GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 13, 2023

Shawn Brown
Domel, Inc.
Suite 112
39293 Plymouth Road
Livonia, MI 48150

RE: License #: AS820414053
Investigation #: 2023A0116025
West Home

Dear Mr. 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.

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,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820414053
Investigation #:	2023A0116025
Complaint Receipt Date:	02/15/2023
Investigation Initiation Date:	02/15/2023
Report Due Date:	04/16/2023
Licensee Name:	Domel, Inc.
Licensee Address:	Suite 112 39293 Plymouth Road Livonia, MI 48150
Licensee Telephone #:	(734) 632-0125
Administrator:	Shawn Brown
Licensee Designee:	Shawn Brown
Name of Facility:	West Home
Facility Address:	23033 Arsenal Flat Rock, MI 48134
Facility Telephone #:	(734) 782-4013
Original Issuance Date:	01/19/2023
License Status:	TEMPORARY
Effective Date:	01/19/2023
Expiration Date:	07/18/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED

	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Incident report received on 02/15/23 documented that staff, Daelonna Bishop, left the four residents home alone while she went to the gas station to get cigarettes.	Yes

III. METHODOLOGY

02/15/2023	Special Investigation Intake 2023A0116025
02/15/2023	Special Investigation Initiated - Telephone Interviewed Home manager, Ann Cavins.
02/15/2023	Referral - Recipient Rights Made by home manager, Ann Cavins.
02/16/2023	Inspection Completed On-site Spoke with Ann Cavins, visually observed Resident's A-D.
02/16/2023	Contact - Telephone call made Interviewed staff, Kathy Weiss.
02/21/2023	Contact - Telephone call received Interviewed staff, Daelonna Bishop.
02/21/2023	Contact - Telephone call made Spoke with Ann Cavins.
02/21/2023	Inspection Completed-BCAL Sub. Compliance
02/22/2023	APS Referral Made.
03/06/2023	Contact - Telephone call received Interviewed assigned Adult Protective Services (APS) investigator, Yolanda Johnson.
03/07/2023	Exit Conference With licensee designee, Shawn Brown.

ALLEGATION:

Incident report received on 02/15/23 documented that staff, Daelonna Bishop, left the four residents home alone while she went to the gas station to get cigarettes.

INVESTIGATION:

On 02/15/23, I interviewed home manager, Ann Cavins. Ms. Cavins reported that staff Kathy Weiss, informed her of the incident on the evening of 02/14/23, and she immediately completed an incident report and sent it to the Office of Recipient Rights (ORR) and to Licensing. Ms. Cavins reported she also called ORR to report the incident. Ms. Cavins reported that Ms. Weiss told her that on 02/13/23, when she arrived at work staff, Daelonna Bishop's, car was not there, so she went to the door to try to go in, but all of the doors were locked. Ms. Cavins reported that Ms. Weiss went back to her vehicle and sat and reported shortly after doing so, observed Ms. Bishop pull into the driveway. Ms. Cavins reported that Ms. Bishop had gone to the gas station to get cigarettes and left the four residents home alone. Ms. Cavins reported that the four residents were unharmed, however, reported that they are severely disabled. Ms. Cavins reported that Resident C is a runner and Resident B has pica, so things could have been worse. Ms. Cavins reported she was not present at the time the incident occurred and reported that Ms. Weiss would be able to provide additional details. Ms. Cavins added that Ms. Bishop has been suspended indefinitely.

On 02/16/23, I conducted a scheduled onsite inspection and spoke to Ms. Cavins and visually observed Residents A-D. Residents A-D are non-verbal and could not be interviewed. I reviewed Residents A-D's individual plans of service (IPOS) all of which document that each resident requires 24-hour staffing, and that staff should know the whereabouts of the residents while in the home.

Ms. Cavins also reported that Ms. Bishop has been in the field for over 11 years and has worked in this home for the past two years. Ms. Cavins reported that she had no issues or concerns with Ms. Bishop's job performance and reported she was really good with the residents.

On 02/16/23, I interviewed staff, Kathy Weiss, and she reported that on 02/13/23, she arrived at work at about 7:09 p.m. and when she pulled up, she noticed that Ms. Bishop's car was not there. Ms. Weiss reported that she thought Ms. Bishop may have been dropped off at work, so she proceeded to get out of her car and went to open the front door. Ms. Weiss reported that the door was locked, so she went to the side of the house to try to look in to see if she could see anyone but could not. Ms. Weiss reported that she called Ms. Bishop and asked her to open the garage so that she could get in the house. She reported that Ms. Bishop said that she would. Ms. Weiss reported that Ms. Bishop then called her right back and said, "You busted me, I'm coming down the street, I had to go get cigarettes." Ms. Weiss reported that Ms.

Bishop pulled back into the driveway of the home at about 7:15 p.m. Ms. Weiss reported when they entered the home Residents A-D were sitting at the table with empty plates in front of them. Ms. Weiss reported that may have been the way Ms. Bishop was able to ensure that they did not try to leave or get into anything while she was gone. Ms. Weiss reported she is not sure if Ms. Bishop had given the residents food or snacks, as she could not tell by looking at the plates. Ms. Weiss reported that that scared her as Residents A-D all have eating guidelines that require staff to help feed them and be within arm's reach of them while eating.

Ms. Weiss reported that she didn't report the incident to her manager, Ms. Cavins, until the following day and apologized as she knows she should have called her as soon as she confirmed that Ms. Bishop had left the residents home alone. Ms. Weiss reported that she is sad that she had to report this and that her co-worker lost her job, however, stated that she had to do what was right.

Ms. Weiss reported that later that same evening she received a text message from Ms. Bishop that read, "My bad, we shall never speak of these events of today. I had to get those smokes, I couldn't take that shit no mo." Ms. Weiss forwarded the text communication between she and Ms. Bishop for my review.

On 02/21/23, I interviewed staff, Daelonna Bishop, and she denied the allegation. Ms. Bishop reported that she was in the home when Ms. Weiss arrived. Ms. Bishop reported that her father had her car as she was having an issue with one of her tires and reported that Ms. Weiss made the entire story up because she does not like her. I asked Ms. Bishop about the text message she sent to Ms. Weiss the same evening of the incident, where she is telling Ms. Weiss not to speak of the incident. Ms. Bishop reported that the text was about something else. Ms. Bishop was not credible and took no responsibility for her actions. Ms. Bishop was evasive when asked questions and provided responses that did not make sense. Ms. Bishop attempted to blame everyone else for her termination. I ended the interview with Ms. Bishop.

On 02/21/23, I spoke with Ms. Cavins and asked her if she recalled Ms. Bishop driving to work that day or being dropped off. Ms. Cavins reported that Ms. Bishop drove to work on the day of the incident and reported nothing was wrong with her vehicle. Ms. Cavins reported she left the home after 3:00 p.m. and Ms. Bishop's car was in the driveway. Ms. Cavins reported that this is Ms. Bishop's way of trying to lie her way out of the choice she made that day.

On 03/06/23, I interviewed Yolanda Jackson, APS investigator. Ms. Jackson reported that she will be closing her investigation out within the coming days. Ms. Jackson reported that she will be substantiating for neglect and reported that she also sent notification of the incident to law enforcement. Ms. Jackson reported being glad that the residents were unharmed.

On 03/07/23, I conducted the exit conference with licensee designee, Shawn Brown. Mr. Brown reported he is aware of the incident and reported Ms. Bishop was suspended immediately and will be terminated at the conclusion of all the current investigations. Mr. Brown reported that Ms. Bishop has not worked since the incident. I informed Mr. Brown of the findings of the investigation, and he reported an understanding.

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:	This violation is established as Ms. Bishop, the staff on duty, who was responsible for the supervision, personal care, and protection of Residents A-D, left them alone in the home, while she went to the gas station to purchase cigarettes. Residents A-D's IPOSs document that they each require 24-hour staffing and staff should know of their whereabouts at all times, even while in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

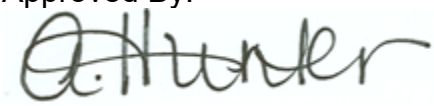
Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

03/13/23

Pandrea Robinson
Licensing Consultant

Date

Approved By:



03/13/23

Ardra Hunter
Area Manager

Date