



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

July 8, 2024

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

RE: License #: AS820369788  
**Garfield House**  
**14175 Garfield**  
**Redford, MI 48239**

Dear Ms. Young:

Attached is the Licensing Study Report for the above referenced facility. The study has determined substantial compliance with applicable licensing statutes and rules. Your license is renewed. It is valid only at your present address and is nontransferable.

Please contact me with any questions. In the event that I am not available and you need to speak to someone immediately, you may contact the local office at (313) 456-0380.

Sincerely,

A handwritten signature in cursive script that reads "LaKeitha Stevens".

LaKeitha Stevens, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Pl. Ste 9-100  
3026 W. Grand Blvd  
Detroit, MI 48202  
(313) 949-3055

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
BUREAU OF COMMUNITY AND HEALTH SYSTEMS  
RENEWAL INSPECTION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS820369788
<b>Licensee Name:</b>	Infinity Care LLC
<b>Licensee Address:</b>	P.O. Box 40658 Redford, MI 48240
<b>Licensee Telephone #:</b>	(313) 516-7947
<b>Licensee/Licensee Designee:</b>	Ateria Young
<b>Administrator:</b>	
<b>Name of Facility:</b>	Garfield House
<b>Facility Address:</b>	14175 Garfield Redford, MI 48239
<b>Facility Telephone #:</b>	(313) 766-4281
<b>Original Issuance Date:</b>	07/02/2015
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

## II. METHODS OF INSPECTION

Date of On-site Inspection(s): 06/27/2024

Date of Bureau of Fire Services Inspection if applicable:

Date of Health Authority Inspection if applicable:

No. of staff interviewed and/or observed 3

No. of residents interviewed and/or observed 2

No. of others interviewed N/A Role:

- Medication pass / simulated pass observed? Yes ☐ No ☒ If no, explain.  
A worksheet inspection was completed.
- Medication(s) and medication record(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident?  
Yes ☒ No ☐ If no, explain.
- Meal preparation / service observed? Yes ☐ No ☒ If no, explain.  
A full worksheet inspection was completed.
- Fire drills reviewed? Yes ☒ No ☐ If no, explain.
- Fire safety equipment and practices observed? Yes ☒ No ☐ If no, explain.
- E-scores reviewed? (Special Certification Only) Yes ☒ No ☐ N/A ☐  
If no, explain.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.
- Incident report follow-up? Yes ☐ No ☒ If no, explain.  
N/A
- Corrective action plan compliance verified? Yes ☐ CAP date/s and rule/s:  
N/A ☒
- Number of excluded employees followed-up? N/A ☒
- Variances? Yes ☐ (please explain) No ☐ N/A ☒

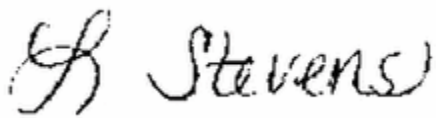
### III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was determined to be in substantial compliance with rules and requirements.

The facility is in compliance with all applicable rules and statutes.

### IV. RECOMMENDATION

I recommend issuance of a 2 year regular adult foster care license.

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

07/08/2024

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LaKeitha Stevens  
Licensing Consultant

Date