GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 18, 2024

Anh Huynh
Twin Oaks Extended Care Corp.
27024 Norfolk
Inkster, MI 48141

RE: License #: AS820272335
Investigation #: 2024A0101037
Twin Oaks II

Dear Ms. Huynh:

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,

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 #:	AS820272335
Investigation #:	2024A0101037
Complaint Receipt Date:	08/20/2024
Investigation Initiation Date:	08/20/2024
Report Due Date:	10/19/2024
Licensee Name:	Twin Oaks Extended Care Corp.
Licensee Address:	27024 Norfolk Inkster, MI 48141
Licensee Telephone #:	(734) 260-8067
Administrator:	Anh Huynh
Licensee Designee:	Anh Huynh
Name of Facility:	Twin Oaks II
Facility Address:	311 Central Inkster, MI 48141
Facility Telephone #:	(734) 729-9142
Original Issuance Date:	01/25/2006
License **Status:**	REGULAR
Effective Date:	08/07/2024
Expiration Date:	08/06/2026
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff Chanel Hicks, Derrick Bradford and Namour Walmsley were yelling “obscenities” at Resident A.	Yes

III. METHODOLOGY

08/20/2024	Special Investigation Intake 2024A0101037
08/20/2024	Special Investigation Initiated - Telephone Spoke with Anh Huynh Licensee Designee
08/20/2024	Adult Protective Services (APS) - Referral received from APS
08/21/2024	Office of Recipient Rights referral made
08/21/2024	Contact - Telephone call made Resident A
08/21/2024	Contact - Telephone call received Spoke with Direct Care Staff (DCS) Derrick Bradford and Chanel Hicks and Resident A.
08/21/2024	Contact - Telephone call received Resident A
08/27/2024	Contact - Telephone call made Spoke with Ms. Huynh
08/30/2024	Inspection Completed-BCAL Sub. Compliance Interviewed Resident A, DCS Chanel Hicks and Namour Walmsley Spoke with Resident A’s designated person.
08/30/2024	Contact – Document received. Resident A’s treatment plan
10/23/2024	Exit conference with Ms. Huynh.

ALLEGATION: Direct care staff Chanel Hicks, Derrick Bradford and Namour Walmsley were yelling "obscenities" at Resident A.

INVESTIGATION: On 08/21/2024, I spoke with direct care staff (DCS) Chanel Hicks. Ms. Hicks stated that she asked Resident A to clean his room, and he became enraged. He was yelling at the staff, and he threatened them.

On 08/21/2024, I spoke with DCS Derrick Bradford. Mr. Bradford stated that on 08/20/2024, he was delivering supplies to the Central Group Home. Mr. Bradford stated he heard and observed Resident A being verbally aggressive and threatening toward Ms. Hicks so he proceeded to intervene.

On 08/21/2024, I spoke with Resident A. Resident A stated that staff were lying, and he has proof.

I spoke with Ms. Huynh on 08/27/2024. Ms. Huynh stated that she suspended her staff without pay because the allegation is true. Ms. Huynh stated Resident A recorded the incident and she could not believe her staff of twenty years would curse at a resident and call him names.

On 08/30/2024, I interviewed Resident A. Resident A played the recording for me. I could her that Resident A was playing his music very loudly. Ms. Hicks asked him to turn the music down because it was disrespectful to the other residents. Resident A began yelling at Ms. Hicks and she responded by yelling back at Resident A. It quickly escalated into a heated argument. Mr. Bradford and Mr. Walmsley intervened which only made the situation worst. The staff and Resident A were name calling and making threats. Resident A stated that he orchestrated the situation in an attempt to obtain a single occupancy room or more importantly return to his designated representative's home. He stated that paying $1000 a month should entitle him to a single occupancy room. I informed Resident A that I do not assist with placement. Resident A called his designated representative who he refers to as "mom". The designated representative stated Resident A is her adoptive brother's son. I explained to them the cost of care rate and the definition of adult foster care. Resident A's designated representative stated Resident A's manipulative, and aggressive behaviors are the reasons he had to leave her home. Resident A apologized for his behavior and asked me to terminate the investigation. He expressed remorse. Resident A stated staff is good to him, and he does not want them to be in trouble. On 09/03/2024, Resident A returned to his designated representative's home.

On 08/30/2024, I interviewed Ms. Hicks and Mr. Walmsley. They stated they were wrong for engaging in an argument with Resident A.

The other residents residing in the home were not interviewed because they are nonverbal.

On 10/24/2024, I conducted an exit conference with Ms. Huynh. Ms. Huynh agrees with my findings.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(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:	DCS Ms. Hicks, Mr. Bradford and Mr. Walmsley subjected Resident A to verbal abuse and made derogatory remarks about him. According to Resident A he intentionally baited staff into a heated argument.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon submission of an acceptable corrective action plan I recommend the status of the license remains unchanged.

Edith Richardson
Licensing Consultant

10/24/2024
Date

Approved By:

11/18/2024

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Ardra Hunter
Area Manager

Date