GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 5, 2022

Mattie Pearson
Safe Haven DHC, LLC
P.O. Box 141
Grand Blanc, MI 48480

RE: License #:	AS250405691
Investigation #:	2023A0872005
	Safe Haven AFC

Dear Ms. Pearson:

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 (517) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250405691
Investigation #:	2023A0872005
Complaint Receipt Date:	10/27/2022
Investigation Initiation Date:	10/27/2022
Report Due Date:	12/26/2022
Licensee Name:	Safe Haven DHC, LLC
Licensee Address:	3429 Barth Street Flint, MI 48504
Licensee Telephone #:	(810) 845-9170
Administrator:	Trina Townsend
Licensee Designee:	Mattie Pearson
Name of Facility:	Safe Haven AFC
Facility Address:	3429 Barth Street Flint, MI 48504
Facility Telephone #:	(810) 845-9170
Original Issuance Date:	04/26/2021
License Status:	REGULAR
Effective Date:	10/26/2021
Expiration Date:	10/25/2023
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 10/25/22, Resident A tried to commit suicide by stepping into the street. Staff pulled her out of the street to save her from being hit by a car. Resident A's face hit the cement and she has injuries as a result of the incident.	No
On 10/25/22, Resident A attempted suicide and received injuries from falling to the ground. Staff did not seek medical attention for her until the next day.	Yes
On 10/28/22, Resident B requested medical care but was not taken to the hospital.	No

III. METHODOLOGY

10/27/2022	Special Investigation Intake 2023A0872005
10/27/2022	Special Investigation Initiated - On Site Unannounced
11/01/2022	Inspection Completed On-site Unannounced
11/01/2022	Contact - Document Sent I emailed the licensee designee requesting information related to this complaint
11/02/2022	Contact - Document Received I received AFC documentation from Ms. Pearson
11/22/2022	APS Referral Janeen Rouse is the APS worker
11/29/2022	Contact - Document Sent I exchanged emails with the APS worker investigating the allegations regarding Resident B, Tiffany Williams
12/02/2022	Contact - Telephone call received I interviewed the licensee designee, Mattie Pearson
12/02/2022	Contact - Telephone call made

	I interviewed staff, Tamaria Jones
12/02/2022	Contact - Telephone call made I interviewed staff Deasha Darrough
12/02/2022	Exit Conference I conducted an exit conference with the licensee designee, Mattie Pearson
12/02/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 10/25/22, Resident A tried to commit suicide by stepping into the street. Staff pulled her out of the street to save her from being hit by a car. Resident A's face hit the cement and she has injuries as a result of the incident.

INVESTIGATION: On 10/27/22, I conducted an unannounced onsite inspection of Safe Haven Adult Foster Care facility and interviewed Resident A. According to Resident A, on the evening of 10/25/22, she told staff that she wanted to go for a walk. Resident A said that her one-on-one staff, Tamiria Jones went with her. According to Resident A, at the beginning of the walk, she was walking, and Ms. Jones was following her in the van. Ms. Jones pulled the van into the church parking lot, parked it, and began walking with Resident A.

Resident A told me that she and Ms. Jones came up to a corner and, "I stepped out in the road trying to get hit by a car." According to Resident A, Ms. Jones grabbed her by the shirt, pulling her out of the road. Resident A said that she fell to the ground, injuring her hands and her face. I asked Resident A if Ms. Jones said anything to her and she said that Ms. Jones yelled, "I'm trying to save you!" Resident A said that she is angry because Ms. Jones pulled her out of the road and is upset because she received injuries from the incident. Resident A showed me some marks on her hands from trying to brace herself when she fell to the sidewalk. Resident A also showed me marks/bruises on the left side of her face, including her eye, nose, and lip and her forehead. Resident A told me that she received these injuries when Ms. Jones pulled her to the ground. I asked her if Ms. Jones deliberately harmed her in any way and she said no but said that she does not think Ms. Jones had the right to grab her and pull her out of the road.

On 12/02/22, I interviewed staff Tamaria Jones via telephone. Ms. Jones confirmed that on 10/25/22, Resident A was upset. Resident A began putting her shoes on, so Ms. Jones followed her in the facility van. At one point, Ms. Jones pulled the van over into a church parking lot and began walking with Resident A. Ms. Jones said that she knew Resident A was upset so she walked in front of her. When they approached the intersection of Mackin Rd. and Ballenger Highway, the light was red. When the light turned green, Resident A "tried to bum rush me and run into the road." Ms. Jones said that she tried to grab Resident A's arm to stop her from entering the road but instead

grabbed her shirt. Resident A fell back, tripped over Ms. Jones feet and both of them fell to the ground. Ms. Jones confirmed that Resident A received injuries to her face and hands from the incident. Ms. Jones told me that she did not hurt Resident A deliberately and was simply trying to save her from being hit by a car. Ms. Jones told me that Resident A was very angry after the incident, she was cussing at Ms. Jones and yelling at her, telling her that she should not have pulled her out of the road.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	Rule 308. (1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	On 10/25/22, Resident A tried to run into the road, in an attempt to be hit by a car. Resident A said that staff Tamaria Jones grabbed her by the shirt and pulled her out of the road, resulting in Resident A receiving marks, bruises, and injuries. Resident A said that she does not believe Ms. Jones intentionally hurt her but she does not believe she should have pulled her out of the road. Tamaria Jones confirmed that on 10/25/22, Resident A attempted suicide by trying to step into a busy road. Ms. Jones said that she tried to grab Resident A's arm but instead grabbed her by the shirt resulting in both of them falling to the ground. Ms. Jones said that she did not intentionally harm Resident A, she was trying to save her life. I conclude that there is insufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **On 10/25/22, Resident A attempted suicide and received injuries from falling to the ground. Staff did not seek medical attention for her until the next day.**
- **On 10/28/22, Resident B requested medical care but was not taken to the hospital.**

INVESTIGATION: On 10/27/22, I interviewed Resident A at Safe Haven AFC. According to Resident A, on 10/25/22 she did attempt suicide by trying to run into the road, but staff Tamaria Jones stopped her. Resident A said that after the incident, she got in the van and went back to Save Haven AFC. She said that one of the other staff, Tiana Horton applied first aid to her injuries and Resident A then went to bed. Resident A told me that she did not ask to go to the hospital and staff never offered to take her. She said that she never lost consciousness and the first aid did help her wounds. Resident A said that the next day, she was having suicidal thoughts and the licensee designee, Mattie Pearson, asked her if she wanted to go to the hospital. Resident A said that she told Ms. Pearson, "Yes" at which time Resident A was transported to the hospital and had a psychiatric evaluation. Resident A said that while at the hospital, nurses examined her wounds but did not take any x-rays. She was not admitted due to medical or psychiatric reasons, and she returned to Safe Haven later that night.

I reviewed an Incident/Accident Report (IR) dated 10/26/22 at 9:00am. According to the IR, "(Resident A) was having suicidal thoughts and requested to go to the hospital." Staff called an ambulance and Resident A was transported to the hospital. The corrective measures taken were, "Talking to social work & staff to ease the thoughts. Took her Ativan to help as well."

On 11/02/22, I received AFC documentation related to this complaint. According to Resident A's Health Care Appraisal, she is diagnosed with prediabetes and hypertension. According to her Assessment Plan, she suffers from flashbacks and hallucinations which causes disorientation. She becomes nervous and anxious "out of the blue." Resident A exhibits self-injurious behaviors and "prefers to have knives and razor blades put up. Crying signals a desire to self-harm."

Resident A's Genesee Health System's Individualized Plan of Service (IPOS) dated 12/14/21 states that she is diagnosed with schizoaffective disorder, bipolar type, borderline personality disorder, and posttraumatic stress disorder. She has an extensive history of hospitalizations and self-harm. Resident A also has a history of verbalizing the desire to commit suicide via "overdosing, trying to run into traffic, hanging self, etc." On 09/27/22, Resident A was given 1-on-1 staffing to reduce her risk of self-harm. Staff is to keep Resident A in their line of sight when she is using items or devices that she could use for self-harm or attempt suicide. When Resident A is agitated or exhibiting problematic behaviors, staff will assist her with positive coping skills. "If the behaviors reach a point that caregivers do not feel safe and/or (she) has hurt herself or others, then caregivers will call 911 and follow the house rules/guidelines."

On 12/02/22, I interviewed the licensee designee, Mattie Pearson via telephone. Ms. Pearson confirmed that on 10/25/22, Resident A attempted suicide by trying to run into a busy road. Staff Tamaria Jones intervened, and Resident A fell, receiving injuries to her hands and face. When they returned to the AFC facility, staff asked Resident A on multiple occasions if she would go to the hospital, but she refused. Ms. Pearson said that she also spoke to Resident A via telephone and asked her to go to the hospital, but Resident A refused. Ms. Pearson said that neither she nor staff called 911 because

Resident A was refusing treatment. According to Ms. Pearson, on the morning of 10/26/22, Resident A finally agreed to go to the hospital. She was transported to the hospital, treated for her injuries, assessed for suicidal ideation, and was released to the AFC home.

Ms. Pearson told me that Resident A has an extensive history of self-harm and suicide attempts. She said that she and staff have worked diligently to help her, but her maladaptive behaviors continue. Ms. Pearson said that two of her staff have quit because they were afraid that Resident A was going to hurt herself or them. Resident A is also on 1-on-1 supervision. As a result of these issues, Ms. Pearson provided Resident A and her case manager with a 30-day discharge notice on 11/02/22.

On 12/02/22, I interviewed staff Tamaria Jones via telephone. Ms. Jones confirmed that Resident A attempted suicide by trying to run into a busy road on 10/25/22. According to Ms. Jones, Resident A received some injuries from falling to the ground. When they returned to the AFC home after the incident, another staff gave Resident A a wet towel to clean herself up and applied antibiotic ointment to her injuries. Ms. Jones said that she and other staff continually asked Resident A to go to the hospital, but Resident A refused. Ms. Jones said that the licensee designee, Mattie Pearson also called Resident A and asked her to go to the hospital, but Resident A refused. The next morning, on 10/26/22, Resident A asked to go to the hospital, so staff made arrangements for her to go. She was treated and released back to the home. I asked Ms. Jones if she or any other staff contacted 911 after the initial incident on 10/25/22 and she said no.

On 11/01/22, I conducted another unannounced onsite inspection of Safe Haven AFC, and I interviewed Resident B. Resident B told me that he has lived at this facility for a couple of weeks. He said that a few days ago, he was feeling “suicidal”, so he asked staff, “Dee Dee” (Deasha Darrough) to take him to the hospital. He said that Ms. Darrough suggested he call the Community Mental Health crisis line before going to the hospital and he agreed. Resident B said that he talked to a crisis counselor and when he hung up, he told staff that he did not want to go to the hospital.

According to Resident B, he is diagnosed with anxiety and depression. He said that he is on medications, and he has been psychiatrically hospitalized approximately 6 times in the past year. Resident B said that he and his therapist are working on ways for him to stay out of the hospital and remain in AFC care.

I asked Resident B if staff refused any other type of medical attention for him and he said, “No.” Resident B said that he last saw his primary care physician a couple of months ago and said that he receives ongoing treatment with a therapist. Resident B was upset that a complaint was made against this facility and told me that “Staff takes good care of me. I don’t know why someone would make a complaint.” Resident B said that staff never denied him medical or psychiatric treatment and he has since talked with his case manager about his thoughts. Resident B told me that he is not “actively suicidal” and said that the thoughts “come and go.”

On 11/02/22, I received AFC documentation related to this complaint. According to Resident B's Health Care Appraisal (HCA), he is diagnosed with mixed hyperlipidemia, hyperglycemia, and some mental health diagnoses that were indecipherable on the form. According to the medication list attached to his HCA, he is on the following psychotropic medications: Buspar, Lexapro, Lithium Carbonate, and Desyrel.

According to Resident B's Gratiot Integrated IPOS dated 10/18/22, "(He) will call crisis and/or talk to staff, call case manager when he is having suicidal thoughts. (He) will attempt to utilize coping skills that he has learned when having suicidal thoughts, if these do not work, (he) will utilize his supports and treatment team." Resident A does not require 1-on-1 or enhanced supervision. Resident B's Assessment Plan states that he does not have a history of self-injurious behavior but did attempt to cut himself with a razor blade 3 years ago.

On 11/29/22, I exchanged emails with Adult Protective Services Worker, Tiffany Williams. Ms. Williams said that she completed her investigation and did not substantiate abuse or neglect of Resident B.

On 12/02/22, I interviewed staff Deasha Darrough via telephone. Ms. Darrough said that on 10/28/22, Resident B told her that he was upset, and he wanted to go to the hospital. Ms. Darrough said that she suggested he contact the crisis line first. Ms. Darrough said that she told Resident B that if he still wants to go to the hospital after talking with a crisis counselor, he will have to wait for 2nd shift staff to come on shift so there is someone available to take him. According to Ms. Darrough, Resident B got done talking to the crisis line and said he did not want to go to the hospital. Ms. Darrough said that at no time did she refuse to seek medical attention for Resident B. She said that when he asked to go to the hospital, he was not in distress and was not actively suicidal.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
ANALYSIS:	**(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.**
ANALYSIS:	On 10/25/22, Resident A tried to commit suicide by running into the road. Staff Tamaria Jones intervened and stopped her. Resident A sustained injuries to her face and hands. Resident A, staff Tamaria Jones, and the licensee designee Mattie Pearson said that staff did not call 911 and/or send Resident A to the hospital after this incident. Ms. Jones and Ms. Pearson said that they repeatedly asked Resident A if she wanted to go to the hospital, but she kept refusing. On the morning of 10/26/22, Resident A eventually agreed to go to the hospital at which time she was treated and released.

	I conclude that staff did not seek immediate medical attention for Resident A after her suicide attempt on 10/25/22 which is a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
ANALYSIS:	**(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.**
ANALYSIS:	On 10/28/22, Resident B told staff, Deasha Darrough that he wanted to go to the hospital. Ms. Darrough suggested he first call the CMH crisis line. Resident B said that after calling the crisis line, he decided he did not want to go to the hospital. Resident B and Ms. Darrough said that at no time did Ms. Darrough refuse to allow Resident B to seek medical treatment. The APS Worker, Tiffany Williams said that she concluded her investigation and did not substantiate any abuse or neglect regarding Resident B. I conclude that there is insufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 12/02/22, I conducted an exit conference with the licensee designee, Mattie Pearson, via telephone. I discussed the results of my investigation and explained which rule violation I am substantiating. Ms. Pearson agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

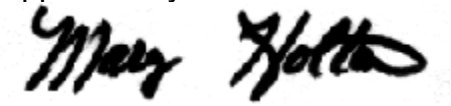
IV. RECOMMENDATION

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

December 5, 2022

Susan Hutchinson Licensing Consultant	Date

Approved By:



December 5, 2022

Mary E. Holton Area Manager	Date