GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 9, 2025

Karen Goreta
Karen's Helping Hands
4425 High Street
Ecorse, MI 48229

RE: License #: AS820285408
Investigation #: 2025A0992036
Monroe Manor

Dear Ms. Goreta:

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) 456-0439.

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 #:	AS820285408
Investigation #:	2025A0992036
Complaint Receipt Date:	07/16/2025
Investigation Initiation Date:	07/18/2025
Report Due Date:	09/14/2025
Licensee Name:	Karen's Helping Hands
LicenseeAddress:	4425 High Street Ecorse, MI 48229
Licensee Telephone #:	(313) 282-6158
Administrator:	Karen Goreta
Licensee Designee:	Karen Goreta
Name of Facility:	Monroe Manor
Facility Address:	4481 Monroe Ecorse, MI 48229
Facility Telephone #:	(313) 383-3498
Original Issuance Date:	10/12/2006
License Status:	REGULAR
Effective Date:	08/12/2025
Expiration Date:	08/11/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
• Resident A was improperly discharged from Karen's Helping Hands AFC while hospitalized and left without placement until July 10, 2025. • Resident A was abandoned at the hospital.	Yes

III. METHODOLOGY

07/16/2025	Special Investigation Intake 2025A0992036
07/18/2025	Special Investigation Initiated - Telephone Adult Protective Services, Jodi Nicoletti.
07/18/2025	Contact - Face to Face Resident A
07/18/2025	Inspection Completed On-site Direct care staff, Godfrey McFarland
07/22/2025	Contact - Telephone call made Licensee designee, Karen Goreta
07/22/2025	Contact - Telephone call made Home manager, Brandy Hick was not available. Message left.
07/23/2025	Contact - Telephone call made Mrs. Goreta
07/24/2025	Contact - Document Received Emergency discharge, incident reports, hospital follow-up notes.
09/17/2025	Contact - Telephone call made Resident A's guardian, Marilyn Little with Conservators Attendee Services was not available. Message left.
09/17/2025	Contact - Telephone call made Message left for Ms. Little.
09/17/2025	Contact - Telephone call made

	Wyandotte Henry Ford Hospital Social Worker Department, Social Worker A.
09/24/2025	Contact - Telephone call made Wyandotte Henry Ford Hospital Social Worker Department, Social Worker B.
09/25/2025	Contact - Telephone call made Wyandotte Henry Ford Hospital Social Worker Department, Social Worker C.
09/26/2025	Contact - Document Received Message received from Ms. Little.
09/26/2025	Contact - Telephone call made Email sent to Director of Residential Services with Detroit Wayne Integrated Health Network (DWIHN), Ryan Morgan and Josephine Alshorbaji.
09/26/2025	Contact - Telephone call made Ms. Little
09/26/2025	Contact - Document Received DWIHN Residential discharge packet
09/29/2025	Contact - Telephone call made Director of Residential Services with DWIHN, Ryan Morgan.
09/30/2025	Exit Conference Mrs. Goreta

ALLEGATION:

- **Resident A was improperly discharged from Karen's Helping Hands AFC while hospitalized and left without placement until July 10, 2025.**

- **Resident A was abandoned at the hospital.**

INVESTIGATION:

On 07/18/2025, I contacted adult protective services (APS), Jodi Nicoletti regarding the allegation. Ms. Nicoletti stated that Resident A was issued an emergency discharge and dropped off at the hospital due to truancy and poor hygiene. Ms. Nicoletti stated she contacted licensee designee, Karen Goreta and she stated she

petitioned Resident A due to her behavior. Ms. Nicoletti stated according to the Courtview system, Resident A has not been petitioned since 2024. Ms. Nicoletti stated Resident A was abandoned at the hospital and remained there for three weeks before placement was secured. Ms. Nicoletti provided me with Resident A's current placement information. She stated she is substantiating against Ms. Goreta. She identified Resident A's guardian as Marilyn Little with Conservators Attendee Services and provided her contact information.

On 07/18/2025, I made face-to-face contact with Resident A. Resident A stated she previously lived at Monroe Manor but was kicked out. She stated she did not feel safe at that home, and when she expressed her concerns to Mrs. Goreta, she kicked her out. Resident A stated she did not feel safe because the residents in the home and people in the community were trying to have sex with her. Resident A stated she ended up at the hospital because she was not feeling well and called 911. She stated she was transported to the hospital by the emergency medical services (EMS). She stated she remained hospitalized for two to three weeks because Mrs. Goreta would not allow her back in the home.

On 07/18/2025, I completed an unannounced on-site inspection at Monroe Manor. Direct care staff, Godfrey McFarland was present. He denied having any knowledge of the allegation. He stated Resident A left the home approximately two weeks ago, but he doesn't know why. Mr. Godfrey suggested I contact Mrs. Goreta or home manager, Brandy Hicks, regarding the allegation.

On 07/22/2025, I contacted Mrs. Karen Goreta regarding the allegation. Mrs. Goreta stated Ms. Hicks was the one communicating with Wyandotte Henry Ford Social Worker Department, specifically social worker C. She stated social worker C never stated Resident A was ready for discharge. As far as being improperly discharged, she stated Resident A was not improperly discharged. She stated she was discharged because she refused to take her medication as prescribed, she was not coming home some days. I asked if placement was secured for her at the time she was discharged because the hospital is not a place to discharge a resident. Mrs. Goreta stated she would need to speak with Ms. Hicks and obtain more information because she handled the situation.

On 07/23/2025, I received a telephone call from Mrs. Goreta. She stated DWIHN terminated the authorization and Ms. Hicks provided social worker C with the emergency discharge documents. She stated DWIHN terminates an authorization once a resident is hospitalized and/or when placement is secured. She stated DWIHN was in receipt of the emergency discharge and Resident A's guardian, Marilyn Little was notified as well. Mrs. Goreta agreed to provide me with a copy of the emergency discharge and supporting documents.

On 07/24/2025, I received an emergency discharge, incident reports, hospital follow-up notes for Resident A. According to the emergency discharge dated 6/13/2025, Resident A was discharged for the following: continuous elopement, panhandling,

and not attending a medical appointment, and Resident A stated, “She does not want to be here.” The incident reports outlined Resident A’s behaviors including smoking in the home, not returning to the home by curfew, leaving the home for more than a day, and not attending a medical appointment. The incident reports were 4/30/2025 through 6/12/2025, prior to the date of the emergency discharge. The outlined behaviors do not warrant an emergency discharge.

On 09/17/2025, I contacted Wyandotte Henry Ford Hospital, social worker A. Social worker A confirmed the allegation and stated Mrs. Goreta refused to pick Resident A up when she was ready for discharge. Social worker A stated Resident A comes to the hospital often. She stated when she is at the hospital, she is typically there for a couple days and seen by the doctors, and multiple social workers. She stated Resident A was admitted and examined by both the medical and psychiatric doctors and ready for discharge. Social worker A stated she was on shift from 7:00 a.m. to 7:00 p.m. and according to the case management notes from the previous social worker, there was a number in the system to call once Resident A was ready for discharge. She stated she called the number and spoke with a staff member from the group home, name unknown. She stated the staff stated they needed to contact Mrs. Goreta. Social worker A stated she had received a call from Mrs. Goreta, stating Resident A was not ready for discharge and that she needed to be admitted. Social worker A stated she explained that Resident A had been evaluated by both the medical and psychiatric doctor, and she is ready for discharge. Social worker A stated Mrs. Goreta stated she did an emergency discharge and notified Detroit Wayne Integrated Health Network (DWIHN) and Resident A's guardian, Marilyn Little. Social worker A stated she requested a copy of the emergency discharge and supporting documents but did not receive the documentation prior to the end of her shift. She stated social workers B and C were also involved; she provided their work schedule and suggested I contact them for more information.

On 09/24/2025, I contacted social worker B regarding the allegation. Prior to addressing the allegation, social worker B explained that Resident A is often seen at the hospital. She stated during this occurrence when she arrived on shift, Resident A was ready for discharge. She stated according to the case management notes from social worker C, Mrs. Goreta submitted an emergency discharge to DWIHN on 6/13/2025, but at this time placement had not been secured. Social worker B stated she tried to contact Ms. Little multiple times but was unable to reach her. She stated in the past Resident A was sent back to the group home by Lyft, but due to the circumstances a Lyft was not provided. Social worker B stated placement was not secured by the time her shift ended. She stated according to the case management notes adult protective services was contacted on 6/27/2025 due to no placement and the lack of response from the guardian. She stated social worker C was also involved and could possibly provide more information.

On 09/25/2025, I contacted social worker C regarding the allegation. Social worker C stated once Resident A was ready for discharge, she contacted the home manager, Brandy Hicks to let her know Resident A was ready for pick-up. She stated Ms.

Hicks made her aware that an emergency discharge was previously submitted to DWIHN on 6/13/2025. Social worker C stated she requested a copy of the emergency discharge, which Ms. Hicks agreed to provide but it was not received. Social worker C stated she contacted DWIHN residential department and obtained a copy of the emergency discharge. Social worker C stated if the resident cannot return to the group home for whatever reason, the social worker on shift completes the residential referral for placement. She stated she received the emergency discharge and supporting documents on 6/24/2025.

On 09/26/20256, I contacted Director of Residential Services with DWIHN, Ryan Morgan and Josephine Alshorbaji via email requesting confirmation that an emergency discharge was submitted by Mrs. Goreta on 6/13/2025.

On 09/26/2025, I received a DWIHN Residential discharge packet for Resident A, confirming the packet was dated 6/13/2025.

On 09/26/2025, I contacted Resident A's guardian, Marilyn Little with Conservators Attendee Services regarding the allegation. Ms. Little confirmed Resident A was discharged from the group home. She stated Mrs. Goreta issued an emergency discharge on 6/13/2025 but after speaking with her, she agreed to take Resident A back. She stated Resident A was not following the rules of the home, she wanted to spend the night out for the weekend and according to Mrs. Goreta, that was not allowed. She stated she was also caught using marijuana by the home staff. Ms. Little stated Resident A did not demonstrate self-destructive or violent behaviors, she was just defiant. She stated during Resident A’s last visit to the hospital mid-June 2025, the group home staff did not pick her up, and she remained at the hospital until another placement was secured.

On 09/29/2025, I contacted Ryan Morgan regarding DWIHN emergency discharge procedure/protocol as it pertains to Resident A’s discharge. He stated once the emergency discharge documentation is received, it is sent over to a supervisor and reviewed. Once reviewed, the packet is accepted, and the residential department begins to search for placement. He stated if the resident is at imminent risk to self or others and unable to return to the facility, the resident will remain hospitalized until placement or pre-placement is secured. He stated if the resident is not at imminent risk and the packet is received, the resident is to return to the facility until an alternative placement is secured. He stated in this instance, placement must be secured prior to discharging Resident A, so that a Resident A is not left without proper housing. I made him aware of the reason for discharge outlined on the emergency discharge submitted for Resident A including continuous elopement, panhandling, and not maintaining medical appointments. He agreed the reasons listed did not pose imminent risk and stated Resident A should have returned to the facility until an alternative placement was secured. Mr. Morgan stated prior to placement, a clinical packet is provided to the licensee outlining the resident’s behaviors, so that the licensee can decide to accept the resident or not. He stated in some instances the direct care staff are not equipped to handle the behaviors which

sometimes leads to an emergency discharge. Mr. Morgan stated he intends to address this issue at the next provider meeting and possibly provide some training.

On 09/30/2025, I conducted an exit conference with Mrs. Goreta. I explained that based on the investigative findings there is sufficient evidence to support the allegation. I explained that Resident A's behaviors did not warrant an emergency discharge according to the emergency discharge and supporting documentation. Also, she failed to notify the department less than 24 hours before discharge Resident A. Based on the findings, I made Mrs. Goreta aware the allegation is substantiated, and a written corrective action plan is required. 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 designee, Karen Goreta; APS, Jodi Nicoletti; Wyandotte Henry Ford Hospital social worker A, B and C; Director of Residential Services with DWIHN, Ryan Morgan; Resident A's guardian, Marilyn Little with Conservators Attendee Services; direct care staff Godfrey McFarland; and Resident A regarding the allegations. I confirmed Mrs. Goreta issued Resident A an emergency discharge. The reason for discharge was as follows: self-destructive behaviors, elopement, panhandling, not maintaining a medical appointment, and stating, “She does not want to be here.” The emergency discharge notice was not in compliance with licensing rules as well as DWIHN. Although Resident A was medically cleared and ready for discharge, she remained hospitalized pending placement. Based on the documentation, Resident A’s behaviors did not pose a substantial risk and warrant an emergency discharge. There is sufficient evidence to support the allegation. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

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.** **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge.** **If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**

ANALYSIS:	During this investigation, I interviewed licensee designee, Karen Goreta; APS, Jodi Nicoletti; Wyandotte Henry Ford Hospital social worker A, B and C; Director of Residential Services with DWIHN, Ryan Morgan; Resident A's guardian, Marilyn Little with Conservators Attendee Services; direct care staff Godfrey McFarland; and Resident A regarding the allegations. Social worker C, Mr. Morgan and Ms. Little confirmed they were notified of the emergency discharge and received supporting documentation from Mrs. Goreta. However, Mrs. Goreta did not notify the department less than 24 hours before discharge. Once Resident A was medically cleared and ready for discharge, Mrs. Goreta refused to take Resident A back into the home and she remained hospitalized pending appropriate placement. Based on the investigative findings, there is sufficient evidence to support the allegation. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/09/2025

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Denasha Walker Date
Licensing Consultant

Approved By:

10/09/2025

_____

Ardra Hunter Date
Area Manager