GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 26, 2023

Tamika Jennings
Ste 212
41800 Hayes Road
Clinton Township, MI 48038

RE: License #: AS500315154
Investigation #: 2023A0617023
Jewel's Place

Dear Ms. Jennings:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (248) 975-5053.

Sincerely,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500315154
Investigation #:	2023A0617023
Complaint Receipt Date:	03/23/2023
Investigation Initiation Date:	03/24/2023
Report Due Date:	05/22/2023
Licensee Name:	Tamika Jennings
Licensee Address:	59260 Amherst Ave New Haven, MI 48048
Licensee Telephone #:	(586) 749-9194
Administrator:	Tamika Jennings
Licensee Designee:	Tamika Jennings
Name of Facility:	Jewel's Place
Facility Address:	30911 Clark Street New Haven, MI 48048
Facility Telephone #:	(586) 749-5811
Original Issuance Date:	09/11/2012
License Status:	REGULAR
Effective Date:	03/11/2021
Expiration Date:	03/10/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
Every weekend staff, Alisha White, leaves the residents in this home alone all afternoon.	**Yes**

III. METHODOLOGY

03/23/2023	Special Investigation Intake 2023A0617023
03/23/2023	APS Referral Adult Protective Services (APS) referral received - assigned worker is Ciera Collins.
03/24/2023	Special Investigation Initiated - Letter Email sent to LD Ms. Jennings.
03/29/2023	Contact - Telephone call received I conducted an interview with Ms. Cierra Collins of Adult Protective Services.
03/29/2023	Contact - Document Received Email with documents received from Ms. Jennings included: Resident Registry, Resident ID forms for all residents, assessment plans for all residents, list of staff with job titles and phone numbers and staff schedule for February, March and April 2023.
04/06/2023	Contact - Telephone call made I conducted an interview with Community Mental Health case worker Susan Polakowski, who is the case manager for Residents B, C, and D.
04/06/2023	Contact - Telephone call made I conducted an interview with Ms. Cindy Rugerro, case manager for Resident A.
04/06/2023	Contact - Face to Face I interviewed Residents B, C, and D, at their workshop.
04/06/2023	Inspection Completed On-site I conducted an unannounced onsite investigation. The residents were not home as they all were at workshop. I interviewed Ms.

	Tamika Jennings via phone and reviewed the staff schedule for the months of February, March and April 2023.
04/13/2023	Contact - Face to Face I interviewed Resident A while she was at workshop.
04/18/2023	Contact - Telephone call made TC to Ms. Alisha White
04/19/2023	Exit Conference I conducted an exit conference with Ms. Jennings at the Jewels Place facility. The findings of this investigation were discussed.
04/19/2023	Contact - Telephone call made TC to Ms. Alisha White

ALLEGATION:

Every weekend staff, Alisha White, leaves the residents in this home alone all afternoon.

INVESTIGATION:

On 03/23/23, I received a complaint regarding the Jewels Place facility. The complaint indicated the following: ‘Every weekend staff, by the name of Alisha White, leaves the residents in this home alone all afternoon. Alisha White brings them their pills in the morning and then leaves and doesn't return until around dinner to give them medications again and get them in bed. Alisha White puts notes on all the appliances saying, "do not use". This home is supposed to be staffed 24/7 so by leaving them alone it puts, Resident A, and potentially the other unknown residents at risk. It is unknown if any of the residents are capable of properly addressing an emergency. Resident A specifically has stated she doesn't know what she'd do if say, the home caught on fire. It is unclear if this was just an expression she used or if Resident A does not have the capacity to address an emergency.’

On 03/29/23, I conducted an interview with Ms. Cierra Collins of Adult Protective Services. According to Ms. Collins, Resident A informed her that staff Alisha White, leaves the residents in this home alone on Saturday afternoon. Alisha White brings them their pills in the morning and then leaves and doesn't return until around dinner to give them medications again and get them in bed. Alisha White puts notes on all the appliances saying, "do not use". Ms. Jennings and Alisha White reported to Ms. Collins that Alisha White will sometimes go outside and sit on the porch or in her car to smoke while the residents are in the home. According to Ms. Jennings, staff can always see the residents while outside. According to Ms. Collins, Ms. Jennings stated that she has two-way cameras in the home that she can access to see and speak with the residents.

On 04/06/23, I conducted an interview with Community Mental Health case worker Susan Polakowski, who is the case manager for Residents B, C, and D. According to Ms. Polakowski, she is unaware of the residents being left alone on the weekends. Ms. Polakowski stated that she has had residents placed in that home for over 10 years and she has not had any issues, nor does she have any concerns.

On 04/06/23, I conducted an interview with Ms. Cindy Rugerro, case manager for Resident A. According to Ms. Rugerro, Resident A has resided in the home since June 2020. Ms. Rugerro stated that Resident A is not capable of being left unattended as she is developmentally disabled. Ms. Rugerro stated that she wasn't personally aware of the allegations, however, Resident A did report the concerns to their agency.

On 04/06/23, I interviewed Residents B, C, and D, at their workshop. Residents B and C stated that they do not have any concerns regarding their care at Jewels Place. Resident D is nonverbal and unable to be interviewed. Residents stated they are never left alone at the home. Resident B stated that staff will sometimes go outside and sit in their cars to smoke for 10-15 minutes at a time. Resident B stated that they are never left alone without staff being nearby.

On 04/06/23, I conducted an unannounced onsite investigation. The residents were not home as they all were at workshop. I interviewed Ms. Tamika Jennings via phone. Ms. Jennings stated that the residents attend workshop Monday through Friday from about 8 AM to about 3 PM. While the residents are gone, there is no staff in the home. Ms. Jennings stated that she is on standby if there are any issues prior to the residents leaving workshop. According to Ms. Jennings, afternoon staff arrives at the facility around 2:50 PM to receive the residents at 3 PM. Afternoon staff then works until 8 AM the next morning or until the residents have left for workshop. Ms. Jennings denies that the facility has a staffing issue. Ms. Jennings stated that there are always staff in the home to care for the residents while they are in the home. Ms. Jennings stated that staff will sometimes go outside and sit on the porch or in her car to smoke while the residents are in the home. According to Ms. Jennings, staff can always see the residents while outside. I observed the home to have a completely covered/screened front porch that blocks visual access into the home. It is not possible to see in the home from outside of the porch. Ms. Jennings stated that she has two-way cameras in the home that she can access to see and speak with the residents. However, Ms. Jennings stated that she does not regular/ routinely check the cameras and she is unaware of when staff takes smoke breaks. Ms. Jennings stated that the residents are provided two-way radios to communicate with staff while staff is outside. However, the home has several residents who have mental disabilities, and one resident is non-verbal.

I reviewed the staff schedule for the months of February, March and April 2023. It appeared that there were enough staff scheduled to care for the needs of the residents. Per the facility staff schedules, the facility has at least one direct care staff during the day and afternoon shift (waking hours). The facility schedules at least one direct care staff during the evening and midnight shift (normal sleeping hours).

On 04/13/23, I interviewed Resident A while she was at workshop. According to Resident A, staff Alisha White used to leave the facility on Saturday nights after the residents would go to bed and not come back until Sunday Morning. According to Resident A, only staff Alisha White does this, however she has stopped recently. Resident A stated that things have improved.

On 04/19/23, I conducted an interview with Ms. Alisha White. Ms. White denied all allegations. Ms. White stated that she has never left the residents alone. Ms. White reported that she works from 10AM on Saturdays to 6AM on Monday mornings.

On 04/19/23, I conducted and exit conference with Ms. Jennings at the Jewels Place facility. The findings of this investigation were discussed.

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:	Based on the information gathered through my interviews and documentation reviews, the facility has a sufficient number of staff scheduled to care for the needs of the residents. I reviewed the staff schedule for the months of February, March and April 2023. There were enough staff scheduled to care for the needs of the residents. Per the facility staff schedules, the facility has at least one direct care staff during the day and afternoon shift (waking hours). The facility schedules at least one direct care staff during the evening and midnight shift (normal sleeping hours).
CONCLUSION:	VIOLATION NOT 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:	Based on the information gathered through my interviews and documentation review, the facility has not met the personal needs, including protection and safety in accordance with the provisions of the act. According to Resident A, staff Alisha White used to leave the facility on Saturday nights after the residents would go to bed and not come back until Sunday Morning. Ms. Jennings stated that staff will sometimes go outside and sit on the porch or in her car to smoke while the residents are in the home. According to Ms. Jennings, staff can always see the residents while outside. I observed the home to have a completely covered/screened front porch that blocks visual access into the home. It is not possible to see in the home from outside of the porch. Ms. Jennings stated that she has two-way cameras in the home that she can access to see and speak with the residents. However, Ms. Jennings stated that she does not regular/routinely check the cameras and she is unaware of when staff takes smoke breaks. Ms. Jennings stated that the residents are provided two-way radios to communicate with staff while staff is outside. However, the home has several residents who have mental disabilities, and one resident is non-verbal.
CONCLUSION:	**VIOLATION ESTABLISHED**

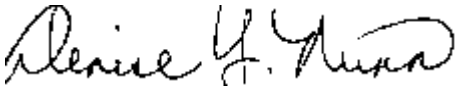
IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

04/19/23

Eric Johnson — Date
Licensing Consultant

Approved By:



04/26/2023

Denise Y. Nunn — Date
Area Manager