GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 14, 2025

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

RE: License #: AS820290866
Investigation #: 2025A0121016
Joyner Home II

Dear Ms. 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 was required. On May 8, 2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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) 456-0439.

Sincerely,

K. Robinson

K. Robinson, MSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820290866
Investigation #:	2025A0121016
Complaint Receipt Date:	02/14/2025
Investigation Initiation Date:	02/19/2025
Report Due Date:	04/15/2025
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 II
Facility Address:	7429 East Robinwood Street, Detroit, MI 48234
Facility Telephone #:	(313) 891-6897
Original Issuance Date:	11/06/2007
License **Status:**	REGULAR
Effective Date:	06/02/2024
Expiration Date:	06/01/2026
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A drank Clorox spray she found in the bathroom cabinet.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/14/2025	Special Investigation Intake 2025A0121016
02/14/2025	Contact - Document Sent Email to licensee
02/14/2025	Contact - Telephone call made Follow up call to Ms. Nichols
02/14/2025	APS Referral
02/14/2025	Referral - Recipient Rights
02/19/2025	Special Investigation Initiated - On Site Interviewed DCS Johnisha Pannell and Resident B
02/19/2025	Contact - Document Received UIR and IPOS
03/05/2025	Contact - Telephone call made DCS Tiniesha Bolden
03/07/2025	Contact - Telephone call received DCS Lakemia Jones
03/08/2025	Contact - Telephone call made Ms. Pannell
03/19/2025	Contact - Telephone call received Message from DCS Lakemia Jones
03/20/2025	Contact - Telephone call made Phone interview with Resident A

04/07/2025	Contact - Telephone call made DCS Makeeba Coan
04/07/2025	Contact - Telephone call made DCS Pancy Glaster
04/10/2025	Contact - Telephone call made Christina Garcia with PsyGenics
04/10/2025	Contact - Telephone call made Follow up with Ms. Coan
04/10/2025	Exit Conference Kim Nichols
05/08/2025	Corrective Action Plan Received/Approved

ALLEGATION: Resident A drank Clorox spray she found in the bathroom cabinet.

INVESTIGATION: On 2/19/25, I initiated the complaint with an unannounced onsite inspection at the facility. Resident A was at the hospital. Direct care staff, Johnisha Pannell was on duty. Resident B was the only resident at home; however, Resident B could not participate in an interview due to her low cognition. Ms. Pannell reported Resident A is known to self-harm. Ms. Pannell stated she was not working the day of the incident. I asked Ms. Pannell to show me where the cleaning supplies are stored. I observed 3 separate compartments inside a locked storage used to store cleaning supplies. Each supply was labeled and properly stored.

On 3/5/25, I interviewed DCS Tiniesha Bolden. Ms. Bolden reported that she was assigned as Resident A's 1:1 staff member on 2/10/25. Ms. Bolden said after dinner Resident A was prepping for her nighttime routine, then ran in the bathroom and slammed the door. According to Ms. Bolden, Resident A "got upset and slammed the bathroom door." Ms. Bolden said she ran and got the key to unlock the door. Ms. Bolden stated it took a "millisecond" to get the door key. Ms. Bolden further explained that once she opened the door, she observed Resident A with a bottle of Clorox cleanser in her hand. Resident A told Ms. Bolden, "I drank some", referring to the cleansing solution. Ms. Bolden said she contacted 911 for emergency assistance. Resident A was released from the hospital on 3/7/25 following the incident.

On 3/20/25, I completed a phone interview with Resident A. Resident A told me that she drank the cleansing solution because "I thought staff hated me." Resident A

expressed feeling anxious, so she locked herself in the bathroom. Resident A said she found the Clorox cleaning supply under the bathroom sink.

I reviewed the incident report and Resident A's most recent Integrated BioPsychosocial Assessment dated 8/27/24. The report states Resident A was admitted to the hospital on 7/26/24 "due to allegedly telling staff that she drank 4 sips of bleach." She was admitted to Hayvnwick Hospital for psychiatric treatment. This incident occurred prior to her placement at Joyner Home II.

On 4/10/25, I phoned Resident A's supports coordinator, Christina Garcia with PsyGenics, Inc. Ms. Garcia reported Resident A's behavior seems to have gotten worst since being placed at Joyner Home II. Ms. Garcia suspects Resident A's boyfriend whom she met at Stonecrest psychiatric hospital may be having a negative influence on her. Ms. Garcia also reported Resident A is known to be manipulative.

On 4/10/25, I completed an exit conference with licensee designee, Kimberly Nichols. Ms. Nichols does not dispute the unlocked cleaning supplies. Ms. Nichols reported Resident A was placed at Joyner Home II last August.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.
ANALYSIS:	Ms. Nichols acknowledges that a bottle of Clorox cleaning solution was left in the downstairs bathroom on 2/10/25 and Resident A gained accessed to this poisonous caustic despite her history of self-harm.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 3/20/25, I asked Resident A what prompted her to drink the Clorox, and she reported DCS Tiniesha Bolden choked her, so she assumed Ms. Bolden "hated me." Resident A presented as a credible witness as she assumed responsibility for initiating the fight. Resident A acknowledged that she hit Ms. Bolden first during a heated argument. According to Resident A, she hit Ms. Bolden in the face, and that's when Ms. Bolden proceeded to choke her. Resident A also said, "Makeeba and Pancy got her off me," but she doubts that they will tell the truth about what happened considering they're "friends" with Ms. Bolden. There are no other witnesses to the event per Resident A. Resident A reported all her

housemates were in their bedrooms when the fight ensued. When I interviewed Ms. Bolden on 3/5/25, she gave a different account about what happened. According to Ms. Bolden, Resident A got upset when she redirected her for eating too fast. Ms. Bolden stated, “I told her not to eat like a pig” in a joking manner. Ms. Bolden’s statement is that Resident A “football tackled me” and that’s what initiated their physical contact. Ms. Bolden said she put Resident A’s “legs in between my leg” … “I had my hands on her hands, they were up by my neck.” Ms. Bolden reported she restricted Resident A’s movement to help calm the resident down.

On 4/7/25, I interviewed DCS Makeeba Coan and Pancy Glaster. Both Ms. Coan and Ms. Glaster reported Resident A was the initial aggressor. Per Ms. Coan, Ms. Bolden “Tried to restrain her”, but she denied Ms. Bolden used force. Ms. Coan described the altercation as “It was more tussling, where they were grabbing each other.” Ms. Coan said she did not see Ms. Bolden “choke” Resident A, but she did acknowledge it could’ve happened after she left the room. Ms. Coan said she rushed the other residents away from the area of the altercation to avoid upsetting the others. Ms. Glaster said she too hurried her 1:1 staffing assignment away from the area. Ms. Glaster explained she could only hear the commotion after she left the room. I asked Ms. Glaster to recall what she heard, and she said Resident A kept repeating, “Why did you choke me?” With only Ms. Bolden left in the room, it’s safe to assume, Resident A was directing that question to her.

I reviewed Resident A’s Behavior Treatment Plan dated 2/17/25 prepared by Jessica M. Bowman, LLP, CIC-CSp. Objective 1 focuses on decreasing Resident A’s aggressive behavior towards self and others. The following is a list of intervention techniques recommended by the psychologist: 1) 1:1 staff within the same room 24hrs/day, 2) 1:1 staff will remain outside of {Resident A’s} bedroom and bathroom when the door is closed, 3) 1:1 staff will be mindful of {Resident A’s} sensitivity to criticism and focus on the solution, rather than addressing the problem, 4) staff will use reflective listening and solution-focused prompts as often as possible to reduce misinterpretation and build communication skills, 5) staff will respond to {Resident A} with social prompts.

On 4/10/25, I completed an exit conference with licensee designee, Kimberly Nichols. Ms. Nichols indicated that she was not aware Ms. Bolden referred to Resident A as a pig. Ms. Nichols said Ms. Bolden is known to work well with the residents. Ms. Nichols seemed surprised by the abuse allegation. Ms. Nichols said she does not believe Ms. Bolden would intentionally cause harm to a resident, but she did express disappointment by all that had occurred. On 5/8/25, Ms. Nichols submitted an approved corrective action plan.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**

	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on a records review and interviews with Resident A, Ms. Bolden, Ms. Glaster, and Ms. Pancy, I determined Resident A was not provided protection and safety as specified in the resident's written assessment plan when Ms. Bolden failed to be mindful of Resident A's sensitivity to criticism and focus on the solution, rather than addressing the problem .
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend the status of this license remain unchanged.

05/12/25

Kara Robinson Date
Licensing Consultant

Approved By:

05/14/25

Ardra Hunter Date
Area Manager