GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 14, 2024

Colleena James
Angel Patient Inc.
12601 East Outerdrive
Detroit, MI 48224

RE: License #: AS820388228
Investigation #: 2024A0901014
ANGEL PATIENCE

Dear Colleena James:

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,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820388228
Investigation #:	2024A0901014
Complaint Receipt Date:	12/21/2023
Investigation Initiation Date:	12/21/2023
Report Due Date:	02/19/2024
Licensee Name:	Angel Patient Inc.
Licensee Address:	12601 East Outerdrive Detroit, MI 48224
Licensee Telephone #:	(313) 926-6609
Administrator:	Colleena James
Licensee Designee:	Colleena James
Name of Facility:	ANGEL PATIENCE
Facility Address:	12601 EAST OUTERDRIVE DETROIT, MI 48224
Facility Telephone #:	(313) 926-6609
Original Issuance Date:	08/08/2018
License Status:	REGULAR
Effective Date:	08/08/2023
Expiration Date:	08/07/2025
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A requires 2:1 supervision and was able to leave the home without staff knowing.	Yes

III. METHODOLOGY

12/21/2023	Special Investigation Intake 2024A0901014
12/21/2023	Special Investigation Initiated - Telephone Colleena James, Licensee Designee
12/21/2023	Document Received Email
12/21/2023	Referral - Recipient Rights
12/21/2023	APS Referral
01/04/2024	Contact - Telephone call made Staff, Charles Bryant
01/04/2024	Contact - Telephone call made Staff, Nikia Bryant
01/05/2024	Contact - Telephone call received Staff, Nikia Bryant
02/14/2024	Contact - Telephone call made Resident A's Guardian
02/14/2024	Exit Conference Colleena James, Licensee Designee
02/14/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A requires 2:1 supervision and was able to leave the home without staff knowing.

INVESTIGATION:

On 12/21/2023, I made a telephone call to the licensee designee, Colleena James. Colleena confirmed the incident occurred and expressed disappointment in her staff for allowing it to happen. Colleena stated everyone is aware that Resident A requires 2:1 supervision and should never be left alone. It was explained that during the time of the incident one staff was in the bathroom and the other one was in the kitchen. Resident A left the facility without anyone knowing and was picked up by police. She was taken to the hospital and examined and returned to the home. The 2 staff involved were Nikia Bryant and Charles Bryant. One of them was suspended and both are being retrained.

On 12/21/2023, Colleena emailed me a copy of the incident reports. There were 2 incident reports, one competed by each staff member. They were dated for 12/19/2023 at 7:10 p.m. and documented the same details. The incident reports indicated that Resident A was in her room pacing. She stated she was going to bed and laid down. Staff left her in her room while she was resting. Ten minutes later it was noticed she was gone. The manager was notified by police that they had her, and she was taken for examination.

On 01/04/2024, I made a telephone call to Charles and left a voice message, but the call was not returned.

On 01/04/2024, I made a telephone call to Nikia and left a voice message. The call was returned on 01/05/2024. Nikia confirmed the allegations. It was reported that Resident A was in her bedroom. Nikia was with her but left to go in the basement. Nikia told Charles and another staff, who were in the kitchen. It was assumed that they would monitor Resident A but when Nikia returned to Resident A's room, she was gone. Before a police report could be made, the home manger called stating the police had her. It was approximately 20 minutes from the time Resident A left until they were contacted by police.

On 02/14/2024, I made a telephone call to Resident A's guardian. The guardian confirmed Resident A requires 2:1 supervision and was aware of the incident. The guardian stated this was the first time something of this nature has occurred at the home. During the guardian's visits to the home, there was always appropriate staffing. The guardian had no other concerns.

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:	Based on the information obtained during this investigation, there was insufficient staffing at the time Resident A left the facility. Resident A requires 2:1 supervision and was left in her room unsupervised, resulting in her leaving the facility without staff knowing.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the license remains unchanged.

_________________________________ 02/14/2024

Regina Buchanan   Date
Licensing Consultant

Approved By:

_________________________________ 02/14/2024

Ardra Hunter   Date
Area Manager