GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 14, 2023

Javon Brown
38855 Plumbrook Dr.
Farmington Hills, MI 48331

RE: License #: AS630404326
Investigation #: 2023A0993033
New Beginnings

Dear Ms. Brown:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. 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. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

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

| | |
|---|---|
| **License #:** | AS630404326 |
| | |
| **Investigation #:** | 2023A0993033 |
| | |
| **Complaint Receipt Date:** | 07/10/2023 |
| | |
| **Investigation Initiation Date:** | 07/10/2023 |
| | |
| **Report Due Date:** | 08/09/2023 |
| | |
| **Licensee Name:** | Javon Brown |
| | |
| **Licensee Address:** | 32999 W. 14 Mile<br>FARMINGTON HILLS, MI 48334 |
| | |
| **Licensee Telephone #:** | (248) 506-5891 |
| | |
| **Administrator:** | Yolanda Matthews |
| | |
| **Licensee Designee:** | N/A |
| | |
| **Name of Facility:** | New Beginnings |
| | |
| **Facility Address:** | 32999 W 14 Mile Rd.<br>Farmington Hills, MI 48334 |
| | |
| **Facility Telephone #:** | (248) 506-5891 |
| | |
| **Original Issuance Date:** | 01/13/2022 |
| | |
| **License Status:** | 1ST PROVISIONAL |
| | |
| **Effective Date:** | 08/03/2022 |
| | |
| **Expiration Date:** | 02/02/2023 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED; AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Administrator's husband, Mr. Matthews, was verbally abusive towards Resident K and Resident L. He kicked them out of the facility without giving them a discharge notice. | Yes |
| Mr. Matthews has not provided Resident K and Resident L with their medications. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 07/10/2023 | Special Investigation Intake<br>2023A0993033 |
| 07/10/2023 | APS Referral<br>Allegations received from adult protective services (APS). The assigned APS specialist is Taneisha Sims. |
| 07/10/2023 | Special Investigation Initiated - Telephone<br>Telephone call made to Disability Network of Mid-Michigan peer support mentor Heather Edwards |
| 07/10/2023 | Contact - Telephone call made<br>Telephone call made to Resident K |
| 07/10/2023 | Inspection Completed On-site<br>Conducted an unannounced onsite investigation |
| 07/10/2023 | Contact - Telephone call made<br>Telephone call made to APS specialist Taneisha Sims |
| 07/10/2023 | Contact - Telephone call made<br>Telephone call made to Resident L |
| 07/10/2023 | Contact - Telephone call made<br>Telephone call made to Resident M. Left a message. |
| 07/10/2023 | Contact - Telephone call made<br>Telephone call made to Resident B. Left a message. |

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|---|---|
| 07/11/2023 | Contact - Telephone call made<br>Telephone call made to Resident M. Left a message. Sent a text message. |
| 07/11/2023 | Contact - Telephone call made<br>Telephone call made to Resident B. Number was not in service. |
| 07/11/2023 | Contact - Telephone call made<br>Telephone call made to administrator Yolanda Matthews |
| 07/13/2023 | Contact - Telephone call made<br>Telephone call made to administrator Yolanda Matthews. Mailbox was full. Sent a text message. |
| 07/13/2023 | Contact - Document Sent<br>Emailed administrator Yolanda Matthews and licensee Javon Brown |
| 07/13/2023 | Contact - Telephone call made<br>Telephone call made to Resident M. Left a message. Sent a text message. |
| 07/13/2023 | Contact - Telephone call made<br>Telephone call made to Resident B. Number was not in service. |
| 07/13/2023 | Contact - Telephone call made<br>Telephone call made to Resident K's guardian (and brother) |
| 07/13/2023 | Contact - Telephone call made<br>Telephone call made to APS specialist Taneisha Sims |
| 07/13/2023 | Contact - Telephone call made<br>Telephone call made to administrator's husband Emory Matthews. Left a message. Sent a text message. |
| 07/13/2023 | Contact - Telephone call made<br>Telephone call made to staff Sofhia Steen. Number not in service. |
| 07/13/2023 | Contact - Telephone call received<br>Telephone call received from administrator Yolanda Matthews |
| 07/13/2023 | Contact - Telephone call made<br>Telephone call made to staff Tikyarra Birl |

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|---|---|
| 07/13/2023 | Exit Conference<br>Attempted to hold an exit conference with licensee Javon Brown. Left a message. |

**ALLEGATION:**

**Administrator's husband, Mr. Matthews, was verbally abusive towards Resident K and Resident L. He kicked them out of the facility without giving them a discharge notice.**

**INVESTIGATION:**

On 07/10/2023, I received the allegations from adult protective services (APS). The assigned APS specialist is Taneisha Sims.

On 07/10/2023, I conducted a telephone interview with Disability Network of Mid-Michigan peer support mentor Heather Edwards. Ms. Edwards stated Resident K was admitted into the licensed adult foster care facility, but she no longer resided there. Ms. Edwards did not know Resident K's admission date. Resident K lived in the facility for about four weeks. Per Ms. Edwards, administrator's husband Emory Matthews gave Resident K "the boot". He told Resident K that she had "X amount of hours to leave". Resident K moved out of the facility on or around 07/08/2023.

On 07/10/2023, I conducted a telephone interview with Resident K. Resident K stated she was admitted into the licensed adult foster care facility about one month ago. She moved out last Friday, 07/07/2023. Per Resident K, Mr. Matthews yelled and screamed at her and Resident L after he learned they called adult protective services (APS). Mr. Matthews also told Resident K and Resident L that they had to leave, or he would call the cops. Resident K stated Mr. Matthews informed them that he did not have to give them a 30-day notice because he no longer had a license.

On 07/10/2023, I conducted an unannounced onsite investigation. I interviewed staff Tikyarra Birl. Ms. Birl stated she was not familiar with Resident K as she did not work in the facility when she was there.

During the time of the unannounced onsite investigation, Ms. Birl stated Resident O was present in the facility. I requested to interview Resident O. Ms. Birl stated Resident O was also not present in the facility when Resident K lived there as she had just been admitted into the facility from the hospital.

On 07/10/2023, I conducted a telephone interview with Resident L. Resident L stated she was admitted to the licensed adult foster care facility for about two months. She moved out last Friday, 07/07/2023. Per Resident K, Mr. Matthews yelled and screamed at her and Resident K after he learned they called APS. Mr. Matthews also told Resident K and Resident L that they had to leave, or he would call the cops. Resident L stated Mr. Matthews informed them that he did not have to give them a 30-day notice.

On 07/11/2023, I conducted a telephone interview with administrator Yolanda Matthews. Ms. Matthews verified Resident K and Resident L lived in the facility. Ms. Matthews did not recall how long they lived there. Ms. Matthews stated Resident K and Resident L was informed last week that they had to find somewhere else to live. Per Ms. Matthews, Resident K and Resident L "did their own thing". There was no lease agreement. There was no adult foster care licensing paperwork completed for them. The residents were not given a discharge notice when they were asked to leave. Ms. Matthews denied that Mr. Matthews was verbally abusive, yelled at, or screamed at Resident K and Resident L.

On 07/13/2023, I sent an email to Ms. Matthews as well as licensee Javon Brown requesting discharge notices for Resident K and Resident L.

On 07/13/2023, I conducted a telephone interview with Resident K's guardian (and brother). Resident K's guardian verified Resident K lived in the facility. He did not know exactly how long she lived there. He stated Resident K informed him she was kicked out and had to find somewhere else to live. As a result, Resident K is currently living with him.

On 07/13/2023, I received a phone call from Ms. Matthews. Ms. Matthews confirmed she received the email. She stated she did not have the requested documents as she did not complete them.

On 07/13/2023, I attempted to conduct a follow up interview with staff Tikyarra Birl. Ms. Birl stated, "I am not answering any more of those questions because I don't have anything to do with that".

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14302** | **Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.** |
| | **(3) A licensee shall provide a resident and his or her designated representative with a 30-day written discharge notice 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.** |
| **ANALYSIS:** | Resident K and Resident L stated they were admitted to the licensed adult foster care facility for about one month and two months, respectively. They stated Mr. Matthews yelled and |

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| | screamed at them after he learned they called APS. Mr. Matthews also told Resident K and Resident L that they had to leave, or he would call the cops. Resident K stated Mr. Matthews informed them that he did not have to give them a 30-day notice because he no longer had a license. Resident L also stated she was not given a discharge notice. Ms. Matthews confirmed discharge notices were not given to Resident K and Resident L. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED.**<br>**Reference Special Investigation Report 06/21/2023.** |

| **APPLICABLE RULE** | |
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| **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:** | Resident K and Resident L stated they were admitted to the licensed adult foster care facility for about one month and two months, respectively. Mr. Matthews yelled and screamed at them after he learned they called APS. Mr. Matthews also told Resident K and Resident L that they had to leave, or he would call the cops. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED.**<br>**Reference Special Investigation Report dated 02/08/2023.**<br>**Reference Special Investigation Report dated 06/21/2023.**<br>**Reference Special Investigation Report dated 07/11/2023.** |

**ALLEGATION:**

**Mr. Matthews has not provided Resident K and Resident L with their medications.**

**INVESTIGATION:**

On 07/10/2023, I conducted a telephone interview with Disability Network of Mid-Michigan peer support mentor Heather Edwards. Ms. Edwards stated administrator's husband Emory Matthews never filled two of Resident K's medications while she was living in the facility. Ms. Edwards did not know the names of the medications.

On 07/10/2023, I conducted a telephone interview with Resident K. Resident K stated Mr. Matthews did not administer her medications to her as he never got the

prescriptions filled. Resident K stated she did not know why he did not fill the prescriptions.

On 07/10/2023, I conducted a telephone interview with Resident L. Resident L stated Mr. Matthews did not always administer her medications to her. There were times when he let her prescriptions sit for one week before getting them filled.

On 07/11/2023, I conducted telephone interview with administrator Yolanda Matthews. Ms. Matthews confirmed Resident K and Resident L were not administered their medications. She stated they “did their own thing”.

On 07/13/2023, I sent an email to Ms. Matthews as well as licensee Javon Brown requesting a copy of the medication administration records (MARs) for Resident K and Resident L.

On 07/13/2023, I received a phone call from Ms. Matthews. Ms. Matthews confirmed she received the email. She stated she did not have the requested documents as she did not complete them.

| **APPLICABLE RULE** | |
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| **R 400.14312** | **Resident medications.** |
| | **(2) Medication shall be given, taken, or applied pursuant to label instructions.** |
| **ANALYSIS:** | Resident K stated Mr. Matthews did not administer her medications to her as he ever got the prescriptions filled. Resident L stated Mr. Matthews did not always administer her medications to her. There were times when he let her prescriptions sit for one week before getting them filled. Ms. Matthews confirmed Resident K and Resident L were not administered their medications and stated they “did their own thing”. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED.**<br>**Reference Special Investigation Report 07/11/2023.** |

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14312** | **Resident medications.** |
| | **(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:**<br>**(b) Complete an individual medication log that contains all of the following information:** |

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|---|---|
| | **(i) The medication.**<br>**(ii) The dosage.**<br>**(iii) Label instructions for use.**<br>**(iv) Time to be administered.**<br>**(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**<br>**(vi) A resident's refusal to accept prescribed medication or procedures.** |
| **ANALYSIS:** | I requested the medication administration records (MARs) for all residents. Ms. Matthews stated she did not have the requested documents as she did not complete it. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED.**<br>**Reference Renewal Licensing Study Report 02/14/2023.**<br>**Reference Special Investigation Report 07/11/2023.** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On 07/10/2023, I conducted a telephone interview with Resident K. Resident K stated when she discharged from the facility, there were five residents remaining in the facility. Resident K only knew the first name of three of the residents. She did not know their last names or birthdays. She could not recall the names of the other two residents. The three residents are coded as Resident B, Resident M, and Resident N in this report.

On 07/10/2023, I conducted an unannounced onsite investigation. I interviewed staff Tikyarra Birl. Ms. Birl stated there were four residents residing in the facility. Ms. Birl did not know the residents' last names or birthdays. Per Ms. Birl, the residents in the facility are Resident B, Resident M, Resident N, and Resident O.

On 07/10/2023, I conducted a telephone interview with Resident L. Resident L stated when she discharged from the facility, there were three or four residents remaining in the facility. Resident B was one of the residents. Resident L did not know the names or birthdays of the other remaining residents.

On 07/11/2023, I conducted a telephone interview with administrator Yolanda Matthews. Ms. Matthews confirmed Resident B and Resident O still lived in the facility. Ms. Matthews stated Resident M and Resident N left the facility a while ago. She stated she could not recall when those residents were discharged from the facility. In addition, she stated she did not know their current whereabouts.

On 07/13/2023, I emailed licensee Javon Brown and Ms. Matthews requesting a copy of the resident register.

On 07/13/2023, I received a phone call from Ms. Matthews. Ms. Matthews stated Resident B and Resident O have moved out of the facility. Ms. Matthews stated she did not know the current whereabouts of any of the residents. Ms. Matthews confirmed she received the email. She stated she did not have a resident register with Resident K and Resident L names on it. When I asked for a copy of the register for the other residents, she stated she would have to locate it.

NOTE: In Special Investigation Report #2023A0993027, I interviewed Ms. Matthews on 06/06/2023. Ms. Williams stated Resident C, Resident E, Resident H, Resident I, and Resident J lived in the facility and were present during the incident on 04/30/2023. As a result of the incident as well as the pending court hearing for this facility, Ms. Matthews stated all the residents had been discharged from the facility. Ms. Matthews denied knowing any of those residents' current whereabouts. I initially requested a copy of the resident register on 06/06/2023 while completing Special Investigation Report #2023A0993024. I requested the register again on 06/15/2023 while completing Special Investigation Report #2023A0993027. On 07/05/2023, I spoke with Ms. Matthews. Ms. Matthews acknowledged that I requested documents from her, and she still had not submitted them to me. Ms. Matthews agreed to get the documents to me. As of the date of this report, I have not received a copy of the resident register.

On 07/13/2023, I attempted to conduct an exit conference with licensee Javon Brown with no success. I left a message.

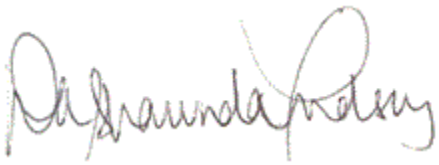
| **APPLICABLE RULE** | |
|---|---|
| **R 400.14103** | **Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.** |
| | **(3) The failure of an applicant or licensee to cooperate with the department in connection with an inspection or investigation shall be grounds for denying, suspending, revoking, or refusing to renew a license.** |
| **ANALYSIS:** | On 06/06/2023, 06/15/2023 and 07/13/2023, I sent an email to Ms. Brown and Ms. Matthews to request a copy of the resident register. On 07/05/2023, I spoke with Ms. Matthews. Ms. Matthews acknowledged that I requested documents from her, and she still had not submitted them to me. Ms. Matthews agreed to get the documents to me. As of the date of this report, I have not received a copy of the resident register. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED**<br>**Reference Special Investigation Report 07/11/2023.** |

| R 400.14210 | **Resident register.** |
|---|---|
| | **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:**<br>**(a) Date of admission.**<br>**(b) Date of discharge.**<br>**(c) Place and address to which the resident moved, if known.** |
| **ANALYSIS:** | I requested a copy of the resident register. Ms. Brown and Ms. Matthews failed to submit a copy of the resident register. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED**<br>**Reference Special Investigation Report 06/21/2023.**<br>**Reference Special Investigation Report 07/11/2023.** |

| **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:** | I interviewed Resident K and Resident L, and they stated there were still residents in the facility when they left on 07/07/2023. During an unannounced onsite investigation on 07/10/2023, Ms. Birl stated there were four residents residing in the facility. Ms. Williams confirmed Resident B and Resident O still lived in the facility on 07/11/2023. Ms. Williams stated all residents have been discharged from the facility on 07/13/2023 and their current whereabouts are unknown.<br><br>As of the date of this report, the whereabouts of the Resident B, Resident M, Resident N, and Resident O are unknown. In Special Investigation Report #2023A0993027, on 06/06/2023, Ms. Matthews stated all residents had been discharged from the facility and their whereabouts were unknown. There is reason to believe that residents are still living in the facility and/or will be returned to the facility at a later time. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED**<br>**Reference Special Investigation Report dated 02/08/2023.**<br>**Reference Special Investigation Report dated 06/21/2023.**<br>**Reference Special Investigation Report dated 07/11/2023.** |

## IV. RECOMMENDATION

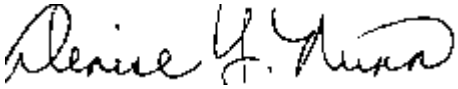
Due to the severity of the quality of care violations, I recommend revocation of the license and that the license be summarily suspended effective immediately.



07/13/2023

DaShawnda Lindsey Date
Licensing Consultant

Approved By:



07/14/2023

Denise Y. Nunn Date
Area Manager