GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 10, 2021

Virgil Yarbrough
Yarbrough Better Living Center Inc.
P O Box 19734
Detroit, MI 48229

RE: License #: AS820382718
Investigation #: 2021A0992022
Yarbrough Better Living Center

Dear Mr. Yarbrough:

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 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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS820382718
Investigation #:	2021A0992022
Complaint Receipt Date:	06/18/2021
Investigation Initiation Date:	06/21/2021
Report Due Date:	08/17/2021
Licensee Name:	Yarbrough Better Living Center Inc.
Licensee Address:	3766 14th Street Ecorse, MI 48219
Licensee Telephone #:	(313) 383-8365
Administrator:	Virgil Yarbrough
Licensee Designee:	Virgil Yarbrough
Name of Facility:	Yarbrough Better Living Center
Facility Address:	3766 14 th Street Ecorse, MI 48229
Facility Telephone #:	(313) 383-6385
Original Issuance Date:	01/12/2017
License Status:	REGULAR
Effective Date:	07/12/2019
Expiration Date:	07/11/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A left the AFC home in Wayne County and made it to Lansing, where Resident A was hospitalized at Sparrow Hospital and is medically ready to be discharged. The AFC provider refused to pick up Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

06/18/2021	Special Investigation Intake 2021A0992022
06/21/2021	Special Investigation Initiated - Telephone Sharon Sabbath, adult protective services (APS)
06/21/2021	Contact - Telephone call made Kristen Bungart, Resident A's guardian with Guardian Care. She was not available, message left.
06/21/2021	Contact - Telephone call made Sparrow Hospital Emergency Department, Case Management. Message left.
06/21/2021	Contact - Telephone call made Virgil Yarbrough, licensee designee and Cassandra Peterson, direct care staff.
06/21/2021	Contact - Telephone call received Ms. Sabbath
06/21/2021	Contact - Telephone call received Ms. Bungart
06/23/2021	Contact - Document Received Resident A's documents
07/08/2021	Contact - Telephone call received Ms. Sabbath
07/23/2021	Contact - Telephone call made Dee Yarbrough, direct care staff
07/27/2021	Inspection Completed On-site Mr. Yarbrough

07/27/2021	Exit Conference Mr. Yarbrough

ALLEGATION: Resident A left the AFC home in Wayne County and made it to Lansing, where Resident A was hospitalized at Sparrow Hospital and is medically ready to be discharged. The AFC provider refused to pick up Resident A.

INVESTIGATION: On 06/21/2021, I contacted Sharon Sabbath, adult protective services (APS) regarding the allegation. Ms. Sabbath explained that since she received the intake she reached out to Kristen Bungart, Resident A's guardian but to no avail. She said at this time Resident A's whereabouts are unknown.

On 06/21/2021, I contacted Virgil Yarbrough, licensee designee and proceeded to interview him regarding the allegation. Mr. Yarbrough said Resident A left the home on or about 5/30/2021. He said Cassandra Peterson, direct care staff was on shift when Resident A left the home. Mr. Yarbrough said once he was notified Resident A left the home, he contacted Ecorse Police Department in an attempt to file a missing person report. However, he was unable to do so because Resident A had not been missing for 48 to 72 hours. Mr. Yarbrough said within 48 hours he received a call from Amy (last name unknown), Social Work Department at Sparrow Hospital in Lansing, MI stating Resident A was there in the emergency department and is medically cleared for discharge. She requested Resident A be picked up, in which Mr. Yarbrough to do so. Mr. Yarbrough said he sent D. Yarbrough, direct care staff to pick up Resident A. Mr. Yarbrough said once transport arrived, he received a call from D. Yarbrough stating once Resident A was in the van, he became very combative, hitting his cane against the dashboard and making threatening statements. He said D. Yarbrough pulled over and requested Resident A calm down but instead, he got out of the van and proceeded to walk away. Mr. Yarbrough said he contacted the Lansing Police Department and Ruth (last name unknown), charge nurse at Sparrow Hospital and made them aware of the situation. He said D. Yarbrough remained in Lansing for an hour, while the police attempted to locate Resident A, which was unsuccessful. Mr. Yarbrough said a day or so later he received a call from Max Baisel, Sparrow of Hospital informing him that Resident A was there and ready for discharge. Mr. Yarbrough said he expressed his concern that he didn't think it was safe for his staff to transport Resident A back to the home and the fact the Resident A had not had any medication since leaving the home. He said Mr. Baisel requested a list of Resident A's medications which he provided. Mr. Yarbrough said he immediately contacted Kristen Bungart, Resident A's guardian and discussed the situation with her and due to Resident A's behaviors, he issued an emergency discharge. Mr. Yarbrough stated Ms. Bungart agreed to seek placement for Resident A. Mr. Yarbrough said he provided a copy of the emergency discharge for Resident A to all involved parties with the exception of Adult Foster Care (AFC) licensing. Mr. Yarbrough agreed to provide me with a copy of Resident

A's AFC assessment plan. He said he has not received a copy of Resident A's individual plan of service.

I interviewed Cassandra Peterson, direct care staff regarding the allegation. Ms. Peterson said 5/30/2021 was a typical day and there were four residents in the home at the time. She said Resident A said he didn't want to be there, he was leaving and left out the door. She said she immediately notified Mr. Yarbrough. Ms. Peterson said to her knowledge Resident A is allowed to be in the community independently. Ms. Peterson said Resident A never returned to the facility.

On 06/21/2021, I contacted Kristen Bungart, Resident A's guardian with Guardian Care and interviewed her regarding the allegation. She confirmed Resident A left the home and never returned. She said he was located in Lansing, MI and admitted into Sparrow Hospital. She said it's uncertain how Resident A got to Lansing but apparently, he's familiar with the area. Ms. Bungart said Resident A went to a home that he claimed to own and from there he was transported to Sparrow Hospital where he remained from 6/2/2021 to 6/10/2021. She said Mr. Yarbrough did agree to go and get Resident A but when his staff arrived Resident A exhibited aggressive behaviors, was uncooperative and he got out of the van and started walking. Ms. Bungart said Mr. Yarbrough expressed concern regarding Resident A ever since he was admitted because Resident A was adamant that he didn't want to be there. She said Mr. Yarbrough gave her proper notice that he was discharging Resident A. I asked if Resident A is able to be in the community independently and she said not to her knowledge. However, Ms. Bungart said she does not have an individual plan of service or treatment plan for Resident A stating he cannot be in the community independently. She said Resident A's psychiatric services were initiated at Heigra but he does not have a case manager at this time. Ms. Bungart said placement has since been secured for Resident A.

On 06/23/2021, I received a copy of Resident A's AFC assessment plan, incident reports and emergency discharge. According to Resident A's assessment, "he uses a cane but knows his way around the bus system." The assessment plan addresses Resident A's mobility but doesn't address rather or not he can have independent access in the community.

On 07/08/2021, I received a follow-up call from Ms. Sabbath. Ms. Sabbath said she is still working on the case but at this juncture the allegations are unfounded. She said Mr. Yarbrough attempted to go and get Resident A from the hospital, but he refused to return to the facility. Ms. Sabbath made me aware that Resident A has since been placed at a different home and he eloped from that home as well.

On 07/23/2021, I contacted D. Yarbrough, direct care staff and interviewed him regarding the allegations. D. Yarbrough said he went to Lansing to pick up Resident A and he was very "frightened" by his behavior. D. Yarbrough went on to say that the nurse brought Resident A out and he got in the van. D. Yarbrough said as soon as they pulled off Resident A said, "I don't want to go back to the home." Mr. Yarbrough

said he tried to explain to Resident A that he was taking him back to the Detroit area. He said Resident A said has limited speech, but he clearly said; “I don’t want to go back to that house, and I’ll kick your ass and everybody’s ass in the house.” He said Resident A started banging his cane against the dashboard and acting irrational. D. Yarbrough said he pulled over because it wasn’t safe to keep driving while Resident A was swinging his cane. He said he tried to redirect Resident A but his attempts were unsuccessful. He said Resident A said, “let me out” and he opened the door and said, “Fuck you and everybody in that house.” D. Yarbrough said he immediately contacted Mr. Yarbrough and made him aware of the situation. He said Mr. Yarbrough contacted the local Lansing police with him on the three-way so that he could provide a description of Resident A and he also contacted Ruth, charge nurse at Sparrow Hospital to make her aware of what was going on. D. Yarbrough said he was instructed to remain in the area, which he did for approximately an hour while the police attempted to locate Resident A. He said after an hour he left and returned to the home. D. Yarbrough said Resident A seemed very agitated and he didn’t think it was a good idea to transport him back to Detroit with his mental state.

On 7/27/2021, I completed an onsite inspection and face-to-face exit conference with Mr. Yarbrough. Mr. Yarbrough said Resident A never returned to the facility and he provided me with a copy of Resident A’s placement packet. I proceeded to conduct an exit conference with Mr. Yarbrough. I explained that based on the investigative findings there is insufficient evidence that he failed to provide supervision, protection, and personal care as defined in the act and as specified in the Resident A's written assessment plan. I made him aware that due to the fact that he didn’t notify adult foster care licensing consultant not less than 24 hours before discharge, he will be cited which requires a corrective action plan. Mr. Yarbrough said he wasn’t aware who to send the emergency discharge notice too. I made him aware of his licensing consultant and told him the emergency discharge notice can be faxed to the same number that he sends the incident reports too. I provided him with number as well. Mr. Yarbrough agreed to submit the corrective action plan as recommended.

APPLICABLE RULE	
R 400.14303	**Staffing requirements.**
	(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:	During this investigation I interviewed Virgil Yarbrough, licensee designee; Cassandra Peterson, direct care staff; Dee Yarbrough, direct car staff; Kristen Bungart, Resident A’s guardian with Guardian Care Services and Sharon Sabbath, adult protective services regarding the allegations.

	I also reviewed Resident A's adult foster care assessment plan that was completed at the time of admission. Based on the assessment plan Resident A is capable of being in the community independently. Based on the investigative findings, I am unable to determine that licensee failed to provide supervision and protection as specified in the resident's written assessment plan.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: On 6/21/2021, during an interview with Mr. Yarbrough he stated he provided a copy of the emergency discharge notice for Resident A to all required persons with the exception of Adult Foster Care (AFC) licensing.

On 7/29/2021, I contacted Regina Buchannan, adult foster care licensing consultant and she stated she ultimately received an emergency discharge notice for Resident A on 6/30/2021, however the notification was dated 6/3/202.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.**

ANALYSIS:	Mr. Yarbrough failed to provide a copy of Resident A's emergency discharge notice to the adult foster care licensing consultant within the required time-frame.
CONCLUSION:	**VIOLATION ESTABLISHED**

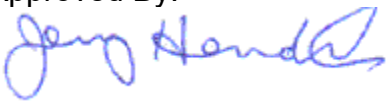
IV. RECOMMENDATION

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

08/10/2021

Denasha Walker — Date
Licensing Consultant

Approved By:



08/10/2021

Jerry Hendrick — Date
Area Manager