GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 4, 2019

Porchia Durant
Simply Beautiful AFC Homes
5685 Westpointe St.
Dearborn Heights, MI 48125

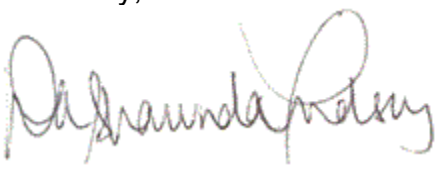
RE: License #: AS630397962
Investigation #: 2019A0993053
Simply Beautiful AFC Homes

Dear Ms. Durant:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (248) 975-5053.

Sincerely,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630397962
Investigation #:	2019A0993053
Complaint Receipt Date:	09/10/2019
Investigation Initiation Date:	09/10/2019
Report Due Date:	11/09/2019
Licensee Name:	Simply Beautiful AFC Homes
Licensee Address:	5685 Westpointe St. Dearborn Heights, MI 48125
Licensee Telephone #:	(248) 238-4084
Administrator:	Porchia Durant
Licensee Designee:	Porchia Durant
Name of Facility:	Simply Beautiful AFC Homes
Facility Address:	13206 Troy St Oak Park, MI 48237
Facility Telephone #:	(248) 238-4084
Original Issuance Date:	04/26/2019
License Status:	1ST PROVISIONAL
Effective Date:	09/11/2019
Expiration Date:	03/10/2020
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident C died unexpectedly.	No

III. METHODOLOGY

09/10/2019	Special Investigation Intake 2019A0993053
09/10/2019	Special Investigation Initiated - Telephone Telephone call received from licensee designee Porchia Durant
09/10/2019	Contact - Telephone call made Telephone call made to Resident C's guardian
09/10/2019	Inspection Completed On-site Conducted an announced onsite investigation
09/11/2019	Contact - Document Sent Requested a copy of the police report
09/11/2019	Contact - Document Received Received the incident report
09/11/2019	Contact - Document Received Received a copy of the police report
09/19/2019	Contact - Document Sent Requested a copy of the medical examiner report
09/19/2019	Contact - Telephone call made Telephone call made to staff Sandra Anthony
09/19/2019	Contact - Telephone call made Telephone call made to staff Veronica Jackson
10/03/2019	Contact - Telephone call made Followed up on the medical examiner's report request. Instructed to email the request to ocmeclerical@oakgov.com
10/03/2019	Contact - Document Sent Requested a copy of the medical examiner report

10/03/2019	Contact - Document Received Received a copy of the medical examiner report
10/03/2019	Exit Conference Exit conference with licensee designee Porchia Durant

ALLEGATION:

Resident C died unexpectedly.

INVESTIGATION:

On 09/10/2019, I received a telephone call from licensee designee Porchia Durant. She stated Resident C died unexpectedly in the facility. Resident C was admitted into the facility on 09/03/2019 around 10:00pm. He died on 09/06/2019 around 7:00pm. Ms. Durant denied any knowledge of medical or health concerns for Resident C. In addition, prior to his death, Resident C did not exhibit any unusual, alarming or concerning behaviors. When staff Sandra Anthony found Resident C unresponsive in his bedroom, she contacted 911. Oak Park Police Department and EMS came to the facility. Resident C was pronounced dead at the facility. Ms. Durant stated Ms. Anthony completed an incident report (IR) and forwarded it to the department.

On 09/10/2019, I conducted a telephone interview with Resident C's guardian. She verified Resident C died in the facility on 09/06/2019. Resident C's guardian stated EMS stated Resident C died from cardiac arrest or natural cause. Resident C's guardian stated Resident C was medically cleared and discharged from the hospital on 09/03/2019. On the same day, Resident C was admitted into the facility. Resident C's guardian stated she visited Resident C daily while he was in the facility. She did not have any concerns about the care Resident C received.

On 09/10/2019, I conducted an announced onsite investigation. I conducted a follow up interview with Ms. Durant. She stated she did not provide care to Resident C. She stated only staff Sandra Anthony and Veronica Jackson provided care to him. While at the facility, I reviewed Resident C's medication administration record (MAR). It appeared staff administered his medications to him as prescribed. Resident C's medications were not in the facility. Ms. Durant stated the police took Resident C's medications after he died.

On 09/11/2019, I reviewed a copy of the police report from Oak Park Police Department. Per the report, officers dispatched to the facility on 09/06/2019 due to a sudden death. Officers observed Resident C laying face down on his bedroom floor. Staff Sandra Anthony informed officers she last saw Resident C at 5:30pm. She discovered him not breathing at 7:40pm. Alliance Mobile Health arrived at the facility and began CPR at 7:50pm. Resident C was pronounced dead by Royal Oak Beaumont Dr. Gratson. Officers did not observe "any signs of foul play."

On 09/19/2019, I conducted a telephone interview with staff Sandra Anthony. She stated Resident C was admitted into the facility on or around 09/04/2019. He died on 09/06/2019. He did not exhibit any unusual, alarming or concerning behaviors. She did not have knowledge of medical or health concerns for Resident C. When she discovered Resident C unresponsive on 09/06/2019, she contacted 911. Oak Park Police Department and EMS arrived at the facility, performed CPR, and later pronounced Resident C dead.

On 09/19/2019, I conducted a telephone interview with staff Veronica Jackson. She stated Resident C was admitted into the facility on or around 09/04/2019. He died on 09/06/2019. He did not exhibit any unusual, alarming or concerning behaviors. She did not have knowledge of medical or health concerns for Resident C. She was not working during the time Resident C was discovered unresponsive in his bedroom.

On 10/03/2019, I reviewed a copy of the Oakland County medical examiner's report. Resident C died on 09/06/2019. The cause of death was arteriosclerotic heart disease. The manner of death was natural.

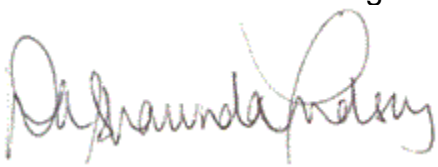
On 10/03/2019, I conducted an exit conference with licensee designee Porchia Durant. I informed her of the findings. She agreed with the findings.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident C was admitted into the facility on 09/03/2019. On 09/06,2019, Ms. Anthony discovered him unresponsive and called 911. Oak Park Police Department and EMS arrived at the facility. Resident C was pronounced death on 09/06/2019. Prior to his death, Resident C did not exhibit any unusual, alarming or concerning behaviors. The cause of death was arteriosclerotic heart disease. The manner of death was natural.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(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:	Resident C was admitted into the facility on 09/03/2019. On 09/06,2019, Ms. Anthony discovered him unresponsive and called 911. Oak Park Police Department and EMS arrived at the facility. Resident C was pronounced death on 09/06/2019. Prior to his death, Resident C did not exhibit any unusual, alarming or concerning behaviors. The cause of death was arteriosclerotic heart disease. The manner of death was natural.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

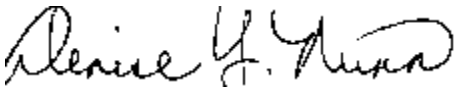
I recommend no change in the license status.



10/04/2019

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



10/04/2019

Denise Y. Nunn — Date
Area Manager