



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 27, 2021

Princess Kennedy
Asanpee Care
PO Box 871665
Canton, MI 48187

RE: License #: AS820286497
Investigation #: 2021A0119030
Princess Home

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

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,

A handwritten signature in black ink that reads "Shatonla Daniel". The signature is written in a cursive, flowing style.

Shatonla Daniel, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-3003

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820286497
Investigation #:	2021A0119030
Complaint Receipt Date:	07/29/2021
Investigation Initiation Date:	07/30/2021
Report Due Date:	09/27/2021
Licensee Name:	Asanpee Care
Licensee Address:	28545 Ford Rd. 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:	11/17/2020
Expiration Date:	11/16/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL DEVELOPMENTALLY DISABLED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was cleared for discharge from the hospital on 7/15/2021 and staff refused to pick him up. An emergency discharge notice was sent to DWIHN on 7/16/2021 while Resident A was in the hospital. Resident A remains in the hospital emergency department waiting for AFC home placement.	Yes

III. METHODOLOGY

07/29/2021	Special Investigation Intake 2021A0119030
07/30/2021	Special Investigation Initiated - Telephone Licensee Designee- Princess Kennedy
08/17/2021	Contact - Telephone call made Staff- Crystal Epps
08/18/2021	Inspection Completed On-site Staff- Frances Felix, Residents B- F
09/21/2021	Contact -Telephone call made Staff- Humphrey Ejinakol and Cyrille Ngong
09/24/2021	Contact Document Received Emergency Discharge of Resident A
09/24/2021	Exit Conference Licensee Designee- Princess Kennedy

ALLEGATION: Resident A was cleared for discharge from the hospital on 7/15/2021 and staff refused to pick him up. An emergency discharge notice was sent to DWIHN on 7/16/2021 while Resident A was in the hospital. Resident A remains in the hospital emergency department waiting for AFC home placement.

INVESTIGATION: On 08/02/2021, I telephoned and interviewed Licensee Designee- Princess Kennedy regarding the above allegation. Mrs. Kennedy stated she received Resident A from Walter Reuther Hospital and he was not ready to be in the community. Mrs. Kennedy stated Resident A was breaking neighbor's fences, neighbor's side/rear doors, destroying the facility, threatening, and attacking staff. Mrs. Kennedy stated Resident A has only been in the facility thirty days and her staff are refusing to work with him. She stated the neighbors have called the police on

Resident A numerous times and he is out of control. She stated Resident A does not have a guardian. Mrs. Kennedy stated all of the residents and staff are scared of him. She stated Resident A repeatedly stated he does not want to live in the facility because the facility is stealing his money.

Mrs. Kennedy stated she talked with a social worker at Walter Reuther Hospital and there was discussion about Resident A's mental instability. She stated Resident A was in the hospital numerous times while in the facility. She stated she submitted an emergency discharge for Resident A and the notice was given to Walter Reuther social worker and the community mental health provider prior to him being discharged from the hospital. Mrs. Kennedy stated when she received the call to pick up Resident A from the hospital, she informed hospital staff that Resident A was not medical stable and needed to be stabilized before returning to the facility. Mrs. Kennedy stated her staff did not pick up Resident A from the hospital for this reason.

On 08/17/2021, I telephoned and interviewed Home Manager Crystal Epps regarding the above allegation. Ms. Epps stated Resident A assaulted staff Humphrey Ejinakol and Cyrille Ngong. Ms. Epps stated Resident A threw trash around the neighborhood and destroyed the house. She stated Resident A was very unpredictable with his behavior and did not want to comply with anything asked of him by staff. Ms. Epps stated staff was threatening to quit because of Resident A. Ms. Epps denied Resident A was not appropriately discharged or that staff refused to pick Resident A up from the hospital. She stated Resident A was not medically stable enough to return to the facility. Ms. Epps stated there was discussion with Resident A's social worker at Walter Reuther in order to find him other place including inpatient hospitalization because of his behaviors. Ms. Epps stated because Resident A was not medically stable and an emergency discharge was submitted, staff did not pick up Resident A from the hospital.

On 08/18/2021, I completed an onsite inspection and interviewed Residents B, C, D, E and F regarding the above allegation. Resident B stated Resident A kicked and destroyed the doors in the home. Resident B denied observing Resident A hit staff or other residents. Resident B stated he was not afraid of him but just stayed away from him.

Resident C stated Resident A destroyed the house. Resident C stated Resident A always seemed upset about a lot of things. Resident C stated Resident A destroyed the coffee pot and threw trash outside the house. Resident C denied observing Resident A hit staff or other Residents. Resident C stated he was afraid of Resident A.

Resident D stated Resident A was kind of on the "wild side". Resident D stated Resident A threw clothing on the floor and destroyed the house. Resident D denied observing Resident A hit staff or other Residents. Resident D stated he was afraid of Resident A.

Residents E and F both stated they have no knowledge of Resident A or the above allegation. Resident F stated Resident A was escorted out the home by the police.

On 09/21/2021, I telephoned and interviewed staff Humphrey Ejinakol and Cyrille Ngong regarding the above allegation. Mr. Ejinakol stated he worked midnights in the facility. He stated Resident A did not sleep and was constantly making threatening gestures toward him, requesting cigarettes and coffee. Mr. Ejinakol stated he constantly reminded Resident A of the house rules regarding smoking and night time coffee drinking. He stated Resident A took the coffee pot outside and broke it. He stated Resident A never assaulted him but was constantly making verbal threats and gestures in an attempt to engage him in an altercation. Mr. Ejinakol reportedly has no knowledge about Resident A being discharged from the facility.

Mr. Ngong stated Resident A did not stay in the facility a long time. Mr. Ngong stated Resident A did kick neighbor's doors and throw trash all over the neighborhood. He stated Resident A did punch him but he just walked away from him. Mr. Ngong reportedly has no knowledge about Resident A being discharged from the facility.

On 09/24/2021, I received the emergency discharge request for Resident A dated 07/13/2021. This discharge notice lists Resident A's current location as Beaumont Hospital. This discharge notice does not list where Resident will reside once he is discharged from the hospital.

On 09/24/2021, I completed an exit conference with Licensee Designee Princess Kennedy regarding the above allegation. Mrs. Kennedy stated she does not have anything to add to this report.

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.

	<p>(ii) The alternatives to discharge that have been attempted by the licensee.</p> <p>(iii) The location to which the resident will be discharged, if known.</p> <p>(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:</p> <p>(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.</p> <p>(ii) The resident shall have the right to file a complaint with the department.</p> <p>(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.</p>
ANALYSIS:	<p>Licensee Designee- Princess Kennedy acknowledged that her staff did not pick up Resident A from the hospital. This was because the licensee had already submitted an emergency discharge notice for Resident A to the Walter Reuther social worker and community mental health provider prior to him being discharged from the hospital.</p> <p>Home Manager Crystal Epps stated because Resident A was not medically stable and an emergency discharge was submitted, staff did not pick up Resident A from the hospital.</p> <p>Resident A's emergency discharge request indicates Resident A's current location as Beaumont Hospital. Therefore, Mrs. Kennedy did not wait until an appropriate setting that meets the resident's immediate needs is located prior to discharge.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Shatonla Daniel

09/24/2021

Shatonla Daniel
Licensing Consultant

Date

Approved By:

Jerry Hendrick

09/27/2021

Jerry Hendrick
Area Manager

Date