GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 29, 2023

Ateria Young
Infinity Care LLC
P.O. Box 40658
Redford, MI 48240

RE: License #: AS820369788
Investigation #: 2024A0119002
Garfield House

Dear Ms. Young:

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,

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 #:	AS820369788
Investigation #:	2024A0119002
Complaint Receipt Date:	10/03/2023
Investigation Initiation Date:	10/05/2023
Report Due Date:	12/02/2023
Licensee Name:	Infinity Care LLC
Licensee Address:	P.O. Box 40658 Redford, MI 48240
Licensee Telephone #:	(313) 516-7947
Administrator:	Ateria Young
Licensee Designee:	Ateria Young
Name of Facility:	Garfield House
Facility Address:	14175 Garfield Redford, MI 48239
Facility Telephone #:	(313) 766-4281
Original Issuance Date:	07/02/2015
License **Status:**	REGULAR
Effective Date:	07/02/2022
Expiration Date:	07/01/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 09/15/2023, Staff- Natasha Simpson refused to transport Resident A to a local hospital for emergency care despite her asking for help.	No
Additional Findings	Yes

III. METHODOLOGY

10/03/2023	Special Investigation Intake 2024A0119002
10/05/2023	Special Investigation Initiated - Telephone Licensee Designee/ Administrator- Ateria Young
10/10/2023	Inspection Completed On-site Staff- Natasha Simpson
11/27/2023	Referral- Recipient Rights Made
11/27/2023	Contact Documents Received Resident A's IPOS, Written Assessment Plan, hospital discharge, and incident report
11/27/2023	Exit Conference- Licensee Designee- Arteria Young

ALLEGATION:

On 09/15/2023, Staff- Natasha Simpson refused to transport Resident A to a local hospital for emergency care despite her asking for help.

INVESTIGATION:

On 10/05/2023, I telephoned and interviewed Licensee Designee/ Administrator- Ateria Young regarding the above allegations. Ms. Young stated Resident A was a previous resident to the facility. She stated Resident A has a history of repeatedly calling the police and/or emergency medical services for help without notifying staff.

Ms. Young stated Resident A was in the home for a week and had contacted the emergency medical services and the police four times. She stated the Staff- Natasha Simpson was not able to take Resident A immediately to the hospital because she was the only staff working at the time in the facility. Ms. Young stated Resident A was transported and discharged from the hospital on the same day. However, Ms. Young stated since that incident Resident A was again taken by staff to the hospital emergency room and she was petitioned for admission due to her mental health needs and is no longer in the facility. Ms. Young stated Resident A has learned all of the appropriate language to trigger a response from the police and emergency medical services for hospital admission.

On 10/10/2023, I completed an onsite inspection and interviewed Staff- Natasha Simpson regarding the above allegations. Ms. Simpson stated the police officer wanted her to follow him to the hospital's emergency room for Resident A. She stated Resident A had contacted the police and expressed she wanted to go the hospital. Ms. Simpson stated she was the only staff working in the home and was unable to follow behind the police officer at that time. She stated she explained to the police officer that she had three other residents in the facility. Ms. Simpson stated she was instructed by Ms. Young to transport the other residents to another facility before transporting Resident A to the emergency room. Ms. Simpson stated she complied with those directions. She stated this is the procedure when the resident does not need immediate medical assistance. Ms. Simpson stated Resident A was later transported to the local hospital and then she was released back into the home on the same day. Ms. Simpson stated since this incident Resident A was later admitted into the hospital and has not returned to the facility.

On 11/27/2023, I received Resident A's emergency room discharge paperwork dated 09/15/2023 and she was treated for suicidal ideation. I received Resident A's individual plan of service which indicated Resident A has treatment goals to stay out of the hospital, will alert staff when she is having violent thoughts and feelings, resolve conflict safely, and avoid self-harm behaviors. I received an incident report dated 09/15/2023 that was completed by Staff- Natasha Simpson which indicated Resident A was transported to the hospital due to wanting to harm herself. I also received Resident A's written assessment plan dated 09/13/2023, which indicated Resident A has a history of exhibiting self-injurious behavior and will contact the police and emergency personnel services for suicidal ideations.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: (a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.

	(b) Be capable of appropriately handling emergency situations.
ANAYLSIS:	Licensee Designee/ Administrator- Ateria Young stated Resident A has a history of repeatedly calling the police and/or emergency medical services for help without notifying staff. She stated the Staff- Natasha Simpson was not able to take Resident A immediately to the hospital because she was the only staff working at the time in the facility. Ms. Young stated Resident A was later transported and discharged from the hospital on the same day. Staff- Natasha Simpson stated she was the only staff working in the home and was unable to follow behind the police officer immediately for Resident A to be seen at the hospital. Ms. Simpson stated Resident A was later transported to the local hospital and then she was released back into the home the same day. On 11/27/2023, I received Resident A's emergency room discharge paperwork dated 09/15/2023 and She was treated for suicidal ideation. I received an incident report dated 09/15/2023 and completed by Staff- Natasha Simpson which indicated Resident A was transported to the hospital due to wanting to harm herself. Therefore, Staff- Natasha Simpson acted suitable and adequately handled the emergency situation with Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/05/2023, I telephoned and interviewed Licensee Designee/ Administrator- Ateria Young regarding the above allegations. She stated the Staff- Natasha Simpson she was the only staff working at the time of incident.

On 10/10/2023, I completed an onsite inspection and interviewed Staff- Natasha Simpson regarding the above allegations. Ms. Simpson stated she was the only staff working in the home on 09/15/2023.

On 11/27/2023, I received Resident A's individual plan of service dated 05/04/2023 from Hegira Health Services. Resident A's individual plan of service indicated she

would receive 1:1 care due to her needed assistance with managing strong emotions, increased self-soothing and reduced anxiety; as evidenced by problem solving, a reduction of verbal and physical outbursts, willingness to be redirected to self-care, shower, take medications, and be a cooperative team player in her recovery.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANAYLSIS:	Licensee Designee/ Administrator- Ateria Young and Staff- Natasha Simpson stated the Ms. Simpson she was the only staff working on at the time of incident. On 11/27/2023, I received Resident A's individual plan of service dated 05/04/2023 from Hegira Health Services. Resident A's individual plan of service indicated she would receive 1:1 care due to her needed assistance with managing her care needs. Based on the above information, Resident A was not provided with 1:1 staffing at the time of in the incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

11/28/2023

Shatonla Daniel Date
Licensing Consultant

Approved By:

11/29/2023

Ardra Hunter Date
Area Manager