GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 28, 2022

Kimberly Nichols
Joyner Home LLC
PO Box 04030
Detroit, MI 48204

RE: License #: AS820338755
Investigation #: 2022A0992028
Joyner Home I

Dear Ms. Nichols:

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,

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

I. IDENTIFYING INFORMATION

License #:	AS820338755
Investigation #:	2022A0992028
Complaint Receipt Date:	05/31/2022
Investigation Initiation Date:	06/02/2022
Report Due Date:	07/30/2022
Licensee Name:	Joyner Home LLC
Licensee Address:	PO Box 04030 Detroit, MI 48204
Licensee Telephone #:	(313) 570-6006
Administrator:	Kimberly Nichols
Licensee Designee:	Kimberly Nichols
Name of Facility:	Joyner Home I
Facility Address:	5522 Webb St Detroit, MI 48204
Facility Telephone #:	(313) 397-1104
Original Issuance Date:	06/07/2013
License Status:	REGULAR
Effective Date:	12/17/2021
Expiration Date:	12/16/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A continuously elopes from the home.	Yes

III. METHODOLOGY

05/31/2022	Special Investigation Intake 2022A0992028
06/02/2022	Special Investigation Initiated - On Site Lakeita Spear, home manager, ShaRon Coleman, direct care staff and Resident A and B.
06/15/2022	Contact - Telephone call made Kimberly Nichols, licensee designee
06/15/2022	Contact - Telephone call made Ms. Spears
07/06/2022	Contact - Telephone call made Ms. Nichols
07/13/2022	Contact - Document Received Incident report and staff schedule
07/27/2022	Contact - Telephone call made Marcella Harris, case manager with Faith Connections
07/27/2022	Contact - Telephone call made Kimberly Franklin, supports coordinator with Wayne Center
07/27/2022	Contact - Telephone call made Complainant
07/27/2022	APS Referral
07/27/2022	Referral - Recipient Rights
07/28/2022	Exit Conference Ms. Nichols

ALLEGATION: Resident A continuously elopes from the home.

INVESTIGATION: On 06/02/2022, I completed an unannounced onsite inspection and interviewed Lakeita Spear, home manager, ShaRon Coleman, direct care staff and Resident B; I observed Resident A sleeping. I proceeded to interview Ms. Spears regarding the allegations, in which she confirmed. She said this has been an ongoing issue with Resident A for the past twelve years. She said Resident A elopes from the home and goes to the local police station or Henry Ford Hospital. She said the officers at the local precinct give Resident A coloring books, buy her McDonald's and give all type of sweets which is why she continuously goes back, and she said she goes to the hospital to eat. Ms. Spears said it does not matter how much food she is given at the home; she elopes for attention and to eat. Ms. Spears said it has gotten to the point where the police will call the home and let staff know Resident A is in their care or they will bring her back to the home. She said Henry Ford staff will call and notify the staff as well. Ms. Spears said everyone knows Resident A. She said staff attempts to stop Resident A from eloping by verbally redirecting her, but it does not work. She said her behavior concerns have been addressed with Kimberly Franklin, support coordinator with Wayne Center and her psychologist. Ms. Spears said Resident A's medications have been adjusted multiple times in attempt to decrease her behaviors, but the medications are not effective. I asked if Resident A requires 1:1 staffing, and she said yes; Ms. Spears said her staff goes along with her. Ms. Spears said Resident A is very smart and she tends to elope when there are certain staff on shift. She said she does not typically elope when she is on shift because she is stern with her. However, she said Resident A can be physically aggressive towards people and property.

ShaRon Coleman, confirmed Resident A elopes form the home and goes to either the police station or Henry Ford Hospital. She said there have been times when the officer brings her back to the home and she refuse to get out the police car. She said Resident A likes the attention and treats the officers give her. She said the nurses at Henry Ford Hospital are familiar with Resident A and her behaviors. She said the nurse will call and say, "We have [Resident A] and we are not feeding her today." Ms. Coleman said Resident A receives ample food at the home, but she still elopes. She said she has attention seeking behaviors.

Resident B confirmed Resident A has left the home without staff permission on several occasions. She said staff have gone out the door behind her, but Resident A will run. Resident B said Resident A is verbally abusive towards staff and she is destructive, she has torn the blinds down off the window and thrown things.

Resident A was sleeping at the time of the inspection, I observed her asleep in her bed.

I obtained a copy of Resident A's individual plan of services (IPOS) and her behavior plan. Resident A's behavior plan states the following "As a result of the frequent exhibition of behaviors which place her and others at significant risk, she continues to receive 1:1 staffing from 7:15 a.m. to 9:15 p.m. on a daily basis." The IPOS states 18 hours of 1:1 staffing, but it does not specify a timeframe. The reports are conflicting.

On 06/15/2022, I made telephone contact with Kimberly Nichols, licensee designee regarding the allegations. Ms. Nichols confirmed, Resident A elopes continuously from the home. Ms. Nichols said this has been an ongoing issue and the behaviors have been addressed with Ms. Franklin, Resident A's psychologist and her guardian. Ms. Nichols said Resident A has 1:1 staffing, and her staff are in a bind because they cannot physically grab and/or restrain her; so, they follow her to a safe space. She said Resident A elopes and goes to either the local police station or the hospital. She said the police give her all type of sweets which seems to motivate her to keep going back. Ms. Nichols said Resident A is very smart, she will elope when her 1:1 goes to the bathroom. She said although her behaviors are very sporadic, they have been ongoing and there have been ongoing discussions, but nothing seems to be changing. She said now that there is an investigation regarding her behaviors, she is sure something will be done as it relates to Wayne Center services.

On 06/15/2022, I made follow-up contact with Ms. Spears for clarity. I explained that I am aware that Resident A requires 1:1 staffing but who was her assigned staff, the day the incident occurred. Ms. Spears said she was her assigned staff at the time. I requested a copy of the incident report and the staffing schedule, in which Ms. Spears agreed to provide.

On 07/06/2022, I made follow-up contact with Ms. Nichols regarding Resident A's behaviors. Ms. Nichols said she believes a medication review was held and a meeting with Resident A's psychiatrist. I also inquired about the incident report and staff schedule that was previously requested. Ms. Nichols agreed to follow-up with Ms. Spears.

On 07/13/2022, I received a copy of the incident report and the staff schedule. Based on the incident report completed by Ms. Spears. On the day in questions, "Resident A went into behavior mode out of nowhere, she got up off the couch and begin destroying the blinds, she threw chairs and tried to attack staff. Resident A eloped from the home with her 1:1 within arm's reach of her. Resident A ignored all of her 1:1 verbal prompt and continued to walk down the street to the police station, the officer transported her back to the home via their care and she refused to walk back with staff."

Based on the staff schedule, Ms. Spears was the only direct care staff on the day shift (7:15 a.m.- 3:15 p.m.) on 5/28/2022; Ms. Spears, Ms. Coleman and Tynita

Mitchell were on the afternoon shift (3:15 p.m. – 11:15 p.m.) and Ms. Coleman and Ms. Mitchell worked the night shift (11:15 p.m. – 7:15 a.m.).

On 07/27/2022, I made telephone contact with Marcella Harris, Resident A's case manager with Faith Connections; I interviewed her regarding the allegations. Ms. Harris denied having any concerns with the amount of supervision Resident A receives at the facility. She said the staff are very attentive and they make the necessary adjustments as it pertains to Resident A's behaviors. She further stated they notify her timely if there are any concerns with Resident A. As far as Resident A's elopement issues, she said that has been an ongoing problem. She said Resident A continuously elopes from the home and goes to the local 10th precinct. She said the officers feed her and give her all kind of goodies, which is why she keeps going back. Ms. Harris said she has addressed these issues with Resident A, but she said she elopes because she wants her sister to obtain guardianship. Ms. Harris said she has also addressed her behaviors and reasoning with her sister, who is not interested in obtaining guardianship at this time. Ms. Harris said Resident A is very attention seeking and when she does not get her way, she elopes. I explained to Ms. Harris that I understand Resident has a history of eloping, but the problem is that she requires 1:1 staffing between 7:15 a.m. to 9:15 p.m. daily and although she continues to elope, her 1:1 staffing should be with her during the specified times. Ms. Harris said her notes does not reflect 1:1 staffing. I referenced the IPOS I obtained on 6/02/2022. I made her aware that the IPOS effective date is 7/01/2022, so technically it has expired but at the time the incident occurred, the IPOS was valid. Ms. Harris said the staff are not with her when she elopes, because there have been times, she received calls from the hospital stating Resident A is there or when she elopes, the staff have called her. Ms. Harris also stated there have been times when Resident A elopes during sleep hours. However, she said she does not recall Resident A having 1:1 staffing. In fact, she said she visited Resident A on 7/16/2022 and at that time there was one staff on shift.

On 07/27/2022, I made telephone contact with Kimberly Franklin, supports coordinator with Wayne Center regarding the allegations and Resident A's IPOS. I asked Ms. Franklin if Resident A's annual IPOS was completed, and she said yes on 6/15/2022. I asked her if Resident A still requires 1:1 staffing, and she said yes. Ms. Franklin said in addition to Resident A's behaviors she was experiencing quite a few falls, so the current IPOS reflects 1:1 staffing as well. Ms. Franklin said Resident A requires 1:1 staffing for from 18-21 hours daily. I asked Ms. Franklin, if Ms. Nichols is aware of Resident A's 1:1 staffing needs and she said yes it has been discussed with her. Ms. Franklin provided me with a copy of the current IPOS.

On 07/27/2022, I made telephone contact with Complainant regarding the allegations. The Complainant said he is very familiar with Resident A; in fact, he said his colleagues are familiar with her as well. He said he is aware Resident A resides in an adult foster care (AFC) home. He said at one point she would show up at his job every other day. I asked if Resident A was accompanied by any staff from the AFC home and he said no. He said most times the staff would call to report her

missing and he would let them know her whereabouts. The Complainant said there were times when his staff would provide Resident A with snacks while she waits on her staff to pick her up but sometimes, she would become disruptive if they did not give her snacks. The Complainant said Resident A's presence and sometimes her behaviors started disturbing the business operations. I asked about the various times of day Resident A would arrive at this place of business and he said it varies. The Complainant said he works from 2:00 p.m.-11:00 p.m., and she would arrive around 4:00 p.m. However, he said his colleagues on the day shift have experienced the same issues with her. The Complainant further stated that he has not seen Resident A in the last month.

On 07/28/2022, I completed an exit conference with Ms. Nichols. I made her aware that based on the investigative findings, I determined there is sufficient evidence to support the allegations. I further explained that it was brought to my attention that Resident A has eloped on several occasions and her 1:1 staffing does not accompany her when she elopes from the home. Ms. Nichols expressed her frustration with Resident A's IPOS and behavior plan not being specific as it pertains to 1:1 staffing hours. She stated she has addressed this on numerous occasions with Wayne Center and although she is told it will be corrected, they have failed to do so. I made Ms. Nichols aware that the behavioral plan outlines 1:1 staffing from 7:15 a.m. to 9:15 p.m. daily. Ms. Nichols said the IPOS, and behavior plans are not thorough as it pertains to 1:1 staffing specifications. Ms. Nichols said she understands and will complete the corrective action plan as required; she is also going to follow-up with Wayne Center to make sure they do their job.

On 07/28/2022, I received an updated Behavior Plan from Ms. Nichols that was revised, 10/6/2021 which corresponds with the IPOS and states Resident A "continues to receive 1:1 staffing from 7:15 a.m. to 9:15 p.m. on a daily basis."

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(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.

ANALYSIS:	During this investigation I interviewed all involved parties, reviewed the incident report, staffing schedule, Resident A's IPOS, and behavior plan. The Complainant stated on more than one occasion Resident A arrived at his place of business alone. Also, Marcella Harris, Resident A's case manager with Faith Connections stated during her most recent visit with Resident A, there was one staff on shift. Based on the investigative findings, I have determined the licensee failed to provide sufficient direct care staff at all times for the supervision, protection of Resident A and to provide the services specified in her assessment plan. This allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/28/2022

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Denasha Walker Date
Licensing Consultant

Approved By:

07/28/2022

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Ardra Hunter Date
Area Manager