GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 1, 2024

Chiquita Thomas
Diamond Adult Foster & Respite Homes LLC
24507 Lafayette Circle
Southfield, MI 48075

RE: License #: AS820339504
Investigation #: 2024A0992034
Diamond Adult Foster Homes

Dear Ms. Thomas:

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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820339504
Investigation #:	2024A0992034
Complaint Receipt Date:	05/08/2024
Investigation Initiation Date:	05/10/2024
Report Due Date:	07/07/2024
Licensee Name:	Diamond Adult Foster & Respite Homes LLC
Licensee Address:	24507 Lafayette Circle Southfield, MI 48075
Licensee Telephone #:	(313) 704-4641
Administrator:	Chiquita Thomas
Licensee Designee:	Chiquita Thomas
Name of Facility:	Diamond Adult Foster Homes
Facility Address:	5400 Oakman Blvd Detroit, MI 48204
Facility Telephone #:	(313) 307-7112
Original Issuance Date:	06/30/2014
License Status:	REGULAR
Effective Date:	12/31/2022
Expiration Date:	12/30/2024
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was discharged without proper notice because she refused to allow Chiquita Thomas, licensee to become her payee.	Yes

III. METHODOLOGY

05/08/2024	Special Investigation Intake 2024A0992034
05/10/2024	Special Investigation Initiated - On Site Felicia Ware, direct care staff and Resident B.
05/10/2024	Contact - Telephone call made Chiquita Thomas, licensee designee
05/10/2024	Contact - Telephone call made Resident A not available. Message left.
05/13/2024	Contact - Telephone call received Resident A
05/13/2024	Contact - Telephone call made Donna Walker, direct care staff was not available. Message left.
05/13/2024	Contact - Telephone call received Ms. Walker
05/13/2024	Contact - Telephone call made Cathy Broadnax, Detroit Wayne Integrated Health Network (DWIHN) Residential Placement Unit.
05/14/2024	Contact - Telephone call made Ms. Thomas
06/12/2024	Contact - Telephone call made Resident A
06/13/2024	Contact - Telephone call made Corneilus Crenshaw, Resident A's support coordinator with Team Mental Health

06/12/2024	Contact - Telephone call made Donnay Castings, Resident A's former support coordinator with Team Mental Health. She was not available, an email was sent.
06/13/2024	Contact - Telephone call made Mr. Crenshaw
06/17/2024	Contact - Telephone call made Ms. Thomas
06/17/2024	Contact - Telephone call made Ms. Broadnax
06/18/2024	Contact - Telephone call made Resident B
06/18/2024	Exit Conference Ms. Thomas
06/24/2024	APS Referral
06/24/2024	Referral - Recipient Rights

ALLEGATION: Resident A was discharged without proper notice because she refused to allow Chiquita Thomas, licensee to become her payee.

INVESTIGATION: On 05/10/2024, I completed an unannounced onsite inspection and conducted a face-to-face interview with direct care staff Felicia Ware and Resident B. Ms. Ware stated Resident A no longer resides at the home; she stated Resident A was discharged. I asked Ms. Ware why Resident A was discharged, and she stated Resident A decided to move out which resulted in her being discharged. Ms. Ware stated she was not on shift when Resident A left the home, and direct care staff Donna Walker was on shift. Ms. Ware stated from her understanding, Resident A took some of her belongings when she left and later returned to get the rest. When I asked Ms. Ware about Resident A's discharge date, she stated she was not sure and agreed to look for the discharge notice. Ms. Ware located the discharge notice and provided me with a copy. According to the emergency discharge notice, Resident A was discharged on 05/06/2024. The reason for the emergency discharge were as follows: "Resident A stated to provider verbally that she was leaving, moving her things with her daughter on 5/5/2024. Because she doesn't need our help or services. Resident A called a ride and took most of her belongings stating I should give her 30 days to get her belongings. I tried communicating with Resident A by cell and she told me that she wasn't up to talking. Provider doesn't think Resident A is fit for adult foster care home, she leaves daily with different males and doesn't follow

home rules." Ms. Ware contacted Chiquita Thomas, licensee designee to make her aware I was onsite. Due to the lack of privacy, I made Ms. Thomas aware of the allegation but agreed to contact her once I left the home to further discuss the allegation, which she agreed.

I interviewed Resident B. Resident B stated she has been in contact with Resident A. She stated Resident A told her she was moving out and was slowly taking her belongings. She stated Resident A said she was moving with her daughter. Resident B showed me a text message she received from Resident A. The text message said, "I'm coming to get my belongings between 8:00-9:00, Ms. Thomas kicked me out."

On 05/10/2024, I contacted Ms. Thomas and interviewed her regarding the allegation, which she denied. Ms. Thomas stated Resident A often leaves the home and gets high. She stated when Resident A returns to the home she wreaks of marijuana and is combative. Ms. Thomas stated Resident A was not following the house rules. She stated Resident A said she was moving out. Ms. Thomas stated she was contacted by Ms. Walker and made aware that Resident A took some of her belongings on 5/5/2024 with the intentions of not returning. Ms. Thomas stated Resident A returned on 5/6/2024 to get her medications. Ms. Thomas stated she was there when Resident A returned and she tried to talk to her, but she refused to talk. I made Ms. Thomas aware that based on her disclosures, an emergency discharge was not warranted and further explained the difference between a 30-day discharge and an emergency discharge. Ms. Thomas stated she contacted Cathy Broadnax, Residential Placement Unit with Detroit Wayne Integrated Health Network (DWIHN) and explained what was going on. Ms. Thomas stated Ms. Broadnax advised her to discharge Resident A. Ms. Thomas stated Resident A does not have a guardian. She stated she receives mental health services through Team Mental Health. I made Ms. Thomas aware of the investigation process and agreed to follow-up with her for an exit conference upon completion of the investigation.

On 05/13/2024, I received a telephone call from Resident A and I interviewed her. Resident A stated she was allowed to go and come as she please, and she would sign in and out. Resident A stated she contacted Ms. Thomas and let her know she was going with her daughter overnight. Resident A said Ms. Walker was on shift and she gave her medication to take with her while she was gone. Resident A stated she had an upcoming social security appointment and agreed to return before her appointment time. Resident A said she did not return in time, and she received a call from Ms. Thomas stating she was being discharged for not returning timely. Resident A said Ms. Thomas wanted to become her payee and she did not agree. Resident A said she is capable of handling her own funds. Resident A said she feel as though it is not fair because she has nowhere to go, and Ms. Thomas put her out. I asked Resident A if she told Ms. Thomas she was moving, packed her belongings and left; Resident A said, "No." Resident A identified Corrine (last name unknown) as her support coordinator with team mental health. She said she has been in contact with her, and she is actively seeking placement.

On 05/13/2024, I received a telephone call from Ms. Walker, and I interviewed her. Ms. Walker stated she was on shift on 5/5/2024 when Resident A left. She stated Resident A told her she was going to stay with her daughter overnight. Ms. Walker stated she gave Resident A her medication for Sunday afternoon, bedtime and Monday morning and afternoon. Ms. Walker confirmed Resident A took some of her belongings. She said Resident A said she was leaving but she is unable to determine if she meant for the night or permanently. However, Ms. Walker stated Resident A did state she would be back to gather the rest of her belongings. Ms. Walker stated she was not on shift when Resident A returned.

On 05/13/2024, I contacted Ms. Broadnax and interviewed her regarding the allegation. Ms. Broadnax confirmed she did receive a call from Ms. Thomas and spoke with her briefly regarding Resident A. Ms. Broadnax stated Ms. Thomas explained that Resident A stated she was leaving and not returning. Ms. Broadnax stated she advised Ms. Thomas to submit discharge documentation to the residential placement department. Ms. Broadnax confirmed the discharge document was received on 5/7/2024.

On 05/14/2024, I contacted Ms. Thomas and made her aware that I interviewed Ms. Broadnax and she confirmed she advised her to discharge Resident A. I also made Ms. Thomas aware that although Ms. Broadnax advised her to discharge Resident A, it is her responsibility as the licensee to discharge Resident A in accordance with licensing rules and she did not do that. I further stated that based on Resident A's behaviors documented on the emergency discharge notice, an emergency discharge was not warranted. Ms. Thomas stated Resident A would go and come as she please, but when she returned, she wreaked of marijuana. She stated Resident A's behaviors posed a risk because Resident A is prescribed psychotropic medication, that should not be combined with marijuana. She also stated Resident A would bring marijuana gummies into the home. Ms. Thomas stated Resident A tried to give marijuana gummies to Resident B. I explained to Ms. Thomas I understand, but she did not properly document Resident A's behaviors in the discharge notice.

On 06/13/2024, I contacted Corneilus Crenshaw, Resident A's support coordinator with Team Mental Health and interviewed him. Mr. Crenshaw denied having any knowledge of the allegation. He stated Resident A was recently transferred to his caseload. He stated Resident A's case was previously assigned to Valencia Thorne from 11/21/2023 - 2/6/2024 and with Donnay Castings from 2/6/2024 - 3/26/2024. He agreed to review Resident A's case file to see if there is any mention of Resident A being discharged from Diamond Adult Foster Home.

On 06/13/2024, I attempted telephone contact with Donnay Castings, Resident A's former support coordinator with team mental health. I was transferred to a number that did not belong to Ms. Castings. The receptionist explained that due to changes within team mental health, she did not have the correct number for Ms. Castings. She agreed to send an email requesting Ms. Castings to contact me.

On 06/14/2024, I received a voicemail from Mr. Crenshaw. He stated that he had an opportunity to conference with Ms. Thorne and Ms. Castings regarding Resident A. He said according to Ms. Thorne the adult foster home was trying to become Resident A's payee and she was not in agreement. He said according to Ms. Castings, Resident A was discharged because she would not agree to allow the home to control her funds. He said the consensus is Resident A was discharged because she did not agree with the home becoming her payee.

On 06/14/2024, a copy of the discharge documentation was not contained in the facility's electronic licensing file. The assigned licensing consultant did not receive a copy of the discharge documentation.

On 06/17/2024, I made follow-up contact with Ms. Broadnax and educated her on the discharge policy. I explained the difference between a 30-day discharge and an emergency discharge. I made her aware that a licensee can discharge a resident by issuing a 30-day discharge if the home can no longer meet the resident's needs. In, addition the licensee is responsible for contacting the placement agency to make sure placement has been secured opposed to just discharging the resident. I further explained that an emergency discharge can be issued if there is a substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home; if there is a substantial risk, or an occurrence, of self-destructive behavior; if there is a substantial risk, or an occurrence, of serious physical assault; and/or there is a substantial risk, or an occurrence, of the destruction of property. I made Ms. Broadnax aware that in this case there was not a substantial risk based on the information received and Resident A is currently homeless. Ms. Broadnax requested Resident A's contact information and she agreed to contact her supervisor in attempt to expedite placement for Resident A.

On 06/18/2024, I conducted an exit conference with Ms. Thomas. I explained that based on the investigative findings there is sufficient evidence to support the allegation. I made Ms. Thomas aware that Resident A's behaviors did not warrant an emergency discharge according to what was documented on the discharge notice. I further explained that if she felt as though Resident A's behaviors posed a substantial risk due to the inability of the home to meet Resident A's needs or assure the safety and well-being of other residents of the home; she needed to document as such. Based on the findings, I made Ms. Thomas aware the allegation is substantiated, and a written corrective action plan is required. Ms. Thomas denied having any questions or concerns. She agreed to review the report and contact me if necessary.

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.**
	(4) A licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home.** **(b) Substantial risk, or an occurrence, of self-destructive behavior.** **(c) Substantial risk, or an occurrence, of serious physical assault.** **(d) Substantial risk, or an occurrence, of the destruction of property.**
ANALYSIS:	During this investigation, I interviewed licensee Chiquita Thomas; direct care staff Felicia Ware and Donna Walker; Resident A's support coordinator Corneilus Crenshaw and Residents A and B regarding the allegations. Resident A stated she was issued an emergency discharge without proper notice. Resident A was adamant that she was discharged because she refused to allow Ms. Thomas to become her payee. Mr. Crenshaw stated based on his knowledge Resident A was discharged because she refused to allow Ms. Thomas to control her funds. Ms. Thomas confirmed Resident A was issued an emergency discharge, she denied it was because Resident A refused to appoint her as her payee and stated Resident A's behaviors posed a risk to herself and the other residents in the home. I observed the emergency discharge notice, which stated Resident A was discharged because she does not require adult foster care services and stated she was moving out. Ms. Thomas did not document behaviors that constitute a substantial risk and/or warrant an emergency discharge. Based on the findings, there is sufficient evidence to support the allegation. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 06/14/2024, I contacted the adult foster care licensing consultant to make sure she received discharge documentation from Ms. Thomas regarding Resident A. The adult foster care licensing consultant she stated she did not receive discharge documentation. The discharge notice was not received by the assigned licensing consultant and is not contained in the facility's electronic licensing file. Ms. Thomas said she could not recall if she sent a copy of the discharge notice to the assigned licensing consultant. She stated she would typically call the assigned licensing consultant, but she did not do that this time.

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.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.**
ANALYSIS:	Chiquita Thomas, licensee did not notify the adult foster care licensing consultant not less than 24 hours before discharge.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend that the status of the license remains the same.

07/01/2024

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Denasha Walker Date
Licensing Consultant

Approved By:

07/01/2024

_____

Ardra Hunter Date
Area Manager