GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 12, 2022

Elissa Jabboury
Novus Living, LLC
5555 Apple Ridge Trl
West Bloomfield, MI 48322

RE: License #: AS820401520
Investigation #: 2022A0119042
Novus Living 1

Dear Ms. Jabboury:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,

Shatonla Daniel, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-3003

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820401520
Investigation #:	2022A0119042
Complaint Receipt Date:	08/01/2022
Investigation Initiation Date:	08/01/2022
Report Due Date:	09/30/2022
Licensee Name:	Novus Living, LLC
Licensee Address:	5555 Apple Ridge Trl West Bloomfield, MI 48322
Licensee Telephone #:	(248) 789-0999
Administrator:	Elissa Jabboury
Licensee Designee:	Elissa Jabboury
Name of Facility:	Novus Living 1
Facility Address:	7860 Wayne Rd Romulus, MI 48174
Facility Telephone #:	(734) 331-6096
Original Issuance Date:	04/20/2020
License **Status:**	REGULAR
Effective Date:	04/20/2021
Expiration Date:	04/19/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A physically attacked Home Manager- Shamika Detvay for unknown reasons and Staff- Kayla Patterson responded by slapping Resident A in the face. Resident A was moved to unlicensed Novus II group home due to this incident.	Yes
Resident A had a swollen and black left eye, swollen left cheek, and swollen left side of her lip.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/01/2022	Special Investigation Intake 2022A0119042
08/01/2022	Special Investigation Initiated - Telephone Complainant
08/01/2022	Received pictures from complainant
08/01/2022	APS Referral Received
08/01/2022	Contact - Document Sent Office of Recipient Rights
08/12/2022	Inspection Completed On-site Staff- Shannon Hill and Vanessa Grier
08/12/2022	Inspection Completed On-site- Unlicensed Novus Licensee Designee/Administrator- Elissa Jabboury and attempted to interview Resident A
08/25/2022	Contact - Telephone call made Licensee Designee/ Administrator - Elissa Jabboury
08/30/2022	Contact - Telephone call made Home Manager- Shamika Detvay, Staff- Brenda Evans and Kayla Patterson
08/30/2022	Contact - Document Sent

	Email follow-up to Licensee Designee/ Administrator - Elissa Jabboury
09/01/2022	Contact - Document Received Email from Licensee Designee/ Administrator - Elissa Jabboury
09/07/2022	Contact - Telephone call made Staff- Darnell Jones
09/14/2022	Inspection Completed On-site Residents B- C, Licensee Designee/ Administrator- Elissa Jabboury
09/14/2022	Contact - Document Received Staff Training, Resident A's Individual Plan of Service
09/14/2022	Contact - Telephone call received ORR investigator- Carol Knight
09/16/2022	Contact - Telephone call received ORR investigator- Carol Knight
09/22/2022	Contact - Face to Face Resident A
09/22/2022	Contact - Telephone call made Resident A's mother
09/22/2022	Inspection Completed-BCAL Sub. Non-Compliance
09/28/2022	Contact- Documents Received Staff Schedule and Resident register
10/11/2022	Exit Conference Licensee Designee/ Administrator - Elissa Jabboury

ALLEGATIONS:

Resident A physically attacked Home Manager- Shamika Detvay for unknown reasons and Staff- Kayla Patterson responded by slapping Resident A in the face.

Resident A had a swollen and black left eye, swollen left cheek, and swollen left side of her lip.

INVESTIGATION:

On 08/01/2022, I telephoned the complainant and I received three pictures of Resident A's face. These pictures showed Resident A's face to be swollen, reddish, and blacken left eye lid with two swollen cheeks.

On 08/12/2022, I completed an onsite inspection and interviewed Staff- Shannon Hill and Volunteer Staff- Vanessa Grier regarding the above allegations. Ms. Hill stated she does not have any information about the incident. Ms. Hill stated she did observe Resident A with a swollen left eye. Ms. Hill stated Resident A has behaviors such as fighting and hitting staff along with crawling on the floor. Ms. Hill stated she thought Resident A's injuries were possibly self-inflicted but she was not sure.

Ms. Grier stated she was volunteering at the time of the incident. She stated she observed Ms. Detvay and Resident A on the floor with Resident A pulling Ms. Detvay braided hair. Ms. Grier stated Resident A was yelling, screaming, and acting out by tearing at the window blinds. Ms. Grier stated Resident A had pulled out five of Ms. Detvay's braids. Ms. Grier was asked the reason she did not assist Ms. Detvay and she responded that she was told that if the manager was handling a situation with a resident do not interfere with them. Ms. Grier stated Ms. Detvay had Resident A penned down to the floor, so she went to attend to another resident. Ms. Grier stated Ms. Detvay told Resident A that she was going to call the police if Resident A did not calm down. Ms. Grier stated Ms. Detvay's daughter- Kayla Patterson, which is a staff and Staff- Brenda Evans had taken other residents on an outing. Ms. Grier stated Ms. Patterson and Ms. Evans work at another facility but returned with Residents B- C from the outing and immediately assisted Ms. Detvay with Resident A. Ms. Grier denies seeing anyone hit Resident A. Ms. Grier stated she was instructed by Ms. Patterson and Ms. Evans to escort Residents B- C to their rooms.

On 08/12/2022, I attempted another onsite inspection at unlicensed Novus II but was greeted by Licensee Designee/Administrator- Elissa Jabboury outside of the home. Ms. Jabboury stated Resident A was out with her mother and she did not have a return time. Ms. Jabboury denied the allegations. Ms. Jabboury stated she was not there when the incident occurred, but Ms. Detvay kept her abreast of the situation via text and video messaging. Ms. Jabboury stated she was telephoned and observed Resident A's behaviors via iPhone facetime. Ms. Jabboury stated she observed Resident A holding Ms. Detvay's braids. Ms. Jabboury stated while on iPhone facetime, Ms. Patterson and Ms. Evans entered the facility. Ms. Jabboury stated she observed Ms. Grier take Residents B- C to the back (she assumed their bedrooms) because of the incident. Ms. Jabboury stated she instructed her staff to contact the police. Ms. Jabboury stated she did not witness any staff hitting Resident A. Ms. Jabboury stated she was informed that Ms. Patterson was assisting Ms. Detvay in getting Resident A's hands off Ms. Detvay's braids. At the time of this

interview, I requested Ms. Detvay's and Ms. Grier's training. I also requested Resident A's individual plan of service.

On 08/24/2022 and 08/25/2022, I emailed and attempted to leave a telephone message with Licensee Designee/ Administrator - Elissa Jabboury to again request staff training and Resident A's individual plan of service.

On 08/30/2022, I telephoned and interviewed Home Manager- Shamika Detvay, Staff-Brenda Evans, and Staff- Kayla Patterson regarding the above allegations. Ms. Detvay stated Ms. Grier informed her that Resident A was kicking her. Ms. Detvay stated she asked Resident A to stop kicking Ms. Grier and change her behavior. Ms. Detvay stated, "[Resident A] jumped up, grabbed my braids, and pulled me to the floor." Ms. Detvay stated, "I had waist length braided hair and I was faced down on the floor." Ms. Detvay stated I was unable to get her off of me. Ms. Detvay stated Ms. Evans and Ms. Patterson were returning with Residents B- C and they observed Resident A attacking me. Ms. Detvay stated Ms. Patterson grabbed Resident A hands and was able to get her hands to release my hair. Ms. Detvay stated Resident A pulled a lot of braids out of my hair and punched me. Ms. Detvay stated Resident A tried attacking Ms. Patterson. Ms. Detvay stated afterwards Resident A was hitting her head on the floor and the walls. Ms. Detvay stated Resident A eventually calmed down. Ms. Detvay stated Resident A had been acting out for four or five days. Ms. Detvay denies Ms. Patterson hitting Resident A. Ms. Detvay denies contacting the police and/or emergency personnel for assistance.

Ms. Patterson stated Ms. Evans and I were on our way back to the facility in order to drop off Residents B- C from an outing. Ms. Patterson stated she received a telephone call from Ms. Detvay that Resident A was pulling her hair and that she needed assistance. Ms. Patterson stated they were about five minutes away from the facility. Ms. Patterson stated she came into the facility and rushed Resident B into her room. Ms. Patterson stated she observed Resident A on top on her mother- Ms. Detvay and holding Ms. Detvay's hair. Ms. Patterson stated, "I told [Resident A] to let my momma (Ms. Detvay) go, twice." Ms. Patterson stated Resident A told her, "no." Ms. Patterson stated, "I grabbed her wrist in order for her to release Ms. Detvay's hair but [Resident A] would grab Ms. Detvay's hair." Ms. Patterson stated she was able to someway get between them, grabbed Resident A's wrist, and Resident A released Ms. Detvay's hair. Ms. Patterson stated Resident A was on the floor and immediately got up and broke the window blinds. Ms. Patterson stated Ms. Grier is a staff person and was attending to Resident C. Ms. Patterson denies hitting Resident A.

Ms. Evans stated Ms. Patterson and I were returning with Residents B- C. Ms. Evans stated, "Ms. Grier called Ms. Patterson's telephone and informed them that [Resident A] was tearing up the house and attacking her mother (Ms. Detvay)." Ms. Evans stated upon arrival she observed Resident A on the floor with her back against the couch with Ms. Detvay on her knees because Resident A was holding her braids with her hands. Ms. Evans stated Ms. Patterson squeezed between them

on her knees and grabbed Resident A's wrist in order for Resident A to release Ms. Detvay's hair. Ms. Evans stated Resident A snatched away from Ms. Patterson and her face hit the floor. Ms. Evans denies observing Ms. Patterson hit Resident A. Ms. Evans stated when she left the home Resident A was calm. Ms. Evans stated Ms. Grier was in the back bedrooms with Residents B- C. Ms. Evans stated she is the manager for Novus II.

On 09/07/2022, I telephoned and interviewed Staff- Darnell Jones regarding the above allegations. Mr. Jones stated he is the only staff working midnights. He stated upon his arrive to his shift, Resident A was no longer in the facility. Mr. Jones stated Resident B told him that staff took Resident A to Novus II. Mr. Jones stated Resident B told him that there was an incident where Ms. Patterson and Ms. Evans beat up Resident A. Mr. Jones stated he tried asking other staff about the incident but no one spoke to him about the reasons Resident A was relocated or the incident.

On 09/14/2022, I completed another onsite inspection and interviewed Residents B and Licensee Designee/ Administrator- Elissa Jabboury regarding the above allegations. Resident C refused to be interviewed and wanted to continue sleeping.

Resident B stated she observed Resident A holding onto Ms. Detvay's braids and Ms. Detvay trying to fight off Resident A. Resident B stated Ms. Patterson wanted to fight because Ms. Detvay is her mother. Resident B stated they came home and she observed Resident A out of control. Resident B stated Ms. Patterson pulled Resident A off the floor and hit her repeatedly in the face. Resident B stated, "I was in the living room and I saw it." Resident B stated, "I was so scared and I did not want to say anything until I knew Resident A was gone." Resident B stated she told Mr. Jones. Resident B stated Resident A left with Ms. Evans the night of the incident.

Ms. Jabboury stated the incident occurred on 07/23/2022 and Resident A left to go to Novus II on 07/25/2022 and stayed there until 08/28/2022. Ms. Jabboury stated Resident A's mother picked her up on 07/24/2022, the next morning and brought her to the other house on 07/25/2022.

On 09/14/2022 and 09/16/2022, I telephoned and spoke with Office of Recipient Rights investigator- Carol Knight regarding the above allegations. She reinterviewed Resident B and stated Resident B informed her that Ms. Patterson hit Resident A several times in the face. Ms. Knight stated she is substantiating her case.

On 09/22/2022, I completed a face-to-face interview with Resident A at her new address. Resident A stated Ms. Patterson hit me a lot of time in my face and left eye. Resident A stated no other staff hit me. Resident A refused to discuss the events leading up to being hit by Ms. Patterson.

On 09/22/2022, I telephoned and interviewed Resident A's mother regarding the above allegations. Resident A's mother stated she has had problems with this

facility since her daughter was placed there in July 2022. Resident A's mother stated her daughter's behaviors were escalating and she has been to the emergency room five times. She stated she was notified on 07/23/2022 that her daughter assaulted Ms. Detvay by pulling out her braids. She stated she informed staff that she was out of town but will be there on Sunday, 07/24/2022 to pick up her daughter. Resident A's mother stated her daughter was not sent to the emergency room. Resident A's mother stated when she picked up Resident A, she observed Resident A's left eye to be swollen shut with a bloody lid and both cheeks were swollen. Resident A's mother stated her daughter told her Ms. Patterson slapped her. Resident A's mother stated she was told by staff that Resident A was self-injurious. Resident A's mother stated she was told that Resident A hit her head on a glass coffee table. Resident A's mother stated Resident A has never been self-injurious. Resident A's mother stated there was a conference held about finding emergency placement for Resident A as she did not feel Resident A was safe at Novus I. Resident A's mother stated she was made aware that there were no emergency placements available for Resident A, so Novus II was suggested by Ms. Jabboury. Resident A's mother stated she had no knowledge that Ms. Patterson worked at Novus II prior to agreeing to move Resident A. Resident A's mother stated she was very upset to learn that Ms. Patterson worked at Novus II and in fact greeted Resident A upon arrival there. Resident A's mother stated she informed Ms. Jabboury of Resident A stating Ms. Patterson slapped her. Resident A's mother stated she did not have any place to put Resident A at the time and was afraid for Resident A's safe.

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:	Home Manager- Shamika Detvay stated Ms. Patterson grabbed Resident A by the hands in order for Resident A to release Ms. Detvay' s hair. Staff- Brenda Evans and Staff- Kayla Patterson stated Ms. Patterson grabbed Resident A by the wrist in order for Resident A to release Ms. Detvay' s hair. Staff- Darnell Jones stated Resident B told him that there was an incident where Ms. Patterson and Ms. Evans beat up Resident A. Resident B stated they came home and she observed Ms. Patterson pulled Resident A off the floor and hit her repeatedly in the face. Office of Recipient Rights investigator- Carol Knight reinterviewed Resident B and stated Resident B informed her Ms. Patterson hit Resident A several times in the face. Resident A stated Ms. Patterson hit me a lot of time in my face and left eye. Based on the above information, there is sufficient evidence that Ms. Patterson used a form of physical force with Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Licensee Designee/ Administrator- Elissa Jabboury stated the incident occurred on 07/23/2022. Ms. Jabboury stated Resident A's mother picked her up on 07/24/2022, the next morning and brought her to the other house on 07/25/2022. Ms. Jabboury stated Resident A left to go to Novus II on 07/25/2022 and stayed there until 08/28/2022. Staff- Darnell Jones stated Resident B told him that staff took Resident A to Novus II. Mr. Jones stated Resident A was not in the facility upon arrival to his shift. Resident B stated Resident A left with Ms. Evans that night. Resident A's mother stated she had no knowledge that Ms. Patterson worked at Novus II. Resident A's mother stated she informed Ms. Jabboury of her daughter stating Ms. Patterson slapped her. Resident A's mother stated she did not have any place to put Resident A at the time and was afraid for Resident A's safety. Resident A was not treated with dignity and her personal needs, including protection and safety, attended to at all times in accordance with the provisions of the act by being placed in the facility where Ms. Patterson continues to work.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	I received three pictures of the Resident A's face from the complainant. These pictures showed Resident A's face to be swollen, reddish, and blacken left eye lid with two swollen cheeks. Staff- Shannon Hill stated she did observe Resident A with a swollen left eye. Ms. Hill stated she thought Resident A's injuries were possibly self-inflicted, but she was not sure. Resident A's mother observed her daughter's left eye swollen shut with a bloody lid and both cheeks were swollen. Therefore, the licensee failed to obtain medical care for Resident A after a sudden adverse change in physical condition.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 08/12/2022, I completed an onsite inspection and interviewed Volunteer Staff- Vanessa Grier regarding the above allegations. Ms. Grier stated she was volunteering at the time of the incident.

On 08/30/2022, I telephoned and interviewed Home Manager- Shamika Detvay and Staff-Brenda Evans regarding the above allegations. Ms. Detvay stated that Ms. Grier is a volunteer and started a few months ago.

Ms. Evans stated Ms. Grier is a volunteer.

On 09/14/2022, I interviewed Licensee Designee/ Administrator- Elissa Jabboury. Ms. Jabboury stated that she misspoke regarding Ms. Grier and that she works as a volunteer. Ms. Jabboury stated that Ms. Grier does not have a file available for review. Ms. Jabboury stated Ms. Grier is not fully trained but she is a part of the staffing ratio.

On 09/14/2022, I reviewed Resident A-C's Individual Plan of Service (IPOS). Ms. Jabboury stated Resident B requires 1:1 staffing for 24 hours. Resident B's IPOS reviewed stated 2:1 staffing required. Resident C's IPOS reviewed stated 1:1 staffing is required for 24 hours. I reviewed staff schedules, and it shows Ms. Grier working covering shifts as a part of the staffing ratio on July 1, 2, 9, 10, 16, 17, 23, and 24, 2022. In addition, the staff schedules show only two individuals working on each shift.

On 09/14/2022, I reviewed the resident register. The resident register list four residents residing in the facility at the time of the incident.

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(1) A licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household shall be in such physical and mental health so as not to negatively affect either the health of the resident or the quality of his or her care.
ANALYSIS:	Volunteer Staff- Vanessa Grier was volunteering at the time of the incident and Ms. Jabboury does not have a file available for review for Ms. Grier with documentation that demonstrates she meets the requirements of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(7) A licensee shall obtain certification from a volunteer that the volunteer is free from communicable disease and that the volunteers physical and mental health will not negatively affect either the health of the resident or the quality of the resident's care.
ANALYSIS:	Volunteer Staff- Vanessa Grier was volunteering at the time of the incident and Ms. Jabboury does not have a file available for review for Ms. Grier with documentation that demonstrates she meets the requirements of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(3) Any individual, including a volunteer, shall not be considered in determining the ratio of direct care staff to residents unless the individual meets the qualifications of a direct care staff member.
ANALYSIS:	Ms. Jabboury stated Ms. Grier has not completed direct care staff training but she is a part of the staffing ratio. Therefore, Ms. Grier doesn't meet the qualifications of a direct care staff member and should not be a part of the staffing ratio.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Resident B and C's reviewed Individual Plan of Service (IPOS) indicate increased staffing is required. Resident B's IPOS reviewed stated 2:1 staffing is required for 24 hours. Resident C's IPOS reviewed stated 1:1 staffing is required for 24 hours. I reviewed staff schedules and it shows only two individuals working on each shift. The resident register list four residents residing in the facility at the time of the incident. Therefore, there is insufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents
CONCLUSION	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 08/12/2022, I completed an onsite inspection and interviewed Volunteer Staff- Vanessa Grier regarding the above allegations. Ms. Grier stated she did not know to contact the police and had not received any training on assisting with problematic residents.

On 08/12/2022, I spoke with Licensee Designee/Administrator- Elissa Jabboury regarding the reasons staff did not contact police for assistance. Ms. Jabboury stated Resident A was having a rough day but was very destructive and abusive towards Ms. Detvay. Ms. Jabboury stated Ms. Detvay oftentimes tries to deescalate residents before contacting the police. Ms. Jabboury showed me small video clips from Ms. Detvay of Resident A throwing papers, ripping window blinds, yelling, and screaming. Ms. Jabboury stated she instructed her staff to contact the police. Ms. Jabboury stated the police was not called despite her request.

On 08/30/2022, I telephoned and interviewed Home Manager- Shamika Detvay, Staff-Brenda Evans, and Staff- Kayla Patterson regarding the above allegations. Ms. Detvay stated Resident A had been acting out for four or five days. Ms. Detvay denies contacting the police and/or emergency personnel for assistance.

Ms. Patterson stated she is not fully trained and is presently taking classes for direct care worker. Ms. Patterson stated she has no direct knowledge of the how to handle challenging behaviors or to handle emergency situations.

Ms. Evans stated Ms. Grier called Ms. Patterson's telephone and informed them that Resident A was tearing up the house and attacking Ms. Detvay. Ms. Evans stated we were telling her to calm down because Resident A was visibly upset because she was crying and refused to take her medications to assist in calming her down.

On 09/14/2022, I interviewed Licensee Designee/ Administrator- Elissa Jabboury and I reviewed staff training for Ms. Detvay, Ms. Patterson, and Ms. Evans. It should be noted Ms. Patterson is not fully trained as a direct care staff with only having the following trainings from Community Living Services: Introduction- completed on 08/22/2022, CPR/ First Aid- completed on 08/25/2022, and Nutrition and Food Service- completed on 09/06/2022. In addition, Ms. Detvay and Ms. Evans received their training from Community Living Services for the following: Virtual Working with People I – completed on 09/07/2022 and Virtual Working with People II- completed on 09/08/2022.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications:

	(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident. (b) Be capable of appropriately handling emergency situations.
ANALYSIS:	Licensee Designee/Administrator- Elissa Jabboury stated Resident A was having a rough day but was very destructive and abusive towards Ms. Detvay. Ms. Jabboury stated Ms. Detvay oftentimes tries to deescalate residents before contacting the police. Ms. Jabboury showed me small video clips from Ms. Detvay of Resident A throwing papers, ripping window blinds, yelling, and screaming. Staff- Vanessa Grier stated she did not know to contact the police and had not receive any training on assisting with problematic residents. Home Manager- Shamika Detvay stated Resident A had been acting out for four or five days. Ms. Detvay denies contacting the police and/or emergency personnel for assistance. Staff- Kayla Patterson stated she has no direct knowledge of the how to handle challenging behaviors or to handle emergency situations. Staff-Brenda Evans stated we were telling her to calm down because Resident A was visibly upset because she was crying and refused to take her medications to assist in calming her down. Based on Resident A's violent behaviors and her inability to be calmed, direct care staff failed to appropriately handle this emergency situation. Staff failed to seek assistance from emergency response personnel such as law enforcement or emergency medical personnel.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing

	assigned tasks, which shall include being competent in all of the following areas: (a) Reporting requirements. (b) First aid. (c) Cardiopulmonary resuscitation. (d) Personal care, supervision, and protection. (e) Resident rights. (f) Safety and fire prevention. (g) Prevention and containment of communicable diseases.
ANALYSIS:	Home Manager- Shamika Detvay and Staff-Brenda Evans were not training until 09/08/2022 despite being assigned direct care worker tasks. Staff- Kayla Patterson has not received her training as of 09/14/2022. Per staff schedules, Ms. Detvay worked at least four days a week in July and August 2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (c) Incidents that involve any of the following: (i) Displays of serious hostility. (ii) Hospitalization. (iii) Attempts at self-inflicted harm or harm to others. (iv) Instances of destruction to property.

ANALYSIS:	Licensee Designee/Administrator- Elissa Jabboury stated Resident A was having a rough day but was very destructive and abusive towards Ms. Detvay. Ms. Jabboury showed me small video clips from Ms. Detvay of Resident A throwing papers, ripping window blinds, yelling, and screaming. Home Manager- Shamika Detvay stated Resident A had been acting out for four or five days. Staff-Brenda stated Ms. Grier called Ms. Patterson's telephone and informed them that Resident A was tearing up the house and attacking Ms. Detvay. Ms. Evans stated we were telling her to calm down because Resident A was visibly upset because she was crying and refused to take her medications to assist in calming her down. Based on Resident A's destructive behaviors, the licensee failed to complete an incident report.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/11/2022, I completed an exit conference with Ms. Jabboury regarding the allegations. Ms. Jabboury stated she did not have anything to add this this report.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend a provisional license.

Shatonla Daniel 10/11/2022

Shatonla Daniel Date
Licensing Consultant

Approved By:

A. Hunter 10/12/2022

Ardra Hunter Date
Area Manager