GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 6, 2025

Kimberly Nichols
Joyner Home LLC
PO Box 04030
Detroit, MI 48204

RE: License #: AS820338755
Investigation #: 2025A0901012
Joyner Home I

Dear Kimberly Nichols:

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,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820338755
Investigation #:	2025A0901012
Complaint Receipt Date:	01/15/2025
Investigation Initiation Date:	01/16/2025
Report Due Date:	03/16/2025
Licensee Name:	Joyner Home LLC
Licensee Address:	PO Box 04030 Detroit, MI 48204
Licensee Telephone #:	(313) 570-6006
Administrator:	Kimberly Nichols
Licensee Designee:	Kimberly Nichols
Name of Facility:	Joyner Home I
Facility Address:	5522 Webb St Detroit, MI 48204
Facility Telephone #:	(313) 397-1104
Original Issuance Date:	06/07/2013
License Status:	REGULAR
Effective Date:	12/17/2023
Expiration Date:	12/16/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A received a double dose of her afternoon medication.	Yes

III. METHODOLOGY

01/15/2025	Special Investigation Intake 2025A0901012
01/15/2025	Referral - Recipient Rights (ORR)
01/15/2025	Adult Protective Services Referral
01/16/2025	Special Investigation Initiated - Telephone Tiffany Burgess, ORR
01/16/2025	Contact - Telephone call made Kellie Broadus, Staff
01/16/2025	Contact - Telephone call made Tynita Mitchell, Staff
01/23/2025	Contact - Telephone call made Tynita Mitchell, Staff
01/23/2025	Contact - Telephone call made Lakeita Spears, Supervisor
01/27/2025	Contact - Document Received Email
01/28/2025	Contact - Telephone call made Resident A
02/25/2025	Contact - Telephone call received Debra Jones, Case Manager
02/25/2025	Inspection Completed-BCAL Sub. Compliance
03/03/2025	Exit Conference Kimberly Nichols, Licensee Designee

ALLEGATION:

Resident A received a double dose of her afternoon medication.

INVESTIGATION:

On 01/16/2025, I made a telephone call to Tiffany Burgess, from ORR. She explained that staff, Tynita Mitchell, had already administered Resident A her medication and completed the log. Staff, Kellie Broadus, did not check the log before re-administering the same medication. Tiffany stated she substantiated the allegations and that Tynita no longer worked at the facility.

On 01/16/2025, I made a telephone call to Kellie. She stated when she arrived to work on 01/08/2025, she asked Tynita if the 4:00 p.m. medications had been passed and she replied “no”. She noticed that Resident A’s 4:00 p.m. medications for that day were gone so she asked Tynita again if she passed the medications and she said “no”. Therefore, Kellie removed Resident A’s 01/09/2025 4:00 p.m. medications from the prescription bubble pack and gave them to her. Afterwards, she was still concerned about Resident A’s 01/08/2025 4:00 p.m. medications being missing, so she asked Tynita once again if she was sure she did not pass the medications. This time Tynita replied she did give Resident A her medications. Kellie said she immediately contacted the supervisor, Lekeita Spears, and took Resident A to the hospital. Resident A was kept for observation but had no complications. Tynita was very apologetic and remorseful for her actions. She stated she never had a medication error before and regretted not looking at the medication log before administering the medications.

On 01/16/2025, I attempted to contact Tynita, but her phone number was disconnected.

On 01/23/2025, I attempted to contact Tynita, but her phone number was disconnected.

On 01/23/2025, I made a telephone call to Lakeita. She stated following her investigation of the incident, Kellie failed to follow the six rights of medication passing, and therefore was suspended and had to redo medication training. She also said Tynita was terminated from employment.

On 01/27/2025, I received an email from Lakeita. It consisted of an incident report, Resident A medication logs, verification of Kellie's suspension and medication training, and verification of Tynita's termination notice. The incident report was dated for 01/08/2025 at 4:00 p.m. and was completed by Kellie. It was consistent with what she previously reported to me. The January medication log sheet verified that Resident A's 4:00 p.m. medications were administered by Tynita. Her initials were documented for each medication. Therefore, Resident A was given by Kellie and extra dose of her Risperdone, Quetiapine, Clonidine, and Clonzapine.

On 01/28/2025, I conducted an onsite inspection at the facility and interviewed Resident A. She stated she was doing okay and that she had no problems since being given too much medication. Resident A said staff took her to the hospital right away and she was given an IV and the doctor said she would be fine. She also said this was the fist time staff made a mistake with her medications.

On 02/25/2025, I made a telephone call to Resident A's case manager, Debra Jones, from Wayne Center. She spoke well of the facility and stated she has never had an issue like this occur before. Debra said management was very organized and staff were not known for medication mishaps.

On 03/03/2025, I conducted an exit conference with the licensee designee, Kimberly Nichols. I informed her of my investigative findings. She said she understood and would send a corrective action plan as soon as she receives the report.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based on the information obtained during this investigation, the allegations are confirmed. Resident A's medications were not given pursuant to label instructions. Kellie admitted to giving her a double dose of her 4:00 p.m. medications on 01/08/2025, although the medication log sheet confirmed it had already been administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

_____ 03/03/2025

Regina Buchanan — Date
Licensing Consultant

Approved By:

03/06/2025

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Ardra Hunter — Date
Area Manager