GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 31, 2022

Jean Nyambio
Detroit Family Home, INC.
Suite 202
17356 W. 12 Mile Road
Southfield, MI 48076

RE: License #: AS630384634
Investigation #: 2022A0465034
Detroit Family Home 2

Dear Mr. Nyambio:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Stephanie Gonzalez

Stephanie Gonzalez, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W Grand Blvd, Suite 9-100
Detroit, MI 48202
(248) 514-9391
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630384634
Investigation #:	2022A0465034
Complaint Receipt Date:	06/14/2022
Investigation Initiation Date:	06/15/2022
Report Due Date:	08/13/2022
Licensee Name:	Detroit Family Home, Inc.
Licensee Address:	Suite 202 - 17356 W. 12 Mile Road Southfield, MI 48076
Licensee Telephone #:	(313) 270-7751
Administrator:	Jean Nyambio
Licensee Designee:	Jean Nyambio
Name of Facility:	Detroit Family Home 2
Facility Address:	21778 Frazer Avenue Southfield, MI 48075
Facility Telephone #:	(313) 270-7751
Original Issuance Date:	11/07/2017
License Status:	1ST PROVISIONAL
Effective Date:	06/16/2022
Expiration Date:	12/15/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 6/8/2022, Resident A was improperly discharged from the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/14/2022	Special Investigation Intake 2022A0465034
06/14/2022	APS Referral Adult Protective Services (APS) referral, assigned to Taneisha Sims for investigation
06/15/2022	Special Investigation Initiated - Telephone AFC Licensing Consultant, Kristen Donnay, spoke to APS Worker, Taneisha Sims via telephone
06/15/2022	Contact - Telephone call made AFC Licensing Consultant, Kristen Donnay spoke to licensee designee, Jean Nyambio and home manager, Trushana Anderson, via telephone
06/15/2022	Contact - Telephone call made AFC Licensing Consultant, Kristen Donnay spoke to Macomb County Community Mental Health Case Manager, Latisha Winn, via telephone
06/15/2022	Contact – Document received Facility documents received via email from Mr. Nyambio
07/07/2022	Inspection Completed On-site Conducted an onsite inspection. No one was home.
07/20/2022	Inspection Completed On-site Conducted onsite inspection at the facility; No one was home.
07/26/2022	Contact -Telephone call made I left a voice message for Guardian A1

07/28/2022	Contact – Telephone call made I spoke to Macomb County CMH Case manager, Latisha Winn, via telephone
07/29/2022	Contact – Telephone call made I spoke to APS Worker, Taneisha Sims, via telephone
07/29/2022	Contact - Telephone call made I spoke to licensee designee/administrator, Jean Nyambio, via telephone
07/31/2022	Contact - Document Received Received additional facility documents from Mr. Nyambio
08/01/2022	Contact – Telephone call made I left a voice message for Guardian A1
08/02/2022	Contact – Telephone call received I spoke to Ms. Winn via telephone
08/03/2022	Contact – Telephone call made I left a voice message for Guardian A1
08/03/2022	Exit Conference Conducted an exit conference with Mr. Nyambio via telephone

ALLEGATION:

On 6/8/2022, Resident A was improperly discharged from the facility.

INVESTIGATION:

On 6/14/2022, a complaint was received, alleging that on 6/8/2022, Resident A was improperly discharged from the facility. The complaint indicated that Resident A is currently inpatient at the hospital but is medically cleared and ready for discharge. The complaint indicated that the facility has refused to allow Resident A to return to the facility.

On 6/15/2022, AFC Licensing Consultant, Kristen Donnay, interviewed APS Worker, Taneisha Sims, via telephone. Ms. Sims informed Ms. Donnay that she was in the process of gathering additional information as part of her investigation. On 7/29/2022, I interviewed Ms. Sims, via telephone. Ms. Sims stated that Resident A is currently still in the hospital, awaiting a new placement. Ms. Sims stated that the facility informed her that Resident A cannot return to their facility. Resident A has significant behaviors that limit placement options. Ms. Sims is unsure if she will substantiate for neglect and will

continue to keep her case open while she assists Resident A in finding a new placement.

On 6/15/2022, Ms. Donnay spoke to licensee designee, Jean Nyambio, and home manager, Trushana Anderson, via telephone.

Ms. Anderson stated that Resident A moved into the facility on 5/14/2022. Ms. Anderson stated that, on 6/8/2022, Resident A was displaying verbally and physically aggressive behavior toward staff and caused physical damage to the home. Resident A hit the window and cracked it, punched the walls, spit at staff and was screaming and hollering. Ms. Anderson stated that 911 was called and the police transported Resident A to the hospital for psychiatric evaluation. Resident A was subsequently discharged from the facility on 6/8/2022. Ms. Anderson stated that on 6/10/2022, she was informed by the hospital social worker that Resident A was ready for discharge. Ms. Anderson informed the hospital staff that they needed to call Resident A's legal guardian and case manager to discuss future placement options. The facility issued several discharge notices to Resident A prior to 6/8/2022 but did not provide a copy of the discharge notices to Ms. Donnay. At the time of Resident A's discharge from the facility on 6/8/2022, he was moved to another licensed adult foster care facility located in Wayne County, Michigan. The facility that Resident A moved to on 6/8/2022 is also a licensed home under the Detroit Family Home Inc. corporation.

Mr. Nyambio stated that Resident A has previously resided in other adult foster care facilities that he oversees. Mr. Nyambio stated that he had previously submitted discharge notices for Resident A in February 2022 and May 2022 from his previous placement, prior to Resident A moving to this facility. However, Mr. Nyambio was only able to provide a copy of one Discharge Notice, dated 4/8/2022, which indicated that he issued a 30-day discharge notice to Resident A due his verbally and physically aggressive behavior towards staff and other residents as well as destruction of property. However, no discharge notice was given from this facility. Mr. Nyambio stated that Resident A was admitted to the facility on 6/15/2022 and has done extensive damage to the home during the time that he resided at the facility. Mr. Nyambio was willing to accept Resident A back to the facility on a temporary basis while a long-term placement is located but he had not been informed by the hospital that Resident A was ready for discharge. Mr. Nyambio stated that Resident A would have to move to one of his other licensed homes instead of returning to the facility.

On 6/15/2022, Ms. Anderson sent Ms. Donnay Resident A's facility documents. The *Face Sheet* indicated that Resident A resided at the facility from 5/14/2022-6/8/2022 and has a legal guardian, Guardian A1. The *Health Care Appraisal* lists Resident A's medical diagnosis as intellectual disability and seizures. The *Assessment Plan for AFC Residents* indicates that Resident A requires supervision in the community, has a history of aggressive behavior, requires prompting for completion of personal care tasks

and does not require use of assistive devices. I reviewed the *30-Day Discharge Notice,* dated 4/8/2022, however, it was not completed for this facility. It was completed specific to another licensed home under the Detroit Family Home Inc. corporation. The discharge notice indicated that Resident A has caused destruction of property on multiple occasions as well as ongoing physical aggression towards staff and others.

On 7/7/2022 and 7/20/2022, I conducted onsite investigations at the facility. During both inspections, it appeared the home was vacant, and no one was home. On 7/29/2022, I spoke to licensee designee/administrator, Jean Nyambio, who informed me that the facility is currently vacant.

On 7/28/2022 and 8/2/2022, I spoke to Macomb County Community Mental Health Case Manager, Latisha Winn, via telephone. Ms. Winn stated the following, “Resident A was first authorized for placement with the Detroit Family Home Inc. corporation on 1/11/2022 and was displaying verbally and physically aggressive behavior at the first home he was placed in. On 5/9/2022, he was moved to this facility. Resident A continued to display verbal and aggressive behaviors. On 6/6/2022, Resident A was sent to the hospital by the facility for aggressive behavior and was discharged this same day back to the facility. On 6/8/2022, Resident A was again sent to the ER for physically aggressive behavior. Mr. Nyambio wanted to discharge Resident A from the facility but was told by AFC licensing that he could not leave Resident A at the hospital without placement. Mr. Nyambio told me that Resident A could not return to the facility due to a fear that his staff would quit if Resident A returned. Mr. Nyambio told me that he had to discharge Resident A from the facility but that he would move him to one of his other licensed adult foster care facilities. I do not remember receiving a written discharge notice. The change of placement was suggested by Mr. Nyambio. We did not have a contract with the other licensed home that Mr. Nyambio moved Resident A to, and we never were able to complete the authorization due to Resident A returning to the hospital less than 24 hours after being moved from this facility to the other home. We technically never completed the written approval for Resident A to move to another facility. Resident A is currently in the hospital while we try to find a new placement that will meet his needs. Mr. Nyambio tried to accommodate Resident A at various homes, and we were unaware of the paperwork required for each admission and discharge of Resident A to the facility.”

On 7/29/2022, I spoke to Mr. Nyambio via telephone. Mr. Nyambio stated that the facility is currently vacant. Mr. Nyambio stated that the facility is primarily a pre-placement home and currently has no residents. Mr. Nyambio stated, “Resident A is no longer residing at the facility. He only lived at the facility for two or three days and then moved to another one of my licensed adult foster care facilities.” Mr. Nyambio acknowledged that Resident A has been residing in the hospital since 6/9/2022, while a new placement is being located.

On 7/26/2022, 8/1/2022 and 8/3/2022, I left voice messages for Guardian A1 and have not received a return call as of the date of this report.

On 8/1/2022, I emailed Mr. Nyambio to request a copy of the *Discharge Notice* for Resident A. Mr. Nyambio responded and stated that he did not issue a discharge notice. Mr. Nyambio stated, "Resident A was never discharged from the home. After the destruction of the property, the home needed some repairs and the county, Ms. Winn and Guardian A1 agreed to place him in another facility."

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.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.**
ANALYSIS:	According to the CMH case manager Ms. Winn, she was informed by the facility on 6/8/2022 that Resident A could not return to the home. Ms. Winn did not receive a written discharge notice from the facility. On 6/10/2022, Ms. Anderson was informed by the hospital that Resident A was ready for discharge. Ms. Anderson and Mr. Nyambio did not allow Resident A to return to the facility. Mr. Nyambio did not issue a written discharge notice to Guardian A1 and Ms. Winn. Resident A has been medically ready for discharge from the hospital for more than 70 days as of this date, without a placement identified. Additionally, the facility did not follow

	proper discharge procedures to notify Guardian A1 and Ms. Winn of the discharge from the facility. Based on the information above, the facility did not properly discharge Resident A from the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

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.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.**
ANALYSIS:	According to Ms. Winn, Resident A has been residing at the hospital since 6/10/2022, due to the facility refusing to accept Resident A back into the home due to his verbal and aggressive behaviors. On 6/10/2022, Ms. Anderson was informed by the hospital that Resident A was ready for discharge. Ms. Anderson and Mr. Nyambio did not allow Resident A to return to the facility. Mr. Nyambio acknowledged that Resident A has been medically ready for discharge from the hospital for more than 54 days but he continues to remain at the hospital without a new placement identified.

	Although Mr. Nyambio stated that he discharged Resident A from the home on 6/8/2022 and is therefore not required to accept Resident A back, he did not follow proper discharge procedures that are required prior to the discharge of a resident. Therefore, Resident A should have been allowed to return to the facility on 6/10/2022. Based on the information above, the facility improperly discharged Resident A from the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

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.**
	(6) A licensee shall not change the residency of a resident from one home to another without the written approval of the resident or the resident's designated representative and responsible agency.
ANALYSIS:	On 6/8/2022, Mr. Nyambio changed Resident A's residency from this facility to another one of his licensed adult foster care facilities. According to Ms. Winn, on 6/8/2022, Mr. Nyambio suggested that Resident A's residency be changed to another one of his licensed adult foster care facilities. Due to not having a community mental health contract with this other facility, Ms. Winn began the contract approval and authorization process, which was required to be done prior to issuing a written approval for Resident A to move to the new facility. Ms. Winn initiated the approval process on 6/8/2022, but never completed the written approval for Resident A's residency to change due to Resident A being re-admitted to the hospital on 6/9/2022, where he currently remains. Mr. Nyambio did not obtain a written approval from Ms. Winn and Guardian A1 prior to changing Resident A's residency because Resident A's discharge from the facility was not initiated by him. Mr. Nyambio and Ms. Anderson initiated the discharge process and were unwilling to allow Resident A to return to the facility. Additionally, Mr. Nyambio is the person that suggested the change of residency and also moved Resident A

	to a different licensed adult foster care facility prior to obtaining written approval. Based on the information above, the facility failed to obtain written approval from Guardian A1 and Ms. Winn prior to changing Resident A's residency.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 7/31/2022, Mr. Nyambio sent Resident A's record to me via email. I reviewed the *Assessment Plan for AFC Residents* and *Resident Care Agreement* documents. Both documents did not contain signatures from Guardian A1 nor Ms. Winn. The documents were signed by Mr. Nyambio on 5/14/2022.

On 8/2/2022, I spoke to Ms. Winn via telephone. Ms. Winn stated that Resident A was admitted to the facility on 5/9/2022, and authorization for payments was effective on this same date. Ms. Winn stated that she was not aware that admission paperwork was required for Resident A when he moved into, and discharged from, the facility. Ms. Winn was not asked by Mr. Nyambio to complete nor sign an assessment plan or care agreement related to Resident A's placement at the facility.

On 8/1/2022, I communicated with Mr. Nyambio via email exchange. Mr. Nyambio confirmed via email that the assessment plan and care agreement were not signed by Guardian A1 nor Ms. Winn. Mr. Nyambio's email stated, "During the admission, Ms. Winn and Guardian A1 approved the stay and per the verbal agreement of Guardian A1, Guardian A1's name was put on the signature line." I obtained a copy of the assessment plan and care agreement and determined that both documents did not contain the signature of Guardian A1. The signature line on both documents did not contain signatures, but rather stated, "Arc Macomb (Guardian A1's first name only)."

On 8/3/2022, I conducted an exit conference with Mr. Nyambio. Mr. Nyambio stated, "Due to COVID, things changed. I began operating the home as a short-term placement facility. We have failed to follow the licensing rules. I agree we made a mistake. But I didn't know I was supposed to do all of these things. I did tell Guardian A1 and Ms. Winn that Resident A could not return to the facility, but I did not complete discharge paperwork. We should have waited for all of the required paperwork before I moved Resident A, but I thought communications were sufficient. I will do all the paperwork moving forward to cover myself. Mr. Nyambio stated that he that he is not in agreement with the recommendation of revocation.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on the information above, Mr. Nyambio did not complete the written assessment plan with the required signatures from Guardian A1 and Ms. Winn at the time of Resident A's admission to the facility on 5/9/2022.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED:** **Reference Licensing Study Renewal dated 5/23/2022; CAP dated 6/16/2022**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.** **(b) A description of services to be provided and the fee for the service.** **(c) A description of additional costs in addition to the basic fee that is charged.**

	(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost. **(e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission.** **(f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule.** **(g) An agreement by the resident to follow the house rules that are provided to him or her.** **(h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident.** **(i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures.** **(j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.14315.** **(k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met.** **(l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.**
ANALYSIS:	Based on the information above, Mr. Nyambio did not complete the resident care agreement with the required signatures from Guardian A1 and Ms. Winn at the time of Resident A's admission to the facility on 5/9/2022.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED:** **Reference Licensing Study Renewal dated 5/23/2022; CAP dated 6/16/2022**

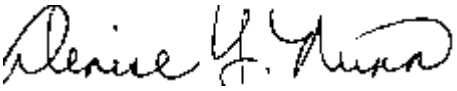
IV. RECOMMENDATION

I recommend revocation of the license.

8/19/2022

Stephanie Gonzalez — Date
Licensing Consultant

Approved By:



08/19/2022

Denise Y. Nunn — Date
Area Manager