GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 11, 2022

Javon Brown
38855 Plumbrook Dr.
Farmington Hills, MI 48331

RE: License #: AS630404326
Investigation #: 2022A0612006
New Beginnings

Dear Ms. Brown:

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.

The issuance of a six-month provisional license was previously recommended in the renewal inspection report completed on 07/06/2022, which remains in effect.

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,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 302-2409

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 #:	AS630404326
Investigation #:	2022A0612006
Complaint Receipt Date:	07/06/2022
Investigation Initiation Date:	07/06/2022
Report Due Date:	09/04/2022
Licensee Name:	Javon Brown
Licensee Address:	32999 W. 14 Mile FARMINGTON HILLS, MI 48334
Licensee Telephone #:	(734) 658-0632
Administrator:	Yolanda Matthews
Name of Facility:	New Beginnings
Facility Address:	32999 W 14 Mile Rd. Farmington Hills, MI 48334
Facility Telephone #:	(248) 506-5891
Original Issuance Date:	01/13/2022
License Status:	TEMPORARY
Effective Date:	01/13/2022
Expiration Date:	07/12/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was admitted into the emergency room at Beaumont hospital on 7/01/2022, due to rib pain and generalized pain. Resident A stated he was punched in the side.	No
Resident A stated, "they don't feed me."	No
Resident A alleged sexual assault from staff.	No
Living conditions within the group home are not satisfactory.	No
Additional Findings	Yes

III. METHODOLOGY

07/06/2022	Special Investigation Intake 2022A0612006
07/06/2022	APS Referral I made a referral a report to Adult Protective Services (APS) via Centralized Intake
07/06/2022	Special Investigation Initiated - On Site I completed an onsite investigation. I interviewed licensee, Javon Brown and administrator, Yolanda Matthews
07/06/2022	Contact - Telephone call made I made a call to Resident A's guardian. There was no answer. I left a voicemail requesting a return call
07/06/2022	Contact - Telephone call made I conducted a telephone interview with Beaumont Social Worker, Kourtni Talley
07/07/2022	Contact - Telephone call received I conducted a telephone interview with Resident A's guardian
07/15/2022	Exit Conference Held via telephone with administrator, Yolanda Matthews
8/1/2022	Contact - Telephone call made I conducted telephone interviews with Resident B, Resident C, Resident D, and Resident E

08/01/22	Exit Conference I held a second exit conference via telephone with administrator, Yolanda Matthews

ALLEGATION:

- **Resident A was admitted into the emergency room at Beaumont Hospital on 7/01/2022, due to rib pain and generalized pain. Resident A said he was punched in the side.**
- **Resident A alleged sexual assault from staff.**

INVESTIGATION:

On 07/06/22, I received a complaint alleging Resident A was admitted into the emergency room at Beaumont Wayne Hospital on 7/01/2022, due to rib pain and generalized pain. Resident A stated he was punched in the side following an altercation. Resident A further stated, "they don't feed me" and living conditions at his group home are not satisfactory. During Resident A's psychiatric assessment at the hospital, he stated, "they made me suck his dick and he fucked me in the ass…."

I initiated my investigation on 07/06/22, by making a referral to Adult Protective Services (APS) Centralized Intake and conducting an onsite investigation. During the onsite investigation, I interviewed licensee, Javon Brown and administrator, Yolanda Matthews. Ms. Matthews and Ms. Brown consistently stated on an unknown date in May 2022, they received a phone call from a psychiatric hospital (hospital name unknown) inquiring if they had an opening at their home. The home had an opening and they agreed to accept Resident A. Ms. Matthews and Ms. Brown consistently stated on an unknown date in May 2022 between 1:00 pm-2:00 pm, Resident A was brought to New Beginnings via medical transport. Ms. Matthews and Ms. Brown both stated Resident A was irate and combative upon his arrival to the home. Resident A was "cussing everyone out." Ms. Matthews and Ms. Brown stated they were frightened by his behavior and called 911. Resident A was picked up from the home by the police and taken to the hospital (hospital name unknown.)

Ms. Matthews and Ms. Brown stated that Resident A was at the home less than one hour and he stayed in the vestibule for most of that time. While at the home, Resident A did not have any physical altercations with any New Beginnings staff or residents. It is possible that the police became physical with Resident A due to his aggressive behavior. When the police arrived at the home, Resident A was rolling in the ditch in the front yard. Ms. Matthews and Ms. Brown were contacted by Resident A's guardian and asked if he could return to the home following his discharge from the hospital. They informed Resident A's guardian that they would not accept him back to the home. Ms. Matthews and Ms. Brown denied physically and sexually assaulting Resident A and further denied knowledge of anyone assaulting Resident A while he was at New Beginnings.

On 07/06/22, I conducted a telephone interview with Kourtni Talley, Beaumont Social Worker. Ms. Talley stated Resident A came into the Beaumont Wayne emergency room (ER) on 07/01/22. He was brought in by a group home (group home name unknown.) While in the ER, Resident A said to a nurse that he was assaulted, and that he was having suicidal/homicidal thoughts Ms. Talley stated Resident A would not discuss these allegations further and was unable to provide any additional information. Ms. Talley stated Resident A has chronic and persistent mental illness. Resident A was recently discharged from a psychiatric hospitalization. Resident A is argumentative and combative. He is a poor source of information and a poor historian. Ms. Talley stated due to Resident A's current mental state, he would likely be unable to productively engage in the interview process and advised that his guardian be contacted for further information related to this investigation. Ms. Talley stated per Resident A's medical records, it can be determined that on June 5, 2022, he was in the ER at Henry Ford Allegiance Hospital in Jackson, Michigan. Then, on May 6, 2022, he was in the ER at Beaumont Farmington Hills hospital. Ms. Talley stated at this time she is looking for a psychiatric inpatient setting for Resident A.

Resident A was not interviewed for this investigation as he is currently hospitalized. Further, Beaumont Hospital Social Worker advised that due to Resident A's current mental state it is unlikely that he could engage in the interview process. As such, Resident A's guardian was interviewed on his behalf.

On 07/07/22, I conducted a telephone interview with Resident A's guardian. Resident A's guardian stated Resident A elopes from every group home where he has resided. Resident A's goal when eloping is to get to St. John Moross hospital. Resident A's guardian stated Resident A spends most of his time in the hospital. Resident A has a long history of mental illness, and he is a poor source of information as he combines details of past experiences. Resident A is verbally and physically aggressive towards others. He uses vulgar language to get a reaction from others. Resident A's guardian stated the guardian's office completes quarterly visits with Resident A and maintains regular communication with his home and mental health providers. Resident A's guardian has no concerns that Resident A was sexually and/or physically assaulted at the facility. Resident A has not mentioned any issues such as this to her and she believes Resident A can and would inform her if he was assaulted. Resident A's guardian stated Resident A went to New Beginnings upon discharge from the hospital. He was at the home for one day. The police were called, and he was picked up and taken to the hospital. Resident A's guardian provided the following timeline of Resident A's recent whereabouts:

- May 3, 2022, Resident A went to St. John Moross hospital
- May 5, 2022, Resident A was discharged from St. John Moross hospital and went to New Beginnings
- May 6, 2022, Resident A was taken from New Beginnings to Beaumont Farmington Hills hospital
- May 16, 2022, Resident A taken to Mclaren Macomb hospital
- June 2, 2022, Resident A was taken to New Beginnings from Mclaren Macomb hospital

- June 7, 2022, Resident A was sent from New Beginnings to Henry Ford West Bloomfield hospital
- June 19, 2022, Resident A was discharged to a home operated by Tracey Harris. He went back and forth to St. John Moross hospital almost every day
- June 29, 2022, Resident A was discharged from the hospital to Preferred Optimal Care, a home in Westland Michigan (address is 1123 Sharon St., Westland, MI 48186)
- July 1, 2022, Resident A eloped from the home in Westland and was taken to Beaumont Wayne hospital.

On 08/01/22, I completed a telephone interview with Resident B. Resident B was unable/unwilling to answer open ended questions. When asked about these allegations Resident B declined to answer. Resident B stated, “that’s enough.” Resident B explained that her “nerves were shot” and declined to continue the interview.

On 08/01/22, I completed a telephone interview with Resident C. Resident C stated he does not know Resident A and does not remember him living in the home. Resident C stated he has never witnessed any staff engage in a physical altercation with any resident. Resident C has no knowledge of a sexual assault involving a resident and a staff. Resident C stated he feels comfortable with staff and has no concerns with the care they provide.

On 08/01/22, I completed a telephone interview with Resident D. Resident D remarked, “I don’t know (Resident A), and I don’t have anything to say.” Resident D stated she has never seen any staff engage in a physical altercation with any resident. Resident D has no knowledge of any staff sexually assaulting any resident. Resident D stated she feels safe in the home with staff.

On 08/01/22, I completed a telephone interview with Resident E. Resident E stated on no occasion has he seen any staff engage in a physical altercation with a resident. Resident E stated he has no knowledge of a sexual assault involving a staff and a resident. Resident E stated he does not know Resident A. Resident E stated he has no concerns regarding the care he receives at his home.

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:	Based on the information gathered through my investigation, there is insufficient information to conclude Resident A was not treated with dignity and his personal needs, including protection and safety were not met. Prior to his most recent hospitalization

	at Beaumont Wayne where Resident A reported he was punched in the side and sexually assaulted by staff, Resident A was not residing at New Beginnings. Resident A was residing at a non-licensed setting in Westland, MI. It was consistently reported by the administrator, Yolanda Matthews, the licensee, Javon Brown, and Resident A's guardian that Resident A did not spend a significant amount of time at the New Beginnings home. During the time he was at the home, there were no reports of sexual and/or physical contact with others. Ms. Matthews and Ms. Brown denied the allegation. Resident A's guardian had no concerns that Resident A was abused and/or neglect in the home. Resident B, Resident C, Resident D, and Resident E consistently stated that they have never seen any staff engage in a physical altercation and/or sexually assault a resident. Resident B, Resident C, Resident D, and Resident E have no concerns with the care that is being provided by staff at the home.
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: (b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude any form of physical force was used against Resident A. During the past three months, Resident A has resided at three different facilities. He has had multiple trips to the emergency room and several hospitalizations. Prior to his most recent hospitalization at Beaumont Wayne where he reported he was punched in the side by staff, Resident A was residing at a non-licensed setting in Westland, MI and not residing at New Beginnings. Resident A. The administrator, Ms. Matthews and the licensee, Ms. Brown denied the allegation. Resident A's guardian had no concerns that Resident A was abused and/or neglect in the home. Resident B, Resident C, Resident D, and Resident E stated they had no knowledge of this allegation and stated that

	they have never witnessed any staff engage in a physical altercation with a resident.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A stated, "they don't feed me."

INVESTIGATION:

On 07/06/22, I interviewed administrator, Yolanda Matthews and licensee, Javon Brown. Ms. Matthews and Ms. Brown both stated on an unknown date in May 2022, Resident A came to New Beginnings upon discharge from the hospital (hospital name unknown.) Resident A was at the home for less than one hour and he stayed in the vestibule for most of that time. Ms. Matthews and Ms. Brown stated Resident A did not ask for food while he was at the home. Resident A did not sit down, go into a bedroom, use the restroom, or eat a meal, as he never fully came inside of the home and got settled. Resident A was aggressive and combative. The police were contacted, and Resident A was transported to the hospital shortly after his arrival to the home.

On 07/07/22, I conducted a telephone interview with Resident A's guardian. Resident A's guardian stated she has no concerns that Resident A was denied food. Resident A's guardian stated Resident A elopes. In the past, group homes have often used food as a bargaining tool to try and get Resident A to not elope from the home. Resident A's guardian stated, on May 5, 2022, upon discharge from St. John Morros hospital Resident A went to New Beginnings. He was at the home one day. On May 6, 2022, the police were called, and he was picked up and taken to Beaumont Farmington Hills hospital. The following month, on June 2, 2022, Resident A was discharged from Mclaren Macomb hospital and went back to New Beginnings. On June 7, 2022, Resident A went from New Beginnings to Henry Ford West Bloomfield hospital.

During the onsite inspection completed on 07/06/22, I observed the refrigerator and freezer at the home to have an adequate food supply. A weekly menu was posted that included options for breakfast, lunch, and dinner. The food in the refrigerator was consistent with the meals posted on the menu.

On 08/01/22, I completed a telephone interview with Resident B. Resident B was unable/unwilling to answer open ended questions. When asked if she gets enough to eat at her home Resident B said, "yes." Resident B declined to answer any additional questions. Resident B stated, "that's enough" and refused to continue the interview.

On 08/01/22, I completed a telephone interview with Resident C. Resident C stated he gets enough food at home. Some of the meals he enjoys eating are macaroni and cheese, pork chops, and hot dogs. Resident C stated he has access to food whenever he is hungry.

On 08/01/22, I completed a telephone interview with Resident D. Resident D stated her home has an adequate amount of food and she likes the meals that she is served.

On 08/01/22, I completed a telephone interview with Resident E. Resident E stated he gets three meals a day at his home. The food is good, and he enjoys it. Resident E stated he always gets enough food to eat.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that the licensee failed to provide a minimum of three regular nutritious meals daily. An adequate amount of food was observed in the home. The home had a menu posted that offered three meals daily. Resident B, Resident C, Resident D, and Resident E all stated they have access to food whenever they are hungry. They are satisfied with the meals that they are served and there is always an adequate amount of food in the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Living conditions within group home are not satisfactory.

INVESTIGATION:

On 07/07/22, I conducted a telephone interview with Resident A's guardian. Resident A's guardian stated she had no concerns regarding the living conditions of home.

During the onsite inspection completed on 07/06/22, I observed that the main living spaces in the home were clean and orderly. There were a few housekeeping items that require attention such as scratched paint on the walls, dust in the air vents, and a greasy film on the inside of the oven. These issues were cited in the renewal completed on 07/06/22. It is not suspected that these issues would impede Resident A's ability to live safely and/or comfortably in the home. Resident A does not have a bedroom as he is not currently residing at this facility. However, all resident bedrooms were observed to have beds, clean bedding, and appropriate bedroom furnishings. The kitchen had adequate appliances. The bathrooms were in working order.

On 08/01/22, I completed a telephone interview with Resident B. Resident B declined to answer questions related to this allegation.

On 08/01/22, I completed a telephone interview with Resident C. Resident C stated he has no concerns with the living conditions in the home. Resident C stated his bedroom is comfortable.

On 08/01/22, I completed a telephone interview with Resident D. Resident D stated she had no concerns with the living conditions at the home.

On 08/01/22, I completed a telephone interview with Resident E. Resident E stated he likes his house and has no complaints regarding the living conditions.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that the home is not maintained to provide adequately for the health, safety, and well-being of occupants. Resident A's guardian provided no concerns regarding the living conditions of home. During my onsite inspection, the home was observed to be properly maintained. Resident B, Resident C, Resident D, and Resident E provided no concerns with the living conditions of this home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite inspection completed on 07/06/22, there was no resident register on site and available for review. Thus, the dates in which Resident A was admitted and/or discharged from the home were unable to be determined. The licensee stated a resident register had not been completed since the original license was obtained for this facility on 01/13/2022.

APPLICABLE RULE	
R 400.14210	**Resident register.**
	A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident: (a) Date of admission. (b) Date of discharge. (c) Place and address to which the resident moved, if known.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude the licensee has not maintained a chronological register of residents who are admitted and/or discharged to the home, as it was not available during the onsite inspection on 07/06/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection completed on 07/06/22, the licensee did not have separate records for each resident that contained all the required information. The licensee was unable to produce a resident record or any documentation regarding Resident A.

On 07/15/22, I held an exit conference with administrator, Yolanda Matthews. I informed her of the violations found and that a copy of the special investigation report would be e-mailed upon approval. I informed her that I recommended the issuance of a 6-month provisional license based on the renewal inspection completed on 07/06/2022, which remains in effect. She was further informed that a corrective action plan would be required. Ms. Matthews stated she understood these requirements.

On 08/01/22, I held a second exit conference with Ms. Matthews and reviewed the violations. Ms. Matthews had no additional information to provide at this time.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: (a) Identifying information, including, at a minimum, all of the following: (i) Name.

	(ii) Social security number, date of birth, case number, and marital status. (iii) Former address. (iv) Name, address, and telephone number of the next of kin or the designated representative. (v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home. (vi) Name, address, and telephone number of the preferred physician and hospital. (vii) Medical insurance. (viii) Funeral provisions and preferences. (ix) Resident's religious preference information. (b) Date of admission. (c) Date of discharge and the place to which the resident was discharged. (d) Health care information, including all of the following: (i) Health care appraisals. (ii) Medication logs. (iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures. (iv) A record of physician contacts. (v) Instructions for emergency care and advanced medical directives. (e) Resident care agreement. (f) Assessment plan. (g) Weight record. (h) Incident reports and accident records. (i) Resident funds and valuables record and resident refund agreement. (j) Resident grievances and complaints.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the licensee failed to complete and maintain a resident record for Resident A and therefore was unable to provide any documentation as requested by the department during the onsite inspection completed on 07/06/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

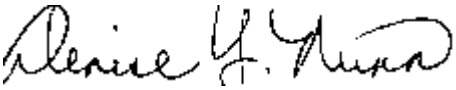
IV. RECOMMENDATION

A previous recommendation for a provisional license was made in the renewal inspection report dated 07/06/2022. Contingent upon the receipt of an acceptable corrective action plan, the recommendation for a provisional license remains in effect.

08/03/2022

Johnna Cade — Date
Licensing Consultant

Approved By:



08/11/2022

Denise Y. Nunn — Date
Area Manager