GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 11, 2023

Johnnie Denham
Slim Haven, LLC
6659 Schaefer Rd Ste. 1137
Dearborn, MI 48126

RE: License #: AS820407225
Investigation #: 2023A0119029
Slim Haven Abington

Dear Mr. Denham:

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,

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 #:	AS820407225
Investigation #:	2023A0119029
Complaint Receipt Date:	04/07/2023
Investigation Initiation Date:	04/10/2023
Report Due Date:	06/06/2023
Licensee Name:	Slim Haven, LLC
Licensee Address:	6659 Schaefer Rd Ste. 1137 Dearborn, MI 48126
Licensee Telephone #:	(800) 993-1287
Administrator:	Johnnie Denham
Licensee Designee:	Johnnie Denham
Name of Facility:	Slim Haven Abington
Facility Address:	9597 Abington Detroit, MI 48227
Facility Telephone #:	(313) 397-8327
Original Issuance Date:	02/09/2022
License **Status:**	REGULAR
Effective Date:	08/09/2022
Expiration Date:	08/08/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Per incident report dated 04/05/2023, the Licensee Designee/ Administrator- Johnnie Denham, physically took Resident A down to the floor on two occasions due to his behavior.	No
Additional Findings	Yes

III. METHODOLOGY

04/07/2023	Special Investigation Intake 2023A0119029
04/10/2023	Referral- Receipt Rights Made
04/10/2023	Special Investigation Initiated - Telephone Licensee Designee/ Administrator- Johnnie Denham
04/10/2023	Contact - Document Received Resident A documents and Mr. Denham training documents.
04/12/2023	Inspection Completed On-site Staff- Donna Stinson, Residents B-D, and Licensee Designee/ Administrator- Johnnie Denham
04/12/2023	Inspection Completed-BCAL Sub. Compliance
04/13/2023	Contact - Telephone call made Resident A's therapist- Ayana Singleton- Team Wellness Resident A’s guardian, left message
04/20/2023	Contact - Document Received Licensee Designee/ Administrator- Johnnie Denham- Crisis Training documents
05/09/2023	APS Referral Made
05/10/2023	Contact- Telephone call made Resident A’s guardian
05/10/2023	Exit Conference

	Licensee Designee- Johnnie Denham

ALLEGATIONS:

Per incident report dated 04/05/2023, the Licensee Designee/ Administrator- Johnnie Denham, physically took Resident A down to the floor on two occasions due to his behavior.

INVESTIGATION:

On 04/10/2023, I telephoned Licensee Designee/ Administrator- Johnnie Denham regarding the above regarding the above allegations. Mr. Denham stated Resident A is currently at St. Mary's Hospital. He stated Resident A was an emergency admission from Detroit Receiving Hospital on 03/31/2023. He stated Resident A required 1:1 staffing. The day of the incident, Mr. Denham stated he was providing Resident A with 1:1 staffing support. Mr. Denham stated Resident A has a guardian. Mr. Denham stated he did not have an individual service plan and/ or behavior plan for Resident A due to not having an assigned case manager. He stated he had no guidance of how to properly manage Resident A's behaviors. Mr. Denham stated Resident A was experiencing an increase in aggressive behaviors towards staff and residents. Mr. Denham stated the incident report received by the department was accurate regarding the events that took place on 04/05/2023.

According to incident report dated 04/05/2023, which was received from Mr. Denham, it indicated, "[Resident A] has been increasingly aggressive to staff and residents. Yesterday, [Resident A] started randomly attacking residents, starting at 4 am. [Resident A] went into a resident's room, after a bathroom break, and hit him in the face with a shoe while sleeping, which resulted in a physical altercation. We had to redirect [Resident A] many times during the day to keep him from engaging in this behavior. Last night, after [Resident A] took his evening meds, [Resident A] appeared drunken and his behavior became more bizarre. [Resident A] started banging his head against the wooden steps while sitting down there. [Resident A] announced that he did not want to be here and that he was going to "kill everybody in this fu**ing house." [Resident A] attempted to run down the stairs, tripping and falling into the wall at the bottom. [Resident A] got up and still tried to get out of the door. When [Mr. Denham] tried to stop [Resident A], he started swinging his fists at me. [Mr. Denham] was able to grab him around the torso and take him down to the floor. We stayed in that position for 15 - 20 minutes until [Resident A] said he was done. [Mr. Denham] let him up and [Resident A] started swinging again. [Mr. Denham] took [Resident A] down to the floor again. When [Resident A] calmed down the second time, [Mr. Denham] immediately called 911. The police came and it was decided that [Resident A] needed to be petitioned. [Resident A] was not accepted at COPE because of his mental state. They directed us to St. Mary's hospital, where [Resident A] was admitted. none of the other residents feel safe around [Resident

A]. Everyone has been resigned [sic] to their respective bedrooms during the day and night because of his behavior. [Resident A] is not appropriate for the current placement setting."

On 04/10/2023, I received Resident A's resident care agreement and written assessment plans via email from Licensee Designee/ Administrator- Mr. Denham.

On 04/12/2023, I completed an onsite inspection and interviewed Staff- Donna Stinson, Residents B-D, and Licensee Designee/ Administrator- Johnnie Denham regarding the above allegations. Ms. Stinson stated Resident A was very aggressive and hit another resident in the head the day of the incident. She stated Resident A also stole her car keys and threw them. She stated most residents tried to stay away from Resident A.

Residents B - C stated they were not present during the incident. Residents B -C stated they have not observed any other resident being "taken down to the floor" by staff.

Resident D stated Resident A was hitting him in the throat the day of the incident. He stated he did not see anyone take Resident A to the floor. Resident D stated after Resident A hit him that he went to his room because he was a little afraid of him.

On 04/13/2023, I telephoned and interviewed Resident A's therapist- Ayana Singleton- Team Wellness regarding the above allegations. Ms. Singleton stated she was not made aware that Resident A was even discharged from the hospital. She stated she became aware when Resident A entered the office for a medication review with the psychiatrist. Ms. Singleton stated Resident A's medications from the hospital made him like a zombie and not really coherent. She stated Resident A was heavily sedated which made it impossible to complete a treatment plan. In terms of Resident A's background, Ms. Singleton stated Resident A has been in and out of the hospital for months due to an instability of his mental health. However, Ms. Singleton stated Resident A does not have a history of being aggressive. She stated Resident A required a 1:1 staff due to being severely developmentally delayed and his compulsive behavior but not aggressiveness. Ms. Singleton stated she is not a case manager and does not complete an individual plan of service.

On 05/10/2023, I telephoned and interviewed Resident A's guardian regarding the above allegations. Resident A's guardian stated Resident A is not aggressive but has had several problems with his medications not working well for him. Resident A's guardian stated Resident A appears to be stable at present.

APPLICABLE RULE	
R 400.14309	**Crisis intervention.**
	(2) Crisis intervention may be used only for the following reasons: (a) To provide for self-defense or the defense of others. (b) To prevent a resident from harming himself or herself. (c) To quell a disturbance that threatens physical injury to any person. (d) To obtain possession of a weapon or other dangerous object that is in the possession or control of the resident. (e) To prevent serious property destruction.
ANALYSIS:	Based on the above information, Resident A was admitted into the facility on 03/31/2023 as an emergency placement. Licensee Designee/ Administrator- Johnnie Denham did not receive an individual service plan and/or behavior plan for Resident A when admitted into the facility. Staff- Donna Stinson stated Resident A hit another resident. Resident D stated Resident A hit him in the throat. Mr. Denham stated Resident A was exhibiting aggressive behaviors, bizarre behavior, and attacking other residents which caused Mr. Denham to use a crisis intervention method to prevent Resident A from further harming other or himself.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 04/10/2023, I telephoned Licensee Designee/ Administrator- Johnnie Denham regarding the type of training he had due to “taking down a resident to the floor”. Mr. Denham stated he does have the appropriate training but was unsure if he had training on physically restraining a resident.

On 04/10/2023, I received Mr. Denham training documents which did not include crisis intervention and how to handle challenging resident behaviors.

On 04/20/2023, I received Licensee Designee/ Administrator- Johnnie Denham's additional training documents. Mr. Denham took a training class for crisis management in care delivery environments and completed the course on 04/12/2023.

APPLICABLE RULE	
R 400.14309	**Crisis intervention.**
	(8) A licensee or a direct care staff member shall not use crisis intervention until he or she has successfully completed crisis intervention training that has been approved by the department.
ANALYSIS:	Mr. Denham used a crisis intervention on Resident A without being properly trained on 04/05/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/10/2023

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Shatonla Daniel — Date
Licensing Consultant

Approved By:

05/11/2023

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Ardra Hunter — Date
Area Manager