GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 18, 2024

Jamise Mitchell
J & M Family Group LLC
1517 Wadsworth Ave.
Saginaw, MI 48601

RE: License #: AS730413028
Investigation #: 2024A0779029
J & M Family Group LLC

Dear Jamise Mitchell:

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 (517) 643-7960.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730413028
Investigation #:	2024A0779029
Complaint Receipt Date:	04/03/2024
Investigation Initiation Date:	04/04/2024
Report Due Date:	06/02/2024
Licensee Name:	J & M Family Group LLC
Licensee Address:	4544 Cadillac Pl SAGINAW, MI 48604
Licensee Telephone #:	(989) 522-0764
Administrator:	Jamise Mitchell
Licensee Designee:	Jamise Mitchell
Name of Facility:	J & M Family Group LLC
Facility Address:	1517 Wadsworth Ave Saginaw, MI 48601
Facility Telephone #:	(989) 522-0764
Original Issuance Date:	11/20/2023
License **Status:**	TEMPORARY
Effective Date:	11/20/2023
Expiration Date:	05/19/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
AFC home is refusing to accept resident back from the ER (Emergency Room).	Yes

III. METHODOLOGY

04/03/2024	Special Investigation Intake 2024A0779029
04/03/2024	APS Referral Complaint was received from APS.
04/04/2024	Special Investigation Initiated - Telephone Voicemail was left for APS worker.
04/08/2024	Contact - Telephone call made. Spoke to APS worker, Rebecca Robelin.
04/08/2024	Contact - Telephone call made. Interview conducted with Resident A.
04/12/2024	Inspection Completed On-site
04/12/2024	Exit Conference Held with licensee designee, Jamise Mitchell.

ALLEGATION:

AFC home is refusing to accept resident back from ER.

INVESTIGATION:

On 4/8/24, a phone conversation took place with APS worker, Rebecca Robelin, who stated that she had already investigated these same allegations and has closed her case. APS Robelin stated that Licensee, Jamise Mitchell, took Resident A to the local emergency room (ER) on 3/15/24, told the hospital staff that she could no longer care for Resident A and would not take Resident A back to the home. APS Robelin reported that an on-call APS worker had spoken to Licensee Mitchell and was told that Resident A was becoming more aggressive while at the home. APS Robelin stated that Licensee Mitchell told the on-call worker that Resident A had snatched a blanket off of her and was aggressively cussing her out. APS Robelin stated that she was not aware of

Licensee Mitchell providing Resident A with any type of discharge notice. APS Robelin reported that Resident A is his own guardian and stayed at the hospital for 2-3 weeks before they could find another appropriate AFC home for Resident A to go too.

On 4/8/24, a phone interview was conducted with Resident A, who confirmed that he stayed at this home from 2/21/24 through 3/15/24, when he was taken to the hospital. Resident A stated that on 3/15/24, Licensee Mitchell took him to the hospital due to health issues he had been having, stayed with him there for about one hour or so and then left him there. Resident A stated that he has not seen or spoken to Licensee Mitchell since 3/15/24 and that he was never given any type of discharge notice from the home. When asked if there were any problems during his stay at this home, Resident A admitted that he would get verbally aggressive and cuss at Licensee Mitchell. Resident A reported that he got into an argument with Licensee Mitchell on the night of 3/14/24 and scared Licensee Mitchell when he snatched a blanket off of her and cussed at her. Resident A stated that he is now in a different AFC home and is doing okay there.

On 4/12/24, an on-site inspection was conducted and Licensee designee, Jamise Mitchell was interviewed. Licensee Mitchell stated that Resident A was her only resident in this home and confirmed that she took Resident A to the hospital on 3/15/24. Licensee Mitchell stated that she initially took Resident A to his physician's office, where Resident A became quite agitated, made a scene, and demanded that he be taken to the hospital. Licensee Mitchell admitted that she refused to take Resident A back to the home and that she did not provide him with any type of discharge notice. Licensee Mitchell reported that she told the hospital social worker that she no longer felt safe with Resident A in the home, since Resident A was her only resident and she was providing all his care alone. Licensee Mitchell stated that Resident A's behavior kept getting more and more verbally aggressive and then on the night of 3/14/24, Resident A snatched a blanket she was covering up with on the couch and started cussing her out and making verbal threats. Licensee Mitchell stated that the nursing home that Resident A came from, prior to admission into this home, was not honest with her about Resident A's behaviors. Licensee Mitchell reported that she had just learned that Resident A has two past assault and battery charges against him, has active warrants and court hearings scheduled that she was not made aware of. Licensee Mitchell stated that she did not provide Resident A with a discharge notice because the hospital social worker said she was very familiar with Resident A and his behaviors and did not want her to give him a discharge notice, because she did not want to upset Resident A. Licensee Mitchell stated that the social worker told her that she understood why she did not want to take Resident A back to the home and that she would find him another AFC placement for him, but that she would still have to report her for refusing to take Resident A back.

Licensee Michell provided an *AFC Licensing Division Incident/Accident Report* (IR) regarding taking Resident A to the hospital on 3/15/24. The information provided on the IR matched the information Licensee Mitchell provided during her interview.

Resident A's *Assessment Plan for AFC Residents* was reviewed. The plan stated that Resident A is quite independent and is able to complete all his activities of daily living on his own but did not mention anything about Resident A not being able to control aggressive behaviors. There was no written discharge notice given to Resident A.

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 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.
ANALYSIS:	It was confirmed that Resident A was taken to the hospital on 3/15/24 and was not allowed to return to this home. Licensee designee, Jamise Mitchell, stated that Resident A was her only resident and that she was providing all his care by herself. Licensee Michell stated that due to his increased aggressive behaviors, she no longer felt safe with Resident A in the home. Licensee Michell admits that she did not provide Resident A with any type of discharge notice.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/12/24, an exit conference was held with licensee designee, Jamise Mitchell. Licensee Mitchell was informed of the outcome of the investigation and that a corrective action plan is required.

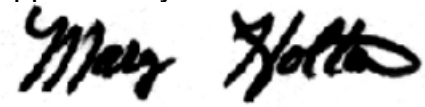
IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

4/18/2024

Christopher Holvey Date
Licensing Consultant

Approved By:



4/18/2024

Mary E. Holton Date
Area Manager