

GRETCHEN WHITMER GOVERNOR STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

MARLON I. BROWN, DPA DIRECTOR

April 22, 2024

Elisa Gill Louisiana Homes Inc 9601 St. Mary's Detroit, MI 48227

RE: License #:	AS820013464
Investigation #:	2024A0121021
-	Louisiana Home 2

Dear Mrs. Gill:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On March 14, 2024, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

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K. Robinson, LMSW, Licensing Consultant Bureau of Community and Health Systems Cadillac PI. 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

#### I. IDENTIFYING INFORMATION

License #:	AS820013464
Investigation #:	2024A0121021
Complaint Pacaint Data:	02/21/2024
Complaint Receipt Date:	02/21/2024
Investigation Initiation Date:	02/22/2024
investigation initiation Date.	
Report Due Date:	04/21/2024
	04/21/2024
Licensee Name:	Louisiana Homes Inc
Licensee Address:	9601 St. Mary's
Licensee Address.	Detroit, MI 48227
Licensee Telephone #:	(313) 838-0046
	(313) 838-884
Administrator:	Elisa Gill, Designee
Administrator.	
Name of Facility:	Louisiana Home 2
Facility Address:	614 W Goldengate
	Detroit, MI 48203
Facility Telephone #:	(313) 368-4857
Original Issuance Date:	N/A
License Status:	REGULAR
Effective Date:	02/08/2024
Expiration Date:	02/07/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED
	MENTALLY ILL
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# II. ALLEGATION(S)

	Violation Established?
On 2/18/24, direct care worker, Robin Jones left the residents home alone before her shift ended.	Yes

## III. METHODOLOGY

02/21/2024	Special Investigation Intake 2024A0121021
02/21/2024	APS Referral Denied
02/21/2024	Referral - Recipient Rights Michelle Livous, Recipient Rights Investigator
02/22/2024	Special Investigation Initiated - Telephone Direct care worker (DCW), Dorene Wade
02/27/2024	Contact - Telephone call received Return call from Elisa Gill, licensee designee.
03/07/2024	Inspection Completed On-site Attempted onsite; all residents and staff gone.
03/11/2024	Contact - Telephone call made Scheduled onsite inspection with Mrs. Gill.
03/13/2024	Inspection Completed-BCAL Sub. Compliance Interviewed Resident A-D, DCW Sherrie Jones, and Mrs. Gill
03/13/2024	Exit Conference Mrs. Gill.
03/14/2024	Corrective Action Plan Received/Approved
04/19/2024	Contact – Telephone call made Attempted call to former direct care worker, Robin Jones, but I received an outgoing message that the owner can't receive calls at this time.
04/19/2024	Contact - Telephone call made

# ALLEGATION: On 2/18/24, direct care worker, Robin Jones left the residents home alone before her shift ended.

**INVESTIGATION:** On 2/22/24, I interviewed Direct Care Worker (DCW) Dorene Wade. Ms. Wade reported that Resident A had to let her in the home on 2/18/24. Ms. Wade indicated that Staff do not possess a key to the home. Ms. Wade said that typically the Staff person on duty will open the door for the relief staff, but when she arrived to work this day, no staff was present. Ms. Wade confirmed (DCW), Robin Jones left the residents unattended. Ms. Wade said this is the first time something like this has happened during her 4-year tenure.

On 2/27/24, I received a phone call from licensee designee, Elisa Gill. Mrs. Gill reported that she terminated Ms. Jones' employment because she left the residents home alone. Mrs. Gill explained Ms. Jones contacted her by phone on 2/18/24 at 1:04 A.M. to let her know that she was leaving her shift without any relief staff. According to Mrs. Gill, Ms. Jones informed her that she had to get home to be with her minor children. Mrs. Gill also indicated that midnight staff person, Mr. Toberi Jones called in sick, so that is why Ms. Jones was expected to stay over until someone came to relieve her. Mrs. Gill stated this is standard practice for all staff to remain on duty to ensure that the residents are properly supervised. Mrs. Gill insists that the incident is isolated which is consistent with Ms. Wade's statement.

On 3/7/24, I attempted to conduct an unannounced onsite inspection, but the residents were away from the home. On 3/13/24, I completed a scheduled onsite inspection at the facility. Resident A explained he woke up around 6:30 A.M. with a migraine headache, so he went downstairs to ask Staff for a pain pill. Resident A said he determined there was no staff present after searching the home. Resident A stated he became "nervous", so he called Ms. Wade to let her know the residents were home alone. Resident A said this is the first time they were left unsupervised. Resident A described the home as a "good home". Resident B said he slept through the whole incident. Resident C said he woke up around 6 or 6:30 A.M. to find no staff present. Resident D said he doesn't remember being left home alone.

On 3/13/24, I completed an exit conference with Mrs. Gill. Mrs. Gill does not dispute the facts surrounding this case. Mrs. Gill is adamant that the situation is related to Ms. Jones and that the residents are never left home alone. On 3/14/24, Mrs. Gill submitted an approved corrective action plan to remedy the situation. On 4/19/24, Mrs. Gill forwarded the message she received from Ms. Jones on 2/18/24. The

message contains the following recorded message from Ms. Jones, "... this is Robin Jones calling for the second time. I'm about to leave the facility. There's no one coming in to fill in. I cannot stay. My kids are at home by they self. I just don't feel right ..." Ms. Jones added that she doesn't feel comfortable staying at the facility with "adults" while her children are at home alone.

APPLICABLE RULE	
R 400.14206	Staffing requirements.
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	On 2/18/24, Mrs. Gill, Resident A and C, and direct care worker, Ms. Wade all reported former direct care worker, Robin Jones left the resident unattended during the midnight shift.
CONCLUSION:	VIOLATION ESTABLISHED

### IV. RECOMMENDATION

An acceptable corrective action plan has been received, therefore, I recommend the status of this license remain unchanged.

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04/19/24

Kara Robinson Licensing Consultant Date

Approved By:

04/22/24

Ardra Hunter Area Manager Date