GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 2, 2022

Princess Kennedy
Asanpee Care
PO Box 871665
Canton, MI 48187

RE: License #: AS820369149
Investigation #: 2022A0992016
Stephanny 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.

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,

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 #:	AS820369149
Investigation #:	2022A0992016
Complaint Receipt Date:	03/02/2022
Investigation Initiation Date:	03/03/2022
Report Due Date:	05/01/2022
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:	Stephanny Home
Facility Address:	31529 Warren Road Garden City, MI 48135
Facility Telephone #:	(313) 522-9587
Original Issuance Date:	11/25/2015
License Status:	REGULAR
Effective Date:	04/21/2021
Expiration Date:	04/20/2023
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 3/1/2022, police dispatched to the home regarding Resident A's altercation with Kinleyia Huddleston, direct care staff. The police are frequently called to the home for difficulties with residents. Concerned the facility is understaffed.	Yes

III. METHODOLOGY

03/02/2022	Special Investigation Intake 2022A0992016
03/03/2022	Special Investigation Initiated - On Site Princess Kennedy, licensee designee; Residents B-E
03/03/2022	APS Referral
03/17/2022	Contact - Telephone call made Kinleyia Huddleston, direct care staff, not available. Per the automated services, the number dialed is temporarily unavailable.
03/23/2022	Contact - Telephone call made Ms. Huddleston, direct care staff, not available. Per the automated services, the number dialed is temporarily unavailable.
04/15/2022	Contact - Telephone call made Ms. Huddleston, direct care staff, not available. Per the automated services, the number dialed is temporarily unavailable.
04/15/2022	Contact - Telephone call made Michigan Guardian Services, no answer. Message left.
04/21/2022	Contact - Telephone call made Monica Hernandez, Resident A's guardian with Michigan Guardian Services.
04/21/2022	Contact - Telephone call made Complainant

04/21/2022	Contact - Document Sent Records request submitted to Garden City Police Department
04/25/2022	Contact - Document Received Police report
04/28/2022	Contact - Telephone call made Ms. Huddleston
04/28/2022	Exit Conference Ms. Kennedy

ALLEGATION: On 3/1/2022, police dispatched to the home regarding an altercation between Resident A and Kinleyia Huddleston, direct care staff. The police are frequently called to the home for difficulties with residents. Concerned the facility is understaffed.

INVESTIGATION:

On 03/03/2022, I completed an unannounced onsite and interviewed Princess Kennedy, licensee designee and Residents B-E regarding the allegations. Ms. Kennedy said she was not present when the incident occurred. However, she said from what she understands, Kinleyia Huddleston, direct care staff was on the telephone and asked Resident A to turn the television down and he refused. She said Ms. Huddleston asked him again and he refused, so she asked him for the remote, but he didn't comply. Ms. Kennedy said Ms. Huddleston unplugged the television and Resident A became enraged. She said he threw the remote at the wall and broke it; grabbed Ms. Huddleston in a bear hug and refused to let her go. Ms. Kennedy said somehow, Ms. Huddleston was able to get a loose and call the police. I asked Ms. Kennedy if there is some reason why Resident A can't have the remote. She explained that Resident A tends to turn the television/radio up extremely loud. She said he turns the television/radio up to a point you can't hear the telephone; you can't hear someone knocking at the door and it's very disruptive to the other residents. She said he's never really attack any of the other staff before, but he tries to intimidate them. She said she's aware that the other residents aren't comfortable when he's around and they don't feel safe; she said she has issued a discharge. She said Resident A remains hospitalized. However, she has been in contact with Detroit Wayne Integrated Health Network (DWIHN) regarding his discharge and securing placement.

I interviewed Resident B. He said on the day in question, Resident A had been in the living room for four hours listening to the television and it was loud. He said when the incident happened, he was in his bedroom, but he could hear the commotion going

on in the living room. He said he heard Ms. Huddleston yell out for him saying, “Get him off of me.” Resident B said he went in the living room and Resident A had Ms. Huddleston in a bear hug. Resident B said he told Resident A to let her go and he did. He said Ms. Huddleston ran behind the desk and Resident A grabbed her again. He said Resident A eventually let her go. Resident B said Ms. Huddleston was obviously scared. He said Resident A is always threatening people and trying to intimidate others. Resident B said he would feel at peace if Resident A moved out of the home. He said the staff cannot handle him which puts him and the other residents at risk. Resident B said Resident A has assaulted other staff in the past.

I attempted to interview Resident C regarding the allegations. He said Resident A was listening to the television loudly and he attacked Ms. Huddleston. I asked why Resident A attacked Ms. Huddleston and he said because he was listening to the television. I asked him if he actually witnessed Resident A attack Ms. Huddleston and he said yes. I asked him to walk me through what happened, and he said he saw him grab her. He said Resident A was listening to the television. Resident C was unable to provide any additional details regarding the altercation. He kept repeating himself.

I attempted to interview Resident D privately, but he shares a room with Resident E and agreed for Resident E to remain present during the interview. Resident D said he witnessed some of the incident. He said he saw Resident A grab Ms. Huddleston and he wouldn’t let her go. He said Ms. Huddleston was screaming and scared. He said he and Resident B helped her get a loose, but from what he understands, Resident A grabbed her again, but he didn’t see it. Resident D said Resident A is very aggressive towards women and he likes to intimidate people. He said the police have been to the home before because of Resident A. Resident D and E said Resident A makes them feel uncomfortable.

I also reviewed Residents A-E’s assessment plans/individual plan of services/treatment plans to determine if any of the residents require additional staffing such as 1:1 staffing. Based on the documents reviewed, Residents A-E do not require additional staffing.

On 04/21/2022, I contacted Monica Hernandez, Resident A's guardian with Michigan Guardian Services regarding the allegations. Ms. Hernandez acknowledged having some knowledge of the allegations. She said she’s aware Resident A pushed a staff. She said following that incident he was hospitalized and has been placed in several different facilities since then. She said currently he is in a shelter. She said it’s very difficult to find placement for him due to his behavior. I asked her if he requires 1:1 staffing when he is in placement, and she was unsure. She said at one point he was going to Team Wellness, but he never stays in a home long enough to receive case management services from a community mental health provider.

On 04/21/2022, I contacted the Complainant regarding the reported allegations. The Complainant stated a call was received regarding threatening behaviors at the home

and policed were dispatched to the home. Upon arrival Ms. Huddleston was interviewed and stated she was physically attacked by Resident A. Ms. Huddleston's shoulder was injured during the altercation, so emergency medical services (EMS) were dispatched. The Complainant said he waited until Ms. Kennedy arrived to supervise the other residents before Resident A was transported to the hospital and petitioned. The Complainant said Ms. Huddleston stated the home was understaffed, so as a result a complaint was filed to determine if there was adequate supervision.

On 04/25/2022, I received a copy of the police report. According to the police report, there was an altercation between Ms. Huddleston and Resident A. It was reported that "[Resident A] grabbed Ms. Huddleston in a bear hug and threw her to the ground where she hit her shoulder on the couch. After [Resident A] let go, Ms. Huddleston ran outside to her vehicle and waited for Garden City Police Department. Resident A is diagnosed with schizophrenia and is legally incapacitated."

Based on the police report, Ms. Huddleston ran outside to her vehicle and waited for Garden City Police Department, leaving the residents without proper supervision.

On 04/28/2022, I contacted Ms. Huddleston and interviewed her regarding the allegations. Ms. Huddleston said she arrived on shift and Resident A had the remote to the television in the living room; she said he's not supposed to have it. I asked her why he's not allowed to have the remote, she said Resident A tends to turn the radio up as high as it will go and listen to his music. Since he couldn't listen to it at a respectable level without disturbing the other residents, the radio was removed from his room. She said Ms. Kennedy found a music station that he can listen to on the television in the living room, so staff will turn it on and keep the remote because if he has the remote, he's going to turn it up as loud as it will go as well. She said she did her normal rounds in the home, checking on the residents and then she went to the bathroom. Ms. Huddleston said when she came out the bathroom, Resident A had turned the television up extremely loud. She said she asked for the remote and he said no, and he agreed to turn it down, but he didn't. She said she started reviewing paperwork and then it was time to administer medications, so she asked him for the remote again and he said no. She said she tried to rationalize with him and explained that she needed to pass medications and would allow him to listen to music when she's finished but he refused; she said she told him that she can easily unplug the television. Ms. Huddleston said Resident A did not turn the television down, so she unplugged it. She said he became angry and threw the remote at the wall near her and broke the remote. Ms. Huddleston said she tried to call Ms. Kennedy but Resident A took the telephone and said nobody can use the telephone. She said he called the police and said people in the home are bothering him; Ms. Huddleston said she could hear the dispatcher trying to calm him down. Ms. Huddleston said she tried to call Ms. Kennedy on her personal cell phone and Resident A pushed everything off the desk onto the floor. She said he walked outside and was yelling. She said when he came back in, he said, "Bet no one close this door." Ms. Huddleston said it was winter, so it was cold in the home, so she closed the door. She said when she turned around, he grabbed her in a bear hug

and wouldn’t let her go. Ms. Huddleston said she was wiggling trying to grab her cell phone and ended up dropping it on the floor and they both fell. She said while they were on the floor, he still had a grip on her. She said as they got up, he came behind her and bear hugged her and refused to let her go. Ms. Huddleston said she yelled out for Resident B asking him to come help her. She said Resident B came out his room and she asked him to grab her cell phone and call the police. She said when she said that Resident A let her go. She said she grabbed her cell phone and ran to her car. Ms. Huddleston said she called the police and sat in her car until they arrived, which was anywhere from 7-10 minutes. She said she was the only staff on shift. Ms. Huddleston said when the police arrived, they contacted EMS because she injured her shoulder and Resident A was going to be transported to the hospital, but they had to wait for Ms. Kennedy to arrived. Ms. Huddleston said she ran out of the house because she was attacked and felt threatened by Resident A. She said she’s no longer employed at the home.

On 04/28/2022, I contacted Ms. Kennedy and conducted an exit conference. I explained that during the investigation, it was brought to my attention that Ms. Huddleston ran out of the home leaving the residents in the home unsupervised. I also informed her that Ms. Huddleston didn’t act appropriately to the situation and as a result, the allegation is substantiated.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	During this investigation I interviewed Princess Kennedy, licensee designee; Kinleyia Huddleston, direct care staff; Monica Hernandez, Resident A's Guardian and Residents B-E regarding the allegations. Kinleyia Huddleston, direct care staff stated she ran out of the house because she was attacked and felt threatened by Resident A. I reviewed Residents A- E adult foster care assessments plans, individual plan of service and/or treatment plan. Although their adult foster care assessments plans, individual plan of service and/or treatment plan doesn't specify 1:1 staffing or supervision regarding their ability to be in the community independently, it does specific 24 -hour adult foster care including protection, supervision and personal care. Based on the investigative findings, there is sufficient evidence to support the allegations that Kinleyia Huddleston did not provide the supervision, as specified in the resident's assessment plan. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: (b) Be capable of appropriately handling emergency situations.

ANALYSIS:	During this investigation I interviewed Princess Kennedy, licensee designee; Kinleyia Huddleston, direct care staff; Monica Hernandez, Resident A's Guardian and Residents B-E regarding the allegations. Kinleyia Huddleston, direct care staff stated she ran out of the house because she was attacked and felt threatened by Resident A. Based on the investigative findings, there is sufficient evidence to support the allegations that Kinleyia Huddleston did not appropriately handle the situation. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

4/28/2022

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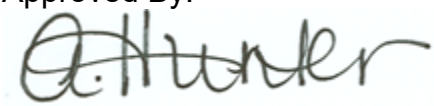
Denasha Walker Date
Licensing Consultant

Approved By:



5/2/2022

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Ardra Hunter Date
Area Manager