GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 9, 2021

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

RE: License #: AS630337268
Investigation #: 2022A0611005
Rochester Home

Dear Ms. Patterson:

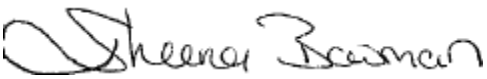
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630337268
Investigation #:	2022A0611005
Complaint Receipt Date:	11/29/2021
Investigation Initiation Date:	12/02/2021
Report Due Date:	01/28/2022
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:	Rochester Home
Facility Address:	4651 Rochester Road Troy, MI 48085
Facility Telephone #:	(248) 688-9032
Original Issuance Date:	12/11/2013
License Status:	REGULAR
Effective Date:	06/11/2020
Expiration Date:	06/10/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident S is being emotionally abused by staff and is not receiving treatment she needs. The same staff member is supervising Resident S every time she has these issues. Resident S is continuously getting degraded and gas lighted by the staff member at the group home that provides care for her. As a result of this ongoing behavior towards Resident S, she is homicidal and suicidal.	Yes

III. METHODOLOGY

11/29/2021	Special Investigation Intake 2022A0611005
12/02/2021	APS Referral The assigned Adult Protective Service worker (APS) is John Cavanaugh.
12/02/2021	Special Investigation Initiated - Telephone I left a voice message for APS worker, John Cavanaugh requesting a call back.
12/07/2021	Inspection Completed On-site On 12/07/21, I completed an unannounced onsite. I interviewed Resident S, Resident B, and staff member Joslyn Flewellen. I received a copy of Resident S incident report and medical records.
12/08/2021	Contact - Telephone call made I left a message for the reporting source requesting a call back.
12/08/2021	Contact - Telephone call made I made a telephone call to the home manager, Shawana Walker. The allegations were discussed.
12/08/2021	Contact - Document Sent I sent the Recipient Rights Specialist, Kathleen Garcia information regarding my interviews at the AFC group home. Ms. Garcia has not interviewed anyone as of yet.
12/08/2021	Contact - Telephone call received I received a telephone call from the APS worker, John Cavanaugh. Mr. Cavanaugh stated he is going to substantiate his investigation.

12/08/2021	Exit Conference I completed an exit conference with the licensee designee, Janet Patterson via email.

ALLEGATION:

Resident S is being emotionally abused by staff and is not receiving treatment she needs. The same staff member is supervising Resident S every time she has these issues. Resident S is continuously getting degraded and gas lighted by the staff member at the group home that provides care for her. As a result of this ongoing behavior towards Resident S, she is homicidal and suicidal.

INVESTIGATION:

On 11/29/21, this intake was re-assigned to me. I received and reviewed an incident report regarding the allegations on 10/21/21. I forwarded the incident report to licensing consultant, Kristen Donnay who is currently investigating a complaint regarding Resident S, SIR #2022A0991002.

On 12/07/21, I completed an unannounced onsite. I interviewed Resident S, Resident B, and staff member Joslyn Flewellen. I received a copy of Resident S incident report and medical records.

On 12/07/21, I interviewed Resident S. Regarding the allegations, Resident S has lived at the AFC group home since June 2021. Resident S stated she likes living at the AFC group home but, she has had issues with getting into arguments with staff members. Resident S stated none of the arguments with staff members have been severe. Resident S doesn't remember what she argued about with the staff members. Resident S stated she has not had an argument with a staff member in a while. Resident S stated she has argued with staff member, Joslyn Flewellen and Kya. Resident S does not know Kya's last name. Resident S stated Kya was fired for calling her a racial slur and calling her out of her name. Resident S stated this incident occurred before Thanksgiving and was the first time Kya used that type of language towards her.

Resident S stated she has not argued with Ms. Flewellen in about a month. Resident S stated she and Ms. Flewellen argue over dumb things. Resident S denied Ms. Flewellen calling her names, hitting her, or doing anything mean to her. Resident S went to the hospital for suicidal ideation because she felt like Ms. Flewellen was accusing her of drinking someone else's orange juice. Ms. Flewellen told her she was "F'ing lying". Resident S then started to have suicidal ideation and requested to go the hospital. Resident S stated that Ms. Flewellen will often use profanity towards her during arguments. Resident S stated sometimes she does not feel safe at the AFC group home because staff will yell and curse at her. Resident S stated Ms. Flewellen is the only staff member that will curse and yell at her.

On 12/07/21, I interviewed Resident B. Regarding the allegations, Resident B has lived at the AFC group home for about five years. Resident B stated she would like her own apartment. Resident B has never heard staff curse or say mean words towards residents. Resident B denied any staff members cursing at her but, staff has said mean things to her in November 2021. Resident B forgot what was said. Resident B did not want to identify which staff member said something mean to her because she does not want to be bothered or get into trouble. Resident B stated she does not know who she would get in trouble by. Resident B stated she feels safe at the AFC group home. Resident B stated Kya no longer works at the AFC group home. Resident B never saw Kya curse at anyone or be mean towards anyone.

On 12/07/21, I interviewed staff member Joslyn Flewellen. Regarding the allegations, Ms. Flewellen has worked at the AFC group home since June 2021. Ms. Flewellen denied getting into any arguments with residents. Ms. Flewellen stated Resident S will start issues with staff members so that she can go to the hospital. Ms. Flewellen denied using profanity towards residents or using profanity around residents. Ms. Flewellen does not know Kya's last name. Ms. Flewellen stated Kya was verbally abusive towards Resident S. Kya called Resident S a "White B****" and she was disrespectful towards her. Ms. Flewellen stated Resident S eloped after this incident happened. Ms. Flewellen stated this incident occurred once and Kya was fired the same day. Ms. Flewellen thinks Kya said these things to Resident S because Resident S had a bad attitude and provoked Kya.

On 12/07/21, I received a copy of an incident report dated 11/29/21. The incident report is regarding Resident S last hospital visit pertaining to homicidal ideation. I received a copy of Resident S's discharge records from Troy Beaumont. The discharge records are dated 11/28/21. The reason for the visit was Resident S being homicidal.

On 12/08/21, I made a telephone call to the home manager, Shawana Walker. Regarding the allegations, Ms. Walker stated Kya's last name is Campbell. Ms. Walker stated Ms. Campbell worked the midnight shift during the incident with Resident S. Ms. Walker was informed of the incident by Ms. Flewellen and she read the incident report completed by Ms. Flewellen. When Ms. Walker arrived to the AFC group home the following morning, she spoke to Ms. Campbell about the incident. Ms. Campbell told Ms. Walker that she and Resident S got into an argument and Resident S got upset and left the home. Ms. Campbell was fired based on what was written on the incident report and what Ms. Flewellen told Ms. Walker about the incident. Ms. Walker also spoke to Resident S. Resident S told Ms. Walker that Ms. Campbell called her dumb, fat, and a white girl. The incident happened on 10/19/21 and Ms. Campbell was fired on 10/20/21. Ms. Walker stated she is not aware of Ms. Flewellen using profanity towards the residents.

On 12/08/21, I received a telephone call from the APS worker, John Cavanaugh. Mr. Cavanagh stated he intends to substantiate his investigation. Mr. Cavanaugh stated Resident S is currently on the waiting list to go to an inpatient psychiatric facility.

On 12/08/21, I completed an exit conference with the licensee designee, Janet Patterson via email. Ms. Patterson was informed that the allegations will be substantiated and a corrective action plan will be required.

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: **(f) Subject a resident to any of the following:** **(ii) Verbal abuse.**
ANALYSIS:	Based on my findings and information gathered, Ms. Campbell used a racial slur and degrading language towards Resident S. The incident occurred on 10/19/21 and Ms. Campbell was terminated on 10/20/21. On 12/07/21, Resident S stated Ms. Flewellen will often use profanity towards her when they are arguing.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Sheena Bowman 12/08/21
Sheena Bowman Date
Licensing Consultant

Approved By:

Denise Y. Nunn 12/09/2021
Denise Y. Nunn Date
Area Manager