GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 17, 2022

Rebirth Community Inclusion Program, LLC
16951 Maryland
Southfield, MI 48075

RE: License #: AS820396286
Investigation #: 2022A0116018
Rebirth Community Inclusion Program

Dear Ms. Jefferson:

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) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820396286
Investigation #:	2022A0116018
Complaint Receipt Date:	02/24/2022
Investigation Initiation Date:	02/24/2022
Report Due Date:	04/25/2022
Licensee Name:	Rebirth Community Inclusion Program, LLC
Licensee Address:	16951 Maryland Southfield, MI 48075
Licensee Telephone #:	(313) 778-3194
Administrator:	Linda Jefferson
Licensee Designee	Linda Jefferson
Name of Facility:	Rebirth Community Inclusion Program
Facility Address:	811 Superior St Wyandotte, MI 48192
Facility Telephone #:	(734) 407-7390
Original Issuance Date:	07/22/2021
License **Status:**	REGULAR
Effective Date:	01/22/2022
Expiration Date:	01/21/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
The home is licensed for six and currently has nine residents.	Yes
Resident A was kicked out of the facility and was not allowed to return.	Yes
Two residents use the enclosed front porch as a bedroom.	No
The home is using space heaters.	Yes

III. METHODOLOGY

02/24/2022	Special Investigation Intake 2022A0116018
02/24/2022	Special Investigation Initiated - Telephone Interviewed assigned Adult Protective Services (APS) worker, Tammy Coleman.
02/25/2022	Inspection Completed-BCAL Sub. Compliance Interviewed Resident's B-G, visually observed Resident's H and I, interviewed staff, Kenneth Oden, Cynthia Wells and licensee designee, Linda Jefferson.
03/14/2022	Exit Conference With licensee designee Linda Jefferson.

ALLEGATION:

The home is licensed for six and currently has nine residents.

INVESTIGATION:

On 02/24/22, I interviewed assigned Adult Protective Services (APS) investigator, Tammy Coleman. Ms. Coleman reported that she had an opportunity to interview Resident A while he was in the hospital and reported that he informed her that the home is only supposed to have six residents, but nine to ten residents live there. Ms. Coleman reported that she has not been to the home.

On 02/25/22, I conducted an unscheduled onsite inspection and interviewed staff Kenneth Oden, Cynthia Wells, licensee designee, Linda Jefferson, Residents B-G and visually observed Residents H and I.

Mr. Oden reported that he has been working at the home for about a month and a half and stated that there are currently eight residents living in the home. Mr. Oden reported that before Resident A was taken to the hospital a few days ago, he was the ninth resident. Mr. Oden reported not being involved in admitting residents and was not aware of the licensed capacity. Mr. Oden contacted Ms. Wells and Ms. Jefferson via telephone, and they informed him that they were en route to the home.

I interviewed Resident B and she reported that she thinks there were eight residents before Resident A left and reported her belief that there are currently seven.

I interviewed Residents C-G and they reported that there are currently eight residents living in the home. They all reported that when Resident A lived there, he made nine. Resident E reported that the house is huge and there is plenty of space for everyone and reported no issues with overcrowding.

I visually observed Residents H and I as they could not be interviewed due to their cognitive impairments.

I interviewed Ms. Wells and Ms. Jefferson and they admitted that prior to Resident A leaving the home there were nine residents living in the home. I informed Ms. Jefferson of the rules and her responsibility to follow them, specifically pertaining to ensuring she always stays within her licensed capacity.

On 03/14/22, I conducted the exit conference with Ms. Jefferson and informed her of the findings of the investigation. Ms. Jefferson reported an understanding and stated that she has secured placement for Resident H and Resident G will be replaced on Friday 03/18/22.

APPLICABLE RULE	
R 400.14105	**Licensed capacity.**
	(1) The number of residents cared for in a home and the number of resident beds shall not be more than the capacity that is authorized by the license.

ANALYSIS:	Based on the findings of the investigation, which included interviews of Mr. Oden, Residents B-G, Ms. Wells and Ms. Jefferson, there is sufficient evidence to establish this violation. Mr. Oden reported that there were currently eight residents living in the home prior to Resident A leaving on or about 02/22/22. Resident B reported her belief that there were currently seven residents living in the home. Residents C-G all reported that prior to Resident A leaving there were nine residents living in the home. Ms. Wells and Ms. Jefferson admitted that there were nine residents living in the home, prior to Resident A's departure.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was kicked out of the facility and was not allowed to return.

INVESTIGATION:

On 02/24/22, I interviewed Ms. Coleman and she reported that she interviewed Resident A while he was hospitalized, and he informed her that Ms. Jefferson took him to the hospital on 02/22/22 and refused to allow him to return to the home. Ms. Coleman reported that Resident A reported that when Ms. Jefferson dropped him off at the hospital, she brought all of his belongings. Resident A reported Ms. Jefferson made it clear to him that he could not return to the home.

On 02/25/22, I conducted an unscheduled onsite inspection and interviewed Mr. Oden, Resident's B-G, Ms. Wells and Ms. Jefferson.

Mr. Oden reported that Resident A failed to follow house rules, was very disrespectful to staff and residents, and was struggling with opioid addiction. Mr. Oden reported Resident A would leave the home at a whim to try to get opiates and any other types of prescription medications. Mr. Oden reported that Ms. Jefferson tried to help Resident A, but he was too far gone. Mr. Oden reported that he was not at work on the day Resident A left or was taken to the hospital but reported he has not been back.

I interviewed Residents B-G and they all reported that Resident A was a troublemaker and caused chaos in the home. Resident D added that Resident A refused to follow rules, was smoking in the house, and was abusing drugs. Resident D reported he is glad he is gone. Residents B-G reported that Ms. Jefferson took Resident A to the hospital at his request and reported that they are glad that he has not and will not be returning to the home.

I interviewed Ms. Wells and she reported that Resident A was addicted to opiates and was only supposed to be in the home until 02/21/22. Ms. Wells reported that Resident A was admitted on or about 02/05/22 and had caused all types of trouble since his arrival. Ms. Wells reported that after continuing to violate the house rules and his erratic behavior Ms. Jefferson took him to the hospital and when he was ready to be discharged Ms. Jefferson informed the hospital that she could not allow him to return to the home.

I interviewed Ms. Jefferson and she reported that earlier in the day on 02/22/22 Resident A wanted to go to the hospital, so he called 911 and was taken to Wyandotte Hospital. Ms. Jefferson reported that he left against medical advice and walked back to the house. Ms. Jefferson reported that he started bothering the other residents and refusing to follow the rules, so she took him back to the hospital. Ms. Jefferson reported that the hospital social worker called her to see if she would allow him to return to the home. Ms. Jefferson reported that she informed the social worker that due to Resident A's behaviors she could not bring him back into the home.

I provided consultation to Ms. Jefferson as she is newly licensed. I informed her of the rule requirements as it relates to proper discharges and her responsibility to familiarize herself with the rules. Ms. Jefferson was receptive and reported that she would do so.

On 03/14/22, I conducted the exit conference with Ms. Jefferson and informed her of the findings of the investigation. Ms. Jefferson reported an understanding.

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.**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	Based on the findings of the investigation, which included interviews with Mr. Oden, Residents B-G, Ms. Wells and Ms. Jefferson, there is sufficient evidence to establish this violation. Mr. Oden, Residents B-G, Ms. Wells and Ms. Jefferson all reported that Resident A was disruptive, failed to follow rules and was abusing drugs. Residents B-G reported that Ms. Jefferson dropped Resident A off at the hospital and they are glad he is not returning to the home. Ms. Jefferson reported that because of Resident A's behaviors she refused to allow him to return to the home once he was medically ready for discharge. This violation is established as Ms. Jefferson failed to provide Resident A with a written 30 day notice before discharging him from the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Two residents use the enclosed front porch as a bedroom.

INVESTIGATION:

On 02/24/22, I interviewed Ms. Coleman and she reported that Resident A told her that he and Resident G slept on the front enclosed porch and reported that it was their bedroom.

On 02/25/22, I conducted an unscheduled onsite inspection and upon entering the home, I observed the enclosed front porch to be fully furnished with patio type furniture. There were no beds in sight, and it did not appear that the space could double as a bedroom.

I interviewed Mr. Oden, Residents B-G, Ms. Wells and Ms. Jefferson. They all denied the allegations and reported that no one ever sleeps in the enclosed porch.

Resident G reported that he and Resident A shared a bedroom on the second floor of the home and reported being unsure as to why Resident A would make up a lie about where they slept.

On 03/14/22, I conducted the exit conference with Ms. Jefferson and informed her of the findings of the investigation. Ms. Jefferson agreed with the findings.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(2) A living room, dining room, hallway, or other room that is not ordinarily used for sleeping or a room that contains a required means of egress shall not be used for sleeping purposes by anyone.

ANALYSIS:	Based on the findings of the investigation, which included consultant observation, interviews of Mr. Oden, Residents B-G, Ms. Wells and Ms. Jefferson, there is insufficient evidence to establish this violation. Mr. Oden, Residents B-G, Ms. Wells and Ms. Jefferson denied the allegation and reported that no one sleeps on the enclosed front porch. Resident G reported that he and Resident A shared a bedroom on the second floor of the home and denied ever sleeping in the enclosed porch.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The home is using space heaters.

INVESTIGATION:

On 02/24/22, I interviewed Ms. Coleman. Ms. Coleman reported that Resident A told her that some of the residents use space heaters for added warmth.

On 02/25/22, I conducted an unscheduled onsite inspection and upon entry into the home, I observed a space heater being used by Resident B.

I interviewed Mr. Oden and he reported that although the home is warm, some of the residents like to use the space heaters for additional warmth.

I interviewed Residents B-G and they reported that the home has operable heat but some of them like it warmer and they are allowed to use the space heaters.

I interviewed Ms. Jefferson and she reported that she was not aware that the home could not use space heaters and reported that she will remove them from the home immediately.

On 03/14/22, I conducted the exit conference with Ms. Jefferson and informed her of the findings of the investigation. Ms. Jefferson reported an understanding.

APPLICABLE RULE	
R 400.14510	**Heating equipment generally.**
	(5) Portable heating units shall not be permitted.
ANALYSIS:	Based on the findings of the investigation, which included consultant observation, interviews of Mr. Oden, Residents B-G and Ms. Jefferson, there is sufficient evidence to establish this violation. I observed space heaters being used during the onsite inspection on 02/25/22. Mr. Oden and Residents B-G admitted that some of the residents use the space heaters for additional warmth. Ms. Jefferson reported being unaware that space heaters were prohibited.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

03/17/22

Pandrea Robinson — Date
Licensing Consultant

Approved By:

03/17/22

Ardra Hunter — Date

Area Manager