GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 6, 2025

Jean Nyambio
Detroit Family Home, INC.
Suite 202
17356 W. 12 Mile Road
Southfield, MI 48076

RE: License #: AS820383893
Investigation #: 2025A0101022
Detroit Family Home

Dear Mr. Nyambio:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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) 456-0439.

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 #:	AS820383893
Investigation #:	2025A0101022
Complaint Receipt Date:	04/03/2025
Investigation Initiation Date:	04/10/2025
Report Due Date:	06/03/2025
Licensee Name:	Detroit Family Home, INC.
Licensee Address:	Suite 202 17356 W. 12 Mile Road Southfield, MI 48076
Licensee Telephone #:	(301) 332-3609
Administrator:	Jean Nyambio
Licensee Designee:	Jean Nyambio
Name of Facility:	Detroit Family Home
Facility Address:	17180 Indiana St. Detroit, MI 48221
Facility Telephone #:	(313) 270-7751
Original Issuance Date:	09/19/2016
License Status:	REGULAR
Effective Date:	03/19/2025
Expiration Date:	03/18/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

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II. ALLEGATION(S)

	Violation Established?
On 04/02/2025, staff allowed an unknown male to sign Resident A out of the group home. Her whereabouts were unknown for four days.	No
Direct care staff Tomecka Singleton is posting pictures of the residents on social media.	No

III. METHODOLOGY

04/03/2025	Special Investigation Intake 2025A0101022
04/07/2025	Contact - Document Received Incident report.
04/10/2025	Special Investigation Initiated - On Site Interviewed Residents B, C and D Direct care staff Folasade Oke
05/07/2025	Adult Protective Services referral received
05/07/2025	Contact - Document Received
06/03/2025	Contact - Telephone call made Direct care staff Diane Hemphill Latoya Burden
06/03/2025	Contact - Telephone call made Resident A's former caseworker Linakia Hubbard, Team Wellness
06/03/2025	Contact – Telephone call made Guardian B1 Guardian C1 Guardian D1
06/03/2025	Exit Conference with the licensee designee Jean Nyambio
06/04/2025	Contact – Telephone call received Direct care staff Diane Hemphill

ALLEGATION: On 04/02/2025, staff allowed an unknown male to sign Resident A out of the group home. Her whereabouts were unknown for four days.

INVESTIGATION: According to the incident report dated 04/02/2025, Resident A and her one-on-one staff Diane Hemphill were sitting on the front porch and Resident A was talking on her phone. The incident report stated that a black vehicle pulled up and Resident A ran to the car. The incident report states Ms. Hemphill told Resident A she could not leave. According to the incident report Ms. Hemphill asked the driver of the vehicle for his driver's license and he refused to cooperate. The incident report further states Resident A became aggressive and she jumped into the vehicle. The incident report also stated that the vehicle took off.

On 06/03/2025, I interviewed direct care staff Latoya Burden. Ms. Burden stated when she saw Resident A get into the black vehicle she jumped in the van and attempted to follow the car. Ms. Burden stated she eventually lost sight of the vehicle.

On 05/07/2025, I reviewed Resident A's treatment plan dated 03/20/2025. The treatment plan did not state that Resident A requires one-on-one staffing, and it did not address elopement behavior interventions.

On 06/03/2025, I spoke with Resident A's former caseworker, Linakia Hubbard. Ms. Hubbard stated that Resident A required one-on-one staffing. Ms. Hubbard stated Resident A had an extensive elopement history. Ms. Hubbard further stated that Resident A is no longer receiving services because Resident A's guardian terminated services.

On 06/03/2025, I conducted an exit conference with Mr. Nyambio. Mr. Nyambio agreed with my findings.

On 06/04/2025, I spoke with direct care staff Diane Hemphill. Ms. Hemphill denied the allegation that staff allowed an unknown male to sign Resident A out of the group home. Ms. Hemphill also reiterated the information contained in the incident report.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Mr. Nyambio provided the supervision, protection and personal care as defined in the act and specified in the resident's written assessment plan. Even though Resident A's assessment plan did not state she required one-on-one supervision Mr. Nyambio was providing one-on-one staffing. Even though Resident A's assessment plan did not address elopement interventions, Ms. Hemphill and Ms. Burden did everything possible to stop Resident A from leaving the group home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff Tomecka Singleton is posting pictures of the residents on social media.

INVESTIGATION: On 04/10/2025, I interviewed Residents B, C, and D. They all stated that staff are not recording them.

On 04/10/2025, I interviewed direct care staff Folasade Oke. Ms. Oke stated she has never witnessed a staff recording the residents. She further stated, "Ms. Singleton is an older woman and wouldn't do something like that."

On 06/03/2025, I interviewed direct care staff Tomecka Singleton. Ms. Singleton stated she has "never" posted pictures of the residents on social media. Ms. Singleton stated, "I have worked in this field for 25 years and I know you can't do that."

On 06/03/2025, I spoke with Guardian B1 who stated Resident B has never mentioned to her that the staff are posting pictures of the residents on social media.

On 06/03/2025, I spoke with the assistant administrator Trushania Anderson. Ms. Anderson stated staff know that they cannot post pictures of the residents on social media because it would be a violation of the confidentiality policy.

On 06/03/2025, I conducted an exit conference with Mr. Nyambio. Mr. Nyambio agreed with my findings.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or

	the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) (o) of this rule.**
ANALYSIS:	Based upon the preponderous of evidence the licensee is safeguarding the residents' right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy. Residents B, C, and D stated that the staff are not recording them. Direct care staff Ms. Oke stated she never witnessed staff recording the residents. Ms. Singleton denied the allegation that she is posting pictures of the residents on social media. Guardian B1 stated Resident B has never mentioned that staff is posting pictures of the residents on social media.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

RECOMMENDATION

I recommend that the status of the license remains unchanged.

Edith Richardson
Licensing Consultant

06/04/2025
Date

Approved By:

06/06/2025

Dawn Timm
Area Manager

Date