GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 25, 2024

Johnnie Denham
Slim Haven, LLC
Ste. 1137
6659 Schaefer Rd
Dearborn, MI 48126

RE: License #: AS820407225
Investigation #: 2024A0101029
Slim Haven Abington

Dear Jr. Denham:

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.

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,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820407225
Investigation #:	2024A0101029
Complaint Receipt Date:	06/06/2024
Investigation Initiation Date:	06/07/2024
Report Due Date:	08/05/2024
Licensee Name:	Slim Haven, LLC
Licensee Address:	Ste. 1137 6659 Schaefer Rd Dearborn, MI 48126
Licensee Telephone #:	(800) 993-1287
Administrator:	Johnnie Denham
Licensee Designee:	Johnnie Denham
Name of Facility:	Slim Haven Abington
Facility Address:	9597 Abington Detroit, MI 48227
Facility Telephone #:	(313) 397-8327
Original Issuance Date:	02/09/2022
License **Status:**	REGULAR
Effective Date:	08/09/2022
Expiration Date:	08/08/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
The staff is smoking marijuana and drinking alcohol with the residents.	No
Additional Findings	Yes

III. METHODOLOGY

06/06/2024	Special Investigation Intake 2024A0101029
06/06/2024	Referral received from Adult Protective Services (APS) and Office of Recipient Rights (ORR)
06/07/2024	Special Investigation Initiated - Telephone Licensee designee, John Denham
06/13/2024	Inspection Completed-BCAL Sub. Compliance Interviews Home Manager, Tekeya Knox Resident A Resident B
06/18/2024	Contact - Telephone call made Mr. Denham
07/17/2024	Contact- Document received Additional information regarding lack of supervision
07/17/2024	Contact – Telephone call made Neighbor 1
07/22/2024	Contact - Telephone call made Recipient Rights Investigator, Ann Alexander
07/22/2024	Contact - Document received Photo, water on basement floor
07/22/2024	Contact - Telephone call made Mr. Denham
07/24/2024	Contact - Document received

	Photo, staff sleeping in a chair, video of resident urinating on the sidewalk in front of the home
07/25/2024	Contact – Telephone call received Ms. Alexander
07/25/2024	Contact - Telephone call made Mr. Denham
07/29/2024	Contact – Document received Incident report from Ms. Alexander
08/13/2024	Contact - Telephone call made Direct care staff (DCS) La Trayer Wilson
08/13/2024	Contact - Telephone call made DCS Lashea Havis
08/13/2024	Contact - Telephone call made DCS John Gibson
08/16/2024	Inspection – Onsite
08/23/2024	Contact – Telephone call made Mr. Denham
08/27/2024	Contact – Documents received, DCS Johnetta Downing employee record (1) CPR and First aid Certificate (2) Direct care worker training certificates (3) TB test result (4) Workforce Background Check Consent and Disclosure (5) Slim Haven Application (6) Medical Clearance Request (BCAL-3704-AFC)
08/28/2024	Contact – Telephone call made Mr. Denham
08/28/2024	Contact – Telephone call made DCS Johnetta Downing
08/29/2024	Contact- Telephone call made Workforce Background Unit Hotline
08/29/2024	Contact – Telephone call received Representative in the LARA Workforce Background Check Section

09/10/2024	Contact – Telephone call made, Direct Care and Resource Training, Bruce McCollum
09/10/2024	Contact- Telephone call made Exit conference with Mr. Denham
09/10/2024	Contact – Telephone call made Ms. Alexander

ALLEGATION: The staff is smoking marijuana and drinking alcohol with the residents.

INVESTIGATION: On 06/06/2024, I spoke with the Licensee designee, Johnnie Denham. Mr. Denham denied the allegation that the staff is smoking marijuana and drinking alcohol with the residents. Mr. Denham stated that the neighbors are making up false allegations because they do not want the group home on their street.

On 06/13/2024, I interviewed the Home Manager, Tekeya Knox. Ms. Knox denied the allegations. Ms. Knox stated that she does not smoke or drink.

On 06/13/2024, I interviewed Resident A and Resident B. They both stated that they have never observed staff smoking marijuana or drinking alcohol while on duty.

On 08/13/2024, I spoke with direct care staff (DCS) Lashea Havis. Ms. Havis stated that Ms. Knox uses drugs. Ms. Havis could not provide direct knowledge of Ms. Knox's drug usage.

On 08/13/2024, I spoke with former DCS LaTrayer Wilson. Ms. Wilson stated that she was wrongfully terminated. Ms. Wilson stated Mr. Denham fired her because she had spoken with the recipient rights investigator. Ms. Wilson stated everything was going well at the group home up until Ms. Knox was appointed the home manager. Ms. Wilson was adamant that Ms. Knox uses drugs and drinks alcohol with the residents. However, Ms. Wilson could not provide any direct knowledge that Ms. Knox smokes marijuana and drinks with the residents. Ms. Wilson further stated a resident told her, "How can you tell me not to smoke marijuana when Ms. Knox smokes marijuana." Ms. Wilson did not remember which resident told her this. Ms. Wilson further stated she took a photo of Ms. Knox passed out from being "high". I informed Ms. Wilson that I have a copy of the photo. I informed Ms. Wilson the photo only shows that Ms. Knox is sleeping which proves she is not providing supervision.

On 08/13/2024, I spoke with DCS John Gibson. Mr. Gibson stated, "I have no knowledge of staff smoking marijuana or drinking alcohol with the residents.

However, I have observed residents smoking marijuana outside of the home."

On 08/20/2024, I conducted an exit conference with Mr. Denham. Mr. Denham agree with my findings.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.
ANALYSIS:	There is no evidence to determine that staff smokes marijuana and drinks alcohol with the residents. Home manager, Tekeya Knox, stated she does not smoke or drink. Resident A and B stated they have never observed staff smoking marijuana or drinking alcohol while on duty. According to Ms. Havis and Ms. Wilson the home manager uses drugs however they did not have any proof of Ms. Knox's drug usage. Direct care staff, John Gibson stated, " I have no knowledge of staff smoking marijuana or drinking alcohol with the residents…"
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: When I arrived at the group home on 06/13/2024, I parked in front of the home. When I exited my vehicle, I noticed a car pull up and it parked directly across the street from my vehicle. I proceeded to the front porch and knocked on the door. The lady who was parked in the vehicle directly across the street from my vehicle walked up behind me and announced that she was staff. She identified herself as home manager, Tekeya Knox. Ms. Knox stated that she went to the gas station to get some snacks. Other than the residents, I did not observe anybody else in the home.

On 06/18/2024, I spoke with Mr. Denham. Mr. Denham stated that on 06/13/2024, Ms. Knox was the only staff working.

On 07/17/2024, the department received additional information regarding a lack of supervision at the group home. I contacted the neighbor who reported the additional information. Neighbor 1 stated staff are leaving the residents alone, and when the residents are left alone, they intimidate the neighbors. Neighbor 1 stated she is afraid to leave her home. Neighbor 1 stated when she leaves for work, she must run to her car because there is a resident at the group home that runs up on her with his hands held in a fist position. Neighbor 1 stated she informed staff of the resident's behavior and the staff responded, "I'm afraid of him too."

On 07/24/2024, I received a picture of Ms. Knox sleeping in a chair at the group home. On 08/13/2024, Ms. Knox acknowledged it was her asleep in the chair, however, she contends it is an old picture. Ms. Knox stated that she received a verbal warning for sleeping while on duty. I agree that it is an older picture because she is wearing a coat in the photo. Ms. Knox acknowledged that she is aware that sleeping on the job and leaving the residents alone are prohibited. Ms. Knox further acknowledged that she is aware that twenty-four-hours supervision is required at all times. Even though Ms. Knox is aware the twenty-four-hours supervision is required at all times she continued to leave the resident in unsupervised situations.

On 07/25/2024, I spoke with the Recipient Rights Investigator Ann Alexander. Ms. Alexander stated that on 06/26/2024, she went to Slim Haven. When she arrived at the group home, she noticed a female leaning into a car in the driveway. When Ms. Alexander got out of her car, the female leaning into the car went on the porch. The female identified herself as Johnetta Downing. Ms. Downing stated she was new staff, and she started her employment with Slim Haven on 06/22/2024. Ms. Downing informed Ms. Alexander that Ms. Knox went to the pharmacy. Ms. Alexander stated she waited 30 minutes and Ms. Knox did not return. Furthermore Ms. Downing called Ms. Knox and Ms. Knox did not return her phone calls. Ms. Alexander stated she later conducted a search in the recipient rights' data base and learned Ms. Downing was not trained and should not have been left alone with the residents. Ms. Alexander stated when she spoke with Mr. Denham regarding Ms. Downing's training, he stated Ms. Downing was not trained because she was new. Ms. Alexander stated she would forward an incident report to me regarding this matter. On 07/29/2024, I received Ms. Alexander's incident report.

On 07/25/2024, I spoke with Mr. Denham regarding Ms. Downing working alone on 06/26/2024, and to determine if Ms. Downing was trained. Mr. Denham initially stated Ms. Downing was not working alone. Mr. Denham stated Ms. Knox was also working. I apprised Mr. Denham that on 06/26/2024, Ms. Alexander conducted an inspection. When she arrived, she learned that Ms. Knox had left Ms. Downing alone in the home with the residents. I asked Mr. Denham if Ms. Downing had been trained. Mr. Denham stated Ms. Downing was not trained because she was new. Mr. Denham further stated that he has thirty days to get a new employee trained. I

informed him that pursuant to licensing rule 204 (3) "… Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas:
(a) Reporting requirements.
(b) First aid.
(c) Cardiopulmonary resuscitation.
(d) Personal care, supervision, and protection.
(e) Resident rights.
(f) Safety and fire prevention.
(g) Prevention and containment of communicable diseases."

On 08/20/2024, I spoke with Mr. Denham regarding the rule violations. Mr. Denham once again stated he was not in violation of licensing rule 204 (3) because he has thirty days to get a new employee trained. I explained to Mr. Denham that I believe it is the Office of Recipient Rights that give you thirty days to get your new employees trained however licensing rule 204 (3) states staff shall be competent before performing assigned tasks. Mr. Denham responded, "so what am I supposed to do about trained staff when I get a one-on-one resident?" I explained licensing rule 301(2) "A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions:
(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.
(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home…."
Therefore if you do not have trained staff to care for that individual you should not be accepting the resident.

On 08/23/2024, I requested that Mr. Denham submit Ms. Downing employee record.
On 08/27/2024, I received the following documents:
(1) CPR and First aid Certificate
(2) Direct care worker training certificates
(3) TB test result
(4) Workforce Background Check Consent and Disclosure
(5) Slim Haven Application
(6) Medical Clearance Request (BCAL-3704-AFC) incomplete no exam given

According to these documents Ms. Downing's date of hire was 06/20/2024.

The training documents Mr. Deham submitted raised my suspicion because on 07/25/2024, and again on 08/20/2024, Mr. Denham admitted to me that Ms. Downing was not trained. According to the CPR and first aid certificate, Ms. Downing completed this training on-line. The certificate contains an assigned certificate identification number on it. On the website for this training, you can enter the certificate identification number to verify who the certificate belongs to. The CPR and First aid certificate Mr. Denham modified and then submitted belongs to another

one of his DCS, Lashea Havis and not Ms. Downing. Ms. Downing's direct care training certificates that Mr. Denham modified and submitted indicated that she was trained at the McCollum Companies doing business as Direct Training and Resource Center. On 09/10/2024, I spoke with the Chief Training Officer and Product Developer at Direct Training and Resource Center, Bruce McCollum. Mr. McCollum verified that Ms. Downing did not attend training at the Direct Training and Resource Center. On 08/29/2024, I spoke with the representative the LARA Workforce Background Check Section. The representative stated that Mr. Denham never conducted a background check for Ms. Downing and if he had he would have known that she is not eligible to work in an adult foster care home until February of 2026. The representative further stated that Ms. Downing was also notified of her ineligibility to work in an adult foster care home. The representative stated in February of 2024, it was a staffing agency that requested a background check on Ms. Downing.

On 08/28/2024, I spoke with Ms. Downing. Initially Ms. Downing was reluctant to speak with me. Ms. Downing stated that she worked at Slim Haven for one month. Ms. Downing stated she left Slim Haven because it was not enough money. Ms. Downing acknowledged that on 06/26/2024, when Ms. Alexander arrived at the home, she was the only staff present. Ms. Downing stated Ms. Knox went to the store. Ms. Downing further stated she was trained and had been fingerprinted. Ms. Downing stated that she would forward me documentation of her training. Ms. Downing verified that the email address on her application with Slim Haven was her correct email address. When I attempted to email Ms. Downing my e-mail address, I learned my messages was undeliverable because her email address was not valid. I immediately attempted to call and send Ms. Downing a text message, however, she did not respond.

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:	The licensee did not have sufficient staff on duty at all times for the supervision, personal care, and protection of residents. On 06/13/2024, I conducted an onsite inspection. Upon my arrival, there was no trained staff present in the home. Ms. Knox, the only staff on duty, returned to the home after I arrived. On 07/25/2024, I spoke the recipient rights investigator, Ann Alexander. Ms. Alexander stated that on 06/26/2024, she arrived at the home and learned that Ms. Knox had left the residents alone with a new staff, Johnetta Downing. Ms. Dowing had only been working for five days and was not trained. On 08/28/2024, I spoke with Ms. Downing. Ms. Downing acknowledged that on 06/26/2024, when Ms. Alexander arrived at the home, she was the only staff present.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	((3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: (a) Reporting requirements. (b) First aid. (c) Cardiopulmonary resuscitation. (d) Personal care, supervision, and protection. (e) Resident rights. (f) Safety and fire prevention. (g) Prevention and containment of communicable diseases.

ANALYSIS:	Ms. Downing was performing assigned task and was not trained. On 07/25/2024 and again on 08/20/2024, Mr. Denham admitted to me that Ms. Downing was not trained.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
MCL 400.14403	**Denying, suspending, revoking, refusing to renew, or modifying license; grounds; written notice; hearing; decision; protest; receiving or maintaining adults requiring foster care as felony; penalty; relocation services.**
	(1) The department may deny, suspend, revoke, or refuse to renew a license, or modify a regular license to a provisional license, if the licensee falsifies information on the application for license or willfully and substantially violates this act, the rules promulgated under this act, or the terms of the license.
ANALYSIS:	The licensee willfully and substantially violated this act, the rules promulgated under this act, or the terms of the license. On 08/27/2024, Mr. Denham submitted the following falsified documents: 1. Ms. Downing's CPR and First Aid training certificate 2. Ms. Downing's direct care training certificates Mr. Denham offered Ms. Downing conditional employment and failed to conduct the Workforce Background Check. According to Ms. Downing she worked at Slim Haven for one month. Ms. Downing is not eligible to work in an adult foster care home.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 07/22/2024, the recipient right investigator, Ann Alexander forwarded me a photo of standing water in the basement of Slim Haven group home.

On 07/22/2024, I informed Mr. Denham that there was standing water on the basement floor.

On 07/24/2024, I spoke with Mr. Denham regarding the standing water in the basement. Mr. Denham stated the laundry tub drain was clogged. Mr. Denham

stated he removed the clog and there is no standing water in the basement.

On 08/16/2024, I conducted an onsite inspection. There was no standing water in the basement of the group home.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(6) All plumbing fixtures and water and waste pipes shall be properly installed and maintained in good working condition. Each water heater shall be equipped with a thermostatic temperature control and a pressure relief valve, both of which shall be in good working condition.
ANALYSIS:	The laundry tub in the basement was not in good working condition. On 07/22/2024, I received a photo of standing water on the basement floor of Slim Haven. On 07/24/2024, I spoke with Mr. Denham regarding the standing water on the basement floor. Mr. Denham stated the laundry tub overflowed due to the drain being clogged.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/10/2024, I conducted an exit conference with Mr. Denham. Mr. Denham did not dispute the findings. Mr. Denham also apologized for submitting false documentation. Mr. Denham stated that he panicked and made the wrong decision.

IV. RECOMMENDATION

In lieu of submitting an acceptable corrective action plan, on 09/10/2024, Mr. Denham forwarded the licensing consultant a letter stating he was voluntarily relinquishing the license. On 09/10/2024, Detroit Wayne Integrated Health Network staff removed all the residents from Slim Haven, and they are not renewing Mr. Denham's contract, scheduled to expire on 09/30/2024. Therefore, I recommend the license be voluntarily closed.

09/17/2024

Edith Richardson — Date
Licensing Consultant

Approved By:

09/25/2024

Ardra Hunter — Date
Area Manager