



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

June 3, 2025

Davina Draughn  
Stallworth AFC 1 Corporation  
645 E Grand Blvd.  
Detroit, MI 48207

RE: License #: AL820007644  
Investigation #: 2025A0121021  
Stallworth AFC

Dear Ms. Draughn:

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) 456-0439.

Sincerely,

A handwritten signature in blue ink that reads "K. Robinson". The signature is written in a cursive style with a large, stylized "K" and a clear, legible "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**

<b>License #:</b>	AL820007644
<b>Investigation #:</b>	2025A0121021
<b>Complaint Receipt Date:</b>	03/25/2025
<b>Investigation Initiation Date:</b>	03/25/2025
<b>Report Due Date:</b>	05/24/2025
<b>Licensee Name:</b>	Stallworth AFC 1 Corporation
<b>Licensee Address:</b>	645 E Grand Blvd., Detroit, MI 48207
<b>Licensee Telephone #:</b>	(313) 662-5113
<b>Administrator:</b>	Davina Draughn
<b>Licensee Designee:</b>	Davina Draughn
<b>Name of Facility:</b>	Stallworth AFC
<b>Facility Address:</b>	645 E Grand Boulevard, Detroit, MI 48207
<b>Facility Telephone #:</b>	(313) 662-5113
<b>Original Issuance Date:</b>	N/A
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	11/19/2024
<b>Expiration Date:</b>	11/18/2026
<b>Capacity:</b>	14
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
On 3/10/25, direct care staff, Tekeya Knox was away from the facility for more than 45 minutes before returning to work.	Yes
Staff Tekeya locked Resident A inside her bedroom while she was AWOL from her work shift.	Yes

**III. METHODOLOGY**

03/25/2025	Special Investigation Intake 2025A0121021
03/25/2025	APS Referral
03/25/2025	Special Investigation Initiated - Letter Email to Detroit Wayne Integrated Health Network (DWIHN)
03/25/2025	Referral - Recipient Rights
03/25/2025	Contact - Document Received- Email from DWIHN; Rights case is assigned to Michelle Livous for investigation.
03/26/2025	Contact - Telephone call made- Michelle Livous, Recipient Rights Investigator (RRI)
04/02/2025	Inspection Completed On-site- Interviewed Resident A-C and direct care staff, Latoya Johnson
04/07/2025	Contact - Telephone call made- Left message for Tekeya Knox; no reply.
04/07/2025	Contact - Telephone call made to Guardian A1
04/21/2025	Contact - Telephone call made- Follow up call to Ms. Livous
04/21/2025	Contact - Telephone call made- Left message for Tekeya Knox
04/24/2025	Contact - Telephone call received- Return call from Tekeya Knox
04/25/2025	Contact - Telephone call made- Follow up call to Guardian A
05/02/2025	Exit Conference with Licensee Designee, Davina Draughn

**ALLEGATION: On 3/10/25, direct care staff, Tekeya Knox was away from the facility for more than 45 minutes before returning to work.**

**INVESTIGATION:** On 3/26/25, I phoned Michelle Livous, Recipient Rights Investigator (RRI) with the Detroit Wayne Integrated Health Network. On 4/2/25, I conducted an unannounced onsite investigation at the facility. Direct care staff, Latoya Johnson was on duty when I arrived. Ms. Johnson indicated that she normally works at another location, so she had little information to offer pertaining to the investigation. I interviewed Residents A-C. Resident A and C had no recollection of being left home alone by staff, Tekeya Knox or anyone else. Resident B reported he has searched for Ms. Knox twice while on duty and he was not able to locate her in the building. Resident B explained he assumed Ms. Knox had gone to the facility next door when he couldn't find her. On 4/7/25, I contacted Guardian A1 by phone. Guardian A1 reported she went to the facility on 3/10/25 to celebrate Resident A's birthday. Guardian A1 stated she called the facility number multiple times before arriving, but no one answered the phone. Guardian A1 further explained she was greeted at the door by an unknown male (presumably a resident). Once inside the facility, Guardian A1 reported she noticed 25 missed calls on the caller ID. In addition, Guardian A1 stated she searched the entire first floor of the facility and could not locate staff. Guardian A1 indicated that she too assumed the staff was in the building next door. *Note: the licensee has two separately licensed afc homes side by side.* Guardian A1 stated she left the facility and made a follow up call to licensee designee, Davina Draughn to report the incident. Guardian A1 was only able to identify the person on duty as a "new staff member" based on a conversation she had with Resident A about who assisted Resident A with showering earlier.

On 4/21/25, I made a follow-up call to RRI, Michelle Livous. Ms. Livous reported Resident B has been identified as the person who opened the door for Guardian A1. Ms. Livous stated she substantiated the case for lack of staffing.

On 4/24/25, I received a return call from Ms. Knox. Ms. Knox denied leaving the residents unattended on 3/10/25. Ms. Knox insisted that Ms. Draughn is using her as a scapegoat to coverup the misdeeds of the favored staff.

On 5/2/25, I completed an exit conference with Ms. Draughn. Ms. Draughn stated that she conducted an internal investigation and determined that Ms. Knox abandoned her job duties for an unknown period on 3/10/25. Ms. Draughn indicated that Ms. Knox has been known to go missing for short periods during her work shift. Ms. Draughn reported there have been times when other staff complained to her about not being able to locate Ms. Knox to assist with meals. As a result, Ms. Draughn reported Ms. Knox's employment was terminated. Ms. Draughn confirmed Ms. Knox was a recent hire.

<b>APPLICABLE RULE</b>	
<b>R 400.15206</b>	<b>Staffing requirements.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	Based on witness statements from Guardian A, Ms. Livous, and Ms. Draughn, I determined there was not sufficient direct care staff on duty on 3/10/25 for the supervision, personal care, and protection of residents.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION: Staff Tekeya locked Resident A inside her bedroom while she was AWOL from her work shift.**

**INVESTIGATION:** Guardian A1 reported when she approached Resident A's closed bedroom door, she noticed a key placed inside the lock. Guardian A1 reported the door had to be unlocked before opening which suggested someone locked Resident A1 in the room. Guardian A1 reported she found Resident A inside the room safe and sound watching TV. According to Guardian A1, Resident A had no knowledge of what happened.

On 4/2/25, Resident A informed me that she had no knowledge about being locked in her room on her birthday. In fact, Resident A denied that staff lock residents in their rooms. Residents B and C also denied that staff lock residents in the bedrooms. I observed Resident A's bedroom door. The door is equipped with non-locking against egress hardware. The door can be locked from the outside with a key, and it locks automatically when closed. I noticed Resident A has the only bedroom downstairs. All others are located on the second floor of the facility.

On 4/21/25, Ms. Livous reported Resident A is known to be a wanderer.

Ms. Knox denied locking Resident A in her bedroom on 3/10/25 or any other day. Ms. Knox stated, "I never lock my clients in a room!" In fact, Ms. Knox said, "I was new", so she didn't know the residents had room keys in their possession.

On 5/2/25, I completed an exit conference with Ms. Draughn. Ms. Draughn reported that every resident bedroom has its own key. Ms. Draughn further explained that each room key is kept on a single keychain for safekeeping and easy access by staff. Ms. Draughn indicated that she believes Ms. Knox left the key in Resident A's door because when she arrived at the facility early the next morning, Ms. Draughn observed the key still inside the door. Ms. Draughn was adamant that room keys

should never be removed from the ring. Ms. Draughn reasoned there was no explanation why Resident A's room key was left in the door other than to lock it from the outside.

<b>APPLICABLE RULE</b>	
<b>R 400.15308</b>	<b>Resident behavior interventions prohibitions.</b>
	<b>(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.</b>
<b>ANALYSIS:</b>	On 3/10/25, Guardian A1 had to unlock Resident A's bedroom door to gain entry when there was no staff on the premises. Because Resident A is known to be a wanderer, it is more likely than not, staff locked her bedroom door to prevent the resident from exiting the area. Therefore, the licensee did not ensure that direct care staff not confine a resident in a room.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

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

*K. Robinson*

05/22/25

Kara Robinson  
Licensing Consultant

Date

Approved By:

*Dawn Timm*

06/02/2025

Dawn Timm  
Area Manager

Date