GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 11, 2024

Johnnie Denham
Stallworth AFC 1 Corporation
645 E Grand Blvd.
Detroit, MI 48207

RE: License #: AL820007645
Investigation #: 2024A0992035
Stallworth AFC

Dear Johnnie 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AL820007645
Investigation #:	2024A0992035
Complaint Receipt Date:	06/03/2024
Investigation Initiation Date:	06/04/2024
Report Due Date:	08/02/2024
Licensee Name:	Stallworth AFC 1 Corporation
Licensee Address:	645 E Grand Blvd. Detroit, MI 48207
Licensee Telephone #:	(313) 319-5526
Administrator:	
Licensee Designee:	Johnnie Denham
Name of Facility:	Stallworth AFC
Facility Address:	651 E Grand Boulevard Detroit, MI 48207
Facility Telephone #:	(313) 469-7183
Original Issuance Date:	N/A
License **Status:**	REGULAR
Effective Date:	06/21/2022
Expiration Date:	06/20/2024
Capacity:	15
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
• It was reported on 05/31/2024, direct care staff LaKeisha Rushing called resident A names, and sprayed chemicals around the residents eating area. • It was reported on 06/24/2024, direct care staff Demetrious Green spoke inappropriately to resident A threatened her.	Yes

III. METHODOLOGY

06/03/2024	Special Investigation Intake 2024A0992035
06/03/2024	APS Referral Denied
06/03/2024	Referral - Recipient Rights
06/04/2024	Special Investigation Initiated - On Site John Denham, licensee designee; and Residents A - D.
06/14/2024	Contact - Telephone call made Tashebia Easley, direct care staff (DCS)
06/14/2024	Contact - Telephone call made LaKeisha Rushing, DCS
06/17/2024	Contact - Telephone call received Ms. Rushing
06/24/2024	Contact - Telephone call made Davina Draughn, home manager
06/24/2024	Contact - Telephone call made Matthew Schneider, office of recipient rights (ORR), was not available. Message left.
06/26/2024	Contact - Document Received DCS termination notice
06/27/2024	Contact - Face to Face Resident A
07/02/2024	Contact - Telephone call made

	Mary Jones, DCS
07/02/2024	Exit Conference Mr. Denham
07/02/2024	Contact - Document Received DCS termination notice
07/03/2024	Contact - Telephone call received Mr. Schneider

ALLEGATION:

- **It was reported on 05/31/2024, direct care staff LaKeisha Rushing called resident A names, and sprayed chemicals around the residents eating area.**
- **It was reported on 06/24/2024, direct care staff Demetrious Green spoke inappropriately to resident A threatened her.**

INVESTIGATION:

On 06/04/2024, I completed an unannounced onsite inspection. I interviewed John Denham, licensee designee; and Residents A - D. Mr. Denham stated Resident A came to him and stated LaKeisha Rushing, DCS, was calling her names and making her feel uncomfortable. Mr. Denham stated he agreed to investigate the situation, but before given the opportunity he received a call from Matthew Schneider, ORR. Mr. Denham stated Mr. Schneider instructed him to keep Ms. Rushing and Resident A separated pending the investigation. Mr. Denham stated technically Ms. Rushing does not work at the facility, she works at his other facility, next door. He stated Ms. Rushing would normally have access to the facility because the facilities are connected by a window, but she has been instructed not to access the facility. Mr. Denham stated he has zero tolerance for DCS intimidating residents.

Resident A stated Ms. Rushing has been bothering her by calling her names and being rude since she was admitted into the facility. Resident A's statements support Mr. Denham stating Ms. Rushing does not work at the facility, she works next door and has access through the connecting window. Resident A stated on May 19, she sat her food on the table in the dining area, near the connecting window while she was in the kitchen with Tashebia Easley, DCS. She stated Ms. Rushing was on the other side of the window. Resident A stated she went to the kitchen and when she returned to eat her food there was a wet residue all over the table by her food and in the chair. She stated she notified Ms. Easley, and Ms. Easley addressed Ms. Rushing. Resident A stated the wet residue was a cleaning agent, "Fabuloso."

Resident A stated she told Mr. Denham and the taunting stopped temporarily. Resident A stated Ms. Rushing has not taunted her in a week or so. Resident A stated Ms. Rushing also pushed a chair in her direction, hitting her leg in the past. Resident A stated Ms. Rushing has thrown change at her through the window. Resident A stated she is fearful of Ms. Rushing.

I conducted separate interviews with residents B, C and D, who all denied having any knowledge of the allegation. Residents B, C and D, confirmed Ms. Rushing does not work at the facility, she works next door.

On 06/14/2024, I contacted Ms. Easley, DCS, and interviewed her regarding the allegation. Ms. Easley confirmed the allegation and provided statements consistent with the statements Resident A provided during her interview. In addition, Ms. Easley stated Resident A was the only resident in the dining area. Ms. Easley confirms she observed the wet residue on the table near Resident A's food, and she could smell it. She stated it was "Fabuloso." Ms. Easley stated when she entered the dining area, she did not see anyone in the window. She stated she went back into the kitchen; she peeked her head around the corner and observed Ms. Rushing looking through the window. Ms. Easley stated she asked Ms. Rushing what was going on and if she sprayed "Fabuloso" through the window. Ms. Easley stated Ms. Rushing became very hostile and threatened to beat her up. Ms. Easley stated Resident A stated she continuously taunts her.

On 06/14/2024, I contact Ms. Rushing, DCS. I interviewed her regarding the allegation, which she denied. Ms. Rushing stated on the day in question, she observed Residents A and B going back-and-forth arguing. She stated there was a bottle that was previously filled with Fabuloso, and it is possible Resident B sprayed it. Ms. Rushing stated she did not see the bottle in Resident B's hand but that is the only thing she can think of. Ms. Rushing stated she did not spray anything through the window. Ms. Rushing also denied taunting Resident A, calling her names, or using inappropriate language towards her.

On 06/17/2024, I received a call Ms. Rushing, making me aware she was terminated.

On 06/24/2024, I contacted Davina Draughn, home manager, and interviewed her regarding the allegation. Ms. Draughn denied witnessing Ms. Rushing taunt Resident A. However, she stated on June 8, she received an audio from Resident A and she could hear "I am better than you…bitch." Ms. Draughn stated she is familiar with Ms. Rushing and recognized her voice. Ms. Draughn stated she had previously asked Ms. Rushing about taunting Resident A, and she denied it. Ms. Draughn stated once she received the recording it was confirmation that she was taunting her. She stated Ms. Rushing was terminated.

On 06/24/2024, I received additional allegation that Demetrious Green DCS spoke inappropriately to Resident A and threatened her.

On 06/26/2024, I received a termination notice for Ms. Rushing. According to the notice, “(Resident A) contacted manager stated she was being taunted and bullied and was afraid to come out of room. Staff is being asked to end assignment and is being terminated due to resident being in fear.”

On 06/27/2024, I completed an unannounced onsite inspection and interviewed Resident A. Resident A stated it was during shift change, Demetrious Green, DCS, shift was ending and Mary Jones, DCS had arrived on shift. Resident A stated she went in the pantry to get cereal, and Ms. Green got mad and started swearing and saying inappropriate things to her. She stated Ms. Green said, “Get the fuck out of the kitchen.” Resident A stated she tried to explain that the other staff allow her to get her cereal. Resident A stated Ms. Green said “Why the fuck are you playing with me. Didn't I say you can't go into the motherfucking kitchen. Don't play with me, little fucking girl. I don’t care who here, I don’t care who on shift. You think I care, just cause Mary here. I don't care about that.” Resident A stated Ms. Jones intervened and notified management.

On 07/02/2024, I contacted Ms. Jones and interviewed her regarding the allegation. Ms. Jones statements were consistent with the statements provided by Resident A during her interview. In addition, Ms. Jones stated while Ms. Green was talking, she said you think I care, just cause Mary here. I don't care about that.” Ms. Jones stated she told Ms. Green keep her name out of her mouth and Ms. Green said “(Resident A) motherfucking ass is always saying Mary let her go into the kitchen.” Ms. Jones stated she tried to explain that she does let her go into the kitchen, but Ms. Green stated, “She can't go into the kitchen and I'm tired of her motherfucking playing with me. I don’t give a fuck who you tell. You can tell who you want to tell. You can tell John too; you got me fucked up around here.”

On 07/02/2024, I contacted Mr. Denham and interviewed him regarding the allegation, which he confirmed. Mr. Denham said once he was notified, Ms. Green was terminated. Mr. Denham agreed to provide me with a copy of Ms. Green’s termination notice. I proceeded to conduct an exit conference with Mr. Denham. I made Mr. Denham aware that based on the findings there is evidence to support the allegations, that Resident A was bullied and mistreated by Ms. Rushing and Ms. Green. I made Mr. Denham aware that a written corrective action plan is required. Mr. Denham denied having any questions or concerns.

On 07/02/2024, I received a termination notice for Ms. Green. According to the notice, “Employee cursed and screamed at (Rresident A), calling her names. Another staffed witnessed the exchange and reported it to admin and (ORR).” Staff was terminated on June 20.

On 07/03/2024, I received a call from Mr. Schneider. He confirmed he previously investigated the reported allegations and substantiated. Mr. Schneider stated he received copy of the audio and agreed to provide me with a copy of the audio. I

received the audio, but do to background noise in the audio, I was unable to determine what was said.

APPLICABLE RULE	
R 400.15308	**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.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with Johnnie Denham, licensee designee; Davina Draughn, home manager; LaKeisha Rushing, Tashebia Easley, and Mary Jones, direct care staff; Matthew Schneider, ORR; and Residents A-D regarding the allegations. There is sufficient evidence to support the allegation that Resident A was bullied and mistreated by Ms. Rushing and Ms. Green. The allegations are substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/10/2024

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Denasha Walker — Date
Licensing Consultant

Approved By:

07/11/2024

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Ardra Hunter — Date
Area Manager