GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 16, 2024

Thomas Quakenbush
Community Homes Inc
3925 Rochester Rd.
Royal Oak, MI 48073

RE: License #: AS630012406
Investigation #: 2025A0611003
Community Homes Inc AFC Home

Dear Mr. Quakenbush:

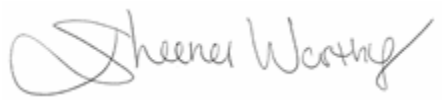
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Sheena Worthy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012406
Investigation #:	2025A0611003
Complaint Receipt Date:	10/03/2024
Investigation Initiation Date:	10/09/2024
Report Due Date:	12/02/2024
Licensee Name:	Community Homes Inc
Licensee Address:	3925 Rochester Rd. Royal Oak, MI 48073
Licensee Telephone #:	(248) 336-0007
Administrator:	Thomas Quakenbush
Licensee Designee:	Thomas Quakenbush
Name of Facility:	Community Homes Inc AFC Home
Facility Address:	2503 W 14 Mile Road Royal Oak, MI 48073
Facility Telephone #:	(248) 549-3928
Original Issuance Date:	N/A
License Status:	REGULAR
Effective Date:	10/12/2023
Expiration Date:	10/11/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff member Daishonay left the AFC home this morning (10/2/24) around 5:00am. This resulted in the residents being left home alone until a replacement staff member came at 7:00am.	Yes

III. METHODOLOGY

10/03/2024	Special Investigation Intake 2025A0611003
10/03/2024	APS Referral Per the intake email, Adult Protective Services (APS) denied investigating the allegations.
10/09/2024	Special Investigation Initiated - On Site I completed an unannounced onsite. I interviewed the home manager Dawn Turner and Resident D. I took pictures of the staff log and staff schedule.
10/10/2024	Contact - Telephone call made I left a voice message for staff member Daishonay Fultz requesting a call back.
10/10/2024	Contact - Telephone call made I made a telephone call to staff member Verdis Gardner. The allegations were discussed.
10/10/2024	Exit Conference I attempted to complete an exit conference with the licensee designee however there was no answer. A voice message was left. A secondary exit conference was completed via email.
10/10/2024	Exit Conference I received a return phone call from the licensee designee Thomas Quakenbush.

ALLEGATION:

Staff member Daishonay left the AFC home this morning (10/2/24) around 5:00am. This resulted in the residents being left home alone until a replacement staff member came at 7:00am.

INVESTIGATION:

On 10/03/24, a complaint was received and assigned for investigation alleging that Resident H is diagnosed with bi-polar, psychotic disorder, autistic disorder, and epilepsy unspecified. Daishonay Fultz is a staff member at the AFC home. Daishonay left the AFC home this morning (10/2/24) around 5:00am. This resulted in Resident M and 3 other residents being left home alone until a replacement staff member came at 7:00am. Resident H and the other residents require 24/7 care and supervision and cannot be left alone. Daishonay texted the home manager at 11:41pm the night prior when she was asleep stating she needed to leave early. When Daishonay did not receive a response or confirmation that she could leave early, she left anyways. Daishonay left because she had an externship for another job she needed to be at. Daishonay signed the staff communication book that she worked from 11:00pm-5:30am. One of the residents woke up at 6:00am and there was no staff at the home. None of the residents were harmed as a result of being left home alone.

On 10/09/24 I completed an unannounced onsite. I interviewed the home manager Dawn Turner and Resident D. I took pictures of the staff log and staff schedule.

On 10/09/24, I interviewed the home manager Dawn Turner. Regarding the allegations, Ms. Turner confirmed that there are five residents in the AFC group home. I observed Resident H walking around the AFC group home. Ms. Turner advised that Resident H does not have the ability to carry on a conversation. Ms. Turner stated the day in question occurred on 09/25/24. Ms. Turner stated staff member Daishonay Fultz is currently suspended pending this investigation. Ms. Fultz was suspended on 09/26/24. Ms. Fultz works the midnight shift from 11:00pm to 7:00am. Ms. Fultz has worked at the AFC group home for four months. On 09/24/24 at 8:53pm, Ms. Fultz sent Ms. Turner a text message stating she cannot work until 7:00am because she has to go to her externship for another job and take her daughter to daycare at 7:00am. Ms. Turner responded at 8:55pm and stated she will see what she can do and she will get back to her tomorrow.

Ms. Fultz sent Ms. Turner another text message at 11:41pm saying she didn't realize that she had responded to her last text message but, she still has to leave at 5:30am. Ms. Turner did not respond because she was asleep. Ms. Turner sent Ms. Fultz a text message at 9:43am saying she just read her text message and noticed that she punched out at 5:30am. Ms. Turner asked Ms. Fultz if anyone was at the home before she left. Ms. Turner did not get a response. Ms. Turner stated staff member Verdis Gardner arrived to the AFC group home at 7:00am. Ms. Gardner informed Ms. Turner

that Ms. Fultz was not present at the home. Ms. Fultz did cook oatmeal for the residents to eat for breakfast before she left the home. When Ms. Gardner arrived to the home, she heated up the oatmeal and served it to the residents. Ms. Turner contacted the main office.

Ms. Turner stated the residents usually wake up between 6:00am and 6:30am. On the day in question, Resident D woke up at 6:15am and saw that no staff member was present. There was four residents in the home when this incident occurred as Resident S was in the hospital. Ms. Turner stated that no one has had contact with Ms. Fultz since she left the home as her phone goes straight to voicemail. On 09/26/24, Ms. Turner sent Ms. Fultz a text message informing her that she is suspended pending an investigation. Ms. Fultz response was “ok”.

On 10/09/24, I observed the staff log book. The entry dated for 09/24/24 from 11:00pm to 5:30am stated “everyone was in bed. All chores done. Resident S still in the hospital. Lunch made. Safety checks done. The staff signature appears to be Ms. Fultz name. I observed the staff schedule and confirmed that Ms. Fultz was scheduled to work on 09/24/24 from 11:00pm to 7:00am. It is noted on the schedule that Ms. Fultz worked from 11:25pm to 530am.

On 10/09/24, I interviewed Resident D. Resident D has lived at the AFC group home for two months. Regarding the allegations, Resident D stated there is one staff member working per shift. Resident D stated there was one instance where a staff member had something to do and she left the home in the morning. Resident D stated he did not see the staff member leave nor is he sure what time she left. Resident D stated he woke up between 5:45am and 6:00am and didn’t see the staff member. Resident D stated this was an isolated incident.

On 10/10/24, I made a telephone call to staff member Verdis Gardner. Regarding the allegations, Ms. Gardner has worked for the AFC group home for 18 years. Ms. Gardner works the day shift. When Ms. Gardner arrived to the AFC group home on the day in question, Resident M and Resident C were in the kitchen, Resident D was in the basement, and Resident H was in the bed. Ms. Gardner does not know why Ms. Fultz left the residents unattended in the AFC group home. Ms. Gardner did not know the residents were alone in the AFC group home prior to her arrival. Resident M told Ms. Gardner that he didn’t know where the staff member was. Resident D went into the basement at 6:15am and he did not see a staff member at that time.

On 10/10/24, I completed an exit conference with the licensee designee Thomas Quakenbush. Mr. Quakenbush was informed that the allegations will be substantiated and a corrective action plan will be required.

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 information above, there is sufficient information to confirm the allegations. The home manager Ms. Turner confirmed that Ms. Fultz clocked out at 5:30am despite her shift ending at 7:00am. Staff member Ms. Gardner confirmed that when she arrived at the AFC group home, Ms. Fultz was not present and the residents were not being supervised. Resident D confirmed that when he woke up around 6:00am he did not see Ms. Fultz in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

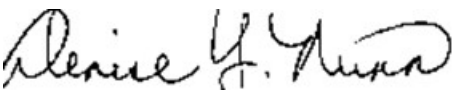
IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.

Sheena Worthy
Licensing Consultant

10/15/24
Date

Approved By:



10/16/2024

Denise Y. Nunn
Area Manager

Date