STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 12, 2023

Adrienne Flowers
Alternative Adult Residence LLC
16610 James Couzens Fwy
Detroit, MI 48221

RE: License #: AS820288859
Investigation #: 2023A0121037
Alternative Adult Residence LLC

Dear Mrs. Flowers:

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,

K. Robinson, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

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 #:	AS820288859
Investigation #:	2023A0121037
Complaint Receipt Date:	07/25/2023
Investigation Initiation Date:	07/26/2023
Report Due Date:	09/23/2023
Licensee Name:	Alternative Adult Residence LLC
Licensee Address:	19163 Woodingham Detroit, MI 48221
Licensee Telephone #:	(313) 215-2303
Administrator:	Adrienne Flowers, Designee
Name of Facility:	Alternative Adult Residence LLC
Facility Address:	19163 Woodingham Detroit, MI 48221
Facility Telephone #:	(313) 864-5120
Original Issuance Date:	12/28/2007
License **Status:**	REGULAR
Effective Date:	06/21/2023
Expiration Date:	06/20/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED TRAUMATICALLY BRAIN INJURED;ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident arrived at the hospital with a black eye. It is unknown how the resident sustained the injury. It is suspected the resident was intentionally harmed by Staff or possibly another resident in the home.	Yes

III. METHODOLOGY

07/25/2023	Special Investigation Intake 2023A0121037
07/26/2023	Special Investigation Initiated - Telephone Call to Mrs. Flowers
08/09/2023	Inspection Completed On-site Interviewed Resident B-D, Direct care worker
08/10/2023	Contact - Telephone call made Tonia McMurray with Recipient Rights
08/11/2023	Contact - Telephone call made Chardonnay McClain, home manager
08/11/2023	Contact - Telephone call received Tonia McMurray, ORR
08/11/2023	Contact - Document Sent Email to licensee requesting copy of Incident Report
08/11/2023	Contact - Telephone call made Tongina Kennedy with Community Living Services; no response
08/11/2023	Contact - Telephone call made Amanda Cooksey, bio mom
08/14/2023	Contact - Telephone call made Left message for DCW Keta Kelly
08/15/2023	Contact - Telephone call made Text to Mrs. Flowers

08/15/2023	Contact - Telephone call received Return call Keta Kelly
08/16/2023	Contact - Telephone call made Phone interview with Keta Kelly
08/16/2023	Contact - Telephone call made Follow up with Ms. Cooksey
08/21/2023	Contact - Telephone call made Follow up with Ms. Cooksey
08/23/2023	Inspection Completed On-site Resident A and Ms. Cooksey
08/24/2023	Contact - Telephone call made DCW Brenda Dixson
08/28/2023	Contact - Telephone call made Left message for Charlene Saiti with CLS; no response
08/29/2023	Contact - Telephone call made Tongina Kennedy
08/29/2023	Contact - Telephone call made Left message for Pamela Morgan with Lincoln Behavior Services
08/29/2023	Exit Conference Mrs. Flowers
09/06/2023	Contact – Telephone call received Return call from Pamela Morgan
09/06/2023	Contact – Telephone call made Jeralyn Robinson
09/06/2023	Contact – Telephone call made Kanissa Dorsey
09/07/2023	Contact – Telephone call made Text to/from Mrs. Flowers

ALLEGATION: Resident arrived at the hospital with a black eye. It is unknown how the resident sustained the injury. It is suspected the resident was intentionally harmed by Staff or possibly another resident in the home.

INVESTIGATION: On 7/26/23, I initiated the complaint with a phone call to licensee designee, Adrienne Flowers. Mrs. Flowers explained Resident A accidentally hit herself in the face with a wooden building block on Wednesday, July 19, 2023. This information is in accordance with what was written in an incident report authored by direct care worker, Keta Kelly. Mrs. Flowers indicated Keta was assigned as Resident A's 1:1 Staffing. Per Mrs. Flowers, Resident A was provided 1:1 staffing 24 hours per day, 7 days a week due to her behavior. Mrs. Flowers reported Resident A is known to self-abuse sometimes causing injury. Resident A was placed in the home on 6/22/23; this was her first out-of-home placement. I reviewed Keta's incident reported describing what happened on 7/19/23. Keta wrote, "While staff was trying to do paperwork, client snatched the pen off the table and threw it on the floor. Client started to yelling you stupid bitch and hit herself in the face with a toy she was holding and it made a scratch mark on the side of her nose." Resident A is the client referred to in the report.

On 8/9/23, I conducted a scheduled onsite inspection at the facility to interview both Staff and residents. Resident B described Resident A as "a handful for Staff" because Resident A was known to grab others unprovoked, spit on Staff, and curse both Staff and residents. Resident B reported seeing Staff "spank" Resident A with a fly swatter or clothes hanger whenever Resident A "got out of hand." Resident B seemed reluctant to disclose these findings, but she insisted she wanted to "be as honest as possible" especially since Resident A was not able to fight her own battles due to having lower cognition. Resident B repeated over and over, that she thought it was "wrong" for staff to physically discipline Resident A. Resident B denied that Staff hit her reasoning, "They know I'll hit them back!" I asked Resident B to identify the abuse perpetrators and she listed: Keta Kelly, Mia Nash, Kanissa Dorsey, and Danielle Marshall. Resident B specified, Keta Kelly and Mia Nash are "the main 2" offenders. However, Resident C denied having ever seen staff hit Resident A. Resident C stated she typically keeps to herself unless she's eating a meal or taking medication within the common areas of the home. Resident B alleged Resident C is not being truthful. In fact, Resident B reported Resident C was also responsible for assaulting Resident A in the past. Resident B recalled an event where Resident A spit on Resident C, so Resident C reacted by forcefully pushing Resident A into a wall. According to Resident B, the push was so hard, she worried Resident A may have sustained a concussion. While at the facility, I also interviewed Resident D. Resident A and D shared a room on the main level of the home. Resident D is legally blind. Resident D denied having any knowledge surrounding Resident A's eye injury. Resident D repeatedly stated, "I'm blind, so I didn't see anything." However, Resident D did state, Resident A had a "bad habit of saying, do it, do it! … and I guess somebody took her up on it and popped her in the eye." Resident D indicated she's been hearing whispers around the facility that Resident A got hit in the eye. Resident D said although Resident A was a "handful" that didn't give Staff

the right to hit her. Resident D described Resident A as a “little kid” that typically meant no harm to others. Resident D told me that she’s been a victim of resident abuse. According to Resident D, direct care worker, Brenda Dixson once hit her, so she reported the abuse to Mrs. Flowers. Resident D stated, Mrs. Flowers’ reply was, “hit her back!” Resident D appeared appalled by Mrs. Flowers’ response. Resident D argued she’s in no condition to fight anyone due to her disability and age. I asked Resident D when the incident happened and she replied, “About a month ago.”

On 8/10/23 and 8/11/23, I conferenced the case with Recipient Rights Investigator, Tonia McMurray. Ms. McMurray reported Resident A does have a history of exhibiting self-injurious behaviors. Ms. McMurray also reported Resident B seemed nervous to talk to her. Ms. McMurray indicated Resident B “shut down” and seemingly didn’t want to discuss the abuse allegations involving Resident A. It should be noted, Ms. McMurray’s interview occurred after my interview with Resident B.

On 8/11/23, I interviewed Resident A’s mother, Amanda Cooksey. Ms. Cooksey reported she went to the home on 7/22/23 to pick Resident A up for a day visit. Ms. Cooksey stated upon entering the home, she immediately noticed Resident A had a black eye on the left. Ms. Cooksey explained Resident A’s first words to her upon arrival were, “She punched me in my eye and then punch me in nose and my nose was bleeding.” Ms. Cooksey stated she reported the abuse allegation to Mrs. Flowers, then transported Resident A to Beaumont Hospital in Farmington Hills. Ms. Cooksey attempted to fax a copy of the hospital visit summary to the department to no avail. On 8/23/23, I made an onsite visit to Ms. Cooksey’s home to interview Resident A and pick up medical records. Resident A was diagnosed by emergency medicine doctor, Sherif G. El-Alayli, DO as having, “eye bruise, left, initial encounter.” When I asked Resident A how she hurt her eye she replied, “Punched me in eye.” I asked, “Who punched you?” Resident A replied, “A girl.” According to Ms. Cooksey, Resident A’s disability limits her speech and intellectual capacity. However, Resident A can express herself with minimal words, like, “she punched me”, but she cannot identify the person by name unless she’s been around them for an extended period. Ms. Cooksey removed Resident A from the home once the bruise was discovered. Ms. Cooksey indicated she removed Resident A because Mrs. Flowers seemed to ignore the violence. Ms. Cooksey is adamant that for the past 19 years, Resident A hasn’t exhibited behaviors that resulted in serious injury. Ms. Cooksey acknowledged Resident A is difficult to care for. Resident A has been in Ms. Cooksey’s care from birth.

On 8/9/23, I interviewed direct care worker, Mia Nash, in-person. Mia denied having ever hit Resident A. Without prompting, Mia recalled an incident where Resident A attempted to take a clothes hanger out of her hand. To redirect the behavior, Mia said she hit a table close-by and told Resident A “no!” Mia did acknowledge she was present the day Resident A was injured. Mia explained she observed Resident A use a toy in gesturing motion like she was going to hit Keta. Mia said Resident A inadvertently hit herself on accident. Mia said she advised Keta to complete an

incident report to document what happened. Mia's explanation of the events is not consistent with what is written in the incident report. There is no mention of Resident A motioning in an intimidating manner towards Keta. On 8/16/23, I interviewed Keta by phone. Keta denied having ever hit Resident A. Keta acknowledged she was assigned as Resident A's 1:1 Staff on 7/19/23. When describing the incident, Keta stated, "She started swinging her arms and nipped her nose," with a building block she was holding, referring to Resident A. Keta also said Mia was in the kitchen, so she doesn't believe Mia witnessed the accident.

On 8/24/23, I interviewed direct care worker, Brenda Dixson about the abuse allegation involving Resident D. Brenda said the incident happened 5-6 years ago. According to Brenda, as Resident D tried to stand from a sitting position, Resident D "almost fell," so Brenda tried to prevent the fall. Brenda explained, "My hand caught the back of her neck," which led Resident D to believe Brenda hit her. Brenda reported Resident D confronted her about the incident "a couple months ago," implying it happened recently, but Brenda corrected her. Brenda denied having ever hit or abused Resident D. On 9/6/23, I interviewed direct care worker, Jeralyn Robinson. Jeralyn reported she works as an on-call Staff member. Jeralyn denied having ever witnessed Staff abuse residents in the home. Jeralyn said she did not work the day Resident A's eye was injured. On 9/6/23, I also interviewed direct care worker, Kanissa Dorsey. Kanissa described Resident A as "hard to manage," but she denied having ever hit or witnessed someone hit Resident A. On 9/11/23, I interviewed direct care worker, Danielle Marshall by phone. Danielle said she is familiar with Resident A, but denied having ever worked with Resident A. According to Danielle, she was primarily assigned to work at Mrs. Flower's second group home while Resident A was in care. Danielle acknowledged being at the facility at the same time as Resident A, but she stated she was only there for a short time to drop off food or the agency van. Danielle said at no time did she interact with Resident A or abuse the resident. Danielle found the allegation laughable and stated she has no idea why someone would accuse her of resident abuse.

Additionally, I contacted Resident A, B, and D's case managers to obtain background information on each to establish their credibility. Resident A's case manager never returned my call (Charlene Saiti with Community Living Services). Resident B's case manager established her as a credible witness, stating, "Yea she's known to tell the truth." Resident B's case manager described her as "very alert" and medication compliant. Resident D's case manager is newer, having only managed her care for 3 months. Resident D's case manager indicated it is difficult to establish her credibility based on how the resident processes what she hears.

On 8/29/23, I completed an exit conference with Mrs. Flowers. Mrs. Flowers is adamant Resident A did not sustain the eye injury from being punched by Staff. Mrs. Flowers stated she saw the injury at its initial encounter. Mrs. Flowers described the injury as "a little red mark" the first day, but "it turned dark under her eye" the very next day. Mrs. Flowers stated she does believe Resident A caused the injury by hitting herself due over-stimulation. Mrs. Flowers described Resident D

as confused due to suffering from dementia. Mrs. Flowers stated Resident D is known to confuse details and accuse others of hitting her when they did not. Mrs. Flowers denied telling Resident D to hit Brenda back when she disclosed the abuse. Mrs. Flowers reported she has observed Brenda interact well with Resident D and the others, so she has no concerns then or now. Mrs. Flowers expressed she is not in agreement with the department's findings or recommendation, insisting that no abuse occurred.

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:	• Keta Kelly was assigned to provide 1:1 supervision of Resident A on 7/19/23 when she was injured. • Resident A was medically diagnosed with an "eye bruise" just days following. • Both Keta Kelly and Mia Nash were on duty 7/19/23. Their descriptions of the incident do not align. • Resident A reported someone female punched her in the eye causing the injury. • Resident B reported she observed Staff hit Resident A with hangers and a fly swatter. • Mia Nash conveniently shared a story with me about how she hit a table to redirect Resident A from taking it out her hand. The approach was intimidating in manner. • Resident B's case manager helped establish her as a credible witness. • Resident D reported being hit by Staff Brenda Dixson in the past. • Resident A's mother has cared for her since birth. Ms. Cooksey is adamant that Resident A does not harm herself causing physical injury. • Therefore, the department has determined there is a preponderance of evidence that Resident A's protection and safety was not attended to despite her having a 1:1 Staff assignment 24/7.
CONCLUSION:	**VIOLATION ESTABLISHED**

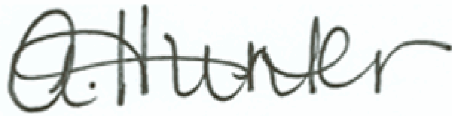
IV. RECOMMENDATION

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

9/12/23

Kara Robinson — Date
Licensing Consultant

Approved By:



9/12/23

Ardra Hunter — Date
Area Manager