GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 30, 2023

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

RE: License #: AS820290866
Investigation #: 2023A0101010
Joyner Home II

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 was required. On 01/30/2023, you submitted an acceptable written corrective action plan.

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,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820290866
Investigation #:	2023A0101010
Complaint Receipt Date:	01/20/2023
Investigation Initiation Date:	01/20/2023
Report Due Date:	03/21/2023
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, Designee
Name of Facility:	Joyner Home II
Facility Address:	7429 East Robinwood Street Detroit, MI 48234
Facility Telephone #:	(313) 891-6897
Original Issuance Date:	11/06/2007
License **Status:**	REGULAR
Effective Date:	06/02/2022
Expiration Date:	06/01/2024
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff Ke'Yonna Moore hit Resident A in the face.	Yes

III. METHODOLOGY

01/20/2023	Special Investigation Intake 2023A0101010
01/20/2023	Complaint received from Adult Protective Services
01/20/2023	Special Investigation Initiated - Telephone Kimberly Nichols.
01/20/2023	Contact - Document Received
01/22/2023	Referral made Office of Recipient Rights (ORR)
01/24/2023	Inspection Completed Onsite
01/24/2023	Exit Conference with Ms. Joyner
01/25/2023	Contact Telephone call made Guardian Faith Connection Faith Connection is not the guardian
01/25/2023	Contact Telephone call made Ebony Bowers, caseworker Wayne Center Left message
01/26/2023	Contact Telephone call made Ms. Joyner provided the correct guardian
01/26/2023	Contact Telephone call made Resident A's guardian.
01/27/2023	Corrective Action Plan Requested and Due on 01/30/2023
01/30/2023	Corrective Action Received
01/30/2023	Corrective Action Plan Approved.

ALLEGATION: Direct care staff Ke'Yonna Moore hit Resident A in the face.

INVESTIGATION: On 01/20/2023, I spoke with the licensee designee, Kimberly Nichols. Ms. Nichols stated the allegation is true. Ms. Nichols stated she conducted an internal investigation and Ms. Moore admitted she hit Resident A.

On 01/20/2023, Ms. Nichols forwarded me the incident reports regarding Ms. Moore hitting Resident A in the face. The incident reports state on 12/22/2022, the licensee designee, Kimberly Nichols reported to the Adult Foster Care (AFC) Licensing Unit, Adult Protective Services, the guardian Faith Connection, the responsible agency Neighborhood Services Organization's (NSO) caseworker and the Office of Recipient Rights (ORR) that on 12/22/2022, direct care staff (DCS) Ke'Yonna Moore hit Resident A in the face. The persons completing these reports were DCS (s) Ke'Yonna Moore, the perpetrator, and Lakemia Jones, witness. The incident reports are consistent.

According to the incident reports, at or about 8:00 P.M. on 12/22/2022, Ms. Jones was having a conversation with Resident A. Ke'Yonna Moore interrupted the conversation. Resident A and Ms. Moore engaged in a verbal confrontation. Resident A told Ms. Moore, "You should mind your own dam business." Then the verbal confrontation became physical. Resident A threw a cup of water, also described as a drink, in Ms. Moore's face and Ms. Moore hit Resident A in the face. Ms. Jones was able to re-direct Resident A. Ms. Moore asked Resident A to go to her bedroom. Ms. Jones also asked Ms. Moore to leave the home and she complied.

Resident A's face was bruised. Ms. Jones called 911 and Resident A was transported to St. John's Hospital for evaluation.

On 01/20/2023, Ms. Nichols emailed me Ms. Moore's termination letter. According to the letter of termination, Ms. Moore's termination date was 12/22/2022.

On 01/22/2023, I reviewed the information contained in Ms. Moore employee record. Ms. Nichols was in compliance with the required hiring practices and Ms. Moore was trained.

On 01/24/2023, I interviewed Resident A. Initially Resident A was not friendly and refused to speak with me. After assuring her I would only ask her a few questions she agreed to be interviewed. I asked Resident A if Ms. Moore hit her, she replied, "I threw a cup of water in her face then she punched me in the face." Then Resident A walked away.

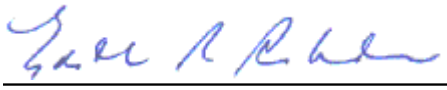
I spoke with Resident A's guardian on 01/26/2023. Resident A's guardian is aware that staff punched her in the face. In fact, she was on the phone with staff when

Resident A threw the water in Ms. Moore's face. Resident A stated she is often contacted when Resident A is acting out and she can usually get her to calm down. Resident A's guardian stated Resident A has Asperger's Syndrome and is very intelligent. Resident A's guardian stated since the age of nine Resident A has been in and out of many mental health facilities. "[Resident A] believes she can do whatever she wants and knows staff cannot do anything to her." Resident A has caused many people to lose their livelihood, including her former wealthy adoptive parents, who have nothing to do with her."

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: **(a) Use any form of punishment.**
ANALYSIS:	DCS Ke"Yonna Moore, the perpetrator, wrote an incident report. The incident report states she "struck [Resident A] physically." DCS Lakemia Jones, a witness, also wrote an incident report. The incident report states," [Resident A] threw a cup of water on staff K. Moore. Staff K Moore then physically struck [Resident A] in the face." On 11/24/2023, I interviewed Resident A. I asked her if Ms. Moore hit her. Resident A replied, "I threw a cup of water in her face then she punched me in the face."
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the status of the license remains unchanged.



01/30/2023

Edith Richardson — Date
Licensing Consultant

Approved By:

01/30/2023

Ardra Hunter — Date
Area Manager