functioning and if staff were sleeping on shift, she would definitely tell her.

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:	Based on the findings of the investigation, which included interviews of staff, Jennifer Jones, Residents B-D, and Guardian C1, I am unable to corroborate the allegations that staff are sleeping on shift. The licensee designee has sufficient staff on duty at all times for the supervision, personal care, and protection of the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A previously lived at the home and reported verbal abuse and neglect by staff toward residents. Resident A reported an unknown staff pushed an unknown resident on the couch.

INVESTIGATION:

On 07/11/24, I conducted an unscheduled on-site inspection and interviewed staff, Jennifer Jones, and Residents B-D. Ms. Jones reported she has worked in the home since April of 2024 and is not aware of the allegations alleged by Resident A. Ms. Jones reported that to her knowledge Resident A left the home in early January of 2024. Ms. Jones reported that she can only speak for herself and reported that she is not in any way abusive or neglectful to the residents and does not believe that any of the other staff are either.

I interviewed Residents B-D separately and they all denied that any of the staff is verbally abusive or neglect them in anyway. They also denied ever being pushed on the couch or observing staff push another resident on the couch. Resident B reported that this allegation has to be coming from Resident A or her family and reported that it is comical. Resident B added that they are high functioning residents and wouldn't stand for any type of abuse.

On 07/12/24, I interviewed licensee designee, Linda Jefferson, and she denied the allegations. Ms. Jefferson reported that none of the residents have expressed any concerns to her regarding abuse or neglect and have not shared that one of them was pushed on the couch by staff. Ms. Jefferson reported that she works shifts in the facility and that the residents would not hesitate to disclose any mistreatment by staff to her.

On 07/30/24, I interviewed Guardian C1, and she reported that Resident C has never disclosed to her any physical or verbal abuse or neglect by any of the staff. Guardian C1 reported that she knows all the staff employed at the home and they are really good with the residents. Guardian C1 reported that when she calls or visits Resident C and asked her questions about the staff and the facility, she always has

good things to say. Guardian C1 reported that licensee designee, Linda Jefferson and her staff have been a blessing to her and Resident C. She reported that Resident C is really thriving and doing well since she placed her there.

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:	Based on the findings of the investigation, which included interviews of staff, Jennifer Jones, Residents B-D, licensee designee, Linda Jefferson, and Guardian C1, I am unable to corroborate the allegations that the residents are not being treated with dignity and their personal needs, including protection and safety are not being attended to at all times, in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was given another residents medication.

INVESTIGATION:

On 07/11/24, I conducted an unscheduled on-site inspection and interviewed staff, Jennifer Jones, Residents B-D and reviewed the medications and medication administration records (MARs). Ms. Jones reported that she was not employed at the facility during the two- or three-weeks Resident A resided there and is unaware of any medication error that may have involved her.

I interviewed Residents B-D separately and they all reported to their knowledge everyone gets only the medication that is prescribed to them. They all denied any knowledge of Resident A being given another resident's medication. I reviewed the medications and MARs for each of the residents and based on my observation the medications and MARs for each resident matched and there did not appear to be any inconsistences.

On 07/12/24, I interviewed licensee designee, Linda Jefferson, and she reported that there has not been a medication error in the home and denied that Resident A was

given another residents medication. Ms. Jefferson reported that the allegation is frivolous.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on the findings of the investigation, which included interviews of staff, Jennifer Jones, Residents B-D, licensee designee, Linda Jefferson, and my observation, I am unable to corroborate the allegation that prescription medication was used by a person other than the resident for whom the medication was prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents do not eat breakfast or lunch.

INVESTIGATION:

On 07/11/24, I conducted an unscheduled on-site inspection and interviewed staff, Jennifer Jones, and Residents B-D. Ms. Jones reported that the residents eat three meals per day and have access to snacks. Ms. Jones reported that the residents eat very well and reported that they wouldn't hesitate to tell me that.

I interviewed Residents B-D separately and they all reported that they eat three meals per day and one or two snacks a day. They reported that the food is good, and they can have seconds if they want more. Resident B invited me to look at the food supply and reported that no one in the house has missed a meal. Resident B reported that Ms. Jefferson does all of the grocery shopping and makes sure there is always food in the home.

I observed the food supply and found that there was an abundance of food in the home. I observed a variety of different foods including breakfast and lunch items.

On 07/12/24, I interviewed licensee designee, Linda Jefferson, and she reported that the residents eat breakfast, lunch and dinner and snacks. Ms. Jefferson reported that she does the grocery shopping weekly and ensures that there is always food in the home.

On 07/22/24, I interviewed assigned APS investigator, Laura DeCarlo, and she reported that she is completing her investigation, and that there is insufficient evidence to substantiate any of the allegations.

On 07/30/24, I interviewed Guardian C1, and she reported that she knows that the residents eat three meals per day for a fact. Guardian C1 reported that Resident C always tells her what she eats in a day when she talks to her. Guardian C1 reported that she frequents the facility and has observed the residents eating. Guardian C1 reported that the residents eat very well at this facility.

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:	Based on the findings of the investigation, which included interviews of staff, Jennifer Jones, Residents B-D, licensee designee, Linda Jefferson, Guardian C1, any my observation, I am unable to corroborate the allegation that the residents are not being provided a minimum of three regular, nutritious meals daily.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/11/24, I conducted and unscheduled on-site inspection. During the inspection I asked staff, Jennifer Jones, to unlock the medication cart so that I could review the medications and MARs. Ms. Jones opened the cart, and I observed Residents B, E, F, and G had medications pre-filled in medication cups. I interviewed Ms. Jones and she reported that she had pre-filled the medication in preparation for the 6:00 p.m. and 8:00 p.m. medication pass. Ms. Jones reported being unaware of the licensing rule that prohibits this practice. Ms. Jones reported moving forward, she would not do that again.

On 07/12/24, I interviewed licensee designee, Linda Jefferson, and she reported that staff is aware that they should not be pre-filling medication. Ms. Jefferson reported that she went to the facility after I left and spoke with Ms. Jones and reiterated to her that medications are not to be pre-filled.

On 07/22/24, I conducted the exit conference with licensee designee, Linda Jefferson, and informed her of the findings of the investigation. Ms. Jefferson reported an understanding and stated that she would submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan

	Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on the findings of the investigation, which included my observation and an interview with Ms. Jones, I am able to corroborate that Residents B, E, F and G had medications were not kept in their original pharmacy supplied container and had been pre-filled hours before they were to be administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

07/30/24

Pandrea Robinson
Licensing Consultant

Date

Approved By:

7/31/24

Ardra Hunter
Area Manager

Date