GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 7, 2024

Phillip Mastrofrancesco
Mastrofrancesco AFC Inc
Suite #5
23933 Allen Road
Woodhaven, MI 48183

RE: License #: AS820095786
Investigation #: 2024A0121024
Ray Residence

Dear Mr. Mastrofrancesco:

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 April 16, 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,

K. Robinson

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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS820095786
Investigation #:	2024A0121024
Complaint Receipt Date:	03/12/2024
Investigation Initiation Date:	03/14/2024
Report Due Date:	05/11/2024
Licensee Name:	Mastrofrancesco AFC Inc
Licensee Address:	Suite #5 23933 Allen Road Woodhaven, MI 48183
Licensee Telephone #:	(734) 671-3654
Administrator:	Phillip Mastrofrancesco,
Name of Facility:	Ray Residence
Facility Address:	18787 Ray Riverview, MI 48192
Facility Telephone #:	(734) 282-8116
Original Issuance Date:	07/16/2001
License **Status:**	REGULAR
Effective Date:	06/09/2022
Expiration Date:	06/08/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Home Manager, Rayshawn Whigham, belittles Resident A and calls him names and she pushes the resident to hurry him along.	Yes

III. METHODOLOGY

03/12/2024	Special Investigation Intake 2024A0121024
03/12/2024	APS Referral Denied
03/12/2024	Recipient Rights – Referral Ann Alexander, Recipient Rights Investigator (RRI)
03/14/2024	Special Investigation Initiated - Telephone Ann Alexander, Recipient Rights Investigator
03/14/2024	Contact - Telephone call made Direct care worker, Cynthia Woods
03/14/2024	Contact - Telephone call made Left message for Philip Mastrofrancesco, Licensee.
03/14/2024	Contact - Telephone call received Return call from Kristen Murphy on behalf of the licensee.
03/14/2024	Contact - Document Received Remedial Action Response.
03/19/2024	Inspection Completed On-site Interviewed Resident A and B, Direct care workers, Cynthia Woods and Nicole Wessel.
04/08/2024	Contact - Telephone call made Guardian B
04/08/2024	Contact - Telephone call made Left message for Mr. Mastrofrancesco; no response.

04/08/2024	Contact – Telephone call made Left message for Rayshawn Whigham; no response.
04/15/2024	Contact - Telephone call made Left message for Mr. Mastrofrancesco.
04/16/2024	Exit Conference Return call from Mr. Mastrofrancesco
04/16/2024	Corrective Action Plan Received

ALLEGATION: Home Manager, Rayshawn Whigham, belittles Resident A and calls him names and she pushes the resident to hurry him along.

INVESTIGATION: On 3/14/24, I initiated the complaint with a phone call to Recipient Rights Investigator, Ann Alexander. Ms. Alexander reported that a year or so ago, she investigated a similar complaint involving Home Manager, Rayshawn Whigham, but there was very little evidence to support the allegation. Ms. Alexander indicated that she also investigated another complaint involving Ms. Whigham using profanity when talking to residents that was substantiated. Ms. Alexander stated that “everyone is afraid of her”, referring to Ms. Whigham.

On 3/14/24, I contacted the facility to determine the day-to-day schedule at the facility. Direct care worker, Cynthia Woods reported Resident A attends a day program at the Arkay, but he’s suspended until 3/20/24. I also attempted to contact Mr. Mastrofrancesco, licensee, but Kristen Murphy indicated Mr. Mastrofrancesco is unavailable. Ms. Murphy reported Mr. Mastrofrancesco implemented a Remedial Action Plan with Ms. Whigham to afford her the opportunity to correct the behavior. Nonetheless, I informed Ms. Murphy that Ms. Whigham should be removed from the staff schedule pending further investigation by the department.

On 3/19/24, I completed an onsite inspection at the facility. Initially, Resident A denied that Ms. Whigham cursed at him, but he did say she would “kick at me as she told me to go to my room.” Then, Resident A admitted Ms. Whigham would tell him to “take your ass to the room” or “take your ass to the shower.” Resident A and Resident B are roommates. Resident B reported the following about Ms. Whigham: “she screams, she cursed, she mentally tormented me.” According to Resident B, he was “afraid to speak up” to report the abuse. Resident B also reported he would bang his head when having a behavior and Ms. Whigham would encourage him to self-harm by saying, “Go ahead, burst it to the white meat!” Resident B also said Ms. Whigham would isolate him and Resident A by forcing them to eat alone, separate from the other residents in the home. Resident B reported witnessing Ms. Whigham “push my roommate”, referring to Resident A, but he denied that she used physical force with him. Lead staff, Nicole Wessel confirmed Ms. Whigham cursed

at residents. Specifically, Ms. Wessel stated she observed Ms. Whigham refer to Resident A and Resident B as a “bitch ass nigga”; she said she also heard Ms. Whigham call Resident A “retarded … special motherfucking nigga!” Ms. Wessel described the abuse as “horrible”. Direct care worker, Cynthia Woods has been working at the home since November 2023. Ms. Woods reported she observed Ms. Wingham call the residents bad names like, “stupid motherfucker” and “ugly motherfuckers”! Ms. Woods described Ms. Whigham as “angry”. Both Ms. Wood and Ms. Wessel stated they were afraid to come forward to report what was happening at the home because Ms. Whigham would threaten to fire staff or reduce their hours, so they kept quiet.

On 4/8/24, I interviewed Guardian B by phone. Guardian B reported she was informed Ms. Whigham threatened to harm Resident A. Guardian B described Ms. Whigham as “rude” and “mean to everybody”. Guardian B reported Ms. Whigham would talk to Resident B with “contempt and disgust”.

On 4/8/24, I made an attempted call to Rayshawn Whigham to obtain her witness statement. There was no answer, so I left a voice message. To date, Ms. Whigham has not returned my call.

On 4/15/24, I completed an exit conference with Phillip Mastrofrancesco, licensee. Mr. Mastrofrancesco apologized for the delay in calling me back. Mr. Mastrofrancesco acknowledged that Ms. Whigham was abusive to the staff, so in his opinion, she inadvertently exposed the residents to verbal abuse. Mr. Mastrofrancesco reported Ms. Whigham has since been relieved of all direct care duties because “I didn’t think she was going to change”, referring to Ms. Whigham. He also explained Ms. Whigham is not likely to return my call since she is no longer employed with him. On 4/16/24, Mr. Mastrofrancesco submitted an acceptable plan of correction identifying the action steps he took to remedy the situation.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means. **(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:** **(a) Use any form of punishment.**

	(b) Use any form of physical force other than physical restraint as defined in these rules. **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.** **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.** **(e) Withhold food, water, clothing, rest, or toilet use.** **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.** **(g) Refuse the resident entrance to the home.** **(h) Isolation of a resident as defined in R 400.14102(1)(m).** **(i) Any electrical shock device.**
ANALYSIS:	• Resident A and B reported former Home Manager, Rayshawn Whigham cursed at residents on several occasions. • Resident A reported Ms. Whigham would “kick at him” in an intimidating manner. • Resident B observed Ms. Whigham push Resident A. • Direct care workers, Nicole Wessel and Cynthia Woods reported former Home Manager, Rayshawn Whigham used gross profanity with residents to intimidate them, in addition to the Staff. • Mr. Mastrofrancesco concurred Ms. Whigham exposed the residents to serious mental harm by verbally abusing the staff in their presence. • Therefore, there is a preponderance of evidence that Ms. Whigham’s conduct created an emotionally cruel home environment for residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/07/24

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Kara Robinson — Date
Licensing Consultant

Approved By:

05/07/24

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Ardra Hunter — Date
Area Manager