



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

June 21, 2023

Javon Brown  
38855 Plumbrook Dr.  
Farmington Hills, MI 48331

RE: License #: AS630404326  
Investigation #: 2023A0993024  
New Beginnings

Dear Ms. Brown:

Attached is the Special Investigation Report for the above referenced facility. Violations have been identified in the report. A previous recommendation for refusal to renew the license was made in the Renewal Licensing Study report dated 02/14/2023, which remains in effect.

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,

A handwritten signature in cursive script, appearing to read "DaShawnda Lindsey".

DaShawnda Lindsey, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Place, Ste. 9-100  
Detroit, MI 48202  
(248) 505-8036

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS630404326
<b>Investigation #:</b>	2023A0993024
<b>Complaint Receipt Date:</b>	04/21/2023
<b>Investigation Initiation Date:</b>	04/24/2023
<b>Report Due Date:</b>	06/20/2023
<b>Licensee Name:</b>	Javon Brown
<b>Licensee Address:</b>	32999 W. 14 Mile Farmington Hills, MI 48334
<b>Licensee Telephone #:</b>	(248) 506-5891
<b>Administrator:</b>	Yolanda Matthews
<b>Licensee Designee:</b>	N/A
<b>Name of Facility:</b>	New Beginnings
<b>Facility Address:</b>	32999 W 14 Mile Rd. Farmington Hills, MI 48334
<b>Facility Telephone #:</b>	(248) 506-5891
<b>Original Issuance Date:</b>	01/13/2022
<b>License Status:</b>	1ST PROVISIONAL
<b>Effective Date:</b>	08/03/2022
<b>Expiration Date:</b>	02/02/2023
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED; AGED ALZHEIMERS

## II. ALLEGATION(S)

	Violation Established?
Resident G was admitted to Garden City Hospital and was medically cleared to discharge. The adult foster care (AFC) facility was contacted and advised that Resident G could not return to the facility.	Yes
Resident G accused administrator Yolanda Matthews of taking his money.	Yes

## III. METHODOLOGY

04/21/2023	Special Investigation Intake 2023A0993024
04/24/2023	Special Investigation Initiated - Letter Emailed adult protective services (APS) specialist Jawana Kelly
04/24/2023	Inspection Completed On-site Conducted an unannounced onsite investigation
04/24/2023	Contact - Telephone call made Telephone call made to administrator Yolanda Matthew
04/24/2023	Contact - Telephone call made Telephone call made to Garden City Hospital
05/16/2023	Contact - Document Sent Emailed adult protective services (APS) specialist Jawana Kelly
05/17/2023	Contact - Document Sent Emailed adult protective services (APS) specialist Jawana Kelly
05/18/2023	Contact - Document Received Received an email from adult protective services (APS) specialist Jawana Kelly
05/22/2023	Contact - Telephone call made Telephone call made to Resident G. Left a message. Sent a text message.
05/22/2023	Contact - Telephone call received Telephone call received from Resident G

06/06/2023	Contact - Document Sent Requested a copy of the resident register, Resident Funds Part I and Resident Funds Part II as well as incident reports
06/07/2023	Contact - Telephone call made Telephone call made to adult protective services (APS) specialist Jawana Kelly
06/07/2023	Contact - Telephone call made Telephone call made to Garden City Hospital. Transferred to social work office. Left a message.
06/07/2023	Contact - Telephone call made Telephone call made to Garden City Hospital mental health social worker Liz Wendt
06/07/2023	Contact - Telephone call made Telephone call made to Beaumont Hospital Farmington Hills emergency room social work office. Left a message.
06/07/2023	Contact - Telephone call received Telephone call received from Beaumont Hospital Farmington Hills social worker Colleen Knurek
06/08/2023	Contact - Telephone call made Telephone call made to licensee Javon Brown
06/08/2023	Contact - Telephone call made Telephone call made to APS specialist Jawana Kelly
06/13/2023	Inspection Completed-BCAL Sub. Non-Compliance Onsite investigation completed on 04/24/2023
06/13/2023	Contact - Telephone call made Telephone call made to Hope Shelter manager Carolyn Robiadek
06/13/2023	Exit Conference Held with licensee Javon Brown

#### **ALLEGATION:**

**Resident G was admitted to Garden City Hospital and was medically cleared to discharged. The adult foster care (AFC) facility was contacted and advised that Resident G could not return to the facility.**

## **INVESTIGATION:**

On 04/21/2023, I received the allegations from adult protective services (APS). The assigned APS specialist is Jawana Kelly.

On 04/24/2023, I conducted an unannounced onsite investigation. I interviewed staff Sofhia Steen. Ms. Steen verified Resident G used to live in the facility, but he no longer lived there. Ms. Steen did not know when Resident G was admitted into the facility. She did not know when he discharged from the facility. She did not know why he no longer lived in the facility. Ms. Steen stated she and administrator Yolanda Matthews were working in the facility the day Resident G was transported to the hospital. Ms. Steen did not provide any other information.

On 04/24/2023, I conducted a telephone interview with administrator Yolanda Matthews. Ms. Matthews verified Resident G used to live in the facility. Ms. Matthews could not recall Resident G's admission date, but she believed he moved in the facility in the end of January 2023. Resident G was admitted into the facility from a homeless shelter in Pontiac. He was transported to the hospital in February 2023 from the facility. Per Ms. Matthews, Resident G was transported to the hospital due to his ankles being sworn, he felt like he was in danger, and he felt that someone was taking his money. Ms. Matthews stated Resident G called a Lyft and had himself transported to the hospital. Ms. Matthews stated she did not know which hospital Resident G was transported to. Ms. Matthews denied that staff refused to allow Resident G to return to the facility after being cleared to discharge. Ms. Matthews stated she never talked with anyone from the hospital. She talked to Resident G one time after being admitted to the hospital. Resident G refused to pay rent. Ms. Matthews informed Resident G he could not return if he did not pay rent.

On 05/22/2023, I conducted a telephone interview with Resident G. Resident G confirmed he used to live at the facility. He stated he did not recall what happened while he lived there.

On 06/06/2023, I requested a copy of the resident register to verify Resident G's admission and discharge date as well as incident reports (IRs). The documents were requested by 5pm on 06/09/2023.

On 06/07/2023, I conducted a telephone interview with APS specialist Jawana Kelly. Ms. Kelly confirmed she talked to Resident G regarding the allegations. Resident G informed her that so much was occurring during the time he lived at the facility. He could not remember what had happened.

On 06/07/2023, I conducted a telephone interview with Garden City Hospital mental health social worker Liz Wendt. Ms. Wendt confirmed Resident G was admitted to the hospital for psychiatric treatment from 03/16/2023 to 03/22/2023. On 03/20/2023, hospital staff spoke with Kim (last name unknown) from Hope shelter. She stated

Resident G could only return to the AFC facility if he had a payee or guardian due to showing signs of mental health and accusing the provider of taking his money. Ms. Wendt stated Resident G was admitted to Garden City Hospital from Beaumont Hospital Farmington Hills.

On 06/07/2023, I conducted a telephone interview with Beaumont Hospital Farmington Hills social worker Colleen Knurek. Ms. Knurek stated Resident G arrived at the emergency room on 03/03/2023 from 32999 14 Mile Rd., Farmington Hills, MI via an ambulance. Resident G was transported to the Garden City Hospital on 03/15/2023.

As of the date of this report and requested on 06/06/2023, I have not received a copy of resident register or any incident reports (IRs).

On 06/08/2023, I conducted a telephone interview with licensee Javon Brown. Ms. Brown stated she was not familiar with Resident G or the allegations. She requested that I contact Ms. Matthews for information.

On 06/13/2023, I conducted a telephone interview with Hope Shelter manager Carolyn Robiadek. Ms. Robiadek verified Resident G was in the shelter from September 2022 to November 2022. His case was closed in November 2022 when he transferred to an AFC facility. Ms. Robiadek did not know the name or address of the facility.

<b>APPLICABLE RULE</b>	
<b>R 400.14210</b>	<b>Resident register.</b>
	<b>A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident:</b> <b>(a) Date of admission.</b> <b>(b) Date of discharge.</b> <b>(c) Place and address to which the resident moved, if known.</b>
<b>ANALYSIS:</b>	On 06/06/2023, I requested a copy of the resident register to verify Resident G's admission and discharge date. The documents were requested by 5pm on 06/09/2023. As of the date of this report, I have not received a copy of the resident register.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.14302</b>	<b>Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting</b>

	<b>resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.</b>
	<b>(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.</b>
<b>ANALYSIS:</b>	Resident G was transported to the hospital. When he was medically cleared for discharge, the facility would not allow him to return. Ms. Matthews denied talking to anyone at the hospital. However, she stated she talked to Resident G. She informed him he could not return unless he paid rent. Ms. Matthews confirmed Resident G did not have a guardian, and a discharge notice was never issued to Resident G.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.14305</b>	<b>Resident protection.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	Resident G was transported to the hospital. When he was medically cleared for discharge, the facility would not allow him to return. Ms. Matthews denied talking to anyone at the hospital. However, she stated she talked to Resident G. She informed him he could not return unless he paid rent. Ms. Matthews confirmed Resident G did not have a guardian, and a discharge notice was never issued to Resident G.
<b>CONCLUSION:</b>	<b>REPEAT VIOLATION ESTABLISHED. Reference Special Investigation Report dated 02/08/2023.</b>

<b>APPLICABLE RULE</b>	
<b>R 400.14311</b>	<b>Investigation and reporting of incidents, accidents, illnesses, absences, and death.</b>
	<b>(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:</b> <b>(c) Incidents that involve any of the following:</b> <b>(ii) Hospitalization.</b>
<b>ANALYSIS:</b>	On 06/06/2023, I requested a copy of IRs. The documents were requested by 5pm on 06/09/2023. As of the date of this report, I have not received any incident reports.
<b>CONCLUSION:</b>	<b>REPEAT VIOLATION ESTABLISHED.</b> <b>Reference Special Investigation Report dated 02/08/2023.</b>

#### **ALLEGATION:**

**Resident G accused administrator Yolanda Matthews of taking his money.**

#### **INVESTIGATION:**

On 04/24/2023, I conducted an unannounced onsite investigation. I interviewed staff Sofhia Steen. Ms. Steen did not have knowledge of administrator Yolanda Matthews of taking Resident G's money. Ms. Steen stated she did not keep track of Resident G's money.

On 04/24/2023, I conducted a telephone interview with administrator Yolanda Matthews. Ms. Matthews denied taking Resident G's money. She stated she kept track of Resident G's rent, and he had control of his other money. Ms. Matthews agreed to forward me a copy of Resident G's Resident Funds Part I and Resident Funds Part II forms.

On 05/22/2023, I conducted a telephone interview with Resident G. Resident G confirmed he used to live at the facility. He stated he did not recall what happened while he lived there.

On 06/06/2023, I requested a copy of Resident G's Resident Funds Part I and Resident Funds Part II forms again. The documents were requested by 5pm on 06/09/2023.



On 06/07/2023, I conducted a telephone interview with Garden City Hospital mental health social worker Liz Wendt. Ms. Wendt confirmed Resident G accused the provider of taking his money.

On 06/08/2023, I conducted a telephone interview with licensee Javon Brown. Ms. Brown stated she was not familiar with Resident G or the allegations. She requested that I contact Ms. Matthews for information.

On 06/08/2023, I conducted a telephone interview with APS specialist Jawana Kelly. Ms. Kelly stated Resident G mentioned that Resident G stated Ms. Matthews and her husband (name not provided) held on to his debit card, and he was missing \$7,000. No other details were provided.

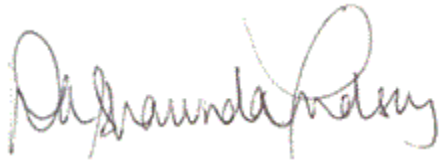
As of the date of this report, I have not received a copy of Resident G's Resident Funds Part I and Resident Funds Part II forms. I was unable to determine if any of Resident G's money was missing.

On 06/13/2023, I conducted an exit conference with licensee Javon Brown. I informed her of the findings. I informed her I never received any of the requested documents. Ms. Brown requested to call Ms. Matthews and will then give me a callback.

<b>APPLICABLE RULE</b>	
<b>R 400.14315</b>	<b>Handling of resident funds and valuables.</b>
	<b>(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.</b>
<b>ANALYSIS:</b>	I requested a copy of Resident G's Resident Funds Part I and Resident Funds Part II forms on 04/24/2023 as well as on 06/06/2023. As of the date of this report, I have not received the documents. I was unable to determine if any of Resident G's money was missing.
<b>CONCLUSION:</b>	<b>REPEAT VIOLATION ESTABLISHED. Reference Renewal Licensing Study Report 02/14/2023.</b>

#### IV. RECOMMENDATION

A previous recommendation for refusal to renew the license was made in the Renewal Licensing Study report dated 02/14/2023, which remains in effect.



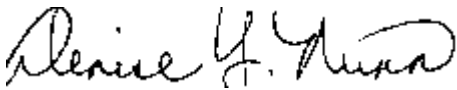
06/14/2023

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DaShawnda Lindsey  
Licensing Consultant

Date

Approved By:



06/21/2023

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Denise Y. Nunn  
Area Manager

Date