GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 12, 2021

Janet Patterson
Advocates for Self Determination, LLC
Suite 102
28237 Orchard Lake Rd.
Farmington Hills, MI 48334

RE: License #: AS630402110
Investigation #: 2021A0993031
St. Marys Home

Dear Ms. Patterson:

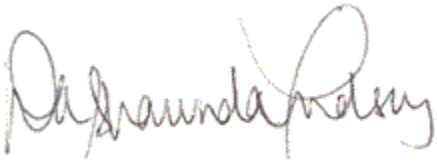
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630402110
Investigation #:	2021A0993031
Complaint Receipt Date:	08/02/2021
Investigation Initiation Date:	08/02/2021
Report Due Date:	10/01/2021
Licensee Name:	Advocates for Self Determination, LLC
Licensee Address:	Suite 102 28237 Orchard Lake Rd. Farmington Hills, MI 48334
Licensee Telephone #:	(248) 723-7152
Administrator:	Janet Patterson
Licensee Designee:	Janet Patterson
Name of Facility:	St. Marys Home
Facility Address:	24156 St. Marys Farmington, MI 48336
Facility Telephone #:	(248) 987-6169
Original Issuance Date:	04/21/2020
License Status:	1ST PROVISIONAL
Effective Date:	08/03/2021
Expiration Date:	02/02/2022
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
• Staff Corey Daniels Jones has been locking Resident H in his bedroom at night. • On 07/17/2021, Resident H was observed to have a bruise appearing to have been “whacked on the side of the head”. • Mr. Jones has been heard telling Resident A “don’t you cry”. • Staff Valentina Reeves kicked Resident C in his leg.	Yes

III. METHODOLOGY

08/02/2021	Special Investigation Intake 2021A0993031
08/02/2021	Referral - Recipient Rights Allegations received from recipient rights advocate Alanna Honkanen
08/02/2021	Special Investigation Initiated - Telephone Telephone call received from recipient rights advocate Alanna Honkanen
08/02/2021	APS Referral I forwarded the allegations to adult protective services (APS)
08/05/2021	Contact - Telephone call made Telephone call made to recipient rights advocate Alanna Honkanen
08/05/2021	Inspection Completed On-site Conducted an unannounced onsite investigation
08/05/2021	Contact - Document Received Received an email from recipient rights advocate Alanna Honkanen
08/17/2021	Contact - Document Received Received an email from recipient rights advocate Alanna Honkanen
08/26/2021	Contact - Telephone call made Telephone call made to staff Corey Daniel Jones. Left a message.

08/26/2021	Contact - Telephone call made Telephone call made to home manager Laporches Welch. Left a message.
08/26/2021	Contact - Telephone call made Telephone call made to staff Raven Rand. The number was not in service.
08/26/2021	Contact - Document Sent Emailed licensee designee Janet Patterson and Advocates for Self Determination, LLC clinical director Shannon Williams
08/26/2021	Contact - Document Sent Emailed recipient rights advocate Alanna Honkanen
08/26/2021	Contact - Telephone call made Telephone call made to staff Corey Daniel Jones
08/26/2021	Contact - Telephone call made Telephone call made to home manager Laporches Welch
08/26/2021	Contact - Telephone call made Telephone call made to staff Raven Rand. Left a message.
09/01/2021	Contact - Telephone call made Telephone call made to staff Raven Rand. Left a message.
09/01/2021	Contact - Telephone call made Telephone call made to Resident H's guardian (and mother). Left a message.
09/02/2021	Contact - Telephone call made Telephone call made to staff Raven Rand. Left a message.
09/02/2021	Contact - Telephone call received Telephone call received from Resident H's guardian (and mother)
09/07/2021	Contact - Telephone call made Telephone call made to staff Raven Rand. Left a message. Sent a text message.
09/09/2021	Inspection Completed On-site Conducted an unannounced onsite investigation
09/29/2021	Contact - Telephone call made Telephone call made to staff Raven Rand. Left a message.

09/30/2021	Exit Conference Attempted to conduct an exit conference with licensee designee Janet Patterson. Left a message.

ALLEGATION:

- Staff Corey Daniels Jones has been locking Resident H in his bedroom at night.
- On 07/17/2021, Resident H was observed to have a bruise appearing to have been "whacked on the side of the head".
- Mr. Jones has been heard telling Resident A "don't you cry".
- Staff Valentina Reeves kicked Resident C in his leg.

INVESTIGATION:

On 08/02/2021, I received the allegations from recipient rights advocate Alanna Honkanen.

On 08/02/2021, I forwarded the allegations to adult protective services (APS).

On 08/05/2021, I conducted a telephone interview with recipient rights advocate Alanna Honkanen. Ms. Honkanen stated she observed Resident H at workshop today. She did not observe any bruises on him.

On 08/05/2021, I conducted an unannounced onsite investigation. I interviewed staff Valentina Reeves. Ms. Reeves stated she stopped working in the facility in May 2021 and started back working in the facility on 07/16/2021. She stated she works 8am to 4pm Monday through Friday. Ms. Reeves stated she overheard staff Corey Daniels Jones tell home manager Laporches Welch that he locks Resident H in his bedroom; however, Ms. Reeves did not hear if Mr. Jones stated why he did it. Per Ms. Reeves, Ms. Welch stated she notified the main office of this. In addition, Ms. Welch appeared shock after Mr. Jones told her about locking Resident H in his bedroom. Ms. Reeves stated she did not know how often Mr. Jones locked Resident H in his bedroom. In addition, she has never observed him doing so. Ms. Reeves stated she did not work on 07/17/2021. She denied ever hearing Mr. Jones threatening to remove any of the residents' belonging due to crying or misbehaving. Ms. Reeves stated Resident H's guardian informed her she has heard Mr. Jones yelling at Resident C. Ms. Reeves denied kicking Resident C in his leg. Ms. Reeves stated Mr. Jones told staff Raven Rand that he was going to get her [Ms. Reeves] in trouble the Saturday prior to him terminating his employment.

During the onsite investigation, I attempted to interview Resident C with no success due to his limited cognitive abilities. I observed Resident C's leg. I observed a faint bruise on one of them. Ms. Reeves stated Resident C had surgery on his leg in February. Ms. Reeves also stated that Resident H was at workshop. Resident A was also not present in the facility. I was unable to interview/observe them.

On 08/17/2021, I received documentation from recipient rights advocate Alanna Honkanen. I reviewed Resident C's health care chronological (HCC). Per the HCC, Resident C was admitted to St. Joseph Mercy Hospital on 02/22/2021 due to cellulitis of left leg. He was discharged with wound care on 02/25/2021. I also reviewed Resident C's appointment record. He received wound care on 03/02/2021, 03/09/2021, and 03/19/2021. Resident C had a physical with Dr. Faiz Mansour on 05/19/2021. Dr. Mansour documented that the left ulcer had healed.

On 08/26/2021, I conducted a telephone interview with staff Corey Daniels Jones. Mr. Jones denied that he locked Resident H or any other resident in their bedroom. Mr. Jones stated there was a power outage in the facility sometime in July 2021. Resident A came downstairs with a laptop that had died. Resident A was about to cry. Mr. Jones stated he said to Resident A, "no. Don't start that. There is nothing I can do about it." Mr. Jones confirmed there was another time when he told Resident A if he did not come downstairs for breakfast, he could not use his laptop. Mr. Jones verified that removing Resident A's laptop privileges is not in his treatment plan. Mr. Jones denied ever removing Resident A's laptop. He stated when he threatened to take it away, Resident A ate breakfast or did whatever he was supposed to do. He stated Resident A "never called my bluff". Mr. Jones stated he learned about the bruise on or behind Resident H's ear when his mother informed him about it. Per Mr. Jones, the bruise looked like someone had popped him or whacked him. Although Mr. Jones stated he did not observe it happened, Ms. Reeves did it. Mr. Jones did not state how he knew Ms. Reeves caused the bruise. Mr. Jones also stated he observed Ms. Reeves kick Resident C in his leg. He stated he did not recall the day of the incident, but he was in the kitchen when it occurred. He stated Resident C was in the adjacent room sitting on the couch. Resident C stomped at Resident C, and Ms. Reeves kicked him in his leg. Mr. Jones stated he did not write an incident report (IR) about the incident because IRs come up missing. In addition, he stated Ms. Reeves was present in the facility so he knew it would have come up missing.

On 08/26/2021, I conducted a telephone interview with home manager Laporches Welch. Ms. Welch denied ever observing Mr. Jones lock any of the residents in their bedrooms. Per Ms. Welch, Ms. Rand heard from Ms. Reeves that Mr. Jones was locking Resident H in his bedroom. Ms. Welch stated she never kept Mr. Jones doing so. Ms. Welch stated she terminated her employment with the company on 07/06/2021. She did not have knowledge of Mr. Jones inappropriately talking to a resident, a bruise being on Resident H's ear or Ms. Reeves kicking Resident C in the leg.

On 09/02/2021, I conducted a telephone interview with Resident H's guardian (and mother). Resident H's guardian stated the recipient rights office investigated Mr. Jones locking Resident H in his bedroom; however, the office did not substantiate the allegations. Resident H's guardian stated she believes Mr. Jones used to lock Resident H in his bedroom because she found a garbage bag of urine in Resident H's bedroom. Per Resident H's guardian, Resident H did not have a reason to urinate in his bedroom if he was not locked in there. In addition, she stated staff Raven Rand was present in the bedroom with her when the bag was found. Resident H's guardian stated she heard Mr. Jones say to Resident C "don't you dare cry" in a mean voice. Resident H's guardian stated she did not know what occurred for him to say that to Resident C. The following day, she heard Mr. Jones tell Resident C if he did not come downstairs, he would take away his tablet for the rest of the day. Resident H's guardian stated she also observed a bruise near Resident H's ear. She did not know how he sustained the bruise as Resident H is not verbal. Resident H's guardian denied ever observing any staff hit or do anything to Resident H to cause him to bruise.

On 09/09/2021, I conducted an unannounced onsite investigation. Staff Tamara Stewart was present in the facility with Resident C and Resident H. Ms. Stewart did not have any knowledge of the allegations as she has only worked in the facility for three weeks. I was unable to interview Resident C and Resident H due to their limited cognitive abilities. I observed Resident C and H. I did not observe any bruises.

On 09/29/2021 as well as on 08/26/2021, 09/01/2021, 09/02/2021 and 09/07/2021, I attempted to interview staff Raven Rand with no success. Ms. Rand did not return any of my phone calls or text messages.

On 09/30/2021, I attempted to contact an exit conference with licensee designee Janet Patterson. I left a message.

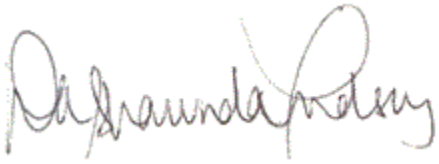
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Mr. Jones denied locking Resident H in his bedroom. Ms. Reeves denied kicking Resident C in his leg. I observed a faint bruise on Resident C's leg. However, I reviewed documentation that Resident C had cellulitis of his leg earlier this year. Dr. Mansour documented that the ulcer on Resident C's was healed in May 2021. It is plausible that the faint bruise was the healed

	ulcer. Ms. Honkanen and I both did not observe a bruise on or near Resident H's ear.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(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: **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.** **(f) Subject a resident to an of the following:** **(iv) Threats.** **(h) Isolation of a resident as defined in R 400.14102(1)(m).**
ANALYSIS:	Mr. Jones denied locking Resident H in his bedroom. Ms. Reeves denied kicking Resident C in his leg. I observed a faint bruise on Resident C's leg. However, Resident C had cellulitis of his leg earlier this year. Dr. Mansour documented that the ulcer on Resident C's was healed in May 2021. It is plausible that the faint bruise was the healed ulcer. Ms. Honkanen and I both did not observe a bruise on or near Resident H's ear. Mr. Jones confirmed there was time when he told Resident A if he did not come downstairs for breakfast, he could not use his laptop. Mr. Jones verified that removing Resident A's laptop privileges is not in his treatment plan. He stated when he threatened to take it away, Resident A ate breakfast or did whatever he was supposed to do.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

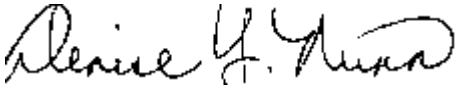
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the current license status.



10/04/2021

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



10/12/2021

Denise Y. Nunn — Date
Area Manager