RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

January 31, 2019

Princess Kennedy
Asanpee Care
PO Box 85766
Westland, MI 48185

RE: License #: AS820286497
Investigation #: **2019A0772003**
Princess Home

Dear Ms. Kennedy:

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.

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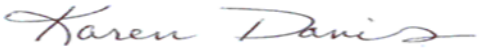
Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (313) 456-0380.

Sincerely,



Karen Davis, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 296-5412

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820286497
Investigation #:	2019A0772003
Complaint Receipt Date:	11/28/2018
Investigation Initiation Date:	11/29/2018
Report Due Date:	01/27/2019
Licensee Name:	Asanpee Care
Licensee Address:	415 Belton Street Garden City, MI 48135
Licensee Telephone #:	(313) 522-9587
Administrator:	Princess Kennedy
Licensee Designee:	Princess Kennedy
Name of Facility:	Princess Home
Facility Address:	29605 Glenwood Inkster, MI 48141
Facility Telephone #:	(313) 522-9587
Original Issuance Date:	12/27/2006
License **Status:**	REGULAR
Effective Date:	11/17/2018
Expiration Date:	11/16/2020
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED/MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was transferred to a different facility and the agency case manager was not notified she moved to an unknown home in Ypsilanti.	No
Additional Findings	Yes

III. METHODOLOGY

11/28/2018	Special Investigation Intake 2019A0772003 Office of Recipient Rights (ORR) and Adult Protective Services(APS) referrals were made.
11/29/2018	Special Investigation Initiated - Telephone Call to the complainant.
12/03/2018	Inspection Completed On-site I reviewed Resident A's facility file, resident register, and interviewed Staff Christine Titus and Carol Oguegiosi. Call to Resident A's caseworker Ms. S. Miller.
12/03/2018	Contact - Telephone call made Call to Princess Kennedy, licensee designee.
12/21/2018	Contact - Telephone call made to Resident A Call to L. Hicks Office of Recipient Rights (ORR)
01/02/2019	Call from L. Hicks (ORR)
01/14/2019	Exit Conference – licensee designee, Princess Kennedy.

ALLEGATION:

Resident A was transferred to a different facility and the agency case manager was not notified she moved to an unknown home in Ypsilanti.

INVESTIGATION: On 11/28/2018, I conducted an unannounced investigation. I reviewed Resident A's facility file, resident register, and interviewed staff Christine Titus and Carol Oguegiosi. Resident A discharged herself to a room and board home. In reviewing her facility records, Resident A has no legal guardian. On 12/03/2018, I interviewed the licensee designee, Princess Kennedy via the telephone. Ms. Kennedy stated that Resident A signed herself out on 10/30/2018 and was picked up by a person named Ce Ce. Ms. Kennedy stated that an incident report was written and that the caseworker for Resident A was informed and an incident report was faxed to the agency. On 12/03/2018, Ms. Kennedy faxed a copy of the incident report to this consultant. The incident dated 10/30/2018, notes that a copy was sent to the agency and the Detroit Wayne Mental Health Authority (DWMHA). The section for the licensing consultant's name was left blank and only the initials of the name(s) of the agency was filled in (ACC, DWMHA, and ORR).

On 12/03/2018, I interviewed Sherri Miller, caseworker at the Arab American Chaldean Council. She stated that she last saw Resident A on 10/18/2018. She stated that she went to the home on 11/15/2018 for a home visit and found Resident A had moved to Ypsilanti MI. Ms. Miller stated that she was not made aware and did not receive anything in writing of the impending voluntary discharge by the client or the facility. Ms. Miller stated that she found out Resident A had moved on 11/15/2018 when she went to the home for monthly case visit. She asked the staff about Resident A's whereabout. The staff on duty was reluctant to give specific information in regard to Resident A and referred her to speak with Ms. Kennedy.

On 01/02/2019, I spoke with L. Hicks Office of Recipient Rights(ORR). She stated based on her investigation that Resident A is her own legal guardian and can determine her own residency. She further stated Resident A is safe and wanted to move. Resident A moved to a room and board and is handling her own finances.

On 01/14/2019, I conducted an exit conference with Princess Kennedy the licensee designee. We discussed the allegation, my findings and recommendation.

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.**
	(6) licensee shall not change the residency of a resident from one home to another without the written approval of the resident or the resident's designated representative and responsible agency.
ANALYSIS:	Resident A left voluntarily and moved to a room and board. This allegation is unsubstituted.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

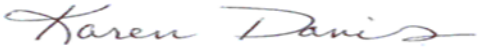
ADDITIONAL FINDINGS:

INVESTIGATION: On 11/28/2018, I reviewed the resident register and I observed the resident register was not completed with the discharge date or the forwarding address for Resident A. I observed the incident report dated 10/30/2018 had the telephone of the room and board, but Ms. Kennedy did not obtain the address to complete the resident register.

APPLICABLE RULE	
R 400.14210	**Resident register.**
	A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident: **(a) Date of admission.** **(b) Date of discharge.** **(c) Place and address to which the resident moved, if known.**
ANALYSIS:	I observed the resident register was not completed according to the applicable rule noted above.
CONCLUSION:	**VIOLATION ESTABLISHED**

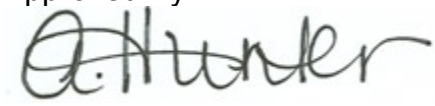
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

 01/23/2019

Karen Davis — Date
Licensing Consultant

Approved By:

 01/31/2019

Ardra Hunter — Date
Area Manager